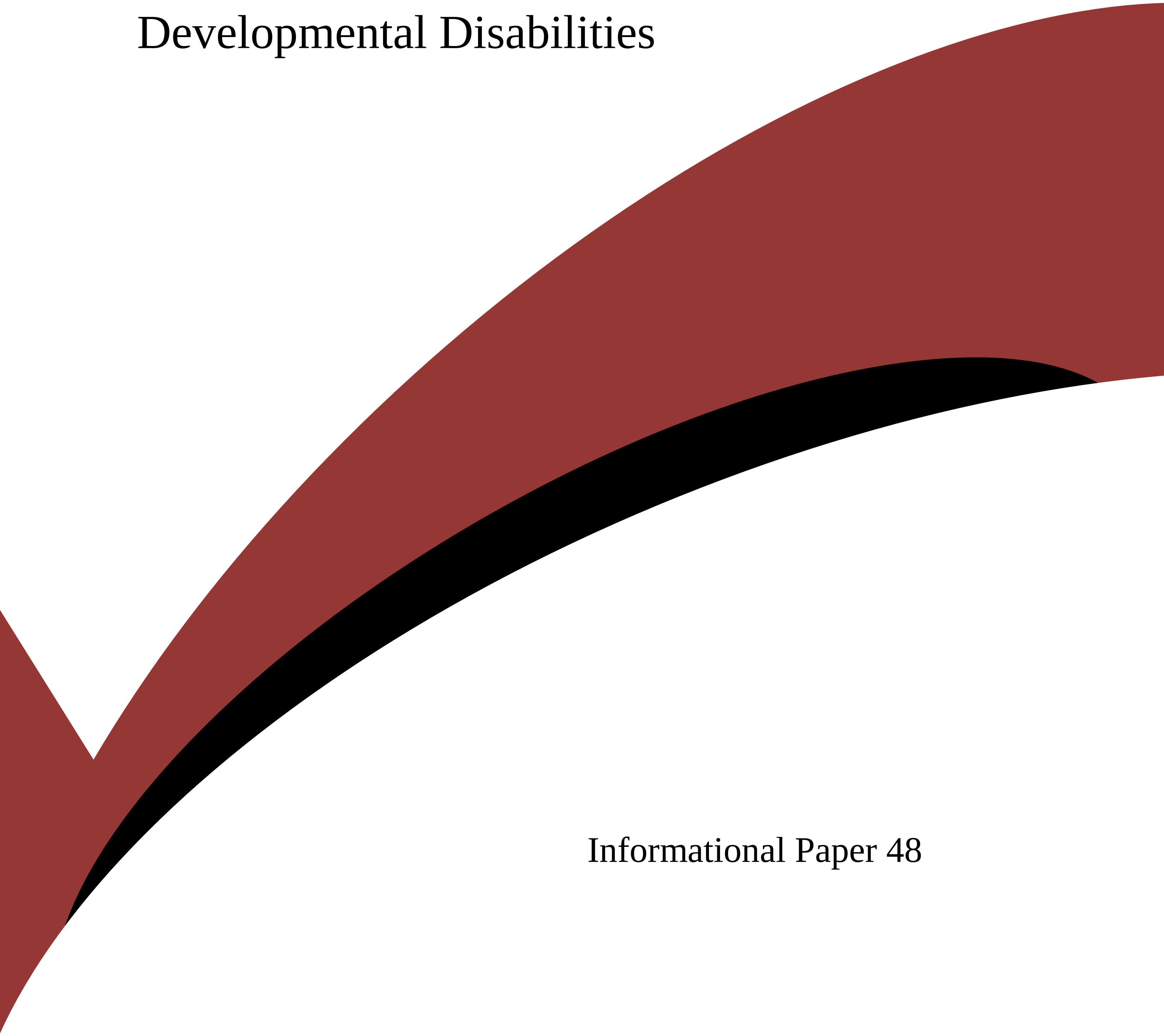
Services for Persons with Developmental Disabilities



Informational Paper 48

Wisconsin Legislative Fiscal Bureau
January, 2015

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Services for Persons with Developmental Disabilities

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

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

The Department of Health Services (DHS) estimates that there are approximately 75,000 adult Wisconsin residents with developmental disabilities who are currently receiving one or more long-term services supported by the state's medical assistance (MA, or Medicaid) program. The Board for People with Developmental Disabilities (BPDD) estimates that an additional 10,000 adults are presumed eligible for, but do not receive, Medicaid-funded services. In addition, the BPDD reports that, nationally, approximately three percent of the total population has a developmental disability, a percentage that applies both to children and adults. Accordingly, based on this percentage and the current number of children in the state, is estimated that approximately 40,000 Wisconsin children have a developmental disability.

