Wisconsin Birth to 3 Early Intervention Program: Recommendations for Sustainability

Report Prepared by:

Birth to 3 Sustainability Workgroup to Wisconsin County Human Service Association (WCHSA)

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Executive Summary

This report assesses the sustainability of Wisconsin's Birth to 3 Early Intervention Services program, which serves over 13,000 children annually. The program faces significant challenges due to flat funding and increasing demand. The current funding model, heavily reliant on county contributions, is unsustainable, further strained by sluggish Medicaid and private insurance reimbursements and a shrinking provider network. These challenges directly undermine the program's ability to prepare children for future academic success, potentially leading to increased strain on K-12 resources and poorer overall educational outcomes.

This report details recommendations developed by four workgroups addressing Medicaid/private insurance reimbursement, the Birth to 3 funding formula, data/research, and advocacy/communications. Key recommendations include establishing a dedicated State Department of Health Services (DHS) liaison to optimize Medicaid reimbursement, pursuing a state plan amendment to include special education services, and increasing state funding by $10 million annually starting in calendar year 2026, with further annual increases to meet growing demand. A long-term investment strategy is proposed to ensure access and high-quality services for all children. This strategic investment will not only strengthen the Birth to 3 program but will also lay a stronger foundation for the success of Wisconsin's K-12 educational system, creating a more vibrant future for all students.

Background

Quick Facts

Population Served: **Infants and toddlers (ages 0-3) with developmental delays or disabilities**

Number of Children Enrolled (2023): **13,200 across Wisconsin**

Budget (2023): **$49 million** statewide

Funding Sources: **County levy & County Aids (47%), state and federal allocations, Medicaid, private insurance, parental contributions, private provider subsidy**

Leading Causes of Referrals: **Developmental delays in communication or motor skills, prematurity, Down syndrome, neurological conditions**

Funding Trend: **Flat** for several years

Enrollment Trend: **Growing** since 2020

Primary Types of Birth to 3 Services

Service Coordination – assists families with accessing Birth to 3 services by scheduling evaluations and creating service plans.

Occupational Therapy (OT) – helps children build skills so that they can participate in their daily routines and activities.

Physical Therapy (PT) – these services assist a child in developing the physical capability to move, play and participate in their daily activities and helps reduce pain and prevent/minimize physical disabilities.

Speech Therapy (ST) and Language Services – builds language development and strengthens muscles to assist a child in the formation of speech.

Special Education – supports a child's learning and development to help them grow, learn, play, and build relationships with others.

How did Sustainability Workgroup Effort Originate?

Birth to 3 Early Intervention is truly what is meant by upstream investment which is the key for improving the health outcomes of the community. Yet, Wisconsin's ability to improve health outcomes is being disrupted by stagnant and insufficient funding in the program. Concern around this lack of funding for a program that determines a child's future success inspired a strong commitment from Milwaukee County providers and Milwaukee County Department of Health and Human Services (DHHS) leadership to act and be solutions focused. An initial meeting in December 2023 included DHHS program staff and providers. At that point, it was clear that there were some highly motivated people who were willing to invest the time and energy to create change.

All Wisconsin counties are struggling with resources to sustainably deliver Birth to 3. This recognition created even more momentum to partner and develop a comprehensive advocacy plan to ensure long-term sustainability for Birth to 3. So initially, those that were at the table talking about these issues were just Milwaukee County's three remaining partner providers – Curative Care Network, Penfield Children's Center, and St. Francis Children's Center. However, from the very beginning, we wanted to involve as many counties and other stakeholders who would devote time exploring various components of a long-term sustainability

plan. We asked other counties to join in this effort and our group then expanded to include Brown, Dane and La Crosse who committed staff to our workgroups.

Because the issues around fiscal sustainability and needed changes identified because of this work are complex, change will take time and long-term commitment to this effort is required. For this reason, we need to continue to raise awareness, expand the network of support so that we engage and create an even broader coalition of stakeholders.

Key Benefits and Challenges

Cost Efficiency: Early intervention reduces the need for costly special education services later in life. A study of six states showed that early intervention helped avoid special education services for up to 3,000 children per state, saving between $7.6 million and $68.2 million annually.[1]

Improved Long-Term Outcomes: Early intervention strengthens cognitive and social development, fostering school readiness and reducing future societal costs.

Parental Support: By providing families with resources and support, Birth to 3 reduces parental stress and increases workforce participation.

Equity and Inclusivity: The program helps mitigate the long-term impacts of social disparities, especially for BIPOC children in underserved areas, by addressing developmental delays early.

Challenges Facing Birth to 3

The sustainability of the Birth to 3 system is threatened by several key challenges:

Flat Funding: Despite growing demand, state/federal funding to counties has remained relatively unchanged at around $12.7 million annually. This is not sufficient to meet the rising costs associated with increased enrollments and service needs.

Local County Burden: Wisconsin is only one of three states (Ohio and Maryland are the other two) in which Birth to 3 services are funded primarily at the county level. Counties contribute 47% of the program's funding through local tax levy and their basic county allocation (community aids), a structure that places a disproportionate financial burden on local governments. In fact, these contributions have increased by $10 million since 2005 as costs and enrollments have increased and other reimbursements have dropped off. This over-reliance on county funds is unsustainable, especially in high-need areas. Given that the program is a federal entitlement, additional state funding is needed to equalize availability of services across counties.

