Services for Persons with Developmental Disabilities

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It is the state's policy to assure the provision of a full range of treatment and rehabilitation services for persons with developmental disabilities, mental disorders, alcoholism, and other drug abuse problems. Further, state law expresses the Legislature's intent to implement a unified system of prevention of these conditions and provision of services that will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care, within the limits of available state and federal funds and county funds required to match state funds.

This paper describes the types of services that are available to persons with developmental disabilities in Wisconsin. The first section presents a brief discussion of the most common types of developmental disabilities and the factors that are believed to cause these disorders. The second section describes the counties' primary role in providing community-based services to persons with developmental disabilities and institutional services available to these persons, including services provided by the state centers for the developmentally disabled.

The Nature of Developmental Disabilities

Wisconsin statutes define a "developmental disability" as "a disability attributable to brain injury, cerebral palsy, epilepsy, Prader-Willi syndrome, autism, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual." This definition is used in determining eligibility for services provided under Chapter 51 of the Wisconsin statutes.

The federal definition, used with respect to federally-supported programs, is somewhat different from the state definition. It defines a developmental disability as a severe, chronic disability of an individual five years of age or older, that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;

- Is manifested before the person attains the age of 22;

- Is likely to continue indefinitely;

- Results in substantial functional limitations in three or more of the following areas of life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; and (g) economic self-sufficiency; and

- Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of a lifelong or extended duration and is individually planned and coordinated.

When applied to infants and young children up to age five, the term describes a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

Using either definition, the Wisconsin Council on Developmental Disabilities estimates that there are approximately 100,000 persons in Wisconsin with developmental disabilities, representing approximately 2.0% of the state's population.

[The Council on Developmental Disabilities is an institutional advocacy and advisory council for individuals with developmental disabilities and is attached to the Department of Health and Family Services (DHFS) for administrative purposes. The Council develops and monitors implementation of the state plan on the provision of services for individuals with developmental disabilities and reviews and advises DHFS on local budgets and plans relating to these services. The Council was established in response to a federal requirement that states establish such a council as a condition of receiving federal funds for advocacy services.]

The most common type of developmental disability is mental retardation. The American Association on Mental Retardation defines mental retardation as a disability characterized by significant limitations in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. In addition, the Association states that mental retardation refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individualized supports.

Mental retardation can be caused by any condition that impairs development of the brain before birth, during birth, or in the childhood years. Several hundred causes of mental retardation have been discovered, but in one-third of those affected, the cause remains unknown. The three major known causes of mental retardation are Down Syndrome, fetal alcohol syndrome, and fragile X syndrome.

Developmental disabilities often result from damage to the brain structure or functioning. These types of disabilities include epilepsy, cerebral palsy, and autism.

Epilepsy is a neurological condition in which the normal pattern of brain activity becomes disturbed, causing strange sensations, emotions, and behavior and sometimes convulsions, muscle spasms, and loss of consciousness. These physical changes are epileptic seizures that may occur in one part of the brain (partial seizures) or affect nerve cells throughout the brain (generalized seizures). For most people with epilepsy, the cause of the condition is not known. However, things that interfere with the way the brain works, such as head injuries, a lack of oxygen during birth, brain tumors, genetic conditions, and infections such as meningitis or encephalitis, may cause epilepsy.

Cerebral palsy is a group of chronic disorders of movement or posture that appear early in life and generally is non-progressive irritation or injury to an immature brain. The causes of cerebral palsy, which are known in approximately 80% of cases, include prenatal maternal diseases and infections, prolonged or abnormal deliveries, birth trauma and prematurity, and several post-natal causes, such as respiratory distress and infections.

Autism is a pervasive developmental disorder of the brain that typically appears before a child is three years old and is characterized by three types of symptoms: (a) impaired social interaction; (b) problems with verbal and nonverbal communication; and (c) unusual or severely limited activities and interests. In addition, autistic behavior frequently includes abnormal responses to sounds, touch, or other sensory stimulation. In most cases, the causes of autism are unknown, although it appears to be a physiological, rather than a psychological disorder.

Evidence suggests that many developmental disabilities can be prevented, primarily through proper perinatal care. Developmental disabilities are commonly associated with low-birthweight and premature babies and the use of alcohol and other drugs and tobacco during pregnancy. In addition, developmental disabilities may occur due to exposure and ingestion of lead or head injuries resulting from accidents and child abuse.

The Role of Counties in Providing Services

In Wisconsin, counties are assigned primary responsibility for the well-being, treatment, and care of persons with mental disabilities (persons with developmental disabilities, persons with mental illness, and alcohol- and other drug-dependent persons) who reside in the county and for ensuring that persons in need of emergency services who are in the county receive immediate emergency services.

Each county establishes its own policy and budget for these services. Because the statutes specify that counties are responsible for the program needs of persons with developmental disabilities only within the limits of available state and federal funds and county funds required to match these funds, counties limit service levels and establish waiting lists to ensure that expenditures for services do not exceed available resources. For this reason, the type and amount of community-based services that are available to persons with developmental disabilities varies among counties in the state.

DHFS rules require each county to meet certain minimum service standards to be eligible for state financial assistance for community-based services for persons with developmental disabilities. These rules define and provide minimum standards for the following 16 different services:

- Information and referral;
- Follow-along;
- Diagnostic;
- Evaluation;
- Counseling;
- Education;
- Recreation;
- Training;
- Treatment;
- Sheltered employment and work activities;
- Day care;
- Personal care;
- Domiciliary care;
- Special living arrangements;
- Transportation; and
- Protective services.

As previously indicated, each county's responsibility to meet the minimum service standards, as specified by rule, is limited by the availability of state, federal, and county matching funds. Further, some counties may offer services to persons with developmental disabilities that are not defined in the rules, such as supported employment services. Finally, state policy has increasingly placed emphasis on tailoring individualized services to the needs of each client. For these reasons, the availability and scope of services in the state varies by county. However, in an effort to ensure that a minimum array of services is available in all counties, the state distributes funding to counties for a variety of programs and services that are intended to complement and support these basic county services.

Programs Funded Under Community Aids

Under the state's community aids program, DHFS distributes state and federal funds to counties for community-based social, mental health, developmental disabilities, and substance abuse services. Community aids funding is allocated to counties on a calendar year basis and is distributed in a single amount that includes federal and state revenue sources. Counties receive both a basic county allocation, which may be expended for any of these eligible services, and categorical allocations, which are funds that are earmarked for specific services and programs. For 2005, the estimated basic county allocation totals $186,483,500 (all funds), representing 90% of all funds to be allocated to counties under the community aids program in that year ($206,154,900). From the remaining portion, counties receive funding earmarked for selected programs, including the family support program.

Services Supported by the Basic County Allocation. Counties may use funding they receive under the community aids basic county allocation for a wide range of services for specified populations, including persons with developmental disabilities. Annually, counties report the amount of community aids funds, including required county matching funds and local funds contributed that are in excess of the required matching funds ("overmatch funds"), to the Wisconsin Council on Developmental Disabilities. Appendix I identifies the budgeted amounts of community aids funds, including county match and overmatch, reported by counties for programs that serve persons with developmental disabilities for calendar year 2003.

