Early Intervention & Education Program, Phase 1

September 19, 2016

Management Audit Committee

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Executive Summary

Early Intervention and Education Program, Phase I

Introduction and Evaluation Purpose

In 2004 and 2005, the Legislature commissioned a comprehensive study, called the Goetze Study, of the State's developmental preschool program to understand costs and services for children with developmental/intellectual disabilities. Subsequent to study, the Legislature embarked on a multi-year effort to revise statute and to build-up the early childhood learning infrastructure for serving these children, age birth through five years. These efforts included greatly increasing State grant funding to fourteen regional child development center non-profit providers to support identification of, and to provide services to, children eligible for services under the most current authority of the federal Individuals with Disabilities Education and Improvement Act (IDEA) and Wyoming's 1989 Services to Preschool Children with Disabilities Act.

The foundation of IDEA is that each eligible child age birth through twenty-one is entitled to a free appropriate public education, to be delivered in the least restrictive regular education environment alongside age-appropriate peers, to the maximum extent possible. To comply with these conditions, regional centers provide regular education, special education, and related therapeutic services, based on individualized service plans and their functional and educational progress. Additionally, early intervention services are available to infants and toddlers with developmental delays or disabilities.

For this evaluation, the Management Audit Committee (Committee) asked the Legislative Service Office (LSO) to evaluate the Early Intervention and Education Program (Program or EIEP) in the Wyoming Department of Health (Health). This Program administers and assures State compliance for two IDEA programs, Part C (for children age birth through two years) and Part B (for children age three through five years) and, in tandem, administers the Wyoming statutorily prescribed program that provides early learning services to children with disabilities. Based on Committee concerns, this report provides background information, findings, and recommendations related to a number of areas: the Program's perceived high child identification (eligibility) rates, administration of the Program statutory funding model, and the appropriate or optimal placement of the Program within State government. Lastly, based on recurring concerns from agency staff, regional centers, other stakeholders, and LSO observations, the report presents multiple policy considerations to the Legislature, including that the State's overall early childhood learning system may benefit from greater coordination of programs and resources, possibly through an Office of Early Learning.

Please note that this report represents Phase 1 of the evaluation topic. Phase 2 of the evaluation is proceeding and will be completed in the first half of 2017. It will cover the Committee's interest in Program outcomes.

Background

Beginning in the late 1960s, Wyoming began focusing on providing services to children with disabilities with emphasis on children's individual needs and capabilities. At this same time, many of the regional centers organized to meet emerging community needs for childcare services. These efforts predate national efforts that eventually led to the passage of the IDEA's precursor acts back to 1975.

Since 1989, Health, with some oversight from the Wyoming Department of Education (Education), has been required to administer the Program for the State. Health has exclusive oversight of Part C, an optional federal program, while Education oversees Health, through a formal memorandum of understanding (MOU), for the Part B program.

From 2006 to 2008, the Legislature passed a number of bills to amend the *Services to Preschool Children with Disabilities Act* under W.S. 21-2-701 through 21-2-706. Perhaps the most significant change was to formalize a specific per-child funding model used to budget and contract for Program services. State Program funding for the most recent FY2017-2018 biennium is approximately $79.9 million, which represents about 90% of all Program funding. However, Governor-proposed budget cuts of $6.7 million of State general funds will reduce Program resources, effective July 1, 2016. This reduction in State general funds may impact the State's ability to meet its federally required maintenance of effort (MOE). The Program is administered by four staff in the EIEP Unit under Health's Behavioral Health Division.

Since FY2010, the number of eligible children served by the program has remained mostly stable near 4,000 children. For the most recent child count, taken on November 1, 2015, there were 1,289 Part C eligible children and 2,612 Part B eligible children (total 3,901). The Part C count is trending upward, while the Part B count is trending downward.

Contributing to these child count levels is that each state is federally required to have a "Child Find" program. The State receives federal grant dollars to finance statewide and local outreach campaigns to encourage families to have children screened, and if necessary, evaluated for developmental disabilities or delays. Through agency rules, Health and Education separately set eligibility criteria for Part C and Part B, respectively. In 2014 and 2015, Health and Education contracted for eligibility studies of these programs and have since implemented administrative changes to manage the budget and related child identification practices throughout the State.

Finding and Recommendation Summary

Findings

The Committee's concerns with the program center on three main issues:

- High child identification/eligibility rates;
- Administration of the statutory funding model (including if it incentivizes greater identification); and
- Appropriate organizational or administrative placement of the Program at the state-level.

Overall, LSO found that when strictly looking at other states' Part C and Part B program identification rates, Wyoming's rates do indeed look high. However, as other states' programs' eligibility and other requirements do not match Wyoming's

requirements, these comparisons have limited value. Using other comparison standards, LSO concludes that the number of eligible children counted (or served) by the regional centers appears appropriate given Health's and Education's oversight practices.

Specifically, Wyoming's Program penetration rates are generally lower than in Wyoming's school districts for the K-12 education system, which are required to use the same eligibility criteria for Part B. Program penetration rates are also lower than projected prevalence of children with disabilities according to the U.S. Centers for Disease Control and Prevention. In fact, as explained to LSO by regional center staff, with advances in technology and medicine, more children with disabilities are surviving with possibly more complex conditions. Likewise, some disabilities, such as autism, are increasing. LSO also found that data reporting and reconciliation between Health and Education can be improved.

With respect to the administration of the statutory funding model, LSO found that as the model is currently administered differently than set out in statute it may not directly incentivize identification of children by the regional centers. In short, despite the per-child and annual child count statutory requirements, Health's mixed use of child count data from year-to-year and emphasis on the federal maintenance of effort (MOE) requirements effectively work to operate the model with a ceiling or maximum funding amount. Additionally, aside from a 2013 Budget Bill footnote exempting Health from contracting according to the model, the Legislature has not provided explicit guidance for Health to disregard using the model to request Program funding.

This has the effect of eliminating funding predictability intended by the Legislature as well as potentially penalizing regional centers by decreasing their per-child contract amounts, possibly below their costs of providing services, for additional children found eligible. With LSO's review of Health's child count data, centers do not stop identifying children throughout the year and they are legally obligated to serve all eligible children, based on their level of need and in their least restrictive environment, regardless of State's funding levels.

The LSO also found that the once-annual child count on November 1st each year does not sufficiently accommodate the federally allowable ninety days eligibility and service plan development process for Part B. This count also does not provide a reliable approximation of eligible children, and their required services, served by the regional centers throughout the year.

In terms of organizational or administrative placement of the Program, agency staff, regional centers, and other stakeholders believe the Program should be clearly valued at the State level. Health leadership has consistently expressed desire to transfer the Program to Education. Despite renewed front-line staff efforts to collaborate between the agencies, the Program does not appear positioned to progress beyond basic regulatory functions. However, there appears to be consensus that Part C and Part B should not be separated and that most stakeholders believe Part B would better align with Education's mission, staff expertise and resources, and related programs.

Finally, LSO encountered a fragmented and disjointed network of programs, resources and perspectives related to the State's overall early childhood learning system. Stakeholders hold misconceptions about what may be included or relate to early childhood learning in the State, or what the State actually spends on services and supports in the system. Furthermore, despite

numerous, federally required advisory councils and some renewed state agency collaborative efforts in recent years, LSO did not encounter a consistent or cohesive message about what the State wants the system to look like, how the funding should be managed, or what the system is expected to accomplish.

Recommendations

The Committee's research questions for this evaluation were mainly focused on Legislative policy considerations. Therefore, most of the recommendations address how the Legislature may amend Program statutes to provide clearer direction to the agencies on how the Program is expected to operate. Overall, the Legislature's decision on program placement between Health and Education could impact its actions on other recommendations.

Specifically, this report recommends:

- Health and Education should provide for a data reconciliation process for Part B to validate whether data reported to the federal government by Education accurately reflects the data submitted by Health to Education.
- Health, through the Governor, should follow the funding model to request the statutorily required funds, allowing the Legislature to understand the results of applying the statutory funding model and potential impacts on meeting or re-setting the federal MOE.
- The Legislature may wish to revise the November 1st child count date or count method to set or estimate the number of children used in the statutory funding formula.
- The Legislature may wish to study and/or revise the statutory funding model based on numerous factors.
- The Legislature may wish to move Part C and/or Part B from Health to Education, but only after development of a comprehensive transition plan based on sufficient study of both intended and possible unintended consequences.
- The Legislature may also want to consider establishing an Office of Early Learning to coordinate and/or manage the Program and other aspects of the early childhood learning system.

Agency Response

Wyoming Department of Health

Health agrees with all recommendations and policy considerations, with the exception of Recommendation 4.1. Health partially agrees with Recommendation 4.1 in that it should report to the Legislature the contracted per-child amounts and ECA amounts each year. However, it does not agree with adjusting the budget request based on the most recent child count prior to the Governor's December 1st budget request submission deadline to the Legislature. Health states that it believes the Program currently runs efficiently and effectively, but that the expertise and support under one department, the Wyoming Department of Education, could minimize challenges presented by multi-agency oversight. Health emphasizes that it has used the November 1st child count data for its budget requests since the funding model was established by W.S. 21-2-706(b).

Wyoming Department of Education

Education agrees with the conclusion noted in Chapter 2 on child identification rates. Education also generally agrees with the remaining recommendations and policy considerations, except Recommendation 4.1, to which it states, it will not comment on how the Wyoming Department of Health manages its budget. Education agrees that a detailed transition plan is required if the Legislature decides to move the Program from Health to Education. It also states that if it receives the Program authority and staff, it can leverage its resources to create an early learning team or division, but that it is concerned with establishing additional bureaucracy.

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Recommendation Locator

Chapter Number	Recommendation Number	Recommendation	Page Number	Party Addressed	Agency Response
2	2.1	The Department of Health and Department of Education should conduct a data reconciliation process prior to submitting any information to the federal government for Part B and work together to identify and resolve potential reporting errors for information already reported to the U.S. Department of Education.	34	Health and Education	**Health:** Agree **Education:** Agree
3	3.1	The Legislature could consider amending W.S. 21-2-706(b), to clarify the following: ▪ Whether an individual family service plan or individual education plan is required for a child to be included in the child count for State general funds. ▪ That the "state rules" for setting the child count standard and distribution of State general funds shall be promulgated by the Wyoming Department of Health for the Part B program.	40	Legislature	**Health:** Agree **Education:** Agree
3	3.2	The Legislature could consider amending W.S. 21-2-706(b), in consultation with Health, to adjust the child count date and count method to better accommodate the federal allowable child assessment and eligibility process timeframes for both Part C and Part B.	41	Legislature	**Health:** Agree **Education:** Agree

4	4.1	Health should build its budget request using the Program statutory funding model outlined in W.S. 21-2-706 when submitting, through the Governor, its biennial and supplemental budget requests to the Legislature. In complying with these requirements, Health should: ▪ Adjust its budget submission to the Governor prior to the December 1st budget submission deadline with the most recent child count data of the year in which the submission is made. ▪ Inform the Legislature each time the per-child funding amount used for regional center contracts of the year in which the budget is submitted differs from the statutory amount. Health should identify the reasons for the different contract amount. ▪ Quantify and report to the Legislature the per-child funding amount increase of all external cost adjustments funded by the Legislature to date.	52	Health	**Health:** Partially Agree **Education:** Not Applicable
4	4.2	Health should annually report to the Legislature's Joint Appropriations Committee prior to budget hearings the most recent maintenance of effort determination for both Part C and Part B programs.	53	Health	**Health:** Agree **Education:** Agree

Policy Considerations

Chapter Number	Policy Considerations	Page Number	Party Addressed	Agency Response
4	The Legislature could consider a new study, similar to the one funded in 2004-2005, to update regional centers' costs information and review alternative funding models and methods of reimbursement.	53	Legislature	**Health:** Agree **Education:** Agree
5	The Legislature could consider amending statute to move the Program (both Part C and Part B) from the Department of Health to the Department of Education, with adequate consideration of a defined, strategic transition plan to ensure, at a minimum, the following: ▪ Program funding, contracts, and services remain uninterrupted; ▪ Program oversight and monitoring maintain the principles of the systemic concerns brought out in the 2011 federal audit; ▪ Changes to Program roles and responsibilities should include input from all relevant system stakeholders, especially from Health, Education, and the regional centers; ▪ How the receipt and disbursement of state and federal funds from the State to the regional centers may need to change if the centers maintain private non-profit status or become public agencies, similar to or incorporated into school districts.	70	Legislature	**Health:** Agree **Education:** Agree

5	The Legislature could reconsider authorizing a coordinating office for the State, such as an Office of Early Learning, to coordinate and monitor programs and funding resources utilized for early childhood learning activities statewide.	78	Legislature	**Health:** Agree **Education:** Partially Agree

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List of Acronyms

Early Intervention and Education Program

* *Acronym or abbreviation is defined in the next section.*

APR .... Annual Performance Report
ASQ .... Ages and Stages Questionnaire
BHD or Division .... Behavioral Health Division
CAP .... Corrective Action Plan
CDC, Regional Center, or Center .... Child Development Center
CDS .... Child Development Services of Wyoming
COS .... Child Outcome Summary
DD .... Developmental Delay* or Developmental Disability
ECA .... External Cost Adjustment
EDFacts .... U.S. Department of Education Reporting Platform
EIEP or Program .... Early Intervention and Education Program
ESA .... Education Services Agency*
FAPE .... Free Appropriate Public Education*
ICC/IEC .... Interagency Coordinating Council/Early Intervention Council
ICO .... Informed Clinical Opinion*
IDEA .... Individuals with Disabilities Education (and Improvement) Act*
IEP .... Individual Education Program*
IFSP .... Individual Family Service Plan*
LEA or IEU .... Local Education Agency or Intermediary Education Unit*
LRE .... Least Restrictive Environment*
MDT .... Multi-Disciplinary Team*
MOE .... Maintenance of Effort
MOU or IA .... Memorandum of Understanding or Interagency Agreement
OSEP .... Office of Special Education Programs (U.S. Department of Education)
PART B .... IDEA Part B, Section 619 Program (for children age 3 through 5)
PART C .... IDEA Part C program (for children age birth through 2)

SEA .... State Education Agency*
SEAS .... Special Education Automation Software
S/L .... Speech-Language Impairment
SPP or SSIP .... State Performance Plan or State Systemic Improvement Plan
WDE or Education .... Wyoming Department of Education
WDH or Health .... Wyoming Department of Health
WIND .... Wyoming Institute for Disabilities
WISER ID .... Wyoming Integrated Statewide Education Record Identifier (WDE)
WOLFS .... Wyoming Online Financial System

List of Definitions

Early Intervention and Education Program

These definitions are provided to help explain key concepts in the report. The language may not directly reflect legal definitions used in federal or state statutes or rules and regulations.

Developmental Delay (DD)

Wyoming defines developmental delay for IDEA Part B as a child with a disability ages three through nine who experience delays below peers of comparable chronological age in one of five developmental domains (physical, cognitive, adaptive, social-emotional, and communication). It is a discretionary eligibility category which varies among states as to the age range to which it applies, the severity of delay at which a child becomes eligible, and the diagnostic instruments and procedures that will be used to determine delay in the developmental domains. For Part C, developmental delay may also be used for eligibility, as noted in Table 1.1 on page 17-18 of the report.

Education Services Agency (ESA)

An ESA does not mean the same from state-to-state because each state determines what type of entity will be recognized as an education services agency. It generally refers to a formal or informal entity that provides general education services, or special education services, or both below the state-level, or state education agency.

Free Appropriate Public Education (FAPE)

In order to be eligible for IDEA grants, states must serve all eligible children with disabilities aged three through five (or through twenty-one in the K-12 system) and have an approved application under Part B of the Individuals with Disabilities Education Act (IDEA). A state that does not comply with IDEA to make a free appropriate public education (FAPE) available to all children with disabilities under IDEA risks financial and possibly civil consequences.

Informed Clinical Opinion (ICO)

ICO is used by early intervention professionals in the evaluation and assessment process in order to make a recommendation as to initial and continuing eligibility for services under Part C and as a basis for planning services to meet child and family needs.

Individuals with Disabilities Education (and Improvement) Act (IDEA)

The IDEA is a four part (A-D) U.S. law that ensures students with a disability are provided with Free Appropriate Public Education (FAPE) that is tailored to their individual needs and served in their least restrictive environment (LRE).

Individual Education Program (IEP)

An IEP refers to a plan of services for teaching a child age three years and up (Part B program), based on the information about the child gained from the screening and diagnostic testing/evaluation. It includes specific and measureable goals and services for the child and is

implemented by preschool classroom teachers with the help of special educators and related service professionals. The plan is developed through professional and parental input.

Individual Family Service Plan (IFSP)

An IFSP refers to a plan of services through which effective early intervention is implemented for children age birth through two years (Part C program). It contains information about the services necessary to facilitate a child's development and enhance the family's capacity to facilitate the child's development. Through the IFSP process, family members and service providers work as a team to plan, implement, and evaluate services specific to the family's concerns, priorities, and available resources.

Local Education Agency (LEA)

As defined in the Elementary and Secondary Education Act, an LEA is a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a state, or for a combination of school districts or counties that is recognized in a state as an administrative agency for its public elementary schools or secondary schools.

Intermediate Education Unit (IEU)

An IEU is an administrative agency responsible for having administrative control and direction over Wyoming's regional child development centers.

Least Restrictive Environment (LRE)

The LRE refers to the federal requirement under the IDEA that a student who has a disability should have the opportunity to be educated with non-disabled peers in their regular education setting, to the greatest extent appropriate to meet the child's needs and functioning.

Multi-Disciplinary Team (MDT)

A MDT includes individuals from different healthcare and education professions with specialized skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality early learning services as outlined in an IFSP or IEP.

State Education Agency (SEA)

An SEA is the formal governmental label for the state-level government agency within each U.S. state responsible for providing information, resources, and technical assistance on educational matters to schools and residents.

Introduction, Scope, and Methodology

Introduction and Scope

The Legislative Service Office (LSO) is authorized by W.S. 28-8-107(b) to conduct evaluations, performance audits, and analyses of policy alternatives. Generally, the purpose of such research is to provide a base of knowledge from which policymakers can make informed decisions.

The Management Audit Committee (Committee), at its July 2015 meeting, voted to have a scoping paper drafted on the Early Intervention and Education Program (Program or EIEP, also known as the developmental preschool program). After receiving and considering the scoping paper, the Committee voted at its January 2016 meeting to direct the LSO Program Evaluation staff to move forward with the full evaluation of the topic. Under the guidance provided by the scoping paper and accompanying discussion of the Committee, evaluation staff targeted the evaluation on the following research questions:

1. Identification rates — Further review could be conducted to evaluate:
    a. The impact of the funding model on identification rates (i.e. eligibility determinations by professionals employed by the regional providers);
    b. The impact of the eligible categories selected by the State of Wyoming on the identification rates (i.e. inclusion of developmental delays); and,
    c. Potential factors contributing to the disparity of the identification rates of eligible children between regions within Wyoming.
2. Organizational structure — Further review could be conducted to identify the expected efficiencies and potential limitations in administering the program within the Department of Health or the Department of Education.
3. Measured outcomes — Further review could be conducted to measure the program's success. Potential example measured outcomes could include:
    a. Review the number of students who received Part B services who did not need K-12 special education services;
    b. Review pre-kindergarten assessment results for students who received Part B services compared

with the same assessment results for non-Part B students, both for those who did and did not receive K-12 special education services; and,

c. Compare Wyoming expenditures on K-12 special education services to other states.

The Committee voted to exclude evaluation of regional centers' staffs' compensation adequacy under W.S. 21-2-706(a)(i).

Summary of Report Considerations

The Committee has had an ongoing interest in the Program over the last three years. The Committee originally voted at its November 2013 meeting to have a scoping paper drafted to inform whether the Committee should pursue a full evaluation. However, during its initial scoping research, LSO found that the Program was undergoing two contracted studies, one on the Individuals with Disabilities Education Improvement Act (IDEA) Part C program (serving children birth through two years old) and the other on the IDEA Part B program (serving children three through five years old). The studies were funded by the Wyoming Department of Education (Education) and Wyoming Department of Health (Health), which currently administer both programs. The Part B study was completed in 2014 and Part C was completed in 2015. Consequently, the Committee modified its original scoping request and received background and update briefings on the Program from Health and LSO at its July 2014 meeting and again a year later at its July 2015 meeting.

This evaluation provides a detailed summary of child identification rates for the Program, how it is funded, and the entities charged with administration and oversight. While the research LSO conducted examined all Program components, operations, practices, and policies, the research questions significantly directed LSO to focus on high level, public policy concerns about how and where to best situate the program for long term success.

In reviewing the program at this high level, additional context is warranted to describe the overall early childhood learning system in the State. This structure and context has been an interest of the Legislature in recent years, especially for the Joint Education Interim Committee since 2012. Contrary to perceptions, the Program is not separate from or the sole component of the early intervention and early learning arena. The report attempts to provide greater clarity that the Program should be viewed in this larger context to understand its administration as well as local communities' operations and preferences.

There are two additional items LSO believes should be considered when reviewing this report. First, while the report makes recommendations and outlines Legislative policy considerations for the funding model and student eligibility identification rates, the implementation of these recommendations will be impacted by changes to the administrative or organizational structure. Second, specific to the funding model, it is important to keep in mind that the funding structure and the amount of State General Fund dollars appropriated to the Program is substantial compared to federal funds allocated to the State. However, LSO was not asked to evaluate whether the amount of State general funds are adequate or covers providers' costs and this information was not pursued during this evaluation.

Additionally, while other states' approaches to funding early intervention and education services to children birth through five years old can provide options on how to budget and allocate funding, this report does not recommend a specific new funding model. Rather, it summarizes the implementation of the current statutory funding model and what possible adjustments could be made to clearly show how the model is managed. It also provides considerations and potential consequences of using other methods to set budget levels or distribute funding to eligible service providers. The Legislature will need to find the best fit to match the State's available resources with its overall policy on the extent of service it believes should be provided.

A 2004-2005 Legislative Study Guided the Legislature's Significant Program Changes

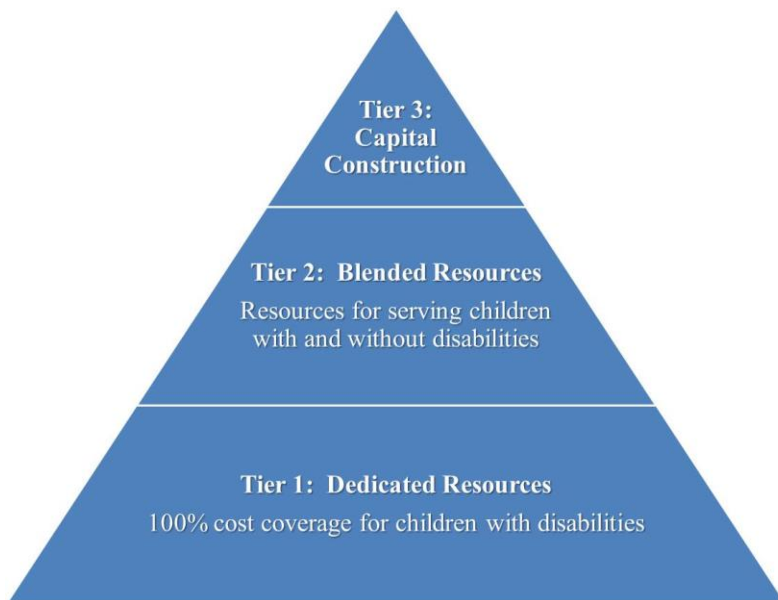
From 2004 through 2007, the Legislature worked through a number of developmental disability program reviews and changes as overseen by different iterations of the Select Committee on Developmental Programs (Select DD Committee). These activities focused on pre-kindergarten (pre-K) services, the home and community based waivers, and other issues related to developmental/intellectual disability services in the State. However, with respect to pre-k services, during the 2004 budget session, the Legislature authorized funding ($250,000; Senate File 84, Chapter 104) for the Select DD Committee to contract for a detailed study of the Program. A preliminary report was required by November 1, 2004, with a final report ready by October 1, 2005.

This study is commonly known as the Goetze Study, named after its primary author. Coincidentally, it was conducted on Wyoming's program at the same time the U.S. Congress passed the most recent update to the IDEA. The central focus of the study was to identify service costs of the system's providers, called

regional child development centers (regional centers) and provide recommendations for better funding these costs.

A key concern with the State's model was that there was reliance on local and other funds to fund some services, which posed risks of equitable service provision and potential for IDEA violations. Additionally, some rural regions struggle with lower populations of children with higher per-child service costs. The report ultimately recommended a three-tiered funding model to better cover the cost of services; see Figure1, below. While the Select DD Committee did not recommend the exact model in the report, the recommendation significantly followed principles for the K-12 system, including providing base population funding for all children served by the providers, funding disability services at 100% cost reimbursement, and providing funding for capital construction and facilities.

Figure 1
2005 Goetze Study Three-Tier Funding Model Recommendation



Source: Legislative Service Office adapted from Goetze Study Report.

Issues, findings, and conclusions included, but were not limited to, the following:

- The State's flat per-child rate is not flexible to meet individual's (children and families) service needs; funding is the same for all children regardless of cost, service type, or type and severity of disability.
- Services were found to be essentially the same for all children, despite legal requirements for individual service program design.

- There were large discrepancies in preschool providers' staffing and staff salaries relative to school districts, hospitals, and other healthcare settings.
- About two-thirds of the preschool providers' total children served had disabilities.
- National average expenditures for Part C children were about $11,000 per year, of which the State was funding about 86% of that average through various State and federal funding sources.
- Preschool providers did not conduct consistent and regular progress evaluations of children to ensure student and program success.
- Preschool providers appeared ambivalent toward the State administration as neither helping/supporting nor hindering their programs.

State's Duty Under IDEA is Different Than for K-12

While the regional centers commonly make reference to the similarities in requirements for special education services under IDEA for Part B as for the K-12 system, there is one important caveat to note with respect to the funding model set out in statute for the Program: the State has a different level of responsibility under IDEA for the Program than for the K-12 system. This distinction was made clear by the Campbell IV case (*Campbell County School Dist. v. State, Nos. 06-74, 06-75, 2008 WY 2*) decided in 2008 where the Wyoming Supreme Court said:

> "The challengers contend that because Art. 7 § 1 requires the state to provide a "complete and uniform" education embracing "free elementary schools of every needed kind and grade … and such other institutions as may be necessary," the reference to youths ages 6 to 21 is not a ceiling on that obligation, but only a minimum…We agree with the district court's legal conclusion that the constitution does not require the state to provide the necessary funds for each district to offer voluntary pre-schools…"

The Courts' position recognized the importance of early learning, but Constitutionally the State's obligation for education services begins at age six. However, the IDEA obligates the SEA (Education) to provide for free appropriate public education for all children with disabilities age three through twenty-one. In short, while the State is not obligated to provide for universal preschool for all children under age six, Education does have responsibilities for services to children with disabilities, age three through five.

Methodology

This evaluation was conducted according to statutory requirements and professional standards and methods for governmental audits and evaluations. The evaluation research was conducted from January through August 2016. The general analytical time frame covered by this evaluation includes documents and data since the 2004-2005 Goetze Study through May 2016, unless noted otherwise.

Research methods included:

Interviews, Observations, and Requests

1. Interviewed Executive Branch programmatic staff at the following agencies: Health; Education; Department of Family Services; Department of Workforce Services; and the Department of Enterprise Technology Services.
2. Observed Health's and Education's monitoring visits and conference calls with the regional centers.
3. Observed various conferences or meetings of stakeholder groups including the following: Early Intervention Council (federally required advisory group to the Part C program); Wyoming Advisory Panel for Students with Disabilities (federally required advisory group to the Part B program); and the Wyoming Early Childhood State Advisory Council (federally required state advisory group).
4. Observed Wyoming Legislature's Joint Appropriations Committee meetings (both interim meetings and during the 2015 and 2016 Legislative Sessions).
5. Developed research questions to clarify agencies' practices based on program requirements or criteria (i.e. statute, rules, policies, guidelines, etc.) and submitted questions to the administering agencies for written response.
6. Surveyed, conducted field visits at, and requested data from all fourteen regional centers.
7. Conducted interviews with other early childhood learning system stakeholders.

Document Review

1. Reviewed current statutes and researched legislative history and changes to State and federal laws governing developmental preschool services.
2. Reviewed current Health and Education rules and regulations, policies, guidelines, manuals, and other administrative documentation.

3. Reviewed programmatic financial information (i.e. budgets, revenues, expenditures) for Health and Education funding for the Program, as well as financial information from other State agencies and regional centers.
4. Requested and reviewed relevant legal guidance provided to Health and Education from the Wyoming Attorney General's Office.
5. Reviewed federal agencies' websites and documents from the Office of Special Education Programs, U.S. Department of Education's EDFacts data reporting system, and other national organizations.
6. Reviewed limited information nationally and from other states regarding screening and identification rates, methods of funding developmental preschool services, and practices/trends in organizational structure of early learning programs.

Data Review

1. Requested and reviewed programmatic data (individualized and aggregated) from Health and Education as permitted through cooperative interagency agreements executed with LSO.
2. Requested and reviewed aggregated data provided by other State agencies and regional centers.

Scope Limitation

This evaluation uses data gathered by the Program through its primary data system, the Special Education Automation System, or SEAS. This proprietary system was originally purchased by Health in 2010 and designed as a case management system for the regional centers, primarily for Part B. Health also paid to customize the system for Part C. During initial research, LSO found that this system has limited automated controls and validation functions to provide assurances for data completeness and accuracy. For example, there is no automatic alert or edit feature to limit birth date data entry to qualified ages for the programs (i.e. age five instead of age fifty-five). Additionally, due to the system's real-time structure, it is virtually impossible to recreate historic reports for quality control and evaluation purposes.

The quality of data produced by this system relies on date-certain data extracts saved outside the system and multi-stepped manual checks and cleaning procedures by Program staff in order to provide State and federal reports. Program staff stated that they must regularly call regional centers to make specific changes and

adjustments to the data as discrepancies or errors are discovered. Therefore, LSO relied on the Program staffs' saved historical extracts to complete some analyses for this report. Importantly, LSO was able to observe and review current, but not historic, Program staff's data check and cleaning procedures, which appear to fit the specific federal and State reporting obligations. However, LSO was unable to independently verify and validate SEAS data or Health's analyses of its past reporting from the system.

Project Phasing

As noted in the third scoping question, the Committee expressed desire for more detailed information on the success of the Program. Specifically, it asked about whether services are leading to better outcomes for children, such as needing less or no services when enrolled in the public education system (kindergarten through twelfth grade or K-12). In order to answer this question, LSO concluded that it needed access to individualized, personally identifiable information from both Health and Education to be able to track children from the early learning arena to the K-12 systems.

In order to access this information, LSO worked with Health and Education from February through May to execute interagency data sharing agreements. These agreements are required to share personally identifiable education records under IDEA and the Family Educational Rights and Privacy Act (FERPA). The agreements were fully executed on April 19, 2016 with Health and May 27, 2016 with Education. This latter date closely corresponded to our project deadline to complete research and draft the report findings.

Due to this unexpected delay, LSO received confirmation by the Committee and LSO leadership to phase this evaluation into two reports. This report constitutes the conclusion of Phase 1, covering issues on organizational structure, identification rates, and Program funding. The final scoping question related to program and student outcomes will be completed in Phase 2 once LSO is able to fully review the data from both Health and Education. While LSO does not intend to perform a full longitudinal analysis for the Phase 2 project, given the timing and of the agreements and the necessary preparation of the Phase 1 report, LSO has not yet been able to request and receive data to complete the outcomes analysis necessary to provide a response to the Committee's concern. Phase 2 research is currently ongoing and will be reported back to the Committee in the first half of 2017.

Acknowledgements

The LSO expresses appreciation to those individuals and agencies that assisted with our research. We convey sincere gratitude to the Wyoming Departments of Health and Education for accommodating our numerous requests for documents, data and interviews. We also appreciate the access to and assistance of the fourteen regional centers. Finally, we thank the Department of Family Services, Department of Workforce Services, and the other stakeholders and advisory councils, boards, and associations that provided additional information, documents, and interviews to complete our understanding of the Program and larger early childhood learning system.

Chapter 1: Background

A primary reason for states implementing early intervention and early childhood learning programs stems from evidence that the earlier a child receives services and supports for learning, the greater future education and work success he or she will experience. This belief relies on research that a child's neural development is significantly formed before he or she enters the traditional K-12 education system. The Early Intervention and Education Program (Program or EIEP) is intended to target those children with, or likely to develop, developmental disabilities and learning delays so that they are school ready and continue to progress at age-appropriate social and academic levels.

Federal Law Guides the Provision of Early Learning Services to Eligible Children with Disabilities

The overarching authority for providing and guaranteeing developmentally/intellectually disabled children with education services comes from the federal Individuals with Disabilities Education Improvement Act (IDEA[1]), last updated by the U.S. Congress in 2004. This law amended previous acts back to the original Education for All Handicapped Children Act (EHA) from 1975. The law applies to all children birth through age twenty-one years and is supported by federal funding for programs and services for this population. Funding and oversight of programs authorized by the law comes from the U.S. Department of Education.

The central theme of the law has remained the same in that disabled children should be able to obtain a free appropriate public education (FAPE) as intended for their non-disabled, or typical learning, peers. However, the law specifies criteria for eligibility, which individual states may adjust, and that each eligible child's education must be tailored to meet their individual needs based on their diagnosed disability(ies) and functional deficits. This requirement includes providing regular and special education services to eligible children in classrooms with their typical learning peers as much as possible, called their least restrictive environment (LRE).

IDEA Part C and Part B

With respect to pre-kindergarten (pre-K) children, the law specifies various legal and service provision requirements based on different programs targeted to specific age groups. The Part C, or early

[1] IDEA is a common abbreviation for the law without inclusion of the "I" for the "Improvement" term.

intervention program, targets funding and services to children birth through age two years. Part C is also a voluntary program for which the State has chosen to operate. The Part B, Section 619, or "preschool" program, targets funding and services to children age three through five years. Additional Part B funding and requirements under Section 611, apply to pre-K as well as the K-12 system (age three through 21). For the purposes of this report, reference to Part B is meant to refer to the Part B, Section 619 preschool program unless otherwise noted in the report text. Once children are age twenty-two or enter post-secondary education, IDEA is not applicable to an individual's education or other life events impacted by their disability.

W.S. 21-2-701 through 21-2-706 Provides Primary Authority for the Program

While Part C and Part B are different programs at the federal level, the Wyoming Department of Health (Health or WDH) administers both programs under the Early Intervention and Education Program (EIEP or Program) unit within the Developmental Disabilities section of the Behavioral Health Division (Division). The unit reports to, and coordinates with, the Division's administration, but specifically contains four employees, including the Unit Manager, a Part B Coordinator, a Part C Coordinator, and a Data and Contracts Specialist.

