Services for Persons with Developmental Disabilities

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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 1 shows the total amount each county reported spending for county-administered programs that serve persons with developmental disabilities for calendar years 2013 through 2017. 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.

As of July 1, 2018, there are approximately 31,000 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. Most Medicaid funded long-term care services are administered by the DHS Division of Medicaid Services. However, 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 DHS reorganization in the 2015-17 biennial budget act.

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 Council, 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 *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 light of the *Olmstead* decision, Wisconsin currently offers home and community-based services through the Medicaid-funded Family Care, IRIS, 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 non-institutional 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, as an alternative to managed care.

As of July, 2018, Family Care and IRIS services are available to qualifying residents in all of the state's 72 counties. Most recently, Family Care services expanded to qualifying residents in

Florence, Forest, Oneida, Taylor, and Vilas counties starting in July, 2017, Dane County, beginning in February of 2018, and Adams County beginning in July, 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.

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. These programs included: (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). Individuals who met the functional and financial eligibility requirements were entitled to receive Medicaid card services, including care provided by nursing homes. However, counties maintained waiting lists for individuals seeking to enroll in home and community based 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 waiting lists for home and community-based long-term care services has decreased significantly, since home and community based long term care program waiting lists only remain 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 some of the Medicaid-funded waiver programs serving people with developmental disabilities.

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 some long-term care card services in addition to the more extensive waiver 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 October, 2018, 22,652 of the 48,636 persons enrolled in Family Care (approximately 47%) 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 October, 2018, there were 46 ADRCs serving all 72 counties and 11 tribes, including 34 single-county ADRCs, 12 multi-county/tribe regional ADRCs, and seven tribal aging and disability resource specialist agreements.

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

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, 2018, DHS had contracts with six ICAs and four FEAs, each responsible for serving different geographical regions of the state.

To be eligible for IRIS an individual must 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. IRIS enrollees have the option of self-directing their personal care services with the help of the ICA. Currently, approximately 43 percent of IRIS enrollees choose this option.

IRIS enrollees are provided an annual budget based on their functional needs and a comparison to historical service costs of other IRIS participants with similar needs. The enrollee then develops an individual support and service 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 individual support and service 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, 2018, there were 17,444 individuals in IRIS, including 3,493 elderly individuals, 6,545 individuals with physical disabilities, and 7,406 individuals with developmental disabilities.

Relocation and Diversion Initiatives. DHS operates three programs that provide people with physical and developmental disabilities, as well as the elderly, who reside in nursing facilities and ICFs-IID, the opportunity to relocate to community-based settings. From 2005-06 through 2015-16, a total of 6,609 people have been relocated from ICFs-IID and nursing homes, other than the state centers, to alternative community-based residential settings. Of the 6,609 relocated individuals, 960 were living with a developmental disability.

The three relocation initiatives operated by DHS are the ICF-IID restructuring initiative, the community relocation initiative (CRI), and CIP 1A (community integration program). However, DHS indicates that with the expansion of Family Care, the use of traditional relocation and diversion measures has diminished.

In 2017-18, the amount estimated to support services and fund all diversion and relocation initiatives was approximately $8.5 million (all funds). Of this amount $3.2 million was estimated to fund the ICF-IID restructuring initiative, as described below.

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.

Table 1 shows the annual number of relocations under the ICF-IID restructuring initiative for 2004-05 through 2015-16, the most recent year for which information is available.

Table 1: 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
2015-16	6
Total	936

MA Purchase Plan (MAPP). MAPP permits adults determined to have a disability under SSI standards (disregarding the individual's ability to work), 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.

2017 Wisconsin Act 59 made substantial changes to MAPP. These changes are contingent on federal approval, and specify that if the federal Department of Health and Human Services (DHHS) does not approve the state plan amendment or waiver in whole or in part, DHS can maintain the current income and asset eligibility requirements, and premium methodologies for MAPP, rather than the income and asset eligibility requirements and premium methodologies in Act 59. Contingent on federal approval, DHS anticipates implementation to begin by the middle of calendar year 2020.