Family Support Program. Funding for the family support program is budgeted as a categorical allocation within the community aids appropriation. DHFS distributes $5,089,800 annually to counties to pay for services that enable parents to keep children who have severe disabilities at home. In order to be eligible for program services, a child must have a severe physical, emotional, or mental impairment which is diagnosed medically, behaviorally or psychologically and which is characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services and which has resulted, or is likely to result in, a substantial functional limitation on at least three of the following seven functions of daily living:

- Self-care;
- Receptive and expressive language;
- Learning;
- Mobility;
- Self-direction;
- Capacity for independent living; and
- Economic self-sufficiency.

For the purposes of this program, a child is defined as a person under the age of 24. However, a county must receive approval from DHFS to provide services for families of children ages 21 through 23. Although family income is not a basis for eligibility, cost-sharing may be required, which is based on a sliding fee scale.

Under the family support program, families receive an assessment to determine which services are needed to enable a child with a disability to live at home. Counties are required to ensure that the family participates in the assessment and that the assessment process involves people who are knowledgeable about the child's condition. The assessment also includes a review of available services and sources of funding, such as the family's health insurance or medical assistance. A written service plan is then developed with family support program funds used to provide services for which other funding sources are not available. Up to 10% of the funds allocated to a county may be used to pay for staff and other administrative costs.

In 2003, 92.9% of the 2,838 children who received services under the program had developmental disabilities. Approximately 18.1% of the children who received services were age six or under, 37.6% were age seven through 12, 44.0% were age 13 through 20, and 0.3% were age 21 or over. Of the children that received services in 2003: (a) 36.4% required personal care services because they were unable to help with their personal care; (b) 60.3% required assistance with some personal care activities; (c) 29.2% could not walk; (d) 17.2% required assistance with walking; (e) 36.1% had a severe developmental delay; and (f) 54.3% had a moderate or mild developmental delay.

Although the program provides up to $3,000 in services and goods annually to eligible families (along with additional amounts that may be provided with the Department's approval), the average per child cost for the 2,406 children served in 2003 was $1,780. Of these children, 655 were served on a one-time basis or considered underserved.

Table 1 identifies expenditures for the family support program, by service category, for calendar year 2003.

Table 1: Family Support Program Expenditures, by Service Category -- Calendar Year 2003

	Program Expenditures	% of Total
Architectural modifications of home	$367,901	8.6%
Child care	279,573	6.5
Counseling and therapeutic resources	246,761	5.8
Dental and medical care	139,352	3.3
Diagnosis and evaluation	13,793	0.3
Diet, nutrition, and clothing	167,626	3.9
Equipment and supplies	1,269,464	29.6
Homemaker services	31,920	0.7
In-home nursing services--attendant care	34,653	0.8
Home training / parent courses	57,596	1.3
Recreation / alternative activities	474,063	11.1
Respite care	898,190	21.0
Transportation	142,576	3.3
Utility costs	47,451	1.1
Vehicle modification	76,438	1.8
Other	34,656	0.8
Total	$4,282,013	100.0%

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

As of December, 2003, 2,758 children were on waiting lists to receive services under the family support program.

Other Community-Based Service Programs Adminstered by DHFS

Early Intervention Services for Infants and Toddlers with Disabilities (Birth-to-Three). The early intervention program for infants and toddlers up to three years of age with developmental delays or disabilities, commonly referred to as the birth-to-three program, is a federal program authorized under Part C of the Individuals with Disabilities Education Act (IDEA). Under the program, Wisconsin supplements federal grant funds with state funds to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families. Counties also provide a significant amount of funding for the program.

The goals of the birth-to-three program, as expressed in the federal legislation, are to: (a) enhance the development of infants and toddlers with developmental delays or disabilities and to minimize their potential for developmental delay; (b) reduce the educational costs to society and schools by minimizing the need for special education and related services; (c) minimize the likelihood of institutionalization of individuals with disabilities and maximize their potential for independent living in society; (d) enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities; and (e) enhance the capacity of state and local agencies and providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations.

Counties are responsible for administering the program, based on state and federal guidelines, and have the following primary responsibilities:

- Establishing a comprehensive child find system to identify, locate, and evaluate children who may be eligible for the birth-to-three program;

- Designating a service coordinator for every child referred to the program for evaluation;

- Ensuring that core services, such as evaluation, service coordination, and the development of an individualized family service plan (IFSP) are provided to families at no cost; and

- Determining parental liability for services received in accordance with the IFSP.

An evaluation of a child is conducted to determine eligibility for the birth-to-three program. This evaluation is conducted by an early intervention team, which includes the service coordinator and at least two professionals from different disciplines of suspected areas of need. Evaluations must be done in consultation with the child's parents. A child is considered eligible if he or she is under three years of age and has a developmental delay or determined to have a physician-diagnosed and documented physical or mental condition which has a high probability of resulting in a developmental delay.

Once eligibility is determined, an assessment is conducted by the early intervention team in order to further identify the unique needs of the child and his or her family. The results of the assessment are used by a team of professionals, the service coordinator, the parents, other family members, and an advocate, if requested by the parent, to develop the IFSP. The IFSP must include a statement of the outcomes expected to be achieved for the child and family, how those outcomes will be achieved, a timeline for the provision of services, the manner in which services will be provided, and how the services will be paid.

While children are eligible for the birth-to-three program beginning after they are born until they reach the age of three, in 2003, almost 61% of program participants were enrolled in the program for one year or less. Table 2 provides the number and percent of children, by age of referral, for program participants for calendar year 2003.

Table 2: Birth-to-Three Program: Age at Referral for 2003 Participants

Age	Number	Percent
Under six months	1,962	18.0%
Six to 12 months	1,717	15.8
12 to 18 months	1,239	11.4
18 to 24 months	2,157	19.8
24 to 30 months	2,676	24.6
30 months or older	1,120	10.3
Total	10,871	100.0%

In 2003, the most frequently used services by participants in the birth-to-three program, other than service coordination (which is mandatory for all participants), included communication services, special instruction, occupational therapy, physical therapy, and family education. In addition to these services, the following services may also be provided: (a) assistive technology services and devices; (b) audiology services; (c) certain health care services; (d) medical services provided only for diagnostic or evaluation purposes; (e) nursing services; (f) nutrition services; (g) psychological services; (h) social work services; (i) transportation; and (j) vision services. In December, 2003, 94% of these services were provided in either the child's home or usual childcare location and 6% of services were provided in a clinic, classroom, or other setting.

In 2004-05, $6,878,700 general purpose revenue (GPR) and $7,086,800 FED is budgeted for birth-to-three allocations to counties and state administrative costs. Appendix II identifies the county-by-county allocation of state, federal, and local birth-to-three funds for calendar year 2004. In addition, Table 3 identifies all of the revenues

Table 3: Total Revenue for Birth-to-Three Program -- Calendar Year 2003

State and federal funds	$12,848,800
County funds	11,934,900
Medical assistance	3,071,200
MA enhanced reimbursement	1,785,300
Private insurance	307,500
Collections for family cost-sharing	327,100
Other revenue	429,900
Total	$30,704,700

Source: DHFS Bureau of Developmental Disabilities.

received by counties in calendar year 2003 for the birth-to-three program.

On January 1, 2002, DHFS began paying an enhanced medical assistance (MA) reimbursement rate for MA- covered services provided to children enrolled in the birth-to-three program that are provided in the child's natural environment. This enhancement reflects the additional costs of providing services to youth in the birth-to-three program in the child's natural environment.