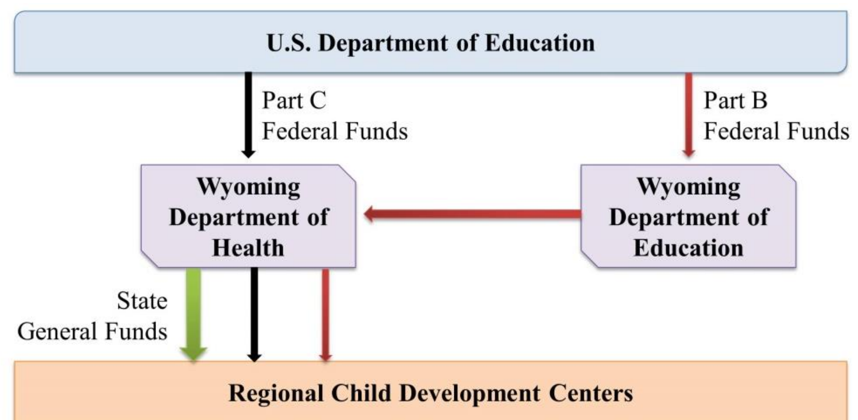
This organizational structure originates from W.S. 21-2-701 through 21-2-706, which outlines the Legislature's policy on developmental preschool services and funding. These sections provide language about the State's receipt and disbursement of federal IDEA Part B funds and define Health as the administrative agency for the Part B program. As federal Part B funds flow through the Wyoming Department of Education (Education or WDE) as the federally defined state education agency (SEA), the statute outlines a supervisory role for Education over Health specific to Part B. Consequently, for Part B, Health is classified as a local education agency (LEA) or intermediate education unit (IEU), similar to school districts in its use of and accountability for Part B federal funds.

For Part C, other than W.S. 21-2-706, which outlines how the State allocates its General Funds for services to children age birth through age five years, there is no specific statute which requires or asks Health to pursue and disburse federal Part C funds. Health relies on two general authorities to pursue these funds. Under its agency organizing statutes, W.S. 9-2-101 through 9-2-108, the agency/director is empowered to accept and draw down federal funds. Under the Community Human Services Act, W.S. 35-1-611

through 35-1-628, the Legislature provides the framework for the State's provision of services for mental health, substance abuse, and developmental disabilities. **Appendix A** provides a listing of applicable statutes and rules for this evaluation.

Figure 1.1, below, summarizes the current organizational structure and flow of federal funds for the Part C and Part B programs.

Figure 1.1
Current (as of FY2017) Organizational Structure and Flow of Federal Part C and Part B Grant Funds for the Early Intervention and Education Program



Source: Legislative Service Office summary.

Part B Oversight is Specified in an MOU

Specific to Part B, under W.S. 21-2-703, Education is statutorily required to provide monitoring and oversight of Health and the regional child development centers (regional centers or CDCs) to ensure the program is administered as intended and services are rendered as required. This section goes on to specify that Health and Education must enter into an interagency agreement to define each agency's duties and roles for the Part B program. Education's Individual Learning Division currently provides oversight of Health and the Program. The most recent memorandum of understanding (MOU) executed between these agencies dates back to 2012.

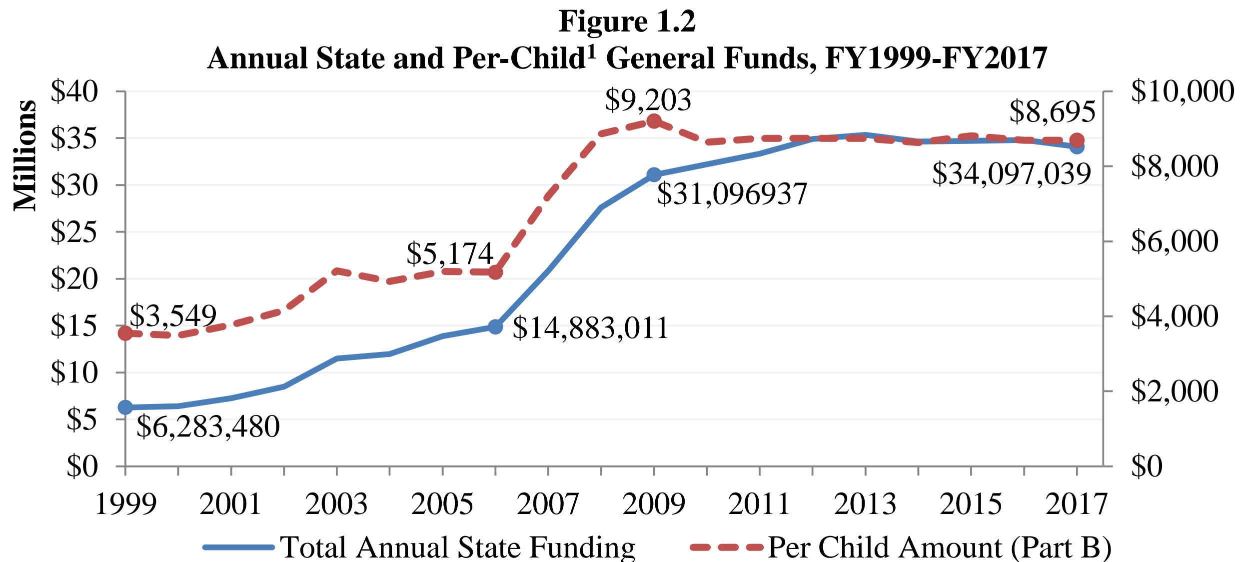
Education staff assists Health by providing staff and support for programmatic monitoring, federal planning and data reporting, as well as training and technical assistance for the regional centers. More recently, Education and Health have set up monthly collaborative meetings to help ensure each agency is kept apprised of Program issues. As Education is not involved with Part C administration, Health's Part C coordinator manages all program administration, including federal planning and data reporting and monitoring of the regional centers. For Part B, the agencies are

currently revisiting this MOU and intend to execute an updated agreement later in 2016 to reflect the current working relationship and responsibilities between the agencies. Chapter 5 provides greater description of current and past Health-Education administrative relationships while explaining potential impacts of changing this structure.

State General Funds Provide the Vast Majority of Program Resources

While the State has appropriated and expended its general funds on Part C and Part B services for several decades, the level of State support has increased greatly in the last decade and a half. This effort has been in large part due to the work of the Select Committee on Developmental Programs (2004-2007). According to Health, in the year 2000, the State spent approximately $6.4 million in General Funds on this program (a total of $12.7 million for the FY1999-FY2000 biennium). For the most current biennium, FY2017-FY2018, the Legislature recently appropriated a total of $79.9 million[2]. This represents more than a 529% increase in State funding, or about 22.7% average biennial increase over this timeframe. Figure 1.2, below, summarizes the annual State funds expended on the Program since FY1999.

Figure 1.2
Annual State and Per-Child[1] General Funds, FY1999-FY2017



Source: Legislative Service Office summary of Wyoming Department of Health information.

[1] The per-child amount reflects the Part B program amount. The Part C per-child amount has been the same as Part B throughout the Program's history until a separate amount was used by Health for FY2016 (at $9,067) and continues in FY2017 ($8,905; before June 2016 proposed budget cuts).

[2] This amount represents total Program funding before budget cuts were proposed in June 2016. While contract amounts to regional centers have gone down for FY2017 based on the proposed cuts, LSO cannot confirm the true impact of cuts for the full biennium as the biennium started on July 1, 2016 and the Legislature may or may not affirm these cuts during the 2017 and 2018 legislative sessions.

The largest increases in funding occurred between FY2006 and FY2009 with program funding remaining fairly level or stable since FY2012. Comparatively, federal funds received for both Part C and Part B represent a fraction of the State's General Fund amounts. For FY2016, Health reported to LSO that it would expend about $1.7 million for each of the Part C and Part B federal funds in grants to the regional centers. As virtually all general funds are expended for regional centers' contract services, the noted federal funds represent only about 10% of the Program's spending for developmental preschool services. The remaining federal funds pay for the Program's staffing and administrative support costs.

Despite the low proportion of federal funds received by the State for the Program, the State must meet maintenance of effort (MOE) requirements. These requirements compel the State to maintain State funding levels at a specified amount based on previous year's budgets and expenditures. The exact requirements are slightly different for Part C and Part B. Chapter 4 provides more detail regarding the MOE standards and implications on continued State General Fund spending.

Regional Center Grant Funding is Based on a Per-Child Amount and Annual Count of Eligible Children

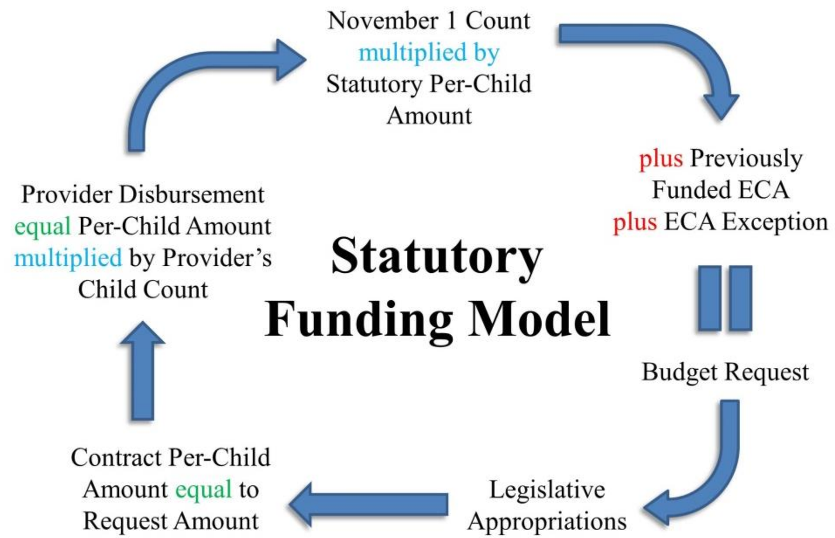
Figure 1.2, previous page, also shows the progression of the per-child funding amount authorized by W.S. 21-2-706 on which grants to the regional centers are based. The current developmental preschool funding model was first initiated with the passage of House Bill 12 (Chapter 85) during the 2006 Budget Session. Further refinements during the 2007 and 2008 sessions provide for the current language in statute, which has remained unchanged since 2008.

While grants to the regional centers are based on this per-child funding amount, the centers receive funding in a block grant fashion with twelve monthly payments throughout the year. There are no legal or contract provisions that require the regional centers to account for their expenditures of the grant dollars for services to each eligible child. During the evaluation, LSO learned that neither Health nor regional centers track the cost of services per Program child they serve.

Figure 1.3 shows a graphic representation of the funding model in statute. The key components or criteria for the model include the November 1st eligible child count calculated by Health each year and the General Fund per-child funding amount (total of at least $8,866 per child, per year specified in statute). These components are to be used to prepare Health's budget request as well as set

contract funding levels with the regional centers. Essentially, as long as the budget request is based on the statutory provisions, and funded accordingly by the Legislature, the regional centers can reliably plan for what is one of their largest funding sources up to eight months ahead using the requested amounts.

Figure 1.3
Wyoming Developmental Preschool
Statutory Funding Model Flowchart



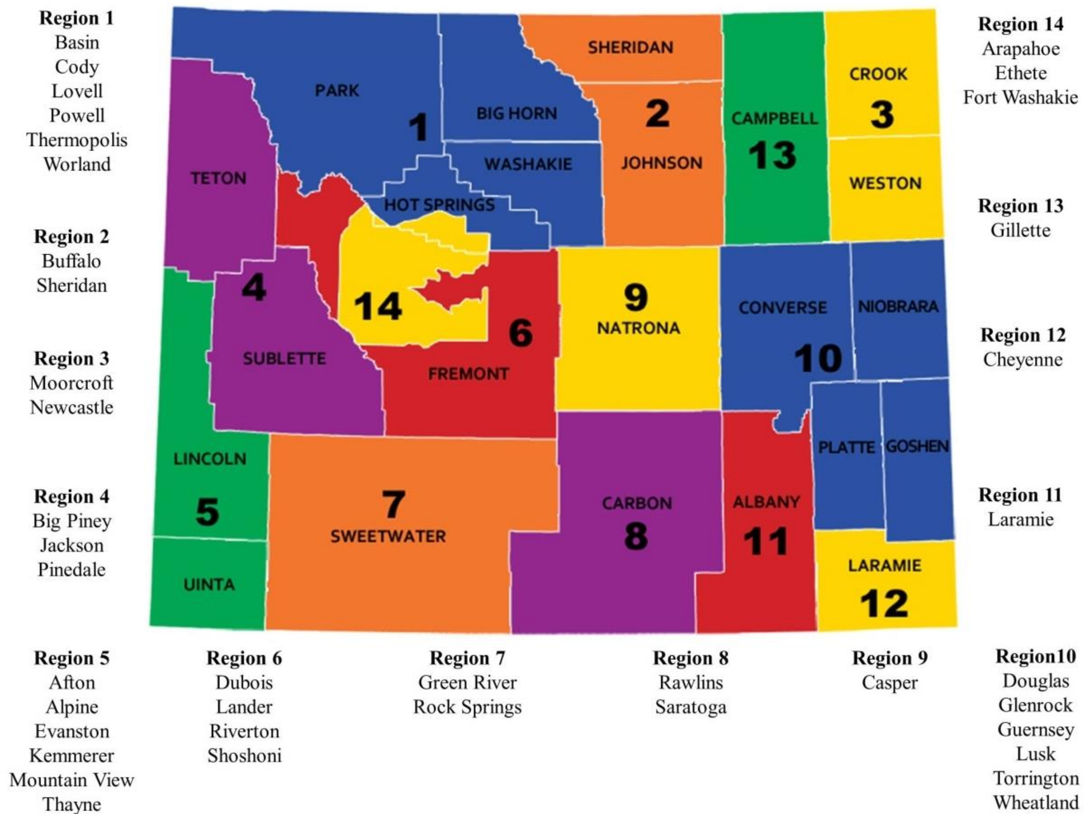
Source: Legislative Service Office summary of W.S. 21-2-706.

The model also requires Health to request an annual external cost adjustment (ECA), similar to an inflation factor, as calculated for the K-12 education system. This request allows the Legislature to know the cost of approving this adjustment for the developmental preschool system. Since the model was finalized in 2008, the Legislature has approved an ECA for the Program three times (FY2009, FY2011, and FY2017). Chapter 4 provides greater explanation of how the Program funding is actually requested and funded with respect to the statutory funding model.

Regional Child Development Centers Provide IDEA Pre-K Services

Across Wyoming, qualifying children and their families may receive services under the Part C and Part B Programs through one of the fourteen regional centers. Each regional center provides services for children and their families in a specific geographic area, including a single county or multiple counties. All but four regional centers have multiple facility locations, as illustrated in Figure 1.4, below.

Figure 1.4
Regional Child Development Centers and Facility Locations



Source: Legislative Service Office analysis of information available through the Department of Health website.

Each regional center employs and contracts with certified professionals and paraprofessionals to provide regular preschool education services as well as screening and services in the areas of special education, speech and language therapy, occupational therapy, and physical therapy. Through the screening process, if a child is determined to have a developmental disability and/or delay, services are offered and provided with parental consent in accordance with an Individual Family Service Plan (IFSP) for Part C, or an Individual Education Program (IEP) for Part B. Services provided at the regional centers should be in accordance with federal and State guidelines, as well as best practice guidelines and professionally approved practices.

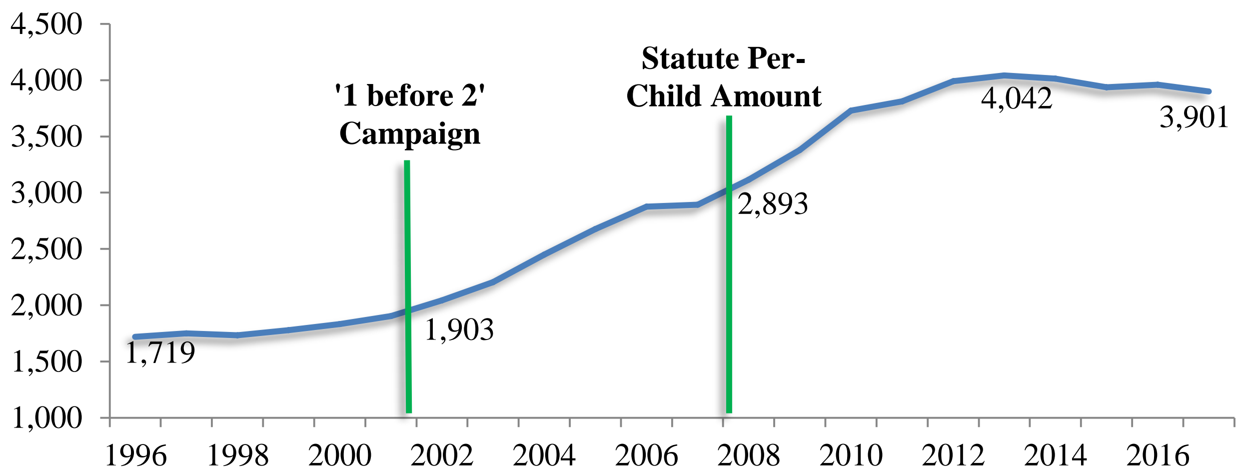
Appendix B contains profiles and descriptions of each regional center. Each profile explains characteristics of the regions, locations of facilities and services, children and programs served by the provider, and additional information provided by the centers through LSO’s survey. **Appendix C** contains the questions we asked in our survey of the regional centers.

IDEA Requires a "Child Find" Program

Under IDEA, both Part C and Part B require the State to ensure sufficient efforts are made to locate and identify children in need of early intervention, special education, and related services. This requirement is generally termed the "child find" program and includes federal funding passed through both programs to state and community agents to accomplish these efforts.

As the Part C lead State agency, Health uses a portion of its Part C federal grant to pay for the statewide "1 Before 2" marketing and advertising campaign. The campaign encourages parents to get their child developmentally screened at least once before they are two years old. The campaign is managed by Child Development Service of Wyoming (CDS), which is a private organization that holds the patent/trademark rights to the campaign. Figure 1.5, below, shows the progression of child counts used by Health to fund the Program with notes on when the campaign and statutory funding models were implemented.

Figure 1.5
Annual Count of Eligible Children for Part C and Part B, 1996-2015



Source: Legislative Service Office summary of Wyoming Department of Health and other information.

Through this evaluation, LSO learned that some of the funding provided to CDS may be passed along to regional centers in the form of mini-grants to pay for local marketing efforts. Similarly, for Part B, Education passes some of its federal funding on to school districts, which may in turn provide grants to the regional centers to help fund their local child find efforts for the Part B age group.

Based on information provided to LSO by Health and the regional centers, the regional centers received a total of $2.0 million from FY2011 through FY2015 specifically for local child-find efforts. The amounts vary from region to region, with a FY2015 range of about $4,000 for Region 8 to $67,000 for Region 13, including

both Part B and Part C child find dollars. Approximately 97% of these funds come from local school districts' federal Part B "child find" funds (average almost $400,000 per year statewide). Each regional center uses these combined dollars differently to help pay for staff and advertising campaigns related to child screening and identification efforts.

Wyoming Program Eligibility is Defined by Both Health and Education

Once a child is found to have a suspected disability, in order to be served under IDEA, the child must meet eligibility criteria that justify their need for early intervention, regular and special education, and related therapeutic services. The IDEA sets broad eligibility criteria, which an individual state may expand in order to serve as the developmentally disabled and delayed population it deems appropriate.

At the federal level, the law broadly defines a child with a disability to include children with cognitive and/or physical disabilities that may limit learning or cognitive functions (i.e. vision, hearing, or speech impairments). Additionally, children experiencing developmental delays in physical, cognitive, adaptive, social-emotional, and communication functional domains may also be eligible. States are not required to include developmental delay within their eligibility criteria for Part B, but must meet minimum federal requirements if adopted.

At the State level, even though both Part C and Part B are administered by Health, both Health and Education separately define eligibility for these programs. The eligibility requirements have not changed over time and still represent the apparent original legislative intent for the system which appeared to be to provide broad access to services. Health sets the eligibility criteria for Part C in its Chapter 1 rules, while Education sets the eligibility criteria for Part B in its Chapter 7 rules. Education's rules apply to both the pre-K and school districts' K-12 special education programs. Table 1.1, below summarizes the eligibility categories for each program.

Table 1.1
Current Part C and Part B Eligibility Criteria

Part C Eligibility Criteria	Part B Eligibility Criteria
Infants and toddlers with disabilities, age birth through two years means: • A child experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one or more development domains	• Autism Spectrum Disorder • Cognitive Disability • Deaf-Blindness • Developmental Delay[1] • Emotional Disability

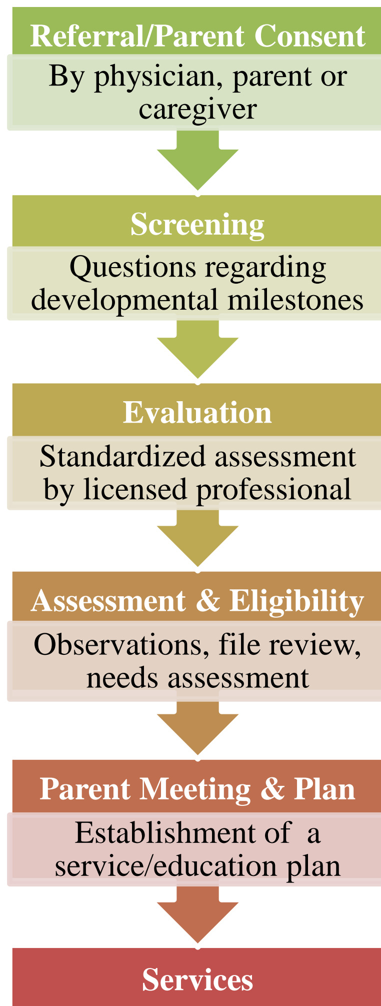
Part C Eligibility Criteria	Part B Eligibility Criteria
(cognitive; physical, including hearing or vision; communication; social-emotional; and adaptive); or • A child with a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.	• Hearing Impairment, including Deafness • Multiple Disabilities • Orthopedic Impairment • Other Health Impairment • Specific Learning Disability • Speech or Language Impairment[2] • Traumatic Brain Injury • Visual Impairment, including Blindness

Source: Legislative Service Office summary of Wyoming Department of Health and Wyoming Department of Education rules.

[1] Developmental delay category can only be used when none of the other categories may be applied to the child.

[2] Speech and language services may be provided as a related service if a child is eligible by one of the other disability categories.

Figure 1.6
Child Identification Process



Source: Legislative Service Office

For Part C, the central premise for eligibility is that a child's condition or disability may lead to learning deficits or problems. As infants and toddlers are more difficult to assess and measure for some developmental milestones, the use of "informed clinical opinion" may be used to determine eligibility. For Part B, where functional deficits are more readily apparent and able to be tested, a child must meet two conditions or "prongs" for eligibility:

1. An established functional deficit based on one of the eligible disability categories found in Education's Chapter 7 rules; and
2. A demonstrated need for specialized education instruction (and sometimes related therapeutic services).

These requirements mean a child may have a disability, but still not need specialized instruction if their learning ability and age-appropriate functioning is not being hampered by the disability.

Child Identification Process is Complicated

Once a child is "found," or screened and suspected of having a developmental disability or delay, the child must be referred through a stepped process to determine eligibility for either Part C or Part B to receive services. This process is shown in the flowchart in Figure 1.6, to the left. The flowchart shows the process separated into six steps, which functions to accomplish two objectives. The first four steps in the process make up the full eligibility determination process. The last two steps set the plan for and delivery of services, according to the evaluation and assessment results, and informed by the multi-disciplinary team of centers' professional staff.

Keep in mind that not all children may enter and exit each step of the process and only those children eventually found eligible and in need of special education services may eventually receive services

through the regional centers. Additionally, children may be re-evaluated with parent consent at any time based on their developmental progress, or at a minimum, every three years to determine if a child remains eligible. Other items to consider related to the pre-K child identification process include the following:

- For Part B, use of the developmental delay category is intended to be a last resort if no other category is found applicable to a child.
- If a child is not found eligible through an initial screening or assessment, the child may be re-screened and found eligible later if they experience below age-appropriate functioning (with an eligible disability) as defined in the eligibility rules.
- A child that is served, but then exits either program, may later become eligible again as their age-appropriate functioning changes after services are discontinued.
- Parental consent and procedural safeguards, and multi-disciplinary teams, help assure accurate and targeted services are provided to each child.

School districts' use of the developmental delay category is different than for Part B and likely impacts different eligibility determinations and use of IDEA services and supports once Program children enter the K-12 system.

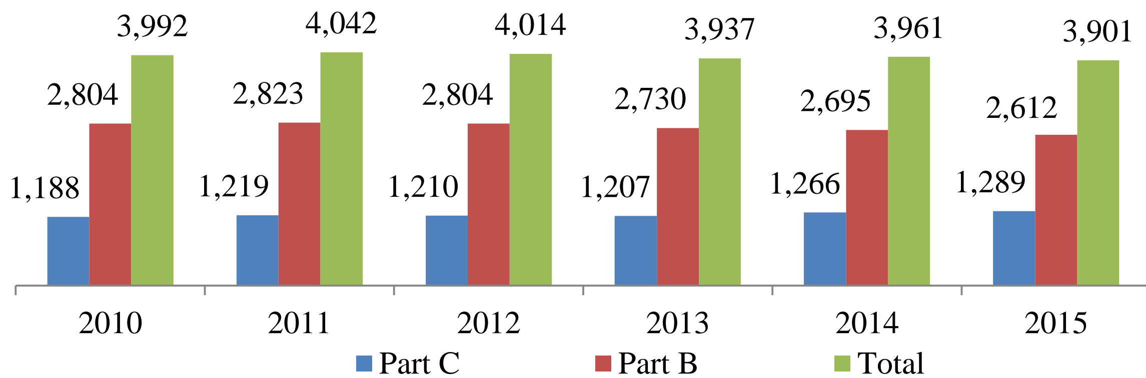
See **Appendix D** for a more detailed flowchart with explanation of each step as well as additional concerns related to disagreements, complaints, and due process concerns relevant to the eligibility and services determination process.

Count of Total Part C and Part B Children Has Mostly Remained Stable

For each of the past six years, approximately 4,000 children in Wyoming have been counted under W.S. 21-2-706 as eligible for services through the Part C and Part B programs. Overall, there has been a slight decrease in the number of children served from a high of 4,042 in 2011 to 3,901 in 2015. Figure 1.7, next page, depicts the number of children counted as eligible to receive services based on the statutorily required November 1st child counts as calculated by the Program staff. During this time, the number of children under the Part B Program has decreased, while the number of children enrolled under the Part C Program has increased.

Figure 1.7

November 1st Eligible Child Counts for Part C and Part B Programs, 2010-2015



Source: Legislative Service Office summary of Wyoming Department of Health count data.

Recent Efforts to Study the Part C and Part B Programs

While the Legislature reviewed and adjusted the developmental preschool system starting in 2004 with the Goetze Study and through several statutory amendments from 2006 through 2008, additional efforts to better understand the Program and statewide early childhood learning have occurred more recently. Specifically, Health and Education contracted for two eligibility studies of the Part C and Part B programs, respectively. Additionally, the Joint Education Interim Committee studied early childhood systems issues in 2012 through 2014.

Education Funded Studies to Look at Identification Rates

The eligibility studies were conducted to assure the eligibility process appropriately identifies children in need of early intervention and preschool special education services. The study for the Part B Program was completed in 2014 and the Part C study was completed in early 2015. Both studies focused on trying to better understand why Wyoming's child identification rates for both programs are high compared to other states. Related concerns included whether pre-K children also received services in the K-12 system, the number of different eligibility assessment tools used across the state, and to measure the type and amount of services provided to eligible children.

Select results for each study are listed and summarized in Table 1.2, on the next page. Overall, additional concerns raised by the studies included that regional centers used an average of thirty different norm-referenced assessments for Part B and that each region's service types and quantities differ for both Part C and Part B programs.

Table 1.2
Select Results of Part B and Part C Studies

Part B — Summary Results	Part C — Summary Results
▪ 13.5% of children aged three and four were receiving services	▪ 4.66% of children birth through age two were receiving services
▪ Wyoming's identification rate is the highest in the nation.	▪ Wyoming's identification rate is the fourth highest in the nation.
▪ Student identification rates vary by region from 2% to 17%	▪ Student identification rates vary by region from 2% to 9%
▪ 22% of a sample of children no longer needed services in K-12, while 13% had their disability category changed	▪ Between 50-58% of children received services under both Part C and Part B.

Source: Legislative Service Office summary of Wyoming Department of Health information.

Through on-site visits, for both Part C and Part B, Health monitors the fidelity of the regional centers' eligibility assessment processes and practices. For Part C, on occasion, Health will also contract with independent professionals to review if the assessments were interpreted appropriately. As a result of the Part B study, Health reduced the number of approved assessment tools from more than thirty to seventeen. Health does allow regional centers to petition to use additional assessments and will approve these requests on a case-by-case basis.

Stakeholder Misconceptions Appear Common about the Program, Regional Centers, and the Overall Early Learning System

From the outset of this evaluation, LSO encountered instances where stakeholders either have fairly isolated views of the Program or that the Program does not fit in with the overall early childhood learning system. Evaluation staff even found references to high-level State agency officials, outside of the administering agencies, in recent years stating that Wyoming does not spend "anything" on early childhood education. This perception, or rather misconception, of State programs, funding, and commitment does not comport with what LSO found during this evaluation. While possibly fragmented, Wyoming does have components of an early childhood learning system, which the State can build upon and improve.

A central theme of this evaluation is to address not only the struggle to fit the Program into the right administrative and organizational package, but to provide context and address continuing concerns that the State is absent from the world of early childhood learning. The following chapters discuss Program identification rates, funding, and complicated organizational and

administrative structure. However, the report ends with a summary of how the Program and regional centers fit within the overall early childhood education system and the Legislature's choice on how this system may become more cohesive and coordinated in the future.

Chapter 2 Part C and Part B Child Identification Rates

Finding 2.1: When considering multiple measures and factors, Wyoming's identification rates for Part C and Part B children appear reasonable and appropriately monitored.

In a given year, Wyoming provides early intervention and early education services to roughly 4,000 children. Numerous factors can be considered in determining whether the number of children identified as eligible for services is low or high, acceptable or not acceptable, or is meeting the intended purpose of the Program. Historically, the purpose of the Program has been to provide broad access to services and higher identification rates of children was seen as a positive indicator of Program success.

Different measures for analyzing the number of children screened, the number of children served in a given population, and the incidence or prevalence of disabilities can provide additional comparisons. To understand Wyoming's identification rates, LSO used several of these factors and measures and concluded that the number of children identified and served appears reasonable given current administrative oversight of the regional centers.

Specifically, the U.S. Center for Disease Control and Prevention (U.S. CDC) estimates the prevalence of developmental disabilities or delays at one in six children in the United States, and this rate appears to be increasing. While IDEA Part C and Part B identification levels in Wyoming are higher than the national average and other states, the total population of children birth through five served by the Child Development Centers more closely aligns with this national prevalence estimate. When using this comparison, other states may be underserving their Part C and Part B child populations.

Wyoming's Part C and Part B Identification Rates are Near the Top in the Nation

For context, the Committee's question about the appropriateness of Part C and Part B identification rates is reflected in the recent eligibility studies conducted by Health and Education. In comparing Wyoming to other states and national averages, Wyoming has the highest identification rate for Part B children and is generally in the top five highest for Part C children. Figures 2.1 and 2.2, on the next page, summarize information from the Part C and Part B eligibility studies, respectively. This information shows the number of children receiving services divided by the number of

children in the population of the same age. States listed include the three highest states outside Wyoming. The data reflects the most recent federally reported data available at the time the studies were completed (the Part C study occurred a year after the Part B study).

Figure 2.1
Wyoming, Select Other States, and National Average of Part C Identification Rates, 2012-2013 School Year

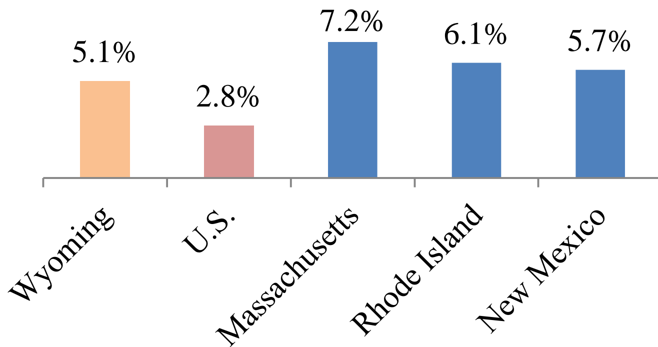
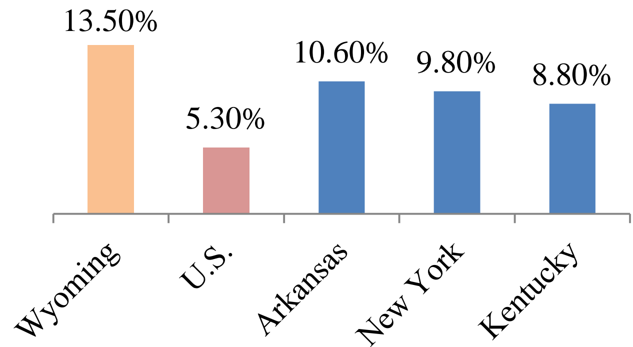


Figure 2.2
Wyoming, Select Other States, and National Average of Part B Identification Rates, Children Three and Four, 2011-2012 School Year



Source: Legislative Service Office summary of Part C and Part B eligibility studies.

