

Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2005



Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Long Term Support

Executive Summary

The Community Options Program (COP) began with the passage of the 1981 state budget. The purpose of the program was to create a home and community-based alternative to nursing home care. The Community Options Program offers more choices for older people and people with disabilities at a lower cost to the state. In 1986, Wisconsin received a federal Medicaid Home and Community-Based Waiver for people who are elderly or have a physical disability, which allowed the state to get federal matching funds for COP. The Community Options Program serves a limited number of people and is not an entitlement.

The state-funded Community Options Program – Regular serves people who are elderly or who have a physical, developmental or mental disability. The COP Medicaid waiver serves only people who are elderly or have a physical disability. This includes the Community Options Program-Waiver (COP-W) and the Community Integration Program II (CIP II). Other waivers, the Community Integration Program (CIP 1A and CIP 1B) and the Brain Injury Waiver, serve people with developmental disabilities. In addition, the Children Long Term Support (CLTS) waivers serve children with developmental and physical disabilities, and severe emotional disturbances.

In 2005, COP and all home and community-based waiver programs served a total of 27,222 people, of which 8,105 or 30 percent were elderly, 13,150 or 48 percent were persons with developmental disabilities, 5,040 or 19 percent were persons with physical disabilities, 919 or 3 percent were persons with mental illness, and 8 were persons with alcohol and/or drug abuse (AODA).

In 2005, \$57 million of state COP served five client populations. In addition, \$155 million of state and federal funding was spent on elders and people with physical disabilities under the COP Waiver and CIP II programs. Long term care waivers for children and those with developmental disabilities spent \$356 million.

Individuals who use waiver services are also eligible for the Medicaid fee-for-service (“card”) benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in CIP II and COP-W used \$130,825,594 in benefits from their Medicaid card. The largest expenditures were for prescription drugs (\$37 million) and personal care (\$30 million).

The *average* daily cost of care for participants in CIP II and COP-W in Calendar Year (CY) 2005 was \$81.20. This includes state and federal funds totaling \$285.9 million per year. The *average* daily cost of care for people in nursing homes, at the same combination of levels of care, was \$104.87 of Medicaid funds.

Almost 70 percent of COP and all waiver participants received care in their own homes or apartments; only 16 percent were living in community-based residential facilities (CBRF). A majority of the participants also had family or friends involved in providing voluntary care. Quality assurance reviews measured high rates of consumer satisfaction, especially for people living in their own homes.

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INTRODUCTION

This report is submitted pursuant to s. 46.27(11g) and s. 46.277(5m), of the Wisconsin Statutes, which requires summary reporting on state funds appropriated in the biennial budget process for the Community Options Program. The Community Options Program (also known as COP-Regular or Classic COP) serves all client groups in need of long-term care and is entirely state-funded.

The statutes also permit COP funds to be used to support the Medicaid waiver programs. The federal government grants waivers of Medicaid rules to permit states to provide long-term care at home to a population that qualifies for Medicaid coverage of nursing home care. State funds are matched by federal Medicaid dollars at a ratio of about 40:60. The Community Options Program-Waiver (COP-W) is limited to persons who are elderly and/or persons with a physical disability. The federal Community Options Program-Waiver also includes the Community Integration Program II (CIP II). (See Appendix B.)

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), and Community Integration Program 1B (CIP 1B) serve the community needs for long-term care participants with developmental disabilities. Brain Injury Waiver (BIW) serves individuals who have received brain injury rehabilitation. The Community Options Program state funding is often used as match for federal funds through these waivers. Children's Long Term Support Waivers (CLTS) serves persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance.

This report describes the persons served, program expenditures and services delivered primarily through COP, COP-W and CIP II in CY 2005. Information on all waivers has been reported where data was available. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP provides a comprehensive health care package to recipients. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Department of Health and Family Services administers COP and COP-W while the programs are managed by county agencies. Funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations or to address waiting lists. The success of the Community Options Program is measured both by how well the program is able to help contain the use and cost of Medicaid-funded nursing home care, and by producing positive outcomes for the program participants. Both COP and COP-W together provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The local Community Options Program Plan describes local resource coordination of the county policies and practices, and assures the prudent, cost-effective operation of the program. Each county COP Plan is updated annually with approval by the local Long-Term Support Planning Committee. State level program management monitors local compliance with federal and state program requirements.

PARTICIPANTS SERVED BY PROGRAMS

The following table provides information about the numbers of participants in various waiver programs. The Community Options Program, in combination with Medicaid waiver funds, is used to support individuals in the community. The program category column in Table 1 lists each funding source by type of Medicaid waiver, and when each waiver is combined with COP funding. (See Appendix B for program definitions.) The categories of participants are elderly, persons with physical disabilities (PD), persons with developmental disabilities (DD), persons with severe mental illness (SMI), and persons with alcohol and/or drug abuse (AODA).

TABLE 1 - Participants Served by Programs During 2005 with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								8,184
Waiver Only	3,984	2,249				6,233		
Waiver/COP	1,445	506					1,951	
CIP II								3,736
Waiver Only	1,107	1,389				2,496		
Waiver/COP	718	522					1,240	
Sub Total COP-W/CIP II	7,254	4,666	0	0	0	8,729	3,191	11,920
CIP 1A	Elderly	PD	DD	SMI	AODA			1,297
Waiver Only	50		1,189			1,239		
Waiver/COP	4		54				58	
CIP 1B Regular								3,306
Waiver Only	246		2,955			3,201		
Waiver/COP	11		94				105	
CIP 1B COP Match								2,276
Waiver/COP for match only	94		1,986			2,080		
COP match waiver w/other COP	13		183				196	
CIP 1B Other Match								4,886
Waiver/other for match	202		4,612			4,814		
Waiver/COP	4		68				72	
Brain Injury Waiver								228
Waiver Only		140	67			207		
Waiver/COP		17	4				21	
Brain Injury COP Match								17
Waiver/COP for match only		9	2			11		
COP match waiver w/other COP		5	1				6	
Brain Injury Waiver Other Match								86
Waiver/other for match		43	41			84		
Waiver/COP			2				2	
Sub Total DD Waivers	624	213	11,259	0	0	11,636	460	12,096
CLTS	Elderly	PD	DD	SMI	AODA			1,653
Waiver Only		5	1,600	33		1,638		
Waiver/COP		1	14	0			15	
CLTS COP Match								57
Waiver/COP for match only		13	13	8		34		
COP match waiver w/other COP		16	5	2			23	
CLTS Other Match								326
Waiver/other for match		13	213	97		323		
Waiver/COP		0	2	1			3	
Sub Total CLTS Waivers	0	48	1,847	141	0	1,995	41	2,036
COP Only Participants	227	113	44	778	8			1,170
Totals by Target Population	8,105	5,040	13,150	919	8	22,360	3,692	TOTAL
% Served by Target Population	29.8%	18.5%	48.3%	3.4%	0.03%	82.1%	13.6%	27,222

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2005 HSRS.

- Total unduplicated participants served in 2005 - 27,222.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 22,360.
- Total Medicaid waiver participants who also received COP funding in CY 2005 - 3,692.
- Total participants who received only COP funding (not Medicaid eligible) - 1,170.
- All participants who received either pure COP or COP to supplement waiver funds - 4,862.
- Total participants served with COP and COP-W funds - 11,095.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 27,222 persons. The table below illustrates participants served in 2005 with COP and Medicaid waiver funding by target group.