Income. Currently, an individual may qualify for MAPP if the individual's net household income is less than 250% of the federal poverty level (FPL) for the size of the individual's household ($2,529 per month for an individual and $3,429 per month for a family of two in 2018). The Act 59 provisions maintain the current income limit, but would expand MAPP eligibility income deductions to allow certain working people with disabilities with high monthly out-of-pocket health care costs to qualify for Medicaid. Specifically, the income provisions in Act 59 would create an exclusion, from countable income, for medical and remedial expenditures and long-term care costs that exceed $500 per month that would be incurred by the individual in absence of coverage under MAPP or an MA long-term care program.

Assets. Currently, an individual may qualify for MAPP if the individual's non-exempt assets do not exceed $15,000. The Act 59 provisions would maintain the $15,000 asset limit, but exclude assets from retirement benefits accumulated from income or employer contributions while the individual is employed and receiving MA benefits.

Assets accrued in an independence account have historically been excluded when determining MAPP eligibility. Under the Act 59 provisions, any assets accumulated in an individual's independence account would also be excluded when determining financial eligibility for Family Care, IRIS, the Family Care Partnership program, and certain SSI Medicaid categories.

Premium Structure. Act 59 would also establish a new premium structure for MAPP participants so that each MAPP participant pays a premium of at least $25 per month. For a participant whose individual income exceeds 100% of the FPL for a single-person household ($12,140 annually in 2018), Act 59 requires the individual to pay, in addition to the $25 monthly premium, a premium equal to 3% of his or her adjusted earned and unearned income that exceeds 100% of the FPL. If DHS determines that paying the premium would be an undue hardship on the individual, DHS must waive the premium payment under Act 59.

Currently, individuals enrolled in MAPP pay a monthly premium if their individual gross monthly income, before deductions or exclusions, exceeds 150% of the FPL for their household size ($18,210 for an individual in 2018). The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the following deductions: (a) special exempt income; (b) impairment-related work expenses; (c) out-of-pocket medical and remedial expenses; and (d) standard living allowance ($874 per month in calendar year 2019). The part of the premium based on earned income is equal to 3% of earned income. If the deductions for unearned income are greater than unearned income, any remaining deductions could be applied to earned income before the 3% premium rate was applied. Based on the current

methodology, pre-implementation of Act 59, approximately 1,200 participants, representing 4% of the total number of MAPP participants, paid premiums.

Work Requirement. In order to be found eligible for the program, MAPP participants must meet a work requirement. Currently, participants are required to engage in a work activity at least once per month or be enrolled in a health and employment counseling (HEC) program. An individual is also considered to be working if he or she is engaged in in-kind work in lieu of employment, meaning he or she receives something of value as compensation for a work activity. However, DHS does not require MAPP members to demonstrate that they are paying income and payroll taxes in order to prove that they are meeting MAPP's work requirement. Under the Act 59 provisions, in-kind work would be considered for the purposes of MAPP eligibility only when the annual value of in-kind compensation received by the member reaches the IRS threshold for reportable earnings. Further, Act 59 requires MAPP participants to prove gainful employment and earned income to DHS by providing wage income or prove in-kind work income by federal tax filing documentation.

EBD Medicaid. If the provisions are implemented, Act 59 would increase the income eligibility limit for medically indigent elderly, blind, or disabled individuals in the MA program by establishing the income threshold at 100% of the FPL. In 2018, this equals monthly income of $1,011.67 for a one-person household and $1,371.67 for a two-person household. The current elderly, blind, and disabled (EBD) medically needy in-come limit in Wisconsin is $591.67 per month for both one- and two-person households, an amount that is not based on annual changes in the FPL. Under Act 59, the same maximum income limit would be established for the EBD medically needy MA recipients as currently applies to able bodied, nonpregnant adults enrolled in BadgerCare Plus, and would change annually to reflect changes in the FPL.

