Informational Paper 50

Services for Persons with Developmental Disabilities

Wisconsin Legislative Fiscal Bureau
January, 2011

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Wisconsin provides a wide range of treatment and rehabilitation services for persons with developmental disabilities, mental disorders, and alcohol and other drug abuse problems. State law aims to maintain a unified system of prevention of these conditions, and the provision of services to ensure access to minimally restrictive treatment alternatives, while providing continuity of care.

This paper describes state programs that provide services to individuals with developmental disabilities and their families.

Provision of Public Services

Chapter 51 of the Wisconsin statutes defines 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."

The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 defines "developmental disability" 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.

The Department of Health Services. The Division of Long Term Care (DLTC) in the Department of Health Services (DHS) is generally responsible for the state's programs for persons with developmental disabilities, including Family Care, the community options program, the Birth-to-3 program, several medical assistance (MA) waiver programs, and the State Centers for the Developmentally Disabled. The DLTC consists of the Bureau of Long Term Support, the Bureau of Aging and Disability Resources, the Bureau of Center Operations, and the Bureau of Nursing Home Services.

Seven councils are organized under the DLTC: the Council for Children with Long-Term Support Needs, the Council for the Deaf and Hard of Hearing, the Birth-to-3 Interagency Coordinating Council, the Committee for People with Disabilities, the Council on Blindness, the Council on Long Term Care, and the Council on Physical Disabilities. These councils each have different membership structures and missions, as designated by statute or established by the Governor.

The Board for People with Developmental Disabilities. The Board for People with Developmental Disabilities ("the Board") is a state agency charged with advocacy, capacity building, and systems change to benefit individuals with developmental disabilities. While the Board is responsible for its own rule-making and policy positions, the Department of Administration performs human resource, payroll, contracting, purchasing, and budgeting functions for the Board.

The Board'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, be

independent and productive, and be integrated and included in the community. The main responsibilities of the Board include reviewing and analyzing available services, developing a state plan for advocacy and systems change, advising DHS, the Governor, and the Legislature, administering programs funded by the Board, advocating for persons with developmental disabilities, strengthening a statewide self-advocacy organization, and supporting opportunities for people with developmental disabilities to participate in coalitions and develop leadership skills.

The agency's governing Board is comprised of 20 members, appointed by the Governor to a four-year term. At least sixty percent of the Board must consist of persons with developmental disabilities, their parents or guardians, or of immediate relatives or guardians of persons with developmental disabilities who cannot advocate for themselves. The remainder of the Board includes representatives from the following agencies or organizations:

- The agency that administers vocational rehabilitation services in the Department of Workforce Development;
- The agency that administers MA (DHS);
- The agency that administers the Older Americans Act (DHS);
- The agency that administers the Maternal and Child Health program (DHS)
- The Department of Public Instruction;
- The Waisman Center at the University of Wisconsin-Madison;
- Disability Rights Wisconsin, the state's designated protection and advocacy agency;
- A public (county) provider;
- A private, not-for-profit developmental disability service provider; and
- A non-governmental advocacy group.

In 2010-11, the Board is budgeted $1,404,500 to support its operations ($841,100 FED and 7.75 FED positions and $19,800 GPR) and grants ($543,600 FED). The Board receives federal funds from the U.S. Department of Health and Human Services, Administration on Developmental Disabilities.

County Service Provision. In Wisconsin, counties are responsible for the well-being, treatment, and care of residents with developmental disabilities, and must ensure that persons in need of immediate emergency services receive these services. Each county establishes its own policy and budget for these services.

State statutes assign counties the responsibility for the program needs of persons with developmental disabilities only within the limits of available state and federal funds, and required county matching funds. Counties may limit service levels and establish waiting lists to ensure that expenditures for services do not exceed available resources. State policy has also emphasized individualized services for the needs of each client.

For these reasons, the type and amount of community-based services available to persons with developmental disabilities varies between counties. However, rules promulgated by DHS require that all counties meet certain minimum service standards to receive state financial assistance for community-based services. These rules (DHS 61) apply to sixteen service areas, including information and referral, diagnosis, evaluation, and counseling. Counties may offer services that are not specified in rule, such as supported employment services.

To ensure that a minimum array of services is available in all counties, the state distributes funding for a variety of programs and services that complement and support these basic services. Most of this funding is provided under the state's MA program.

Medical Assistance Community-Based Services

Medical assistance (MA) is a state and federally-funded entitlement program that provides primary, acute, and long-term care services to certain low-income individuals. Under the MA program, recipients are entitled to receive MA card services, such as physician services, dental services, home health and case management services, as long as the services are medically necessary and provided within the limitations set by state and federal law and policy. Some children with long-term disabilities and complex medical needs may also qualify for MA coverage under the Katie Beckett provision.

In addition, the MA program offers several comprehensive program options to persons in need of long-term care for a developmental disability. These programs include the MA home- and community-based waiver programs, the state-funded community options program, and Family Care. Children with developmental disabilities may also receive services under the children's long-term support waiver program. These programs are summarized in this section and described in more detail in the Legislative Fiscal Bureau Informational Paper entitled "Medical Assistance, BadgerCare Plus, SeniorCare, and Related Programs."

Some low-income individuals with disabilities are 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 and for any other personal expenses common to community life. Eligibility for SSI provides categorical eligibility for MA.

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 levels. In addition, due to the high cost of long-term care, individuals enrolled in home- and community-based waiver programs and Family Care have a special income limit that allows them to have a higher maximum monthly income than participants receiving standard MA services.

Alternatively, disabled individuals who are working or enrolled in a certified job counseling program or involved in competitive, supported or sheltered employment may also qualify for MA by meeting the qualified working and disabled individuals (QWDI) or the MA purchase plan (MAPP) criteria.