TABLE 2
Participants Served by Target Group During 2005 with COP and All Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CLTS, BIW	GRAND TOTAL
Elderly	227 19.4%	5,249 66.3%	5,656 60.5%	750 43.1%	1,107 44.4%	7,513 53.5%	592 4.3%	8,105 29.8%
PD	113 9.7%	2,755 33.7%	2,868 30.7%	560 32.2%	1,389 55.6%	4,817 35.4%	223 1.6%	5,040 18.5%
DD	44 3.8%	0 0%	44 0.5%	428 24.5%	0 0%	472 3.5%	12,678 93.0%	13,150 48.3%
SMI	778 66.5%	0 0%	778 8.3%	3 .2%	0 0%	781 5.7%	138 1.0%	919 3.4%
AODA	8 0.7%	0 0%	8 0.1%	0 0%	0 0%	8 0.06%	0 0%	8 0.03%
Total	1,170 4.3%	8,184 30.1%	9,354 34.4%	1,739 6.4%	2,496 9.2%	13,591 49.9%	13,631 50.1%	27,222 100.0%

Note: Totals may not equal 100% due to rounding. Source: 2005 HSRS.

- 8,105 or 30% were elderly;
- 5,040 or 19% were persons with physical disabilities (PD);
- 13,150 or 48% were persons with developmental disabilities (DD);
- 919 or 3% were persons with severe mental illness (SMI); and
- 8 or less than 1% were persons with alcohol and/or drug abuse (AODA).

FIGURE 1
Participants Served by Target Group During 2005 with COP and All Waivers

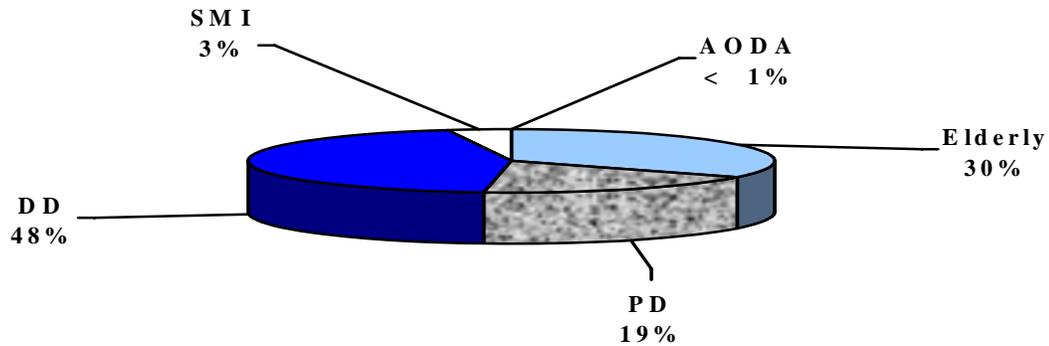


TABLE 3

Participants Served by Programs on December 31, 2005 (Point-In-Time) with COP and All Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								6,506
Waiver Only	3,366	1,331				4,697		
Waiver/COP	1,447	362					1,809	
CIP II								3,199
Waiver Only	967	1,335				2,302		
Waiver/COP	505	392					897	
Sub Total COP-W/CIP II	6,285	3,420				6,999	2,706	9,705
CIP 1A	Elderly	PD	DD	SMI	AODA			1,248
Waiver Only	47		1,155			1,202		
Waiver/COP	4		42				46	
CIP 1B Regular								3,235
Waiver Only	237		2,914			3,151		
Waiver/COP	10		74				84	
CIP 1B COP Match								2,154
Waiver/COP for match only	88		1,917			2,005		
COP match waiver w/other COP	13		136				149	
CIP 1B Other Match								4,777
Waiver/other for match	191		4,529			4,720		
Waiver/COP	3		54				57	
Brain Injury Waiver								220
Waiver Only		135	65	1		201		
Waiver/COP		15	4	0			19	
Brain Injury COP Match								14
Waiver/COP for match only		8	5			13		
COP match waiver w/other COP		0	1				1	
Brain Injury Waiver Other Match								87
Waiver/other for match	1	43	41			85		
Waiver/COP	0	1	1				2	
Sub Total DD Waivers	594	202	10,938	1	0	11,377	358	11,735
CLTS	Elderly	PD	DD	SMI	AODA			1,544
Waiver Only		5	1,495	32		1,532		
Waiver/COP		1	11	0			12	
CLTS COP Match								50
Waiver/COP for match only		15	11	8	1	35		
COP match waiver w/other COP		9	4	2	0		15	
CLTS Other Match								318
Waiver/other for match		16	211	91		318		
Waiver/COP		0	0	0			0	
Sub Total CLTS Waivers		46	1,732	133	1	1,885	27	1,912
COP Only Participants	180	87	62	725	6			1,060
Totals by Target Population	7,059	3,755	12,732	859	7	19,991	3,091	24,412
% Served by Target Population	28.9%	15.4%	52.2%	3.5%	0.03%	86.8%	13.2%	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2005 HSRS.

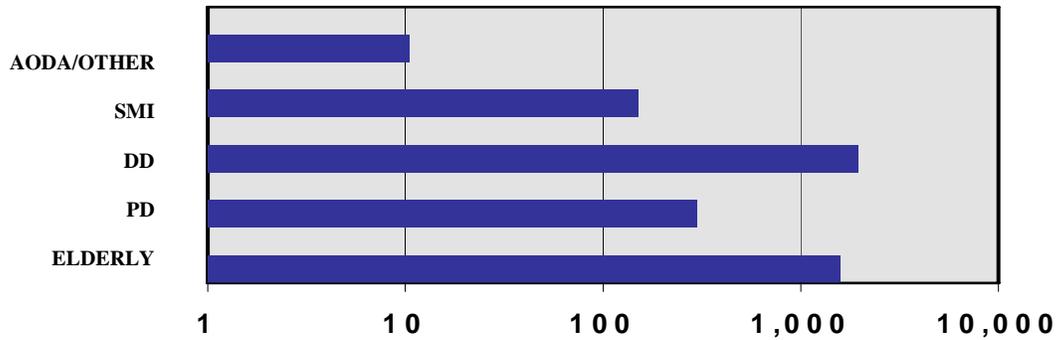
ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2005, 6,708 assessments were conducted, and 3,780 care plans were prepared.

NEW PERSONS

Figure 2 illustrates the target group distribution of the 3,274 new persons served during 2005. The majority of the new participants served in 2005 were persons with a developmental disability. Clients are considered new if they have services and costs in the current year and no long-term support services of any type in the prior year.

FIGURE 2
New Persons Receiving Services by Target Group in 2005
For COP and All Waivers



	Elderly	PD	DD	SMI	AODA/Other	TOTAL
<18 yrs.	NA	19	467	102	1	589
18 – 64 yrs.	NA	419	872	103	9	1,403
65+ yrs.	1,282	NA	NA	NA	0	1,282
TOTAL	1,282 (39.1%)	438 (13.4%)	1,339 (40.9%)	205 (6.3%)	10 (.3%)	3,274

Source: 2005 HSRS.

