MISC-102 (25) 52-1 K ✓ SJ

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
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June 10, 2003

JUN 11 2003

Members of the Legislature

Re: Emergency Rule affecting Section Ins 17.01(3), 17.28(6) and 17.285(14), Wis. Adm. Code, relating to annual patients compensation fund fees beginning July 1, 2003 and establishing a rate of compensation for fund peer review council

Dear Senator or Representative to the Assembly:

I have promulgated the attached rule as an emergency rule. The rule will be published in the official State newspaper on June 11, 2003.

The attached copy of the rule includes the Finding of Emergency which required promulgation of the rule.

If you have any questions, please contact Alice M. Shuman-Johnson at (608) 266-9892 or e-mail at Alice.Shuman-Johnson@oci.state.wi.us.

Sincerely,

Jorge Gomez
Commissioner

JG:AS
Attachment: 1 copy rule

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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June 6, 2003

STATE OF WISCONSIN |
| SS
OFFICE OF THE COMMISSIONER OF INSURANCE |

I, Jorge Gomez, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting Section Ins 17.01(3), 17.28(6) and 17.285(14), Wis. Adm. Code, relating to annual patients compensation fund fees beginning July 1, 2003 and establishing a rate of compensation for fund peer review council, is duly approved and adopted by this Office on June 6, 2003.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF,
I have hereunto set my hand at
121 East Wilson Street, Madison, Wisconsin,
on June 6, 2003.

Jorge Gomez
Commissioner

STATE OF WISCONSIN
RECEIVED & FILED
JUN - 6 2003
DOUGLAS LA FOLLETTE
SECRETARY OF STATE

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

AND THE

BOARD OF GOVERNORS OF THE PATIENTS COMPENSATION FUND

AMENDING, REPEALING AND RECREATING AND CREATING A RULE

The office of the commissioner of insurance and the board of governors of the patients compensation fund propose an order to amend s. Ins 17.01 (3), to repeal and recreate s. Ins 17.28 (6), and to create s. Ins 17.285 (14), relating to annual patients compensation fund and mediation fund fees for the fiscal year beginning July 1, 2003 and relating to establishing a rate of compensation for fund peer review council members and consultants.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 655.004, 655.275 (10), 655.27 (3) (b), and 655.61, Stats.

Statutes interpreted: s. 655.27 (3), Stats.

The commissioner of insurance, with the approval of the board of governors (board) of the patients compensation fund (fund), is required to establish by administrative rule the annual fees which participating health care providers must pay to the fund. This rule establishes those fees for the fiscal year beginning July 1, 2003. These fees represent a 5% increase compared with fees paid for the 2002-03 fiscal year. The board approved these fees at its meeting on February 26, 2003, based on the recommendation of the board's actuarial and underwriting committee.

The board is also required to promulgate by rule the annual fees for the operation of the patients compensation mediation system, based on the recommendation of the director of state courts. This rule implements the funding level recommendation of the board's actuarial and underwriting committee by establishing mediation panel fees for the next fiscal year at $19.00 for physicians and $1.00 per occupied bed for hospitals, representing no increase from 2002-03 fiscal year mediation panel fees.

This rule also creates s. Ins. 17.285 (14) that establishes a rate of compensation for fund peer review council members and consultants of $250 per meeting attended or $250 per report filed by consultant based on the consultant's review of a file.

FINDING OF EMERGENCY

The commissioner of insurance (commissioner) finds that an emergency exists and that promulgation of this emergency rule is necessary for the preservation of the public peace, health, safety or welfare. The facts constituting the emergency are as follows:

Actuarial and accounting data necessary to establish PCF fees is first available in January of each year. It is not possible to complete the permanent fee rule process in time for the patients compensation fund (fund) to bill health care providers in a timely manner for fees applicable to the fiscal year beginning July 1, 2003.

The commissioner expects that the permanent rule corresponding to this emergency rule, clearinghouse No. 03-039, will be filed with the secretary of state in time to take effect October 1, 2003. Because the fund fee provisions of this rule first apply on July 1, 2003, it is necessary to promulgate the rule on an emergency basis. A hearing on the permanent rule, pursuant to published notice thereof, was held on May 14, 2003.