State and county agencies administer several programs that support individuals with developmental disabilities in Wisconsin. Most of the programs that provide long-term care services to this population are provided as part of the state's Medicaid program, which serves individuals and families that meet certain financial and functional eligibility standards. Consistent with federal policy and recent court decisions, Wisconsin has increasingly relied on Medicaid's home and community-based services (HCBS), including services authorized under Medicaid waiver programs, to serve this population outside of institutional settings.

Appendix I shows the total amount each county reported spending for county-administered programs that serve persons with developmental disabilities for calendar years 2007 through 2013. The expenditure totals include a combination of state, federal and county funds, but do not include expenditures for programs not administered by counties, such as Family Care.

This paper describes services that are available to individuals with developmental disabilities in Wisconsin that are provided through the state's Medicaid program, and other non-Medicaid services administered by DHS and counties. Other agencies, including the Department of Workforce

Development and the Department of Public Instruction, administer programs to meet the vocational and educational needs of Wisconsin residents with developmental disabilities. These programs are described in other informational papers prepared by this office.

DHS and BPDD

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

The Department of Health Services. The Division of Long Term Care (DLTC) in DHS is primarily responsible for overseeing the administration of the state's programs for individuals with developmental disabilities. The DLTC consists of the Bureau of Long Term Care Financing, the Bureau of Managed Care, the Bureau of Aging and Disability Resources, the Bureau of Center Operations and the Bureau of Children's Services. In addition, the DLTC operates the three residential State Centers for People with Developmental Disabilities.

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

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

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 and be independent, productive, and integrated in the community. The responsibilities of the Board include developing and monitoring a state plan for advocacy and systems change, advising DHS, the Governor, and the Legislature, administering programs funded by the Board, and advocating for people with developmental disabilities.

Federal Law Guiding the Provision of Services

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

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

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

In an effort to comply with the *Olmstead* decision, Wisconsin currently offers home and community-based services through the Medicaid-funded Family Care, IRIS, and legacy waiver programs, as well as several programs not supported by Medicaid funding.

Medicaid Home and Community-Based Services

Medicaid is a state and federally-funded entitlement program that provides primary, acute, and long-term care services to certain individuals with limited resources. Under the Medicaid program, recipients are entitled to receive Medicaid card services, such as physician services, dental services, home health, and care provided by nursing homes, as long as the services are medically necessary and provided within the limitations set by state and federal law and policy.

Individuals with developmental disabilities may be eligible for Medicaid card services under an elderly, blind, or disabled (EBD) Medicaid plan. To qualify for EBD Medicaid programs, individuals must meet both financial and non-financial eligibility standards, which vary by plan. Individuals who apply for an EBD Medicaid plan must meet a disability standard, defined as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Disability determinations are conducted by the DHS Disability Determination Bureau (DDB). For more information regarding MA eligibility and benefits, see the Legislative Fiscal Bureau's informational paper entitled "Medical Assistance and Related Programs (BadgerCare Plus, Family Care, SeniorCare)."

Wisconsin has also obtained several waivers to federal Medicaid law that permit the state to provide comprehensive program options to persons with developmental disabilities who require long-term care services.

The Family Care program provides community-based long-term care services through managed care organizations (MCOs), which manage enrollee care and provide some Medicaid card services and other long-term care services. The state also offers a self-directed long-term care program called IRIS (Include, Respect, I Self-Direct), which operates in counties where the Family Care benefit is offered as an alternative to managed care. As of January 1, 2015, Family Care and IRIS were available to residents in 57 counties. In November, 2014, the Legislature's Joint Committee on Finance approved the DHS proposal to offer Family Care services to seven additional northeastern counties, beginning in

June, 2015.

For residents of the counties where Family Care and IRIS services are not offered, there are four programs that provide home and community-based care to adults with developmental disabilities. These programs include: (1) the community integration program 1A (CIP 1A); (2) the community integration program 1B (CIP 1B); (3) the ICF-ID restructuring initiative; and (4) the non-waiver community options program (COP). These programs are commonly referred to as "legacy waiver" programs because Family Care and IRIS have replaced these programs in most counties.

Prior to the initial implementation of Family Care in five pilot counties in calendar years 2000 and 2001, all Wisconsin counties provided home and community-based services to persons with developmental disabilities through the legacy waiver programs. While individuals who met the functional and financial eligibility requirements were entitled to receive Medicaid card services, including care provided by nursing homes, they were not entitled to receive waiver services under these programs. Consequently, counties maintained waitlists for individuals seeking to enroll in the HCBS waiver programs as a means of receiving community-based care.

As the Family Care program has expanded to additional counties, the number of individuals on waitlists for home and community-based long-term care services has decreased significantly.

Medicaid-funded benefits may also be available to certain individuals who earn income through work, are enrolled in a certified job counseling program, or are involved in competitive, supported, or sheltered employment and who would not otherwise meet the financial eligibility standards for non-institutional Medicaid through the MA Purchase Plan (MAPP). Children with long-term disabilities may also receive Medicaid card services through the Katie Beckett program and long-term care services through the children's long-term support (CLTS) waiver program.