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2005 for various reasons. 2,757 cases, which equals approximately ten percent of all participants' cases, were closed during 2005. About 46 percent of elderly case closures and 40 percent of closures of persons with physical disabilities were due to death. Approximately 31 percent of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 40 percent were due to moving to an institution.

TABLE 4
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	860	174	109	13	3	2	1,161
Transferred to or Preferred Nursing Home Care	748	63	27	5	1	2	846
No Longer Income or Care Level Eligible	73	76	52	11	0	0	212
Moved	65	28	63	8	0	2	166
Voluntarily Ended Services	53	39	90	24	0	0	208
Other Funding Used for Services	36	44	41	9	0	0	125
Reside in ICF-MR/IMD Center	3	0	10	0	0	0	13
Medical Issues/Behavioral Challenges	7	2	0	2	0	0	9
Inadequate Service/Support	2	1	2	0	0	0	18
Transferred to Partnership Program	5	3	0	0	0	0	8
Other	0	1	0	0	0	0	1
Total Cases Closed (all reasons)	1,852	431	394	70	4	6	2,757

Source: 2005 HSRS.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. At the end of 2005, one-third of COP and COP-W participants had received services for three years or less. The other two-thirds of program participants are longer-term participants who received services for longer than three years. In fact, thirty-nine participants have received services for as many as ten years or more.

Turnover is defined as the number of new participants who need to be added in order to keep the caseload constant. For example, a local program may need to serve 125 persons during a year to maintain an average ongoing caseload of 100, and would have had a turnover of 25 participants. The turnover rate equals the amount of turnover divided by the total caseload. In this example, the turnover rate is 25 percent.

Table 5 illustrates the number of cases closed during 2005 divided by the caseload size on December 31, 2004 for each target group. The shaded row of Table 5 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2006.)

TABLE 5
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2005	8,105	5,040	13,150	919	8	0	27,222
Point-in-Time Number of Persons Served on December 31, 2005	7,059	3,755	12,732	859	7	0	24,412
Number of Cases Closed During 2005 (Excludes Transfers to the Family Care Program)	1,852	431	394	70	4	6	2,757
Point-in-Time Number of Persons active on December 31, 2004 (Caseload Size)	7,465	3,892	11,928	763	6	0	24,054
Turnover Rate for the Above Case Closures	25%	11%	3%	9%	67%	n/a	11%

Source: 2005 HSRS.

NURSING HOME RELOCATIONS

In 2005, county long-term support agencies in 52 counties relocated 235 people from general nursing homes to community-based settings using funding from the COP-Waiver/CIP II program and the Community Relocation Initiative (CRI). The Community Relocation Initiative, which was approved in the 2005-07 biennial budget and became effective July 2005, expanded the opportunity for relocations by enabling any eligible nursing home resident who wishes to relocate to do so. This year's report on 2005 activity reflects relocations from that initiative which was in effect for a few months.

TABLE 6A
Number of Relocated Participants by Age Group

AGE GROUPS	18-34	35-54	55-64	65-74	75-89	90+	TOTAL
CIP II/COP-W Participants	5	23	13	32	56	15	144
CRI Participants	1	12	16	19	37	6	91
TOTALS	6	35	29	51	93	21	235

Source: 2005 HSRS

TABLE 6B
COP-W/CIP II Relocated Participants by Type of Residence

TYPE OF RESIDENCE	Adult Family Home	CBRF	Own Home or Apartment	RCAC	Supervised Community Living	TOTAL
CIP II/COP-W Participants	15	46	80	3	0	144
CRI Participants	7	48	32	4	0	91
TOTAL	22	94	112	7	0	235
PERCENTAGE	9%	40%	48%	3%	0%	100%

Source: 2005 HSRS

ICF-MR RESTRUCTURING INITIATIVE

In 2005, county long-term support agencies in 51 counties relocated 293 people with developmental disabilities from non-state-owned Intermediate Care Facilities for the Mentally Retarded (ICF-MR) or a non-state-owned nursing facility. The ICF-MR Restructuring Initiative was passed in the 2003-05 biennial budget and became effective on January 1, 2005. The ICF-MR Restructuring Initiative allows money to follow a person from an institution into a community setting if the court determines the community setting is the most integrated setting appropriate to the needs of the individual. Following is a summary of the relocations under the ICF-MR Restructuring Initiative in 2005.

TABLE 6C
ICF-MR Relocated Participants by Type of Residence

TYPE OF RESIDENCE	Own Home or Apartment	Adult Family Home 1 - 2 BEDS	Adult Family Home 3 - 4 BEDS	CBRF 6 - 8 BEDS	TOTAL
PARTICIPANTS	36	13	195	49	293
PERCENTAGE	12%	4%	67%	17%	100%

COP FUNDING FOR EXCEPTIONAL NEEDS

Within the statewide Community Options Program a fund exists for exceptional needs. The Department may carry forward to the next fiscal year any COP and COP-W GPR funds allocated but not spent by December 31 (s. 46.27(7)(g), Wis. Stats.). These exceptional funds are made available to applicant counties for the improvement or expansion of long-term community support services for clients. Services may include:

- a) start-up costs for developing needed services or eligible target groups;
- b) home modifications for COP eligible participants and housing funding;
- c) purchase of medical services and medical equipment or other specially adapted equipment; and
- d) vehicle modifications.

In 2005, funds for exceptional needs were awarded to 52 counties. For example, individual awards include “homecoming” funds that allow people to purchase or pay for household furnishings, equipment, security deposits and other items to enable them to move from an institution into the community. Awards were made for home repairs and modifications such as ramps, mobility lifts, overhead track lifts, roll-in showers, raised toilets, lowered cabinets and fixtures, grab bars, wider hallways and doors, door openers, automatic controls for windows, lights, temperature devices, adapted beds, adapted chairs and other items. Awards were also made for adapted mobility equipment such as wheelchairs, walkers and scooters not covered by Medicaid, as well as van modifications.

SIGNIFICANT PROPORTIONS AND TARGET GROUPS SERVED WITH COP AND COP-W FUNDS

The **COP and COP-W funding** is intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP funding serve persons from the major target groups in proportions that approximate the percentages of Medicaid-eligible persons who are served in nursing homes or state institutions. These percentages are called “significant proportions.”

The minimum percentages for significant proportions were initially set in 1984 and have been periodically adjusted to reflect changes in the growth of the long-term care population. The percentage for elderly has been set lower than the actual population to allow some county flexibility. The total minimum percentages add up to 84.2 percent with 15.8 percent reserved for county discretion.