Supported Employment Opportunities. DHFS provides $60,000 GPR annually to fund supported employment opportunities for individuals with developmental disabilities. These funds, which are used to match federal funds received by the Department of Workforce Development, Division of Vocational Rehabilitation under Title I-B of the federal Rehabilitation Act, are awarded to counties under a competitive process. Counties use these funds to contract with private agencies to provide assessment, job development, job coaching, and other necessary support services, such as transportation and adoptions to an individual’s work environment. Beginning July 1, 2004, through June 30, 2005, funding was provided to support seven projects in Chippewa, Clark, Rock, Sheboygan, Taylor, Waupaca, and Washburn Counties. Projects are supported for a three-year period and are given grant money each year if outcomes are achieved.

Epilepsy Service Grants. In the 2003-05 biennium, DHFS provided $150,000 GPR annually to private, nonprofit organizations or county agencies that provide direct or indirect services to or on behalf of persons with epilepsy. "Direct services" include services provided to a person with epilepsy or a member of the family of a person with epilepsy, including counseling, referral to other services, case management, daily living skills training, providing information, parent helper services, employment services, and support group services. "Indirect services" include services provided to a person working with or on behalf of a person with epilepsy and including service provider training, community education, prevention programs and advocacy.

In reviewing applications for epilepsy grants, DHFS is required to review the need for direct and indirect services to persons with epilepsy and their families in the area in which the applicant provides services or proposes to provide services and ways to ensure that both urban and rural areas receive services under the program.

Agencies that receive grant funding are required to report to DHFS annually: (a) the estimated number of persons with epilepsy that reside within the area served by the agency; and (b) the number of persons with epilepsy and other persons and organizations who received services within the area served by the agency.

In 2003, $30,000 grants were distributed to five affiliates of the Epilepsy Foundation. In that year, these associations provided direct services to approximately 12,333 individuals and indirect services to 35,046 individuals with state and local funds.

Medical Assistance Community-Based Services

Low-income individuals with disabilities can be eligible for federal and state supplemental security income (SSI) benefits. For many individuals with developmental disabilities, SSI payments are the only income they receive. Recipients often use these benefits to pay room and board in community-based settings. Eligibility for SSI provides categorical eligibility for medical assistance (MA), a state and federally-funded entitlement program that provides primary, acute, and long-term care services to certain low-income individuals.

Individuals with developmental disabilities whose income and resources exceed the SSI limits may also qualify for MA by spending down to the medically needy income and asset criteria. Disabled individuals who are working or enrolled in a certified job counseling program may also qualify for MA by meeting the qualified working and disabled individuals (QWDI) or the MA purchase plan (MAPP) criteria.

Under the MA program, recipients are entitled to receive MA card services, such as home health and case management services, as long as the services are medically necessary and are provided within the limitations set by state and federal law and policy.

In addition to MA card services, the MA program offers persons who are developmentally disabled and in need of long-term care several comprehensive program options. These programs include the MA home- and community-based waiver programs, the state-funded community options program, and Family Care. Certain children may also be eligible for MA under the Katie Beckett provision, while working disabled adults may qualify under the MAPP or QWDI criteria. These programs are summarized below and described in more detail in Legislative Fiscal Bureau Informational Paper, "Medical Assistance, BadgerCare, SeniorCare, and Related Programs."

Medical Assistance Community-Based Waiver Programs

Federal law authorizes the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, to waive certain MA requirements to enable states to provide home- and community-based services to persons who would otherwise require care in an institution. In Wisconsin, there are seven such programs that operate under six MA waivers: (1) the community integration program IA (CIP IA); (2) the community integration program IB (CIP IB); (3) the community integration program II (CIP II); (4) the community options waiver program (COP-W); (5) the brain injury waiver (BIW); (6) the children's long-term care waivers (CLTC); and (7) the intensive in-home autism waiver. Five of these programs, CIP IA, CIP IB, BIW, CLTC, and the intensive in-home autism waiver provide services to persons with developmental disabilities[j2].

The Family Care program, which provides comprehensive services to elderly, physically disabled and developmentally disabled individuals through care management organizations, also operates under four federal waivers.

CIP IA and CIP IB. The distinction between CIP IA and CIP IB is that CIP IA supports services for persons who are relocated from the three state centers for the developmentally disabled, whereas CIP IB supports services for persons who are diverted or relocated from nursing homes and ICFs-MR other than the centers to community-based programs. However, CIP IA and CIP IB are administered under a single federal waiver of MA rules. Further, CIP IA and CIP IB participants are eligible to receive the same array of community-based support services, such as supported employment services and prevocational services, that are not otherwise reimbursed under the state's MA program.

CIP IA and CIP IB participants also have the option of participating in the self-determination project. The project was created in 1998 under a three-year Robert Wood Johnson Foundation grant to expand consumer choice and control for individuals with developmental disabilities in three Wisconsin counties (La Crosse, Winnebago, and Dane). Under the initiative, participants are part of a person-centered team that is responsible for identifying the care needs of the individual and how those needs will be met by: (a) identifying the enrollee's goals and establishing a method to attain those goals; (b) adhering to the constraints of a care budget established for the individual; (c) strengthening social supports and using community resources; and (d) establishing processes and supports to meet the needs identified in a consumer-directed service plan. The project allows participants to have greater choice in determining what services will be provided and who will provide those services, while technical functions, such as payroll-related duties are designated to fiscal intermediaries. In calendar year 2003, 82 CIP IA and 834 CIP IB enrollees participated in this option.

Community placements using CIP funding are usually initiated by county staff, parents or guardians, the courts, or, if a client lives at one of the centers, by staff at the center. Once a person is identified as having needs that can be met in a community setting, county staff seek permission from the person's parents or guardian to allow the individual to participate in a community-based program.

County and center staff are responsible for completing an assessment of each individual's functional and comprehensive needs to determine the individual's abilities, disabilities, and need for social and medical long-term care services, taking into account the interests and preferences of the person. Appendix III to this paper describes some of the criteria DHFS uses in assigning individuals to various levels of care. An individual service plan (ISP) is also developed for each waiver applicant that indicates what supports and services will be available to an applicant, how and when they will be delivered, the cost of these services, and how the services will be funded.

Staff in the DHFS Bureau of Developmental Disabilities determine whether the individual's needs can be effectively met under the proposed ISP and whether the care costs are within the limits of available CIP funding. The person is transitioned to the community only after DHFS approves the care plan and all the necessary community resources are in place. Counties are responsible for assuring that clients receive all necessary services identified in the ISP. Since not all of the costs identified in an ISP are eligible for MA reimbursement, counties may have to support 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 COP program and the community aids programs.

DHFS reimburses counties for the actual costs of eligible services based on monthly cost reports submitted by counties. For the 2004-05 fiscal year, under CIP IA, eligible services are funded up to a maximum average per day allowance of $125 for each person relocated from the centers before July 1, 1995, $153 for relocations that occurred between July 1, 1995 and June 30, 1997, $225 for persons placed between July 1, 2002 and June 30, 2003, and $325 for persons placed on or after July 1, 2003. For CIP IA clients whose service costs exceed the fully funded rate, counties can be reimbursed with federal matching funds for approximately 58% of the excess costs, as long as overall expenditures for these services are below the maximum permitted under the waiver. This additional funding is available as a result of the county, rather than the state, providing match for federal MA dollars.