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 six such programs: (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); and (6) the children's long-term support waivers (CLTS), which include the intensive in-home autism waiver. Four of these programs, CIP IA, CIP IB, BIW, and CLTS, provide services to persons with developmental disabilities. CIP IA and CIP IB only serve persons with developmental disabilities, BIW only serves persons with brain injuries, and CLTS has three separate waivers for persons with developmental disabilities, persons with physical disabilities, and persons with mental illness.

The Family Care program provides a similar package of community-based services for people who are elderly, physically disabled, or developmentally disabled. It also provides certain standard MA long-term care services, such as personal care and home health care, through managed care organizations (MCOs). This broader range of services allows the MCO to manage all long-term care ser-

vices and avoids creating a fiscal incentive for the MCO to use less efficient services in order to shift costs to standard MA services. Family Care operates under four federal waivers. The Family Care program replaces many of the services provided under several of the other waiver programs in counties choosing to participate in the program. Finally, the state has a federal waiver to offer a self-directed care program, called "Include, Respect, I Self-Direct" (IRIS), which covers waiver services and operates in Family Care counties as an alternative to managed care.

State Relocation Initiatives

DHS operates four separate MA waiver programs that offer community-based services to individuals who previously received services in institutions. Two of these programs -- the community integration program IA (CIP IA) and the intermediate care facility for the mentally retarded (ICF-MR) restructuring initiative -- specifically serve individuals with developmental disabilities. The ICF-MR restructuring initiative is operated under the same authority as the CIP IB waiver program. These program distinctions are all established at the state level. Federally, all of these waivers for people with developmental disabilities are operated under a single federal waiver.

Community Integration Programs (CIP IA and CIP IB). CIP IA and CIP IB provide MA-funded, community-based services to individuals with developmental disabilities. CIP IA supports services for persons who are relocated from the State Centers for the Developmentally Disabled (Centers), while CIP IB supports services for other qualified persons. 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, which are not available to other MA recipients.

Community placements using CIP funding can be initiated by county staff, parents or guardians, the courts, or, if a client lives at one of the Centers, by staff at the Center. Placements can also be initiated as part of facility closing plans for private intermediate care facilities for the mentally retarded (ICFs-MR). Once a person is identified for community placement, county officials work with the person's parents or guardian to plan for the individual's community-based services. Courts are often involved in ordering placements so the individual can live in the most integrated and least restrictive setting available.

County and facility staff completes a comprehensive assessment of each individual's needs, preferences and desired outcomes to determine the services and supports the individual requires for a successful community placement. An individualized service plan (ISP) is also developed for each applicant. This plan details the supports and services that will be made available to the individual, how and when they will be delivered, the cost of these services, and how the services will be funded.

Staff in the DHS Bureau of Long Term Support determines whether the individual's needs can be effectively met under the proposed ISP and are charged with the responsibility of reviewing and approving all initial plans. The review process determines whether the individual's needs can be effectively met with the services and supports proposed in the plan and whether the costs are appropriate and all the necessary community resources are in place. The state and counties are jointly responsible for assuring that clients receive all necessary services identified in the ISP. Since not all of the costs of community living identified in a person's plan are eligible for MA reimbursement, counties may have to fund certain costs, such as room and board services, with funding from other sources. These costs are frequently supported by funding made available to counties under the state-funded community options and community aids programs.

DHS reimburses counties for the services they provide to CIP IA and CIP IB enrollees based on the total actual costs of eligible services. Some of

these costs are fully reimbursed by state MA funds, while others require the county to allocate other local funding sources, including local taxes levied by the county. For individuals who were placed from the Centers beginning in fiscal year 2009-10, the state reimburses counties at rates that reflect the funding needed to meet the individual's ISP in the community. Table 1 shows the maximum average per day allowance that DHS provided counties for CIP IA clients prior to fiscal year 2009-10, by relocation date.

Table 1: Rates for CIP IA Regular Slots to 6/30/09

Per Diem Amounts	From:	To:
$125.00	Prior to	7/1/1995
$153.00	7/1/1995	6/30/1997
$184.00	7/1/1997	6/30/2000
$190.00	7/1/2000	6/30/2001
$200.00	7/1/2001	6/30/2002
$225.00	7/1/2002	6/30/2003
$325.00	7/1/2003	6/30/2004
$325.00	7/1/2004	6/30/2009

For CIP IA clients whose service costs exceed the fully funded rate, counties can be reimbursed with federal matching funds for approximately 60% of the excess costs. This additional funding is available as a result of the county, rather than the state, providing the match for federal MA dollars.

Prior to January 1, 2008, services provided to eligible individuals under CIP IB were funded by state/federal MA at various reimbursement levels. The basic per day amount a county received for a state-funded CIP IB slot was $49.67 per day. This amount was often lower than the actual costs, requiring counties to allocate other funds to cover the entire cost of the services provided. In addition, enhanced rates were available to cover the entire cost of services provided to individuals who were placed in the community from facilities that closed or approved plans for significant downsizing. The enhanced rate was determined by the person's costs as estimated in the person's initial service plan. Similar to CIP IA, additional federal funds were available to support approximately 60% of MA-eligible service costs that exceeded the applicable CIP IB rate (if below the federal maximum).

As of January 1, 2008, state funding provided to counties for both CIP IA and CIP IB services is now treated as an allocation to counties. Counties can use the total available funding to serve as many individuals as possible, regardless of the number of slots allocated. State funding allocations are still based on the reimbursement rate, number of allocated slots and total number of days in the contract year. In addition, counties may not transfer funds between waiver programs. This mechanism provides counties flexibility in managing resources to maximize program participation.

In calendar year 2009, 833 individuals received services under CIP IA and 7,215 individuals received services under CIP IB.