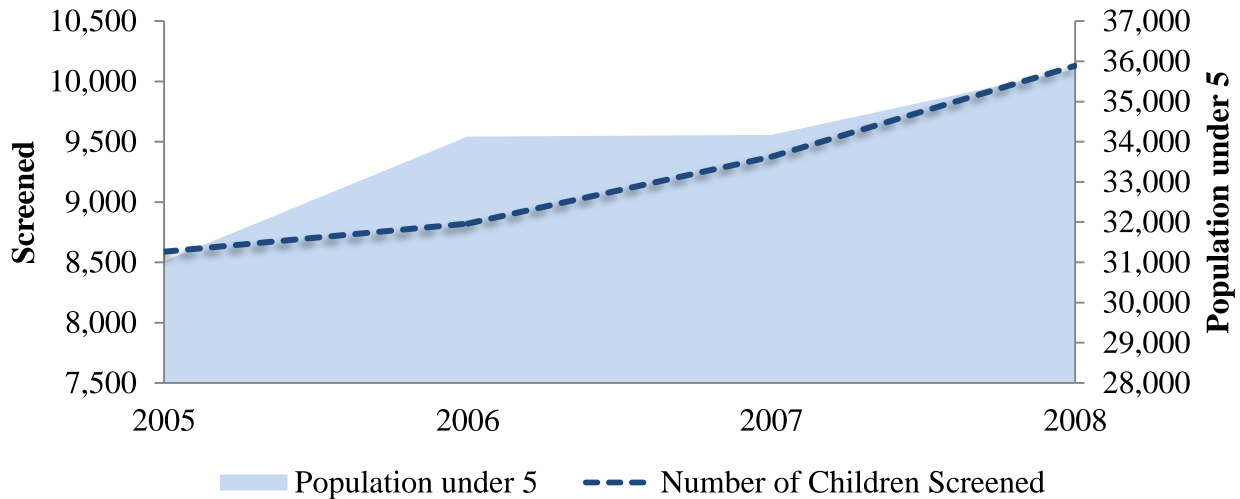
A central caveat to this information is that each state does not use the same eligibility criteria on which to identify children. Additional considerations include each state's child find programs, screening levels, and funding methods may impact the extent they want or are able to identify and serve children. Therefore, these comparisons to other states are not effectively apples-to-apples comparisons and may lead to the incorrect conclusion that Wyoming's identification rates for these programs are *unreasonably* high. For example, some states may or may not utilize the discretionary eligibility category of developmental delay, which could constrain their eligibility to more severe disabilities. Additionally, at least for the Part B study, the population-based penetration rates do not include children age five, as is included in Wyoming statute for Part B.

Child Development Screenings

One alternative hypothesis offered by several stakeholders during evaluation research was that the State has a robust Child Find campaign, which would contribute to higher child identification rates. Stakeholders have stated that the success of the campaign, in combination with the grassroots, community-based regional centers, allow Wyoming to screen, identify, and ultimately serve more children than almost any other state for both Part C and Part B programs. While Health requires that screening data be collected, neither Health nor Education have studied screening data and trends to validate this hypothesis.

Historically, the percentage of children screened has increased proportionally with the population of children age birth through five years, as shown in Figure 2.3, below.

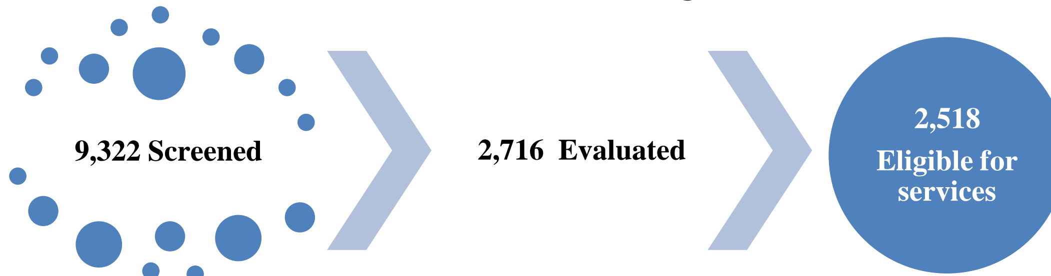
Figure 2.3
Historical Screening and Population in Wyoming



Source: Legislative Service Office analysis of U.S. Census data and historical screening data provided by regional centers.

Wyoming screened 20% of its population of children age birth through five years in the 2008-2009 school year, which is slightly lower than the 24.5% (9,322 screened of 38,097 children) in 2015. Figure 2.4, below, provides data on Wyoming children screened through eligibility determination for FY2015. This figure shows that approximately 27% of screened children were found eligible or qualified for services (once evaluated and assessed after initial screening). These screening numbers include data from the fourteen regional centers totaling 3,976 Part C children and 5,346 Part B children.

Figure 2.4
FY2015 Children Screening Data



Source: Legislative Service Office summary of Child Development Services of Wyoming information.

Other Wyoming Programs Provide for Early Childhood Screening

For the most part, LSO concentrated research on early childhood developmental screenings specifically provided by regional centers. However, LSO learned of a number of other screening efforts, including other developmental screening programs offered or authorized under Health. One example includes a separate developmental screening initiative, called "Help Me Grow," funded by a federal grant to Health's Maternal and Child Health Unit.

Additional developmental or medically focused screening efforts are paid through the State's Medicaid program, including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Health also leads hearing screening efforts through the Early Hearing Detection Intervention (EHDI) grant. Health staff also said that the agency and Program has recently emphasized vision screening and assisted regional centers with purchasing vision screening equipment and training.

Screening in Other States

During this evaluation, LSO learned that Health and Education do not study screening data to evaluate child find and better understand overall State and regional centers' identification rates. LSO found that Wyoming is not alone with respect to screening data. In our effort to collect and analyze screening efforts in other states and through national platforms, LSO found only a single entity that collected, and studied such data. The U.S. Department of Health and Human Services conducted a National Survey of Children's Health (NSCH) in 2011-2012.

This survey was conducted nationwide using a cross-sectional telephone survey of households with at least one child age birth through seventeen years. One of the questions asked respondents if their child had received a developmental screening in the past twelve months. While this data does not provide an ideal data set for this evaluation, it was considered useful in comparing Wyoming with national screening numbers. According to the survey, 30% of the country's children under six received developmental screenings in 2011-2012. Wyoming's rate, according to this survey was 27%, slightly higher, but consistent with Wyoming's FY2015 screening rate of 24.5%.

Penetration Rates Offer a More Objective Comparison of Child Identification Rates

Another way LSO attempted to quantify if Wyoming's child identification rate is high was to review identification statistics in relation to the greater population of same-aged children. This is

generally referred to as penetration rate. These rates offer a more objective measure of child identification as it is not clouded by the uncertainties of comparing other states' programs eligibility criteria to qualify children for their Part C and Part B programs differently than Wyoming.

Using county level data from the U.S. Census Bureau, LSO calculated the penetration rates for Program children and other related programs, such as school district special education rates. These statistics provided a comparison of identified children in each region with the statewide average using the reported child counts since 2012.

Penetration rates in Wyoming

For both Part C and Part B programs, LSO utilized data from the eligibility studies commissioned by Health and Education, respectively, to calculate penetration rates. These analyses reflect the years noted in these studies.

For Part C, LSO calculated the 2013 penetration rate. Consequently, the 2013 statewide penetration rate for the Part C program was 4.66%. Among the different regional centers, Region 1 had the highest rate at 8.59% and Region 5 had the lowest rate at 2.47%. For 2012, the statewide average penetration rate for Part B children was 9.61%. This rate means that almost 10% of children ages three through five years were found eligible for services in 2012. Among the different regions, Region 1 had the highest rate at 18.49% and Region 4 the lowest at 5.74%.

The above regions and percentages aside, one caveat to these analyses is the geography of the Wind River Reservation. The Reservation, which makes up Region 14 is in the center of Fremont County, which is Region 6. The Reservation also extends into Hot Springs County (within Region 1). Therefore, it is not possible to definitely identify the populations of children from the Reservation that may be counted or served among these three regional centers. However, stakeholders generally recognize that the number of children served by Region 14 is the lowest in the State for both Part C and Part B. **Appendix E** provides additional detail for each regional center's penetration rates. At this regional level, rates vary in large part due to individual business practices, such as when or whether a center focuses initial screening efforts, outreach, or campaigns over the summer and throughout the school year.

Special Education in K-12

One stakeholder stated that perhaps the biggest goal of the Program is that children identified and receiving services through

Part C and Part B could in effect lessen the need to serve those children as they progress through the K-12 school system. As an initial step in evaluating the Program's success in reducing services in K-12, LSO calculated the special education student penetration rates for the K-12 system. This comparison is applicable since the K-12 system must utilize the same rules (Chapter 7 promulgated by Education) to identify children eligible for special education services. However, keep in mind that the following analyses provide a snapshot and that rates will differ each year as more or less children are identified to enter services and leave services at each age level.

Using U.S. Census Bureau data and Education reports, the penetration rate of K-12 students receiving special education services statewide was 14.04%. This rate is more than 50% higher when compared to the 9.61% penetration rate for children age three through five years receiving services. This rate is another approximate indicator that the identification rates of the Program are lower than in Wyoming's K-12 system and that the Program does not serve and support all children that end up needing special education services in the K-12 system.

It should also be noted, however, that because student data was not made available by Education until the end of LSO's research period, there was no way to determine if the children served by the school districts had previously received services from the regional centers. As noted in the opening to this report, additional comparative analysis of the Program and special education K-12 services will be reported in the Phase 2 report on this topic.

Children Served in other States

The U.S. CDC estimates that 13.87% of children in the United States have a developmental disability (or about one in six children). Using the US Census data and data from the US Department of Education IDEA Section 618 reports, LSO calculated penetration rates for other states, as shown in Table 2.1, below.

Table 2.1
Total Children under Age 5 Served in Wyoming Compared to Surrounding States, 2011-2012

State	Part C Birth-2 Served	Part B 3-5 Served	Total Served[1]	Total Population under 5	% of the Population
CO	5,806	12,348	18,154	412,681	4.4%
ID	1,717	3,379	5,096	143,848	3.5%
MT	728	1,696	2,424	74,286	3.3%
NE	1,496	5,175	6,671	157,930	4.2%

State	Part C Birth-2 Served	Part B 3-5 Served	Total Served[1]	Total Population under 5	% of the Population
ND	922	1,791	2,713	53,907	5.0%
SD	1,091	2,726	3,817	71,545	5.3%
UT	3,392	8,856	12,248	314,119	3.9%
Total Surrounding States	**16,330**	**39,400**	**51,123**	**1,228,316**	**4.2%**
WY	1,178	3,429	4,607	47,538	9.7%

Source: U.S. Department of Education 2011 IDEA Section 618 Data Products: State Level Data Files
http://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bcc
http://www.census.gov/popest/data/historical/2010s/vintage_2011/state.html

[1] The total children served for Wyoming according to the U.S. DOE 618 data is not the same as the annual State child counts for Part C and Part B.

The table indicates that Wyoming served 9.7% of its population ages five years and younger in 2011-2012 compared with a surrounding states average of 4.2% (excludes Wyoming's numbers). While Wyoming's rate is nearly double that of most of the states shown in the table, this rate is still below the projected rate noted by the U.S. CDC.

Health's Management of the Statutory Funding Model May Not Provide Regional Centers Incentive to Identify More Children

From the outset of this evaluation, one expressed concern was that the State's perceived high identification rates may result from the statutory funding model that incentivizes regional centers to identify more children for the November 1st child count. However, as shown in Chapter 4 regarding the current implementation of the funding model, this connection does not always hold true.

Over the last few years, Health has attempted to operate the Program with a maximum General Fund budget over concerns about the State's ability to manage its maintenance of effort requirements from the federal government. In doing so, as child numbers increase, the per-child funding amount may decrease. This decrease in available funding essentially forces the regional centers to provide any needed services for identified children with potentially lower per-child contract amounts.

Agency Monitoring Reveals No Over-Identification

This financial incentive concern is also based on the premise that regional centers may be unreasonably enriched by the model as more children are identified. LSO did hear from providers that getting children counted on November 1st each year is important, since their next year's budget is dependent on this count. Yet, for each child found eligible whether included in the November 1st count or not, that child must be served. These children's services

and centers' costs may or may not fit within the per-child amount received by the regional centers.

Health and Education have created monitoring processes for Part C and Part B, respectively, which require annual review of multiple regions' eligibility determinations of individual children. Additionally, over the last two monitoring cycles, 2015 and 2016, Education and Health have worked to improve the monitoring methodology of Part B.

Using regional center data, the agencies conduct risk analysis, with the assistance of a data consultant, to develop hypotheses of potential compliance problems among the regions. In addition to this risk-based approach, the agencies conduct on-site visits of selected centers each year to review regional protocols and processes for evaluation and eligibility determinations. If a monitoring visit yields results that indicate the regional center has not complied with the IDEA, Health (for Part C) and Health and Education (for Part B) work together to develop corrective action plans (CAPs) for these regional centers. These plans may address all areas of noncompliance, potentially including requiring regional centers to re-evaluate and re-assess specific children to confirm eligibility.

LSO observed these monitoring visits throughout the spring 2016, totaling five regional centers. Based on these visits and those conducted in 2015, Education staff stated that they have not found any evidence that children are being inappropriately identified by the centers. Similarly, Health staff told LSO that they have identified isolated incidences of possible inappropriate identification through its monitoring efforts, but there is no conclusive evidence of systemic or intentional over-identification of children. From interviews and through observation of Health's monitoring visits, LSO could not conclude that providers are identifying children and then setting inappropriate service plans for children merely to receive additional marginal revenues for their programs.

Health Has Reduced the Number of Approved Assessment Tools for Child Eligibility Determinations

As detailed in the Chapter 1 Background, eligibility studies from 2014 and 2015 precipitated Health to implement Program changes to better assure the eligibility process results in an appropriate identification of children in need of services. Subsequent to these studies, in the summer 2014, Health reduced the list of approved assessments for use in the evaluation process so that all regional centers in the State are evaluating through licensed professionals using standardize tools.

The Division also changed policy to ensure that all children identified as eligible for services have an IFSP or IEP in place in order to be included in the November 1st eligible child count used for allocating State general funds. While this effort was to streamline counts and provide for greater standardization and comparison between regions, Health noted that this requirement "*will result in a reduction of children that are found to be eligible for services by the November 1st deadline*."

Conclusion 2.1: While identification rates for Wyoming's Part C and Part B programs appear higher than other states, Wyoming's penetration rates appear reasonable given other identification comparison standards. Additionally, Health's monitoring practices and approved assessment policy help verify accurate eligibility determinations among regional centers.

As explained above, even as Wyoming appears to be screening children comparable to the national trends, Wyoming does have a higher identification rate for children age birth through five years compared to many states. However, other states' unique Part C and Part B program criteria and other conditions make direct comparison to Wyoming somewhat problematic.

In looking at other standards on which to compare Wyoming's identification rates, Wyoming's Part C and Part B identification rates appear lower than what occurs in the State's K-12 system as well as what may be expected from disability prevalence according to the US. CDC. That is to say, 13.7% of all children age birth through five years would mean as many as 6,500 or more children could have a disability or delay and be potentially served by the Program. Table 2.2, below, summarizes these comparisons.

Table 2.2
Wyoming Part C and Part B Penetration Rates Compared to Benchmarks

Benchmark for Children Age 5 and Younger	Rate
K-12 Special Education Rate	14.04%
US CDC Disability Prevalence Rate	13.87%
Program Rates	**Rate**
Part C (age birth -2 years) Penetration Rate 2012	4.66%
Part B (age 3-5 years) Penetration Rate 2012	9.61%

Source: Legislative Service Office summary of Center for Disease Control and Prevention information.

Finding 2.2: Education's reporting of Part B data to the federal government cannot be reconciled with Health data for the same program.

According to the federal education reporting site EDFacts, 91.5% of all Program children identified in Wyoming are classified in three disability categories: Developmental Delay, Speech or Language Impairment, or Specific Learning Disabilities. However, there is a clear discrepancy between the child count reported by Health to Education and what is reported from the Education to the U.S. Department of Education as part of the IDEA 618 reporting requirements (EDFacts) for the IDEA Part B.

Health's Data Indicates "Speech or Language Impairments" is the Most Utilized Eligibility Category for Part B

For Part B, children are identified as eligible based on their disability determination according to one or more of the thirteen categories discussed in Chapter 1. Using Health's data, the most identified disability category in the age three through five years group in Wyoming is speech or language impairment.

The State's high speech or language impairment levels may be a result of how Education's Chapter 7 eligibility rules control the use of the Developmental Delay category. Education's rules specify that developmental delay category is "available to children…who do not qualify in other categories under these rules, but meet the Developmental Delay category." So while a child may have developmental delays that also include speech, they must be categorized within the "Speech or Language Impairment" category. It should be noted that, nationally, the speech or language impairment category is the highest classified category for this age group.

Health's data indicates that for the 2014-2015 school year, the Speech or Language Impairment category has the highest number of children, showing 2,315 children within this category. Health indicated only one child within the Specific Learning Disability Category. Conversely, EDFacts, showing data reported from Education to the federal government, lists only 454 children under the Speech or Language Impairments, and 1,946 children under the Specific Learning Disabilities category within its 2014-2015 report.

Table 2.3
WDE and Child Count Reported by the Department of Health

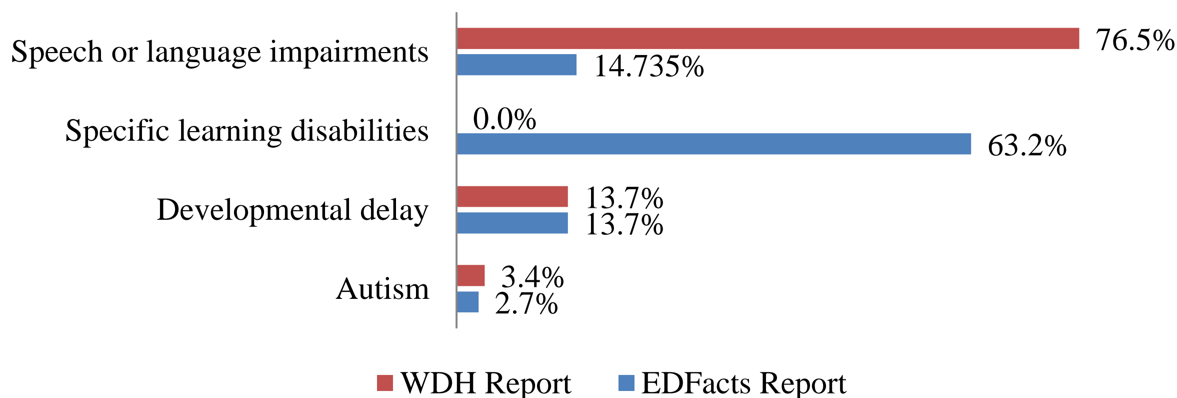
Disability Category	Education EDFacts Count	Health Count
Autism	83	104
Deaf-blindness	0	0
Developmental delay	421	414
Emotional disturbance	1	0
Hearing impairments	33	33
Intellectual disabilities	24	24
Multiple disabilities	26	30

Disability Category	Education EDFacts Count	Health Count
Orthopedic impairments	9	10
Other health impairments	74	83
Specific learning disabilities	1,946	1
Speech or language impairments	454	2,315
Traumatic brain injury	5	7
Visual impairments	5	7
Total	3,081	3,028

Source: Wyoming Department of Health Child Count 2014-2015 and U.S. Department of Education, EDFacts Data Warehouse (EDW): "IDEA Part B Child Count and Educational Environments Collection," 2014-15

These differences are shown in Table 2.3, above. The fifty-three additional children reported to EDFacts by Education could be explained by the number of children served in the school district under IDEA Part B, Section 619. However, this difference appears unrelated to the category designation discrepancies comparing Health's and Education's reported data, including 1,861 more children with a speech or language impairment in Health's data compared to Education's EDFacts-reported data.

Figure 2.5
Discrepancies Between Department of Health and WDE data to EDFacts 2014-2015 Data on Children Ages 3-5[1]



Source: Wyoming Department of Health 2014-2015 child count; U.S. Department of Education, EDFacts Data Warehouse (EDW): "IDEA Part B Child Count and Educational Environments Collection," 2014-15. Data extracted as of July 2, 2015 from file specifications 002 and 089.

[1] The developmental delay percentages match due to rounding.

Figure 2.5, above, also shows this data graphically and by percent of children in each disability category. The figure notes that according to Health, more than 76% of Part B eligible children fall under Speech or Language Impairments, while the Education-reported data indicates that Specific Learning Disabilities covers 63.2% of Part B children.

All Part B Data is Reported to Education Before Reporting to the Federal Government

All Wyoming school districts and the Health's Program staff (for Part B) submit data through Education's 684 report. Prior to submitting data to the federal government through EDFacts, Education told LSO that it performs two levels of data validation. At the first level, a data analyst looks for missing data and asks the school districts, or Health's Program staff, to submit the missing information. During the second level of data validation, Education staff reviews existing data and compares it to submitted data to check for any inconsistences. However, according to Education, the data submitted by Health only receives the first level of data validation, as Education does not have the programmatic level expertise to understand where there may be inconsistencies.

As a result of these data discrepancies or inconsistencies, LSO asked Education about the high level of children within the Specific Learning Disabilities category reported to EDFacts. Education staff did not question the high number, stating that at a national level, the Specific Learning Disability category is consistently higher than other disability categories. This category indicates that a child may have a specific disability in learning certain subject matters areas, which may or may not have a speech-language impairment or other disability, for example. While that statement may be true for the K-12 population nationally, the most commonly used category for children age three through five years is speech or language impairment, followed by developmental delay and autism.

One possible explanation for the discrepancy could be a data management error on the part of Education. As Health's data is not transmitted directly to EDFacts from Health, and Education does not perform both levels of data validation, the number of children within a given category may have been inappropriately entered into the data file uploaded to EDFacts by Education. Furthermore, neither Health nor Education provide for a quality control review of reported data to the original data provided by Health. While the data submitted by the Health does have elevated percentage for the speech or language impairment category, when compared nationally, the use of this category does appear to align with national trends where this category is among the utilized.

Recommendation 2.1: The Department of Health and Department of Education should conduct a data reconciliation process prior to submitting any information to the federal government for Part B and work together to identify and resolve potential reporting errors for information already reported to the U.S. Department of Education.

Chapter 3 IDEA Part C and Part B Child Count

Finding 3.1 Health's child count standard is no longer defined through rules, and the single, November 1st count date may not provide the best timing or information to determine the number of children served by the Program.

Wyoming Statutes require that "state rules" establish how Health defines when a child may be counted for regional centers to receive State general funds. However, the way in which Health has most recently set its November 1st eligible child count standard no longer comports with its own rules, and therefore statute. Health intends to repeal its Chapter 13 rules meant for this purpose and has instead implemented its current standard through policy changes, rather than rule changes.

Additionally, the November 1st count date prescribed in statute does not well represent the variations in the number of eligible children served by the providers. This count date also appears to inhibit regional centers from providing adequate time for parents and families to consider their children's disability diagnosis and service needs during the eligibility determination and enrollment process.

Health No Longer Uses its Chapter 13 Rules to Establish its Count Criteria for Allocating State General Funds

Under W.S. 21-2-706(b), Health is required to determine the November 1st eligible child count. The criteria, or count standard by which Health defines when a child is "eligible" to be counted, is required to establish in rules. The eligibility is not the same as clinical or educational eligibility for services, but is meant to qualify children to be counted for regional centers to receive State general funds. Specifically, the statute states:

> "(b) For purposes of calculating payments to service providers for the subsequent fiscal year and preparing the division's budget request to the legislature, **the division shall multiply the number of children age birth through five (5) years of age with developmental disabilities who are eligible for developmental preschool services** on November 1 of the year**…[e]ligibility for developmental preschool services shall be determined by the state rules and regulations governing an individualized education program or an individualized family service plan**." (LSO emphasis)

This language was implemented during the Legislature's 2008 Budget Session. To comply with this requirement, Health adopted its Chapter 13 Early Intervention and Developmental Preschool State Funding rules in 2009. Under the rules, Health states that funding will only be provided for an eligible child receiving services, which meets three conditions:

1. Signed and dated parental consent to evaluate a child; and
2. A parent indicates they "anticipate" providing consent for services; and
3. The child has met disability or informed clinical opinion (only for Part C) diagnoses requirements.

Keep in mind that these conditions are meant to apply to both Part C and Part B children: age birth through five years. While Health does set the clinical eligibility for Part C, these rules do not restate or reset the clinical and education eligibility criteria for either Part C or Part B (set by Education in its Chapter 7 eligibility rules). Chapter 13 rules merely specify at which point in the eligibility determination and service provision process a child can be counted in order for the State to fund that child's services, or potential services, through a child's respective regional center.

Legislature Loosened Requirements for Children to be Counted for Funding

Prior to the 2008 statute change, children were required to be ready to receive services through their individual family service plan (IFSP, for Part C) or individual education plan (IEP, for Part B), on December 1st. With the 2008 change, the Legislature specifically removed reference to children having "to be subject to" an IFSP or IEP, and inserted the language noted above that rules should be devised. Health's rules should specify where in the process the count standard should be applied.

In combination with moving the count date from December 1st to November 1st, this change appears to be a direct acknowledgment by the Legislature as to how the eligibility process works according to federal law and provider practices. For example, as Part B operates on a traditional school year timeframe of September to June, many children's initial interactions for referral and screening process occur at the beginning of the school year, around September 1st or later. For Part B, the required maximum timeline to move from screening through eligibility determination and service plan implementation is about ninety days (sixty days from screening with parental consent for evaluation to full evaluation and eligibility determination, with an additional thirty days from eligibility determination to service

plan implementation; refer to Figure 1.6 in the Chapter 1 Background or see Appendix D).

Essentially, if the Legislature requires a count only two months into the school year, regional centers may only complete the eligibility determination process for State funding before the November 1st count occurs. This earlier date reduces the possible process timeframe by a full month for regional centers to obtain a stronger idea of the number of children they expect to serve and for which they should expect to receive State funding for the next year.

The Legislature's intent seems clear that to receive State general funds, children must be found eligible, but not fully complete the process to devise and execute the IFSP or IEP. Consequently, Health's Chapter 13 rules, developed directly after the statute change, do not require written parental consent for services, a full service plan to be in place, or that services have already started to be a counted eligible child.

For 2014 and 2015, Health Gradually Restricted Count Criteria Through Policy and not Through Rules

Beginning in 2014, after the first eligibility study for Part B was completed, Health embarked on modifying its count standard for regional centers to receive State general funds. Through a conference call with regional centers in the fall 2014, Health stated that children would only be counted if they have a multi-disciplinary team (MDT) meeting completed for a child by the count date. This standard was applied to the November 1, 2014 count. Health's stated reason for this change was that the language in rules potentially contradicted with federal parental consent regulations where parents did not have to provide written consent for their "anticipation" of services (as phrased in the Chapter 13 rules). The new count standard did not require that a service plan be complete or that services had started for a child.

Following this development, in May 2015, Health submitted a second policy change further restricting the count standard. With this change, Health required that each eligible child have an IFSP or IEP in place by the count date. Health reasoned that this condition is the point when the regional centers, and State, are legally obligated to provide services. This phase is also the closest standard to the federal count standard of students receiving services.

<u>Health is Repealing and Modifying its Rules</u>

Health explained to LSO that one of the reasons these changes occurred is that its Wyoming Attorney General representative believes that Health has overstepped its authority to implement

rules for the Part B program. Despite that W.S. 21-2-706(b) specifically references Health's division (currently the Behavioral Health Division) to conduct the child count and the requirement to define the count standard in "state rules," Health and their legal counsel reason that formal rules for Part B are the exclusive domain of Education and not Health. This interpretation may be supported in part by the fact that in W.S. 21-2-703(a)(i), it states that the State Superintendent of Public Instruction shall promulgate rules to implement the developmental preschool act.

Therefore, Health informed LSO that it will repeal its Chapter 13 rules and implement its newest Part B count standard through its administrative policy. As Chapter 13 rules also address the Part C program, Health is taking this opportunity to repeal its Part C rules and implement a single new rule for Part C, which will address the count standard only for Part C children.

For additional context, LSO's rule review on Health's proposed Chapter 13 rules in 2009 and found that the rules appeared to meet the "scope of authority and legislative intent." Furthermore, W.S. 9-2-102(a)(iv) provides Health with the responsibility to establish minimum standards for developmental disability services supported by State funds, while W.S. 9-2-106(a)(vii) requires Health's director to ensure promulgation of rules for all "state and federal public health, mental health and medical services laws."

A Date-Specific Child Count Based on Eligibility May Not be Representative of the Number of Children Actually Served

As stated above, the November 1 eligible child count date does not mesh well with the federally recognized child eligibility and enrollment process timelines. A concurrent impact of this count date is that a singular count is not representative of the full population of eligible children served by the regional centers throughout the year. Even if the count was originally intended as a reasonable approximation of the children served by the Program, the variations from month-to-month indicate the current count may not provide adequate information on which to base annual funding decisions. Compounded by Health's desire to move the State general funds count standard closer to the federal funds standard, regional centers noted to LSO that they have concerns as to whether they can both meet the needs of their students as well as maintain adequate reimbursement for those required services.

To put this concern into perspective, one regional center mentioned that in their region, they serve eligible children from the local Head Start preschool program. This federal program has its own rules and regulations to follow and it is only after this program has worked with, and possibly screened the child, that the regional

center may interact and begin the evaluations, assessment, eligibility, and enrollment process. Additional regional centers' staff noted that due to this more restrictive count standard, they have had to adjust or modify their screening and evaluation process to compress the ninety day timeline into sixty days, or often less, to assure a reasonable count is obtained, or risk survival of their businesses and services in their communities.

Centers said that this circumstance can cause them to receive an appreciable increase in eligible children in December or later each year, which miss the child count date. This impact, if paid at $9,000 per child, equates to $45,000 in lost funding for every five additional children the regional center serves after the count is completed. One stakeholder stated that this could equate to one less staff member for the center to provide services during the year. While some children exit or leave services throughout the year, the savings from potential reduced services may or may not fully off-set to match the initial lost revenue.

Health Monthly Child Counts Also Show Annual and Regional Variability in Children Served

In order to help quantify this issue, LSO requested monthly child count data for previous fiscal years, which Health tracks to meet federal Part C and Part B requirements. Similar data was also requested of the regional centers for this same purpose. However, on the whole, data reported to LSO by the regional centers was variable and inconsistent (difficult to match assumptions across the State), so LSO was not able to conduct a Program-wide review of the centers' data.

With respect to Health's data, LSO reviewed Health's monthly count data extracts it collects for federal reporting on the number of children in services. The count methodology is similar to the State general funds count with a count at the first of each month rather than just the November 1st count. While this data is based on the federal count standard, this regular, monthly review is adequate to show the common variations of children served by the Program throughout the school year.

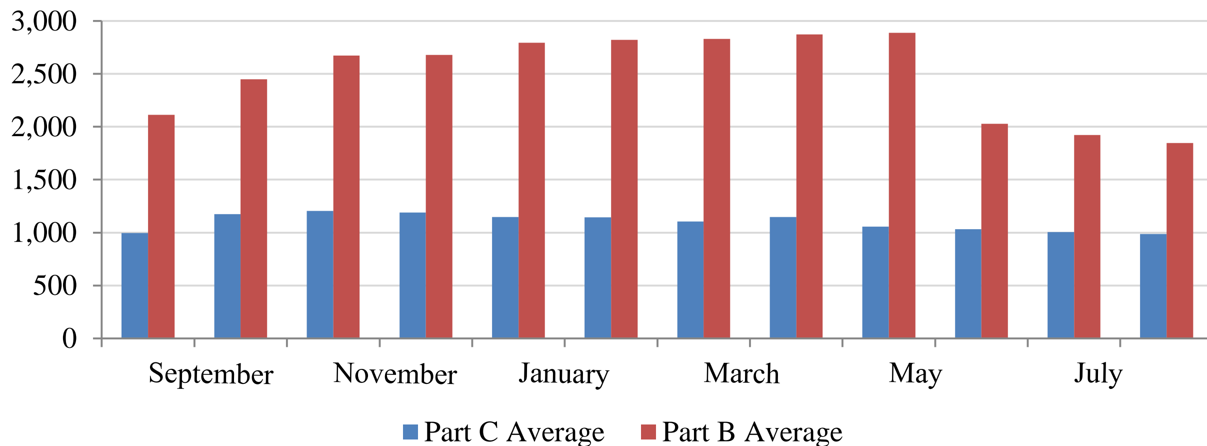
For both programs, there appears to be lower numbers of children during summer months (June through August), and generally the November count may not the highest single month count. Specifically for Part B, the count of children for the months between January and May can be higher than is reflected in the November 1 count of the same school year. For example, during the 2013-2014 school year, for each month January through May of 2014, the monthly child count was at or above 2,833. This

equates to approximately 187 or more children served during those months than were counted on November 1st.

Graphically, Figure 3.1, below, shows the slow increase of children throughout the year, with the summer drop-off in the number of children counted. The summer change is more noticeable for Part B, with a drop of about 28% from the September-May average. This drop corresponds to the typical nine-month focus for Part B, similar to school districts, with extended school year (ESY) services for only those children with an established need during summer months. For Part C, which is intended to be a full year, twelve-month service program, the drop during the summer months is much less at about 11%.

Figure 3.1

Monthly Average Federal Count of Part C and Part B Children Served, School Years 2012-2013 through 2016-2016



Source: Legislative Service Office analysis of Wyoming Department of Health data.

Recommendation 3.1: The Legislature could consider amending W.S. 21-2-706(b), to clarify the following:

- **Whether an individual family service plan or individual education plan is required for a child to be included in the child count for State general funds.**
- **That the "state rules" for setting the child count standard and distribution of State general funds shall be promulgated by the Wyoming Department of Health for the Part B program.**

Health has operated for most of the developmental preschool funding model's history with the understanding that the State child count standard should differ from the federal standard and that the count standard should be defined in its rules. However, in light of Health's recent policy changes and proposed Chapter 13 rules

repeal, there are two statutory issues that appear to create conflict with what LSO believes was the legislative intent to accommodate the federal eligibility process timelines. The current count standard implemented through policy attempts to go back to the statutory language

First, Health's current policy to move the State general funds count standard closer to the federal standard could be a reasonable interpretation of the broad language in W.S. 21-2-706(b), which says the count standard for eligible children shall be according to rules "governing" IFSPs and IEPs. Yet, this effort appears to equate eligibility determination with the service plan development and implementation, which is not the way LSO or the regional centers understand the IDEA eligibility determination process.

Second, W.S. 21-2-706(b) states that the eligible children for the State general funds child count shall be defined in "state rules," not Health's or its Division's rules. More specifically, even as the full W.S. 21-2-706 section commonly references Health's Division as responsible for budgeting and contracting for State general funds and to conduct and set the standard for applying the child count, statute does not specifically reference the Division as the entity to promulgate these specific rules.

Therefore, as long as the November 1st child count remains in statute, LSO recommends the Legislature consider clarifying statute so the standard for both Part C and Part B State general funds child counts should be defined in Health's rules. Additionally, the child count standard should reviewed and clarified as to whether program eligibility <u>or</u> a full service plan is intended to include children in the State child count. In re-establishing rules, regional centers and public comment will assist Health in determining potential challenges and unintended consequences of restricting the count standard from what is currently in Chapter 13 rules. This recommendation may be impacted by the Legislature's choice to maintain the Program in Health or move it to Education as noted in Chapter 5.