SECTION 1. Ins 17.01 (3) is amended to read:

Ins 17.01 (3) FEE SCHEDULE. (intro.) The following fee schedule shall be effective July 1, ~~2002~~ 2003:

(a) For physicians-- $19.00

(b) For hospitals, per occupied bed-- $1.00

SECTION 2. Ins 17.28 (6) is repealed and recreated to read:

Ins 17.28 (6) FEE SCHEDULE. The following fee schedule is in effect from July 1, 2003, to and including June 30, 2004:

(a) Except as provided in pars. (b) to (f) and sub. (6e), for a physician for whom this state is a principal place of practice:

Class 1	$1,534	Class 3	$6,366
Class 2	$2,761	Class 4	$9,204

(b) For a resident acting within the scope of a residency or fellowship program:

Class 1	$ 767	Class 3	$3,183
Class 2	$1,381	Class 4	$4,602

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	$ 920

(d) For a medical college of Wisconsin, inc., full-time faculty member:

Class 1	$ 614	Class 3	$2,548
Class 2	$1,105	Class 4	$3,684

(e) For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: $ 384

(f) For a physician for whom this state is not a principal place of practice:

Class 1	$ 767	Class 3	$3,183
Class 2	$1,381	Class 4	$4,602

(g) For a nurse anesthetist for whom this state is a principal place of practice: $ 377

(h) For a nurse anesthetist for whom this state is not a principal place of practice: $ 189

(i) For a hospital:

1. Per occupied bed $ 92; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available: $4.60

(j) For a nursing home, as described under s. 655.002 (1) (j), Stats., which is wholly owned and operated by a hospital and which has health care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed $ 17

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of partners and employed physicians and nurse anesthetists is from 2 to 10 $ 53

b. If the total number of partners and employed physicians and nurse anesthetists is from 11 to 100 $ 528

c. If the total number of partners and employed physicians and nurse anesthetists exceeds 100 $1,319

2. The following fee for each of the following employes employed by the partnership as of July 1, 2003:

Employed Health Care Persons	July 1, 2003 Fund Fee
Nurse Practitioners	$ 384
Advanced Nurse Practitioners	537
Nurse Midwives	3,375
Advanced Nurse Midwives	3,528

Advanced Practice Nurse Prescribers	537
Chiropractors	614
Dentists	307
Oral Surgeons	2,301
Podiatrists-Surgical	6,520
Optometrists	307
Physician Assistants	307

(L) For a corporation, including a service corporation, with more than one shareholder organized under ch. 180, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of shareholders and employed physicians and nurse anesthetists is from 2 to 10 $ 53

b. If the total number of shareholders and employed physicians and nurse anesthetists is from 11 to 100 $ 528

c. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $1,319

2. The following for each of the following employes employed by the corporation as of July 1, 2003:

Employed Health Care Persons	July 1, 2003 Fund Fee
Nurse Practitioners	$ 384
Advanced Nurse Practitioners	537
Nurse Midwives	3,375
Advanced Nurse Midwives	3,528
Advanced Practice Nurse Prescribers	537
Chiropractors	614
Dentists	307
Oral Surgeons	2,301
Podiatrists-Surgical	6,520

Optometrists	307
Physician Assistants	307

(m) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, all of the following fees:

1. a. If the total number of employed physicians and nurse anesthetists is from 1 to 10 $ 53

b. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $ 528

c. If the total number of employed physicians or nurse anesthetists exceeds 100 $1,319

2. The following for each of the following employes employed by the corporation as of July 1, 2003:

Employed Health Care Persons	July 1, 2003 Fund Fee
Nurse Practitioners	$ 384
Advanced Nurse Practitioners	537
Nurse Midwives	3,375
Advanced Nurse Midwives	3,528
Advanced Practice Nurse Prescribers	537
Chiropractors	614
Dentists	307
Oral Surgeons	2,301
Podiatrists-Surgical	6,520
Optometrists	307
Physician Assistants	307

(n) For an operational cooperative sickness care plan as described under s. 655.002 (1) (f), Stats., all of the following fees:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.11

2. 2.5% of the total annual fees assessed against all of the employed physicians.

3. The following for each of the following employes employed by the operational cooperative sickness plan as of July 1, 2003:

Employed Health Care Persons	July 1, 2003 Fund Fee
Nurse Practitioners	$ 384
Advanced Nurse Practitioners	537
Nurse Midwives	3,375
Advanced Nurse Midwives	3,528
Advanced Practice Nurse Prescribers	537
Chiropractors	614
Dentists	307
Oral Surgeons	2,301
Podiatrists-Surgical	6,520
Optometrists	307
Physician Assistants	307

(o) For a freestanding ambulatory surgery center, as defined in s. HFS 120.03 (10), per 100 outpatient visits during the last calendar year for which totals are available: $22.00

(p) For an entity affiliated with a hospital, the greater of $100 or whichever of the following applies:

1. 7% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 10% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims-made coverage.

SECTION 3 Ins 17.285 (14) is created to read:

Ins. 17.285 (14) MEMBER AND CONSULTANT COMPENSATION. Council members and consultants shall be paid $250 per meeting attended or $250 per report filed by a consultant based on the consultant's review of a file under s. 655.275(5)(b), Stats.