For CIP IB, services are funded, up to an average of $49.67 per person per day. In addition, an enhanced rate is available for placements made from facilities that close or have approved plans for significant downsizing. The enhanced rate is determined by a formula that is related to the facility's MA reimbursement rate. Similar to CIP IA, additional federal funds are available to support approximately 58% of the costs that exceed the applicable CIP IB rate (if below the federal maximum). In calendar year 2003, counties and tribes contributed $87.2 million as the local match for federal MA funds under CIP IB and $6.2 million as the local match for federal MA funds under CIP IA.

The CIP reimbursement rates represent an average amount that may be reimbursed by the state for services provided to all participants within a county. Consequently, the state permits more funds to be spent on behalf of one individual and less on another as long as the average per diem expenditure for participants does not exceed the overall allowable per diems. If expenditures exceed the allowable per diems, counties use their own funds (combined with available federal matching funds) to support the excess costs. This mechanism provides counties flexibility in managing resources to maximize program participation.

Table 4 illustrates the growth in CIP IA and CIP IB expenditures and participants between calendar years 1993 and 2003. As of July 1, 2004, there were 1,134 active CIP IA cases and 9,544 CIP IB cases. The CIP IB slots can be either state-supported (the state pays the 42% match under MA) or locally-supported from county COP or community aids funds or county property taxes. Table 4 includes both locally- and state-supported expenditures and participants.

Table 4: CIP IA and IB Expenditures and Participants (Calendar Years 1993 thru 2003)

		Funding*	Participants**
CIP IA	1993	$23,033,600	621
	1994	29,346,300	693
	1995	34,595,700	795
	1996	42,309,000	846
	1997	45,716,300	938
	1998	55,619,900	1,068
	1999	63,407,100	1,115
	2000	67,125,200	1,115
	2001	70,464,000	1,130
	2002	72,797,100	1,145
	2003	74,601,400	1,165
CIP IB	1993	$32,724,100	1,483
	1994	48,722,500	2,270
	1995	73,878,600	3,848
	1996	109,520,600	4,806
	1997	139,695,900	6,098
	1998	172,738,900	7,424
	1999	198,498,200	7,849
	2000	212,463,400	8,849
	2001	227,372,100	9,299
	2002	254,507,000	8,961
	2003	283,297,500	9,444

*Includes local expenditures.
**Number of participants as of December 31 of each year.

Source: DHFS Bureau of Developmental Disability Services

DHFS estimates that, in calendar year 2003, the average cost of providing care for persons with developmental disabilities in institutions was $466.52 per day for the three state centers and $181.65 per day in other ICFs-MR, when including card costs. By comparison, the average cost to serve a person under CIP IA and CIP IB was estimated to be $257.24 per day and $131.77 per day, respectively, when expenditures for MA card services are included. These cost differences may be due to several factors, including differences in the care needs for individuals who currently live in institutions versus in community-based settings, increasing costs of care per individual in institutions as resident populations decrease, and differences between wage rates of caregivers in institutions and in community-based settings.

Brain Injury Waiver (BIW). Individuals who are substantially handicapped by a brain injury and receive or are eligible for post acute rehabilitation institutional care may receive community-based support services under this waiver program, which began on January 1, 1995. Before the waiver was implemented, individuals who had a brain injury were most frequently institutionalized, since: (a) the other MA waiver programs for which these individuals are eligible do not provide sufficient funding to meet the needs of this group; and (b) people who suffer a brain injury after they are 21 years old are not considered developmentally disabled and thus are not eligible for the CIP IA or CIP IB programs. For fiscal year 2004-05, the budgeted reimbursement rate is $190.16 per day, and funding is budgeted to support a total of 212 participants in the program. In calendar year 2003, program expenditures totaled approximately $17.8 million when including local expenditures (approximately $1.2 million). As of July 1, 2004, 315 individuals were enrolled in this waiver program.

Children's Long-Term Care (CLTC) Waiver. 2003 Wisconsin Act 33 provided funding to support a new MA waiver program, operating under three MA home- and community-based waivers, that provides children with long-term care needs MA services and a single entry point for eligibility determinations in each county. These waivers include: (a) the children's developmental disability waiver for children who meet the ICF-MR level of care; (b) the children's mental health waiver for children who meet the psychiatric hospital or severe emotional disturbance level of care; and (c) the children with physical disabilities waiver for children with hospital, intensive skilled nursing, skilled nursing, and intermediate care facility levels of care.

The CLTC program seeks to improve access to services, choice, coordination of care, quality, and financing of long-term care services for children with physical, sensory, and developmental disabilities, and severe emotional disturbance.

2003 Wisconsin Act 33 provided $821,800 in 2004-05, to support MA benefits to individuals participating in the CLTC program. These waiver slots have been allocated to various counties around the state. Counties are also permitted to create waiver slots by supplying the local match to obtain the federal financial participation on these services. As of October, 2004, there were 120 locally-matched CLTC slots.

In order to be eligible to participate in the CLTC waiver, children must meet functional and financial eligibility criteria that are similar to the family support program and the Katie Beckett eligibility criteria. The functional criteria require a child to have a severe physical, emotional or mental impairment which is diagnosed medically, behaviorally or psychologically and which is characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services and which has resulted, or is likely to result in, a substantial functional limitation in at least two of the five following functions of daily living: (a) learning; (b) mobility; (c) receptive and expressive language skills; (d) self-direction; and (e) self-care.

The financial eligibility criteria require that, in 2004, the child's income may not exceed $1,692 per month and countable assets may not exceed $2,000. Children who have income and/or assets that exceed these limits may become eligible for MA by "spending down" to the CLTC income and asset criteria.

Although the income of the parents of the child is not considered for determining eligibility for MA, families may be required to contribute to the cost of services. DHFS is currently developing parental cost share criteria.

The services provided under the CLTC waiver are similar to those available under other MA home- and community-based waivers. Some of the services that are necessary for adults, such as home-delivered meals, housing counseling, adult day care, and services provided by adult family homes, residential care apartment complexes, and community-based residential facilities, are not available to children under the waivers. Similarly, the CLTC waiver supports services that are not available under the other waivers, including intensive in-home autism services and specialized medical and therapeutic supplies. The average daily rate that will be paid to counties to provide services under the waiver is $48.42 in 2004. In addition to receiving waiver services, CLTC participants have access to all MA-covered card services. As with other MA waiver programs, a calendar year allocation is identified for each county and program, based on estimated expenditures.

Similar to other MA waiver programs, counties may establish waiting lists for services when the funding provided is not sufficient to provide services to all eligible individuals. As of October, 2004, 1,159 children were on the CLTC waiting list. Children may continue receiving services under the waiver until they reach the age of 21 (as long they continue to be eligible for MA), after which they would need to receive some services under another waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 21 years of age, although counties can prevent a disruption in services by placing children already receiving services under CLTC on waiting lists for adult waiver slots.

Intensive In-Home Autism Services. 2003 Wisconsin Act 33 also created an intensive in-home autism benefit operating under two of the three children's long-term care waivers (the children's developmental disability waiver and the children's mental health waiver). Intensive, in-home autism services are defined as one-on-one behavioral modification therapy services for children with autism disorder, Asperger's disorder, or pervasive developmental disorder. These services are intended to teach autistic children the skills that children would typically learn by imitating others around them, such as social interaction and language skills.