Recommendation 3.2: The Legislature could consider amending W.S. 21-2-706(b), in consultation with Health, to adjust the child count date and count method to accommodate the federal allowable child assessment and eligibility process timeframes for both Part C and Part B.

The November 1st count date, while possibly administratively and budgetarily convenient, does not adequately allow the full Part B, and possibly Part C, eligibility process to occur under federal requirements. The counts also do not appear to contribute a

reliable count of students actually served by the regional centers from month-to-month throughout the school year. Example approaches could be a multiple month count (December 1, or November 1, and May 1) previously used for the Program, or other methods like an average daily count of children with service start dates (similar to an average daily membership (ADM) model), or average monthly count of children served.

Each approach may have positive and negative administrative impacts on the State and regional centers. Any count method should be reviewed with Health to identify feasibility with its current data system. Finally, if the November 1 count date is changed for State funds distributions, Health will need to re-establish the December 1 federal count under W.S. 21-2-705.

Chapter 4 Developmental Preschool Funding

Finding 4.1 Budget cuts and Health's management of the State's federal maintenance of effort requirement are the primary contributors to Health and the Legislature not implementing the statutory Program funding model as intended, essentially eliminating consistency and stability for the Program.

From near inception, neither Health nor the Legislature has followed the Program funding model as written in statute. Consequently, the predictability desired for program funding has not occurred and has contributed to perceptions that the model is broken. However, without a consistent and complete use of the model, it is unclear if these perceptions are accurate, whether the model is thought to be ineffective or unreasonable from the different stakeholders' perspectives. In order to achieve consistency and predictability, the State has two options moving forward: implement and assure the model's application each year or study and revise the model to satisfy expectations of desired services and available resources.

Statute Prescribes How Program Funding Will Flow to Regional Centers

Prior to the statute changes spurred by the Goetze Study in 2005, the Program methodology for funding the developmental preschool system appeared to be at the discretion of Health to request what level of State financial support the Program should have. Budget requests asked for intermittent increases in total Program funding from biennium-to-biennium and Health distributed any funding increases by a count of served children. Health's central concern was deriving a per-child amount on which to base the financial terms of contracts with the regional centers. Yet with the 2006 through 2008 statute changes, the Legislature attempted to remove uncertainty and provide for a stable and predictable funding commitment.

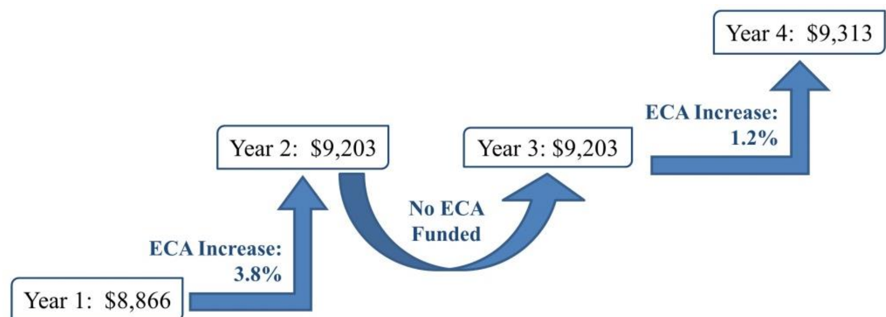
While LSO found that a per-child funding methodology has long been used by Health to allocate State general funds for developmental preschool services, this provision was the first to specify an amount in statute. Together with the annual eligible child count requirement, these factors make up the central items on which the Legislature based the program funding formula. The specific formula and process is outlined in the criteria below:

- The same formula and factors shall be used for both budget requests and for contract payments. (LSO emphasis)
- An annual count of children eligible for services on November 1 of each year will be used as the count factor.
    - The count applied in the formula should be from the same year in which the budget is prepared/submitted (i.e. November 1, 2015 for the December 1, 2015 budget request submission).
- The State General Fund per-child amount of $8,866 ($8,503 plus $363 for socio-emotional services and staff training) shall be used as the per-child funding factor.
- Each external cost adjustment (ECA) based on the k-12 ECA model) approved by the Legislature shall be added to and compounded onto all previous ECAs to raise the per-child amount.

Despite the traditional biennial state budget process and fiscal cycle, the formula is intended to set an annual state budget and annual contract payment levels to eligible providers. That is to say, these factors must be calculated annually and require Health and the Legislature to confirm or reset the Program budget each year based on the most recent information.

The funding model has remained unchanged in statute since the 2008 Session. Based on LSO's understanding, Figure 4.1, below, shows how the per-child factor is understood to account for cost increases or inflation over time with application of the ECA.

Figure 4.1
Example Trajectory of Statutory Developmental Preschool Per-Child Amount with Funded and Compounded External Cost Adjustments



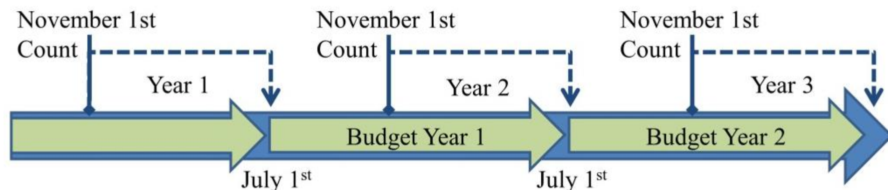
Source: Legislative Service Office summary and analysis of Wyoming Statutes and Wyoming Department of Health information.

Figures 4.2, below, shows that the annual child count and resulting Legislative appropriations are used to fund the next year's budget and contracts for services. In practice, the count should occur about eight months (November 1 – July 1) before the next fiscal

year budget and contracts begin. Based on LSO research, the legislature created this model with the aim of providing per-child funding stability.

Figure 4.2

Statutory Developmental Preschool Funding Model Budget and Contract Timing



Source: Legislative Service Office analysis of Wyoming Statutes.

For the distribution and contracting of IDEA Part C and Part B funds, W.S. 21-2-705(c)(iii) states the federal count shall occur on December 1 of each year. Health then divides the federal grant dollars by the number of children actually receiving services and accordingly distributes these funds to each regional center. Despite this statutory provision for the December 1st federal count date, for ease of administration, Health has substituted the November 1 count to cover distributions of both State and federal funds. However, this administrative change date does comply with federal allowances.

Information Used for Budget Preparation and Contracts is Not Applied Consistently or According to Statute

At first glance, it appears that Health has always been following the statutory funding model by the way it structures its budget requests for the Program. Health has referenced a child count and a per-child funding amount in each request since before the model became fully effective after the 2008 Session. However, when compared to statute, the per-child funding amount does not appear to have any current relationship to the statutory amount.

LSO research indicates several issues contribute to the difference between statute and Health's approach:

1. Health uses outdated and inconsistent child count figures in its budget requests to derive an undulating per-child amount for contract payments from year-to-year.
2. Budget cuts and Health's continued consideration of a 2013 budget footnote may be used to justify Health not using the model for its budget requests.
3. Federal maintenance of effort (MOE) requirements have given Health pause to request additional program funds for fear the State cannot backtrack on its funding commitments.

Health's Budgeting and Contracting Methodology Essentially Follows Pre-Funding Model Practices

Since the funding model change, aside from FY2009, Health has mostly migrated back to pre-model methods to focus on what the contract per-child amount needs be, regardless of what is in statute. More specifically, after the FY2009 budget request was submitted and funded, Health has reset the per-child amount based on previous year's contracted per-child amounts, rather than based on the statutory requirements (per-child amount + ECA1 + ECA2 + etc.). Additionally, the child count figures used in budget preparation are not the same as those used for contracting.

Table 4.1 shows how each child count number has been used for each budgeted fiscal year and each contracted fiscal year, along with reference to the statutory fiscal year for which the count is intended. This illustration shows that for its budget, Health uses the count of eligible children taken a full year prior to what is required in statute and what is used in contracts (budget information taken approximately 20 months from the beginning of the contract fiscal year). As the budget assumptions do not match the contract information, regional centers will not know the contracted per child rate until shortly before contracts become effective on July 1 of each year.

Table 4.1
Eligible Child Count Data used for Budget and Contract Fiscal Year Preparations
(Required Statutory Fiscal Year for Reference)

Count Date (Fiscal Year)	Child Count	Budget Fiscal Year	Contract Fiscal Year	Statutory Fiscal Year
12/1/2006 (FY2007)	3,114	2009		
12/1/2007 (FY2008)	3,379	2010	2009	2009
11/1/2008 (FY2009)	3,729	2011	2010	2010
11/1/2009 (FY2010)	3,813	2012	2011	2011
11/1/2010 (FY2011)	3,992	2013	2012	2012
11/1/2011 (FY2012)	4,042	2014	2013	2013
11/1/2012 (FY2013)	4,014	2015	2014	2014
11/1/2013 (FY2014)	3,937	2016	2015	2015
11/1/2014 (FY2015)	3,961	2017	2016	2016
11/1/2015 (FY2016)	3,901		2017	2017

Source: Legislative Service Office analysis of Health information.

Health Says Complying with Statute is Difficult in Budgeting Process and with Budget Cuts

Statute provides the most current count to be used for budgeting and contracting purposes. Specifically, statute requires the count to be "of the year in which the budget request is being prepared…"

(i.e. 2015 budget submission should use the November 1, 2015 count). However, Health states this count is difficult to handle in the budgeting process, noting that it forms its original budget requests in the summer, well before the November 1st count date.

Therefore, the count used for the initial draft request is not the count taken in the same year. Health does not change the count built into the request between November 1st and the Governor's December 1st deadline for the budget submission to the Legislature. However, Health said it provides this clarification about the count issue to the Legislature during budget hearings, but LSO could not confirm this approach or that the Legislature uses this information to acknowledge an adjustment to the budget request and corresponding appropriations that reflect the appropriate count.

2013 Budget Footnote Still Impacting Per Child Amounts

Another feature of the State budget and appropriations process that Health stated has impacted the per-child funding amount is budget cuts, including a 2013 budget footnote that temporarily (for one year) allowed the agency to reduce contractor payments to the regional centers.

More specifically, throughout the time the statutory funding model has been effective, the State has implemented (or considered) three budget cut actions: FY2010, FY2014, and proposed cuts for FY2017-2018. Related to the developmental preschool program, the FY2010 plan of the Governor proposed just over a $3.1 million budget reduction to require a 10% reduction in provider reimbursement rates. For FY2014, with the assistance of the following 2013 Budget Bill footnote number sixteen, Health was able to lower the per-child amount from $8,743 to 8,632 (about 1.3% decrease):

> "16. Notwithstanding W.S. 21-2-706(b) and (d), to the extent there are insufficient legislative appropriations to achieve the calculated payment amount in W.S. 21-2-706(b) and (d), the per child amount for all providers shall be reduced proportionately to the available legislative appropriation, as calculated by the department of health."

Health staff provided conflicting information on whether the Program still relies on this expired 2013 footnote to continue maintaining the per-child funding level below the statutory amount.

Finally, Health presented the most recent budget reduction proposal to the Legislature's Joint Appropriations Committee in June 2016, where Health, through the Governor, proposed $6.7 million in General Fund cuts to the Program for the FY2017-2018

biennium. As of writing this report, Health stated that the FY2017 Program budget would decrease regional center contract funding by almost $2.9 million.

As Health applied the budget cuts to Part C and Part B equally, the impact on the per-child amount is uneven. Based on the November 1, 2015 eligible child count, this cut translates into $938 and $375 less per-child for the Part C and Part B programs, respectively (pre-cut amount: $8,906 for Part C, 8,695 for Part B; post-cut amount: $7,968 for Part C; $8,284 for Part B). Keep in mind, state statute provides for no allowance for the per-child amounts to differ between Part C and Part B.

Program's State General Funds Now Mostly Based on the Federal Maintenance of Effort Requirement

Perhaps the most unique feature of the current statutory funding model for State general funds is that there is no inherent limit placed on the State's financial commitment. In other words, for both the child count and the per-child funding amount, as written, the Legislature states that it intends to support the requisite amount of funding based on the annual eligible children and an ever increasing per-child amount, *so long as the ECA requests are funded*. It is also important to re-emphasize that the 2008 statute changes allows the State to diverge from the federal count criteria to count children before an IFSP or IEP is in place and before services have begun (refer to Finding 3.1). Program funding has few constraints, so long as it is followed and funded based on the model formula.

This concept has become an issue related to how the State manages its maintenance of effort (MOE) requirement of the federal government. Simply stated, this requirement specifies that Local Education Agencies (LEA), such as Health for Part B, to spend at least the same amount on special education services for students with disabilities that they spent in the preceding year. This requirement is not the same as a matching requirement where the State must expend a certain percentage of the federal funds or a percentage of the total Program budget. There are exceptions and Table 4.2, below, summarizes the relevant details of the MOE for both Part C and Part B programs.

Table 4.2
Part C and Part B Maintenance of Effort Requirements and Allowances for Lowering the State's Level of Effort Threshold

Part C MOE
• The State must provide assurance that Federal funds will be used to supplement and in no case to supplant State and local funds • To meet the requirement, the total amount of State and local funds budgeted for expenditures in the current fiscal year must be at least equal to the total amount of State and local funds actually expended

in the most recent preceding fiscal year for which the information is available
• Allowance may be made for:
  o Decreases in the number of children who are eligible to receive early intervention services; and
  o Unusually large amounts of funds expended for such long-term purposes as the acquisition of equipment and the construction of facilities

Part B MOE

• LEA MOE requirement has two standards: the eligibility standard (§300.203(a)); and the compliance standard (§300.203(b)) for state or state and local funds
  o Eligibility Standard: LEA has budgeted at least the amount it spent in the preceding year
  o Compliance Standard: LEA has expended at least the amount it spent in the preceding year
• An LEA may use the following four methods to meet both the eligibility and compliance standards:
  o Local funds only
  o The combination of State and local funds
  o Local funds only on a per capita basis
  o The combination of State and local funds on a per capita basis
• The level of effort that an LEA must meet in the year after it fails to maintain effort is the level of effort that would have been required in the absence of that failure and not the LEA's actual reduced level of expenditures
• There are five instances where an LEA may reduce the level of expenditures below the level of the preceding fiscal year (for the compliance standard), and below the level of those expenditures for the most recent fiscal year for which information is available (for the eligibility standard):
  o The voluntary departure or departure for just cause of special education or related services personnel;
  o A decrease in the enrollment of children with disabilities;
  o The termination of the obligation of the agency to provide a program of special education to a particular child with a disability that is an exceptionally costly program;
    ▪ Has left the jurisdiction of the agency;
    ▪ Has reached the age at which the obligation to provide FAPE has terminated; or
    ▪ No longer needs the program of special education;
  o The termination of costly expenditures for the acquisition of equipment or facility construction; and
  o The assumption of cost by the high cost fund operated by the SEA

Source: Legislative Service Office summary of federal regulations.

If Health fails to meet the MOE compliance standard for Part B, Education can be liable to return non-Federal funds equal to the amount by which the LEA failed to meet the MOE, or the amount of the Part B sub-grant in that fiscal year, whichever is lower. The justification for this MOE and payback requirement is termed "a harm to an identifiable Federal interest." As of the writing of this report, Health and Education have not determined if a waiver or other adjustment to the MOE will be requested from the federal government. The agencies are continuing to discuss options for how Health may meet the federal MOE for the upcoming fiscal year in light of the expected budget cuts.

Generally, Health has interpreted the MOE requirements to mean that it can only count State funds (not local funds) in its calculations and that it can only apply the fewer children exception when lowering the State's funding commitment. For example,

Table 4.3 summarizes how Health applied the formula for FY2017 as expressed to the regional centers in a May 2016 conference call (before proposed budget cuts are taken into account).

Table 4.3

Wyoming Department of Health FY2017 Maintenance of Effort Calculations

Part C

11/1/2014 Child Count	FY2016 GF Expenditure	FY2016 Per-Child Amount	11/1/2015 Child Count	Total FY2017 GF MOE Level	FY2017 Per-Child Amount
1,266	$11,479,722	$9,068	1,289	$11,479,722	**$8,906**

Part B

11/1/2014 Child Count	FY2016 GF Expenditure	FY2016 Per-Child Amount	11/1/2015 Child Count	Total FY2017 GF MOE Level	FY2017 Per-Child Amount
2,695	$23,336,005	$8,659	2,612	$23,336,005	$8,934.15

Maintenance of Effort Exception

FY2017 Final MOE Level	State Commitment Reduction	Child Reduction
	-$718,697	-83
	$22,617,308	**$8,659**

Source: Legislative Service Office summary of Wyoming Department of Health information.

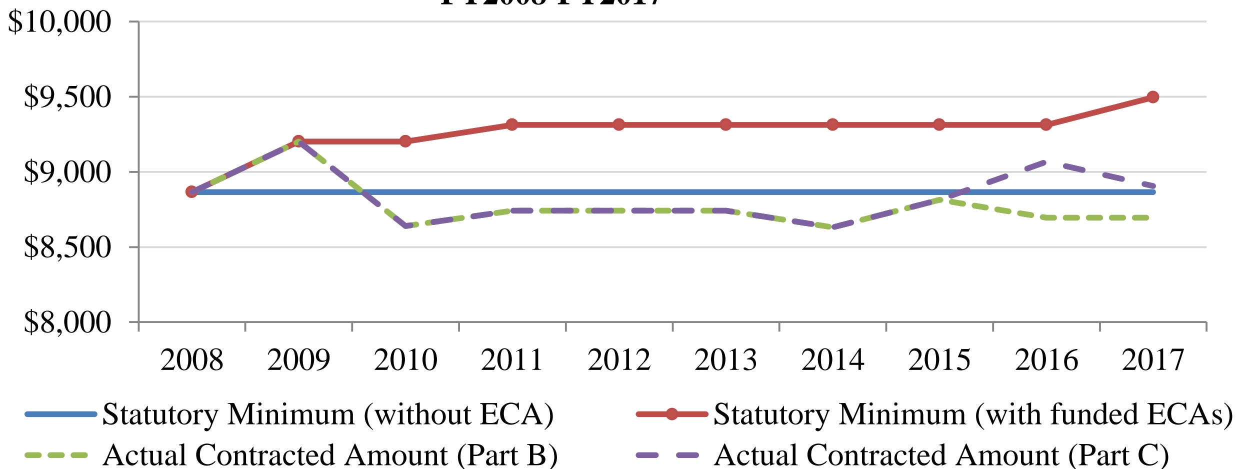
Regardless of what was in the budget request, Health's starting point for each year's contracts is the contracted amounts from the previous year. This table also shows the application of the child count numbers from November 1, 2015. Due to increased children for Part C, the per-child amount decreased due to a capitated total funding amount. For Part B, with decreased children, the per-child amount stays the same, but Health was able to deduct almost $719,000 from the total funding amount.

Additionally, even though the FY2017 ECA was appropriated at a lower amount than requested ($954,000 requested, $675,000 funded), it does not have the same impact on each program. Importantly, even as the ECA is supposed to augment Program funding, which has traditionally been applied by Health to the per-child amount, the FY2017 per-child ECA amount of $173 ($675,000 divided by the 3,901 child count) instead barely off-sets the per-child amount reduction for the Part C program of $161. During interviews and observations, LSO heard regional centers express confusion at how the ECA would allow regional centers to break even on the per-child amount rather than see the per-child amounts increase by the full $173.

Health's Child Count, Budgeting, and Contracting Practices Result in Irregular Funding and Confused Centers

The use of the MOE to maintain a constant, if not decreasing, level of State commitment has resulted in fluctuating and unpredictable funding for the Program. After the per-child funding amount was lowered to $8,639 (an approximate 6.1% cut) in FY2010, Health has chosen to use previous years' per-child contracted amount, rather than the base amounts shown in W.S. §21-2-706 (inclusive of the FY2009 and additional ECA amounts) to build its budget request to the Legislature. As the Legislature has generally followed these requests, the Legislature is funding not based on the statutory model, but Health's administrative methodology.

Figure 4.3
Actual versus Statutorily-Driven Per-child Funding Amounts, FY2008-FY2017



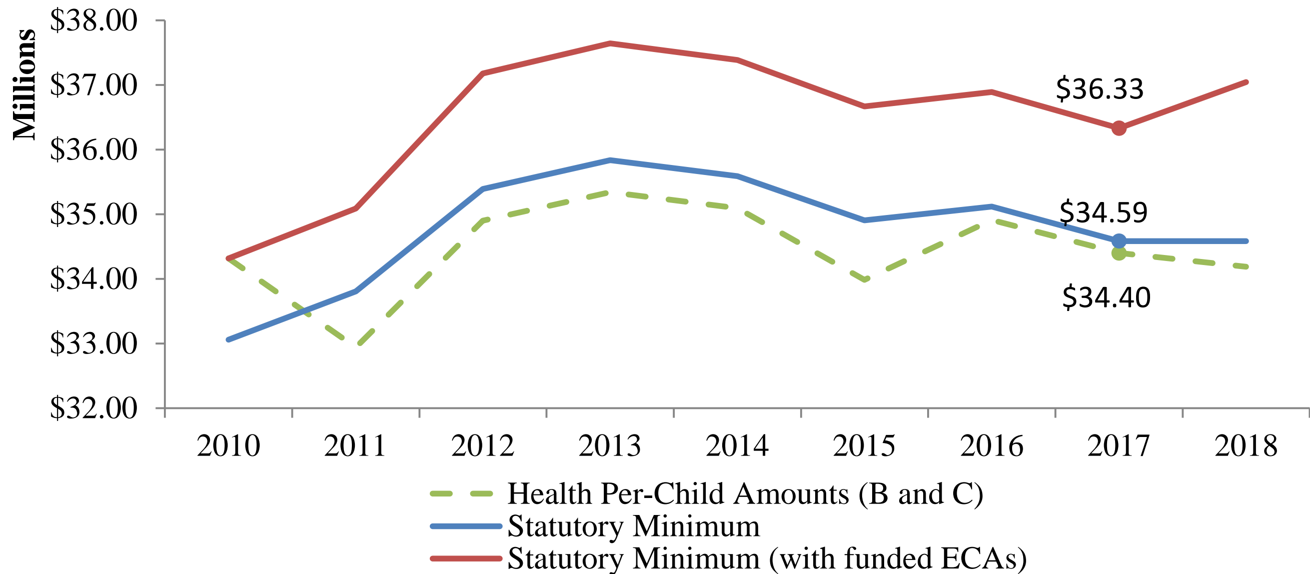
Source: Legislative Service Office analysis of Wyoming Statutes and Wyoming Department of Health information.

Figure 4.3, above, shows a graph comparing the expected per-child amount based on statute to the actual per-child amounts used by Health and the Legislature to fund the Program. As noted, the per-child amount has fluctuated from year-to-year from the amount set in statute (viewed by LSO as the statutory minimum) with and without accounting for the ECAs funded by the Legislature. Note that between FY2010 and FY2017, Part B State General Fund per-child amount has not met the $8,866 minimum (which does not account for funded ECAs). For Part C, over this same timeframe, the per-child amount only exceeded statute in FY2016 and FY2017[3].

[3] FY2017 amounts reflect the appropriated funds after the 2016 Budget Session, but without accounting for the Governor's proposed $6.7 million budget cuts.

Figure 4.4, below, illustrates the *potential* budget impacts of the different per-child amounts referenced in Figure 4.3 back to FY2010. For example, if the per-child amount for FY2017 followed the model including accumulated ECAs ($9,313 per-child for FY2016), the FY2017 budget request would be approximately $36.3 million ($9,313 multiplied by 3,901 children from the November 1, 2015 count). If the child count stayed the same, the FY2018 base budget request would be approximately $37 million, which includes the 2017 funded ECA of $675,000 (a $173 per-child, or 1.9%, increase). For FY2017, there is almost a $2 million difference between the $34.4 million level of Health's per-child amount compared to the statutory amount with ECAs at $36.3 million.

Figure 4.4
Potential Budget Impacts of Health and Statutory Model Per-Child Funding (with and without ECAs)



Source: Legislative Service Office analysis of Wyoming Department of Health and budget information.

Therefore, as the child count information changes, the per-child amount will fluctuate, both between budget and contract amounts for a fiscal year, but also from contract year to contract year. This uncertainty makes it difficult for regional centers and those outside Health to understand why the per-child budget request amounts (on which appropriations should be based) differs from the amounts set in statute and contracts. Additionally, without going back to the statutory amount to build each request, Health has essentially implemented a rolling per-child amount that is based entirely on differing assumptions and conditions from previous years, and no longer on statutory provisions.

Overall, while statute says the per-child amount should start at $8,866 and with any previously funded ECAs added thereafter, the vital issue is that Health is not using the same information to apply to the budget request and contract payments. This practice effectively eliminates any predictability for regional centers that serve the Program's eligible children.

Recommendation 4.1: Health should build its budget request using the Program statutory funding model outlined in W.S. 21-2-706 when submitting, through the Governor, its biennial and supplemental budget requests to the Legislature.

In complying with these requirements, Health should:

- **Adjust its budget submission to the Governor prior to the December 1st budget submission deadline with the most recent child count data of the year in which the submission is made.**
- **Inform the Legislature each time the per-child funding amount used for regional center contracts of the year in which the budget is submitted differs from the statutory amount. Health should identify the reasons for the different contract amount.**
- **Quantify and report to the Legislature the per-child funding amount increase of all external cost adjustments funded by the Legislature to date.**

Following the statutory funding model requires a joint effort by Health and the Legislature to understand what the model requires and what level of commitment the State is willing to make. Yet due to budget requests that do not follow the model, Health has effectively taken the policy decision for affirming the Program's funding acceptability out of the Legislature's hands. The model starts with Health building and submitting its budget request according to statutory principles. If the Legislature does not fund the requested amounts, Health will have clear indication that the Legislature does not want the model fully funded and can contract accordingly with regional centers.

Recommendation 4.2: Health should annually report to the Legislature's Joint Appropriations Committee prior to budget hearings the most recent maintenance of effort determination for both Part C and Part B programs.

This report should include both the aggregate budget and expenditure levels the State must maintain, and the potential impact on the per-child amount used for upcoming regional center contracts. For Part B, the report should include the eligibility

component and compliance component for the most recent years that Health and Education have a determination.

Policy Consideration

The federal maintenance of effort appears to be the biggest determining factor for the current per-child amount. Regardless of the budget request, Health targets Program expenditures to the previous year's MOE level and either reduces the per-child contract amount to fit with child count increases or looks to reduce the MOE when child counts go down. Despite the statutory requirements of the funding model, it appears Health believes that the MOE should be followed to assure that the Program contains costs.

Additionally, in reference to the previous Chapter 3 finding, Health has restricted the child count standard to closely resemble the federal standards. On one hand, while these approaches may be financially beneficial to the State, neither approach appears to follow the Legislature's original aim to reshape the funding model. Yet on the other hand, as one stakeholder noted, the model is intended to maintain a robust infrastructure as much as it is to fund each child's service needs.

If cost containment is what the Legislature believes is necessary to pursue or assure, it may be time to reassess the State's role and level of financial commitment for the Program. Eleven years have passed since the Legislature commissioned and funded the Goetze Study to understand Program costs and infrastructure considerations. This moment appears to be an opportune time for the Legislature to revise its understanding of the system and to confirm or modify its overall approach to maintaining the Program and infrastructure.

The Legislature could consider a new study, similar to the one funded in 2004-2005, to update regional centers' costs information and review alternative funding models and/or methods of reimbursement.

Below are example issues to consider if the Legislature revisits the model. Several of these issues interplay with, or build on, each other and may also require some discussion with specific recommendations in this report. Reviewing any of these policy considerations may need to be completed with differing assumptions, as expressed by Health staff in the past. This includes whether the State wishes to continue to receive any federal funds for the Part C and Part B programs, due to the MOE impact with the federal government only accounting for about 10% of the programs' budgets, or if it wants to continue participating in the Part C program, which is an entirely optional program for the State to administer.

What Proportion of Provider Costs Will State Funding Cover?

Throughout the evaluation research, LSO received different opinions from stakeholders as to how far the State should go in funding developmental preschool services. A central concern was how the regional centers are education centers, essentially comparable to school districts. A common example is that both regional centers and school districts have a need for similar types of and trained staff (i.e. general education and special education teachers, professional therapists, etc.). Additional examples include the development or adoption of standard curricula and ongoing professional development.

Under this premise, stakeholders mentioned that school districts receive 100% reimbursement of allowable special education service costs and do not have to conduct much or any community fundraising to cover unfunded costs. The developmental preschool model sets a fixed per-child dollar amount that does not cover 100% of costs to provide required services at the regional centers. However, one stakeholder stated that the per-child amount was deliberately set with consideration of other available resources in communities along with the federal funds. This amount included consideration of maintaining the regional centers and public/private partnership service delivery model.

State Funding to Cover Regular Education and Special Education Costs and Average Daily Membership Funding?

Concurrent with the previous consideration is the concern that the statutory per-child amount for the developmental preschools is expected to cover regular education and special education costs. Health's interpretation is that the State general funds are intended for Part C and Part B program-eligible children's services. Therefore, compliance with IDEA means the regional centers must meet requirements to serve children in their least restrictive, regular education environments. In other words, eligible children's service requirements include both the regular education and special education services, State grant dollars are expected to fund both types of services for these children.

In order for regional centers to meet the regular education environment, there should be typical learning peers included as more than 50% of the students in each classroom. If the typical learner ratio falls to 50% or below, the classroom may be considered a special education classroom, which by definition is not an inclusive environment. Logically, if the Program funds are meant only to cover IDEA-eligible children's services, then regional centers must be expected to fund more than 50% of their expected student population from non-Program sources.

Additionally, related to the similarities between the educational focus of the regional centers and school districts, school districts receive a separate regular education allowance as determined by the average daily membership (ADM) funding allocated on a per-child basis to the districts. This funding is intended to support the traditional, regular education services and supports for all students.

Block Grant versus Fee-for-Service Model

Related to these previous considerations, regional centers noted that with both the per-child amount and annual eligible child counts fluctuating each year, there is need for a stable funding model. Even as the State disburses developmental preschool funding as a block grant, some regional centers believe a cost-plus or base-plus grant model may be a viable option. Under this option, the system would be provided a base amount of funding to maintain basic provider services and staffing to keep the regional centers in business. The State would then provide additional, per-child or other cost-based funding for serving each child, potentially on each child's individual service needs. Additionally, while a fee-for-service model was mentioned as potentially advantageous for regional centers to be reimbursed for or close to their actual costs, administrative overhead for the providers and the State may be cost prohibitive.

Chapter 5: Program Organizational Placement and the Early Learning System

Finding 5.1: Administration for the Program is operational but the current organizational structure does not sufficiently align authority with purpose and responsibility.

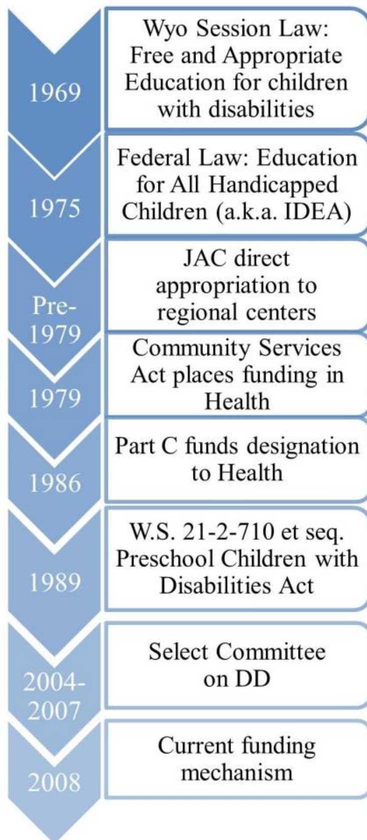
It appears early on in the Program's history, the State's or Legislature's desire for the Program was to provide broad access to services to children age birth through five years with disabilities. However, based on the Committee's question for this evaluation about where the Program should be located, it seems the Legislature has re-emphasized that the Program should also be administered optimally for the State, regional centers, and children.

Primarily due to past political, rather than programmatic, concerns, having the Program run through Health has resulted in an operational program which currently meets the requirements and purposes of IDEA. However, compared to national trends, program development has not effectively progressed beyond basic regulatory oversight. There are abundant concerns regarding the interdependent relationships between the Program, regional centers, and other stakeholders, which must be considered and planned for if the Legislature chooses to move the Program from Health to Education.

Origins of Wyoming's Organizational Structure Administering Services to Preschool Children with Disabilities

Wyoming's interest and investment in free and appropriate educational services for children with disabilities is long standing and existed years before federal laws. As early as 1969, Wyoming Session Laws Ch. 111 §284-286 stated that "each and every child of school age in the State of Wyoming having a mental, physical or psychological handicap or social maladjustment which impairs learning, shall be entitled to receive a free and appropriate education in accordance with his capabilities." See Figure 5.1, on the next page at the left, for a timeline of events related to the Program.

Figure 5.1
Program Timeline



Source: Legislative Service Office.

In addition, the law provided that each school district, subject to rules and regulations of the State Board of Education (State Board), should provide for the appropriate diagnosis, evaluation, education or training, and necessary related services for those children. If the services were not available through the district, the State Board was responsible for assisting the districts in contracting with outside agencies to ensure that the child received the needed services.

Prior to FY1980, state funding for Wyoming's developmental preschool services was by direct appropriation whereby local providers prepared and presented budgets to the Legislature, which determined the amount each program received. This method produced considerable variation in the amount of State support provided on a per capita basis throughout the state. Services to children with disabilities were largely limited to communities in which providers were located and clearly not a statewide system of services.

Funding process changes occurred with the passage of the Community Services Act in 1979 (W.S. 31-1-601, et seq.). As a result, State funds for the developmental preschool services were appropriated to Health and administered through the Developmental Disabilities Division. In 1989, the Legislature passed the *Services to Preschool Children with Disabilities Act.* This Act created W.S. 21-2-701 through 705 and established the duties of Health and Education by outlining the Legislature's policy on services and funding for children age birth through five years. The W.S. 21-2-706 was added in 2006.

W.S. 21-2-701 through 21-2-706 Designates Authority and Duties for Health and Education

As briefly noted in the Chapter 1 Background, in order to receive and distribute the federal funding to the regional centers, W.S. 21-2-702 defines the Division (currently the Behavioral Health Division) as intermediate education unit (IEU). This term has since been replaced in federal law and is now known as an educational services agency (ESA). Health is also defined as a Local Educational Agency (LEA) with similar responsibilities as school districts for developmental disability education services.

