Services for Persons with Developmental Disabilities

Informational Paper 47

Wisconsin Legislative Fiscal Bureau

January, 2017

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Chapter 51 of the Wisconsin statutes defines a developmental disability as "a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to an intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual."

The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 created a somewhat different definition that applies to several federally-funded programs, including Medicaid. Under the Act, a developmental disability is defined as "a severe, chronic disability that is attributable to a mental or physical impairment or combination of impairments, is manifested before age 22, is likely to continue indefinitely, and requires a combination of individually planned and coordinated services, supports, or other forms of assistance of lifelong or extended duration." In addition, the disability must result in "substantial functional limitations in three or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; or (g) economic self-sufficiency."

State and county agencies administer several programs that support individuals with developmental disabilities in Wisconsin. Appendix I shows the total amount each county reported spending for county-administered programs that serve persons with developmental disabilities for calendar years 2011 through 2015. The expenditure totals include a combination of state, federal, and county funds, but do not include expenditures for programs not administered by counties, such as Family Care.

Most of the programs that provide long-term care services to people with developmental disabilities are provided as part of the state's Medicaid program. Consistent with federal policy and court decisions, Wisconsin has increasingly relied on Medicaid's home and community-based services (HCBS) waiver programs to serve this population outside of institutional settings. However, only individuals who meet the more restrictive federal definition of what constitutes a developmental disability are eligible for services provided under Medicaid's HCBS programs.

There are approximately 26,600 adults with developmental disabilities receiving one or more long-term services supported by the state's Medicaid long-term care programs. However, this number does not include Medicaid recipients with developmental disabilities who rely solely on Medicaid fee-for-service benefits for long-term care services, since these individuals are not required to complete a functional screen as part of their eligibility requirements.

This paper describes services available to individuals with developmental disabilities in Wisconsin that are provided through the state's Medicaid program, and other non-Medicaid services administered by the Department of Health Services (DHS) and counties. Other agencies, including the Department of Workforce Development and the Department of Public Instruction, administer programs to meet the vocational and educational needs of people with developmental disabilities. These programs are described in other informational papers prepared by this office.

DHS and the Board for People with Developmental Disabilities (BPDD)

DHS and its contracted entities, such as counties and managed care organizations, administer most of the state's health programs that serve people with developmental disabilities, while BPDD's mission is to advocate on behalf of individuals with developmental disabilities, foster inclusive communities, and improve the disability service system.

DHS. As a result of a reorganization of DHS, authorized by 2015 Wisconsin Act 55 (the 2015-17 biennial budget act), most Medicaid funded long-term care services will be part of the DHS Division of Medicaid Services. The DHS Division of Care and Treatment Services operates the three State Centers for People with Intellectual Disabilities, and the DHS Division of Public Health operates the DHS Bureau of Aging and Disability Resources. Until recently, all of these programs were administered by the Division of Long Term Care (DLTC), which was eliminated as part of the reorganization.

Several councils and committees provide advice to DHS relating to these programs, including: the Governor's Autism Council, the Children's Long-Term Support Council, the Governor's Birth to 3 Interagency Coordinating Council, the Governor's Committee for People with Disabilities, the state's Long-Term Care Advisory Committee, and the IRIS (Include, Respect, I Self-Direct) Advisory Committee. These councils and committees each have different membership structures and missions, as designated by statute or established by the Governor or DHS Secretary.

BPDD. BPDD is a state board attached to the Department of Administration that works in conjunction with Disability Rights Wisconsin (DRW) and the Waisman Center (the state's University Center for Excellence in Developmental Disabilities), as a part of the Disability Policy Partnership. Each of these agencies is authorized under the federal Developmental Disabilities Act to improve the quality of life for persons with disabilities and their families through public policy, and each organization is charged with a unique mission and set of responsibilities to carry out this objective.

BPDD's mission is to promote a consumer and family-directed system of services and informal supports that enable people with developmental disabilities to exercise self-determination and be independent, productive, and integrated in the community. The responsibilities of BPDD include developing and monitoring a state plan for advocacy and systems change, advising DHS, the Governor, and the Legislature, administering programs funded by BPDD, and advocating for people with developmental disabilities.

Federal Law Guiding the Provision of Services

The state's policies with respect to services for people with developmental disabilities are based on federal law, including federal Medicaid statutes as they relate to Medicaid-funded services, the Developmental Disabilities Assistance and Bill of Rights Act of 2000, and the Americans with Disabilities Act of 1990 (ADA).

In addition, court decisions, including the 1999 U.S. Supreme Court decision in *Olmstead vs. L.C.*, have affected the implementation of state and federal law. On June 22, 1999, the United States Supreme Court held in *Olmstead* that unjustified segregation of persons with disabilities constitutes discrimination in violation of the ADA, and that public entities must provide community-based services to persons with disabilities when: (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based

services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

In its decision, the Supreme Court explained that its holding reflects two "evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

In an effort to comply with the *Olmstead* decision, Wisconsin currently offers home and community-based services through the Medicaid-funded Family Care, IRIS, adult legacy waiver programs, and the children's long-term support (CLTS) waiver program, as well as several programs not supported by Medicaid (MA) funding.

Medicaid Funded Services

Card Services. MA is a state and federally-funded entitlement program that provides primary, acute, and long-term care services to qualifying individuals with limited resources. Under the program, recipients are entitled to receive primary and acute care services and certain long-term care services, identified in the state's MA plan (commonly referred to as "state plan services" or "card services") as long as the services are medically necessary and provided within the limitations set by state and federal law and policy. These services include most medical services provided by noninstitutional providers such as physicians and dentists, hospital services, drugs, and care provided by nursing homes.