TABLE 7A
Detail of 2005 Significant Proportions by Target Groups

2005		Elderly	PD	DD	SMI	AODA	Other	Total
	Total served excluding the Partnership Program and Milwaukee County Disability Services ¹	5,551	1,651	1,930	735	39	0	9,906
	Percentage for above total	56.0%	16.7%	19.5%	7.4%	0.4%	0.0%	100%
	Partnership Program participants served ²	1,090	605	0	0	0	0	1,695
	Total including the Partnership Program participants	6,641	2,256	1,930	735	39	0	11,601
	Percentage for above total	57.2%	19.4%	16.6%	6.3%	0.3%	0.0%	100%
	Participants served by Milwaukee County Disability Services ³	7	412	825	111	0	0	1,355
	Standard Methodology (including the above participants) ⁴	6,648	2,668	2,755	846	39	0	12,956
Percentage for above total	51.3%	20.6%	21.3%	6.5%	0.3%	0.0%	100.0%	

Source: 2005 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

TABLE 7B
Individuals and Percentages Used for Monitoring Significant Proportions 2001 - 2005

Year	Elderly	PD	DD	SMI	AODA	Other	Total
	Minimum Percentages	57.0%	6.6%	14.0%	6.6%	0%	
2005	6,648 51.3%	2,668 20.6%	2,755 21.3%	846 6.5%	39 0.3%	0 0.0%	12,956 ⁴ 100%
2004	6,824 51.5%	2,603 19.6%	2,879 21.7%	909 6.9%	19 0.1%	27 0.2%	13,261 ⁴ 100%
2003	7,003 49.6%	2,861 20.3%	3,327 23.6%	881 5.2%	23 0.2%	30 0.2%	14,125 ⁴ 100%
2002	6,738 48.8%	2,911 21.1%	3,338 24.2%	819 5.9%	8 0.1%	1 0.0%	13,815 100%

Note: Counts reflect individuals served with COP and COP-W funding on December 31st of each year with adjustments applied.
 Source: 2005 HSRS, Reconciliation Schedules, and Partnership Enrollment Data.

1. These numbers include calculation for COP funding used as overmatch and for county specific variances. They do not include individuals served by Milwaukee County Disability Services or those served by the Partnership Program who count for significant proportions.
2. Numbers of individuals served by the Partnership Program in Chippewa, Dane, Dunn, Eau Claire and Milwaukee County Disability Services who are counted for significant proportions.
3. Numbers of individuals served by Milwaukee County Disability Services with COP and COP-W funding.
4. Unduplicated count of individuals whose services are funded with COP Regular, COP-W or CIP IB when COP funding is used to provide the local match. The numbers include a calculation adjustment to factor in the amount of COP funding that is used as match for services above the CIP I and CIP II rate. (This methodology counts approximately one additional person for every \$10,000 of COP regular funds used in this way.) Totals include adjustments for county specific variances and persons served by the Partnership Program and Milwaukee County Disability Services.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 8 - Census 2000 Wisconsin Population Compared to COP and All Waiver Participants by Race/Ethnic Background

RACE GROUPS/ ETHNIC BACKGROUND	Wisconsin Census 2000 Population by Race/Ethnic Groups		COP and All Waiver Participants By Race/Ethnic Groups	
	All Wisconsin Residents	Percent	COP and Waiver Participants	Percent
Caucasian	4,769,857	89%	24,813	91%
African American	304,460	6%	1,334	5%
American Indian/Native American	47,228	1%	320	1%
Asian	88,763	2%	370	1%
Other	153,367	3%	24	<1%
Hispanic	*n.a.	*n.a.	**361	**1%
TOTAL	5,363,675	100%	26,923	100%
*Hispanic/Latino (all races) 2000 Census	*192,921	*4%		

NOTE: *The U.S. Census considers "Hispanic/Latino" an ethnicity, not a race. "Hispanic/Latino" is reported in addition to race, and is not included in the race totals or percents in this table. **HSRS considers "Hispanic" a race; therefore, a comparison of the Census Hispanic Wisconsin residents and Hispanic COP & all waiver participants may not be consistent. Some totals may not equal 100% due to rounding. Source: 2000 Census, 2005 HSRS.

TABLE 9 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
						Number	Percent
Caucasian	8,345	3,375	12,002	1,032	59	24,813	91%
African American	169	481	621	61	2	1,334	5%
American Indian/Alaska Native	117	65	119	18	1	320	1%
Asian/Pacific Islander	190	44	130	5	1	370	1%
Unknown	14	0	8	2	0	24	<1%
Hispanic	76	71	199	15	0	361	1%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 10 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	Number	Percent
Diverted from Entering any Institution	23,251	85%
Relocated from General Nursing Home	1,598	6%
Relocated from ICF/MR	2,128	8%
Relocated from Brain Injury Rehab Unit	235	<1%
Other	10	<1%
TOTAL	27,222	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 11 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	6,580	2,223	5,394	552	33	14,782	54%
Male	2,331	1,813	7,685	581	30	12,440	46%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 12 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	82	2,373	140	1	2,596	9%
18 – 64 years	0	3,954	10,706	993	62	15,715	58%
65 – 74 years	2,658	0	0	0	0	2,658	10%
75 – 84 years	3,320	0	0	0	0	3,320	12%
85 years and over	2,933	0	0	0	0	2,933	11%
TOTAL	9,324	4,210	12,226	1,084	79	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 13 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	4,104	163	38	13	6	4,324	16%
Never Married	1,513	1,686	12,557	835	25	16,616	61%
Married	1,786	858	161	46	8	2,859	11%
Divorced/Separated	1,373	1,251	182	216	21	3,043	11%
Other	135	78	141	23	3	380	1%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 14 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	4,339	560	28	42	11	4,980	18%
Non-Relative	1,132	760	2,161	251	10	4,314	16%
Spouse	1,380	759	108	30	7	2,284	8%
Parent	105	1,065	8,431	387	11	9,999	37%
Other Relative	1,321	553	1,597	136	12	3,619	13%
No Primary Support	634	339	752	287	12	2,024	7%
Other	0	0	2	0	0	2	<1%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 15 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	2,363	1,612	6,020	226	12	10,233	38%
Living with Others with Attendant Care	1,563	447	3,244	297	20	5,571	20%
Living Alone	3,161	1,013	747	341	14	5,276	19%
Living with Others	1,033	381	2,286	219	13	3,932	14%
Living Alone with Attendant Care	436	294	422	29	2	1,183	4%
Living with Immediate Family with Attendant Care	197	217	220	4	0	638	2%
Living with Extended Family	121	53	116	12	2	304	1%
Living with Extended Family with Attendant Care	25	13	14	0	0	52	<1%
Transient Housing Situation	5	5	2	5	0	17	<1%
Other	7	1	8	0	0	16	<1%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

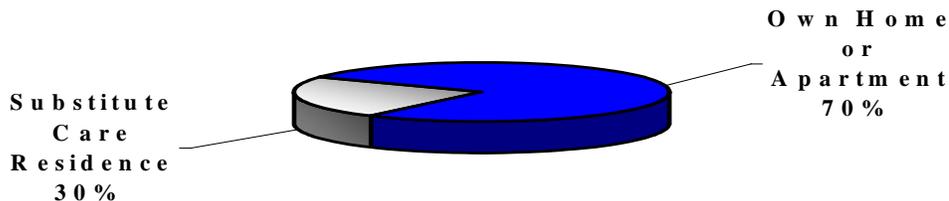
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

TABLE 16 - COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	1	78	4	0	83	<1%
Adult Family Home (AFH)	636	212	2,766	136	10	3,760	14%
Brain Injury Rehab Unit	1	15	6	0	0	22	<1%
Child Group Home	0	1	4	1	0	6	<1%
Community Based Residential Facility (CBRF)	2,115	363	1,534	287	22	4,321	16%
Foster Home	22	6	235	49	2	314	1%
ICF/MR: Not State Center	1	0	2	0	0	3	<1%
Nursing Home	8	2	0	0	0	10	<1%
Other Living Arrangement	1	0	0	0	0	1	<1%
Own Home or Apartment	5,854	3,411	8,419	624	29	18,337	67%
Residential Care Apartment Complex (RCAC)	239	13	0	2	0	254	1%
Residential Care Center (RCC)	1	0	0	0	0	1	<1%
Shelter Care Facility	2	0	7	3	0	12	<1%
State DD Center	0	0	1	0	0	1	<1%
Supervised Community Living	28	12	27	27	0	94	<1%
Unknown	3	0	0	0	0	3	<1%
TOTAL	8,911	4,036	13,079	1,133	63	27,222	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2005 HSRS.