As of July 1, 2018, approximately 31,485 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 conditions, including developmental disabilities, severe emotional disturbance, physical disabilities, and chronic mental illness. Under the provision, children, who would not otherwise qualify for Medicaid coverage while living at home due to the income 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 1, 2018, 6,202 children in Wisconsin were enrolled in MA under this provision.

CLTS Waiver Program. The children's long-term support (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 2018, the child's income not exceed $2,250 per month. Children with greater income may become eligible for Medicaid by meeting the calculated cost-share requirement to the CLTS income 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. In accordance with state law, families with income that exceeds 330% of the FPL ($68,574 for a family of three in 2018) 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 CLTS.

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. Traditionally, some counties served additional children by supplying the non-federal share of matching funds to obtain federal matching funds on CLTS services.

Similar to other HCBS waiver programs, the state may establish a waiting list for CLTS services when the state does not have sufficient funding to provide services to all eligible individuals.

Historically, counties kept their own waiting lists for CLTS services. However, the federal Centers for Medicare and Medicaid Services (CMS) has required that the state transition from county administered waiting lists to a single statewide waiting list administered by DHS.

Act 59 provided DHS with an additional $14.2 million (all funds) in 2017-18 and an additional $25.4 million (all funds) in 2018-19 to fund CLTS services for children who were on the waiting list. These amounts were calculated based on the number of children on the waiting list for services at the time Act 59 was deliberated. However, the waiting list for CLTS services has subsequently grown. Since the funding budgeted for this effort was sum certain, rather than sum sufficient, the current waiting list may not be eliminated or a new waiting list may need to be reestablished in the absence of additional funding.

In addition, Act 59 authorized DHS to require counties to continue to provide funding that the counties had previously been contributing to partially support program costs, and required counties to cooperate with DHS to determine an equitable funding methodology and county contribution mechanism for contributing local funds to support CLTS services.

Children may continue receiving services under the waiver until they reach the age of 22, 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. However, most children receiving CLTS services will transition to IRIS or Family Care upon turning 18. Counties can prevent a disruption in services for children already receiving services under CLTS by planning for their transition to Family Care or IRIS.

As of July, 2018, 7,302 children were enrolled in the CLTS waiver program, including 5,179 children with developmental disabilities. As of July, 2018, an additional 2,054 children were on the CLTS waitlist, including 1,162 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 began 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 October 2018, 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 2005 there were 26 facilities, with 990 total licensed beds, serving individuals with developmental disabilities in Wisconsin. As of July, 2018, there were four facilities with 95 licensed beds, excluding the three state centers.

Table 2 provides information on the various types of institutions that serve persons with developmental disabilities in Wisconsin from 2014 through 2017. As shown in this table, the number of individuals in institutions decreased by 98 (18%) over this four-year period, from 532 on December 31, 2014, to 434 on December 31, 2017. 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 (87 of 95), excluding the state centers. Almost all the residents of ICFs-IID are eligible for, and enrolled in, the state's Medicaid program.

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

Institution Type	2014	2015	2016	2017
State Centers	398	375	361	348
Nursing Homes*	24	25	17	21
Non-State ICF-IIDs*	110	84	72	65
Total	532	484	450	434

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

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 a 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 3 shows the populations of the state centers as of July 1, 2018, and the private pay reimbursement rates for each of the state centers for 2018-19. The population at the centers has declined significantly over the years. In 1970, nearly 3,700 persons resided in the state centers, compared to 346 as of July 1, 2018. 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 centers' mission shifted from primarily a residential to a treatment approach. This movement of residents

Table 3: State Centers Population and Daily Rates

Facility	Population*	Private Pay Rate**	Intensive Treatment Services Rate**
CWC	201	$877	$1,354
NWC	14	1,494	1,354
SWC	131	963	1,354
Total	346		

*Population as of July 1, 2018, including long-term and intensive treatment populations.
**2018-19

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 4 shows the total budget and the number of authorized, full-time equivalent (FTE) staff positions for each state center for 2017-18. 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 community mental health services block grant, substance abuse prevention and treatment 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."