Individuals with developmental disabilities may be eligible for Medicaid card services either because they meet income standards to qualify for coverage under BadgerCare Plus (MA coverage for individuals and families with low income) or because they meet income, asset, and functional eligibility requirements to qualify for elderly, blind, or disabled Medicaid coverage (EBD Medicaid). In order to qualify for EBD Medicaid, a person must be 65 years of age or older, blind, or disabled. For purposes of EBD eligibility, a disability is defined as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Disability determinations are conducted by the DHS Disability Determination Bureau (DDB). For more information regarding MA eligibility and benefits, see the Legislative Fiscal Bureau's informational paper entitled, "Medical Assistance and Related Programs (BadgerCare Plus, EBD Medicaid, Family Care, and SeniorCare)."

Long-Term Care Waiver Services. Wisconsin has also obtained several waivers to federal Medicaid law that permit the state to provide certain types of long-term care services, in addition to card services, to persons with disabilities and elderly individuals who require long-term care services. These services are commonly referred to as "waiver services," to distinguish them from card services.

Family Care provides community-based long-term care services through managed care organizations (MCOs), which manage enrollee care and provide some Medicaid card services and other long-term care services. The state also offers a self-directed long-term care program called IRIS, which operates in counties where Family Care is offered as an alternative to managed care.

As of July, 2016, Family Care and IRIS ser-

vices were available to qualifying residents in 65 of the state's 72 counties. The seven remaining counties (Adams, Dane, Florence, Forest, Oneida, Taylor, and Vilas) continue to administer "legacy" home and community-based long-term care programs. DHS intends to contract with a managed care entity to begin providing Family Care services to qualifying residents in all of the remaining counties, other than Dane County, in July, 2017, and to qualifying residents in Dane County, beginning in the first quarter of 2018. Qualifying individuals are entitled to receive services under these programs no later than three years after Family Care and IRIS services are first made available in their county of residence.

For residents of the seven counties where Family Care and IRIS services currently are not offered, there are four programs that provide home and community-based care to adults with developmental disabilities. These programs include: (1) the community integration program 1A (CIP 1A); (2) the community integration program 1B (CIP 1B); (3) the intermediate care facilities for individuals with intellectual disabilities (ICF-IID) restructuring initiative; and (4) the non-waiver community options program (COP).

Prior to the initial implementation of Family Care in five pilot counties in calendar years 2000 and 2001, all Wisconsin counties provided MA-funded home and community-based long-term care services to qualifying persons with developmental disabilities through the legacy waiver programs. While individuals who met the functional and financial eligibility requirements were entitled to receive Medicaid card services, including care provided by nursing homes, they were not entitled to receive other services that were only available to individuals enrolled in the state's HCBS programs. Consequently, counties maintained waitlists for individuals seeking to enroll in HCBS waiver programs as a means of receiving community-based long-term care services. However, as Family Care has expanded to additional counties, the statewide number of individuals on waitlists for home and community-based long-term care services has decreased significantly since HCBS waiting lists only remain in counties still operating legacy waivers programs and in counties still in their initial Family Care start-up period.

Certain individuals who earn income through work, are enrolled in a certified health and employment counseling program, or are involved in competitive, supported, or sheltered employment and who would not otherwise meet the financial eligibility standards for non-institutional Medicaid may be eligible for Medicaid-funded benefits through the MA Purchase Plan (MAPP).

Children with long-term disabilities may also receive Medicaid card services through the Katie Beckett provision and long-term supports and services through the children's long-term care support (CLTS) waiver program.

The remainder of this section provides additional information regarding each of the Medicaid-funded waiver programs.

Family Care. Family Care is a comprehensive long-term care program that was created to improve the quality of long-term care services individuals receive, provide individuals with more choices and greater access to services, and be a cost-effective system for delivering long-term care services in a community setting.

Under Family Care, DHS makes monthly capitation payments to MCOs, which provide comprehensive long-term care services for enrollees through their contracted health care providers. Family Care includes long-term care card services in addition to the more extensive home and community-based services. Acute medical services, such as inpatient and outpatient hospital and physician services, are not funded as part of the capitation payment. Consequently, providers submit reimbursement claims for these services to the state Medicaid program, rather than the

enrollee's MCO.

In order to be eligible for Family Care, enrollees must meet both functional and financial eligibility criteria. In general, enrollees must be at least 18 years of age and their primary disability must be a condition other than mental illness or substance abuse. An individual meets the functional eligibility criteria if the person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application and if one of the following applies: (a) the person's functional capacity is at the nursing home level, meaning they require ongoing care, assistance, or supervision; or (b) the person's functional capacity is at the non-nursing home level, but the person is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

As of July, 2016, 18,281 of the 43,295 persons enrolled in Family Care (42%) were people with intellectual or developmental disabilities.

As a part of the long-term care reform initiatives that created Family Care, the state began funding services provided by aging and disability resource centers (ADRCs). ADRCs offer the general public a single source of information and assistance on issues affecting elderly individuals and people with disabilities. ADRCs employ options counselors to present information on the choices individuals have to meet their long-term care needs, and serve as an entryway to publicly funded long-term care programs.

Individuals with developmental disabilities and their families often seek assistance from ADRCs when their life circumstances change, such as the declining health or death of a caretaker, or at the time an individual is transitioning from school-based programs to adult services.

As of September 2016, there were 40 ADRCs serving all 72 counties and 11 tribes, including 27 single-county ADRCs and 13 multi-county/tribe regional ADRCs.

IRIS. The Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (DHHS) required the state to offer an alternative to managed care in order to provide individuals with sufficient choice in obtaining long-term care services. The IRIS program is a self-directed support waiver under the Medicaid HCBS waiver authority, through which individuals may self-direct their long-term care supports and services through management of a designated budget amount. IRIS is available in all counties where Family Care is offered.