SECTION 4 EFFECTIVE DATE. This rule will take effect on July 1, 2003.

Dated at Madison, Wisconsin, this 4th day of June 2003.

Jorge Gomez
Commissioner of Insurance

FISCAL ESTIMATE
DOA-2048 N

☐ ORIGINAL ☐ UPDATED
☐ CORRECTED ☐ SUPPLEMENTAL

2002 Session

LRB or Bill No./Adm. Rule No.
Ins. 17.01, 17.28

Amendment No. if Applicable

Subject
Relating to annual Patients Compensation Fund fees for fiscal year 2003-2004

Fiscal Effect

State: ☐ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☐ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
☐ Towns ☐ Villages ☐ Cities
☐ Counties ☐ Others ____
☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

The Patients Compensation Fund (Fund) is a segregated fund. Annual Fund fees are established to become effective each July 1, based on actuarial estimates of the Fund's needs for payment of medical malpractice claims. The proposed fees were approved by the Fund's Board of Governors at its February 26 2003 meeting.

There is no effect on GPR.

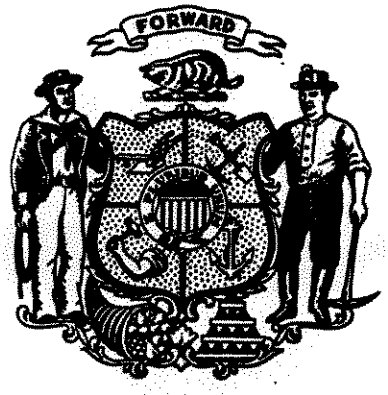
Estimated revenue from fees, for fiscal year 2003-2004, is approximately $28.8 million, which represents a 5% increase to fiscal year, 2002-2003 fee revenue.

Long-Range Fiscal Implications

None

Agency/Prepared by: (Name & Phone No.)	Authorized Signature/Telephone No.	Date
PCF/Theresa Wedekind (608)266-0953	(608) 266-0102	April 1, 2003

END



END

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

Health

April 17, 2003

Donald J. Schneider
Senate Chief Clerk
17 West Main Street, Suite 401
P.O. Box 7882
Madison, Wisconsin 53707-7882

Patrick E. Fuller
Assembly Chief Clerk
17 West Main Street, Room 208
P.O. Box 8952
Madison, Wisconsin 53708-8952

Dear Mr. Fuller and Mr. Schneider:

The attached report is submitted to the Legislature pursuant to s.46.27(11g) and s.46.277(5m) of the state statutes. The state statutes require the Department of Health and Family Services to submit an annual report for the Community Options Program (COP) and the Home and Community-Based Waivers (COP-W/CIP II). The attached report describes the persons served, program expenditures, and services delivered through the COP, COP-Waiver and CIP II programs in calendar year 2001.

The Community Options Program provides services to people who are elderly or who have a physical, developmental or mental disability, and is closely coordinated with all of Wisconsin's Medicaid Home and Community-Based Waivers. With the Department's oversight, county agencies are able to ensure that a comprehensive and individualized care plan is provided, while maintaining program flexibility and integrity, and maximizing federal matching funds.

Sincerely,

Helene Nelson
Secretary

Attachment

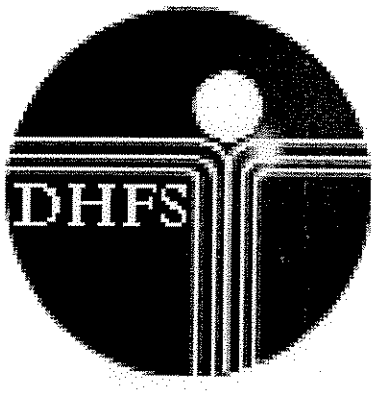
cc: Bob Lang, Legislative Fiscal Bureau

Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2001



Making Wellness and Safety Happen

Department of Health & Family Services
Division of Supportive Living
Bureau of Aging & Long Term Care Resources

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. Wisconsin had a high use of nursing homes, with dramatic annual increases in nursing home spending. The Community Options Program was intended to offer 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 with some flexibility in how it would meet the Title 19 (Medicaid) requirements. The Community Options Program serves a limited number of people and is not an entitlement.

The COP General Purpose Revenue (GPR) 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. Three other waivers serve people with developmental disabilities.

In 2001, the state and federal government spent $180,902,789 on COP and the COP waivers administered by all counties and one tribe. This is equal to about 44 percent of the total spending on all home and community-based waiver programs (Appendix B). Waivers for people with developmental disabilities spent $232,614,494 in 2001.

Individuals who use waiver services are also eligible for the Medicaid card benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in the Community Integration Program II (CIP II) and the Community Options Program-Waiver (COP-W) used $109,122,025 in benefits from their Medicaid card. The largest expenditures were, not surprisingly, for prescription drugs ($31 million) and personal care ($32 million).