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

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 in a community setting.

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

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

As of July, 2014, 13,591 of the 37,790 persons enrolled in Family Care (36%) were people with developmental disabilities.

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

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

As of January 1, 2015, there were 41 ADRCs serving all 72 counties and 11 tribes, including 28 single-county ADRCs and 13 multi-county/tribe regional ADRCs.

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

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

Previously, DHS contracted with one agency, The Management Group, to serve as the ICA for all IRIS enrollees, and another agency, iLIFE, to serve as the FEA for all IRIS enrollees. However, the state was only eligible to receive the federal administrative matching rate (approximately 50 percent) to support these services. Beginning in January, 2015, DHS will allow several agencies to fulfill these responsibilities so that IRIS enrollees may choose between two or more agencies to provide these services. This change will permit the state to claim costs for these services based on the MA services matching rate (approximately 58%) and will, therefore, reduce the state's cost of providing these services.

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

The services available under the IRIS program are limited to the home and community-based services not available through Medicaid card services. This differs from Family Care, which covers all long-term care services, including those otherwise available through the Medicaid card. Instead, IRIS enrollees continue to receive these services through their Medicaid card. Although provided as a Medicaid card service, IRIS enrollees have the option of self-directing their personal care services with the help of the ICA.

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

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

As of August, 2014, there were 10,837 individuals in IRIS, including 1,734 elderly individuals, 5,093 individuals with physical disabilities, and 4,010 individuals with developmental disabilities.

Community Integration Programs (CIP 1A and CIP 1B). CIP 1A and CIP 1B provide Medicaid-funded, community-based services to individuals with developmental disabilities. CIP 1A supports services for persons who previously resided at the State Centers for People with Developmental Disabilities (state centers), while CIP 1B supports services for individuals that previously resided in intermediate care facilities for the intellectually disabled (ICF-ID) other than the state centers. CIP 1A and CIP 1B participants are eligible to receive community-based services, such as supported employment and prevocational services, which are not available as Medicaid card services.

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

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

DHS provides the funding needed to meet the individual's care plan in the community. In 2013-14, the maximum average per day allowance for state reimbursement under CIP 1B was $49.67, although DHS pays a higher rate for placements from facilities that close or have on file a Department-approved plan for significant downsizing.

Table 1 provides information on the annual number of CIP 1A placements for state fiscal years 2004-05 through 2013-14. The table shows that there have been no CIP 1A placements from the state centers during the past several years, which DHS attributes to guardian opposition to community placement.

Table 1: CIP 1A Placements from State Centers

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

In CY 2013, 246 individuals received services under CIP 1A, with 240 individuals receiving services in the average month. In that same year, 3,182 individuals received services under CIP 1B.

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

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

Under the relocation initiative, DHS establishes a single budget to provide services to all eligible individuals, including institutionalized and non-institutionalized individuals. In 2014-15, the amount budgeted to support services under this initiative is approximately $20.9 million (all funds).

From 2005-06 through 2012-13, 844 persons with developmental disabilities were relocated from ICFs-ID and nursing homes, other than state centers, to alternative community-based residential settings. Table 2 shows the annual number of relocations under the IFC-ID restructuring initiative for state fiscal years 2004-05 through 2012-13, the most recent year for which information is available.

Table 2: Annual Relocations under ICF-ID Restructuring Initiative

Fiscal Year	Relocations
2004-05	94
2005-06	340
2006-07	143
2007-08	39
2008-09	37
2009-10	72
2010-11	19
2011-12	36
2012-13	64
Total	844

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

In CY 2013, 278 of the 2,497 adults receiving services under the GPR-funded COP program (11.1%) were persons with developmental disabilities. In CY 2015, DHS plans to distribute $24.3 million for the GPR-funded COP program.

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

An individual is eligible to participate in MAPP if: (a) the individual's family income, minus income that is excluded under federal SSI rules, is less than 250% of the federal poverty level ($2,431 per month for an individual and $3,277 per month for a family of two in 2014); (b) the individual's countable assets do not exceed $15,000; (c) the individual is determined to have a disability under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHS; and (e) the individual is at least 18 years old. Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,459 per month for an individual in 2014).

As of July, 2014, approximately 24,250 individuals were enrolled in MAPP. It is not known how many of these individuals had developmental disabilities.

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

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

As of July, 2014, 5,034 children in Wisconsin were enrolled in the Katie Beckett program.

Similar to the ADRCs that serve as a gateway for adults seeking long-term care services, CompassWisconsin: Threshold offers families a way to apply for multiple programs through a single application and eligibility process. Threshold assists family in understanding and applying for the Katie Beckett program, as well as the children's long-term support (CLTS) program, autism treatment services, the Family Support Program, and GPR-funded COP services. As of January, 2015, CompassWisconsin: Threshold operated in 13 counties.