DHS contracts with IRIS consulting agencies (ICAs) and fiscal employment agencies (FEAs) to assist enrollees in managing their services. ICAs are responsible for assisting each enrollee in developing an individualized support and service plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must ensure the individual will be healthy and safe. FEAs assure that all services are paid according to an individual's plan and assist each enrollee in managing all fiscal requirements, such as paying providers and assuring that employment and tax regulations are met.

As of October, 2016, DHS had contracts with five ICAs and three FEAs (with a fourth FEA pending certification status), each responsible for serving different geographical regions of the state.

To be eligible for IRIS, an individual must reside in a Family Care county, meet functional eligibility requirements, and reside in an eligible living arrangement, such as a home, apartment, adult family home limited to four beds, or residential care apartment complex.

The services available under IRIS are limited to the home and community-based services not available through Medicaid card services. This

differs from Family Care, which covers all long-term care services, including those otherwise available through the Medicaid card. Instead, IRIS enrollees continue to receive these services through their Medicaid card. Although provided as a Medicaid card service, IRIS enrollees have the option of self-directing their personal care services with the help of the ICA. Currently, over 40 percent of IRIS enrollees choose this option.

IRIS enrollees are provided an annual budget based on their functional needs and a comparison to people with similar needs in the managed care programs, as well as the historical service cost of representative Family Care members. The enrollee then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person may use funds from his or her individual budget to obtain the services needed on a fee-for-service basis.

Individuals are not permitted to use any of their individual budgets to pay for room and board. Enrollees work with an IRIS consultant to develop an appropriate care plan that fits their individual budget. While individuals enrolled in IRIS have control over an annual budget, only services that are received and authorized as rendered are paid to providers by DHS.

As of July 1, 2016, there were 13,577 individuals in IRIS, including 1,612 elderly individuals, 6,758 individuals with physical disabilities, and 5,207 individuals with developmental disabilities.

Community Integration Programs (CIP 1A and CIP 1B). CIP 1A and CIP 1B provide Medicaid-funded, community-based services to individuals with developmental disabilities. CIP 1A supports services for persons who previously resided at the State Centers for Individuals with Intellectual Disabilities (state centers). In addition, if a CIP 1A enrollee dies or otherwise exits the program, the county may use the CIP 1A funding that had previously been used to fund services for that individual to fund services for other eligible individuals who had not previously resided at one of the state centers.

CIP 1B supports services for individuals that previously resided in an ICF-IID other than the state centers or are at risk of entering an ICF-IID. CIP 1A and CIP 1B participants are eligible to receive community-based services, such as supported employment and prevocational services, which are not available as Medicaid card services.

Community placements using CIP funding can be initiated by county staff, parents or guardians, the courts, or, if a client lives at one of the state centers, by center staff. Placements can also be initiated as part of facility closing plans for private ICFs-IID. Once a person is identified for community placement, county staff and staff at an individual's residential facility assess the individual's needs, preferences, and desired outcomes. Based on this assessment, county officials work with the person's parents or guardian to develop an individualized service plan (ISP), which details the supports that will be made available to the applicant, as well as how and when they will be delivered, the cost of these services, and how the services will be funded. DHS reviews the ISP to determine whether: the individual's needs can be effectively met with the services and supports proposed in the plan, the costs are appropriate, and all the necessary community resources are in place.

The CIP 1A and 1B programs are funded through state reimbursements to counties and county payments for costs that exceed the state payment rates, as well as federal matching funds for both state and county payments. Because not all of the costs of community living identified in a person's plan are eligible for Medicaid reimbursement, counties may have to fund certain costs, such as room and board services, with funding from other sources. These costs are frequently supported by funding made available to

counties under the state-funded community options and community aids programs.

DHS provides the funding needed to meet the individual's care plan in the community. In 2015-16, the maximum average allowance for state reimbursement under CIP 1B was $49.67 per day, although DHS pays a higher rate for placements from facilities that close or have a DHS-approved plan for significant downsizing.

Table 1 provides information on the annual number of CIP 1A placements for state fiscal years (SFYs) 2004-05 through 2015-16. The table shows that there have been no CIP 1A placements from the state centers during the past several years, which DHS attributes to guardian opposition to community placement.

Table 1: CIP 1A Placements from State Centers

	Central Wisconsin Center	Northern Wisconsin Center	Southern Wisconsin Center	Total
2004-05	4	83	5	92
2005-06	7	17	8	32
2006-07	20	2	11	33
2007-08	7	0	6	13
2008-09	6	0	12	18
2009-10	1	0	8	9
2010-11	1	0	2	3
2011-12	1	0	2	3
2012-13	0	0	0	0
2013-14	0	0	0	0
2014-15	0	0	0	0
2015-16	0	0	0	0

In CY 2015, 246 individuals received services under CIP 1A, with 204 individuals enrolled in the average month. In that same year, 3,298 individuals received services under CIP 1B, with an average monthly enrollment of 2,676.

ICF-IID Restructuring Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-IID. With limited exceptions, the act prohibits individuals with developmental disabilities from being placed in an ICF-IID and prohibits an ICF-IID from admitting an individual unless, before the placement or admission and after considering a plan developed by the county, a court finds that the placement is the most integrated setting appropriate to the needs of the individual.

In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals served under this initiative. However, DHS allocates funds equal to the expected cost of care for each individual in the community, and counties are only responsible for costs that exceed this allocation.

In SFY 2015-16, the amount estimated to support services and fund all relocations under the relocation initiative is approximately $21.5 million (all funds).