Until January 1, 2004, in-home autism services were provided as a fee-for-service benefit under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. However, in June of 2000, the U.S. Department of Health and Human Services (HHS) notified the state that in-home autism services offered under the EPSDT benefit would no longer be eligible for federal MA matching funds. HHS later indicated that the appropriate method for claiming federal financial participation for intensive in-home autism services is through a section 1915 (c) home- and community-based waiver. As a result, the administration developed a proposal to recreate the benefit as a service available under the CLTC waivers.

The state began providing intensive in-home autism services under the CLTC waivers on January 1, 2004. When the in-home autism benefit became available under the waivers, responsibility for administering the in-home autism benefit was transferred from the state to counties. As a result, counties began conducting assessments, establishing individual service plans (ISPs), and performing quality assurance activities for each participant.

In order to qualify for intensive in-home autism services, a child must have a verified diagnosis of an autism spectrum disorder. The vast majority of children eligible to receive autism services are eligible for MA under the Katie Beckett provision, while a small number of eligible individuals qualify for MA as supplemental security income (SSI) recipients.

Services may be provided at the either the intensive or ongoing level. Children are eligible for in-home autism services at the intensive level for up to three years as long as the individual begins receiving services by eight years of age. Services are available on an ongoing basis until the individual reaches 16 years of age. As of September, 2004, 637 children were receiving intensive in-home autism services, while 607 children were receiving ongoing autism services.

Participants at the intensive level may receive 20 to 35 hours per week of intensive in-home autism services plus one hour per week of case management services, while participants at the ongoing level are limited by the services identified in the ISP and the funding that is available. An ISP is developed for each participant to identify the type of care and number of hours of service that each individual requires.

Funding is provided to counties to support intensive in-home autism services based on an established weekly rate and the number of hours specified in each participant's individual service plan. In addition, counties receive funding to support approximately one hour per week of case management services per recipient and are permitted to claim up to 7% of direct service and case management costs to support administrative expenses. At the ongoing level, counties receive $31 per enrollee per day to support all benefit and administrative costs. The calendar year 2004 weekly rates for the intensive in-home autism services are listed in Table 5. In 2003-04,

Table 5: Intensive In-Home Autism Services Weekly Rates

Number of Hours	Weekly Rate
20	$450
21	465
22	485
23	510
24	535
25	555
26	575
27	600
28	620
29	645
30	665
31	685
32	710
33	730
34	755
35	780

approximately $13 million was expended for benefits provided to children participating in the CLTC waivers.

Community Options Program

Under the community options program (COP), individuals who are at risk of entering a nursing home are screened to determine if they could continue to remain in the community if adequate support services are provided. COP includes services that are entirely funded from state general purpose revenues and services that are funded with state and federal MA funds for services provided under an MA waiver. Although the COP-waiver program only serves persons over the age of 65 and persons who are physically disabled, the state-funded COP program serves the following groups: (a) persons with developmental disabilities; (b) elderly persons; (c) persons with chronic mental illness; (d) persons with physical disabilities; and (e) persons with Alzheimer's disease. The state-only COP funds are also used to support MA-eligible services when costs exceed the state reimbursement rate for a waiver program and to support services that are not covered under MA, such as room and board costs.

Funding for the state-only and COP-waiver program is provided to counties as a calendar year allocation that counties may then use to serve as many or as few participants as the funding allows. However, counties are subject to a federal waiver requirement that the average cost of care statewide under the COP-waiver program may not exceed the average cost of care in nursing homes. Currently, DHFS limits the average expenditure per COP-waiver participant to $41.86 per day-the same limit that is applied to CIP II. In calendar year 2003, the average total cost of care for COP-waiver and CIP-II participants, including MA card costs, was $73.16 per day, while the average cost for MA nursing home recipients was $110.44 per day. These average cost differences may be due to several factors including differences in the care needs for individuals who currently live in institutions and community-based settings and differences in the wage rates of caregivers in institutions and community-based providers.

In calendar year 2003, approximately $29 million of the $57.4 million expended (50.5%) under the GPR-funded COP supported services to persons with developmental disabilities.

Family Care

The Family Care program is a comprehensive long-term care program that attempts to: (a) increase flexibility and consumer choice; (b) improve access to services; (c) improve the quality of long-term care services; and (d) develop a cost-effective system for delivering long-term care services.

The Family Care program consists of two major components. First, resource centers provide information, assessments, eligibility determinations and other preliminary services. Second, care management organizations (CMOs) manage and provide the Family Care benefit for every person enrolled in the program under a capitated, risk-based payment system. The Family Care benefit provides a comprehensive and flexible range of long-term care services, including the types of services currently available under COP, the MA community-based waiver programs, and the MA fee-for-service program. Acute care services, such as hospital care or physician care, are supported outside of the monthly capitation rate on a fee-for-services basis.

Family Care enrollees may participate in the "self-directed supports" option, which is available through each of the CMOs. Under the self-directed supports option, participants have greater control over how services are received and who provides such services. For instance, participants work with an interdisciplinary team to determine when and where work will be performed and are permitted to employ family members and friends to provide services. When an individual chooses to self-direct certain services, the associated funding is carved out of the capitation rate and managed by either a "fiscal intermediary" or "co-employment agency."

Currently, nine counties operate resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau), while five counties operate CMOs (Fond du Lac, La Crosse, Milwaukee, Portage and Richland). Four of the CMOs (Fond du Lac, La Crosse, Portage, and Richland) provide services to individuals who are elderly, developmentally disabled, and physically disabled. The Milwaukee County CMO serves only the elderly population. As of June 30, 2004, 1,153 of the 8,900 persons (13.0%) enrolled in Family Care were developmentally disabled.

In order to be eligible for the Family Care benefit, 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 something other than mental illness or substance abuse. An individual meets the functional eligibility criteria if one of the following applies: (a) the person's functional capacity is at the comprehensive level; (b) the person's functional capacity is at the intermediate level; or (c) 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 the person was a resident in a nursing home or was receiving long-term care services when the Family Care benefit became available in the person's county of residence. Financial eligibility criteria are met if an individual either: (a) qualifies for MA; or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rules (non-MA Family Care).

The Family Care benefit is not an entitlement for non-MA eligible persons and the provision of services is limited by program funding. As of May 1, 2003, DHFS instructed CMOs not to admit most non-MA eligible applicants until further notice. As of December 31, 2003, 219 (2.7%) of the 8,186 enrollees were not eligible for MA. In 2003-04, approximately $209.5 million was expended on services provided by Family Care CMOs and resource centers.

The Katie Beckett Provision

Before 1982, federal MA income and resource guidelines presented eligibility barriers for disabled children who could be provided needed care in their homes. If a child under the age of 21 was living at home, the income and resources of the child's parents were automatically considered available for medical expenses for the child. However, if a child was institutionalized for longer than a month, the child was no longer considered to be a member of the parent's household and only the child's own financial resources were considered available for medical expenses. The child was then able to qualify for MA.

These restrictions created a situation where children would remain institutionalized even though their medical care could be provided at home. In 1982, federal MA law was modified to incorporate the "Katie Beckett provision" after Katie Beckett, a ventilator-dependent, institutionalized child, was unable to go home, not because of medical reasons but because she would have lost her MA coverage.

This provision permits states to extend MA coverage to disabled children under the age of 18 who: (1) would be eligible for MA if they were in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR); (2) require a level of care typically provided in a hospital, skilled nursing facility, or ICF-MR; (3) are determined to be appropriate to receive care outside of a facility; and (4) have an estimated cost of care outside of an institution that is no more than the estimated cost of institutional care. Unlike certain other MA recipients, the families of the children eligible under the Katie Beckett provision are not subject to co-payment or deductible requirements.