Table 4: State Centers Budget and Authorized Full-Time Equivalent Positions, 2017-18

	CWC	NWC	SWC	Total
Program Revenues - MA				
State Operations	$63,218,800	$16,200	$37,978,800	$101,213,800
Utilities & Fuel	2,160,900	1,346,300	2,032,600	5,539,800
Institutional Repair & Maintenance	308,300	0	400,400	708,700
Subtotal	$65,688,000	$1,362,500	$40,411,800	$107,462,300
Program Revenues - Other				
Alternative Services	$201,600	$7,560,600	$24,100	$7,786,300
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	20,000	39,600	18,000	77,600
Interagency and Intra-agency programs	176,200	1,086,500	301,600	1,564,300
Subtotal	$525,200	$8,704,500	$461,200	$9,690,900
Total Funding (All Sources)	$66,213,200	$10,067,000	$40,873,000	$117,153,200
Total Authorized FTE Positions (All Sources)	808.00	119.50	533.60	1,461.10

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 service. In 2019, DHS will distribute approximately $169.6 million (all funds) under the BCA. In 2017, counties reported spending approximately $19.7 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 the children's community option program (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 2019 DHS plans to distribute $11.2 million 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, as such 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 younger 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 2017, Wisconsin's Birth to 3 Program evaluated 21,188 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, 12,108 were eligible, enrolled, and provided early intervention services through the Birth to 3 Program, with average program participation lasting 11.5 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 5 shows the calendar year 2017 reported expenditures for the Birth to 3 program from all sources. Appendix 2 provides total expenditures reported by counties for Birth to 3 and the number of children each county served in calendar year 2017.

Table 5: Birth to 3 Program Expenditures, by Source, 2017

Funding Type	Amount
Federal Part C Allocation	$5,847,796
State GPR Allocation	5,722,041
Medicaid (estimated)	7,712,898
Community Aids (BCA)	4,865,192
County Funding	12,722,567
Parental Cost Share	435,369
Private Insurance	2,414,304
Other	655,430
Total	$40,375,596

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 all 46 aging and disability resource centers (ADRCs), covering all 72 counties. Great Lakes Inter-Tribal Council also employs three DBS to serve tribal members. The DHS Office for the Deaf and Hard of Hearing employs a DBS to serve individuals who use American Sign Language. DBS provide services such as help with program applications, discussions about program choices to meet the individuals' needs, and, at times, representation in appeals processes for certain programs.

In 2017, a total of 12,676 cases were closed by these benefit specialists, with an additional 15,011 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 (42%), the MAPP program (16%), Medicare Part D options and enrollment (14%), and Medicare Savings Programs (9%).

DHS allocated a total of $10.9 million ($6.1 million GPR and $4.8 million FED) funds) for DBS services in calendar year 2017. Costs are divided between GPR and FED, and depend on federal cost reporting submitted by ADRCs to the

Department. In 2017, approximately 56% of these costs were supported with GPR, with the remaining 44% supported with federal funds. Most of these costs are for services provided by ADRCs ($9.8 million in 2017), with the remainder for legal services and training (approximately $1.1 million in 2017).

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. By statute, DHS is authorized to provide up to $150,000 annually in epilepsy service grants, with no one entity eligible to receive more than $50,000 annually. Funding for the epilepsy service grants is budgeted in a larger community aids appropriation from which a number of smaller grant programs are funded.