Children's Long-Term Support (CLTS) Waiver Program. The CLTS waiver program provides services and support for children with physical and developmental disabilities, and severe emotional disturbance.

In order to be eligible to participate in the

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

The financial eligibility criteria require that, in 2014, the child's income not exceed $2,163 per month and, for youths 18 and over, countable assets not exceed $2,000. Children with greater income or assets may become eligible for Medicaid by "spending down" to the CLTS income and asset criteria.

Although the income of the child's parents is not considered in determining program eligibility, some families are required to contribute to the cost of services based on their annual income and family size. Families with income that exceeds 330% of the FPL ($65,307 for a family of three in 2014) are required to share in program costs on a sliding scale based on income.

The services provided under the CLTS waiver are similar to those available under other Medicaid HCBS waiver programs. However, some of the services that are necessary for adults, such as home-delivered meals, adult day care, and services provided by residential care apartment complexes and community-based residential facilities, are not available to children under the waivers. The CLTS waiver also supports services that are not available under other waivers, including autism treatment services. In addition to receiving waiver services, CLTS participants have access to Medicaid card services.

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

Similar to other HCBS waiver programs, the state may establish waiting lists for services when the state does not have sufficient funding to provide services to all eligible individuals. Children may continue receiving services under the waiver until they reach the age of 22, as long as they continue to be eligible for Medicaid, after which they would need to receive services under an adult HCBS waiver program. This could result in some individuals being placed on waiting lists for Medicaid 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, or by planning for their transition to Family Care or IRIS.

As of July, 2014, 5,201 children were enrolled in the CLTS waiver program, including 2,344 children who received exclusively CLTS services (not including autism treatment services). As of August, 2014, an additional 2,388 children were on the combined CLTS and Family Support Program waiting list, including 1,402 children with developmental disabilities. This figure excludes children with multiple or unknown disabilities.

Autism Treatment Services. 2003 Wisconsin Act 33 created the intensive in-home treatment services benefit for children with autism spectrum disorders. In 2011, the Department began to phase out its former intensive in-home treatment program and created two distinct levels of autism treatment services -- the Early Intensive Behavioral Intervention (EIBI) service and the Consultative Behavioral Intervention (CBI) service -- to reflect the most recent research into the benefits of early intervention. The two services remain fundamentally the same, but children in the EIBI service receive 30 to 40 hours of face-to-face treatment and children in the CBI service receive 10 to 20 hours of face-to-face treatment.

In order to qualify for autism treatment services, a child must have a verified diagnosis of Autism Spectrum Disorder. This requirement is in addition to all other CLTS waiver eligibility criteria.

Autism treatment services are intended to teach children with autism spectrum disorder the skills that developing children would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to improve a child's social, behavioral, and communicative skills in order to demonstrate measurable outcomes in these areas and overall developmental benefits in both home and community settings. The intent is for the child to make clinically significant improvements and have fewer needs in the future as a result of the service.

An individualized service plan (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 autism treatment services at the EIBI or CBI levels for up to three years as long as the child is placed on the state waitlist for these services before the time he or she is eight years old. Weekly services received prior to the CLTS waiver are figured into this total, regardless of the funding source. Each week children receive their weekly hours of treatment and case management services.

Children who have received autism treatment services for at least 12 of the past 18 months at the required minimums under the EIBI or CBI models are eligible to receive ongoing CLTS waiver services focused on addressing the diverse needs of a growing child. Ongoing services must be identified in the ISP, and may include any services allowable under the waiver in which the child is enrolled. During FY 2013-14, 1,164 children received autism treatment services, while 1,991 children received ongoing autism services.

The wait list for intensive autism services is managed at the state level and functions on a first-come, first-served basis. Each week a specified number of children are released from the wait list for the opportunity to receive services. The child's county and provider meet with the child to determine the number of hours of treatment the child will need each week. Autism treatment service providers currently receive an hourly rate of $22.52.

The MA program pays counties up to $30.60 per day for each child who receives ongoing autism services, based on each child's individual needs as identified in the ISP. Counties may contribute additional funding, or use an average cost across all children they serve, as long as the average cost is no more than $30.60 per day. When a child is no longer eligible for ongoing autism services, the county retains the funding to serve other children in need of those services. Counties are permitted to claim up to 7% of direct service and case management costs to support administrative expenses in both the CLTS waiver and the autism treatment program.

On July 7, 2014, CMS released an Informational Bulletin to state Medicaid agencies providing guidance on the treatment of children with autism spectrum disorders. This bulletin requires states covering autism treatment services through a waiver program, such as Wisconsin, to transition coverage of medically necessary autism treatment services from a waiver to the state plan. DHS has begun this transition in accordance with guidance from CMS.