The average daily cost of care for participants in CIP II and COP-W in CY 2001 was $67.20. This includes state and federal funds and Supplemental Security Income, totaling $254.1 million per year. The average daily cost of care for persons at the same mix of levels of care living in nursing homes was $96.90 of Medicaid funds. Hypothetically, if all of the CIP II and COP-W participants had entered nursing homes last year, the total cost would have been about $366.4 million for the year, instead of $254.1 million.

Three-fourths of COP, COP-W and CIP II participants received care in their own homes or apartments; only 14 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.

In 2000, the introduction of Family Care (a comprehensive long-term care benefit) began in five Wisconsin counties. Consequently, in 2001 there was a decline in the numbers of COP, COP-W and CIP II participants in those counties as participants transferred into the Family Care program.

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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 with the flexibility to expand 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 Community Options Program-Waiver also includes the Community Integration Program II (CIP II).

Other Medicaid waiver programs are targeted to specific populations in need of long-term care services. Community Integration Program 1A (CIP 1A), Community Integration Program 1B (CIP 1B), Community Supportive Living Arrangements (CSLA) and Brain Injury Waiver (BIW) all serve the community needs for long-term care participants with developmental disabilities. The Community Options Program state funding is often used as a match for federal funds through these waivers.

This report describes the persons served, program expenditures and services delivered through COP, COP-W and CIP II in calendar year 2001. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP, provide 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 to contain the costs of providing long-term care to a fragile population.

STRUCTURE

The Community Options Program and Community Options Program-Waiver funds are administered by the Department of Health and Family Services, and the programs are managed by county agencies. These funds are allocated to counties based on the Community Aids formula (base allocation) or for special needs, such as nursing home relocations.

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 coordination of county resources is outlined in the local Community Options Program Plan, a description of the county policies and practices, which assures the prudent, cost-effective operation of the Community Options 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 statutory program requirements, including:

- significant proportions;
- allowable residential settings;
- county COP plan approval; and
- the mandated use of the federally-funded home and community-based Medicaid waivers prior to using the state-funded COP.

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 definitions of community long-term care programs.) The categories of participants are (vertical) 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

Program Category	Elderly	PD	DD	SMI	AODA	Other	Participants Served with Medicaid Waiver Funds Only	Waiver Participants with Additional COP	Total Participants Served Unduplicated
COP-W									9,538
Waiver Only	5,346	1,440					6,786		
Waiver/COP	2,299	453						2,752	
CIP II									2,970
Waiver Only	944	1,117					2,061		
Waiver/COP	547	362						909	
Sub Total COP-W/CIP II	9,136	3,372					8,847	3,661	12,508
CIP 1A									1,124
Waiver Only	38		1,003				1,041		
Waiver/COP	10		73					83	
CIP 1B Regular									2,397
Waiver Only	164		2,082				2,246		
Waiver/COP	37		114					151	
CIP 1B/CSLA COP Match									2,262
Waiver/COP for match only	107		1,813				1,920		
COP match waiver w/other COP	33		309					342	
CIP 1B/CSLA Other Match									3,539
Waiver/other for match	154		3,287				3,441		
Waiver/COP	6		92					98	
Brain Injury Waiver									238
Waiver Only	0		218				218		
Waiver/COP	0		20					20	
Sub Total Developmental Disabilities Waivers	549		9,011				8,866	694	9,560
COP Only Participants	961	184	129	940	17	23			2,254
Totals by Target Population	10,380	3,510	9,109	1,102	39	182	17,713	4,355	TOTAL
% Served by Target Population	42.7%	14.4%	37.5%	4.5%	0.16%	0.75%	72.8%	17.9%	24,322

- Total unduplicated participants served in 2001 - 24,322.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 17,713.
- Total Medicaid waiver participants who also received COP funding in CY 2001 - 4,355.
- Total participants who received only COP funding (not Medicaid eligible) - 2,254.
- All participants who received either pure COP or COP supplementing funds - 6,609.
- Total participants served with COP and COP-W funds - 15,315.

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 24,322 persons. The table below illustrates participants served with COP and Medicaid waiver funding by target group in 2001.