As of June, 2004, 5,145 children in Wisconsin qualified for MA under the Katie Beckett provision. In the 2003-04 fiscal year, MA expenditures for these children totaled approximately $49.1 million ($18.9 million GPR and $30.2 million FED).

MA Purchase Plan

1999 Act 9 created an option provided under federal MA law to extend MA coverage to certain working, disabled persons. The goal of this program, the "MA purchase plan" (MAPP), is to remove financial disincentives for individuals with disabilities to work. For instance, a disabled person may want to work, but choose not to do so because the additional income the individual would receive may make him or her ineligible for health care coverage under MA or Medicare. The MA purchase plan provides the opportunity for an individual to earn more without losing his or her health care coverage. This plan also allows an individual to accumulate savings from earned income in an independence account to increase the rewards from working.

An individual is eligible to participate in the MA purchase plan if: (a) the individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL ($1,939.58 per month for an individual and $2,602.08 per month for a two-person family in 2004); (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 DHFS; and (e) the individual is at least 18 years old. As of the end of June, 2004, 6,584 individuals were enrolled in MA under MAPP.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,163.75 for an individual and $1,561.25 for a couple in 2004).

Institutional Services

State Centers for the Developmentally Disabled

The DHFS Division of Disability and Elder Services (DDES) currently operates three residential facilities for the care of persons with developmental disabilities. Northern Center in Chippewa Falls, Central Center in Madison; and Southern Center in Union Grove (Racine County).

As counties' capacity to serve individuals in the community has increased, there has been a movement from long-term extended care admissions to short-term admissions at the centers. In 1995, Central Center and Southern Center entered into an agreement with the United States Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA). Under the agreement, the facilities may not accept permanent placements unless services outside of the centers are not adequate to meet the needs of the individual, in which case an admission may only be made on a temporary basis. All requests for temporary admission must be approved by the appropriate court.

A short-term admission is typically made to provide evaluation, assessment, crisis intervention, or to allow the county and provider adequate time to redesign a community support plan. This type of admission requires the approval of the local community board, the director of the center and the guardian, unless the admission is ordered by a court. A short-term admission is typically for a 30- to 90-day period and may be extended to 180 days at the discretion of the Director. Within 30 days after a person is admitted for short-term care, DHFS and the county must identify the support services that would be necessary for an individual to successfully live in the community. In addition, a person over the age of 18 may only be admitted to a center if he or she is determined to be in need of protective placement under Chapter 55 of the statutes.

The purpose of the centers is to provide residents with services that may not otherwise be available to them and assist them in returning to the community when their needs can be met at the local level. Counties are responsible for the care and treatment of persons with developmental disabilities and, thus, play a significant role in determining where an individual will receive services.

The state centers provide the following services: (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 intensive treatment program (ITP) services, to help prevent long-term institutionalization. In addition to these services, the centers may offer dental, mental health, therapy, psychiatric, psychological, general medical, pharmacy, and orthotics services.

The population at the centers has declined considerably over the years. In 1970, nearly 3,700 persons resided in the centers, compared to 767 on June 30, 2004. The state-initiated movement to relocate center residents into the community began in the early 1970's as the centers' mission shifted from primarily a residential to a treatment approach. This movement of residents into the community was further increased as a result of implementation of the community integration program (CIP IA) in 1983 and the recent phase-out of long-term care services of Northern Center. The resident population for each center, as of June 30, 2004, is shown in Table 6.

Table 6: State Centers Resident Population and Daily Inpatient Rates as of June 30, 2004

	Rates	Population
Northern Center	$597	157
Central Center	540	349
Southern Center	520	261
Total		767

The centers are certified as ICFs-MR by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). An ICF-MR provides care and active treatment to residents with long-term disabilities or illnesses who need medical or nursing services to maintain stability. This certification makes the centers eligible for federal cost sharing under the state's MA program. Unlike MA payments to other ICFs-MR, MA payments to the centers are based on the actual eligible costs of operating each center, as limited by the amount budgeted by the Legislature for this purpose.

Table 7 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each center for the 2004-05 fiscal year. In the

Table 7: State Centers for the Developmentally Disabled – Adjusted Base Budget and Authorized Positions – State Fiscal Year 2004-05

	Central Center	Northern Center	Southern Center	Total
I. Program Revenues—MA				
State Operations	$55,288,000	$6,485,400	$37,983,900	$99,757,300
Utilities and Fuel	1,453,900	832,700	1,012,900	3,299,500
Repair and Maintenance	258,300	0	350,400	608,700
Subtotal	$57,000,200	$7,318,100	$39,347,200	$103,665,500
II. Program Revenues—Other				
Alternative Services	$199,400	$4,566,800	$28,100	$4,794,300
Farm Operations	$0	$0	$31,000	$31,000
Activity Therapy	14,000	43,800	20,100	$77,900
Gifts and Grants	35,000	70,000	30,000	$135,000
Interagency and Intra-Agency Programs	152,400	78,900	147,000	378,300
Subtotal	$400,800	$4,759,500	$256,200	$5,416,500
Total Program Revenue Funding	$57,401,000	$12,077,600	$39,603,400	$109,082,000
III. GPR Funding				
General Program Operations	$3,000	$20,000	$0	$23,000
Total Funding (All Sources)*	$57,404,000	$12,097,600	$39,603,400	$109,105,000
Total Authorized Positions (All Sources)*	883.52	281.50	575.54	1,740.56

*Authorized positions and funding will be adjusted as part of the 2005-07 budget to reflect actual CIP IA placements that occurred in the 2003-05 biennium.

past, both the funding and position reductions were made as part of 2003 succeeding biennial budget. However, under 2003 Act 33, 116.0 positions were deleted at Southern and Central Centers in anticipation of an increase in CIP IA placements that would occur in 2003-05 as a result of a CIP IA rate increase.

By July 1, 2005, only two state-operated facilities will serve individuals with developmental disabilities on a long-term basis. The 2003-05 biennial budget (Act 33) required DHFS to relocate Northern Center's residents to either a community-based setting or to another ICF-MR, but authorized that facility to continue to provide short-term ITP services and certain alternative services. In 2003-04, approximately 34 individuals residing at Northern Center were relocated.

Other Institutional Services

Other facilities offer institutional care for Wisconsin residents with developmental disabilities. Like the state centers, these ICFs-MR are certified by the U.S. Department of Health and Human Services, CMS and must meet federal MA care and treatment standards. Excluding the three state centers, on January 1, 2003, there were 35 ICFs-MR operating in Wisconsin with 1,820 licensed ICF-MR beds. The 35 ICFs-MR ranged in size from 14 to 220 staffed beds. Counties operated 19 of the 35 ICFs-MR (54%), which accounted for 41% of the licensed ICF-MR beds (752 of 1,820). Nearly all ICF-MR residents are supported by MA.

Act 33 included provisions that encourage counties to provide care to persons with developmental disabilities in the community. These changes included: (a) requiring counties to provide services to persons with developmental disabilities in the community unless it is determined that a community-based placement would not be the most integrated setting appropriate to the needs of the individual, taking into account information presented by all affected parties; (b) transferring responsibility for the non-federal share of ICF-MR costs for persons with developmental disabilities from the state to counties; and (c) providing funding to ICFs-MR entering into phase-down agreements and to counties to encourage community-based placements through additional CIP IB slots and one-time funding allotments. These provisions are described in greater detail in Appendix IV.