Shrinking Provider Network: The size of the provider network has been shrinking, particularly in Milwaukee County, where two-thirds of providers have exited the system since 2018. The financial gap between their contracts with Milwaukee County and the cost for services averages about $1.5 million annually. Given the flat funding, provider rates have not increased which impact the ability to retain qualified Birth to 3 staff, offer training and specialized services. The declining number of providers limits access to care and creates barriers for families needing timely services. Additional funding is needed not only to keep up with growing caseload, but also to give rate increases to service providers.

Racial Disparities: Black infants in Milwaukee County are 2.5 times more likely to be born with low birth weight than white infants, contributing to higher developmental delays and the need for Birth to 3. Despite this, BIPOC children are often underrepresented in early intervention services.

Reductions to Medicaid and Private Insurance Reimbursement: Both Medicaid and private insurance contributions to Birth to 3 have declined, increasing the financial burden on counties to cover the cost of services.

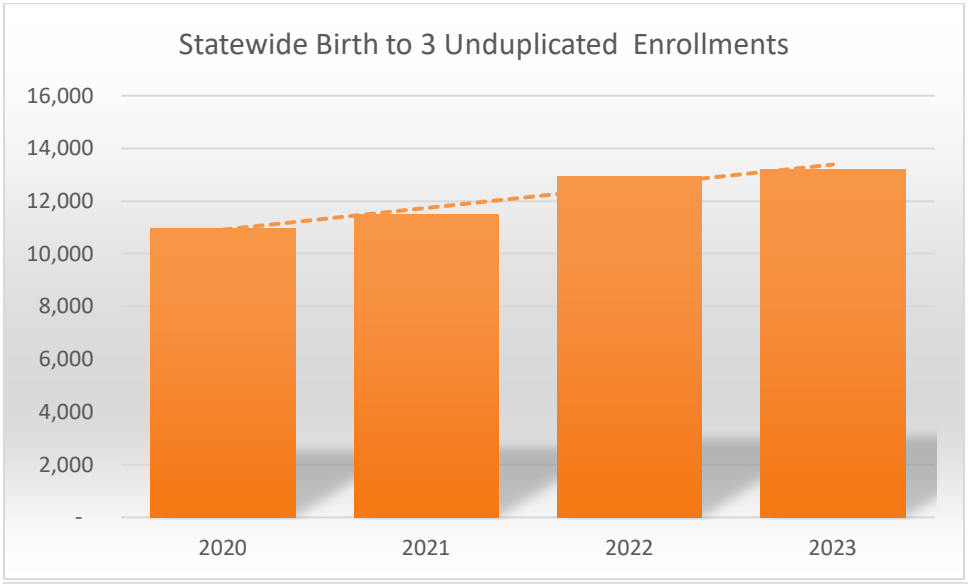
[1] Emerald Consulting. (n.d.). Cost avoidance return on investment. Document provided to the Prenatal-to-3 Policy Impact Center by Maureen Greer, Executive Director at the IDEA Infant & Toddler Coordinators Association, via email on April 1, 2020.

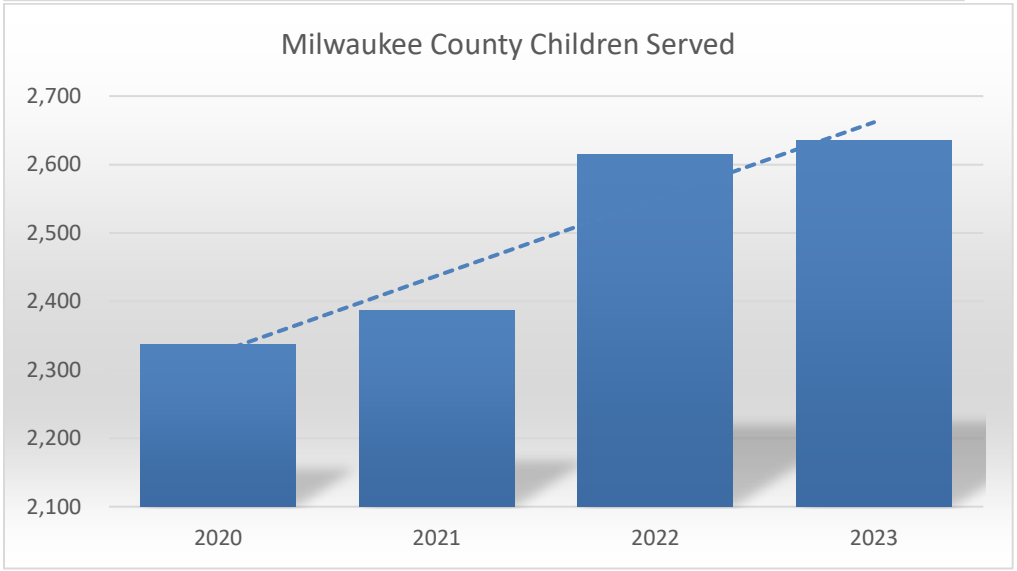
Milwaukee County Experience and Statewide Challenges

Children we are serving has gradually increased over the past few years. Enrollment for children of color increased by 13% and enrollment for white infants and toddlers increased by 14% from 2020-23. This is an untenable gap that has been assumed by Milwaukee's partner providers. And despite the existing financial gap - the challenge is that we know there are more children in our community who are eligible but aren't being served. Yet, if we ramp up our outreach, we could enroll and serve more kids, but the financial gap is so significant already – how do we pay for additional children?

Enrollment and Children Served

Enrollment trends show that the number of **children served has increased over the last three years** for both Milwaukee County and Wisconsin as a whole. Milwaukee County continues to sustain increasing numbers as the state does overall.[2] Since 2020, Milwaukee County has seen a 13% increase of children served while funding remained flat.