FIGURE 3
Percentage of Participants Living in Own Home or Substitute Care Residence



FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of \$556,932,024 (federal waiver and state funds) was spent in 2005 on Community Options and all long-term care Medicaid Home and Community-Based Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 10 percent of the overall total. COP-Regular and COP-Waiver together contribute 28 percent of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

TABLE 17
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2005

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLTS, BIW*	GRAND TOTAL
Elderly	13,864,695 24%	65,247,687 73%	79,112,382 54%	24,662,617 44%	103,774,999 52%		103,774,999 19%
PD	6,645,847 12%	23,560,924 27%	30,206,771 21%	30,833,820 56%	61,040,591 30%		61,040,591 11%
DD	25,500,101 45%		25,500,101 17%		25,500,101 13%	355,639,187 100%	381,139,288 68%
SMI	10,809,427 19%		10,809,427 7%		10,809,427 5%		10,809,427 2%
AODA	167,719 <1%		167,719 <1%		167,719 <1%		167,719 <1%
Other	0.0%		0.0%		0.0%		0.0%
Total	\$56,987,789 10%	\$88,808,611 16%	\$145,796,400 26%	\$55,496,437 10%	\$201,292,837 36%	\$355,639,187 64%	\$556,932,024 100%

Source: 2005 HSRS and Reconciliation Schedules.

*All costs for Children's waivers and BIW are counted in the DD category.

Children's waivers serve children with a physical disability, a developmental disability and those children who have a severe mental illness.

- The elderly received 19% of the funds;
- Persons with physical disabilities (PD) received 11% of the funds;
- Persons with developmental disabilities (DD) received 68% of the funds;
- Persons with severe mental illness (SMI) received 2% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 4
Total COP and Waivers Spending by Target Group

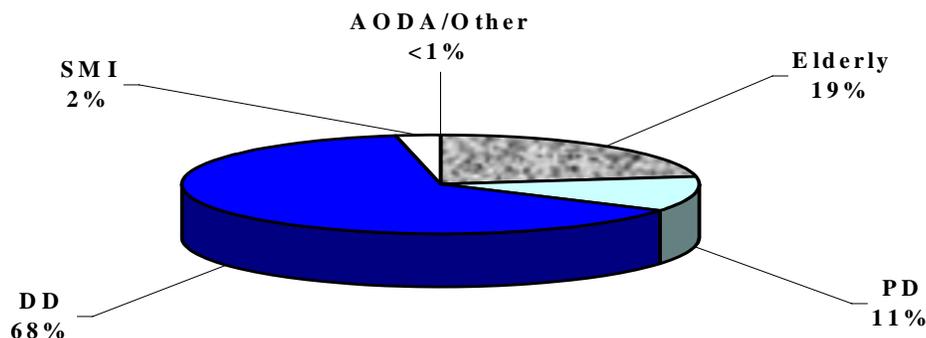
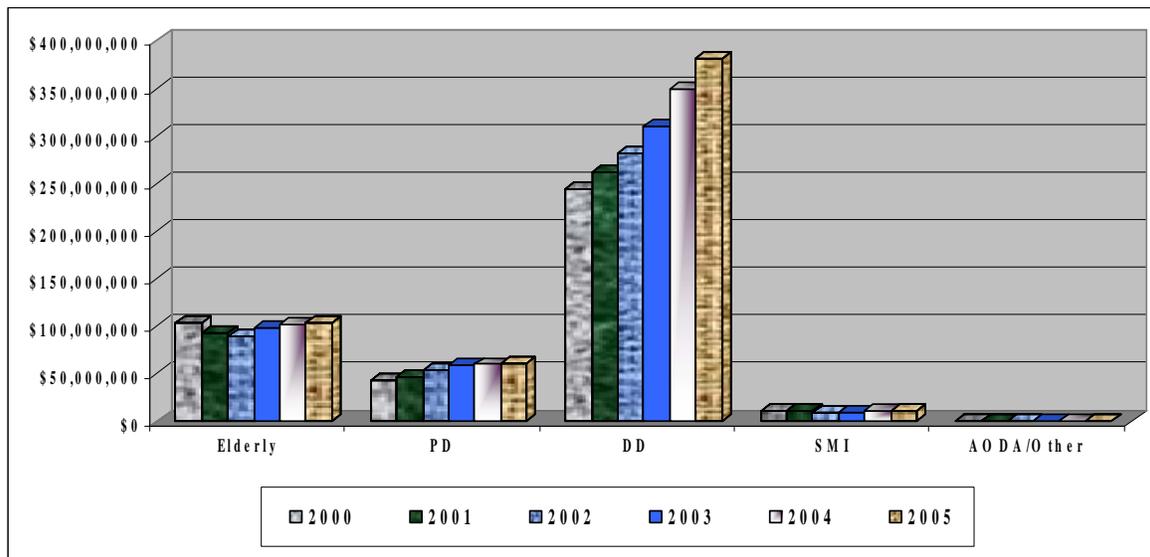


Figure 5 illustrates spending for participants by target groups. The “elderly” category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 5
Increase/Decrease in Funding for Community Long Term Care by Target Group 2000 – 2005



Note: In 2001 and 2002 COP and waiver participants converted to Family Care in five pilot counties.
 Source: 2005 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED
Table 18 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	13.3%	58.0%	18.3%	17.5%	55.9%	24.3%
PD	7.1%	30.9%	8.1%	6.8%	24.1%	11.7%
DD	4.7%	11.1%	73.6%	17.3%	16.0%	44.7%
SMI	73.8%	0.0%	0.0%	57.6%	3.6%	19.0%
AODA/Other	1.1%	0.0%	0.0%	00.8%	0.4%	0.3%
TOTAL	20.9%	14.0%	55.0%	5.9%	4.1%	100.0%
Costs Reported*	\$12,966,409	\$8,675,767	\$34,091,798	\$3,634,351	\$2,550,720	\$61,909,045*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was \$56,987,789.

- 21 percent of the total COP-Regular funds were used for services for COP only participants, 74 percent of whom are persons with a severe mental illness. There is no federal waiver available for the long-term care needs of this group.
- 14 percent of COP-Regular was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 6 percent was used for program and service coordination including one percent for special projects.
- 4 percent of COP-Regular funds were used to conduct assessments and develop care plans.

\$34 million was used as match to serve more people or for increased service costs for existing participants. Of the funds used for additional match, \$25 million was used for persons with developmental disabilities: of that amount, \$4.6 million was used to fund the match for CIP I so counties could earn additional federal funds when the average costs exceeded the allowable rate. When COP funding is used in this way it is referred to as “overmatch.” For persons who are elderly or have physical disabilities, \$7.7 million of COP-Regular funds were used as match to expand the COP-W program and \$1.3 million of COP-Regular funding was used to fund the match for CIP II federal dollars when average costs exceeded the allowable reimbursement rate.