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 September, 2018, approximately 133,400 Wisconsin residents received SSI and SSI related benefits. In 2018, eligible individuals living independently received up to $833.78 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 1

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2013 through 2017

County	2013	2014	2015	2016	2017
Adams	$ 2,228,460	$2,428,751	$2,502,713	$3,103,376	$3,000,650
Ashland	85,213	25,620	28,252	19,398	22,216
Barron	1,022,835	1,004,407	1,017,422	987,550	883,437
Bayfield	189,032	207,032	198,521	165,971	155,175
Brown	41,121,303	42,153,169	23,880,112	4,017,732	4,284,877
Buffalo	372,048	291,364	284,123	324,805	327,011
Burnett	182,879	407,322	196,067	168,028	230,052
Calumet	1,742,447	1,921,378	2,162,247	2,086,452	1,999,303
Chippewa	1,091,100	993,811	1,305,675	938,581	1,210,090
Clark	2,160,577	1,497,728	1,263,727	1,609,330	1,761,003
Columbia	897,377	1,534,783	1,817,243	1,797,326	1,425,699
Crawford	217,563	201,799	217,987	188,564	209,504
Dane	89,082,747	91,695,431	95,009,875	99,585,103	106,969,768
Dodge	1,493,966	1,888,786	2,739,414	346,846	1,514,472
Door	5,534,460	5,414,321	4,072,875	1,053,704	1,220,282
Douglas	982,845	1,031,432	907,855	813,659	880,324
Dunn	737,185	808,386	842,649	268,271	719,912
Eau Claire	2,875,798	1,716,607	1,474,354	2,692,706	1,555,410
Florence	447,094	474,755	426,056	408,059	307,158
Fond du Lac	3,233,303	3,260,759	3,490,861	3,685,520	3,750,752
Forest-Oneida-Vilas	11,368,687	12,212,586	13,003,906	12,736,114	7,714,931
Grant-Iowa	1,087,418	1,084,464	1,015,711	1,103,288	1,182,185
Green	236,369	248,216	221,928	232,712	196,690
Green Lake	748,811	895,779	1,052,459	1,347,221	1,588,559
Iron	45,940	39,043	**	10,787	67,649
Jackson	152,654	188,745	192,390	283,053	427,399
Jefferson	1,570,439	1,650,341	1,583,878	1,382,814	1,872,255
Juneau	301,304	485,869	557,150	522,439	490,717
Kenosha	1,831,401	1,893,752	2,467,615	2,432,863	2,004,173
Kewaunee	4,010,794	3,669,055	2,225,748	1,624,425	1,026,895
La Crosse	2,979,399	3,116,980	3,868,339	3,296,911	2,998,336
Lafayette	463,705	265,030	283,650	243,823	433,546
Langlade-Lincoln-Marathon	9,716,232	9,046,142	8,970,245	9,192,690	8,837,474
Manitowoc	2,008,684	2,257,980	2,478,830	1,784,815	1,661,665
Marinette	4,327,885	4,551,428	3,632,897	723,954	623,424
Marquette	306,015	313,339	314,892	149,982	149,982
Menominee	1,842,504	1,553,910	1,480,115	1,484,100	1,502,296
Milwaukee	10,276,190	10,032,172	10,035,923	20,922,742	18,124,260
Monroe	539,886	1,187,222	1,359,753	1,297,890	1,395,346
Oconto	9,025,328	9,151,410	6,307,391	2,777,850	2,395,263

APPENDIX 1 (continued)