TABLE 2
Participants Served by Target Group

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, CLSA, BIW	GRAND TOTAL
Elderly	961 42.6%	7,645 80.2%	**8,606** **73.0%**	193 7.4%	1,491 50.2%	**10,290** **59.2%**	356 5.1%	**10,380** **42.7%**
PD	184 8.2%	1,893 19.8%	**2,077** **17.6%**	0 0%	1,479 49.8%	**3,556** **20.5%**	0 0%	**3,510** **14.4%**
DD	129 5.7%	0 0%	**129** **1.1%**	2,421 92.6%	0 0%	**2,550** **14.7%**	6,590 94.9%	**9,109** **37.5%**
SMI	940 41.7%	0 0%	**940** **8.0%**	0 0%	0 0%	**940** **5.4%**	0 0%	**1,102** **4.5%**
AODA	17 0.8%	0 0%	**17** **0.1%**	0 0%	0 0%	**17** **0.1%**	0 0%	**39** **0.16%**
Other	23 1.0%	0 0%	**23** **0.2%**	0 0%	0 0%	**23** **0.1%**	0 0%	**182** **0.75%**
Total	**2,254** **9.3%**	**9,538** **39.2%**	**11,792** **48.5%**	**2,614** **11%**	**2,970** **12.2%**	**17,376** **71.4%**	**6,946** **28.6%**	**24,322** **100.0%**

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

- 10,380 or 43% were elderly;
- 3,510 or 14% were persons with physical disabilities (PD);
- 9,109 or 37% were persons with developmental disabilities (DD);
- 1,102 or 5% were persons with severe mental illness (SMI); and
- 221 or 1% were persons with alcohol and/or drug abuse (AODA) or other conditions.

FIGURE 1
Participants Served by Target Group
COP and All Waivers

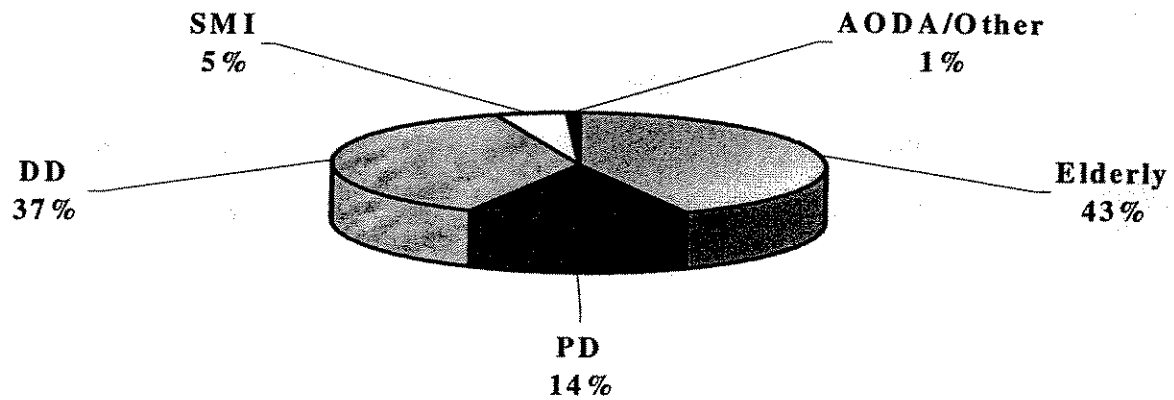
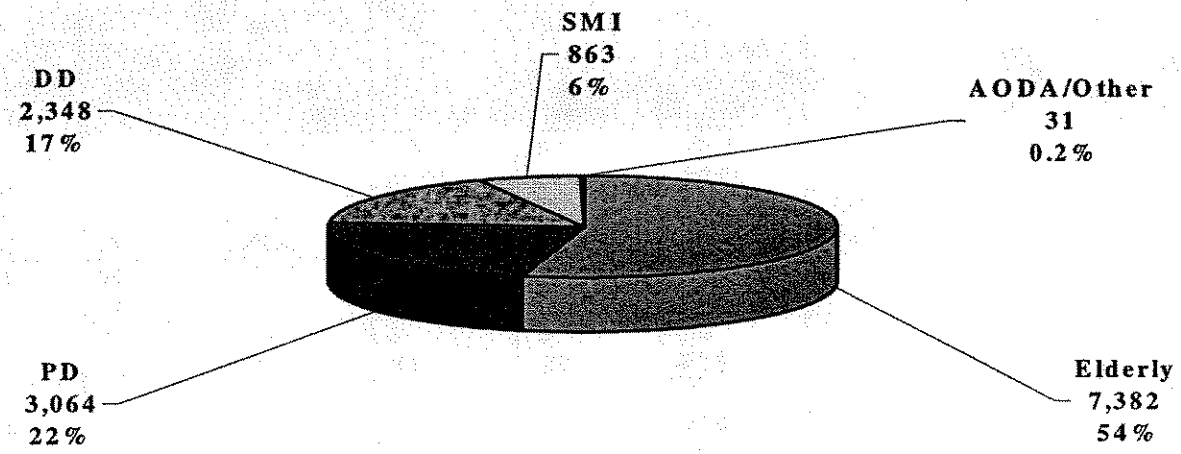


FIGURE 2
Point-in-Time Percentage of Persons Receiving COP, COP-W and CIP II Services Participants by Target Group on December 31, 2001

Figure 2 depicts the percentage of persons from each COP target group who received COP-Regular, COP-W and CIP II services on December 31, 2001.