From 2005-06 through 2014-15, 941 persons with developmental disabilities were relocated from ICFs-IID and nursing homes, other than the state centers, to alternative community-based residential settings. Table 2 shows the annual number of relocations under the ICF-IID restructuring initiative for SFYs 2004-05 through 2014-15, the most recent year for which information is available.

Table 2: Annual Relocations under ICF-IID Restructuring Initiative

Fiscal Year	Relocations
2004-05	94
2005-06	340
2006-07	143
2007-08	39
2008-09	37
2009-10	72
2010-11	19
2011-12	36
2012-13	64
2013-14	48
2014-15	38
Total	930

Community Options Program (COP). The state's general purpose revenue-supported (GPR) COP and the Medicaid-funded community options waiver program (COP-W) provide home and community-based services to elderly and disabled persons at risk of entering a nursing home. The COP-W program exclusively serves elderly individuals and individuals with physical disabilities who would otherwise receive care in a nursing facility, while the GPR-supported COP program serves individuals with developmental disabilities and other individuals in need of long-term care services. Counties may use the non-waiver, GPR-supported COP funding allocations to supplement other state and local funds to provide long-term care services, including services that cannot be funded under the Medicaid waiver programs, such as room and board costs.

In CY 2015, 209 of the 2,291 adults receiving services under the GPR-funded COP program (9.1%) were persons with developmental disabilities. For CY 2017, DHS plans to distribute $6.4 million for the GPR-funded COP program, with $6.3 million going to Adams, Dane, Florence, Forest, Oneida, Taylor, and Vilas Counties and $0.1 million distributed to the Oneida Tribe.

MA Purchase Plan (MAPP). MAPP permits disabled adults, including adults with developmental disabilities, to remain eligible for Medicaid if their earnings would otherwise disqualify them from coverage under the state's Medicaid program.

An individual is eligible to participate in MAPP if: (a) the individual's family income, minus income that is excluded under federal SSI rules, is less than 250% of the federal poverty level ($2,475 per month for an individual and $3,338 per month for a family of two in 2016); (b) the individual's countable assets do not exceed $15,000; (c) the individual is determined to have a disability under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHS; and (e) the individual is at least 18 years old. Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,485 per month for an individual in 2016).

As of July, 2016, approximately 27,700 individuals were enrolled in MAPP. It is not known how many of these individuals had developmental disabilities.

Katie Beckett Provision. The Katie Beckett provision provides Medicaid eligibility to children who live at home and have substantial medical problems, including developmental disabilities, severe emotional disturbance, physical disabilities, and chronic mental conditions. Under the provision, children, who would not otherwise qualify for Medicaid coverage while living at home due to the income and assets of their parents, may obtain Medicaid-funded services if they meet other eligibility criteria. For these children, the parents' income and assets are not considered in determining eligibility.

In order to be eligible for MA under this provision, a child must meet all of the following criteria: (a) be under 19 years of age; (b) require an institutional level of care at home that is typically provided in a hospital or nursing facility; (c) be provided safe and appropriate care; (d) not have income in their name that exceeds the current standards for a child living in an institution; and (e) not incur a cost of care at home that exceeds the cost Medicaid would pay if the child were in an institution.

As of July, 2016, 5,283 children in Wisconsin were enrolled in MA under this provision.

CLTS Waiver Program. The CLTS waiver program provides services and supports for children with significant physical and developmental disabilities and severe emotional disturbance.

In order to be eligible to participate in the CLTS waiver program, children must meet functional and financial eligibility criteria. The functional criteria require a child to have a physical disability, developmental disability, or severe emotional disturbance that is diagnosed medically, behaviorally, or psychologically. The impairment must be characterized by the need for individually planned and coordinated supports, treatment, or other services that permit the child to remain living in the home or other community-based settings. In addition, CLTS waiver participants must also be eligible for Medicaid card services.

The financial eligibility criteria require that, in 2016, the child's income not exceed $2,199 per month and, for youths 18 and over, countable assets not exceed $2,000. Children with greater income or assets may become eligible for Medicaid by "spending down" to the CLTS income and asset criteria.

Although the income of the child's parents is not considered in determining program eligibility, some families are required to contribute to the cost of services based on their annual income and family size. Families with income that exceeds 330% of the FPL ($66,528 for a family of three in 2016) are required to share in program costs on a sliding scale based on income.

The supports and services provided under the CLTS waiver program are similar to those available under other Medicaid HCBS waiver programs. However, some of the services that are necessary for adults, such as home-delivered meals, adult day care, and services provided by residential care apartment complexes and community-based residential facilities, are not available to children under the waivers.

DHS provides each county with a funding allocation to support CLTS services. Counties must serve children on a first-come, first-served basis, so long as funds are available. Counties may serve additional children by supplying the non-federal share of matching funds to obtain federal matching funds on CLTS services. Children applying for state-matched funding must meet the functional level of care requirement and be determined disabled by DDB. Children applying for county-matched funding need only meet the functional level of care requirements.

Similar to other HCBS waiver programs, the state may establish waiting lists for services when the state does not have sufficient funding to provide services to all eligible individuals. Children may continue receiving services under the waiver until they reach the age of 18 in a Family Care county or up to age 22 in a legacy waiver county, as long as they continue to meet functional and Medicaid eligibility requirements, after which they would need to receive services under an adult HCBS waiver program. This could result in some individuals residing in legacy waiver counties being placed on waiting lists for Medicaid waiver services once they reach 22 years of age. Counties can prevent a disruption in services by placing children already receiving services under CLTS on waiting lists for adult waiver slots, or by planning for their transition to Family Care or IRIS.

As of July, 2016, 6,083 children were enrolled in the CLTS waiver program, including 4,611 children with developmental disabilities. As of July, 2016, an additional 2,517 children were on the CLTS waitlist, including 1,573 children with developmental disabilities. This figure excludes children with multiple or unknown disabilities.