Health's role and responsibilities under Part C are clear as it is the lead agency and directly administers the early intervention program for children birth through two years. However, staff from Education sometimes refer to the Part B program as Health being the "49th school district." This organizational structure is unique in that Wyoming appears to be the only state to have a program for services related to Part B administered outside of the state

education agency. Consequently, the net result of W.S. 21-2-702 is that the statute creates a supervisory role for Education over Health specific to the Part B program.

Health's and Education's statutory responsibilities are set out in Table 5.1, below. Health is responsible for the administration of the Program and service delivery, while Education carries the legal authority with oversight of Part B.

Table 5.1
Wyoming Statute Duties for Health and Education

Duties of Health	Duties of Education
▪ Administer Education's rules and regulations promulgated under the Act ▪ Monitor the regional centers ▪ Insure children with disabilities receive services	▪ Promulgate rules to carry out the Act ▪ Monitor Health's duties as an intermediate educational unit ▪ Insure State adherence to all federal rules and regulations under IDEA for children 3-21 ▪ Distribute federal Section 611 funds to Health per statutory formula and requirements
Enter an interagency agreement to define roles and responsibilities	
Distribute Part B funds in a manner jointly determined by Education and Health for direct services to children with disabilities eligible for services under federal law	

Source: Legislative Service Office summary of Wyoming Statutes.

2011 Audit from the Federal Office of Special Education Programs (OSEP) and the 2012 MOU

The federal government, through OSEP, conducted a verification visit in 2010 to ensure compliance with and improve the State's performance under the Part B. As Education is the State agency under direct Federal oversight, OSEP found "serious concerns about Education's exercise of its general supervisory responsibility over DDD [Division of Developmental Disabilities] with respect to the implementation of the State's special education preschool program." Federal OSEP also conducted a verification monitoring for Part C, which also included a lack of general supervision finding for Health.

Education and Health corrected deficiencies and developed a memorandum of understanding (MOU) in 2012. The 2012 MOU is currently under revision with plans for completion in 2016. Table 5.2, below, illustrates the roles and responsibilities of Health and Education pursuant to the 2012 MOU, indicating how the agencies developed objectives related to specific federal findings.

Table 5.2

Example Roles and Responsibilities from 2012 Part B MOU for Health and Education

Responsibilities of Health	Responsibilities of Education
▪ Implement a comprehensive monitoring system and ensure correction of noncompliance in accordance with Education's monitoring process and manual ▪ Provide Education with quarterly progress reports on regional centers covered by corrective action plans ▪ Complete monitoring activities and documents as requested by Education and within set timelines ▪ Complete all required data submissions, utilize the Grants Management System (GMS) for grant submittal and ensure allowable use of federal funds ▪ Ensure that regional centers provide services in compliance with Part B and Education's rules, policies, and procedures ▪ Ensure smooth transition from Part C to Part B in alignment with IDEA requirements ▪ Ensure staff are trained in IDEA dispute resolution processes and procedures ▪ Provide technical assistance and professional development to regional centers	▪ Conduct monitoring activities to validate and verify the accuracy of the Health's identification of noncompliance and timely correction of noncompliance ▪ Independently monitor additional regions each year and re-monitor (verify) at least two regions from the previous year ▪ Make an annual determination regarding the performance of Health each year using State Performance Plan indicators ▪ Provide access to the Grant Management System (GMS) for Health and review all grant requests to ensure allowable use of federal funds ▪ Review all Health policies and procedures to assure alignment with Education's and IDEA ▪ Ensure smooth transition from Part C to Part B in alignment with IDEA requirements ▪ Conduct all dispute resolution activities ▪ Provide technical assistance to Health and the regional centers

Source: Legislative Service Office summary of 2012 Part B memorandum of understanding between the Wyoming

System Development Through Coordination, Consolidation, or Creation

In researching organizational structure options for this evaluation, LSO found that the structure of an organization should support its purpose and performance. A sound organizational structure aligns functions, the location of each function, and the positioning of authority and responsibility in decision making.

According to the BUILD initiative, a national organization which offers states technical assistance for developing comprehensive early childhood programs and services, states have three options on how to develop their early childhood learning systems:

- Coordination;
- Consolidation; or
- Creation.

Coordination means common work among different agencies, each with administrative authority that is expected to collaborate through formal agreements. **Consolidation** means multiple programs are administered by the same agency, commonly centered in a state's education agency. **Creation** means a new agency is established with the primary purpose and authority over early childhood learning and care services.

Each organization/administrative structure offers advantages and disadvantages in their functioning. For example, under the "coordination" structure, effective mission setting or leadership may not occur at the individual agency level, but may require higher level leadership, initiative, or planning, perhaps at the Governor or legislative level. With the "creation model," while potentially beneficial to gain a cohesive message and strategy among many programs, this model relies on centralizing many programs, funding, and staff.

The current structure of the Program between Health and Education resides firmly in the "coordination" realm of the State's early childhood learning system. Yet, as noted below, this level of organization, interaction, and operation does not appear to maximize and efficiently use Health's and Educations resources. These concepts are equally applicable to Finding 5.2 regarding the overall early childhood learning system, beginning on page 72 of this report.

Current Organizational Structure Challenges Prevent Administration Optimization

It is important to note that Wyoming is one of sixteen states that houses Part C and Part B in the same agency. However, Wyoming is the only state combining Part C and B administration outside of its state education agency.

Recently one State official made comments to a legislative committee that Wyoming has "flip flopped" health and education programs when compared to other states. A comment was made that "in all states except Wyoming, Part B and Part C reside in Education" and it was curious that Education has vision and hearing impaired programs as logically one would expect these programs would be located within Health. Another comment made by a State official noted that Part C and Part B services are similar and that the main difference is the age requirement of the recipients. Finally, another comment was made stating that Education has no obligation to serve children until they are in school (K-12 system) and even then it is the districts' responsibility.

These example perceptions illustrate the misconceptions, or misperceptions, about the Program's legal authority and responsibilities which are the main challenges of the current organizational structure. Neither Health nor Education has a complete understanding of either Part B and Part C respectively, and how they relate to each other within their own agency and across both the agencies. For example, Education does not appear to have a clear understanding of the State General Fund statutory funding model, how Health implements it, and how this can impact or be impacted by the federal maintenance of effort requirement for Part B, which is ultimately Education's responsibility according to the 2011 federal audit.

Additionally, although the budget for the Program is the third largest in Health, its human resource capacity, while being efficient, is limited in supporting professional training, guidance, and individualized technical assistance to meet the regional centers' needs. Without the positive working relationship and resources within Education, the regional centers would not have access to current professional development venues, which are typically sponsored by Education through the school districts. In the end, the following program challenges and inefficiencies were observed.

The Administration of The Program is Fragmented, Duplicative, and Impacts the Performance

Neither Health nor Education are able to assume complete authority, responsibility, and accountability for the Program in such areas as rule and regulations, monitoring of regional centers, grants management, data collection and reporting systems, and outcomes. The end result is that administration is fragmented and neither agency has full knowledge of the scope of duties, requirements, performance, and results of the Program.

- **Authority and Responsibility for Rules and Regulations:** Health states the rule making authority for administration of the Part B program belongs to Education. While Education's Chapter 7 eligibility rules provide guidance and criteria related to special education services for children ages 3-21years, until recently, Health and Education interpreted statute to provide Health with rule making authority related to the funding model for children age three through five year.
- **Part B Monitoring:** As referenced earlier in this Chapter, Education establishes the structures and processes for monitoring. However in implementing Part B monitoring visits, there is duplication and related inefficiencies. For example, in the monitoring visits observed by LSO, Health and Education staff go to the regional centers at the same time and

Education reviews casefiles to verify Health monitoring team's casefile assessments.

While timing these visits together reduces some inefficiencies there is confusion as to whether Health or Education leads the monitoring and which agency has charge over regional centers corrective action plans. During recent collaborative meetings, Education suggested that it assume all the monitoring functions. However, Health indicated it would need to consider the appropriateness of this action given Health's statutory responsibility to monitor the regional centers. In many ways, Health is acting as the "middle man" in that Education is conducting the monitoring in addition to Health.

- **Data Management and Federal Reporting:** There were inefficiencies and discrepancies observed regarding Health and Education's management of data collection and reporting. Both agencies appear to exert a lack of ownership regarding which agency is ultimately responsible for the Part B data. Education considers the data is "owned" by Health, but as the State Education Agency, Education is responsible to collect and report data to the U.S. Dept. of Education. As discussed in Chapter 2 related to the number of children in Part B, by disability category, LSO discovered that Education reported Part B data to the federal government that appears mismatched with what Health reported to Education.

  Additionally, in the past, staff conducted data validation checks during the monitoring visits with the regional centers. However, Program staff told LSO that they were directed by Education to discontinue this type of monitoring because of legal concerns regarding differences between the paper casefile and the data reported into the Program's software program, SEAS. The current SEAS software program utilized by Health includes a $50,000 maintenance fees per year for a system with serious deficiencies. Given budget constraints, Health states there is no funding to replace the SEAS system. However, the resources in Education have not been considered or leveraged for the Program.

- **Outcomes:** For a number of years, Education has allowed student identification numbers from its WISE data system, called WISER IDs, to be assigned through Health for the Part B children. However, during the evaluation, LSO learned that some regional centers can call Education directly to receive a WISER ID when they cannot receive a timely response from Health. There were further conflicting comments between Education, Health, and the regional centers regarding the access to and management of the WISER IDs. This inefficient

process is impacting systemic capacity to effectively collect and analyze longitudinal data to gauge the Program's ultimate impact and outcomes.

The Program also utilizes the Child Outcome Summary (COS) by requiring providers to assess children's progress at program entrance and exit. This COS has been a work in progress for at least eight years. It was created through Wyoming stakeholders and the scoring and reporting framework is led by Health. The developmental process has been compromised over the years by staff turnover in Health, leading to no clear direction, policy, or consistency in the COS' use among the regional centers. Additionally, according to current Health and Education staff, Education has not historically been involved in development or implementation of COS, despite its impacts for reporting Part B information to the federal government.

- **The Grant Management System:** Education controls access to its Grant Management System (GMS), which is the grant and administration system for grant announcements, applications, awards, payments and reporting within Education. Education provides access to Health for the uploading of information for Part B. Both agencies, per the MOU, are responsible for submitting grants and meeting the requirements for allowable use of the federal funds. Part C grants are managed directly between Health and the U.S. Department of Education.

The Program Lacks a Strong Foundation of Effective Governance

Generally, LSO could not determine that the Program has been overtly harmed by its placement in Health, at least related to the current front-line staff at both Health and Education. Health and Education staff are engaged in positive working relationships with progress noted by both agencies since January 2015. Current staff in both agencies appears knowledgeable and are executing their job responsibilities. Recent collaboration on monitoring visits, while possibly redundant, has helped promote more transparent regulatory compliance. Essentially, the Program is operational, funding is flowing to regional centers, and services are being delivered and monitored.

Yet the Program's location in Health can be described as misaligned as its role is to provide support to early intervention and education services for young children with disabilities. At a basic level, the mission of Health is to "serve the healthcare needs of Wyoming residents" and Education's role is to administer the public education system. Functionally, the Program has limited or no connection with other programs in Health's developmental disabilities section, or with Health's other divisions, programs, or units.

Program lacks an effective governance structure that aligns authority and responsibility for making program, policy, and fiscal decision making. For example, Health officials assert concerns regarding its restricted ability to make decisions and perform program functions due to impediments of Education's authority over Health. Health is obligated to execute Education's rules and policies. Education and Health also noted that regional centers have been known to shop for responses between the agencies' staffs on issues of compliance, training, or other regulatory or administrative items.

What is not in place in the organizational structure is the singular or combined leadership that demonstrates a clear vision and purpose of the Program which actively guides decisions and direction. According to a previous Legislator and many stakeholders, irrespective of the organizational structure, the Program should be administered by an agency that can move beyond Program maintenance. In the past, when working relationships between Health and Education have been fragmented, the Program lacked cohesion of staff, resources, and direction.

Features of the Current Organizational Structure

The Program has endured staff turnover both at Health and Education. Historical documents are not readily available and the Program is functionally managed by staff that is in place at a given time. In fact, staff noted that only through LSO's evaluative process has Health begun to organize and save legacy documents to maintain Program administrative consistency in the future.

The regional centers voiced concerned regarding changing practices and inconsistencies in the content of communication between Health and Education, and between staff within the Program unit. One of the chief concerns both at the local and state level centered on Program staff credentials and experience. Based on a comprehensive review of credentials, duties, responsibilities and performance, LSO concludes that Program staff has both the credentials and experience in early childhood to sustain the Program. Additionally, Education staff have longstanding histories in Wyoming's special education system.

Program Coordination with Other Health Programs is Limited

The Program has been continually located within the developmental disabilities structure of Health. There are limited linkages within Division programs and between other programs within Health. The closest relationship is with the Maternal and Child Health Unit. Primary interactions occur through representation on the federally required advisory councils. Additionally the "Help Me Grow" initiative through Maternal and Child Health provides outreach

assistance in developmental screenings and improving access to resources and services. This initiative does not overlap with the Program but involves the work of the regional centers.

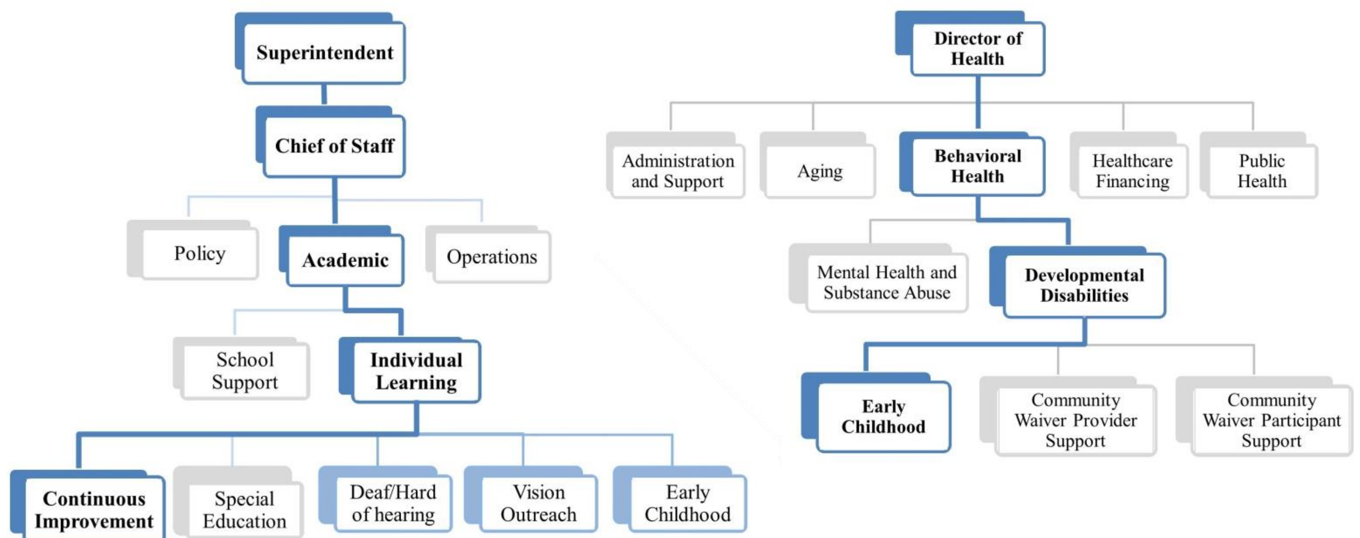
Education Oversees Numerous Programs that Complement the Program

Direct oversight from Education of the Program falls under the Continuous Improvement Program. The Division of Individual Learning is responsible for the Continuous Improvement program as well as other special education related programs, such as dispute resolution, K-12 special education monitoring, outreach services for deaf and hard of hearing individuals, and vision outreach services.

The two outreach programs provide services and oversight of services for hearing and vision for individuals of all ages, to include students served at the regional centers. There is also a newly transferred position to the Division of Individual Learning (i.e. Early Childhood Consultant). This position is responsible for grant administration, reading intervention, oversight of the Temporary Assistance for Needy Families (TANF) grant program, coordination related to the Every Student Succeeds Act, and coordination for federal Title 1 funds.

Illustrated below in Figure 5.2 are organization charts for Education and Health which displays programs that have direct or indirect roles and duties related to the Program.

Figure 5.2
Department of Education (left) and Department of Health (right) Organization Charts



Source: Legislative Service Office summary of FY2017-2018 agencies' budget requests, staff interviews, and agency websites.

<u>Program Operates as Necessary in Health with Current, Expected Collaboration from Education</u>

The administration of the Part C and Part B programs is problematic because of the different regulatory structures in federal and state statutes. This structure requires the Program staff to "juggle" two different programs with limited resources. However, given these constraints, staff are efficiently managing the core functions of the programs, including budgeting for and distributing funds through contracts with the regional centers to fulfill the basic compliance monitoring requirements.

At the time of the 2011 federal audit, the environment in Education included extraordinary staff turnover and there was no framework created or managed related to the Program. While both agencies have been impacted by staff turnover, LSO recognizes that current staffs from both agencies are making progress in re-building the necessary relationships to support Program infrastructure. For example, Health and Education engage in monthly collaborative meetings to review compliance with the interagency agreement. The cooperative working relationship between Health and Education appears beneficial to both agencies.

Establishment of the Program in Health vs Education is Based Mostly on Historical Political Debates

The history of early childhood disability services in Wyoming started through grass roots movements. In the 1960s and 1970s families recognized the need for services for their young disabled children and communities reportedly began self-funding services to meet these needs. State funding became available in the 1970's and over the next decade federal funds became available as well.

Interviews with key professionals who had historical experience in the formation of the Program stated that Wyoming decided to support the public-private partnerships between the State and regional centers. It was reported that regional centers were asked by the State to start providing Part C services in the 1980s because of the limited number of providers in rural areas. Communities have influenced the regional variations of the centers' business practices and local support has been instrumental in making the centers what they are today.

Arguments can be made that the Part C services are family focused health prevention and early intervention services, just as Part B are education services specially designed to meet the unique needs of a child with a disability. Further arguments can be made whether it is one program, or two. From the federal perspective Part C and Part B are two distinct programs, but with related and complementary service requirements and goals. Wyoming statute

speaks to services for children with disabilities birth through five years of age. This has created the conditions wherein Part C and Part B are integrated and embedded so that it is difficult to separate and missions and purposes of each at the state level.

One explanation for the Program being placed within Health was attributed to the alignment of Part B and especially Part C programs and professional staff with the health sciences professions, which distinguish regional centers from the teaching professions in K-12. Another explanation credited the contentious relationship between the Superintendent of Public Instruction with the Legislature wherein it was decided that the Program would be administered within Health. Political posturing was said to have prevailed instead of alignment of program services with the purposes of federal law or within the mission of the administering agency. Irrespective of the historical consideration and ultimate decision making, it is clear that the placement of the Program continues to be one of debate.

Is the Grass Greener on the Other Side of the Fence?

LSO conducted a survey of the regional centers, as well as site visits and interviews, and asked for feedback regarding potential administrative changes for Part C and Part B and whether the Program should be administered within one agency or two. The clear majority of responses were that Part B and Part C services should remain integrated and administered by one state agency. There were varying comments, however, as to whether the Program should remain in Health or be transferred to Education. Many centers feel the Program could be better aligned in Education through state curriculum, assessment, and professional development focusing on the same results.

LSO also asked Health and Education about their positions regarding where Part C and Part B programs should reside. The leadership of Health is clear and consistent in recommending the transfer of both programs to Education. Front line staff in the Program unit also generally agree that Education may provide better programmatic alignment for Part B and possibly also for Part C. Education on the other hand welcomes dialogue and collaboration in determining what is best for early childhood education and learning in Wyoming.

Administrative Priority of the Program is Secondary to Other Developmental Disabilities Programs in Health

A common perception in the history of the Program is that the greater administrative demands of other programs in the Division have taken priority over the Program. A review of the Program's development provides evidence that apart from meeting federal and

state requirements, the Program has not developed over time and has primarily focused on meeting federal compliance with IDEA.

These conditions can be attributed to leadership direction, management support, and limited resources. The amount of FTEs dedicated to the Program are sufficient to manage basic oversight monitoring and contract functions but t resources are taxed to manage policy, rules, data , training, technical assistance and professional development, which are goals noted by Program staff. Based on State and local stakeholder feedback, the current organizational structure does not appear to be aligned to meet these goals.

Policy Consideration

As noted at the beginning of this finding, it appears the Legislature's concern with organizational placement of the Program re-emphasizes the desire for optimal Program administration. Taken together with concerns over the funding model discussed in Chapter 4, there also appears to be thought to the level of care or duty the State has for the Program: merely providing funding for services, or providing for and assuring the best possible services (akin to the K-12 system).

While LSO received feedback on these themes throughout this evaluation, a core concern among stakeholders is for the Program to have cohesive leadership that works to assure consistency, efficiency, and support in program administration. Input ranged from statements like "[i]t doesn't matter where the program is placed as long as there is a program champion because support for the program is more important than its organizational placement." Most of the recommendations favored a move of Part B to Education, but with a strong caveat that Part C needs to remain administratively attached to Part B. However, LSO believes immediate movement of the Program from Health to Education would likely have undesirable consequences without full consideration of Program funding, staffing, regulatory, and other functions.

The Legislature could consider amending statute to move the Program (both Part C and Part B) from the Department of Health to the Department of Education, with adequate consideration of a defined, strategic transition plan to ensure, at a minimum, the following:

- ***Program funding, contracts, and services remain uninterrupted;***
- ***Program oversight and monitoring maintain the principles of the systemic concerns brought out in the 2011 federal audit;***
- ***Changes to Program roles and responsibilities should include input from all relevant system stakeholders, especially from Health, Education, and the regional centers;***
- ***How the receipt and disbursement of state and federal funds from the State to the regional centers may need to change if the centers maintain private non-profit status or become public agencies, similar to or incorporated into school districts.***

In addition to the above broad considerations, Table 5.3, on the next page identifies more specific consideration of transferring the Program to Education under different scenarios. Overall, there is no easy fix or resolution to the organizational structure. This policy consideration is intended to aid in future discussions related to continued administration of the Program within Health or potential transfer to Education. Immediate movement of the Program from Health to Education would likely have significant adverse impacts without full consideration of the intended and unintended consequences of a change in administration.

Finally, other policy considerations made in this report may be impacted by how the Legislature chooses to move forward with organizational placement of the Program. The Chapter 4 consideration on the funding model revision as well as the consideration related to revisiting legislation for an Office of Early Education or Office of Early Learning will be greatly influenced by this organizational movement.

Table 5.3
Advantages, Disadvantages, or Other Considerations for Different Scenarios for Moving Part C and Part B to Education

Move Part B to Education	Move Part C to Education	Move Part C and Part B to Education
✓ Education is well versed in Part B for children age six years and older ✓ Part B duties and functions align with Education's mission ✓ Current Part B Coordinator has ability to administer the program in Education ✓ Chapter 7 Rules are the same for Part B and K-12 system ✓ Continuous Improvement-Focused Monitoring System would be inclusive of all Part B, children age three though twenty-one years ✓ Alignment of Part B with K-12 in the areas of assessment, curriculum, teaching, data systems, etc. o Education believes it is only authorized to offer special education services to children once they reach kindergarten	✓ Greater coordination of children transitioning from Part C into Part B and the K-12 system ✓ Current Part C Coordinator has ability to administer the program in Education o Education has limited knowledge or expertise about Part C services, particularly the family-centered practice approach o Part C could be isolated and the services misunderstood as Part C is not a strictly education program o The program could be dramatically cut or eliminated as evidenced by June 2016 proposed cuts to the vision, and the deaf and hard of hearing outreach programs	✓ Education's recent realignment process may create an opportunity to organize the Program with clear mission and function inside the department ✓ MOU would not be needed ✓ One agency would manage ▪ Fiscal accountability ▪ Monitoring responsibilities ▪ Ability to leverage other federal funding sources ▪ Professional development, technical assistance and support functions ▪ Data collection and reporting systems, and ability to monitor long term outcomes ✓ More diverse staffing resources and supports to mitigate staff turnover issues for Part B ✓ Transition of children age birth through twenty-one years would be more seamless, coordinated and consistent through functional relationships between providers and school districts ✓ Stakeholder consensus appears to support the move ✓ Enhanced coordination with other Education programs, such as vision and hearing services and child outcomes assessment functions o The Program could be overshadowed by K-12 needs o Education staff have concerns about existing personnel capacity to provide adequate services *if Health's program resources are not transferred to Education* o Funding impacts are currently unknown, especially related to the flow of federal funds, MOE, and the private/ public status of centers (different than school districts) o Regional centers likely cannot apply directly through Education's GMS for federal grant funds

Source: Legislative Service Office.

Finding 5.2 The Program is a part of the overall early childhood learning system in the State, but appears to be viewed independently or separately of other programs, services, and funding.

While conducting research on this evaluation, LSO quickly learned that Part C and Part B funding, children, and services cannot be easily separated from other components of the State's overall early childhood learning system, both at the State and local levels. Parents and families, providers, children, and funding from different programs affect the entirety of early learning services for children with and without disabilities throughout the State. LSO learned that the integration of resources, children, regional center staff, and local system priorities all play a role in how the regional centers and other local providers are able to operate. While initial Legislative efforts in 2014 to create an Office of Early Learning did not pass, LSO believes it appropriate for the Legislature to reconsider these efforts.

Regional Centers Business Models Differ Based on Their Individual Communities' Needs and Funding Resources

Each program funding source, with its separate and distinct requirements, practices, or processes impacts how the regional centers provide service to Part C and Part B children as well as others within their communities. Evaluating the Program for outcomes, quality, compliance, and consistency is difficult given the administrative structure. The diversity of funding sources and programs utilized by the regional centers also does not offer simple conclusions as to how much or how little the Program alone is able to accomplish.

Several factors influence this perspective, including how the regional centers:

- Generally developed programs and community networks prior to the passage of IDEA and its precursor acts, to meet individual communities' child care and service needs.
- Must not just serve developmentally disabled children in order to meet FAPE requirements within the IDEA for inclusive classroom learning environments.
- Must obtain a variety of funding sources, braided or blended, to establish and maintain their regional centers.
- Must provide a basic/regular education preschool program and staff as well as provide for the special education and related service supports to IDEA eligible children.
- Generally develop both formal and informal relationships and to coordinate with other community childcare providers and school districts.

Even as each regional center operates as a separate business and service provider for their communities, they each appear to incorporate coordinating and collaborative principles to assure funding and services are provided where needed. For example, multiple regional center staff stated that they will pay tuition for some children served by other daycare or preschool providers so that a child can be served in an inclusive environment and comport with families' care wishes. In these cases, regional center staff go to other locations to provide direct services to IDEA-eligible children. These staff also coach or train other providers' staff on the services and follow-through activities with the children so that there is continuous practice for both the students and staff.

Regional Center Resources

To put the various regional center approaches into perspective, LSO also requested financial information from the regional centers to understand how these providers meet their obligations under IDEA. Table 5.4, below, shows the different business models used by the regional centers to accomplish their obligations for the Program. This issue goes beyond the statutory requirement that providers come up with a 3% local cash match for the Program grant dollars they receive from the State. Each center must find multiple ways to supplement their businesses with other government and private pay sources in order to completely fund the requirements of the Program, such as billing Medicaid for eligible children's services.

Keep in mind that services for Early Head Start (EHS), Head Start (HS), Temporary Assistance for Needy Families (TANF), and the Program (EIEP) may be provided at an alternative location from the facility owned or leased by the regional centers. Examples of "Other" funds include fundraising campaigns, donations, and other government or private sector programs' grants for facilities, vehicles, or other costs.

Table 5.4

Regional Child Development Center Providers' Funding Sources

Region	EIEP	EHS	HS	TANF	Private Pay	Other
1	x				x	x
2	x				x	x
3	x		x	x	x	x
4	x	x	x	x	x	x
5	x		x	x	x	x
6	x				x	x
7	x				x	x
8	x				x	x

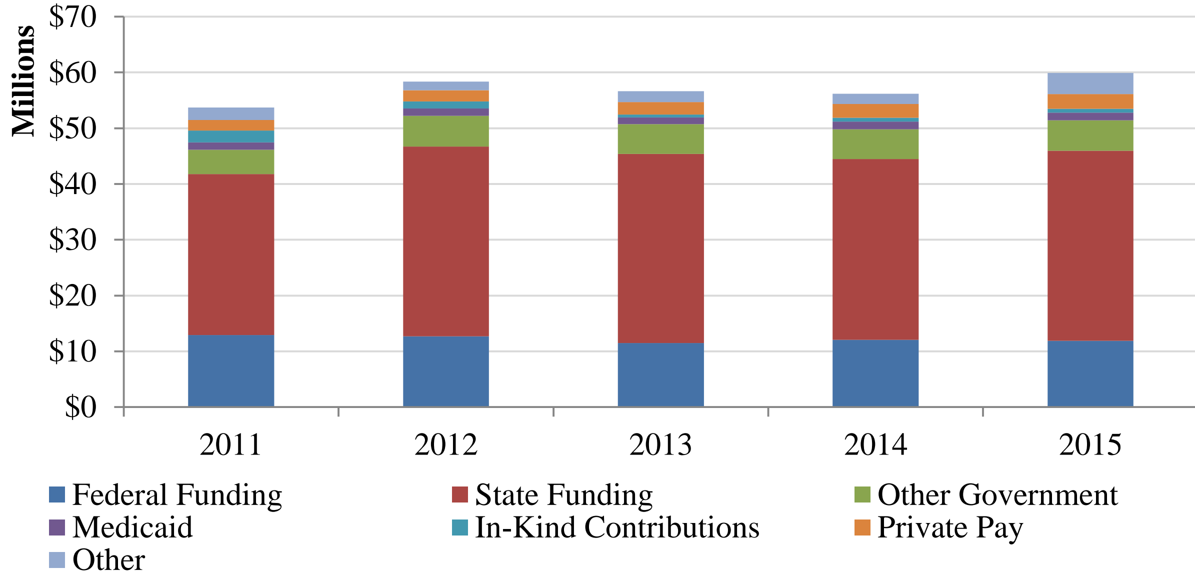
Region	EIEP	EHS	HS	TANF	Private Pay	Other
9	x				x	x
10	x	x	x	x	x	x
11	x				x	x
12	x				x	x
13	x	x			x	x
14	x			x		x

Source: Legislative Service Office analysis of regional child development center providers' information.

<u>Program Funds Account for Majority of Regional Center Resources</u>

LSO requested regional centers to provide their fiscal year funding for the last five completed years, based on different funding sources. The request was for full budgetary coverage, to include government (federal, state, and local) and non-government sources. Medicaid funding was specifically requested to be separated from other state and/or federal funds. While LSO did review regional centers' most recent Program applications and example financial audits required of their contracts, LSO could not independently verify centers' responses.

Figure 5.3
All Regional Child Development Center Funding by Source, FY2011-FY2015



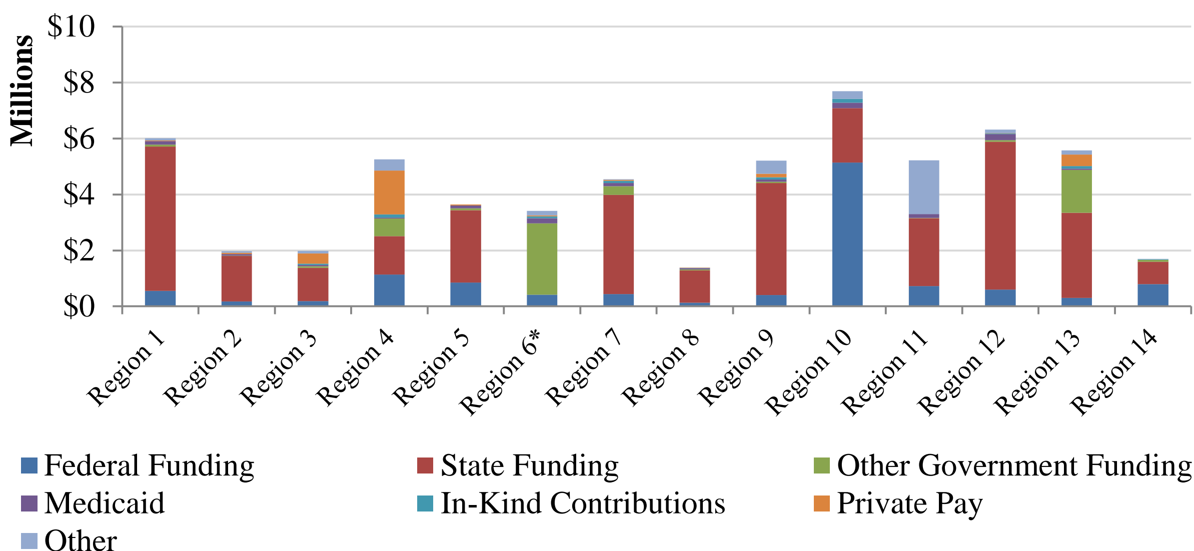
Source: Legislative Service Office analysis of regional child development center providers' information.

Figure 5.3, above, summarizes the responses from the regional centers. The figure shows that in total, the centers annually received/budgeted between about $54 million (FY2011) and almost $60 million (FY2015) for their operations. Overall, State funds, primarily from the Program grant dollars for Part C and Part

B, accounted for more than half of the centers' total funding, toppng out at 59.8% in FY2013.

Figure 5.4, below, provides similar information as the preceding figure, except it shows the funding by each region for FY2015. The proportion of Program funds for each center is different. For example, in FY2015, only 26.1% of funding in Region 4 were from State dollars, but 85.8% for Region 1 were from State dollars.

Figure 5.4
Individual Regional Child Development Center Funding by Source, FY2015



Source: Legislative Service Office analysis of regional center information.
* Region 6 placed all non-federal government funds, including State general funds, into the "Other Government Funding" category.

Program is Part of Network of Early Learning Efforts

Throughout this evaluation, LSO learned of a multitude of programs, services, and supports offered by a variety of state, local, and private agencies that impact the Part C and Part B programs and early childhood care and education in general. In order to put the Program into perspective among other early learning programs, LSO contacted several State and federal agencies to outline government-funded early learning programs. **Appendix F** provides summary information provided by several different agencies related to early learning in the State. Table 5.5, on the next page, outlines the most integral agencies and programs that specifically impact, or are impacted by, the Program and regional centers.

Federal law and regulations require an advisory group be established for each of the Part C and Part B programs. The advisory groups are made up of individuals such as parents of

students with disabilities, providers, program administrators, legislators, and individuals with disabilities.