Table 8 provides information on these types of institutional settings for persons with developmental disabilities in Wisconsin at the end of 2001, 2002, and 2003. As shown in Table 8, the number of developmentally disabled persons in institutions decreased by 514 (18.3%) over this two-year period, from 2,814 on December 31, 2001, to 2,300 on December 31, 2003.

Table 8: People with Developmental Disabilities in Institutions on December 31, in 2001, 2002, and 2003

Setting	No. of Residents 12/31/01	No. of Residents 12/31/02	No. of Residents 12/31/03	Change Over Two Years
State Centers	821	795	772	-6.0%
Other ICFs-MR	1,859	1,655	1,415	-23.9
Nursing Homes	134	130	113	-15.7
Total	2,814	2,580	2,300	-18.3%

APPENDIX I

2003 County Community Aids Funds Budgeted for Services to Persons With Developmental Disabilities

	Community Aids Budgeted for Developmental Disabilities*	Family Support Allocation	County Matching Funds	County Overmatch
Adams	$20,936	$16,828	$3,735	$28,770
Ashland	200,000	24,652	15,000	85,000
Barron	299,836	50,087	29,654	219,826
Bayfield	97,850	27,695	12,416	96,321
Brown	2,782,034	197,378	294,017	2,912,936
Buffalo	162,165	16,634	17,683	63,117
Burnett	98,000	15,689	11,244	64,070
Calumet	452,340	37,481	48,443	980,928
Chippewa	529,492	55,842	52,368	72,632
Clark	636,027	40,172	71,225	1,168,825
Columbia	254,286	87,964	29,647	224,735
Crawford	675,704	18,811	68,174	0
Dane	4,597,200	303,794	588,119	15,848,622
Dodge	786,962	78,028	78,696	383,664
Door	340,742	45,433	36,000	563,471
Douglas	585,880	48,175	57,944	849,764
Dunn	260,000	31,900	28,869	500,000
Eau Claire	2,829,849	88,244	288,603	223,807
Florence	22,500	13,360	2,500	0
Forest/Oneida/Vilas	733,440	72,806	70,355	125,499
Grant/Iowa	770,550	72,339	76,208	135,058
Green	172,923	27,976	19,869	318,156
Green Lake	153,402	20,632	18,408	165,500
Iron	32,314	9,048	4,000	6,000
Jackson	502,661	29,715	49,714	155,741
Jefferson	578,534	69,461	57,218	1,173,122
Juneau	140,355	24,826	16,337	60,372
Kenosha	1,241,112	97,783	122,747	58,669
Kewaunee	433,662	27,444	42,890	55,947
Lafayette	234,500	37,214	26,000	0
Langlade/Marathon	1,668,127	152,766	166,813	3,430,257
Lincoln	335,461	37,170	33,177	0
Manitowoc	1,050,350	77,626	111,558	504,025
Marinette	620,477	49,370	61,366	190,095
Marquette	84,660	16,275	8,373	343,134
Menominee	$51,085	$22,872	$6,076	$49,265
Milwaukee	9,464,347	852,668	936,034	350,000
Monroe	299,444	47,550	34,318	1,020,602
Oconto	604,009	41,726	67,112	825,116
Outagamie	1,905,965	135,504	188,500	2,682,157
Ozaukee	518,484	59,410	51,297	1,777,672
Pepin	167,786	14,176	17,996	165,103
Pierce	200,000	27,996	22,549	39,026
Polk	262,434	41,518	30,897	201,161
Price	159,000	26,183	15,725	92,275
Racine	1,397,700	168,420	159,519	808,441
Rock	2,132,848	130,421	233,696	1,858,481
Rusk	235,000	18,690	23,357	2,966
St. Croix	668,748	58,331	66,140	1,320,085
Sauk	375,678	46,765	41,620	455,622
Sawyer	183,242	37,275	20,720	0
Shawano	560,174	39,067	56,017	84,026
Sheboygan	759,807	98,798	75,981	1,661,239
Taylor	285,100	20,050	28,510	6,973
Trempealeau	462,365	32,932	45,728	127,509
Vernon	535,305	25,175	52,942	139,289
Walworth	898,599	66,956	95,494	899,931
Washburn	281,652	17,128	27,856	36,144
Washington	731,990	96,352	72,247	1,317,841
Waukesha	2,364,345	247,632	258,327	2,951,265
Waupaca	487,662	52,668	53,439	813,515
Waushara	117,300	41,622	11,730	404,009
Winnebago	2,127,511	126,074	225,570	1,450,801
Wood	673,675	86,461	65,195	1,434,276
Total	$52,680,612	$3,939,005	$5,880,396	$43,673,169

Source: Wisconsin Council on Developmental Disabilities

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

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

APPENDIX II

Birth-to-Three Allocations and Budgeted Local Funds
Calendar Year 2004

County	Maintenance of Effort (1999 Actual Expenditures)	2004 State/Fed Allocation	2004 Local Funds Budgeted	2004 Total State/ Federal and Local Funds
Adams	$29,297	$33,423	$38,281	$71,704
Ashland	22,283	34,984	24,540	59,524
Barron	70,000	105,858	94,454	200,312
Bayfield	39,294	40,647	39,294	79,941
Brown	746,434	705,420	746,434	1,451,854
Buffalo	24,516	30,187	17,013	47,200
Burnett	25,592	35,854	34,905	70,759
Calumet	136,044	127,436	174,844	302,280
Chippewa	45,686	111,226	111,618	222,844
Clark	36,802	69,163	91,190	160,353
Columbia	114,781	123,459	120,969	244,428
Crawford	21,832	30,610	21,832	52,442
Dane	530,747	795,013	792,328	1,587,341
Dodge	148,178	170,091	150,890	320,981
Door	93,818	88,613	121,474	210,087
Douglas	66,865	99,946	79,800	179,746
Dunn	153,855	145,775	222,105	367,880
Eau Claire	164,405	232,782	170,413	403,195
Florence	500	16,358	500	16,858
Fond du Lac	211,284	235,630	328,266	563,896
Forest/Oneida/Vilas	151,916	161,595	148,630	310,225
Grant/Iowa	108,817	134,517	124,964	259,481
Green	22,338	60,262	22,338	82,600
Green Lake	31,688	39,490	39,571	79,061
Iron360	18,806	360	19,166	
Jackson	12,667	39,673	36,517	76,190
Jefferson	148,415	187,112	225,961	413,073
Juneau	29,124	50,723	67,636	118,359
Kenosha	127,995	336,115	127,995	464,110
Kewaunee	35,429	47,829	48,868	96,697
La Crosse	115,671	205,509	218,094	423,603
Lafayette	2,446	28,936	31,464	60,400
Langlade	203,339	153,436	225,718	379,154
Lincoln	70,611	72,175	143,911	216,086
Manitowoc	76,442	214,393	135,371	349,764
Marathon	381,338	361,434	839,998	1,201,432
Marinette	54,463	82,100	82,474	164,574
Marquette	27,018	31,299	29,398	60,697
Menominee	12,045	20,856	13,450	34,306
Milwaukee	2,190,392	3,034,838	2,190,392	5,225,230