Institutional Services

Several facilities offer institutional care for Wisconsin residents with developmental disabilities. The largest facilities, including the state centers, are certified by CMS as intermediate care facilities for the mentally retarded (ICFs-MR), and must meet federal Medicaid care and treatment standards. 2011 Wisconsin Act 126 replaced the phrases "mentally retarded" and "mental retardation" with "intellectual disability" in state statutes, and retitled ICFs-MR as ICFs-ID. However, federal law continues to refer to these facilities as ICFs-MR.

An ICF-ID provides care and active treatment to residents with intellectual disabilities 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 Medicaid program. However, as state and federal policies encourage counties to provide care to persons with developmental disabilities through community-based services rather than institutional care, the number of these facilities has decreased over time. For example, excluding the three state centers, at the end of CY 2005 there were 26 facilities, with 990 total licensed beds, serving individuals with developmental disabilities in Wisconsin. As of August, 2014, there were seven facilities with 208 licensed beds, excluding the three state centers.

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

Institution Type	2010	2011	2012	2013	2014
State Centers	449	427	415	402	398
Nursing Homes**	48	39	36	34	24
Non-State ICF-IDs**	334	289	268	210	110
Total	831	755	719	646	532

*2014 data reflect claims processed and paid as of December 9

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

Table 3 provides information on the various types of institutions that serve persons with developmental disabilities in Wisconsin at the end of 2010, 2011, 2012, 2013, and 2014. As shown in this table, the number of individuals in institutions decreased by 299 (36.0%) over this five-year period, from 831 on December 31, 2010, to 532 on December 9, 2014. Current facilities range in size from nine to 55 staffed beds, excluding the state centers. Counties operated five of the seven ICFs-ID, which accounted for 61.8% of the licensed ICF-ID beds (144 of 233), once again excluding the state centers. Over 99% of the residents of ICFs-ID are eligible for, and enrolled in, the state's Medicaid program.

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

Currently, two of the three state facilities, CWC and SWC, serve individuals with developmental disabilities on a long-term basis. These individuals have lived at the state centers many years. 2003 Wisconsin Act 33 required DHS to relocate NWC's residents to either a community-based setting or to another ICF-ID, but authorized the facility to continue to provide short-term services.

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

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

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

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

Table 4 shows the populations of the state centers as of June 30, 2014, and the private pay reimbursement rates for each of the state centers for CY 2015. The population at the centers has declined significantly over the years. In 1970, nearly 3,700 persons resided in the state centers, compared to 385 as of November 30, 2014. This decrease is largely due to the state-initiated movement to relocate center residents into the community that began in the early 1970's as the centers' mission shifted from primarily a residential to a treatment approach. This movement of residents into the community was further increased due to implementation of CIP 1A in 1983 and the recent phase-out of long-term care services at NWC.

Table 5 shows the total budget and the number of authorized, full-time equivalent (FTE) staff positions for each state center for FY 2013-14. As noted, most of the program revenue funding for the state centers is comprised of payments through the state's Medicaid program.

Table 4: State Centers Population and Daily Rates

Facility	Population*	Private Pay Rate**	Intensive Treatment Services Rate**
CWC	229	$821	$1,056
NWC	13	1,385	1,056
SWC	143	946	1,056
Total	385		

*Population as of November 30, 2014, including long-term and intensive treatment populations.
**CY 2015 rates.

Table 5: State Centers Budget and Authorized Full-Time Equivalent Positions, FY 2013-14

	CWC	NWC	SWC	Total
Program Revenues - MA				
State Operations	$61,712,500	$16,200	$38,167,300	$99,896,000
Utilities & Fuel	2,160,900	1,346,300	2,032,600	5,539,800
Institutional Repair & Maintenance	258,300	0	350,400	608,700
Subtotal	$64,131,700	$1,362,500	$40,550,300	$106,044,500
Program Revenues - Other				
Alternative Services	$202,700	$7,294,900	$200,000	$7,697,600
Extended Intensive Treatment Surcharge	250,000	0	250,000	500,000
Farm Operations	0	0	50,000	50,000
Activity Therapy	77,400	17,800	17,500	112,700
Gifts and Grants	35,000	70,000	30,000	135,000
Interagency and Intra-agency programs	176,200	1,198,800	303,100	1,678,100
Subtotal	$741,300	$8,581,500	$850,600	$10,173,400
Total Funding (All Sources)	$64,873,000	$9,944,000	$41,400,900	$116,217,900
Total Authorized FTE Positions (All Sources)	811.40	119.50	532.55	1,463.45

Unlike Medicaid payments to other ICFs-ID, however, Medicaid payments to the state centers are based on the actual eligible costs of operating each facility, as limited by the amount budgeted by the Legislature for this purpose.