ICF-MR Restructuring Initiative. 2003 Wisconsin Act 33 (the 2003-05 biennial budget act) included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-MR. With limited exceptions, the act prohibits a person from placing an individual with a developmental disability in an ICF-MR, and prohibits an ICF-MR 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, Act 33 transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services at a developmental disability level of care in ICFs-MR and nursing homes, other than the Centers. However, since the beginning of the initiative, DHS has continued to pay the state's share of the MA payment to facilities on behalf of counties.

Under this initiative, DHS has established a single budget to provide services to individuals

with development disabilities who were in institutions as of December, 2004, and individuals in MA-supported community-based programs. Institutions continue to receive payment for care they provide from the state's MA program. However, under the global budget DHS has established for these services, DHS may reallocate funding initially budgeted to reimburse ICFs-MR to support community-based services. The principal is frequently referred to as "the money follows the person."

Act 33 also provided funding for DHS to pay ICFs-MR that agreed to reduce the number of their licensed beds.

These changes were intended to increase access to community-based, long-term care services for individuals with developmental disabilities by allowing counties access to funding which had been previously designated solely for institutional care, as long as total program costs for institutional and community services could be managed within the same allowable funding limit established in the state budget.

From January 1, 2005 to June 30, 2009, 653 individuals at a developmental disability level of care had been successfully relocated from ICFs-MR and nursing homes, other than the Centers, to alternative community-based residential settings.

Other MA-Supported Programs for Individuals with Disabilities

Brain Injury Waiver (BIW). Individuals who have 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. The annual amount budgeted to provide these waiver services is determined by the number of approved slots, which are allocated to counties based on the number of eligible individuals residing in each respective county, and the applicable reimbursement rate.

For 2009-10, the budgeted reimbursement rate was $180 per day, and the total number of approved waiver slots was 217. Counties have the option of funding additional slots, with county funds serving as the match for federal MA funds. In calendar year 2009, 215 individuals received services under the program.

Children's Long-Term Support (CLTS) 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 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 CLTS 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 disturbances.

DHS allocates waiver slots and funding to counties throughout the state based on each county's estimated expenses for eligible waiver services. In 2010, the daily rate paid to counties to provide services (excluding intensive in-home treatment services for children with autism) under the CLTS waivers was $30.60. For children in crisis, the daily rate was $48.42. Counties may also create

additional waiver slots by supplying the local match to obtain the federal financial participation on these services. Once funding has been allocated, counties then have the authority to serve as many individuals as available funds will allow. As of June 30, 2010, 4,582 children received services under the CLTS waiver.

Similar to other MA waiver programs, counties may establish waiting lists for services when the funding provided by the state is not sufficient to provide services to all eligible individuals. As of June 30, 2010, 2,663 children were on the CLTS waiting list, including 269 waiting for intensive in-home treatment services. Children may continue receiving services under the waiver until they reach the age of 22 (as long they continue to be eligible for MA), after which they would need to receive some services under an adult waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 22 years of age, although counties can prevent a disruption in services by placing children already receiving services under CLTS on waiting lists for adult waiver slots.

In order to be eligible to participate in the CLTS 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 2010, the child's income may not exceed $2,022 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 CLTS income and asset criteria. The income threshold, which is indexed to three times the federal payment rate for SSI, is also adjusted annually to reflect inflation.

Although the income of the parents of the child is not considered for determining eligibility for MA waiver services, families may be required to contribute to the cost of services based on annual income and family size. Fees are assessed for families with income equal to or greater than 330% of the federal poverty level (FPL), beginning at one percent of the service plan costs and increasing up to a maximum of 41% of service costs for families with incomes over 1580% of the FPL. County support, service coordination and administrative costs are excluded for purposes of calculating the fee. Families may request a fee recalculation if they experience a dramatic change in income, and may deduct a disability allowance from their adjusted gross income of either the standard $3,300 or their actual allowable medical deduction reported on their income taxes from the previous calendar year, whichever is greater.

The services provided under the CLTS waiver are similar to those available under other MA home- and community-based waivers. However, 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 (RCACs), and community-based residential facilities (CBRFs), are not available to children under the waivers. The CLTS waiver also supports services that are not available under other waivers, including specialized medical and therapeutic supplies. In addition to receiving waiver services, CLTS participants have access to all MA-covered card services.

Intensive In-Home Treatment Services. 2003 Wisconsin Act 33 created the intensive in-home treatment services 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 treatment services are defined as one-on-one behavioral modification therapy services for children with an autism disorder, Asperger's disorder, or a pervasive developmental disorder. These services are intended to teach children with autism the skills that children would typically learn by imitating others around them, such as social interaction and language skills.

Until January 1, 2004, intensive in-home treatment services were provided as a fee-for-service benefit under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. However, in June, 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 CLTS waivers.

The state began providing intensive in-home treatment services under the CLTS waivers on January 1, 2004. When the intensive in-home treatment 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 treatment services a child must have a verified diagnosis of autism, Asperger's Disorder or Pervasive Developmental Disorder, not otherwise specified (PDD-NOS). The vast majority of children eligible to receive intensive in-home treatment 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.

Some children receive 20 to 35 hours per week of intensive in-home treatment services plus one hour per week of case management services (the intensive level of service), while other children receive ongoing services, which 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. A child is eligible for intensive in-home treatment services at the intensive level for up to three years as long as the child begins receiving services by the time he or she is eight years old. As of June 30, 2010, 889 children were receiving intensive in-home treatment services, while 1,399 children were receiving ongoing autism services.

Funding is provided to counties to support intensive in-home treatment 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 $30.60 per enrollee per day to support all benefit and administrative costs.

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 (COP-regular) and services that are funded with state and federal MA funds for services provided under an MA waiver (COP-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; (e) persons with Alz-

heimer's disease; and (f) persons suffering from Alcohol and Other Drug Abuse (AODA).