Autism Treatment Services. Prior to calendar year 2016, all MA-supported autism treatment services were provided as part of the CLTS waiver program. In 2014, CMS modified its policy regarding these services and notified states that, if they wished to receive federal financial participation to support the cost of these services, they should be provided as state plan services, rather than as waiver services. In 2016, DHS be-

gan transitioning these services from waiver services to state plan services and, as of January, 2017, all autism treatment services are provided as state plan services.

Unified Intake. Similar to the ADRCs that serve as a gateway for adults seeking long-term care services, CompassWisconsin: Threshold (CWT) offers families a way to apply for multiple programs for their children through a single application and eligibility process. CWT assists families in understanding and applying for the Katie Beckett provision, CLTS Waiver Program, and the GPR-funded Children's Community Option Program (CCOP). As of January 2017, CompassWisconsin: Threshold was operating in 17 counties.

Institutional Services

Several facilities offer institutional care for Wisconsin residents with developmental disabilities. The largest facilities, including the state centers, are certified by CMS as intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), and must meet federal Medicaid care and treatment standards.

An ICF-IID provides care and active treatment to residents with developmental disabilities who need medical, nursing, or psychiatric supports to acquire skills for personal independence. This certification makes these facilities eligible for federal cost sharing under the state's Medicaid program. However, as state and federal policies encourage counties to provide care to persons with developmental disabilities through community-based services rather than institutional care, the number of these facilities has decreased over time. For example, excluding the three state centers, at the end of CY 2005 there were 26 facilities, with 990 total licensed beds, serving individuals with developmental disabilities in Wisconsin. As of July, 2016, there were four facilities with 99 licensed beds, excluding the three state centers.

Table 3: People with Developmental Disabilities in Institutions as of December 31

Institution Type	2012	2013	2014	2015
State Centers	415	402	398	375
Nursing Homes*	36	34	24	25
Non-State ICF-IIDs*	268	210	110	84
Total	719	646	532	484

*Nursing home and ICF-IID populations indicate fee-for-service MA populations, and exclude individuals with traumatic brain injuries.

Table 3 provides information on the various types of institutions that serve persons with developmental disabilities in Wisconsin from 2012 through 2015. As shown in this table, the number of individuals in institutions decreased by 235 (33%) over this four-year period, from 719 on December 31, 2012, to 484 on December 31, 2015. Current facilities range in size from eight to 46 beds, excluding the state centers. Counties owned three of the four ICFs-IID, which accounted for 92% of the licensed ICF-IID beds (91 of 99), once again excluding the state centers. Almost all the residents of ICFs-IID are eligible for, and enrolled in, the state's Medicaid program.

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

Currently, two of the three state centers, CWC and SWC, serve individuals with developmental disabilities on a long-term basis. These individuals have lived at the state centers many years. 2003 Wisconsin Act 33 required DHS to relocate

NWC's residents to either a community-based setting or to another ICF-IID, but authorized the facility to continue to provide short-term services.

In recent years there have been no new admissions for long-term care to the state centers. However, if there were, the statutes require that, within 30 days after a person is admitted for long-term care, DHS and the county or appropriate MCO identify the support services that would be necessary for the individual to successfully live in the community. In addition, a person over the age of 18 may only be admitted to a state center for long-term care if he or she is determined to be in need of protective placement under Chapter 55 of the statutes. Community support plans are reviewed annually in the Watts review for all long-term residents at the state centers. The Watts review determines whether each person is in the least restrictive environment appropriate for their needs and abilities.

As counties' and MCOs' capacity to support individuals in the community has increased, there has been a shift from long-term extended care admissions to short-term admissions at the state centers.

A short-term admission is typically made to provide evaluation, assessment, crisis intervention, or to allow the county and provider adequate time to redesign a community support plan. Short-term programs are the intensive treatment programs (ITPs) at all three state centers and the medical short-term care program at CWC. Short-term admissions provide services to individuals who need active treatment that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. These types of admissions require the approval of the local community board or appropriate MCO, the director of the state center, and the parent or guardian, unless the admission is ordered by a court. A short-term admission is typically for a 30- to 90-day period but may be extended to 180 days with mutual agreement of the referring entity and the director of the state center. Short-term admissions are typically voluntary admissions.

The state centers provide residents with services that may not otherwise be available to them and assist them in returning to the community. These services include: (a) education, training, habilitative, and rehabilitative services for residents; (b) behavioral evaluation of individuals at the request of county community program boards and county developmental disabilities boards; (c) assistance to county boards to enable them to better meet the needs of developmentally disabled persons; and (d) short-term care to individuals, including ITP services, to help prevent long-term institutionalization. In addition to these services, the state centers may offer dental, mental health, therapy, psychiatric, psychological, general medical, pharmacy, and orthotic services.