PARTICIPANTS WITH ALZHEIMER'S DISEASE AND RELATED IRREVERSIBLE DEMENTIAS

In 2005, a total of 1,476 participants served in the COP, COP-W and CIP II programs were reported as having an Alzheimer's disease or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's disease and Parkinson's disease). Of these 1,476 individuals, 7 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were \$17,760,058.

MEDICAID NURSING HOME USE

The Community Options Program and the Medicaid Home and Community-Based Waivers have made possible a lower utilization of nursing home beds by Medicaid participants in Wisconsin. At the same time, COP also filled the gaps in unpaid care provided by family and friends. The extra support services paid for by COP reduce the burden on families who provide substantial amounts of unpaid care. The Community Options Program has enabled people with long-term care needs to continue to live in their own homes and communities. The Community Options Program has also been a stimulus to the growth of community care providers in the private sector. Since the beginning of COP and the development of alternatives to nursing home care, days of care paid for by Medicaid in nursing homes have declined. A portion of nursing home bed closures resulted in an additional 50 CIP II slots available in 2005.

CIP II AND COP-W SERVICES

Community Integration Program II and COP-Waiver participants utilize services federally authorized through its Medicaid waiver application and services traditionally available to all Medicaid recipients through the state's Medicaid Plan (e.g., card services). State Medicaid Plan services are provided to all Medicaid recipients eligible for a Medicaid card. The Medicaid Plan services are generally for acute medical care. Waiver services are generally non-medical in nature. Since both types of services are needed to maintain individuals in the community, expenditures for both types must be combined to determine the total public cost of serving waiver participants.

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The waiver services provided, their utilization rate, and the total costs for each service are outlined in the table below. The total cost of Medicaid fee-for-service card costs for these waiver participants was \$130,825,594.

TABLE 19
2005 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	\$155,049,697
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	\$130,825,594
Total 2005 Medicaid Expenditures for CIP II and COP-W Recipients	\$285,875,291

Source: 2005 Federal 372 Report.

Costs of care, services and environmental adaptations for waiver participants are always a combination of Medicaid State Plan benefits and waiver benefits. The coordination of benefits across the program is a key component of the Community Options Program and the waivers.

TABLE 20
2005 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	99.99	\$20,378,049	13.14
Supportive Home Care/Personal Care	82.14	57,248,038	36.92
Adult Family Home	5.19	11,853,619	7.65
Residential Care Apartment Complex	2.44	3,954,026	2.55
Community Based Residential Facility	22.06	42,140,842	27.18
Respite Care	4.05	1,580,615	1.02
Adult Day Care	5.12	3,121,834	2.01
Day Services	1.94	1,528,134	0.99
Daily Living Skills Training	1.09	800,567	0.52
Counseling and Therapies	4.00	787,608	0.51
Skilled Nursing	2.90	259,483	0.17
Transportation	27.36	2,419,949	1.56
Personal Emergency Response System	41.04	1,405,743	0.91
Adaptive Equipment	16.48	1,559,116	1.01
Communication Aids	1.62	49,131	0.03
Housing Start-up	.15	13,858	0.01
Vocational Futures Planning	.02	1,103	0.00
Medical Supplies	23.99	1,226,527	0.79
Home Modifications	3.20	1,149,005	0.74
Home Delivered Meals	25.96	3,239,336	2.09
Financial management Services	6.74	333,114	0.21
Total Medicaid Waiver Service Costs		\$155,049,697	

Note: Totals may not equal 100% due to rounding. Source: 2005 Federal 372 Report.

TABLE 21
2005 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	3.4%	\$5,436,346	4.1%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	75.3%	4,307,700	3.3%
Outpatient Hospital	52.4%	2,609,606	2.0%
Lab and X-ray	61.6%	842,117	0.6%
Prescription Drugs	95.1%	48,697,020	37.2%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	49.3%	2,716,007	21%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5.1%	243,992	0.2%
Dental Services	17.8%	505,973	0.4%
Nursing (Nurse Practitioner, Nursing Services)	0.4%	1,196,972	0.9%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	70.8%	12,918,771	9.9%
Personal Care (Personal Care, Personal Care Supervisory Services)	35.5%	38,546,787	29.5%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSTD, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	58.7%	12,804,303	9.8%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		\$130,825,594	

Notes: Totals may not equal 100% due to rounding. Source: 2005 Federal 372 Report.

PUBLIC FUNDING AND COST COMPARISON OF MEDICAID WAIVER AND MEDICAID NURSING HOME CARE

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed. Table 22 below indicates total public funds on an average daily basis for nursing home and waiver care.

**TABLE 22
2005 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day**

Year	Cost Category	Community Care Costs			Nursing Home Costs ¹			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2005	Medicaid Program Per Diem	\$41.89	\$17.62	\$24.27	\$103.04	\$43.34	\$59.70			
	Medicaid Card	35.35	14.87	20.48	17.38	7.31	10.07			
	Medicaid Costs Subtotal²	\$77.24	\$32.49	\$44.75	\$120.42	\$50.65	\$69.77	\$43.18	\$18.16	\$25.02
	COP – Services w/Admin.	1.96	1.96	0.00	n/a ³	n/a ³	n/a ³			
	COP – Assessments & Plans	0.69	0.69	0.00	n/a ³	n/a ³	n/a ³			
	SSI	1.20	0.50	0.70	unk.	unk.	unk.			
	Community Aids	0.11	0.05	0.06	unk.	unk.	unk.			
	Total	\$81.20	\$35.69	\$45.51	\$120.42	\$50.65	\$69.77	\$39.22	\$14.96	\$24.26

Source: 2005 HSRS and 2005 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged \$81.20 per person per day in 2005, compared to \$120.42 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-W during 2005 was \$39.22 less than the cost of nursing home care.

**TABLE 23
2005 Estimated Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents
Adjusting for Level of Care Average Cost per Person per Day**

Year	Cost Category	Community Care Costs			Nursing Home Costs ¹			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2005	Medicaid Program Per Diem	\$41.89	\$17.62	\$24.27	\$87.49	\$36.80	\$50.69			
	Medicaid Card	35.35	14.87	20.48	17.38	7.31	10.07			
	Medicaid Costs Subtotal²	\$77.24	\$32.49	\$44.75	\$104.87	\$44.11	\$60.76	\$27.63	\$11.62	\$16.01
	COP – Services w/Admin.	1.96	1.96	0.00	n/a ²	n/a ²	n/a ²			
	COP – Assessments & Plans	0.69	0.69	0.00	n/a ²	n/a ²	n/a ²			
	SSI	1.20	0.50	0.70	n/a ²	n/a ²	n/a ²			
	Community Aids	0.11	0.05	0.06	unk.	unk.	unk.			
	Total	\$81.20	\$35.69	\$45.51	\$104.87	\$44.11	\$60.76	\$23.67	\$9.96	\$13.71

Source: 2005 HSRS and 2005 Federal 372 Report.

Assuming the same Medicaid card costs and other expenses, the average daily cost of nursing home care would have been \$104.87 per person (Table 23, instead of \$120.42 as reported in Table 22). The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been \$23.67 instead of \$39.22. This represents a difference of 23 percent, compared to 33 percent. Table 23 presents the estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 22 after adjusting the average nursing home per diem in this manner.