COP ASSESSMENTS, CARE PLANS AND PERSONS SERVED

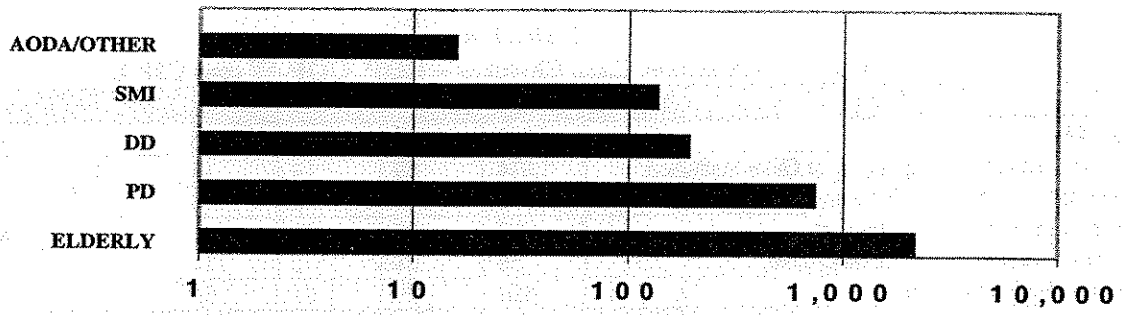
The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate 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 2001:	**9,271**	**Assessments** were conducted.
	5,799	**Care plans** were prepared.
	2,947	**New persons** were served with COP funds and/or COP-W.
	12,368	**Persons continuing** COP/COP-W services began services prior to 2001.
	15,315	**Total persons served** with COP funds and/or COP-W funds in 2001.

NEW PERSONS

Figure 3 illustrates the target group distribution of new persons served during 2001. The majority of the new participants served in 2001 were elderly.

FIGURE 3
New Persons Receiving Services by Target Group in 2001
For COP, COP-W and CIP II*



AODA/Other	SMI	DD	PD	Elderly
16 (0.5%)	138 (4.2%)	194 (5.9%)	750 (22.9%)	2,179 (66.5%)

* Clients are considered new 2001 service clients if they have 2001 services and costs and no long-term support services of any type in 2000.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-Waiver participants received services for three years or less. The other one-third of program participants are longer-term participants, receiving services for as long as ten years.

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 3 illustrates the number of cases closed during 2001 divided by the caseload size on December 31, 2000 for each target group for COP, COP-W and CIP II. The shaded rows of Table 3 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2002.)

TABLE 3
Calculation of Turnover by Target Group – COP, COP-W and CIP II

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2001	10,290	3,556	2,550	940	17	23	17,376
Point-in-Time Number of Persons Served on December 31, 2001	7,382	3,064	2,348	863	14	17	13,688
Number of Cases Closed During 2001 (Excludes Transfers to the Family Care & Partnership Programs)	2,346	459	71	92	6	23	2,997
Point-in-Time Number of Persons Served on December 31, 2000 (Caseload Size)	8,835	2,918	2,332	921	16	26	15,048
Turnover Rate for the Above Case Closures	27%	16%	3%	10%	38%	n/a	20%
Number of Transfers to the Family Care and Partnership Programs During 2001	692	27	30	3	2	46	800
Turnover Rate for Transfers to the Family Care and Partnership Programs	8%	1%	1%	0%	13%	n/a	5%

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2001 for various reasons. Approximately 22 percent of all participants' cases were closed during 2001, of these 5 percent transferred into the Family Care and Partnership Programs. About 33 percent of elderly case closures and 41 percent of closures of persons with physical disabilities were due to death. Approximately 29 percent of all cases that were closed were due to moving to an institution. Of the elderly cases closed, 33 percent were due to moving to an institution.

TABLE 4
Reasons for Participant Case Closures – COP, COP-W and CIP II

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	1,008	201	22	18	3	11	1,263
Moved to Hospital/Nursing Facility or Other Institution	1,014	69	14	14	2	3	1,116
Transferred to Partnership Program	5	4	0	0	1	0	10
Transferred to Family Care Program	687	23	30	3	1	46	790
No Longer Income or Care Level Eligible	56	31	1	11	0	0	99
Voluntarily Ended Services	129	75	17	34	1	4	260
Moved	124	80	16	13	0	3	236
Other	15	3	1	2	0	2	23
Total Case Closed (all reasons)	3,038	486	101	95	8	69	3,797

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

Community Options Program and COP-Waiver are intended to serve persons in need of long-term support at an institutional level of care. State statutes require that COP/COP-W 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. (The percentage for elderly has been set lower than the actual population, to allow some county flexibility.) These minimum percentages have been periodically adjusted to reflect changes in the growth of the long-term care population. The total minimum percentages add up to 84.2 percent with 15.8 percent reserved for county discretion.