Table 4 shows the populations of the state centers as of July 1, 2016, and the private pay reimbursement rates for each of the state centers for SFY 2017. The population at the centers has declined significantly over the years. In 1970, nearly 3,700 persons resided in the state centers, compared to 369 as of July 1, 2016. This decrease is largely due to the state-initiated movement to relocate state center residents into the community that began in the early 1970's as the

Table 4: State Centers Population and Daily Rates

Facility	Population*	Private Pay Rate**	Intensive Treatment Services Rate**
CWC	221	$876	$1,069
NWC	13	1,378	1,069
SWC	135	896	1,069
Total	369		

*Population as of July 1, 2016, including long-term and intensive treatment populations.
**SFY 2017

Table 5: State Centers Budget and Authorized Full-Time Equivalent Positions, SFY 2016

	CWC	NWC	SWC	Total
Program Revenues - MA				
State Operations	$62,686,100	$16,200	$38,968,700	$101,671,000
Utilities & Fuel	2,160,900	1,346,300	2,032,600	5,539,800
Institutional Repair & Maintenance	258,300	0	350,400	608,700
Subtotal	$65,105,300	$1,362,500	$41,351,700	$107,819,500
Program Revenues - Other				
Alternative Services	$202,700	$7,645,300	$21,600	$7,874,600
Extended Intensive Treatment Surcharge	50,000	0	50,000	100,000
Farm Operations	0	0	50,000	50,000
Activity Therapy	77,400	17,800	17,500	112,700
Gifts and Grants	35,000	70,000	30,000	135,000
Interagency and Intra-agency programs	176,200	1,105,400	306,400	1,588,000
Subtotal	$546,300	$8,838,500	$475,500	$9,860,300
Total Funding (All Sources)	$65,651,600	$10,201,000	$41,827,200	$117,679,800
Total Authorized FTE Positions (All Sources)	811.00	119.50	533.55	1,464.05

centers' mission shifted from primarily a residential to a treatment approach. This movement of residents into the community was further increased due to implementation of CIP 1A in 1983 and the phase-out of long-term care services at NWC.

Table 5 shows the total budget and the number of authorized, full-time equivalent (FTE) staff positions for each state center for SFY 2016. As noted, most of the program revenue funding for the state centers is comprised of payments through the state's Medicaid program. However, unlike Medicaid payments to other ICFs-IID, Medicaid payments to the state centers are based on the actual eligible costs of operating each facility, as limited by the amount budgeted by the Legislature for this purpose.

Non-Medicaid Community-Based Services

While the Medicaid program is the primary source of public funding for services for individuals with developmental disabilities, counties receive funding under other programs administered by DHS. Some of these programs are partially supported by Medicaid funds.

Community Aids. DHS distributes state and federal funds to counties under the community aids program for community-based social, mental health, developmental disability, and substance abuse services. Counties receive both a basic county allocation (BCA), which they may expend for any of these eligible services, and categorical allocations, including funding for the mental health block grant, substance abuse block grant, and Alzheimer's family and caregiver support program, each of which is designated to provide specific services and programs. Additional information on the community aids program is provided in the Legislative Fiscal Bureau's informational paper entitled, "Community Aids/ Children and Family Aids."

BCA. Counties use the BCA, in combination with funding from other sources, to support a wide range of human service programs, including services for individuals with developmental disabilities. Counties may use the basic county allocations for any allowable community aids ser-

vice. In CY 2017, DHS will distribute approximately $170.0 million under the BCA. In CY 2015, counties reported spending approximately $28.2 million of the BCA on services for persons with developmental disabilities.

CCOP. As part of 2015 Act 55, and effective January 1, 2016, the Family Support Program funding was merged with the portion of COP funding allocated to children, to form CCOP. CCOP provides supports and services to children 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 disturbance. For CY 2017 DHS plans to distribute $9,025,900 GPR to counties and nonprofit agencies to support CCOP services.

Eligibility Criteria. In order to be eligible for CCOP, the child's disability must be characterized by a substantial limitation on functional ability in at least two of the following areas: self-care, receptive and expressive language, learning, mobility, and self-direction. Further, the child must meet the following eligibility criteria: be under 22 years of age; be a resident of Wisconsin with intent to remain; live in a home or community setting; and require a level of care typically provided at an ICF-IID, a nursing home, or a hospital.

Covered Services. CCOP funding can be used to provide a range of services and supports that allow the child to remain in the home or community. Allowable services are selected based on an individualized assessment of the child's needs and a service plan completed by the local county CCOP agency, in consultation with the child's family. Some examples of covered services include home modifications, respite care, adaptive equipment, transportation, care management, and communication aids. Parents may be required to pay a sliding scale fee, based on the family's income and service costs. CCOP is a payer of last resort-- CCOP funding cannot be used to replace services that are available through Medicaid, HCBS waiver programs, schools, income maintenance programs, or private insurance.

Early Intervention Services for Infants and Toddlers with Disabilities (Birth to 3). The Birth to 3 Program, authorized under Part C of the federal Individuals with Disabilities Education Act (IDEA), utilizes state, federal, and local funds to support a statewide, comprehensive program of services for infants and toddlers with disabilities, and their families. Program goals established in federal law include enhancing the development of children with developmental disabilities, minimizing the need for special education, and decreasing rates of institutionalization.

Counties are responsible for administering the program based on state and federal guidelines. Specific county responsibilities include establishing a comprehensive system to identify, locate, and evaluate children who may be eligible for the program.

An early intervention team, comprised of a service coordinator and staff working in at least two different disciplines related to the child's suspected areas of need, evaluates children referred to the program to determine their eligibility for the program. A child qualifies for the program if he or she is less than three years old and has a significant developmental delay of 25% or more or a physician-diagnosed and documented condition likely to result in a developmental delay.

Once eligibility is determined, the early intervention team conducts an assessment to further identify the unique needs of the child and the family. The results of the assessment are used by a team of professionals, the service coordinator, the parents, other family members, and an advocate (if requested by the parent), to develop the individualized family service plan (IFSP). The plan must include a statement of the expected outcomes, how those outcomes will be

achieved, a timeline for the provision of services, the manner in which services will be provided, and the sources of payment for the services. Eligible children are ensured the provision of core services at no cost to the family. Core services include evaluation, service coordination, and the development of an IFSP.

The services Birth to 3 Program participants most frequently use include mandatory 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 CY 2015, Wisconsin's Birth to 3 Program evaluated a total of 19,530 children, including new and ongoing participants, those who did not enroll in the program, and those who were found to be ineligible. Of these children, 12,538 were eligible, enrolled, and provided early intervention services through the Birth to 3 Program, with average program participation lasting 18 months.