The following footnote references are for Table 22 and Table 23:

1. IMD costs are omitted from the total nursing home cost because persons who require institutionalization primarily due to a chronic mental illness are not eligible for CIP II or COP-W.
2. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
3. Nursing home residents are not eligible for the Community Options Program.

Note: The cost per day (per diem) was less in 2005 than in 2004. While the overall spending was higher, the total waiver days were also higher. Waiver days increased primarily because individuals served spent fewer days in a hospital or nursing home while an active waiver participant. This finding is supported by the 8 percent drop in costs for hospital care and an overall reduction in Medicaid card costs of 9 percent.

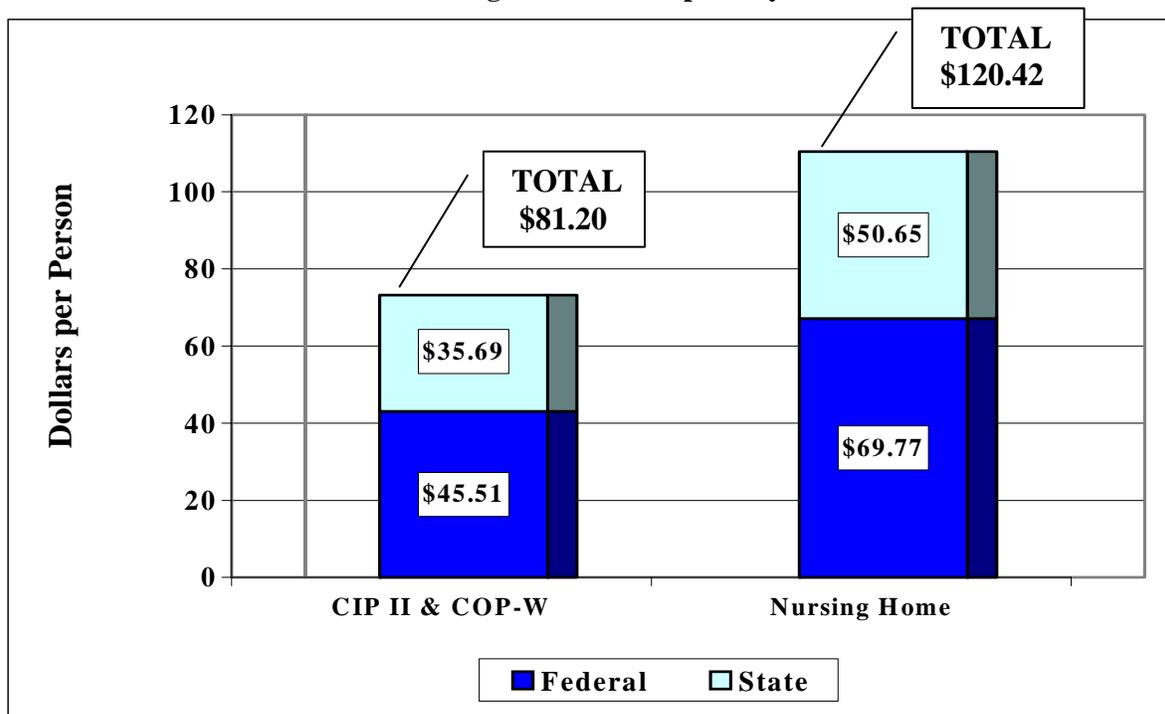
CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons, while calculated using actual costs of care for waiver participants and nursing home residents, may be influenced by differences in the care needs of these two populations. In 2005, 76 percent of CIP II and COP-W participants were rated at the intermediate care facility (ICF) level and 24 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2005 were four percent ICF and 96 percent SNF, based on aggregate calendar year nursing home days of care. The significance of any care level difference that exists can be determined by re-estimating average daily and total public costs after adjusting the reported care level proportions.

Based on data supplied for the Department's annual cost report to the Centers for Medicare and Medicaid Services (CMS), the actual 2005 nursing home Medicaid per diem for ICF residents was approximately \$88.04. For SNF residents the Medicaid per diem was approximately \$118.04. If the proportions of nursing home residents receiving care at the ICF and SNF levels had been equal to the proportions reported for CIP II and COP-W participants (76 percent ICF and 24 percent SNF), estimated costs to Medicaid for nursing home care would have been \$819,281,879 instead of \$940,764,030. Given that there were 7,812,357 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2005, this level of total Medicaid spending would have translated to an average per diem across care levels of \$104.87 (Table 23), instead of the previously calculated \$120.42 (Table 22).

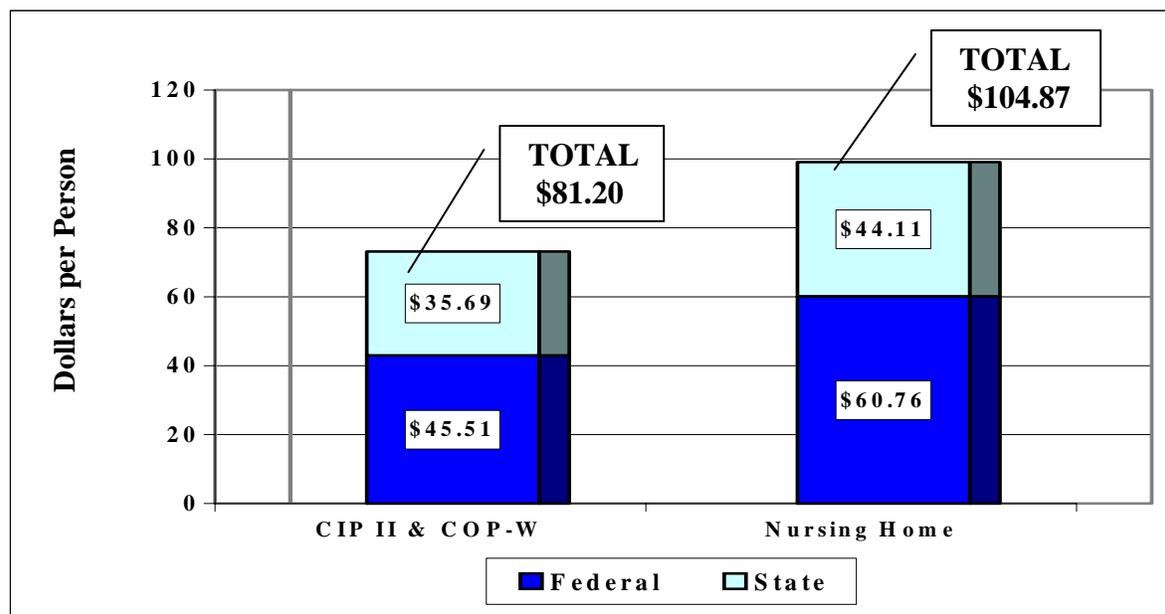
Using these adjusted figures, the potential impact of waiver utilization on total public spending can be estimated as it was in the previous section. That is, if the 11,920 waiver participants had spent the same 3,700,939 days residing in nursing homes, they would have incurred total public costs of \$388,117,473 (\$104.87 per day for 3,700,939 days), compared with the \$285,875,291 they incurred while residing in the community. **Assuming equivalent care level proportions**, then, total public spending for CIP II and COP-W participants during 2005 was \$102,242,182 less than the predicted cost of nursing home care for a comparable group. This figure is fifteen percent less than the \$445,667,074 estimated using actual 2005 data, but it still represents a difference in total public costs of 26 percent compared with the cost of an equivalent volume of nursing home care. This revised estimate may represent the lower boundary of the difference in costs attributable to these waivers, while the estimate based on actual costs represents an upper boundary.