TABLE 5
Significant Proportions and Target Groups

Year	Elderly	PD	DD[1]	SMI	AODA	Other	Total
2001[2]	6,430 50.9%	2,035 16.1%	3,106 24.6%	967 7.7%	29 0.2%	68 0.5%	**12,635** 100%
2000[2]	7,972 56.1%	2,062 14.5%	3,155 22.2%	993 7.0%	23 0.2%	0 0%	**14,205** 100%
1999[2]	8,875 57.3%	2,306 14.9%	3,221 20.8%	1,068 6.9%	25 0.2%	0 0%	**15,495** 100%
1998[2]	8,602 55.8%	2,382 15.4%	3,061 19.8%	1,119 7.3%	27 0.2%	233 1.5%	**15,424** 100%
1997[2]	8,185 57.1%	2,025 14.1%	2,792 19.5%	1,053 7.3%	30 0.2%	261 1.8%	**14,346** 100%
1996[2]	7,695 57.6%	1,829 13.7%	2,594 19.4%	988 7.4%	40 0.3%	212 1.6	**13,358** 100%
Minimum Percentages	**57.0%**	**6.6%**	**14.0%**	**6.6%**	**0%**		

1. Calculations include the use of COP-Regular funds for services above the CIP I rate.
2. Unduplicated count of persons with services funded by COP-Regular, COP-W, or CIP IB where COP is used to provide the local match.

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

In 2001, Community Integration Program II and COP-Waiver provided funding for home and community-based services to 12,508 elderly and persons with physical disabilities with long-term care needs. Since 1991, the census of persons served for all program participants has increased on average 13.4 percent* annually.

TABLE 6
CIP II and COP-W Program Growth

Year	CIP II & COP-W Participants	Growth from Previous Year Including CIP II & COP-W Only	Family Care Participants	*Growth from Previous Year Including CIP II, COP-W & Family Care
1991	5,501	+ 34.9%	n/a	+ 34.9%
1992	6,129	+ 11.4%	n/a	+ 11.4%
1993	7,625	+ 24.4%	n/a	+ 24.4%
1994	8,326	+ 9.2%	n/a	+ 9.2%
1995	9,369	+ 12.5%	n/a	+ 12.5%
1996	10,670	+ 13.9%	n/a	+ 13.9%
1997	11,791	+ 10.5%	n/a	+ 10.5%
1998	12,895	+ 9.4%	n/a	+ 9.4%
1999	13,900	+ 7.8%	n/a	+ 7.8%
2000	13,546	- 2.5%	1,444	+ 7.8%
2001	12,508	- 7.7%	3,338	+ 5.7%

TABLE 7
COP, COP-W and CIP II Participants by Age

AGE	NUMBER	PERCENT
Under 18 years	458	2.6
18 – 64 years	6,894	39.7
65 – 74 years	3,040	17.5
75 – 84 years	3,921	22.6
85 years and over	3,063	17.6

TABLE 8
COP, COP-W and CIP II Participants by Gender

GENDER	NUMBER	PERCENT
Female	11,446	65.9
Male	5,930	34.1

TABLE 9
COP, COP-W and CIP II Participants by Race/Ethnic Background

RACE/ETHNIC BACKGROUND	NUMBER	PERCENT
Caucasian	15,098	86.9
African American	1,610	9.3
Hispanic	187	1.1
American Indian/Alaska Native	255	1.5
Asian/Pacific Islander	226	1.3

TABLE 10
COP, COP-W and CIP II Participants by Marital Status

MARITAL STATUS	NUMBER	PERCENT
Widow/Widower	5,255	30.2
Never Married	5,690	32.7
Married	3,127	18.0
Divorced/Separated	2,903	16.7
Unknown	401	2.3

TABLE 11
Total Number of COP, COP-W and CIP II Participants Served During the Year

TARGET GROUP	NUMBER	PERCENT
Elderly	10,290	59.2
Physically Disabled	3,556	20.5
Developmentally Disabled	2,550	14.7
Severe Mental Illness	940	5.4
AODA/Other	40	0.2

TABLE 12
COP, COP-W and CIP II Participants by Natural Support Source

NATURAL SUPPORT SOURCE	NUMBER	PERCENT
Adult Child	5,361	30.9
Non-Relative	2,685	15.5
Spouse	2,469	14.2
Parent	2,660	15.3
Other Relative	2,430	14.0
No Primary Support	1,771	10.2