The program is funded from several sources, including the federal IDEA grant, state GPR, county funds, community aids, Medicaid, private insurance reimbursement, and parental cost sharing. Table 6 shows the calendar year 2015 reported expenditures for the Birth to 3 program from all sources. Appendix II provides total expenditures reported by counties for Birth to 3 and the number of children each county served in that year.

Disability Benefit Specialists. The disability benefit specialist (DBS) program provides assistance and information to people with disabilities between the ages of 18 and 59 (individuals 60 years of age or older can receive similar services from elder benefit specialists). Benefit specialists work in 40 ADRCs covering all 72 counties, and provide services such as help with program applications, discussions regarding program choices to meet the individual's needs, and, at times, representation in appeals processes for certain programs.

Table 6: Birth to 3 Program Expenditures, by Source, CY 2015

Funding Type	Amount
Federal Part C Allocation	$5,923,328
State GPR Allocation	5,709,654
Medicaid (estimated)	9,059,296
Community Aids (BCA)	4,460,645
County Funding	11,826,228
Parental Cost Share	491,447
Private Insurance	2,773,801
Other	612,806
Total	$40,857,205

In 2015, a total of 14,013 cases were closed by these benefit specialists, with an additional 10,436 information-only contacts. While the majority of clients served had either a physical disability or a mental illness, eight percent of DBS clients had a developmental disability and no other diagnosis. The most common issues addressed by DBS are Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) eligibility (44%), Medicare Part D (14%), and the MAPP program (14%).

DHS allocated a total of $8.9 million ($4.9 million GPR and $4.0 million FED) funds) for DBS services in calendar year 2015. Costs are divided between GPR and FED, and depend on federal cost reporting submitted by ADRCs to the Department. In 2015, approximately 55% of these costs were supported with GPR, with the remaining 45% supported with federal funds. Most of these costs are for services provided by ADRCs ($7.9 million in 2015), with the remainder for legal backup services and training (approximately $1.0 million in 2015).

Epilepsy Service Grants. DHS allocates state funds to private, nonprofit organizations or county agencies that provide direct or indirect services to persons with epilepsy. Direct services include services provided to a person with epilepsy or a family member of a person with epilepsy, such as counseling, referral to other services, case management, and daily living skills training. Indirect services include services provided to a person working with or on behalf of a person with epilepsy, such as service provider training, community education, prevention programs, and advocacy. Table 7 shows the epilepsy service grant allocations for FYs 2011-12 through 2015-16.

Table 7: Epilepsy Service Grant Allocations

Fiscal Year	Allocation
2011-12	$141,400
2012-13	131,400
2013-14	145,500
2014-15	130,600
2015-16	131,200

Supplemental Security Income. The supplemental security income (SSI) program provides cash benefits to elderly, blind, and disabled individuals, many of whom have developmental disabilities. In July, 2016, approximately 133,700 Wisconsin residents received SSI and SSI related benefits. In 2016, eligible individuals living independently received up to $816.78 in state and federal benefits, which they may use for any purpose. Participants also automatically qualify for coverage under the Medicaid program. Additional information on the SSI program is provided in the Legislative Fiscal Bureau informational paper entitled, "Supplemental Security Income."

Additional Resources

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

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

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

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

APPENDIX I

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Adams	$2,099,322	$ 2,074,240	$ 2,228,460	$2,428,751	$2,502,713
Ashland	217,960	49,125	85,213	25,620	28,252
Barron	719,271	825,413	1,022,835	1,004,407	1,017,422
Bayfield	289,040	235,957	189,032	207,032	198,521
Brown	40,637,664	40,886,846	41,121,303	42,153,169	23,880,112
Buffalo	111,316	161,316	372,048	291,364	284,123
Burnett	243,579	251,392	182,879	407,322	196,067
Calumet	1,493,733	1,908,708	1,742,447	1,921,378	2,162,247
Chippewa	1,444,218	1,019,865	1,091,100	993,811	1,305,675
Clark	2,080,684	2,029,925	2,160,577	1,497,728	1,263,727
Columbia	1,049,897	868,768	897,377	1,534,783	1,817,243
Crawford	303,460	305,547	217,563	201,799	217,987
Dane	85,792,836	86,890,597	89,082,747	91,695,431	95,009,875
Dodge	1,626,945	1,624,167	1,493,966	1,888,786	2,739,414
Door	5,995,083	5,795,859	5,534,460	5,414,321	4,072,875
Douglas	1,316,893	1,069,833	982,845	1,031,432	907,855
Dunn	1,364,074	897,511	737,185	808,386	842,649
Eau Claire	2,561,393	2,123,091	2,875,798	1,716,607	1,474,354
Florence	502,105	509,782	447,094	474,755	426,056
Fond du Lac	3,215,712	3,383,271	3,233,303	3,260,759	3,490,861
Forest-Oneida-Vilas	11,569,463	11,401,791	11,368,687	12,212,586	13,003,906
Grant-Iowa	930,445	1,175,618	1,087,418	1,084,464	1,015,711
Green	536,610	175,483	236,369	248,216	221,928
Green Lake	1,534,944	1,549,383	748,811	895,779	1,052,459
Iron	70,240	58,781	45,940	39,043	**
Jackson	129,535	99,784	152,654	188,745	192,390
Jefferson	1,404,903	2,046,727	1,570,439	1,650,341	1,583,878
Juneau	529,187	384,109	301,304	485,869	557,150
Kenosha	1,377,788	1,876,481	1,831,401	1,893,752	2,467,615
Kewaunee	4,228,789	3,994,326	4,010,794	3,669,055	2,225,748
La Crosse	2,745,427	3,025,051	2,979,399	3,116,980	3,868,339
Lafayette	308,101	277,207	463,705	265,030	283,650
Langlade-Lincoln-Marathon	10,182,895	8,893,629	9,716,232	9,046,142	8,970,245
Manitowoc	2,192,376	2,304,477	2,008,684	2,257,980	2,478,830
Marinette	4,174,520	4,108,373	4,327,885	4,551,428	3,632,897
Marquette	339,744	278,344	306,015	313,339	314,892
Menominee	**	**	1,842,504	1,553,910	1,480,115
Milwaukee	11,076,897	10,321,403	10,276,190	10,032,172	10,035,923
Monroe	**	562,009	539,886	1,187,222	1,359,753
Oconto	8,973,422	8,796,177	9,025,328	9,151,410	6,307,391