The state-only COP funds (within the limits of the portion of COP state funds allocated specifically for this purpose) are used to provide the cost of an individualized assessment and care plan for any person who is seeking admission to or is diverted from admission to a nursing home, the service funds are used to support COP eligible individuals who are likely to become medically indigent within six months by spending excess income or assets for medical or remedial care. In addition COP-regular funds may be used to provide the non federal portion of MA-eligible waiver services to serve more waiver eligible people, for the non federal match portion of MA-eligible services when costs exceed the state reimbursement rate for a waiver program, and to support "wrap around" services for individuals that are not covered under MA, such as room and board costs. In calendar year 2009, 6.8% of the individuals receiving services under the GPR-funded COP program were persons with developmental disabilities.

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 state 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, DHS limits the average expenditure per COP-waiver participant to $41.86 per day. The COP allowable average is calculated annually. Under current statute, the average per person reimbursement for COP regular may not exceed the state share of the average per person payment rate the department expects for nursing home reimbursement.

Family Care. The Family Care program 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.

The Family Care program consists of two major components. First, aging and disability resource centers (ADRCs) provide information, assessments, eligibility determinations and other preliminary services. Second, managed care organizations (MCOs) 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.

While MCOs provide comprehensive case management services, Family Care enrollees may also choose to participate in the "self-directed supports" option, which is available through each of the MCOs. Under the self-directed supports option, participants have greater control over how most 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."

As of October, 2010, 24 counties were independently operating resource centers, while 33 counties operated ten additional ADRCs collaboratively. At the same time, MCOs operated in 55 counties. All of the MCOs provide services to individuals who are elderly, developmentally disabled, and physically disabled. As of July 1, 2010, 11,008 of the 30,013 persons (36.7%) enrolled in Family Care were people with developmental disabilities.

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 nursing home level; (b) the person's functional capacity is at the non-nursing home level and that person has a condition that is expected to last at least 90 days or result in death within 12 months after application; 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.

IRIS (Include, Respect, I Self-Direct). As a condition for federal authority to expand the Family Care managed care program statewide, the Centers for Medicare and Medicaid Services (CMS) required the state to offer a fee-for-service alternative to managed care in order to provide individuals with sufficient choice in obtaining long-term care services. The IRIS Program is a self-directed support waiver under the MA home and community-based services waiver authority where individuals are given the ability to fully self-direct their own care and manage an individually designated budget amount. IRIS participants have greater control over how they receive services and who provides these services. IRIS is only available in counties where Family Care services are also available.

The IRIS program consists of two major components. First, an independent consulting agency (ICA) is responsible for assisting individuals in selecting a consultant that will work with the individual to develop a support 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. The ICA also maintains a 24-hour call center that provides immediate access to IRIS participants who may need assistance in resolving any unanticipated and urgent issues. DHS has contracted with The Management Group to provide these services.

Second, a financial services agency (FSA) assures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements such as payment to providers and assuring that employment and tax regulations are met. The FSA also provides training and support to help individuals with financial accountability and processes all payments to service providers. DHS has contracted with Milwaukee Center for Independence to serve as the fiscal agent for all individuals enrolled in IRIS throughout the state.

To be eligible for IRIS services, an individual must reside in a Family Care county and meet the same financial and non-financial eligibility requirements as Family Care participants. This includes meeting a nursing home level of care as determined by the long-term care functional screen.

The services available under the IRIS program are the same as the services allowed by the other MA home- and community-based services waiver programs in Wisconsin. In addition, IRIS also allows enrollees to receive customized goods and services, which are services, support or goods that enhance the individual's opportunity to achieve outcomes related to living arrangements, relationships, community inclusion, work and functional or medical status.

Individuals participating in the IRIS program are given an annual budget based upon their functional needs and a comparison to people with comparable needs within the managed care programs. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person may use funds from his/her individual budget to obtain the services they need on a fee-for-service basis.

Individuals receiving IRIS services may reside on a short-term basis in any living arrangement (such as a CBRF, adult family home, or RCAC) as long as it is not a nursing home or other institutional facility. Further, IRIS enrollees may use their individual budget to pay caregivers, including family members, friends and members of their community, to provide services. Individuals may not use any of their budgets to pay for room and board. Enrollees work with an ICA consultant to develop an appropriate care plan that fits their individual budget. The budget amount determined by DHS is based on results from the individual's long-term care functional screen.

The estimated costs for the services included in the plan are based on the average Family Care capitation rates. Once the care plan and budget have been determined, the FSA then assists enrollees in managing the payments for services received. Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed.

MA Purchase Plan. 1999 Act 9 created an option provided under federal MA law to extend MA coverage to certain working persons with disabilities. 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 ($2,256 per month for an individual and $3,035 per month for a two-person family in 2010); (b) the individual's countable assets do not exceed $15,000; (c) the individual is determined to have a disability under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHS; and (e) the individual is at least 18 years old. As of July 1, 2010, approximately 16,500 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 ($1,354 for an individual in 2010).

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. As a result, some 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," named after Katie Beckett, a child who was dependent upon a ventilator and was unable to return to her home, not for 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: (a) would be eligible for MA if they were in a hospital, nursing facility or ICF-MR; (b) require a level of care typically provided in a hospital, skilled nursing facility, or ICF-MR; (c) are determined to be appropriate for receiving care outside of a facility; and (d) 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 July 30, 2010, 4,789 children in Wisconsin were enrolled in the Katie Beckett program.

Institutional Services

Several facilities offer institutional care for Wisconsin residents with developmental disabilities. All of these facilities, including the State Centers, are certified by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) as ICFs-MR, and must meet federal MA care and treatment standards.