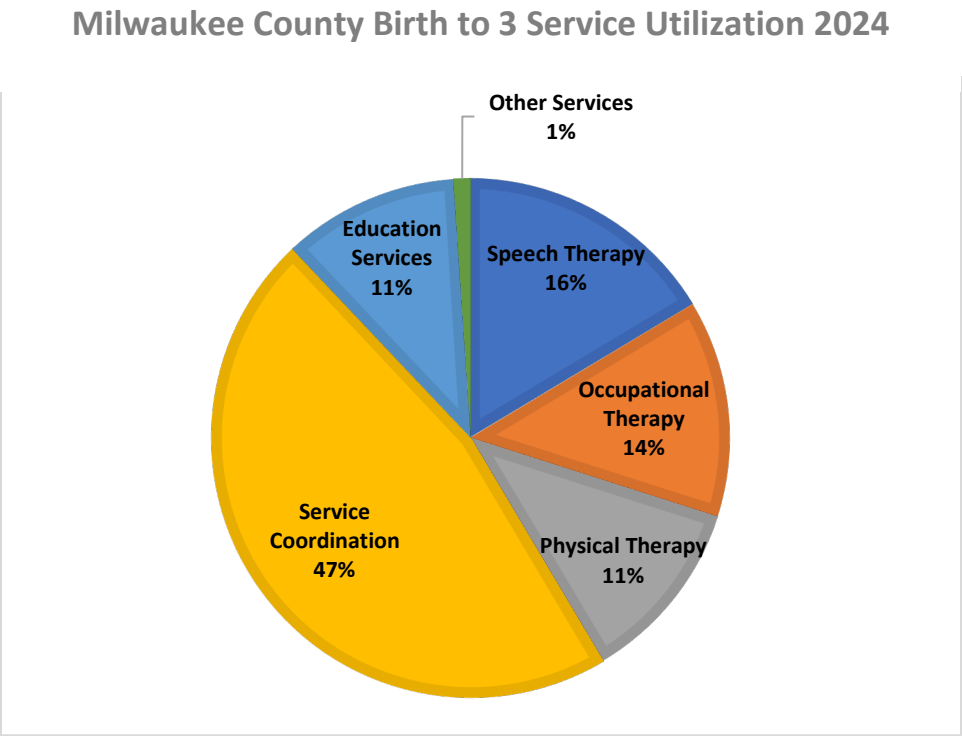
[3]

[2] Chart reflects total number of unique children enrolled any point in time in the Birth to 3 Program from DHS-Bureau of Children's Services.

[3] Reflects total children served in Milwaukee County including closed cases.

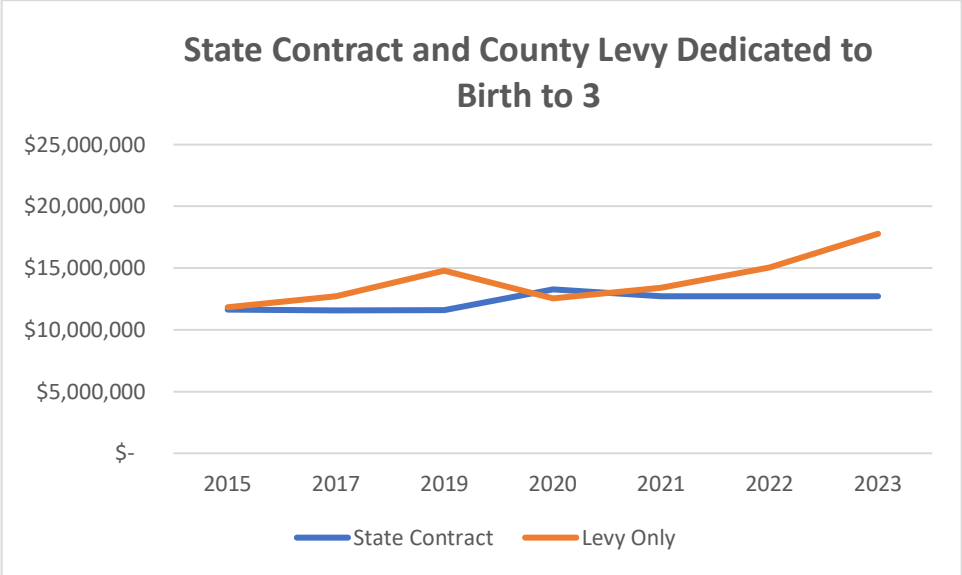
Service Utilization

The table below shows service utilization for children being served in Milwaukee County throughout 2024. The service type reflecting the highest utilization rate is service coordination which assists families with accessing Birth to 3 services by scheduling evaluations and creating service plans. The next most common utilized service is speech therapy which builds language development and strengthens muscles to assist a child in the formation of speech.



Revenue Sources

The statewide $49 million Birth to 3 budget is heavily reliant on county contributions in levy and community aids, which together cover 47% of the total budget. Medicaid and private insurance have declined over the last five years and the State's contracted allocation to counties has remained relatively flat. The charts below show the trend toward increased levy investment by counties from 2015 to 2023.