Table 5.5
State Program Used by or Impacting Program Regional Centers

Wyoming Department of Health	Wyoming Department of Education	Department of Family Services	Wyoming Department of Workforce Services
• Part C Program • Part B Program • Maternal and Child Health	• Title IA Preschool Funding (through school districts) • TANF Preschool Coordinator • Continuous Improvement Monitoring (for special education and oversight of Health for Part B Program) • Outreach for Vision Services • Outreach for the Deaf and Hard of Hearing	• Childcare Licensing • Community Partnership Grant Program • TANF Preschool Grantor • Childcare Subsidy Payments	• Head Start and Early Head Start Collaborator • WY Quality Counts

Source: Legislative Service Office summary of state agencies' information.

Federally Required Councils Help Advise Health, Education, and the State

The Early Intervention Council (EIC) is established to satisfy requirements under Part C to provide advice related to children with disabilities ages birth through two years. The Wyoming Advisory Panel for Students with Disabilities (WAPSD) is established for all Part B programs to counsel the lead agency (Education) in areas related to children with disabilities ages three to twenty-one. The functions of the advisory groups are prescribed in federal law and include functions such as identifying sources of fiscal and other support services for early intervention service programs, the transition of children receiving services to preschool and other appropriate services, and reporting annually to the Governor on the status of the Program.

Wyoming Early Childhood State Advisory Council

Through Governor's executive order EO 2010-2, the State also operates the Wyoming Early Childhood State Advisory Council, made up of similar members and constituencies as those on the EIC and WAPSD. The council replaced the Wyoming Early Childhood Development Council, also implemented by executive order in 2000. During the evaluation, LSO learned that this Council has had intermittent functioning, primarily due to inconsistent funding and staffing issues. It was first funded by American Recovery and Reinvestment Act (ARRA) funding, then through the Department of Family Services (DFS), and is now staffed and funded through the Department of Workforce Services (DWS).

Individuals interviewed by LSO stated that the council was dormant for most of 2014 and 2015. The Council has recently reorganized and is working with the Governor to issue another executive order to reconstitute and refocus the council's purpose and activities. One council member stated that a central issue it intends to address in the near future is defining a consistent understanding of what kindergarten readiness is or looks like in order to help inform and evaluate how preschool children are being prepared for the K-12 education system.

Historical Efforts to Create an Office of Early Education

The Joint Education and Joint Labor, Health and Social Service Interim Committees met in 2013 and 2014 to receive information on early childhood education and learning programs. In 2013, the committee was specifically tasked with exploring "current efforts in the area of early childhood education and possible mechanisms to streamline consolidate and improve efforts in this area." It was during these meetings that Health initially offered the Program to move to Education.

Testimony was received from the provider community as well as other State agencies involved with child service delivery. Public comment urged the Legislature to close the gaps between preschool, K-12, and post-secondary. Recommendations from those meetings included a single point of contact be established within the State to coordinate efforts and Education was cited as the most logical location with a newly created Office of Early Education. This office would collaborate and coordinate early education programs across State agencies.

Two bills were proposed by the Joint Education Interim Committee during the 2014 Budget Session, requiring two-thirds affirmative votes for introduction. House Bill 81 was eventually withdrawn while House Bill 26 did not receive the two-thirds vote for introduction. While these bills didn't directly address Part C and Part B, the overall concept appears in line with the "consolidation" or "creation" structural options outlined by the BUILD Initiative for better focused, efficient, or productive early childhood learning systems.

Stakeholders Appear to Welcome Better Coordination of the Early Childhood Learning System Statewide

Throughout this evaluation, many stakeholders expressed to LSO that the early childhood learning system is mostly fragmented and insufficiently coordinated, especially at the state level. Even with the various, federally required councils and advisory boards, often with very similar memberships, each of these efforts is focused on specific child populations or specific service concerns. The larger

picture of what the State wishes for the system to accomplish is not cohesive and clear.

In the preceding Finding 5.1, LSO focuses on how the organizational structure specific to Part C and Part B administration could be changed to Education. However, based on the preceding discussion in this finding about the various programs and resources utilized by the regional centers, LSO concludes that the greater early childhood learning system may benefit from better coordination as well.

In many respects, each regional center has attempted to implement regional systems of services for early childhood learning in their communities. Movement to an Office of Early Learning at the state level would require applying similar principles as the regional centers. For example, regional centers have worked over the years to cultivate a blend of resources and networks to meet the needs of different program requirements (i.e. State general funds, federal funds, private donation programs, etc.) to ultimately meet the needs of its children and community cultures.

Policy Consideration

The Legislature could reconsider authorizing a coordinating office for the State, such as an Office of Early Learning, to coordinate and monitor programs and funding resources utilized for early childhood learning activities statewide.

The Office of Early Learning would attempt to accomplish the same goal for the State as the collaborative cultures at the regional center level. Conceptually, this Office would establish a governance structure under which early learning system administrative functions could occur in unison. These functions would include budgeting/resource management and allocation, data management, monitoring, and developing aligned rules, procedures, policies and goals.

As the 2014 Joint Education Interim Committee bills were not actually considered by the Legislature (for lack of introduction), it may be efficient for the Legislature to review both the potential move of the Program to Education in tandem with the overall early childhood learning system. The key question is whether this coordination and cohesion will be better assured if the Office is a separately created agency or a unit within an established State agency?

Agency Response

Wyoming Department of Health

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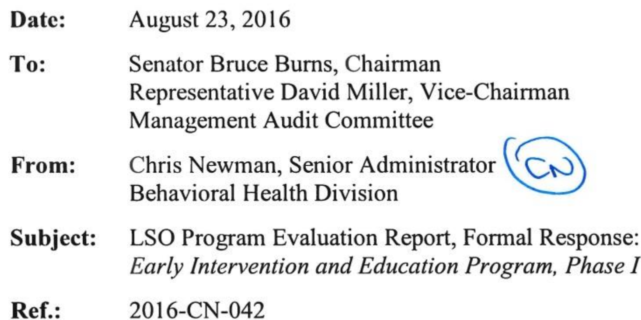
MEMORANDUM



Date: August 23, 2016

To: Senator Bruce Burns, Chairman
Representative David Miller, Vice-Chairman
Management Audit Committee

From: Chris Newman, Senior Administrator
Behavioral Health Division

Subject: LSO Program Evaluation Report, Formal Response:
Early Intervention and Education Program, Phase I

Ref.: 2016-CN-042

Dear Chairman Burns and Vice-Chairman Miller,

Thank you for the opportunity to respond to the evaluation report prepared by the Legislative Service Office (LSO) Program Evaluation Team; *Early Intervention and Education Program (Program), Phase I.* The Phase I Report of LSO's evaluation provides background information related to the Program's child identification rates, the statutory funding model, and overall organization and placement of the Program. The Wyoming Department of Health, Behavioral Health Division (Agency) has thoroughly reviewed and, in accordance with W.S. 28-8-107(c), please consider this the Agency's formal written response to the Report.

This response will mainly focus on the five recommendations and three policy considerations in the Report. The audit and Report have been useful tools for the Agency, providing insight and reflection on manners in which the Agency can continue to strengthen and see success in the Program. Before addressing the recommendations and policy considerations, the Agency has briefly summarized general comments on the overall report.

General Comments

The Agency appreciates the LSO Program Evaluation Team's professionalism and collaboration as they completed the Phase I Report. With several exceptions, noted below, the Agency supports the recommendations and policy considerations in the Report. The two parts of the Program are complex, for multiple reasons, including differing regulations, oversight, eligibility requirements, and to some extent, differences in funding. The current funding model creates challenges, which are further complicated when trying to meet the federal maintenance of effort requirements and implement budget reductions as required by the legislature or Governor.

The Agency, wants to clarify that the suggestions that have been made to relocate the Program to the Department of Education does not mean there has been a lack of support for this Program. The Program consists of four full-time equivalent positions, with administrative and other Agency support. This Program is currently being managed very efficiently and effectively, but there have been challenges in the past when there is staff turnover, or when there has been a change in the relationship with the Department of Education.

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The support and expertise that could be provided by the Department of Education would minimize these challenges to a level that cannot be achieved by the Agency.

The Agency looks forward to working with the LSO Program Evaluation Team on Phase II of this audit, and looks forward to working with the Wyoming Legislature as they consider the recommendations made in this Report.

Program Evaluation Report Recommendations

Recommendation 2.1: "The Department of Health and Department of Education should conduct a data reconciliation process prior to submitting any information to the federal government for Part B and work together to identify and resolve potential reporting errors for information already reported to the U.S. Department of Education."

Agency Response:
The Agency agrees with this recommendation.

Recommendation 3.1: "The Legislature could consider amending W.S. 21-2-706(b), to clarify the following:

- Whether an individual family service plan or individual education plan is required for a child to be included in the child count for State general funds.
- That the 'state rules' for setting the child count standard and distribution of State general funds shall be promulgated by the Wyoming Department of Health for the Part B program."

Agency Response:
The Agency agrees with this recommendation.

Recommendation 3.2: "The Legislature could consider amending W.S. 21-2-706(b), in consultation with Health, to adjust the child count date and count method to accommodate the federal allowable child assessment and eligibility process timeframes for both Part C and Part B."

Agency Response:
The Agency agrees with this recommendation.

Recommendation 4.1: "Health should build its budget request using the Program statutory funding model outlined in W.S. 21-2-706 when submitting, through the Governor, its biennial and supplemental budget requests to the Legislature.

In complying with these requirements, Health should:

- Adjust its budget submission to the Governor prior to the December 1st budget submission deadline with the most recent child count data of the year in which the submission is made.
- Inform the Legislature each time the per-child funding amount used for regional center contracts of the year in which the budget is submitted differs from the statutory amount. Health should identify the reasons for different contract amount.

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- Quantify and report to the Legislature the per-child funding amount increase of all external cost adjustments funded by the Legislature to date."

Agency Response:
The Agency agrees with the second and third bullet points in this recommendation.

The Agency does not agree with the recommendation to adjust the budget submission to the Governor prior to the December 1st budget submission deadline. The Child Development Centers (Centers) are required to submit their child count to the Program on November 1st of each year. The Program then works with each Center to validate the numbers reported, which may take up to three weeks. The result is that the Agency is submitting updated information to the Administration and Information's Budget Office toward the end of November, which does not leave the Budget Office or the Governor's office time to include this information by the Governor's budget submission deadline.

Recommendation 4.2: "Health should annually report to the Legislature's Joint Appropriations Committee prior to the budget hearings the most recent maintenance of effort determination for both Part C and Part B programs."

Agency Response:
The Agency agrees with this recommendation.

Program Evaluation Report Policy Considerations

Policy Consideration 4.1: "The Legislature could consider a new study, similar to the one funded in 2004-2005, to update regional centers' costs information and review alternative funding models and/or methods of reimbursement."

Agency Response:
The Agency agrees with this recommendation.

Policy Consideration 5.1: "The Legislature could consider amending statute to move the Program (both Part C and Part B) from the Department of Health to the Department of Education, with adequate consideration of a defined, strategic transition plan to ensure, at a minimum, the following:

- Program funding, contracts, and services remain uninterrupted;
- Program oversight and monitoring maintain the principles of the systemic concerns brought out in the 2011 federal audit;
- Changes to the Program roles and responsibilities should include input from all relevant system stakeholders, especially from Health, Education, and the regional centers;
- How the receipt and disbursement of state and federal funds from the State to the regional centers may need to change if the centers maintain private non-profit status or become public agencies, similar to or incorporated into school districts."

Agency Response:
The Agency agrees with this recommendation.

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Policy Consideration 5.2: "The Legislature could reconsider authorizing a coordinating office for the State, such as an Office of Early Learning, to coordinate and monitor programs and funding resources utilized for early childhood learning activities statewide."

Agency Response:
The Agency agrees with this recommendation.

Other Agency Comments

1. Pg. 8 "While LSO does not intend to perform a full longitudinal analysis for the Phase 2 project, given the timing and of the agreements and the necessary preparation of the Phase 1 report, LSO has not yet been able to request and receive data to complete the outcomes analysis necessary to provide a response to the Committee's concern."

   Agency Comments:
   The Department understands the delay in completing the outcomes analysis and is prepared to provide the data and information needed by the LSO Program Evaluation Team as they complete Phase II of the audit.

2. Pg. 45 "Health uses outdated and inconsistent child count figures in its budget request to derive an undulating per-child amount for contract payments from year-to-year."

   Agency Comments:
   The Agency disagrees. The Agency has used the November 1st child count consistently since this requirement was placed into legislation via W.S. 21-2-706(b).

CN/kp

c: Thomas O. Forslund, Director, Wyoming Department of Health
Joe Simpson, Developmental Disabilities Section Administrator, Behavioral Health Division
Kathy Escobedo, Early Intervention and Education Program Unit Manager, Behavioral Health Division

Agency Response

Wyoming Department of Education

WYOMING DEPARTMENT OF EDUCATION
Jillian Balow, Superintendent of Public Instruction
Hathaway Building, 2nd Floor, 2300 Capitol Avenue
Cheyenne, WY 82002-2060

MEMORANDUM

To: Management Audit Committee
Senator Bruce Burns, Chairman
Representative David Miller, Vice Chairman

From: Superintendent Jillian Balow

Date: August 22, 2016

Re: Agency Response to Early Intervention and Education Program, Phase I

INTRODUCTION

The Wyoming Department of Education (WDE) appreciates the time, effort and depth of analysis that went into the Early Intervention and Education Program (EIEP) Phase I Audit. The state early childhood system is a multi-faceted, complex program which extends far beyond the WDE's Division of Individual Learning. The WDE appreciates the courtesy and respect we received from the Legislative Services Office (LSO) staff as evidence was collected and interviews conducted and the thoroughness of the staff's inquiry into the EIEP program.

WDE views this audit as an opportunity to refine and improve our oversight and procedures as we work with the Wyoming Department of Health (Health) to implement the EIEP. We believe both entities are committed to effectively adhering to the Individuals with Disabilities Education Act (IDEA) and providing quality programming for children with disabilities. We look forward to the discussions that will result from this program management audit.

RESPONSES:

Chapter 2

Finding 2.1: When considering multiple measures and factors, Wyoming's identification rates for Part C and Part B children appear reasonable and appropriately monitored.

Conclusion 1:

While identification rates for Wyoming's Part C and Part B programs appear higher than other states, Wyoming's penetration rates appear reasonable given other identification comparison standards. Additionally, Health's monitoring practices and approved assessment policy help verify accurate eligibility determinations among regional centers.
Response: Agree

Finding 2.2: Education's reporting of Part B data to the federal government cannot be reconciled with Health data for the same program.

Recommendation 1:
The Department of Health and Department of Education should conduct a data reconciliation process prior to submitting any information to the federal government for Part B and work together to identify and resolve potential reporting errors for information already reported to the U.S. Department of Education.
Response: Agree

WDE agrees that a reconciliation process prior to submission of any information to the federal government for Part B and identifying and resolving reporting errors is critical. With legislative support and resources, the WDE and Health will be able to collaborate on this recommendation.

Chapter 3

Finding 3.1: Health's child count standard is no longer defined through rules, and the single, November 1st count date may not provide the best timing or information to determine the number of children served by the Program.

Recommendation 1:
The Legislature could consider amending W.S. 21-2-706(b), to clarify the following:

- Whether an individual family service plan or individual education plan is required for a child to be included in the child count for State general funds.
- That the "state rules" for setting the child count standard and distribution of State general funds shall be promulgated by the Wyoming Department of Health for the Part B program.

Response: Agree

As a point of information, WDE is obligated to report child count data between October 1 and December 1 of each year according to §300.641.

Recommendation 2:
The Legislature could consider amending W.S. 21-2-706(b), in consultation with Health, to adjust the child count date and count method to better accommodate the federal allowable child assessment and eligibility process timeframes for both Part C and Part B.
Response: Agree

As a point of information, the WDE is required to adhere to the federal requirements to report

child count data between October 1 and December 1 of each year according to §300.641.

Chapter 4

Finding 4.1: Budget cuts and Health's management of the State's federal maintenance of effort requirement are the primary contributors to Health and the Legislature not implementing the statutory Program funding model as intended, essentially eliminating consistency and stability for the Program.

Recommendation 1:
Health should build its budget request using the Program statutory funding model outlined in W.S. 21-2-706 when, submitting, through the Governor, its biennial and supplemental budget requests to the Legislature.

In complying with these requirements, Health should:

- Adjust its budget submission to the Governor prior to the December 1st budget submission deadline with the most recent child count data of the year in which the submission is made.
- Inform the Legislature each time the per-child funding amount used for regional center contracts of the year in which the budget is submitted differs from the statutory amount. Health should identify the reasons for the different contract amount.

Response: N/A

WDE declines to comment on how Health should manage its budgets.

Recommendation 2:
Health should annually report to the Legislature's Joint Appropriations Committee prior to budget hearings the most recent maintenance of effort determinations for both Part C and Part B programs.
Response: Agree

Policy Consideration:
The Legislature could consider a new study, similar to the one funded in 2004-2005, to update regional center's costs information and review alternative funding models and/or methods of reimbursement.
Response: Agree

Chapter 5

Finding 5.1: Administration for the Program is operational but the current organizational structure does not sufficiently align authority with purpose and responsibility.

Policy Consideration:
The Legislature could consider amending statute to move the Program (both Part C and Part

B) from the Department of Health to the Department of Education, with adequate consideration of a defined, strategic transition plan to ensure, at a minimum, the following:

- Program funding, contracts, and services remain uninterrupted;
- Program oversight and monitoring maintain the principles of the systemic concerns brought out in the 2011 federal audit;
- Changes to Program roles and responsibilities should include input from all relevant systems stakeholders, especially from Health, Education, and regional centers;
- How the receipt and disbursement of state and federal funds from the State to the regional centers may need to change if the centers maintain private non-profit status or become public agencies, similar to or incorporated into school districts.

Response: Agree

WDE agrees, assuming that adequate resources are allocated, time is afforded, and Health prepares and the legislature agrees with a fully developed transition plan.

Finding 5.2: The Program is a part of the overall early childhood learning system in the State, but appears to be viewed independently or separately of other programs, services, and funding.

Policy Consideration:
The Legislature could reconsider authorizing a coordinating office for the state, such as an Office of Early Learning, to coordinate and monitor programs and funding resources utilized for early childhood learning activities statewide.
Response: Partially Agree

The WDE is concerned about adding additional bureaucracy in state government during a time of declining revenue. As an agency, should Part B and C move to WDE, we are capable of leveraging existing resources to potentially create a early learning team/division within WDE.

Once again, the WDE appreciates the efforts of the LSO staff in undertaking this complex work. The report provides opportunities for our agency, Health, the legislature, centers, and others to better align our work now and going forward.

Sincerely,

Jillian Balow
State Superintendent of Public Instruction

Page 4

Appendices

Early Intervention and Education Program

STATE of WYOMING
LEGISLATURE
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Appendix A

Federal and Wyoming Laws and Regulations

Federal Laws and Regulations

Title 1. Amendments to the Individuals with Disabilities Education Act, **Section 101.** Amendments to the Individuals with Disabilities Education Act

Parts A through D of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) are amended to read as follows:

Part B. Assistance for Education of All Children with Disabilities

Sec. 611. Authorization; allotment; use of funds; authorization of appropriations.

Sec. 612. State eligibility.

Sec. 613. Local educational agency eligibility.

Sec. 614. Evaluations, eligibility determinations, individualized education programs, and educational placements.

Sec. 615. Procedural safeguards.

Sec. 616. Monitoring, technical assistance, and enforcement.

Sec. 617. Administration.

Sec. 618. Program information.

Sec. 619. Preschool grants.

Part C. Infants and Toddlers With Disabilities

Sec. 631. Findings and policy.

Sec. 632. Definitions.

Sec. 633. General authority.

Sec. 634. Eligibility.

Sec. 635. Requirements for statewide system.

Sec. 636. Individualized family service plan.

Sec. 637. State application and assurances.

Sec. 638. Uses of funds.

Sec. 639. Procedural safeguards.

Sec. 640. Payor of last resort.

Sec. 641. State interagency coordinating council.

Federal Regulations

Code of Federal Regulations (CFR) Title 34. Education, **Subtitle B.** Regulations of the Offices of the Department of Education, **Chapter III.** Office of Special Education and Rehabilitative Services, Department of Education

Wyoming Statutory Provisions

Title 21. Education, **Chapter 2.** The Administration of the State – System of Education and the State Level, **Article 7.** Services to Preschool Children with Disabilities

W. S. 21-2-701 through 21-2-706

Title 9. Administration of Government, **Chapter 2.** Agencies, Boards, Commissions and Departments Generally, **Article 1.** Department of Health

W.S. 9-2-101 through 9-2-108

Title 35. Public Health and Safety, **Chapter 1.** Administration, **Article 6.** Community Human Services

W.S. 35-1-611 through 35-1-628 (Community Human Services Act)

Wyoming Department of Health Rules

Part C Program

Chapter 1. General – Purpose, Eligibility, and other General Provisions

Chapter 2. Applications and Procedures for Making Grants to States

Chapter 3. Program and Service Components of Statewide System of Early Intervention Services

Chapter 4. Procedural Safeguards

Chapter 5. State Administration

Chapter 6. State Interagency Coordinating Council

Part C and Part B State Program Funding

Chapter 13. Early Intervention and Developmental Preschool State Funding

Wyoming Department of Education Rules

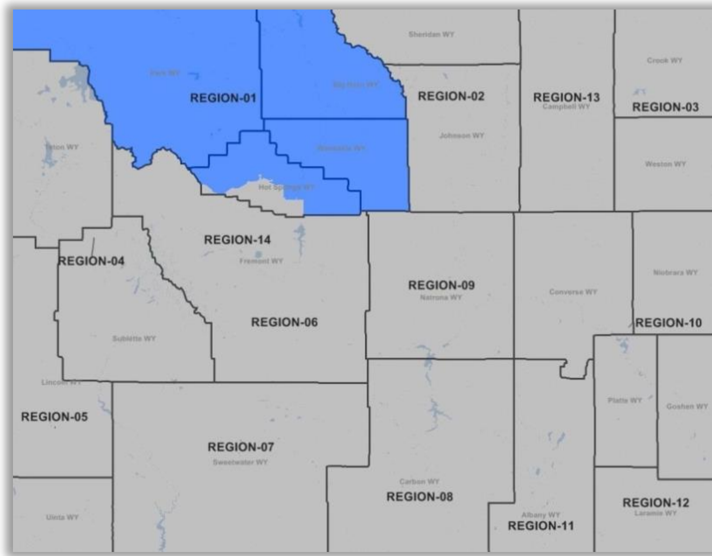
Chapter 7. Services for Children with Disabilities

Appendix B

Regional Child Development Center Profiles

In March 2016, the LSO conducted a survey of the Child Development Centers and all regional centers responded. This appendix provides a snapshot of information provided by all fourteen regional centers: the data in the profiles represents regional center information as of March 2016 and may not reflect current circumstances based on the proposed June 2016 budget cuts and resulting FY2017 contracts between Health and the regional centers.

Furthermore, all regional centers provide screening, evaluation, assessment, IFSP, IEP, and related services in addition to the child-specific treatment and education services listed in the profiles. The information provided in the following pages reflects service information by profession or specialty type.



Region 1

Children's Resource Center

Mission: To provide early intervention programs which focus on the development and educational needs of children, birth through five, and to offer support to the child's family.

Contact Information:
Director: Mitch Brauchie
307-587-1331

Physical Location

Counties: Park, Big Horn, Washakie, and Northern part of Hot Springs.

Facility Locations: Basin, Cody, Lovell, Powell, Thermopolis, and Worland

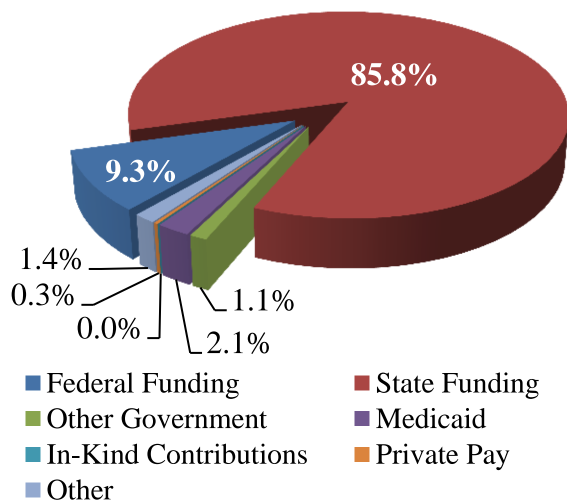
Staff and Services

Total Staff: 62 full-time and 19 part-time

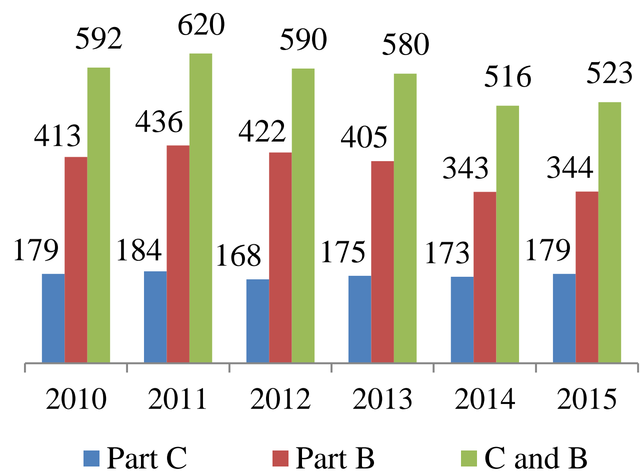
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision. Children in need of audiology, health, medical, nursing, nutrition, psychological, and social work services are referred to the appropriate provider agency or professional; Transportation is offered at all sites via parent reimbursement and local contracts

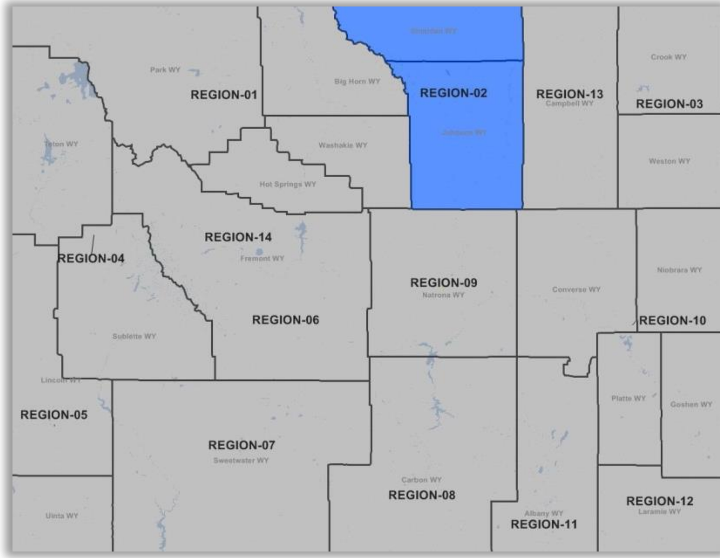
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $6,010,690



November 1st Child Count, 2010-2015





Region 2

Child Development Center

Mission: To support and strengthen children, families, and professionals in our communities by working together to provide developmental information and services.

Contact Information:
Director: Marsha Riley
307-672-6610

Physical Location

Counties: Sheridan and Johnson

Facility Locations: Two in Sheridan and one in Buffalo

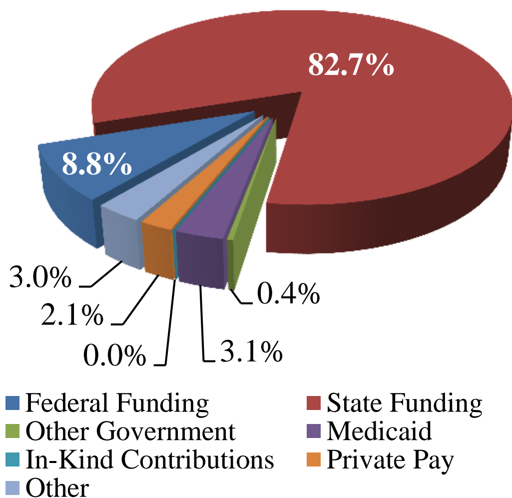
Staff and Services

Total Staff : 16 full-time and 18 part-time

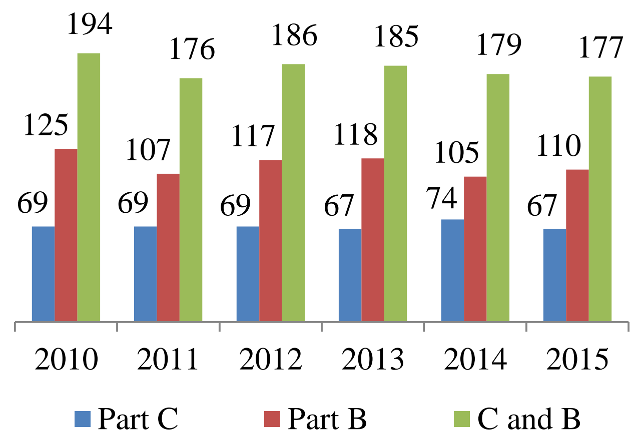
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation; Health, Medical, Nursing, Nutrition, Social-Work, Audiology and Vision services are offered to parents through referral to local professionals

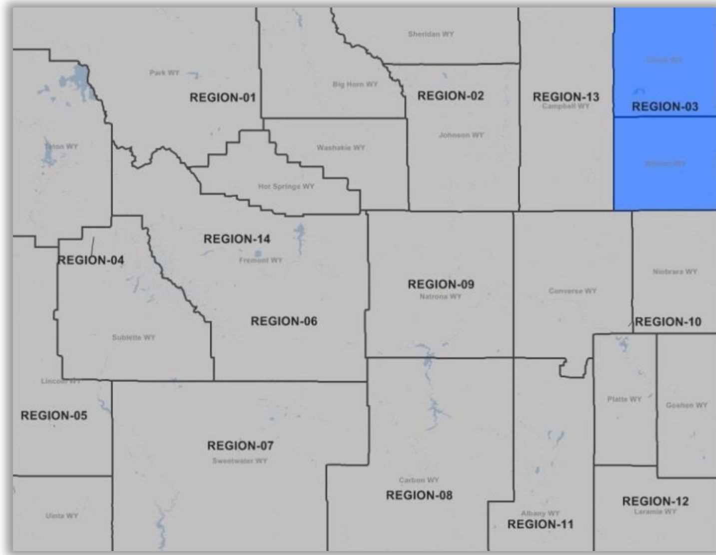
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $1,972,247



November 1st Child Count, 2010-2015





Region 3

Weston County Children's Center

Mission: To provide early care and education appropriate to each individual child.

Contact Information:
Director: Jane Rhoades
307-746-4560

Physical Location

Counties: Weston and Crook

Facility Locations: Newcastle, Upton, Moorcroft, and Hulett

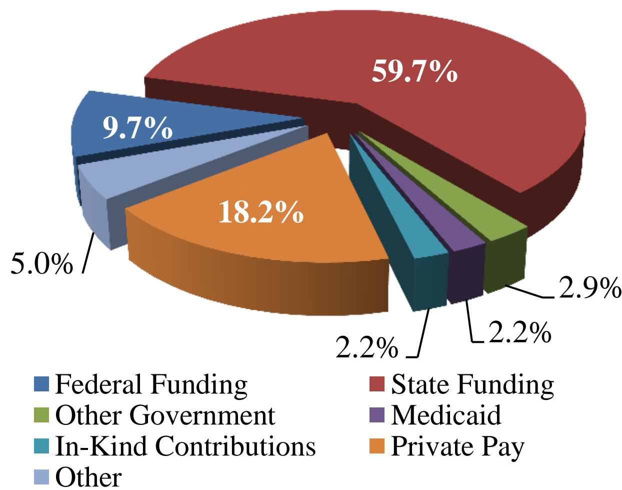
Staff and Services

Total Staff : 28 full-time and 11 part-time

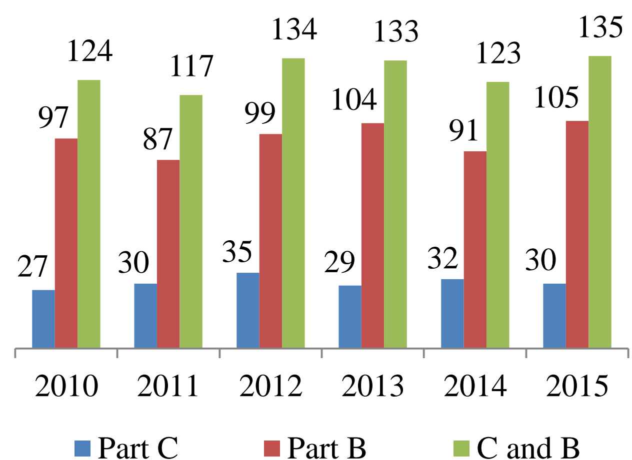
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Psychology Services, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

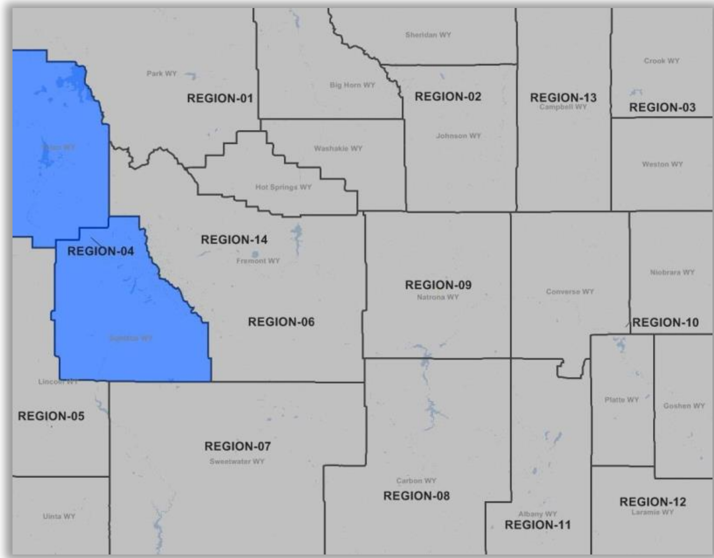
Programs Administered: Part C, Part B, TANF, Head Start, and private pay preschool

Funding for FY2015: $1,986,587



November 1st Child Count, 2010-2015





Region 4

Children's Learning Center

Mission: CLC supports the development of the whole child through Early Childhood Care and Education, Early Interventions and access for all.