An ICF-MR provides care and active treatment to residents with mental retardation (intellectual disability) and who need medical, nursing and/or psychiatric supports to acquire skills for personal independence. This certification makes these facilities eligible for federal cost sharing under the state's MA program.

As noted above, DHS encourages counties to provide care to persons with developmental disabilities in the community rather than institutions. Policies intended to promote community care include: (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 under the prior section on MA waiver programs, under the "Relocation Initiatives" heading.

As a result, the number of these facilities has continued to decline over time, as an increasing number of individuals receive services in a community-based setting. For example, excluding the three State Centers, at the end of calendar year 2005 there were 26 facilities, with 990 total licensed beds, serving individuals with developmental disabilities operating in Wisconsin. As of November 17, 2010, there were 12 facilities with 381 licensed beds. Current facilities range in size from nine to 96 staffed beds. Counties operated nine of the 12 ICFs-MR (75%), which accounted for 59% of the licensed ICF-MR beds (223 of 381). Nearly all ICF-MR residents in the state are supported by MA.

Table 2 provides information on the various types of institutional settings for persons with developmental disabilities in Wisconsin at the end of 2006, 2007, 2008, and 2009. As shown in this table, the number of developmentally disabled persons in institutions decreased by 374 (30.7%) over this four-year period, from 1,219 on December 31, 2006, to 845 on December 31, 2009.

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

Institution Type	2006	2007	2008	2009
State Centers	540	498	461	440
Other ICFs-MR	603	511	439	348
Nursing Homes	76	65	63	56
Total	1,219	1,074	964	845

State Centers. The DHS Division of Long Term Care (DLTC) currently 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 (Racine County).

As counties' 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 Centers. In 1995, CWC and SWC entered into an agreement with the United States Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA). Under the agreement, CWC and SWC were not permitted to 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. Although this agreement terminated as of February, 2006, state law still mandates that all requests for longer-term admissions 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. Short-term programs are the Intensive Treatment Programs (ITPs) at all three Centers and the Medical Short Term Care Program at CWC. These types of admissions require the approval of the local community board or appropriate managed care organization, the director of the 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 and may be extended to 180 days with mutual agreement of the referring entity and the Center Director. Short term admissions are typically voluntary admissions.

In recent years there have been no admissions for long-term care to the 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 an individual to successfully live in the community. In addition, a person over the age of 18 may only be admitted to a Center for long-term care if he or she is determined to be in need of protective placement under Chapter 55 of the statutes. Community support plans are reviewed annually in the Watts review for all long-term admissions to the Centers. The Watts review determines whether each person is in the least restrictive environment appropriate for their needs and abilities.

The Centers provide residents with services that may not otherwise be available to them and assist them in returning to the community. 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 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 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.

Currently, two of the three state-operated facilities, Central and Southern Centers, serve individuals with developmental disabilities on a long-term basis. These individuals have lived at the Centers many years. The 2003-05 biennial budget (2003 Wisconsin Act 33) required DHS to relocate Northern Center's residents to either a community-based setting or to another ICF-MR, but authorized the facility to continue to provide short-term ITP services and certain alternative services. The 2009-11 biennial budget (2009 Wisconsin Act 28) directed DHS to accelerate relocations of individuals who were receiving long-term care services at SWC to alternative community-based settings on a voluntary basis. Individuals who choose not to relocate would still be permitted to remain at SWC on a long-term basis.

Table 3 shows the respective population and reimbursement rates as of July 1, 2010, for each of the Centers. The population at the centers has declined significantly over the years. For example, in 1970, nearly 3,700 persons resided in the Centers, compared to 449 as of July 1, 2010. This decrease is largely due to the state-initiated movement to relo-

cate center residents into the community which 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 at Northern Center and restructuring at Southern Center.

Table 3: State Centers Resident Population and Daily Inpatient Rates as of July 1, 2010

Facility	Rates	Population
CWC	$830	260
NWC	1,953	14
SWC	634	175
Total		449

Table 4 shows the number of residents that have been relocated from the Centers into a community-based setting as a result of the CIP IA program from 2007-08 through 2009-10.

Table 4: CIP IA Relocations

Facility	2007-08	2008-09	2009-10
CWC	7	6	1
NWC	0	0	0
SWC	6	12	8
Total	13	18	9

Finally, Table 5 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each center for fiscal year 2009-10. As noted, most of the PR funding for the Centers is comprised of payments through the state's MA program. Unlike MA payments to other ICFs-MR, however, 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.

Non-MA Community-Based Services

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

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 designated for specific services and programs.

Basic County Allocation. In calendar year 2011, DHS will distribute $174.4 million under the community aids BCA. Counties use the BCA, in combination with funding from other sources, to support their human services programs, including the services they provide for individuals with developmental disabilities. In 2009, counties reported spending approximately $38.9 million of the BCA on services for persons with developmental disabilities.

Additional information on community aids is available in the Legislative Fiscal Bureau Informational Paper entitled "Community Aids/Children and Family Aids."

Family Support Program. The family support program is a categorical allocation within community aids. DHS will distribute $4,909,300 to counties in CY 2011 to pay for services that help children who have severe disabilities remain in their homes. Counties may spend up to 10% of these funds for staff and other administrative costs. Local advisory committees determine who receives funding, and how the funding is allocated.