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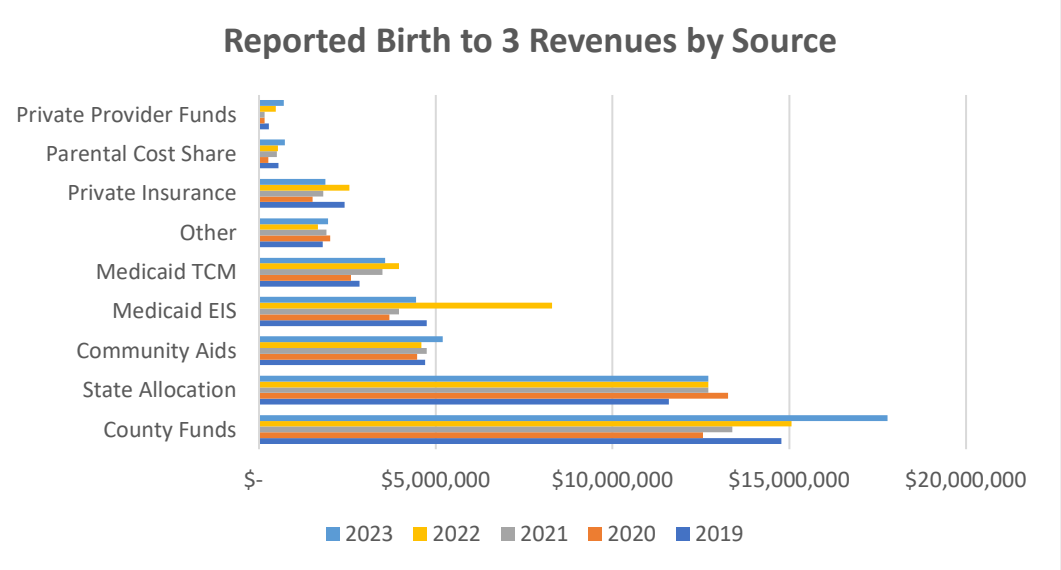


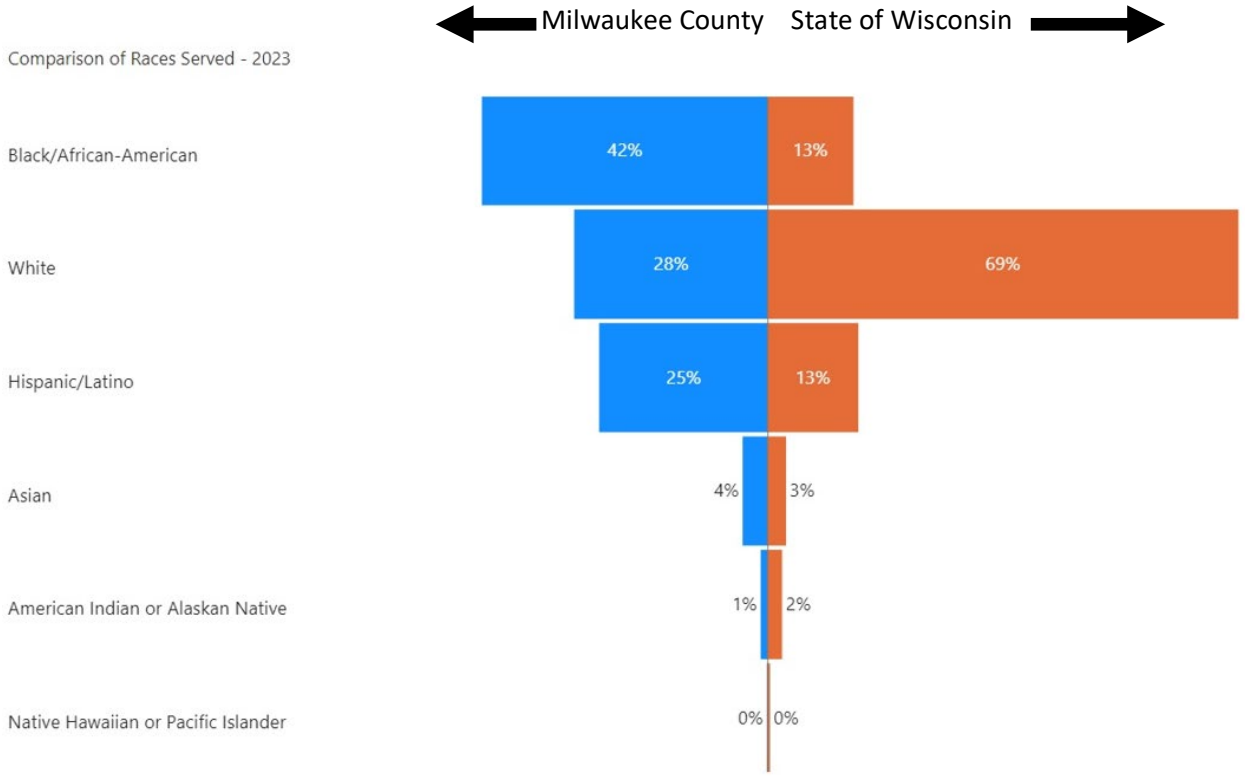
[5]

[4] 2015-2023 Wisconsin Legislative Fiscal Bureau informational papers on Services for Persons with Developmental Disabilities

[5] Reported Birth to Three Revenues, CY2019-23, County and Private from Wisconsin DHS-Bureau of Children's Services