Contact Information:
Executive Director: Patti Boyd
Special Education Director: Davey Hough
307-746-4560

Physical Location

Counties: Teton and Sublette

Facility Locations: Jackson, Pinedale, and Big Piney

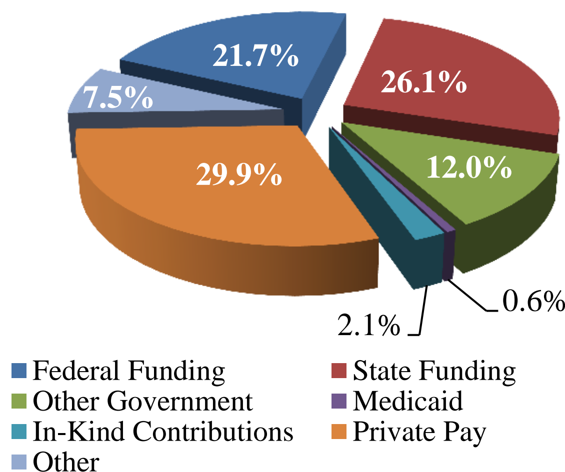
Staff and Services

Total Staff : 17 full-time and 9 part-time

Services Offered: Audiology, Health Services, Nursing Services, Nutrition Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

Programs Administered: Part C, Part B, TANF, Early Head Start, Head Start, child care and private pay preschool

Funding for FY2015: $5,249,581



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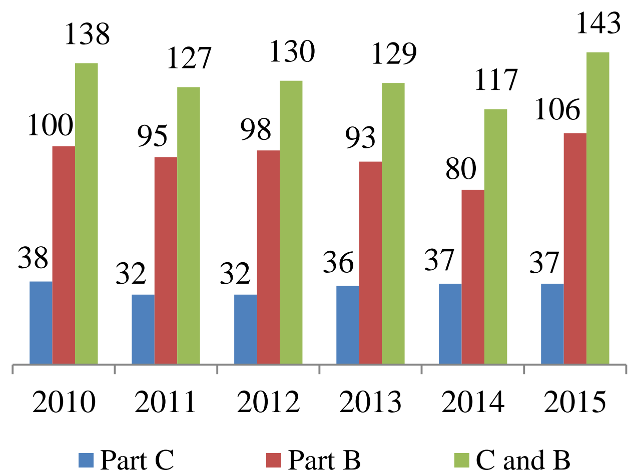
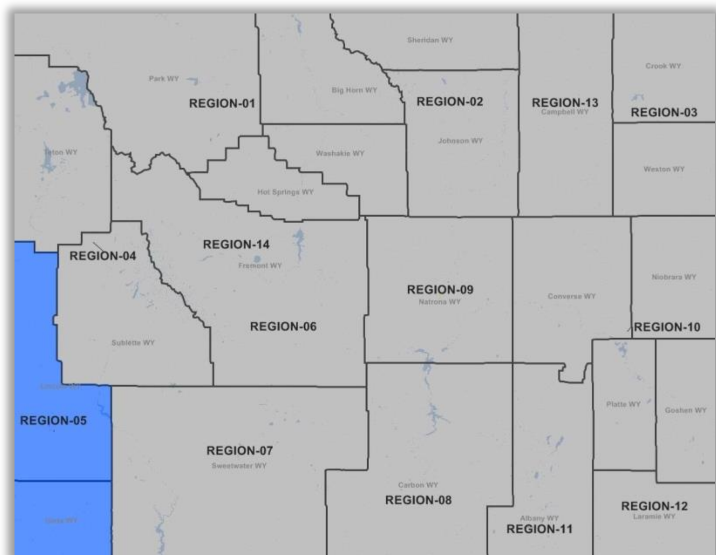




Region 5

Lincoln-Uinta Child Development Association

Mission: To improve outcomes for children by supporting families, and designing services to best meet the needs of individual children within the community.

Contact Information:
Director: Shauna Lockwood
307-782-6602

Physical Location

Counties: Lincoln and Uinta

Facility Locations: Afton, Alpine, Evanston, Kemmerer, Mountain View, and Thayne

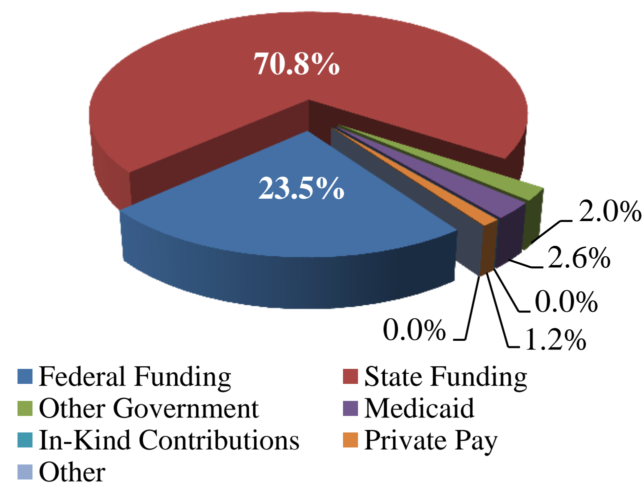
Staff and Services

Total Staff : 57 full-time and 43 part-time

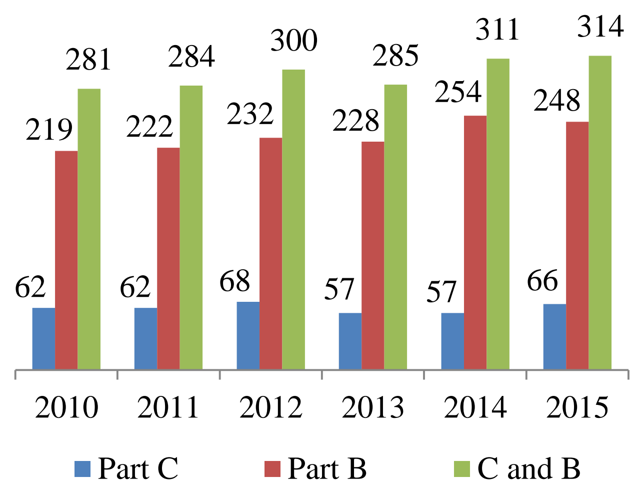
Services Offered: Audiology, Health Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

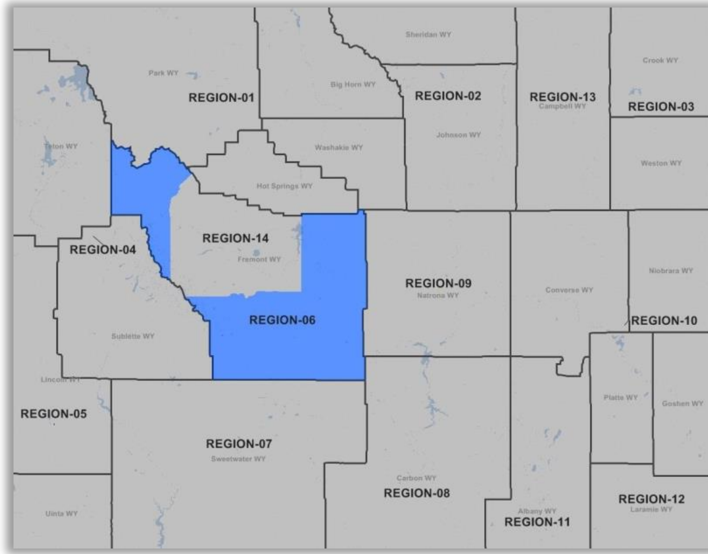
Programs Administered: Part C, Part B, TANF, Head Start, and private pay preschool

Funding for FY2015: $3,644,429



November 1st Child Count, 2010-2015





Region 6

Child Development Services of Fremont County, Inc.

Mission: To provide early childhood education and intervention services for families with infants and preschool children with developmental disabilities and delays.

Contact Information:
Director: Lori Morrow
307-332-5508

Physical Location

County: Fremont

Facility Locations: Dubois, Shoshoni, Lander, and Riverton

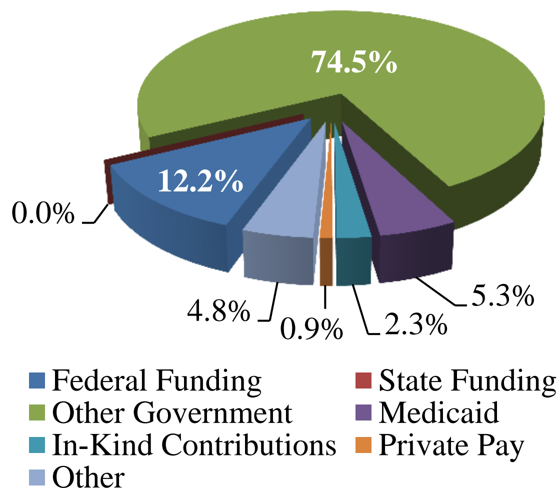
Staff and Services

Total Staff: 60 full-time and 4 part-time

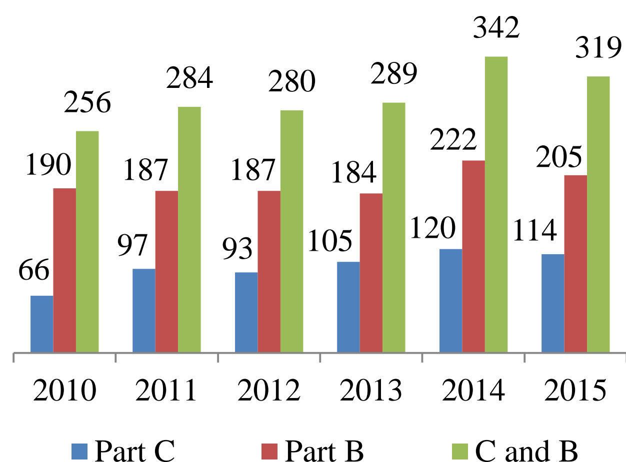
Services Offered: Audiology, Health Services, Medical Services, Nursing Services, Nutrition Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

Programs Administered: Part C, Part B, private pay preschool

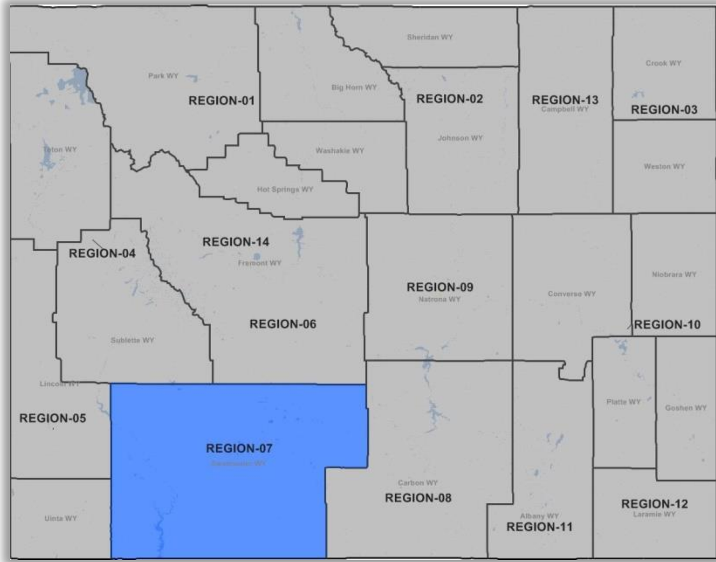
Funding for FY2015: $3,417,289[1]



November 1st Child Count, 2010-2015



[1] State Program funds are listed under "Other Government"



Region 7

Sweetwater County Child Development Center

Mission: To improve the quality of life of all children and their families through early childhood education.

Contact Information:
Director: Lucinda Kasper
307-872-3290

Physical Location

County: Sweetwater

Facility Locations: Green River and Rock Springs

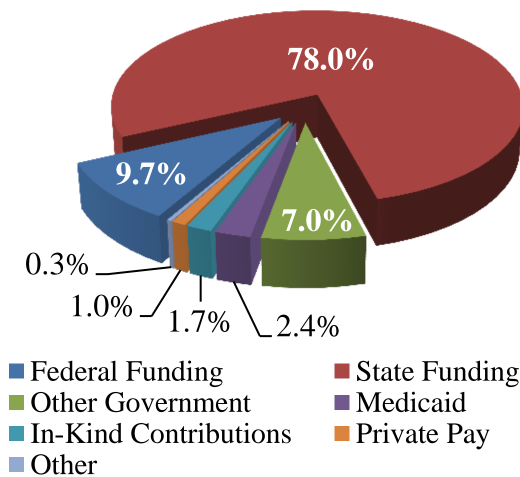
Staff and Services

Total Staff : 41 full-time and 18 part-time

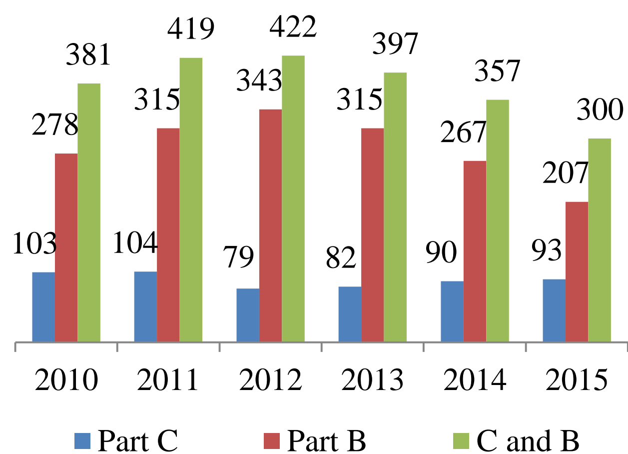
Services Offered: Audiology, Health Services, Medical Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

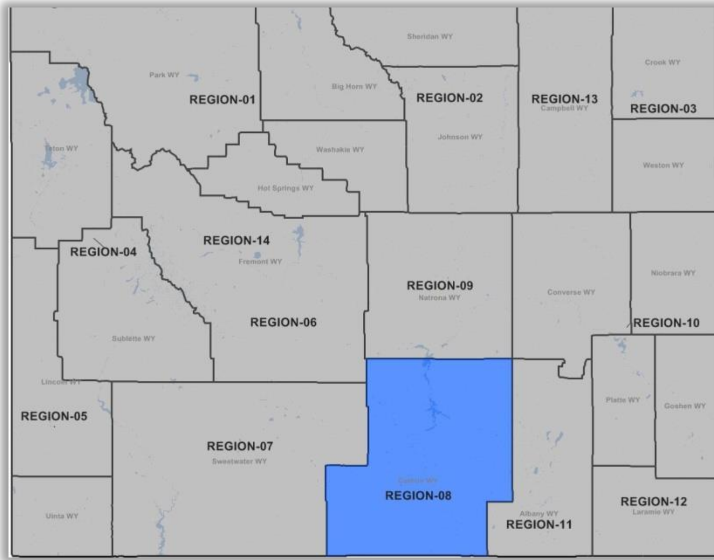
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $4,540,350



November 1st Child Count, 2010-2015





Region 8

Developmental Preschool and Day Care

Mission: To provide quality child care, preschool and early intervention services to children in Albany and Carbon counties.

Contact Information:
Director: Jaime Stine
307-742-3571

Physical Location

County: Carbon (Region 8 only)

Facility Locations: Saratoga, Rawlins, and Other locations (private preschools in Hanna, Baggs and Rawlins)

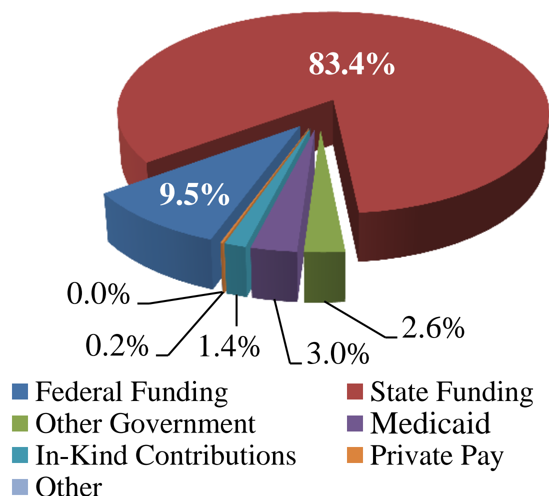
Staff and Services

Total Staff : 25 full-time and 3 part-time

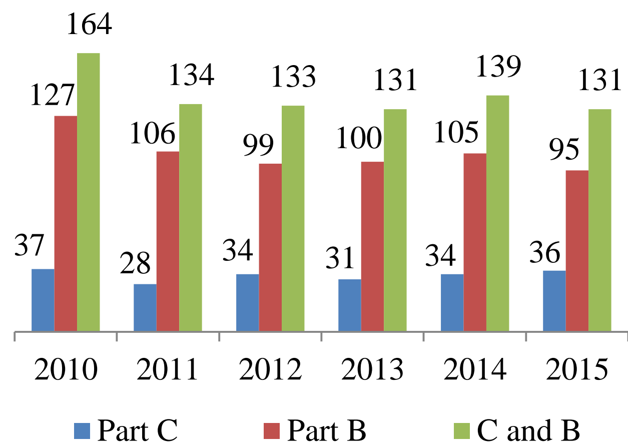
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

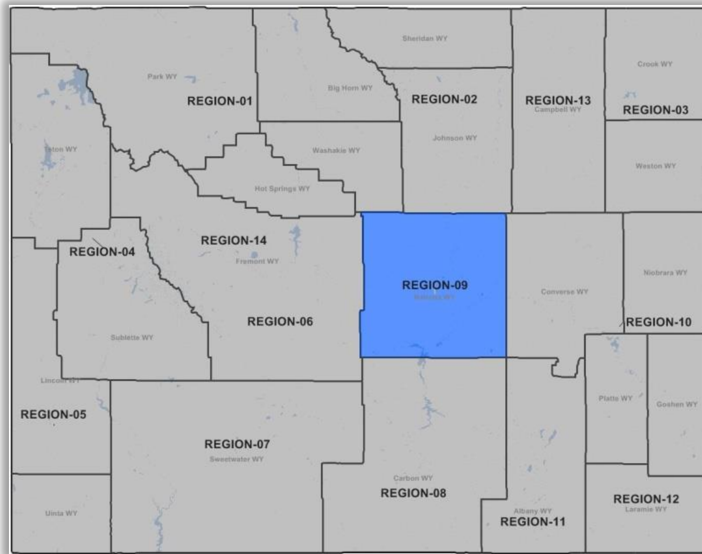
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $1,383,796



November 1st Child Count, 2010-2015





Region 9

Child Development Center of Natrona County

Mission: The Child Development Center exists to provide premier, family-focused, developmentally appropriate services for children birth through age five.

Contact Information:
Director: John Starnes
307-235-5097

Physical Location

County: Natrona

Facility Location: Casper

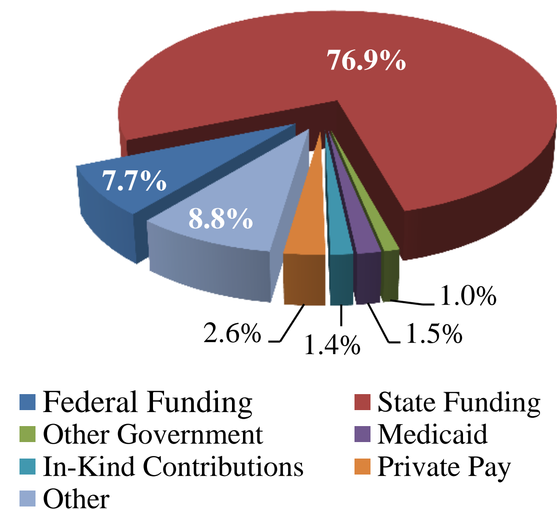
Staff and Services

Total Staff: 100 full-time and 2 part-time

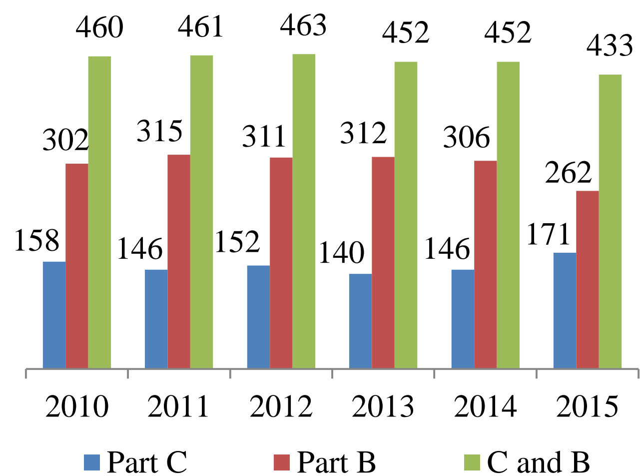
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

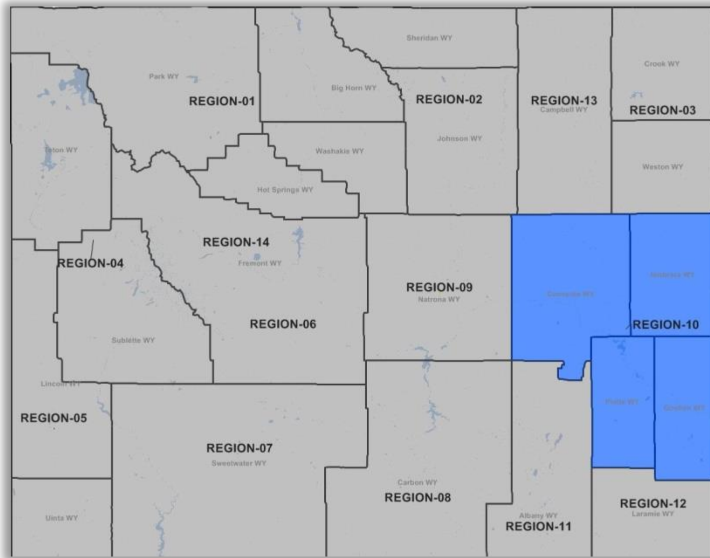
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $5,202,237



November 1st Child Count, 2010-2015





Region 10

Wyoming Child and Family Development

Mission: We make a positive difference for young children, families, and communities through partnerships and comprehensive early childhood development services.

Contact Information:
Director: Lauren Nordeen
307-836-2751

Physical Location

Counties: Converse, Niobrara, Platte, Goshen (Also contract to provide services to Campbell, Crook, and Natrona counties)

Facility Locations: Wheatland, Guernsey, Lusk, Douglas, Glenrock, and Torrington

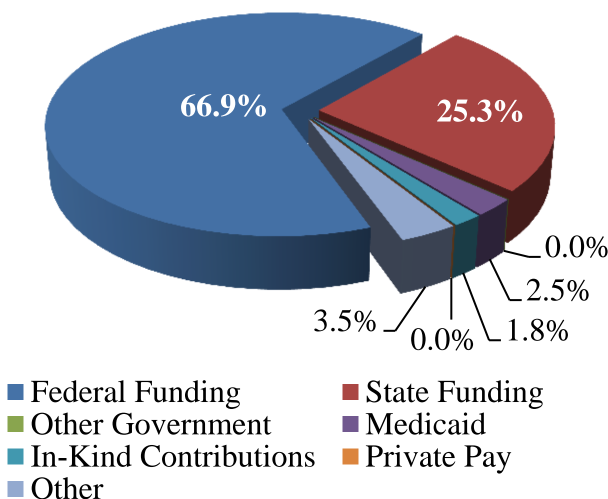
Staff and Services

Total Staff: 76 full-time and 1 part-time

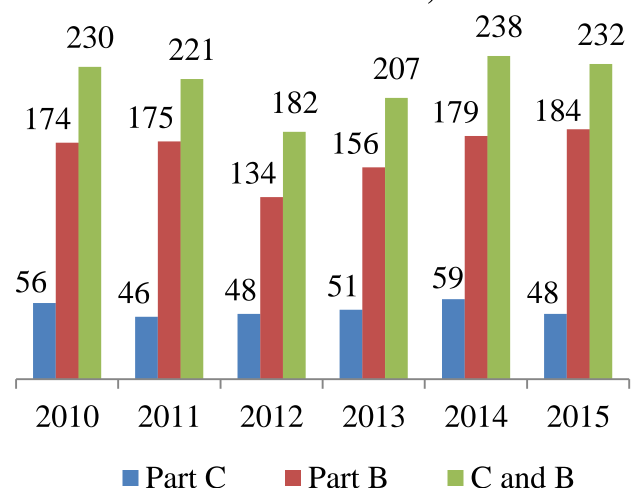
Services Offered: Audiology, Health Services, Medical Services, Nursing Services, Nutrition Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision.

Programs Administered [1]: Part C, Part B, Early Head Start, Head Start, TANF

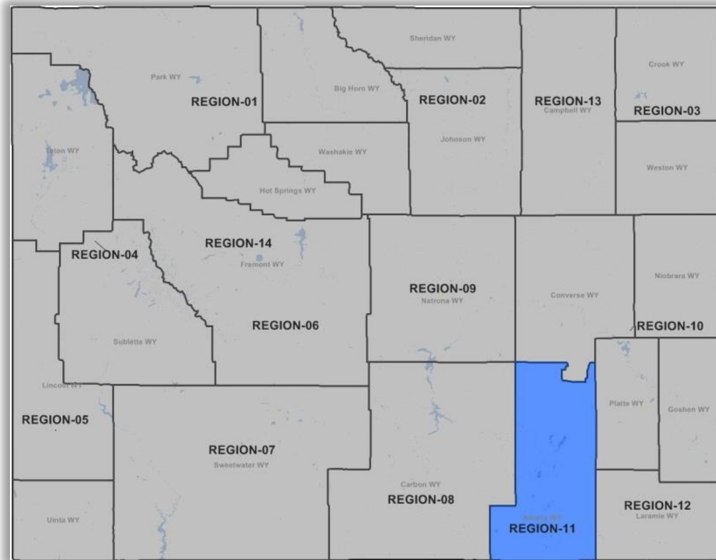
Funding for FY2015: $7,683,871



November 1st Child Count, 2010-2015



[1] Region 10 provides additional services in Natrona, Campbell, Crook, and Weston counties



Region 11

The Developmental Preschool and Day Care

Mission: To provide quality child care, preschool and early intervention services to children in Albany and Carbon counties.

Contact Information:
Director: Jaime Stine
307-742-3571

Physical Location

County: Albany (Region 11 only)

Facility Location: Laramie

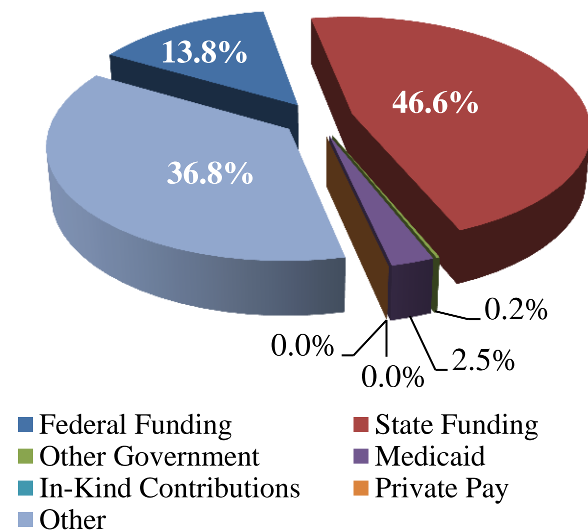
Staff and Services

Total Staff : 27 full-time and 12 part-time

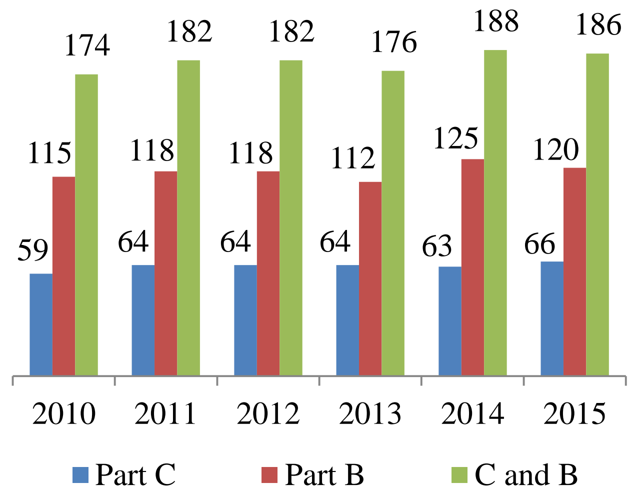
Services Offered: Audiology, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation; and Audiology and Vision Screenings

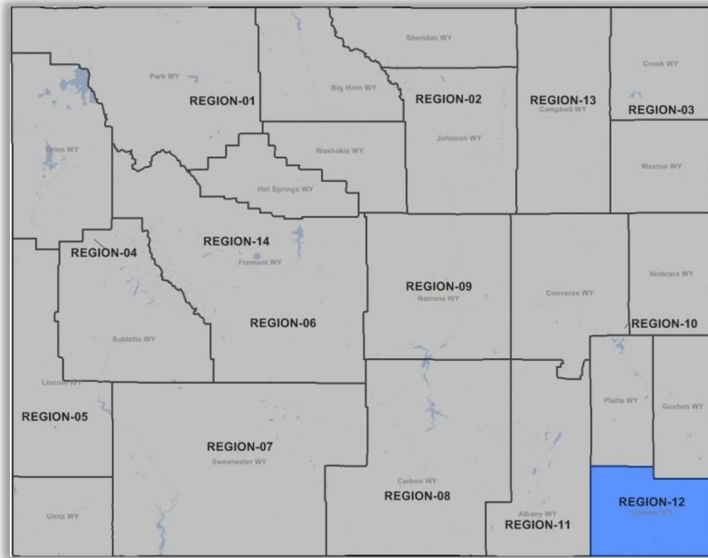
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $5,218,235



November 1st Child Count, 2010-2015





Region 12

Stride Learning Center

Mission: To provide comprehensive, quality services for children with special needs and their families in a safe and compassionate environment so that they may achieve their fullest potential

Contact Information:
Director: Tricia Whynott
307-632-2991

Physical Location

County: Laramie

Facility Location: Cheyenne

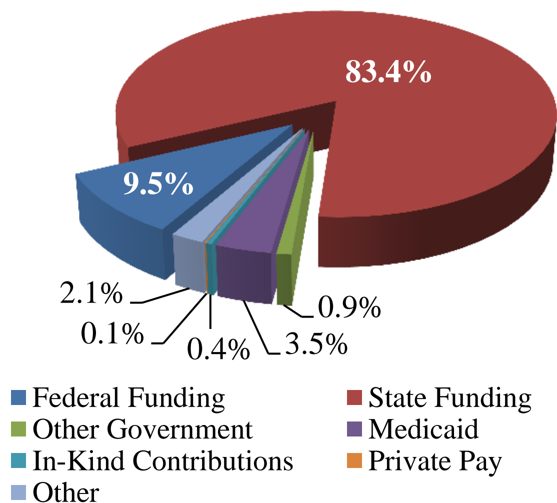
Staff and Services

Total Staff: 90 full-time and 15 part-time

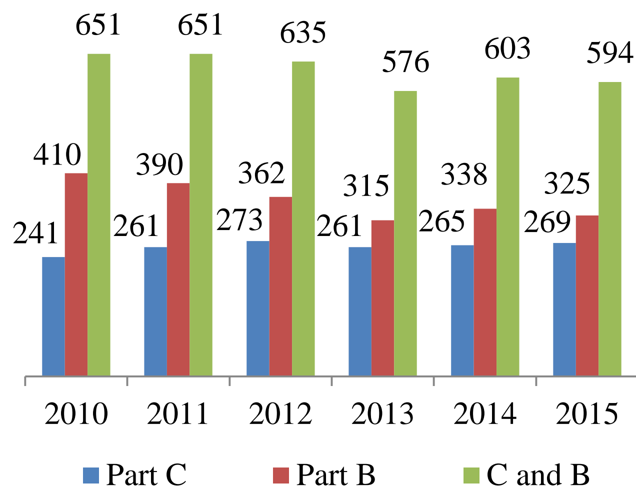
Services Offered: Nursing, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Social Work, Special Education Services, Teaching (non-special education), Transportation (employees and contractor); referrals are made for Audiology, Nutrition, and Vision services

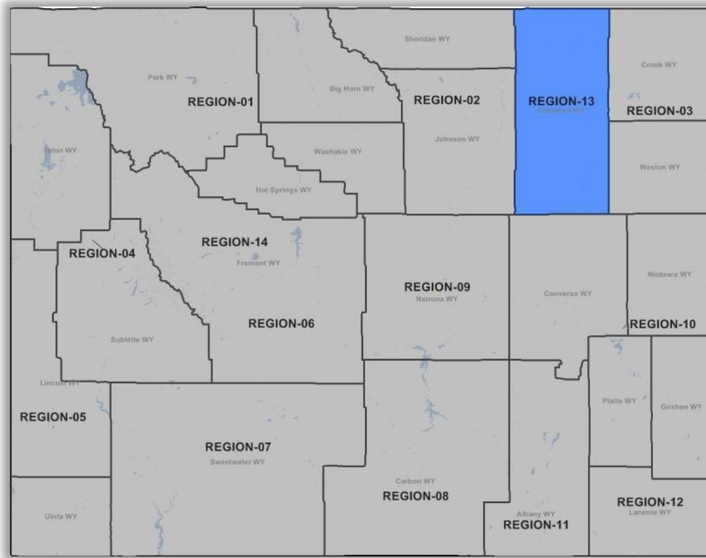
Programs Administered: Part C, Part B, and private pay preschool

Funding for FY2015: $6,321,182



November 1st Child Count, 2010-2015





Region 13

Children's Developmental Services of Campbell County

Mission: To serve the community by providing comprehensive quality early childhood services for children and their families, in caring and compassionate integrated environments, so that all children may achieve their fullest potential as unique individuals in society.