County	Maintenance of Effort (1999 Actual Expenditures)	2004 State/Fed Allocation	2004 Local Funds Budgeted	2004 Total State/ Federal and Local Funds
Monroe	$50,134	$73,768	$65,832	$139,600
Oconto	13,861	58,785	194,899	253,684
Outagamie	157,066	368,664	445,686	814,350
Ozaukee	256,396	217,378	256,617	473,995
Pepin	35,261	44,720	36,466	81,186
Pierce	23,860	70,540	38,903	109,443
Polk	78,745	99,828	84,918	184,746
Portage	173,154	175,257	173,677	348,934
Price	1,568	23,361	1,956	25,317
Racine	299,898	474,475	301,081	775,556
Richland	51,044	53,194	51,044	104,238
Rock	142,984	370,870	251,130	622,000
Rusk	26,110	36,280	26,110	62,390
St. Croix	117,392	137,928	168,383	306,311
Sauk	144,001	137,854	186,900	324,754
Sawyer	10,963	38,207	17,993	56,200
Shawano	53,881	75,110	59,359	134,469
Sheboygan	255,696	288,213	257,264	545,477
Taylor	4,863	36,306	11,040	47,346
Trempealeau	9,186	54,179	9,186	63,365
Vernon	33,815	51,591	88,909	140,500
Walworth	136,180	165,652	159,999	325,651
Washburn	24,000	37,340	49,238	86,578
Washington	100,920	205,459	116,251	321,710
Waukesha	277,602	619,189	277,602	896,791
Waupaca	151,886	155,158	179,619	334,777
Waushara	22,722	39,478	46,353	85,831
Winnebago	270,287	340,019	303,614	643,633
Wood	17,228	131,295	56,511	187,806
TOTAL	$9,425,431	$13,093,671	$12,050,800	$25,144,471

Source: DHFS, Bureau of Developmental Disabilities

APPENDIX III

Developmental Disabilities Levels of Care

Persons with developmental disabilities are evaluated to determine the severity of their functional, behavioral and health problems. Based on these evaluations, they are assigned one of four levels of care (DD-1a, DD-1b, DD-2 and DD-3), each with a different program emphasis and treatment goal. Generally, no single factor, such as level of retardation, determines an individual's classification. Instead, evaluations reflect a combination of factors that suggest which treatments may be appropriate for the individual.

Persons classified as DD-1a include developmentally disabled children and adults who require active treatment and whose health status is fragile, unstable or relatively unstable. The health care needs of these persons may be complex, requiring frequent professional assessments and monitoring. These individuals are often unable to communicate needs to caregivers verbally and may be totally dependent on staff for accomplishment of most activities of daily living. These persons are usually severely or profoundly retarded (IQ levels below 40). The program emphasis for these individuals is on the development of sensory and motor skills and environmental awareness.

Persons classified as DD-1b include developmentally disabled children and adults who require active treatment and considerable guidance and supervision. These persons frequently exhibit behaviors directed toward themselves and others which may be dangerous, including physical aggression or assaults to peers and staff, destruction of environment and hyperactivity. These persons may be unable to communicate needs to caregivers verbally and may have only limited understanding of the spoken word. Similar to DD-1a patients, DD-1b patients are usually severely or profoundly retarded. Persons classified as DD-1b have varying degrees of functional abilities and require different amounts of assistance from staff to accomplish basic skills, such as feeding, dressing and bathing themselves. Health care assessments and monitoring is required at regular intervals for these individuals.

Persons classified as DD-2 generally include moderately retarded adults (IQs between 35 and 55) who require active treatment with an emphasis on skills training. These persons may only occasionally exhibit physically aggressive or undesirable social behaviors. They may have only limited understanding of the spoken work, but may know people by name and understand simple directions. These persons have varying degrees of functional abilities--most will be able to feed themselves with some degree of neatness, drink without assistance, and pull off clothing, but may require assistance with buttons, zippers and shoelaces. Persons in this category usually have stable health, but require assessment and monitoring of their health status at regular intervals.

Persons classified as DD-3 generally include mildly retarded adults (IQs between 55 and 70) who require active treatment with an emphasis on refinement of social skills and attainment of domestic and vocational skills. At this level, persons can usually participate in menu planning, shopping and food preparation. They are capable of daily participation in vocational training programs and sheltered workshops. Persons at this care level usually exhibit appropriate social behavior and have good language skills. They are capable of self-care for personal grooming, feeding, bathing and toileting, but may require assistance in other skills, such as managing money and selecting clothing. Since the health status of these persons is stable, health care focuses on prevention and health education.

APPENDIX IV

Major Program Changes in 2003-05

Children's Long-Term Care Waiver. 2003 Wisconsin Act 33 provided funding to implement a new MA waiver program to provide children with developmental disabilities and other long-term care needs services and a single entry point for eligibility determinations and information in each county. Act 33 provided $420,000 ($210,000 GPR and $210,000 FED) in 2003-04 and $1,091,800 ($476,800 GPR and $615,000 FED) in 2004-05 to support: (a) children's long-term care waiver services, beginning January 1, 2005; and (b) contracted services, including program development, functional screens, quality assurance, and database revisions.

In-Home Autism Waiver. 2003 Act 33 provided funding to support intensive, in-home autism services under an MA home- and community-based waiver program. In the past, services were provided as fee-for-service benefit under the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Under the new program, children are eligible to receive 20-35 hours of intensive in-home autism services for a maximum of three years, while children at the post-intensive level are limited by the services and funding identified in each individual's service plan. Responsibility for administering the in-home autism benefit under the waiver was transferred from the state to counties, beginning January 1, 2004.

Limiting ICF-MR Placements. 2003 Act 33 included provisions that limit the placement of individuals with developmental disabilities in ICFs-MR and nursing homes and transfer the responsibility for the non-federal costs of care for individuals with developmental disabilities who receive services in ICFs-MR (other than the state centers for the developmentally disabled) and for permissible services in nursing homes from the state to counties, beginning January 1, 2005. These provisions included funding changes to support county funding allotments equal to the MA fee-for-service costs for institutional services provided to individuals with developmental disabilities in ICFs-MR and nursing homes; 25 new CIP IB slots, incentive payments to encourage ICFs-MR to enter into phase-down agreements; the deletion of funding to support services for former residents of the Christian League for the Handicapped, DHFS administrative staff, and information technology changes. DHFS will reallocate funding currently used to support these institutional services to counties, which counties can use to either pay for institutional care or community-based services under CIP IB.

Phase-Out Long-Term Care Services at Northern Wisconsin Center. Under 2003 Act 33, funding was reduced by approximately $41.2 million ($6.5 million GPR, $9.2 million FED, and $25.5 million PR) in the 2003-05 biennium to reflect the elimination of long-term care services at the Northern Center for the Developmentally Disabled. By June 30, 2005, DHFS expects that all residents (except 30 intensive treatment program participants) will be relocated to a community-based setting or another ICF-MR. DHFS was also directed to sell surplus land at Northern Center. The proceeds from the land sales will be available to support state activities conducted on that campus.

CIP IA Rate Increase. 2003 Act 33 increased the maximum rate DHFS pays to counties to provide services to individuals who are relocated from the state centers to the community and the budget reduction rate to the state centers following each placement under the CIP IA program from $225 for placements made between July 1, 2002, and June 30, 2003, to $325 per day for individuals relocated on or after July 1, 2003.