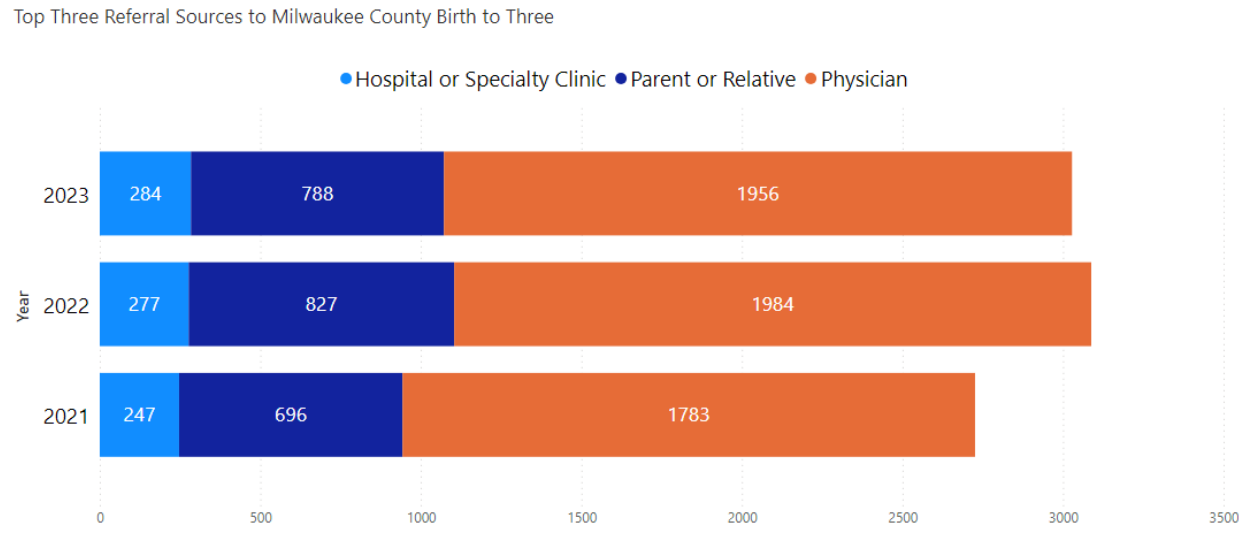
Population Served: By Race and Gender

Milwaukee County serves a significantly different demographic population than the State of Wisconsin as a whole. Black/African-American and Latino/Hispanic children are much more represented in Milwaukee County as shown in the chart reflecting data from 2023 below. This may present additional cultural challenges with a dynamic group of children served.



Referral Sources Milwaukee County

Data: Hospital/Specialty Clinic, Parent/Relative, and Physician referrals make up 82% of all referrals to Milwaukee County's Birth to 3 Program. **Physician referrals alone in 2023 made up 56% of all referrals.** State of Wisconsin data similarly mirrors Milwaukee County.

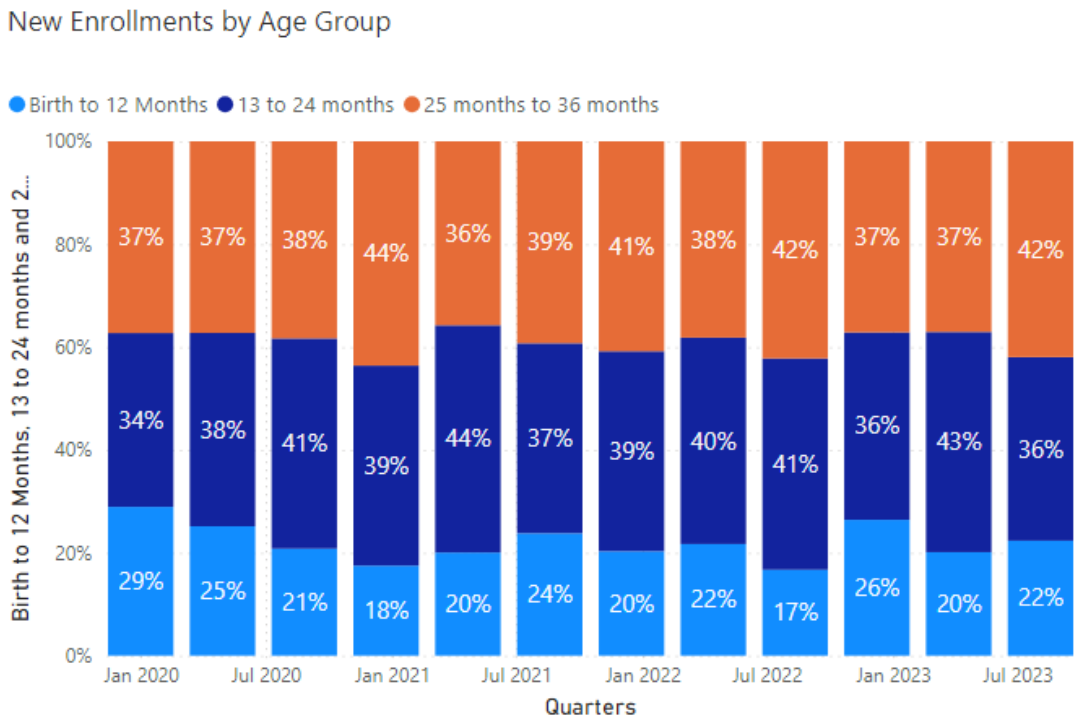


Percentage of Children Potentially Eligible

Milwaukee County evaluation staff calculated the percentage of children estimated to be eligible for Birth to 3 programming **but who are not receiving services at 73%** based on a formula utilized by researchers in early intervention. [6] That means that only 27% of eligible children are receiving services.