Contact Information:
Director: Robert Tranas
307-682-2392

Physical Location

County: Campbell

Facility Location: Gillette

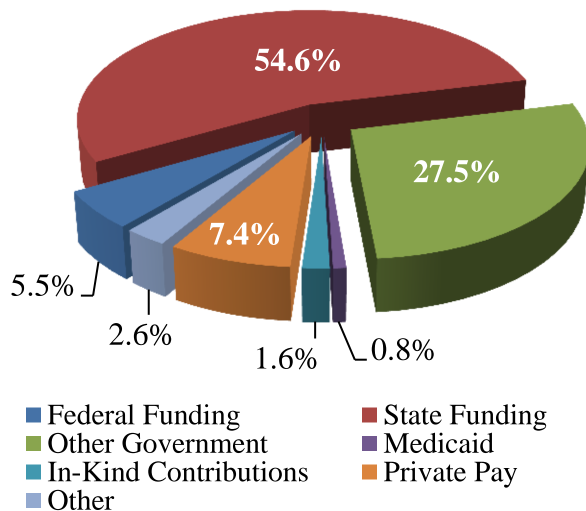
Staff and Services

Total Staff: 61 full-time and 5 part-time

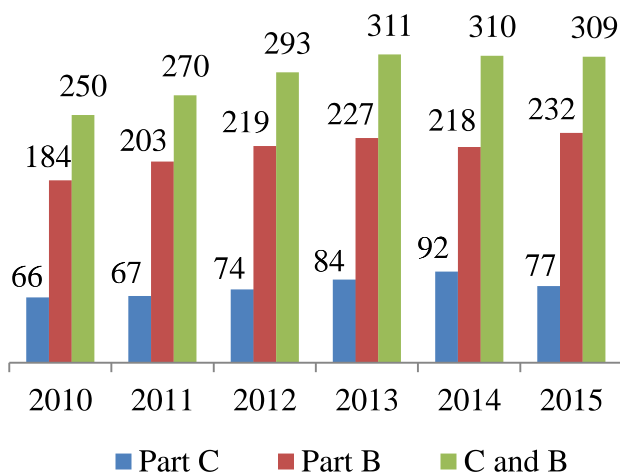
Services Offered: Audiology, Nursing Services, Nutrition Services, Occupational Therapy, Physical Therapy, Psychological Services, Service Coordination, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation, and Vision

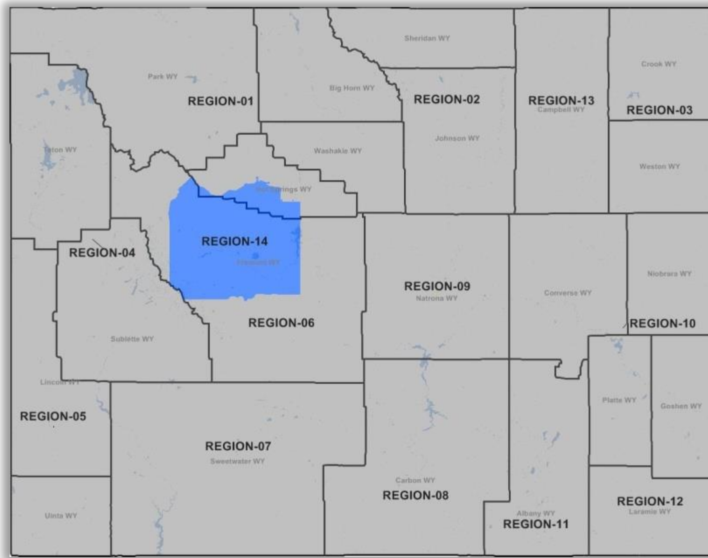
Programs Administered: Part C, Part B, Early Head Start, childcare, and private pay preschool

Funding for FY2015: $5,570,892



November 1st Child Count, 2010-2015





Region 14

Shoshone and Arapahoe Early Intervention Program

Mission: To prepare and support all children on the Wind River Reservation so they may reach their individual learning potential, participate successfully in school with their peers, and in all family activities to achieve their life goals.

Contact Information:
Director: Lindsey Van Dusen

307-332-3516

Physical Location

County: Wind River Reservation

Facility Location: Fort Washakie and Arapahoe

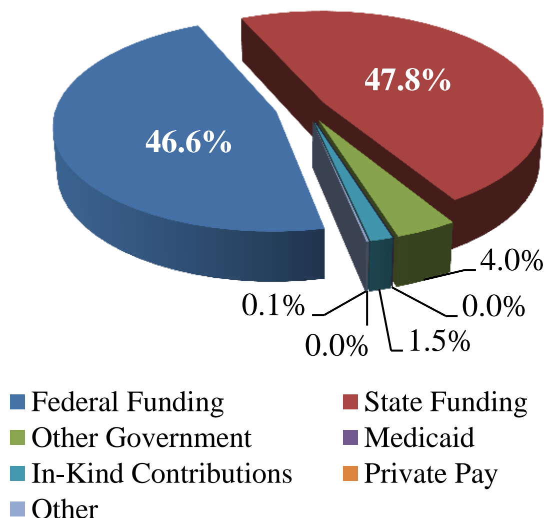
Staff and Services

Total Staff: 20 full-time and 6 part-time

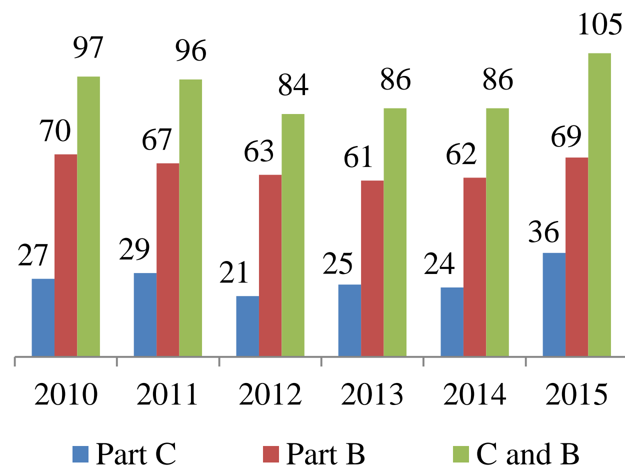
Services Offered: Occupational Therapy, Physical Therapy, Family Service Coordination, Social Work, Special Education Services, Speech and language therapy, Teaching (non-special education), Transportation

Programs Administered: Part C, Part B, and TANF

Funding for FY2015: $1,692,452



November 1st Child Count, 2010-2015



STATE of WYOMING
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Appendix C

LSO Child Development Center Survey Questionnaire

Wyoming Legislative Service Office, Program Evaluation Section

Child Development Center Survey Questionnaire

Introduction

On January 5, 2016, the Wyoming Legislature's Management Audit Committee authorized the Program Evaluation Section of the Legislative Service Office to conduct a program evaluation (or performance audit) of the Early Intervention and Education Program (EIEP; also known as the Developmental Preschool program). As part of our research of the program we would like to offer opportunities for community providers, which receive funding through this state/federal program, to provide comments, feedback, or other information that will inform and assist us in our research.

We have developed this preliminary survey to better structure initial input from providers and we would greatly appreciate any and all information you can supply through this survey. We also anticipate a possible future survey or follow-up inquiries with providers based on these initial survey results and our other research activities during the project. Additionally, we plan to accompany State personnel from the Wyoming Department of Health (Health) and the Wyoming Department of Education (Education) during some of the planned training and monitoring site visits in the coming months.

Survey Completion

We did want to provide to you notice that while we are not directly evaluating providers, we are looking at the program from both the State and local levels. Accordingly, you will see questions related to what data we may want to gather directly from providers to help provide specific background information to the Legislature.

In completing this survey, please take into account any issues you believe are important for us to know related to either the Part B program (ages three to five), the Part C program (age birth to two), or both programs, where applicable and/or outlined in the survey. We also welcome additional comments and information for any question in the survey as well as in the general comments box at the end of the survey. Please be as clear and as complete as possible in your responses. This will help prevent our process from disturbing provider staff and activities as much as possible.

To be clear, your responses to our survey and other inquiries and correspondence will be confidential and will not be forwarded to or reviewed by Health or Education. We may include aggregate or combined results of this survey and any subsequent surveys in our final report, but we will work to make sure that published information is de-identified and cannot be tracked back to the original respondents. If you would you like to discuss any additional concerns you have regarding this evaluation or survey questions, please contact us at kathy.misener@wyoleg.gov or 307-777-7881

General

1. What is the overall purpose of your organization, and how does this purpose relate to the purpose of the EIEP specific to Part B and Part C?
    a. How does this purpose of your organization related to the purpose of the Early Intervention and Education Program?
    b. How does your organization fulfill both purposes?
2. Please describe your organization's typical interactions with Wyoming Department of Health related to Part B and Part C.
3. Please describe your organization's typical interactions with Wyoming Department of Education related to Part B and Part C.
4. Please provide any specific examples of conflicts between federal and State regulations (IDEA, state statutes, rules and regulations), and the administration of the program related to Part B and C.

Location and Services

5. Please provide the number of child development centers/sites in your region where Part B and Part C services are offered.
6. A. Please list the child development center/sites, within your region, and hours where Part B services are offered.
    i. Please identify the city/town/community locations
    ii. Please provide the business hours
    iii. Please provide the number of days open

    B. Please describe any non-owned/non-leased facilities where Part B services are provided.

    C. Please list the child development centers/sites, within your region, and hours where Part C services are offered.
    i. Please identify the city/town/community locations
    ii. Please provide the business hours
    iii. Please provide the number of days open

    D. Please describe any non-owned/non-leased facilities where Part C services are provided.
7. A. For Part B, please describe the standard/typical duration and frequency of preschool sessions. (e.g. three days per week for 2.5 hours per day)

    B. For Part B, how many months per year does your organization offer preschool services (e.g. 9 months, 12 months)? Please describe.

    C. For Part C, please describe the standard/typical duration and frequency of on-site sessions. (e.g. two days per week for 2.5 hours per day).

    D. For Part C, how many months per year does your organization offer on-site sessions (e.g. 9 months, 12 months)? Please describe.

    E. For Part C, please describe the standard/typical duration and frequency of off-site services. (e.g. two days per week for 2.5 hours per day).

8. For your region, please indicate the number of locations where services are offered, and who provides the service (employees/staff or contract providers).
    a. Audiology Services
    b. Family training, counseling and home visits
    c. Health Services
    d. Medical services
    e. Nursing Services
    f. Nutrition Services
    g. Occupational therapy
    h. Physical therapy
    i. Psychological services
    j. Service Coordination
    k. Social Work
    l. Special education services
    m. Speech and language therapy
    n. Transportation
    o. Vision
    p. Other- please describe

Staff

9. Please provide the number of current staff positions (filled and vacant) (full-time and part-time) for your organization for the following personnel:
    a. Occupational Therapist
    b. Physical Therapist
    c. Speech and Language Pathologist
    d. Special Education Teacher
    e. Regular Education Teacher
    f. Teaching assistant / paraprofessional
    g. Administration and Office (to include coordinators, caseworkers)
    h. Family Service Coordinator/Case Manager
    i. Social Worker
    j. Psychologist
    k. Other
10. If applicable, how often does your organization typically contract for the following services (hours of service per month):
    a. Occupational Therapist
    b. Physical Therapist
    c. Speech and Language Pathologist
    d. Special Education Teacher

    e. Other
11. Are you able to report staffing turnover data that includes the number of professionals (OT, PT, Speech and Language, and Special Education) that terminated their employment for positions with local school districts, as well as the number of days professional positions remain vacant?
12. In order to illustrate, from a statewide perspective, the number of the children served by the CDCs, are you able to provide the following data:
    a. Total number of children served (unduplicated count)?
    b. Total number of children served for the Part B program?
    c. Total number of children served for the Part C program?
    d. If you are also a Head Start or Early Head Start provider, the number of children served utilizing these funds?
    e. If you also receive TANF funds, number of children served utilizing these funds?
    f. Number of children served under Part B and Part C who may also be included in Head Start, Early Head Start, or TANF counts?
    g. The percent of children served who are typical learners?
    h. Please specify for what time period this data is available. We would like monthly statistics for the last five state fiscal years (July 1, 2010 – June 30, 2015), and through December 31, 2015?
13. Is preschool offered at your centers to <u>any</u> child (i.e. children who do not qualify for services under any program)?
    a. If yes, what are your tuition rates?
14. Do you offer services to <u>any</u> child two-years old and younger (i.e. children who do not qualify for services under any program)?
    a. If yes, what you're your tuition rates?
15. Do your facilities operate at capacity? If yes, is there a waiting list? What is the typical wait time?

Child Find

16. A. Are you able to report the following related to Part B program:
    a. Number of children screened?
    b. Number of children referred for evaluation?
    c. Number of children evaluated?
    d. Number of children identified?
    e. Number of children served?
    f. If yes for any of the above, are you able to:
        i. Report this information for each of the last five state fiscal years (July 1, 2010 – June 30, 2015), and through December 31, 2015?
        ii. Report this information on a monthly basis?

    B. Are you able to report the following related to Part B program:

g. Number of children screened?
h. Number of children referred for evaluation?
i. Number of children evaluated?
j. Number of children identified?
k. Number of children served?
l. If yes for any of the above, are you able to:
    i. Report this information for each of the last five state fiscal years (July 1, 2010 – June 30, 2015), and through December 31, 2015?
    ii. Report this information on a monthly basis?

17. How much funding have you received for Child Find activities from CDS of Wyoming in each of the last five state fiscal years?
    a. FY2015 (7/1/2014 -6/30/2015)
    b. FY2014 (7/1/2013 -6/30/2014)
    c. FY2013 (7/1/2012 -6/30/2013)
    d. FY2012 (7/1/2011 -6/30/2012)
    e. FY2011 (7/1/2010 -6/30/2011)
18. How much funding do you receive for Child Find activities from local school districts?
    a. FY2015 (7/1/2014 -6/30/2015)
    b. FY2014 (7/1/2013 -6/30/2014)
    c. FY2013 (7/1/2012 -6/30/2013)
    d. FY2012 (7/1/2011 -6/30/2012)
    e. FY2011 (7/1/2010 -6/30/2011)
19. Are you aware of direct Child Find activities, other than funding, provided by the school districts? Please describe.
20. Please explain if/when your organization has utilized non-CDS or non-school district funding sources, and how much of the other funding sources on 'Child Find' activities.

Funding

21. Please list the amount of funding your organization receives from each of the following sources, for each of the past five state fiscal years (July 1, 2010 – June 30, 2015), and through December 31, 2015 .
    a. FY2015 (7/1/2014 -6/30/2015)
        i. Federal
        ii. State
        iii. Other government or other grant revenue
        iv. Private pay
        v. All other sources
    b. FY2014 (7/1/2013 -6/30/2014)
        i. Federal

ii. State
iii. Local Public (city, counties, etc.)
iv. Private
v. All other sources

c. FY2013 (7/1/2012 -6/30/2013)
   i. Federal
   ii. State
   iii. Local Public (city, counties, etc.)
   iv. Private
   v. All other sources
d. FY2012 (7/1/2011 -6/30/2012)
   i. Federal
   ii. State
   iii. Local Public (city, counties, etc.)
   iv. Private
   v. All other sources
e. FY2011 (7/1/2010 -6/30/2011)
   i. Federal
   ii. State
   iii. Local Public (city, counties, etc.)
   iv. Private
   v. All other sources

Closing Remarks

22. Please describe what works well about the Early Intervention Education Program?

23. Please describe needed improvements for the Early Intervention Education Program?

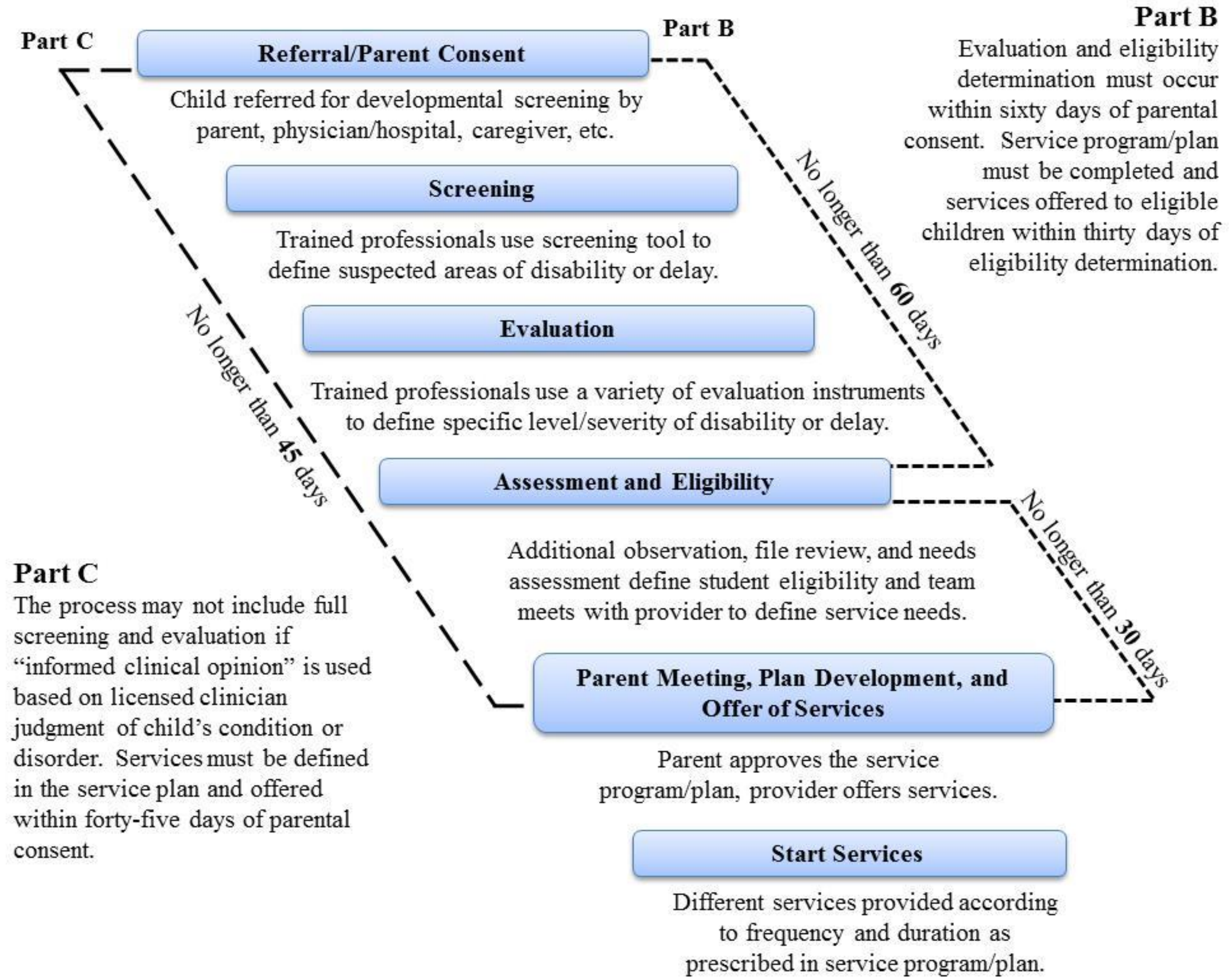
24. Please provide feedback or comments regarding moving administration of the program for Part B, or both Part B and Part C from Wyoming Department of Health to Wyoming Department of Education.

25. Please describe your organization's typical interactions with local school districts and whether moving administration from Department of Health to Department of Education would positively or negatively impact these interactions.

Appendix D

IDEA Part C and Part B Eligibility Process

The below flowchart represents a high-level view of the process and does not include all actions and activities required to complete the process (i.e. parental consent and safeguards notice, multi-disciplinary team participation and review, etc.)



Disagreements and Due Process: Parents have the ability to initiate formal complaints upon disagreement with plan or service decisions. Parents may also lodge due process complaints if they believe their contributions have been ignored or dismissed during the process.

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Appendix E

Regional Center Statistics Information

Table E.1
Part B Penetration Rates by Region (2010-2012)

Region	3-5 Years Population Census	2010		2011		2012	
		Part B Child Count	Rate	Part B Child Count	Rate	Part B Child Count	Rate
1	2061	388	18.83	362	17.56	381	18.49
2	1468	119	8.11	100	6.81	87	5.93
3	551	82	14.88	82	14.88	89	16.15
4	1150	88	7.65	59	5.13	66	5.74
5	1955	199	10.18	211	10.79	195	9.97
6	1845	179	9.70	182	9.86	152	8.24
7	2164	260	12.01	297	13.72	315	14.56
8	674	115	17.06	94	13.95	75	11.13
9	3202	291	9.09	268	8.37	238	7.43
10	1348	166	12.31	168	12.46	106	7.86
11	1105	110	9.95	99	8.96	83	7.51
12	4023	397	9.87	338	8.40	291	7.23
13	2356	173	7.34	179	7.60	176	7.47
14	1342	45	3.35	48	3.58	44	3.28
TOTAL	**23,902**	**2,612**	**10.93**	**2,487**	**10.40**	**2,298**	**9.61**

Note: Regions 14 is not included in statewide count only Fremont County is represented.
Source: U.S. Census Bureau, 2010 Census

Table E.2
Part C Penetration Rates by Region (2013)

Region	Main Office	0-2 Years Population Census	2013	
			Child Count	Rate
1	Cody	1,886	162	8.59
2	Sheridan	1,441	65	4.51
3	Newcastle	558	29	5.20
4	Jackson	1,244	33	2.65
5	Mt. View	1,904	47	2.47
6	Lander	1,886	91	4.83
7	Green River	2,175	81	3.72
8	Rawlins	692	30	4.34

Region	Main Office	0-2 Years Population Census	2013	
			Child Count	Rate
9	Casper	3,183	120	3.77
10	Guernsey	1,285	46	3.58
11	Laramie	1,285	59	4.59
12	Cheyenne	4,024	254	6.31
13	Gillette	2,471	78	3.16
14	Ft. Washakie	1,388	25	1.80
	Statewide Total	**24,034**	**1,120**	**4.66**

Note: Regions 14 is not included in the statewide census population; only Fremont County is included.
Source: U.S. Census Bureau, 2010 Census; and Wyoming 2015 Part C Eligibility Study

Table E.3
Child Count, Average Count, and Percent Change for Eligible Child Count, by Regional Center, 2010 and 2015

Regional Center	2010		2015		Average 2010-2015		Percent Change 2010-2015	
	Part C	Part B	Part C	Part B	Part C	Part B	Part C	Part B
1	179	413	179	344	176	394	0.0%	-16.7%
2	69	125	67	110	69	114	-2.9%	-12.0%
3	27	97	30	105	31	97	11.1%	8.2%
4	38	100	37	106	35	95	-2.6%	6.0%
5	62	219	66	248	62	234	6.5%	13.2%
6	66	190	114	205	99	196	72.7%	7.9%
7	103	278	93	207	92	288	-9.7%	-25.5%
8	37	127	36	95	33	105	-2.7%	-25.2%
9	158	302	171	262	152	301	8.2%	-13.2%
10	56	174	48	184	51	167	-14.3%	5.7%
11	59	115	66	120	63	118	11.9%	4.3%
12	241	410	269	325	262	357	11.6%	-20.7%
13	66	184	77	232	77	214	16.7%	26.1%
14	27	70	36	69	27	65	33.3%	-1.4%
Subtotal	**1,188**	**2,804**	**1,289**	**2,612**	**1,230**	**2,745**	**8.5%**	**-6.8%**
Program Total	**3,992**		**3,901**		**3,975**		**-2.3%**	

Source: Legislative Service Office analysis of Wyoming Department of Health count data.

Appendix F

Wyoming State Agencies' Early Learning Efforts

Source: Wyoming Department of Workforce Services.

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WYOMING DEPARTMENT OF EDUCATION		
Program and Description	Funding	Program Data
Title 1 Used in whole or part by school districts to provide education services to children below school age.	**Federal** $724,607.46 **State** $0 **Local** $0	Children who participate in high quality early learning programs: • Require less special education, • Are less likely to need child welfare services, • Enroll in K-12 education better prepared resulting in lower spending on extra help services, • Are less likely to engage in criminal activity as juveniles and adults, • Are less likely to need social welfare support services as adults, • Generally have higher incomes when they enter the labor force, • Are likely to have employer-provided health insurance.[1]
K-3 Reading Assessment Provides implementation funds for reading assessment and intervention strategies for Wyoming school personnel.	**Federal** $0 **State** $371,192.00 **Local** $0	• 60.65% of Wyoming third grade students scored proficient or advanced in reading in 2014-2015.[2] • Students who do not read proficiently by third grade are four times more likely to leave high school without a diploma than proficient readers.[3]
Early Learning K Readiness Collect data to evaluate kindergarten readiness; facilitate inter-agency coordination for early childhood programs and services; support efforts to ensure all students succeed in Pre-K through 3rd Grade.	**Federal** $0 **State** $182,000.00 **Local** $0	• 39% of Wyoming kindergarten students scored "proficient" in fall of 2014 according to the WDE's Instructional Foundations for Kindergarten assessment. 3,473 kindergarten students were rated by 211 kindergarten teachers in 78 schools across 26 districts.[4] • All children can and will improve, but for those who enter kindergarten behind, around 75 percent will never catch up to their classmates.[5] • The primary driver of low achievement is not parent wealth or skin color. It is starting behind. Students who spend little time on basic skills and knowledge from birth to five typically start behind.[6]
Temporary Assistance for Needy Families (TANF) Fund contracts with local entities to provide preschool programs for economically disadvantaged students.	**Federal** $1,500,000.00 **State** $0 **Local** $0	• Poverty compounds student achievement challenges: Students who have lived in poverty are three times more likely to drop out or fail to graduate on time than their more affluent peers.[iv] • See outcomes above for children who participate in high quality early learning programs.
21st Century No information at this time.	**Federal** $? **State** $? **Local** $?	

<table>
<tr><th colspan="3">WYOMING DEPARTMENT OF FAMILY SERVICES</th></tr>
<tr><th>Program and Description</th><th>Funding</th><th>Program Data (Needs and Successes)</th></tr>
<tr><td>Child Care Development Block Grant
Support toward child care licensing, early childhood quality programs, infant and toddler training for licensed child care providers and facilities, and child care subsidy (approximately 70% of total funds are used for subsidy).

*State dollars are matching funds that are used to match the subsidy that families with low income receive to pay for child care; dollars are only used if the subsidy is approved through the federal program.</td><td>Federal
$9,199,272.00
State
$8,503,691.00
Local
$0</td><td>• Wyoming has 697 licensed or exempt child care facilities that provide 20,733 early care and education slots for children.[7]
○ 258 child care centers,
○ 147 family child care centers,
○ 292 family child care homes,
○ 63% of facilities are family child care facilities.
• The high cost of child care put quality early care and education out of reach for many families, particularly families with low income. Access to child care subsidies helps families afford high quality child care.[8]
• Children who participate in high quality early learning programs:
○ Require less special education,
○ Are less likely to need child welfare services,
○ Enroll in K-12 education better prepared resulting in lower spending on extra help services,
○ Are less likely to engage in criminal activity as juveniles and adults,
○ Are less likely to need social welfare support services as adults,
○ Generally have higher incomes when they enter the labor force,
○ Are likely to have employer-provided health insurance.[9]</td></tr>
<tr><td>Early Childhood Community Partnership Grants
Funds fourteen community grantees to develop, enhance and sustain high quality early childhood education programs that ensure children are ready to be successful in school.</td><td>Federal
$0
State
$740,000.00
Local
$149,125.00</td><td>• 14 community grantees have (in less than one year of grant implementation):
○ Invested $262,369.33 in matching and in-kind dollars in community grant work,
○ Hosted 80 family activities or events that reached 3,952 children and 3,052 adults,
○ Given away 1,832 books,
○ Disseminated 5,929 marketing messages,
○ Hosted 31 trainings that reached 450 early care and education providers.
• The easiest place to change a child's academic trajectory is from birth to age five.[10]
• Forward looking communities create simple organizational structures to help and inform parents of the lowest 40 percent of students to do what the parents of the top 40 percent of students do – read 20 minutes every day to their children beginning at birth, talking to them and spending another 5 to 10 minutes each day on age appropriate literacy, math and social skills.[11]</td></tr>
</table>

<table>
<tr><th colspan="3">WYOMING DEPARTMENT OF HEALTH</th></tr>
<tr><th>Program and Description</th><th>Funding</th><th>Program Data</th></tr>
<tr><td>Part C of IDEA
Early Intervention for children ages 0-3.</td><td>Federal
$1,650,285.00
State
$11,479,722.00
Local
$0</td><td rowspan="2">• Administered through Dept. of Health and the Child Development Center's to serve approximately 4,100 children for Part B and C in early childhood statewide.
• Outcomes for young children who participate in early intervention services include increased motor, social, and cognitive functioning; the acquisition of age-appropriate skills; and reduced negative impacts of their disabilities or delays.[12]
• Families benefit from early intervention by being able to better meet their children's special needs from an early age and throughout their lives.[13]
• Benefits to society include reducing economic burden through a decreased need for special education.[14]</td></tr>
<tr><td>Part B of IDEA
Special Education for children ages 3-21.</td><td>Federal
$1,709,512.00
State
$23,336,005.00
Local
$0</td></tr>
<tr><td>Early Childhood Comprehensive Systems (ECCS)
Funds support developmental screenings and the Help Me Grow model implementation.</td><td>Federal
$140,000.00
State
$0
Local
$0</td><td></td></tr>
<tr><td>Title V Block Grant
Serves target populations of women and children. Provides genetics clinics, parent leadership, basic reproductive health, dental sealants, vision collaborative, SafeKids contract, home visiting, infant metabolic screening, immunizations, and care coordination for children and youth with special health care needs. Funding is not solely used for birth to 8 years of age.

*These state dollars reflect the Maintenance of Effort, required by the Title V grant, for Wyoming. In other words, no less than this SGF dollar amount can be spent on the Title V target populations.</td><td>Federal
$1,000,000.00
State
$2,375,591.00
Local
$0</td><td>• Mothers who receive prenatal care are less likely to have preterm or low birth weight infants, and are more likely to obtain regular pediatric care for their young children.[15]
• Low birth weight infants (<5.5 pounds at birth) experience higher rates of developmental delays and higher rates of poor school performance, and are more likely to require special education.[16]
• Car seat use reduces the risk for death to infants (aged <1 year) by 71%; and to toddlers (aged 1–4 years) by 54% in passenger vehicles.[17]
• Late or missing immunizations can lead to preventable illnesses and long-term physical and developmental problems.[18]
• Home visiting programs that focus on supporting families with tough challenges can improve critical child outcomes:
○ Reduce the number of low-birth-weight babies.
○ Reduce the rate of child abuse and neglect by nearly one-half.
○ Improve kindergarten readiness and increase reading and math test scores in grades 1-3 by 25 percent.
○ Increase children's, of mothers participating in home visiting, high school graduation rates by 60 percent.[19]
• Studies show that high-quality home visiting programs offer returns on investment ranging from $1.26 to $5.70 for every dollar spent due to reduced costs of child protection, k-12 special education and grade retention, and criminal expenses.[20]</td></tr>
</table>

WYOMING DEPARTMENT OF WORKFORCE SERVICES		
Program and Description	**Funding**	**Program Data**
Head Start Collaboration Office Funds a required federal grant to support coordination and collaboration for Head Start programs and state level systems to support needs of children and families with low-incomes (see Head Start Programs under Non-Agency Programs).	**Federal** $125,000.00 **State** $25,000.00 **Local** $0	• In 2014-2015, 2,472 children and families received comprehensive, evidence-based birth through five services from Head Start and Early Head Start. Specific outcomes include: ○ 540 families receiving emergency/crisis intervention, ○ 572 families receiving mental health services, ○ 1,787 families receiving health education, ○ 1,869 families receiving parenting education, ○ 274 receiving adult education such as GED or college selection support.[21] • Approximately 28.6% of families with children who are eligible for Head Start services are able to access a program.[22] • According to the U.S. Census Bureau, there are 8.622 children under the age of six living in Wyoming living in families with incomes less than 100% of the federal poverty line. • Poverty compounds student achievement challenges: Students who have lived in poverty are three times more likely to drop out or fail to graduate on time than their more affluent peers.[iv]
WY Quality Counts This program provides scholarship and training grants for licensed child care providers. Dollars support both attendance at trainings, and brining trainings to areas where trainings are scarce. All educational opportunities support best business and high quality early childhood practices. Additional dollars generate public awareness about a child's earliest years, and honor families in their role to prepare children for success in school and in life.	**Federal** $0 **State** $1,069,856.00 **Local** $0	• 9,632 early care and education providers are active in the state registry.[23] ○ 185 (2%) self-report that they have an Associate Degree in Child Development, ○ 2,991 (30%) self-report that they have a certificate or license, an Associate degree, a Bachelor degree, a Master degree, or a Doctorate in any field. • In five years, WY Quality Counts has: ○ Awarded 235 college scholarships for $664,819.72 that affected 1,160 early care and education providers (27 scholarships for $115,329.59 affected 184 providers in 2015). ○ Awarded 171 Child Development Associate (CDA) scholarships for $393,129.74 that affected 574 early care and education providers (41 scholarships for $83,792.17 affected 116 providers in 2015). ○ Awarded 98 training grants totaling $828,012.89 affecting 679 early care and education providers (24 grants for $225,244.44 affected 195 providers in 2015). • High quality early learning programs offer the most promise for increasing children's school readiness. • Research shows that early care and education providers with specialized training in early childhood are more effective and more actively engaged with the children they teach.[24]

NON-AGENCY PROGRAMS		
Program and Description	Funding	Program Data
Head Start and Early Head Start *(Contracted to local grantees)* Funds awarded directly to local entities to provide high quality early learning experiences and family support to families with low income and children who are at-risk. Local matches are mostly in the form of in-kind donations.	**Federal** $13,750,805.00 **State** $0 **Local** $0	• In 2014-2015, 2,472 children and families received comprehensive, evidence-based birth through five services from Head Start and Early Head Start. Specific outcomes include: ○ 540 families receiving emergency/crisis intervention, ○ 572 families receiving mental health services, ○ 1,787 families receiving health education, ○ 1,869 families receiving parenting education, ○ 274 receiving adult education such as GED or college selection support.[25] • Approximately 28.6% of families with children who are eligible for Head Start services are able to access a program.[26] • According to the U.S. Census Bureau, there are 8.622 children under the age of six living in Wyoming living in families with incomes less than 100% of the federal poverty line. • Poverty compounds student achievement challenges: Students who have lived in poverty are three times more likely to drop out or fail to graduate on time than their more affluent peers.[iv] • Children who participate in high quality early learning programs: ○ Require less special education, ○ Are less likely to need child welfare services, ○ Enroll in K-12 education better prepared resulting in lower spending on extra help services, ○ Are less likely to engage in criminal activity as juveniles and adults, ○ Are less likely to need social welfare support services as adults, ○ Generally have higher incomes when they enter the labor force, ○ Are likely to have employer-provided health insurance.[27]
Maternal, Infant and Early Childhood Home Visiting Grant *(Administered by Parents as Teachers National and the Wyoming Citizen Review Panel)* Supports the implementation of evidence-based home visiting models in four Wyoming counties, and early childhood systems development and coordination statewide.	**Federal** $1,200,000.00 **State** $0 **Local** $0	• Home visiting programs that focus on supporting families with tough challenges can improve critical child outcomes: ○ Reduce the number of low-birth-weight babies. ○ Reduce the rate of child abuse and neglect by nearly one-half. ○ Improve kindergarten readiness and increase reading and math test scores in grades 1-3 by 25 percent. ○ Increase children's, of mothers participating in home visiting, high school graduation rates by 60 percent.[28] • Studies show that high-quality home visiting programs offer returns on investment ranging from $1.26 to $5.70 for every dollar spent due to reduced costs of child protection, k-12 special education and grade retention, and criminal expenses.[29]

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