Non-Medicaid Community-Based Services

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

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

Basic County Allocation. Counties use the BCA, in combination with funding from other sources, to support a wide range of human service programs, including services for individuals with developmental disabilities. Counties may use the basic county allocations for any allowable community aids service. In CY 2015, DHS will distribute approximately $170.0 million under the BCA. In CY 2013, counties reported spending approximately $33.0 million of the BCA on services for persons with developmental disabilities.

Family Support Program. The Family Support Program is a categorical allocation within community aids that funds services that help children with severe disabilities remain in their homes. The program provides up to $3,000 per year in services and goods to eligible families, along with additional amounts that may be provided with the Department's approval.

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 must also 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). Although eligibility does not depend on income, some families are required to share in the cost of program services based on a sliding scale, beginning with families at 330% of the FPL.

Families receive an assessment to determine what services a child requires to be able to 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 Medicaid 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.

In CY 2013, 2,571 children received services under the program. Approximately 2,115 (82.3%) of these children had developmental disabilities, although the program also provides services to children with physical disabilities and severe emotional disturbance. An additional 509 children were served under the CLTS program and used Family Support Program allocations as a non-federal funding source, but it is unknown how many of these children had developmental disabilities.

In CY 2015, DHS will distribute $5.1 million to counties for the Family Support Program. Counties may spend up to 10% of these funds for staff and other administrative costs. Table 6 identifies expenditures for the Family Support Program for specific service categories in CY 2013.

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

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

Table 6: Family Support Program Expenditures by Service Category, CY 2013

Service Category	Amount	% of Total
Architectural Modification of Home	$139,579	3.4%
Child Care	109,538	2.6
Children's Long-Term Support Waiver Services	1,044,341	25.1
Counseling and Therapeutic Resources	120,193	2.9
Dental and Medical Care Not Otherwise Covered	34,268	0.8
Diagnosis and Evaluation	6,139	0.1
Diet, Nutrition, and Clothing	79,068	1.9
Equipment and Supplies	1,125,028	27.1
Home Training and Parent Courses	44,086	1.1
Homemaker Services	8,212	0.2
In-Home Nursing Services - Attendant	18,422	0.4
Recreation and Alternative Activities	484,333	11.7
Respite Care	789,285	19.0
Transportation	86,544	2.1
Utility Costs	14,570	0.4
Vehicle Modification	34,063	0.8
Other	17,973	0.4
Total	$4,155,642	100.0%

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

Once eligibility is determined, the early intervention team conducts an assessment to further identify the unique needs of the child and the family. The results of the assessment are used by a team of professionals, the service coordinator, the parents, other family members, and an advocate (if requested by the parent), to develop the individualized family service plan (IFSP). The plan must include a statement of the expected outcomes, how those outcomes will be achieved, a timeline for the provision of services, the manner in which services will be provided, and the sources of payment for the services. Eligible children are ensured the provision of core services at no cost to the family. Core services include evaluation, service coordination, and the development of an IFSP.

The services Birth-to-3 Program participants most frequently use include mandatory service coordination, communication services, special instruction, occupational therapy, and physical therapy. Children in the program may also receive audiology services, assistive technology services, family training, counseling and home visit services, nursing services, certain medical services, nutrition services, psychological services, sign language and cued language services, social work services, transportation, and vision services.

In CY 2013, approximately 12,000 children in Wisconsin received Birth-to-3 services.

The program is funded from several sources, including the federal IDEA grant, state general purpose revenue, county funds, community aids, Medicaid, private insurance reimbursement, and parental cost sharing. Table 7 shows the calendar year 2013 reported expenditures for the Birth-to-3 program from all sources. Appendix II provides total expenditures reported by counties for Birth-to-3 and the number of children each county served in that year.

Table 7: Birth-to-3 Program Revenues, CY 2013

Revenue Type	Amount
County Funds (includes Community Aids)	$15,880,876
State and Federal Funds	11,273,513
Medicaid	2,808,128
Parental Cost Share	336,369
Private Insurance	255,384
Other	323,536
Total	$30,877,806

Disability Benefit Specialists. The disability benefit specialist (DBS) program provides assistance and information to people with disabilities between the ages of 18 and 59 (individuals 60 years of age or older can receive similar services from elder benefit specialists). Benefit specialists work in 41 ADRCs covering all 72 counties, and provide services such as help with program applications, discussions regarding program choices to meet the individual's needs, and, at times, representation in appeals processes for certain programs.

In 2013, a total of 11,584 cases were closed by these benefit specialists, with an additional 9,302 information-only contacts. While the majority of clients served had either a physical disability or a mental illness, eight percent of DBS clients had a developmental disability and no other diagnosis. The most common issues addressed by DBS are Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) eligibility (40%), Medicare Part D

(16%), and the MAPP program (13%).