APPENDIX I (continued)

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2011 through 2015

County	2011	2012	2013	2014	2015
Outagamie	$2,221,802	$2,147,840	$2,627,556	$3,450,695	$3,659,414
Ozaukee	2,724,092	2,453,329	1,676,915	1,660,237	1,253,991
Pepin	69,106	89,844	182,654	159,849	138,405
Pierce	418,205	339,799	270,656	293,326	201,419
Polk	391,732	298,853	421,525	538,802	537,951
Portage	1,292,182	1,307,119	1,328,710	1,225,311	1,543,435
Price	483,308	525,102	274,344	250,639	256,036
Racine	2,728,517	3,260,811	3,615,103	2,770,916	2,897,396
Richland	289,970	325,777	315,980	247,325	145,578
Rock	25,712,818	26,115,764	27,214,754	27,682,690	31,102,007
Rusk	254,498	162,279	284,204	296,508	336,906
St. Croix	**	795,124	981,814	1,366,301	1,373,814
Sauk	1,244,273	753,986	738,400	1,135,226	1,204,591
Sawyer	375,887	297,701	183,690	334,128	282,621
Shawano	6,219,010	6,090,033	6,448,593	6,572,608	5,480,743
Sheboygan	1,770,979	1,679,626	2,184,535	2,533,625	2,612,295
Taylor	3,566,156	3,620,703	3,988,085	4086,565	3,953,258
Trempealeau	518,744	401,182	370,758	796,444	1,150,169
Vernon	433,005	262,193	472,315	310,953	264,136
Walworth	444,004	482,990	927,767	1,518,346	359,297
Washburn	323,828	442,512	459,553	248,355	438,710
Washington	1,285,685	1,000,730	1,136,259	1,148,330	1,042,194
Waukesha	9,961,107	8,047,574	10,452,568	10,972,037	12,520,580
Waupaca	4,334,276	4,126,679	4,471,076	5,039,901	5,163,676
Waushara	425,325	330,980	375,990	364,710	284,394
Winnebago	6,228,034	6,144,016	5,215,811	4,479,576	4,592,532
Wood	1,993,699	837,477	1,080,185	1,127,340	1,188,967
Total	$291,080,713	$286,582,401	$296,239,690	$303,411,847	$288,874,680

* Data obtained from the Human Services Revenue Reports (HSRR) collected by DHS. Family Care expenditures are not reported.

**No data reported.

APPENDIX II

Birth to 3 Expenditures* and Number of Children Served, By County
Calendar Year 2015

	Total Expenses	Children Served		Total Expenses	Children Served
Adams	$ 89,502	61	Marquette	$ 102,352	22
Ashland	112,792	18	Menominee	66,091	14
Barron	242,376	99	Milwaukee	4,988,440	2,775
Bayfield	86,481	18	Monroe	287,011	93
Brown	1,218,210	562	Oconto	309,355	74
Buffalo	112,428	26	Outagamie	845,420	371
Burnett	120,827	36	Ozaukee	548,628	173
Calumet	513,088	120	Pepin	112,046	15
Chippewa	445,173	167	Pierce	167,020	84
Clark	302,092	84	Polk	265,775	95
Columbia	270,824	65	Portage	411,219	102
Crawford	103,443	39	Price	95,816	25
Dane	2,483,580	921	Racine	813,802	422
Dodge	501,284	206	Richland	164,571	35
Door	327,451	40	Rock	1,379,779	363
Douglas	178,579	97	Rusk	95,260	27
Dunn	554,400	93	St. Croix	361,071	187
Eau Claire	407,763	255	Sauk	641,643	125
Florence	24,825	2	Sawyer	118,783	25
Fond du Lac	551,788	181	Shawano	323,364	102
Forest/Oneida/Vilas	416,459	165	Sheboygan	619,403	328
Grant/Iowa	233,720	74	Taylor	120,408	49
Green	139,853	82	Trempealeau	176,443	57
Green Lake	110,225	31	Vernon	152,455	54
Iron	24,108	4	Walworth	797,500	192
Jackson	132,496	22	Washburn	110,639	30
Jefferson	744,225	226	Washington	534,874	291
Juneau	194,911	56	Waukesha	852,113	527
Kenosha	520,765	402	Waupaca	495,157	105
Kewaunee	141,113	40	Waushara	130,158	34
La Crosse	482,784	205	Winnebago	751,349	269
Lafayette	110,613	28	Wood	486,647	142
Langlade/Lincoln/ Marathon	1,569,354	393	Total**	$ 31,644,012	12,358
Manitowoc	612,934	235			
Marinette	238,941	98			

*Total expenses include all Birth to 3 costs, including costs for early intervention services, service coordination, administrative costs, outreach, and other costs.

**This amount does not include Medicaid expenditures on children in the Birth to 3 program.