Ages of referral to Birth to 3 in Milwaukee County

Data: **Enrollment beyond the age of 12 months accounts for about 78% of all enrollments** in each period on average. This means that **only 22% of children are accessing services within the first 12 months** of life. The data currently shows that the most prevalent age for a child to connect to services is 24 months. See the chart below:



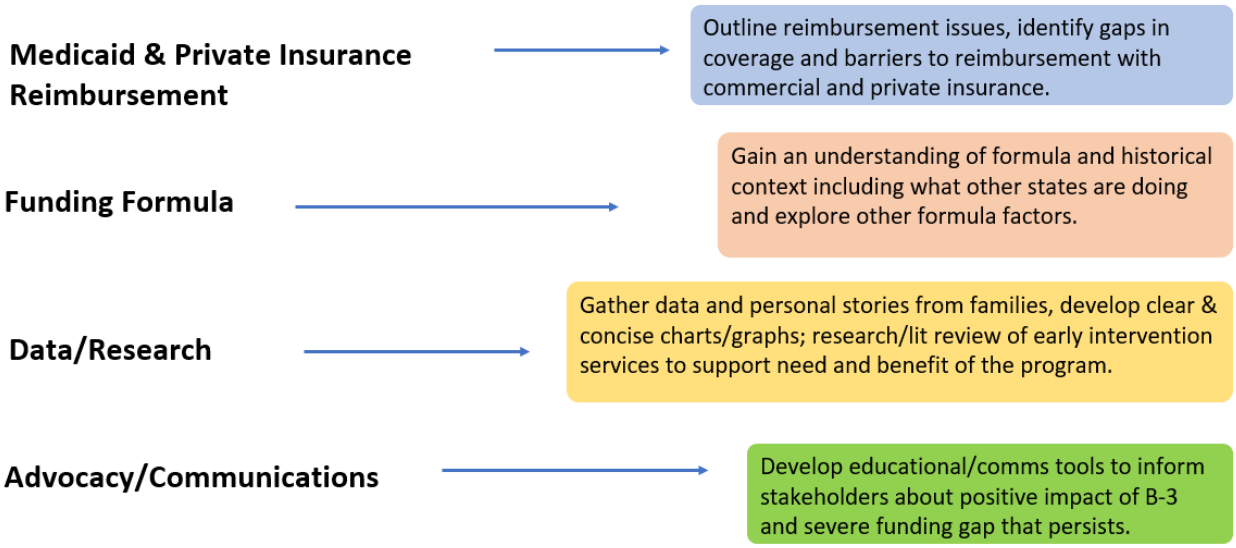
To address this issue, the State initiated the First 1,000 Days Wisconsin Child Find Campaign in the spring of 2021. This campaign was launched to assist families of children with delays or disabilities in learning about the Birth to 3 Program and facilitating early connections to services. Considering the results presented above, what outcomes are expected as a result of the campaign?

[6] Rosenberg, Robinson, Shaw and Ellison (2013). "Part C Early Intervention for Infants and Toddlers: Percentage Eligible Versus Served." Pediatrics, Volume 131(1); Rosenberg, Ellison, Fast, Robinson and Lazar (2013). "Computing Theoretical Rates of Part C Eligibility Based on Developmental Delays." Maternal & Child Health Journal, Volume 17(2), 384-390.

Workgroup Recommendations

Workgroup Charter/Deliverables

After a large group meeting in the spring of 2024 to identify major issue areas, participants were asked to join a workgroup charged with exploring that particular area. Each workgroup (Communications, Research/Data, Medicaid/Private Insurance Reimbursement, and Funding Formula) met several times over the course of about five months and developed a charter with deliverables, issuing final recommendations for addressing sustainability.



Recommendations

The following is a summary of recommendations made by the workgroups. Because the issues are complex, the recommendations are identified for immediate action or long-term.

Medicaid and Private Insurance Reimbursement Workgroup

Project Lead: Joy Gravos, President & CEO, Curative Care Network

When comparing the revenue streams for the Birth to 3 Program between 2015 to 2023, the most dramatic changes occurred with Medicaid, private insurance, and County tax levy. During this period, Medicaid reimbursement fell by 7%, private insurance declined by 42% while County levy contributions increased by 50%. It's clear that new approaches are needed to assist counties in maximizing Medicaid reimbursement as well as reinforcing an expectation that private insurance companies be viewed as the payor of first resort.

Billing Medicaid and private insurance can be a highly intricate process. Although resources like the Forward Health Handbook offer guidance to counties and providers, the challenges posed by staff turnover and the complexities of reimbursement necessitate more direct support. Regarding private insurers, some companies do not cover Birth to 3 services, which requires diligent follow-up to understand the reasons behind any claim denials. Enhanced assistance is essential to navigate these challenges effectively.

Recommendations

- Establish a dedicated liaison within the DHS-Bureau of Children Services (BCS) to focus exclusively on the Birth to 3 program funding/sustainability issues. This role would help optimize Medicaid insurance reimbursement (Occupational Therapy/Physical Therapy and Speech Language Pathology services, along with Targeted Case Management) and effectively address claims-related issues. Additionally, there is a need for specialized expertise within the private

insurance sector to navigate claims processes and resolve denial challenges. A deeper understanding of the reasons behind these denials, along with strategies to address them, is essential for improving outcomes. This could include: 1) understanding and utilization of billable MA Targeted Case Management (TCM) reimbursement around team meetings and other billable time and 2) the need for BadgerCare Plus disenrollment to fee-for-service Medicaid.

- DHS pursue a Medicaid state plan amendment to include special education services and provide guidance on how special education services can be considered medically necessary. Currently, the cost for these services is not covered because it is not considered a medical service yet it's a requirement of Birth to 3. Federal law requires state Medicaid programs to pay for services that are both educationally and medically necessary. This is an exception to the general rule that Medicaid is the payor of last resort when other sources of coverage are available. The key is the special education services need to be medically necessary as well as for the child's education and development. It's estimated that about 25% of the ongoing services budget is most likely dedicated to early/special education.