Table 5: State Centers for the Developmentally Disabled -- Total Budget and Authorized Positions, State Fiscal Year 2009-10

	CWC	NWC	SWC	Total
Program Revenues – MA				
State operations	$64,702,300	$20,800	$37,689,700	$102,412,800
Utilities and fuel	2,019,300	1,258,000	1,899,400	5,176,700
Repair and maintenance	258,300	0	350,400	608,700
Subtotal	$66,979,900	$1,278,800	$39,939,500	$108,198,200
Program Revenues – Other				
Alternative services	$229,800	$8,994,600	$26,000	$9,250,400
Farm operations	0	0	30,000	30,000
Activity therapy	22,100	5,300	5,000	32,400
Gifts and grants	35,000	70,000	30,000	135,000
Interagency and intra-agency programs	178,900	1,279,500	324,400	1,782,800
Subtotal	$465,800	$10,349,400	$415,400	$11,230,600
Total Funding (All Sources)	**$67,445,700**	**$11,628,200**	**$40,354,900**	**$119,428,800**
Total Authorized Positions (All Sources)	**830.46**	**128.01**	**537.7**	**1,496.17**

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. Table 6 identifies expenditures for the family support program for specific service categories in calendar year 2009.

To qualify for program services, a child must be diagnosed with a severe physical, emotional, or mental impairment which requires individually planned and coordinated care, treatment, vocational rehabilitation, or other services. The condition also must have resulted, or be likely to result, in a substantial limitation in at least three of seven functions of daily living (self-care, receptive and expressive language, learning mobility, self-direction, capacity for independent living, and economic self-sufficiency).

Under the family support program, families receive an assessment to determine what services a child requires to be able live at home. Counties ensure that the family participates in the assessment and that the assessment process involves people knowledgeable about the child's condition. The assessment also includes a review of other available services and funding sources, such as medical assistance or the family's private health insurance coverage. A written service plan is developed, with family support program funds allocated for services for which other funding sources are not available.

Although eligibility does not depend on income, some families are required to share in the cost of program services based on a sliding fee scale. Families with income under 330% of the fed-

Table 6: Family Support Program Expenditures, by Service Category (Calendar Year 2009)

Service Category	Amount	% of Total
Architectural Modification of Home	$212,600	5.0%
Child Care	135,900	3.2
Children's Long Term Support Waiver Services	699,500	16.4
Counseling / Therapeutic Resources	198,900	4.7
Dental / Medical Care Not Otherwise Covered	84,300	2.0
Diagnosis and Evaluation	10,400	0.2
Diet, Nutrition and Clothing	139,100	3.3
Equipment and Supplies	1,266,800	29.7
Home Training / Parent Courses	62,400	1.5
Homemaker Services	14,700	0.3
In-Home Nursing Services - Attendant	10,400	0.2
Recreation / Alternative Activities	513,900	12.0
Respite Care	750,700	17.6
Transportation	78,000	1.8
Utility Costs	28,100	0.7
Vehicle Modification	40,700	1.0
Other	24,200	0.6
Total	$4,270,600	100.0%

eral poverty level (FPL) do not have any cost sharing requirement. In 2010, 330% of the FPL equaled $60,423 for a family of three. For families with income at or above 330% of the FPL, the family's contribution begins at 1% of service costs, and increases to 41% of service costs for families at 1,580% of the FPL or above. DHS Administrative Rule 1.065 sets these cost sharing requirements, which also apply to several other programs.

In calendar year 2009, 3,025 children received services under the program. Most of these children had developmental disabilities, although the program also provides services to children with physical disabilities and children with severe emotional disturbances. In that year, 441 of the participating families were considered "underserved," and 2,203 children were on a waiting list for services.

Table 7 provides the age of family support program participants and the reason the participant received program services for calendar year 2009.

Table 7: Family Support Program Participant Age and Reason for Care, Calendar Year 2009

Age of Participant	Percent
Under 6 years	17%
7 to 12 years	37
13 to 20 years	44
Over 21 years	2
Reason for Care*	
Unable to help with personal care	33.5%
Needs assistance with personal care	60.5
Cannot walk	23.7
Requires assistance to walk	12.6
Severe developmental delay	31.1
Moderate or mild developmental delay	59.0

* Some participants may exhibit several of these needs

Early Intervention Services for Infants and Toddlers with Disabilities (Birth-to-3). The Birth-to-3 program is a federal program authorized under Part C of the Individuals with Disabilities Education Act. Under the program, state, federal and local funds support a statewide, comprehensive program of services for infants and toddlers with disabilities, and their families.

Federal legislation establishes the following goals of the program: (a) enhance the development of infants and toddlers with developmental delays or disabilities and minimize the potential for further developmental delay; (b) minimize the need for special education and related services; (c) decrease the institutionalization of individuals with disabilities, and increase the potential for independent living in society; (d) enhance the capacity of families to meet the special needs of children with disabilities; and (e) enhance the capacity of state and local agencies and providers to meet the needs of historically underrepresented populations.

Counties are responsible for administering the program based on state and federal guidelines. Specific county responsibilities include the following:

- Establish a comprehensive system to identify, locate, and evaluate children who may qualify for the program;

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

- Ensure that families receive core services at no cost, such as evaluation, service coordination, and the development of an individual family service plan (IFSP); and

- Determine parental cost-sharing for services received in accordance with the IFSP.

An early intervention team evaluates children referred to the program to determine their eligibility for services. These early intervention teams are comprised of a service coordinator and at least two professionals from different disciplines of suspected areas of need. A child is eligible if he or she is under three years of age and has a significant developmental delay or has a physician-diagnosed and documented physical or mental

condition with a high probability of resulting in a developmental delay. Children can receive services until they reach the age of three.

Once eligibility is determined, the early intervention team conducts an assessment 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 individual family service plan (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 payment sources for the services.

The most frequently used services by Birth-to-3 program participants include mandatory service coordination, communication services, special instruction, occupational therapy, physical therapy, and family education. Children in the program may also receive audiology services, certain medical services, nursing services, nutrition services, psychological services, social work services, transportation, and vision services.

The most recent available county expenditure data from DHS for the Birth-to-3 program are for calendar year 2008. Counties have submitted calendar year 2009 information to the Department, but the statewide data is not yet available due to problems in the compilation of those reports. Appendix I provides county Birth-to-3 funding, by funding source for calendar year 2008. Similar information for calendar year 2009 is not yet available. Table 8 summarizes this Appendix, showing calendar year 2008 expenditures for the Birth-to-3 program from all sources.