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2013 through 2017

County	2013	2014	2015	2016	2017
Outagamie	$2,627,556	$3,450,695	$3,659,414	$3,901,530	$4,871,738
Ozaukee	1,676,915	1,660,237	1,253,991	1,137,842	1,092,742
Pepin	182,654	159,849	138,405	184,631	343,659
Pierce	270,656	293,326	201,419	173,839	270,834
Polk	421,525	538,802	537,951	587,860	471,869
Portage	1,328,710	1,225,311	1,543,435	1,206,730	1,247,391
Price	274,344	250,639	256,036	285,807	221,964
Racine	3,615,103	2,770,916	2,897,396	2,831,960	2,700,240
Richland	315,980	247,325	145,578	74,881	63,648
Rock	27,214,754	27,682,690	31,102,007	185,373	53,314
Rusk	284,204	296,508	336,906	269,165	269,415
St. Croix	981,814	1,366,301	1,373,814	1,556,294	2,334,521
Sauk	738,400	1,135,226	1,204,591	1,157,103	983,035
Sawyer	183,690	334,128	282,621	288,544	406,532
Shawano	6,448,593	6,572,608	5,480,743	2,122,572	1,739,386
Sheboygan	2,184,535	2,533,625	2,612,295	2,449,878	1,922,308
Taylor	3,988,085	4086,565	3,953,258	3,922,996	2,434,719
Trempealeau	370,758	796,444	1,150,169	1,197,766	951,015
Vernon	472,315	310,953	264,136	268,850	268,351
Walworth	927,767	1,518,346	359,297	566,110	677,900
Washburn	459,553	248,355	438,710	541,434	534,120
Washington	1,136,259	1,148,330	1,042,194	737,769	1,064,815
Waukesha	10,452,568	10,972,037	12,520,580	13,236,150	**
Waupaca	4,471,076	5,039,901	5,163,676	4,634,587	3,969,879
Waushara	375,990	364,710	284,394	338,364	795,542
Winnebago	5,215,811	4,479,576	4,592,532	4,660,611	4,584,545
Wood	1,080,185	1,127,340	1,188,967	1,237,809	1,229,955
Total	$296,239,690	$303,411,847	$288,874,680	$237,577,429	$222,623,577

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

**No data reported.

APPENDIX 2

Birth to 3 Expenditures* and Number of Children Served, By County
Calendar Year 2017

	Total Expenses	Children Served		Total Expenses	Children Served
Adams	$133,753	60	Marquette	$ 132,235	16
Ashland	105,183	23	Menominee	71,650	18
Barron	242,699	128	Milwaukee	5,005,215	2,739
Bayfield	79,622	14	Monroe	321,451	105
Brown	1,331,824	568	Oconto	328,047	81
Buffalo	112,558	26	Outagamie	875,336	376
Burnett	110,948	35	Ozaukee	572,543	170
Calumet	542,303	132	Pepin	102,643	14
Chippewa	467,791	153	Pierce	172,676	87
Clark	321,064	70	Polk	254,361	91
Columbia	262,711	82	Portage	414,815	105
Crawford	118,984	46	Price	111,220	24
Dane	2,553,347	865	Racine	784,588	400
Dodge	497,007	183	Richland	141,688	46
Door	315,145	57	Rock	1,351,020	327
Douglas	182,125	96	Rusk	101,980	28
Dunn	598,285	114	St. Croix	427,624	203
Eau Claire	474,311	253	Sauk	691,513	150
Florence	52,744	5	Sawyer	110,724	23
Fond du Lac	562,525	167	Shawano	347,673	117
Forest/Oneida/Vilas	459,546	84	Sheboygan	745,868	219
Grant/Iowa	233,720	73	Taylor	121,617	40
Green	126,084	70	Trempealeau	184,528	63
Green Lake	115,945	26	Vernon	145,668	60
Iron	22,867	10	Walworth	1,022,317	187
Jackson	142,111	24	Washburn	109,598	37
Jefferson	785,631	231	Washington	495,504	290
Juneau	194,044	48	Waukesha	985,361	511
Kenosha	528,896	359	Waupaca	503,475	89
Kewaunee	241,747	59	Waushara	120,305	22
La Crosse	474,003	214	Winnebago	771,128	331
Lafayette	104,235	22	Wood	527,164	178
Langlade/Lincoln/ Marathon	1,440,111	323	Total**	$ 32,901,145	12,108
Manitowoc	669,280	240			
Marinette	246,460	101			

*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.