- DHS provide greater guidance on reimbursement of costs for the initial evaluation and assessment even if that process ultimately determines that a child is ineligible for the program or the family declines to enroll. Currently, there is confusion on what is reimbursable.

- DHS-BCS provide additional technical assistance on completing the annual cost reconciliation report to ensure data integrity and all costs are being captured.

- DHS-BCS educate providers on how to explain the consent to access insurance to parents. Since families only pay a cost share, not health insurance coverage deductibles or copayments, there is not a disadvantage usually to families to consent to health insurance coverage.

- DHS-BCS educate counties in utilizing Children's Long Term Services (CLTS) when appropriate. Children can be co-enrolled in both CLTS and Birth to 3. This may work better for smaller counties as it could be used as another tool to maximize resources for children.

Specialized Services

The current funding structure for Birth to 3 services creates significant financial barriers for accessing specialized care such as vision and hearing services. Without adequate funding, children are not accessing these services early enough which results in critical lost time potentially setting them back in school and later in life.

Individual counties or agencies must pay for these services, without any additional support in their contract. For example, for an agency like Vision Forward, which is the only agency providing services statewide, the agency must navigate almost 30 different contracts with agencies/counties across the state.

Recommendations

- Allocate special population funding to support children with specific needs, such as those with vision or hearing impairments, who are eligible for services but face barriers due to a lack of available state funding.

- Explore centralizing specialized services through a Request for Proposals (RFP) process to be administered by DHS.

Funding Formula Workgroup:

Project Lead: Christina Courtney, Children's Services Manager, Brown County

The funding formula workgroup was tasked with understanding, discussing, and generating ideas for potentially amending the current Birth to 3 funding formula. The funding formula is used to guide how much each county in Wisconsin receives from the total state and federal dollars provided to fund Birth to 3. The current funding formula was established in 2019 by Wisconsin Department of Health Services and is described in DMS Numbered Memo 2023-02.

To summarize, three primary factors go into the current funding formula:

- A base rate per county agency
- An agency-specific percent that is calculated using the average of the most recent three years of data combining Individualized Family Service Plan (IFSP) rate (enrolled children) and the 0-3 population rate (census).
- A historical minimum allocation to avoid significant reductions for counties that would have been negatively impacted by the 2019 formula.

Upon understanding the funding formula and discussing the current model with DHS staff, the workgroup feels there would need to be significant cause for DHS to support a change in the current formula. DHS suggests that each county be able to more clearly identify their actual costs of providing Birth to 3 services using the existing annual reconciliation report. DHS shared that current reconciliation report data provided by counties is not consistent or accurate.

The workgroup agreed that accurate reconciliation data is key for advocacy efforts and a better understanding of actual costs that each county incurs to provide Birth to 3. This would then allow for more ability to advocate to DHS for any adjustments to the formula to better support counties that may have more needs-based factors that contribute to the cost of providing services. Future needs-based considerations may include program structure, fidelity to Primary Coach Approach model, CAPTA referrals, premature birth data and actual cost variability.

Recommendations

- DHS provide further support to counties to ensure that annual reconciliation data completed by each county is accurate and consistent.
- Encourage each county to determine their actual cost of providing Birth to 3 services.
- Continue workgroup efforts to learn more about needs-based funding formula factors that other states are utilizing to determine if they may be of benefit to advocate for.

Data/Research

Project Lead: Clare O'Brien, Budget and Policy Director, Milwaukee County DHHS

The data that is cited throughout this paper originates from the diligent work of the measurement and evaluation team within Milwaukee County DHHS as well as a graduate intern with Marquette University assigned to Milwaukee County's Office of Equity. As a result of this work, a focus group was held involving families whose children are receiving Birth to 3 services. The results of this focus group are attached to this report and high-level recommendations from parents are identified below:

- **Increase Communication and Awareness**– Enhanced communication and awareness of available services if a development delay is suspected or has been diagnosed is needed. In addition, this

information should be shared with expectant parents so that they are aware of services available just in case their child or someone else's child may need it.

- **Targeted Outreach to Pediatricians and Community** – ensure that pediatricians, medical centers, community centers, and daycares receive materials to increase knowledge and awareness to enhance access to services. Pediatricians are the main source of referral to Birth to 3 so it's critical that this group is aware of these services.
- **Parental Advocacy Guidance** – parents expressed a need for greater support around skill building when it comes to advocating for their child starting with Birth to 3 but also as they navigate through future service system touchpoints.

In addition, a research review identifying prevailing studies and data in Birth to 3 Early Intervention Services and its importance in the development and success of infants and toddlers was prepared by a graduate intern who participated in the Data/Research Workgroup. This report provided the research background and benefits of Birth to 3 that are identified in this report. The full research review is attached to this report.

Communications

Project Lead: Polina Makievsky, President & CEO, Penfield Children's Center

This workgroup developed original content, branding and graphs much of which has already been incorporated into this document. The final drafts of an infographic and legislative policy brief developed by this workgroup are currently in the process of being laid out and published by the communications team at Milwaukee County DHHS. Once complete, these materials are intended to facilitate discussion, raise awareness and create consistency in messaging across stakeholder groups.