Table 8: Calendar Year 2008 Birth-to-3 Funding

Revenue Type	Amount
County Funds (includes Community Aids)	$15,164,400
State and Federal Funds	12,951,400
Medicaid	2,072,700
Parental Cost Share	428,000
Private Insurance	275,200
Other	294,400
Total	$31,186,100

Epilepsy Service Grants. DHS allocates $133,500 GPR annually to private, nonprofit organizations or county agencies that provide direct or indirect services to persons with epilepsy. "Direct services" are services provided to a person with epilepsy or a member of the family of a person with epilepsy, such as counseling, referral to other services, case management, and daily living skills training. "Indirect services" are 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. DHS issued grants to four regional affiliates of the Epilepsy Foundation.

Total County Expenditures. Appendix II shows county expenditures for programs that serve persons with developmental disabilities for calendar years 2005 through 2009. This appendix includes expenditures from all sources at the county level, but does not include Family Care expenditures.

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

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

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

APPENDIX I

Birth-to-3 State & Federal Allocations and County Expenditures Calendar Year 2008*

County	State / Federal Allocation	County Expenditure	Total
Statewide Total	$12,951,352	$15,164,390	$28,115,742
Adams	$33,057	$32,618	$65,675
Ashland	34,601	67,257	101,858
Barron	104,699	127,008	231,707
Bayfield	40,202	39,294	79,496
Brown	697,702	799,214	1,496,916
Buffalo	29,856	19,290	49,146
Burnett	35,461	52,147	87,608
Calumet	126,041	201,148	327,189
Chippewa	110,009	226,606	336,615
Clark	68,406	85,075	153,481
Columbia	122,108	130,886	252,994
Crawford	30,275	57,680	87,955
Dane	786,314	1,693,827	2,480,141
Dodge	168,230	272,221	440,451
Door	87,643	96,489	184,132
Douglas	98,852	107,166	206,018
Dunn	144,180	284,194	428,374
Eau Claire	230,235	166,574	396,809
Florence	16,179	2,518	18,697
Fond du Lac	233,052	315,960	549,012
Forest / Oneida / Vilas	159,827	254,796	414,623
Grant / Iowa	133,045	184,560	317,605
Green	59,602	36,989	96,591
Green Lake	39,057	49,061	88,118
Iron	15,575	360	15,935
Jackson	39,238	81,201	120,439
Jefferson	185,064	577,171	762,235
Juneau	50,168	87,533	137,701
Kenosha	332,437	127,995	460,432
Kewaunee	47,305	72,172	119,477
La Crosse	203,260	212,014	415,274
Lafayette	28,619	13,745	42,364
Langlade / Marathon	509,230	667,703	1,176,933
Lincoln	71,385	100,781	172,166
Manitowoc	212,047	343,798	555,845

APPENDIX I (continued)

Birth-to-3 State & Federal Allocations and County Expenditures Calendar Year 2008*

County	State / Federal Allocation	County Expenditure	Total
Marinette	$81,201	$85,491	$166,692
Marquette	30,956	46,057	77,013
Menominee	20,627	44,582	65,209
Milwaukee	3,005,634	2,193,274	5,198,908
Monroe	72,960	176,504	249,464
Oconto	58,141	274,419	332,560
Outagamie	364,630	519,215	883,845
Ozaukee	214,999	256,902	471,901
Pepin	44,230	31,757	75,987
Pierce	69,768	71,838	141,606
Polk	98,736	108,302	207,038
Portage	173,339	173,154	346,493
Price	23,105	17,409	40,514
Racine	469,283	301,999	771,282
Richland	52,612	81,532	134,144
Rock	366,812	486,284	853,096
Rusk	35,883	30,087	65,970
St. Croix	136,418	149,405	285,823
Sauk	136,345	341,163	477,508
Sawyer	37,788	31,125	68,913
Shawano	74,288	65,230	139,518
Sheboygan	285,059	312,437	597,496
Taylor	35,908	25,289	61,197
Trempealeau	53,586	73,088	126,674
Vernon	51,026	94,155	145,181
Walworth	163,839	392,116	555,955
Washburn	36,931	56,098	93,029
Washington	203,211	173,151	376,362
Waukesha	612,414	277,602	890,016
Waupaca	153,460	272,260	425,720
Waushara	39,046	64,723	103,769
Winnebago	336,298	270,908	607,206
Wood	129,858	79,782	209,640

* The most recent available expenditure data from DHS for the Birth-to-3 program are for calendar year 2008. Counties have submitted calendar year 2009 information to the Department, but that data was not yet available for inclusion in this paper due to problems in the compilation of those reports.

** This appendix provides the state / federal and local allocations for the Birth-to-3 program. Other funding sources include Medicaid, private insurance, and parental cost-sharing requirements.