FIGURE 6
CIP II & COP-W vs. Nursing Home Care in 2005
Average Public Costs per Day



Source: 2005 Federal 372 Report.

FIGURE 7
CIP II & COP-W vs. Nursing Home Care in 2005
Adjusting for Level of Care
Estimated Average Public Costs per Day



Source: 2005 Federal 372 Report.

Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program (COP). In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.

Empowerment of individuals to make choices, the foundation of ethical home and community-based long-term support services, is supported.

Services that are easy to access and delivered promptly, tailored to meet unique individual circumstances and needs are provided.

Physical and mental health services are delivered in a manner that helps people achieve their optimal level of health and functioning.

Enhancement and maintenance of each participant's sense of self-worth, and community recognition of his or her value is fostered.

Community and family participation is respected and participants are supported to maintain and develop friendships and share in their families and communities.

Tools for self-determination are provided to help participants achieve maximum self-sufficiency and independence.

RESPECT performance standards are measured by the extent to which:

- care managers identify a participant's health status and care needs, create or arrange for appropriate services to support and not supplant the help available from family, friends and the community, and monitor the performance of service providers;
- services respond to individual needs;
- participant preferences and choices are honored, and the participant is satisfied with the services delivered; and most importantly,
- participants are able to maintain a home of their own choice and participate in community life.

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):

The Community Options Program, administered by the Department of Health and Family Services, is managed by local county agencies to deliver community-based services to Wisconsin citizens in need of long-term assistance. Any person, regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.

Funding: GPR/State = 100%

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):

A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

*Funding: GPR/State = Approximately 40% (budgeted separately with COP GPR/state funds)
Federal = Approximately 60%*

COMMUNITY INTEGRATION PROGRAM II (CIP II):

A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities after a nursing home bed is closed.

*Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)*

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):

A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

*Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)*

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):

A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities – Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled.

*Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)*

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:

A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

*Funding: GPR/State = Approximately 40% (Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)*

CHILDREN'S LONG TERM SUPPORT WAIVERS (CLTS-WAIVER):

A Medicaid-funded waiver program that serves children and persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance. CLTS waivers provide funds that enable individuals to be supported in the community.

*Funding: GPR/State = Approximately 40% (state Medicaid, Community Aids, county match, or COP funds)
Federal = Approximately 60% (federal Medicaid funding)*

BRAIN INJURY WAIVER:

A Medicaid-funded waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. This program began January 1, 1995.

*Funding: GPR/State = Approximately 40% (state Medicaid funding)
Federal = Approximately 60% (federal Medicaid funding)*

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

Wisconsin has implemented a plan to demonstrate and document quality assurance efforts, which will ensure the health, safety and welfare of community waiver program participants. The quality assurance and improvement program combines a number of activities to assess and monitor program integrity, customer safety, customer satisfaction and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement.

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 488 cases in 2005. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 89 percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

Monitoring Components:

- ✓ *Medicaid financial eligibility as approved in state plan*
- ✓ *Cost share*
- ✓ *Spend down*

Findings: *93 percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:

- ✓ *Health form*
- ✓ *Functional screen*

Findings: *94 percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

Monitoring Components:

- ✓ *Individual Service Plan (ISP) developed and reviewed with participant*
- ✓ *Services waiver allowable*
- ✓ *Services appropriately billed*

Findings: *90 percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

Monitoring Components:

- ✓ *Waiver-billed services met necessary standards and identified needs*
- ✓ *Care providers appropriately trained and certified*

Findings: *87 percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

Monitoring Components:

- ✓ Services accurately billed
- ✓ Only waiver allowable providers billed
- ✓ Residence in waiver allowable settings during billing period

Findings: 92 percent compliance was found in these categories. Disallowances were taken.

Category: SUBSTITUTE CARE

Monitoring Components:

- ✓ Contracting requirements have been met
- ✓ Only waiver allowable costs calculated and billed

Findings: 96 percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.

CORRECTIVE ACTION

In addition to a wrap-up meeting following a monitoring visit, a written report of each monitoring review was provided to the director of the local agency responsible for implementation of the waiver. The report provides the agency with a list of health or safety issues, indicating where action is needed at the local level. The reports also cited errors or deficiencies and required that the deficiency be corrected within a specified period of time, between 1 and 60 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Results from the consumer outcomes and satisfaction surveys are written in the report to present an overview of the county system and identify trends in service areas.

Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. In addition, agencies were required to develop a plan to modify their practices. In **19** instances, disallowances were taken where retroactive corrections could not be implemented. The total disallowance within those 19 counties was **\$54,301**.

Funding was disallowed in areas that included billing of non-waiver allowable services, lack of documentation for billed services, insufficient documentation or non-waiver allowable room and board costs, billing during a period of participant ineligibility for waiver services (temporary institutionalization), and inaccurate collection of cost share.

PROGRAM QUALITY

During 2005, 488 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:

- Responsiveness to consumer preferences
- Quality of communication
- Level of understanding of consumer's situation
- Professional effectiveness
- Knowledge of resources
- Timeliness of response

The factors studied for in-home care were:

- Timeliness
- Dependability
- Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:

- Responsiveness to consumer preferences
- Choices for daily activities
- Ability to talk with staff about concerns
- Comfort

Table 24 combines and summarizes the findings of the survey. Satisfaction in substitute (residential) care settings is somewhat lower than satisfaction with services in one's own home.

**Table 24
Program Quality Results**

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	92%
Good communication with care manager	93%
Care manager is responsive	92%
Active participation in care plan	94%
Satisfaction with in-home workers	93%
Substitute care services are acceptable	78%
Satisfaction with substitute care living arrangement	80%

Source: 2005 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- ◆ Provide issue specific or county specific intensive monitoring or training where significant errors have been identified. Repeat monitoring where necessary.
- ◆ Develop issue specific technical assistance documents. This includes answers to the most frequently asked questions. The document entitled "WaiverWise" is now available on the Department of Health and Family Services website.
- ◆ Conduct statewide training in the areas of Fiscal Management, Eligibility, Service Standards, Advanced Care Manager/Economic Support Training, and Outcome-Based Care Planning.
- ◆ Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance.
- ◆ Produce and distribute case specific fiscal reports containing potentially correctable reporting errors.
- ◆ Provide Long Term Care Functional Screen trainings for certified screeners.
- ◆ Update Medicaid Waiver Manual and develop an orientation to the manual for care managers.
- ◆ Continue to transition responsibility to county agencies for quality assurance of the annual recertification of participant eligibility.

We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP and waiver activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

Irene Anderson
Bureau of Long Term Support
Division of Disability and Elder Services
Wisconsin Department of Health and Family Services
P.O. Box 7851
Madison, WI 53707-7851
Phone: (608) 266-3884
Fax: (608) 267-2913
E-mail: anderil@dhfs.state.wi.us