Overall Funding Recommendations

Request for 2025-2027 State Budget

- As stated previously, local county contributions to Birth to 3 have increased by $10 million since 2005 as costs and enrollments have increased and other reimbursements have dropped off. This over-reliance on county funds is unsustainable, especially in high-need areas. A $10 million annual budget increase in State General Purpose Revenue (GPR) starting in calendar year 2026 is needed to stabilize the system, with additional long-term investments required to ensure equitable access and high-quality services for all children.

Long-Term Investment Strategy

- Establish annual GPR increases to cover projected caseload growth and service costs. This will ensure that Birth to 3 remains sustainable as the demand for services continues to rise.

- Work with State DHS to explore adding certain Birth to 3 services to the Medicaid state plan such as early education, increasing federal reimbursements for the program.

- Increase the Medicaid TCM rate to allow counties to generate more federal Medicaid TCM to cover costs of service coordination. In Milwaukee County, this is the most common service need. Since DHS passes through only the federal Medicaid share, there is no state budget impact to increasing the TCM rate. It is important to note that while federal funds would be leveraged to pay for the majority of a TCM rate increase, counties would also experience an increase to their nonfederal share of the cost.

- Establish a statewide point of access and targeted funding for children with specific needs such as those with vision or hearing impairments, who are eligible for services but face barriers due to a lack of available state funding. Establishing targeted funding for specialized services ensures that all eligible children receive the specialized support they need to thrive.

- DHS work with the Office of the Insurance Commissioner to provide direction about Birth to 3 services to insurance companies and enforce existing requirements for private insurance to be the first payor for Birth to 3. Services provided by medical health care providers such as Speech Therapy, Physical Therapy and Occupational Therapy should be reimbursed by private insurance as it covers those services when authorized by doctors.

Create a Legislative Study Committee

- Seek the establishment of a Legislative Study Committee to assess options to improve Wisconsin's Birth to 3 system and review the state's funding allocation formula by considering new factors such as preterm birth rates, racial disparities, and poverty rates.

Final Thoughts

Wisconsin has the potential to become a national leader in early intervention services for infants and toddlers. This report outlines a multi-faceted strategy for achieving long-term sustainability for the Birth to 3 program, extending beyond simply securing additional funding in the 2025-2027 State Budget, although that funding is critical. Many recommendations focus on improving reimbursement with Medicaid and private insurance by collaborating with the Department of Health Services (DHS).

While the complexities of this issue and competing county priorities necessitate a phased approach and long-term commitment, the shared vision is clear: early intervention profoundly influences a child's future success. By investing in the Birth to 3 program, Wisconsin can build a stronger foundation for its K-12 system, reducing the need for costly special education services later and significantly improving a child's readiness for kindergarten. This investment is not just about supporting vulnerable children; it is about securing a more successful educational future for the entire state.

Summary Table – Birth to 3 Recommendations

Area	Recommendation	Description
Medicaid & Private Insurance Reimbursement	Establish a dedicated DHS liaison for Birth to 3 funding/sustainability.	Optimize Medicaid reimbursement (OT/PT/SLP, Targeted Case Management), address claims issues, and gain private insurance sector expertise to resolve denials. Includes understanding & utilizing billable MA Targeted Case Management (TCM) and BadgerCare Plus disenrollment.
	DHS pursue Medicaid state plan amendment to include special education services.	Address the fact that special education, while required by Birth to 3, isn't currently covered by Medicaid because it's not considered a medical service. Highlights the 25% of the budget likely dedicated to early/special education.
	DHS-BCS provide additional technical assistance on annual cost reconciliation reports.	Ensure data integrity and capture all costs.
	DHS-BCS educate providers on explaining insurance consent to parents.	Clarify that families only pay cost-shares, not deductibles/copayments.
	DHS-BCS educate counties on utilizing Children's Long Term Services (CLTS) when appropriate.	Co-enrollment in CLTS and Birth to 3 may maximize resources, especially for smaller counties.
	DHS work with the Office of the Insurance Commissioner to enforce private insurance as the first payor for Birth to 3 services.	Ensure appropriate reimbursement from private insurance for covered services.
Specialized Services	Allocate special population funding for children with vision/hearing impairments.	Address barriers to accessing specialized services due to lack of state funding.
	Explore centralizing specialized services through a Request for Proposals (RFP) process.	Improve access and efficiency in providing specialized services.
Funding Formula	DHS provide support to counties to ensure accurate and consistent annual reconciliation data.	Improve data accuracy for advocacy efforts.
	Encourage each county to determine their actual cost of providing Birth to 3 services.	Support better advocacy for needs-based funding adjustments.

	Continue workgroup efforts to learn more about needs-based funding formula factors used in other states.	Identify potential advocacy targets for improving the funding formula.
Communications	Increase communication and awareness of available services.	Improve outreach to expectant parents and pediatricians.
	Targeted outreach to pediatricians and community.	Enhance access to services by informing key referral sources.
	Parental advocacy guidance.	Provide support and resources for parents advocating for their children.
Overall Funding Recommendations	$10 million annual budget increase in State General Purpose Revenue (GPR) starting in CY2026.	Stabilize the system and ensure equitable access and high-quality services.
	Establish annual GPR increases to cover projected caseload growth and service costs.	Ensure long-term program sustainability.
	Work with State DHS to explore adding Birth to 3 services to the Medicaid state plan.	Increase federal reimbursements for the program.
	Increase the Medicaid TCM rate.	Generate more federal Medicaid TCM to cover service coordination costs.
	Establish statewide point of access and targeted funding for children with specific needs.	Address service access barriers for children with specific needs.
	Create Legislative Study Committee.	Assess options to improve Wisconsin's Birth to 3 system and review the state's funding allocation formula.