DHS allocated a total of $8.6 million (all funds) for DBS services in calendar year 2013. Costs are divided between GPR and FED, and depend on federal cost reporting submitted by ADRCs to the Department. In 2013, approximately 65% of these costs were supported with GPR, with the remaining 35% supported with federal funds. Most of these costs are for services provided by ADRCs ($7.5 million in 2013), with the remainder for legal backup services and training (approximately $1.1 million in 2013).

Epilepsy Service Grants. DHS allocates state funds to private, nonprofit organizations or county agencies that provide direct or indirect services to persons with epilepsy. Direct services include services provided to a person with epilepsy or a 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 include services provided to a person working with or on behalf of a person with epilepsy, such as service provider training, community education, prevention programs, and advocacy. Table 8 shows the epilepsy service grant allocations for FYs 2010-11 through 2014-15.

Table 8: Epilepsy Service Grant Allocations

Fiscal Year	Allocation
2010-11	$117,600
2011-12	141,400
2012-13	131,400
2013-14	145,500
2014-15	130,600

Supplemental Security Income. The supplemental security income (SSI) program provides cash benefits to elderly, blind, and disabled individuals, many of whom have developmental disabilities. In October, 2014, approximately 120,100 Wisconsin residents received SSI benefits. In 2015, the program's enrollees can receive up to $793.78 in state and federal benefits, which they may use for any purpose. Participants also automatically qualify for coverage under the Medicaid program. Additional information on the SSI program is provided in the Legislative Fiscal Bureau informational paper entitled "Supplemental Security Income."

Additional Resources

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

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

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

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

APPENDIX I

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2009 through 2013

County	2009	2010	2011	2012	2013
Adams	$1,980,882	$2,037,811	$2,099,322	$ 2,074,240	$ 2,228,460
Ashland	1,138,757	35,597	217,960	49,125	85,213
Barron	3,244,802	915,420	719,271	825,413	1,022,835
Bayfield	1,100,363	256,536	289,040	235,957	189,032
Brown	38,888,719	40,182,368	40,637,664	40,886,846	41,121,303
Buffalo	587,121	126,690	111,316	161,316	372,048
Burnett	963,108	341,170	243,579	251,392	182,879
Calumet	5,871,902	1,371,408	1,493,733	1,908,708	1,742,447
Chippewa	1,490,770	1,235,397	1,444,218	1,019,865	1,091,100
Clark	3,262,519	2,777,030	2,080,684	2,029,925	2,160,577
Columbia	1,342,949	1,265,554	1,049,897	868,768	897,377
Crawford	2,021,782	372,589	303,460	305,547	217,563
Dane	83,717,973	84,198,388	85,792,836	86,890,597	89,082,747
Dodge	1,767,629	1,751,584	1,626,945	1,624,167	1,493,966
Door	5,866,988	5,726,272	5,995,083	5,795,859	5,534,460
Douglas	2,689,375	1,260,888	1,316,893	1,069,833	982,845
Dunn	1,350,362	1,460,636	1,364,074	897,511	737,185
Eau Claire	3,838,672	2,694,911	2,561,393	2,123,091	2,875,798
Florence	461,795	381,459	502,105	509,782	447,094
Fond du Lac	3,735,920	3,528,738	3,215,712	3,383,271	3,233,303
Forest-Oneida-Vilas	11,939,559	11,498,566	11,569,463	11,401,791	11,368,687
Grant-Iowa	7,335,296	3,115,532	930,445	1,175,618	1,087,418
Green	538,296	560,438	536,610	175,483	236,369
Green Lake	1,462,448	1,501,002	1,534,944	1,549,383	748,811
Iron	465,559	61,304	70,240	58,781	45,940
Jackson	547,047	165,006	129,535	99,784	152,654
Jefferson	3,770,415	1,285,683	1,404,903	2,046,727	1,570,439
Juneau	2,182,402	875,284	529,187	384,109	301,304
Kenosha	1,645,070	1,720,978	1,377,788	1,876,481	1,831,401
Kewaunee	4,168,256	4,467,733	4,228,789	3,994,326	4,010,794
La Crosse	3,347,165	2,886,566	2,745,427	3,025,051	2,979,399
Lafayette	1,243,482	507,723	308,101	277,207	463,705
Langlade-Lincoln-Marathon	15,275,358	16,752,198	10,182,895	8,893,629	9,716,232
Manitowoc	16,100,917	7,976,367	2,192,376	2,304,477	2,008,684
Marinette	3,736,240	3,916,477	4,174,520	4,108,373	4,327,885
Marquette	308,272	301,258	339,744	278,344	306,015
Menominee	1,228,982	**	**	**	1,842,504
Milwaukee	89,988,449	40,670,414	11,076,897	10,321,403	10,276,190
Monroe	334,435	**	**	562,009	539,886
Oconto	8,720,597	8,490,651	8,973,422	8,796,177	9,025,328