APPENDIX II

Services for Individuals with Developmental Disabilities
Calendar Years 2005 through 2009 (Fund Sources Spent at the County Level)*

County	2005	2006	2007	2008	2009
Statewide Total	$598,573,952	$634,999,017	$664,908,131	$624,709,428	$480,483,586
Adams	$1,385,761	$1,538,971	$1,973,785	$1,881,648	$1,980,882
Ashland	1,836,958	2,142,815	2,076,148	2,122,171	1,138,757
Barron	5,587,788	4,999,725	5,176,560	6,163,216	3,244,802
Bayfield	2,095,892	2,140,297	2,014,224	1,894,981	1,100,363
Brown	26,958,707	32,498,956	36,002,133	37,106,651	38,888,719
Buffalo	1,860,067	2,423,887	2,201,337	2,470,745	587,121
Burnett	1,253,313	1,602,039	1,896,717	2,085,708	963,108
Calumet	4,482,321	4,681,869	5,267,270	5,514,710	5,871,902
Chippewa	7,282,954	9,132,282	10,355,084	6,391,723	1,490,770
Clark	6,807,819	6,901,356	7,114,980	7,126,867	3,262,519
Columbia	8,567,147	9,385,151	9,957,657	4,837,510	1,342,949
Crawford	2,962,825	3,234,339	3,312,938	3,357,515	2,021,782
Dane	78,889,136	80,989,610	80,930,404	83,008,577	83,717,973
Dodge	7,655,241	8,903,195	9,444,040	7,882,550	1,767,629
Door	3,512,613	4,481,317	4,860,290	5,153,439	5,866,988
Douglas	6,703,822	6,546,397	6,747,704	6,515,175	2,689,375
Dunn	5,409,055	6,182,229	6,984,458	5,256,295	1,350,362
Eau Claire	12,872,099	13,925,266	14,552,945	14,692,439	3,838,672
Florence	349,685	406,046	381,298	341,223	461,795
Fond du Lac	3,103,202	2,858,176	3,054,442	3,348,983	3,735,920
Forest-Oneida-Vilas	10,226,039	11,596,284	11,556,512	11,454,290	11,939,559
Grant-Iowa	6,484,135	6,594,559	6,648,995	7,070,046	7,335,296
Green	3,007,606	2,788,219	3,035,761	3,272,922	538,296
Green Lake	3,360,345	3,490,884	3,613,179	3,184,426	1,462,448
Iron	796,712	923,910	875,742	669,611	465,559
Jackson	3,379,455	3,707,839	4,108,035	4,332,404	547,047
Jefferson	13,899,921	14,476,593	17,262,039	17,066,045	3,770,415
Juneau	2,242,811	2,607,522	2,899,390	3,019,505	2,182,402
Kenosha	14,578,861	15,357,821	11,395,539	1,278,549	1,645,070
Kewaunee	3,350,892	3,437,525	3,437,525	3,957,565	4,168,256
La Crosse	2,119,770	2,132,016	2,505,136	3,185,901	3,347,165
Lafayette	2,031,981	2,348,876	2,139,189	2,268,984	1,243,482
Langlade-Lincoln-Marathon	25,313,284	27,971,517	28,938,548	28,295,215	15,275,358
Manitowoc	9,889,545	12,384,703	14,139,212	15,793,049	16,100,917
Marinette	3,193,998	3,607,221	3,891,529	3,721,970	3,736,240

APPENDIX II (continued)

Services for Individuals with Developmental Disabilities
Calendar Years 2005 through 2009 (Fund Sources Spent at the County Level)*

County	2005	2006	2007	2008	2009
Marquette	$1,555,752	$1,482,720	$1,412,435	$1,095,156	$308,272
Menominee	382,545	463,895	489,591	877,940	1,228,982
Milwaukee	90,070,410	83,691,641	87,323,875	88,178,161	89,988,449
Monroe	5,068,056	5,544,127	6,040,049	6,364,429	334,435
Oconto	7,830,253	7,871,525	8,207,649	8,594,857	8,720,597
Outagamie	16,395,219	18,942,458	20,525,504	21,203,498	21,657,105
Ozaukee	9,012,186	8,989,087	10,243,581	4,780,388	3,293,958
Pepin	1,799,986	1,865,382	1,874,952	1,799,592	347,005
Pierce	4,734,038	4,410,740	4,436,298	3,052,190	400,254
Polk	3,407,889	3,265,349	3,615,375	3,723,720	1,858,299
Portage	1,301,070	1,301,562	1,218,870	1,435,725	1,391,813
Price	2,280,547	2,815,150	2,960,079	2,960,545	2,002,788
Racine	11,982,693	10,985,143	5,019,013	2,581,108	3,219,027
Richland	279,134	301,513	364,507	468,118	247,993
Rock	20,787,800	24,127,433	24,961,084	25,364,097	27,253,078
Rusk	2,627,032	2,971,349	2,963,381	3,022,695	1,867,512
St. Croix	2,532,199	7,343,190	7,746,633	5,688,119	1,425,586
Sauk	6,401,226	2,244,162	2,519,693	1,994,923	1,264,506
Sawyer	2,188,340	4,928,395	5,218,421	6,213,600	6,540,519
Shawano	4,414,040	14,349,614	18,605,875	8,472,836	1,973,511
Sheboygan	11,407,513	2,377,199	2,646,396	3,048,391	1,621,298
Taylor	3,074,434	3,262,112	3,172,103	3,370,174	3,369,551
Trempealeau	3,479,514	3,699,622	3,811,033	4,216,132	577,655
Vernon	3,146,918	3,190,461	3,963,278	3,497,130	259,281
Walworth	6,676,988	6,800,798	6,909,952	7,437,534	6,660,114
Washburn	2,438,532	2,573,529	2,669,587	2,712,552	1,313,320
Washington	13,550,552	14,303,386	14,958,023	8,767,081	3,457,198
Waukesha	25,298,511	27,086,075	30,965,719	26,752,062	7,540,456
Waupaca	7,859,958	9,026,085	10,388,623	12,069,802	10,615,706
Waushara	2,042,870	2,221,559	2,310,583	1,677,033	594,125
Winnebago	21,869,243	22,847,728	24,291,294	25,054,517	25,937,859
Wood	9,226,744	11,316,616	12,323,930	12,512,715	4,133,436

* Data obtained from the Human Services Reporting System (HSRS) operated by DHS. The decrease in reported county expenditures in 2008 and 2009 is mainly due to decreases in county spending on Community Integration Program waivers as the Family Care program expands. Family Care expenditures are not reported in HSRS.