APPENDIX I (continued)

Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2009 through 2013

County	2009	2010	2011	2012	2013
Outagamie	$21,657,105	$21,840,695	$2,221,802	$2,147,840	$2,627,556
Ozaukee	3,293,958	2,486,746	2,724,092	2,453,329	1,676,915
Pepin	347,005	107,640	69,106	89,844	182,654
Pierce	400,254	448,077	418,205	339,799	270,656
Polk	1,858,299	289,668	391,732	298,853	421,525
Portage	1,391,813	1,144,359	1,292,182	1,307,119	1,328,710
Price	2,002,788	316,459	483,308	525,102	274,344
Racine	3,219,027	3,346,792	2,728,517	3,260,811	3,615,103
Richland	247,993	269,605	289,970	325,777	315,980
Rock	27,253,078	27,650,581	25,712,818	26,115,764	27,214,754
Rusk	1,867,512	255,320	254,498	162,279	284,204
St. Croix	1,425,586	1,384,652	1,244,273	795,124	981,814
Sauk	1,264,506	354,302	375,887	753,986	738,400
Sawyer	6,540,519	6,279,619	6,219,010	297,701	183,690
Shawano	1,973,511	1,753,458	1,770,979	6,090,033	6,448,593
Sheboygan	1,621,298	1,601,890	**	1,679,626	2,184,535
Taylor	3,369,551	3,458,711	3,566,156	3,620,703	3,988,085
Trempealeau	577,655	537,568	518,744	401,182	370,758
Vernon	259,281	446,575	433,005	262,193	472,315
Walworth	6,660,114	1,784,484	444,004	482,990	927,767
Washburn	1,313,320	326,093	323,828	442,512	459,553
Washington	3,457,198	2,744,464	1,285,685	1,000,730	1,136,259
Waukesha	7,540,456	7,116,914	9,961,107	8,047,574	10,452,568
Waupaca	10,615,706	8,250,676	4,334,276	4,126,679	4,471,076
Waushara	594,125	506,294	425,325	330,980	375,990
Winnebago	25,937,859	16,353,201	6,228,034	6,144,016	5,215,811
Wood	4,133,436	2,102,066	1,993,699	837,477	1,080,185
Total	$480,483,586	$371,830,535	$291,080,713	$286,582,401	$296,239,690

* Data obtained from the Human Services Revenue Reports (HSRR) collected by DHS. Overall declines in reported county expenditures can largely be attributed to Family Care expansion. Family Care expenditures are not reported.

**No data reported (Menominee County for 2010-2012, Monroe County for 2010 and 2011, and St Croix County for 2011).

APPENDIX II

Birth-to-3 Expenditures and Number of Children Served, By County
Calendar Year 2013

	Total Expenses	Children Served		Total Expenses	Children Served
Adams	$84,769	45	Marquette	$84,272	15
Ashland	149,333	25	Menominee	51,775	20
Barron	272,432	101	Milwaukee	4,974,503	2,655
Bayfield	125,793	23	Monroe	243,340	111
Brown	1,138,711	480	Oconto	304,873	69
Buffalo	113,568	26	Outagamie	1,189,667	333
Burnett	113,175	30	Ozaukee	483,222	162
Calumet	482,589	134	Pepin	86,512	12
Chippewa	429,919	191	Pierce	152,251	77
Clark	302,123	90	Polk	263,773	102
Columbia	236,956	80	Portage	416,937	118
Crawford	71,611	24	Price	65,899	25
Dane	2,483,580	939	Racine	780,381	393
Dodge	496,344	203	Richland	234,125	32
Door	279,851	39	Rock	883,803	330
Douglas	185,501	89	Rusk	92,938	28
Dunn	542,862	115	St. Croix	353,177	198
Eau Claire	419,848	286	Sauk	581,431	132
Florence	20,390	5	Sawyer	143,788	48
Fond Du Lac	524,271	172	Shawano	365,259	105
Forest/Oneida/Vilas	395,428	131	Sheboygan	571,119	302
Grant/Iowa	323,667	75	Taylor	155,534	41
Green	117,684	105	Trempealeau	175,733	53
Green Lake	100,364	23	Vernon	160,131	70
Iron	26,320	11	Walworth	742,138	173
Jackson	116,367	34	Washburn	99,601	33
Jefferson	738,865	248	Washington	632,946	255
Juneau	173,543	43	Waukesha	851,824	465
Kenosha	509,370	382	Waupaca	499,903	118
Kewaunee	151,770	53	Waushara	123,987	30
La Crosse	469,150	200	Winnebago	688,156	251
Lafayette	125,924	31	Wood	414,392	127
Langlade/Lincoln/ Marathon	1,453,255	423	Total	$30,877,803	12,113
Manitowoc	633,834	295			
Marinette	201,247	79			

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