TABLE 13
COP, COP-W and CIP II Participants by Level of Care

LEVEL OF CARE	NUMBER	PERCENT
Intermediate Care	12,897	74.1
Skilled Care	3,943	22.7
Mental Illness Diagnosis	391	2.3
Other	145	0.8

TABLE 14
COP, COP-W and CIP II Participants who Relocated/Diverted from Institution

RELOCATED/DIVERTED	NUMBER	PERCENT
Diverted from Entering any Institution	15,786	90.8
Relocated from General Nursing Home	1,281	7.4
Relocated from ICF/MR	263	1.5
Relocated from Brain Injury Rehab Unit	46	0.3

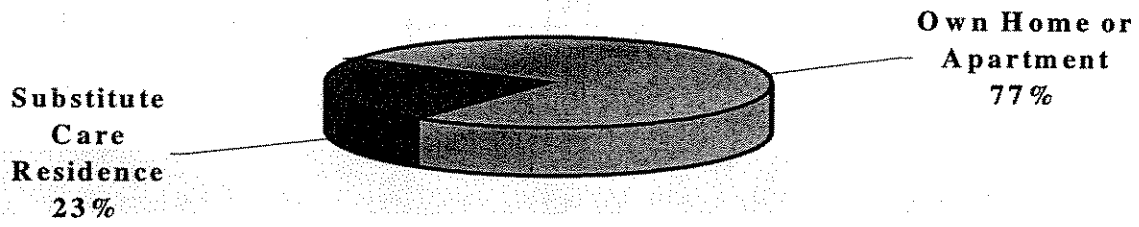
TABLE 15
COP, COP-W and CIP II Participants by Living Arrangement

LIVING ARRANGEMENT	NUMBER	PERCENT
Living with Immediate Family	5,632	32.4
Living Alone	5,496	31.6
Living with Others with Attendant Care	2,504	14.4
Living with Others	1,722	9.9
Living Alone with Attendant Care	1,017	5.9
Living with Immediate Family with Attendant Care	705	4.1
Living with Extended Family	229	1.3
Living with Extended Family with Attendant Care	50	0.3
Transient Housing Situation	21	0.1

TABLE 16
COP, COP-W and CIP II Participants by Type of Residence

TYPE OF RESIDENCE	NUMBER	PERCENT
Own Home or Apartment	13,338	76.8
Community Based Residential Facility (CBRF)	2,363	13.6
Adult Family Home	1,022	5.9
Other	146	0.8
Supervised Community Living	201	1.2
Residential Care Centers for Youth & Children (RCC)	12	0.1
Residential Care Apartment Complex (RCAC)	121	0.7
Child Foster Care	173	1.0

FIGURE 4
Percentage of Participants in Own Home or Substitute Care Residence



COP AND ALL HOME COMMUNITY-BASED WAIVER FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $413,517,283 (federal waiver and state funds) was spent in 2001 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 16 percent of the overall total. COP-Regular and COP-Waiver together contribute 34 percent of the overall total. [These figures do not include funds spent under the regular (non-waiver) Medicaid program.]

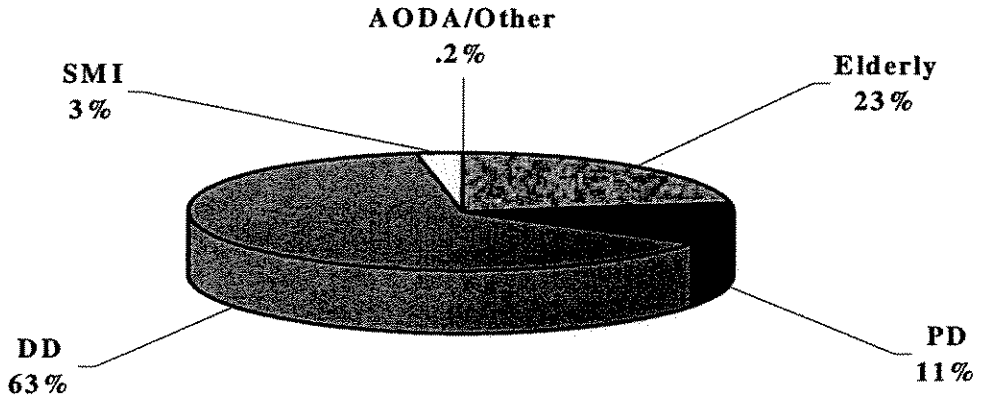
TABLE 17
Funding of Community Long-Term Care by Target Group

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLSA, BIW	GRAND TOTAL
Elderly	21,058,992 31.3%	55,470,358 74.4%	**76,529,350** **53.9%**	16,469,006 42.3%	**93,020,985** **51.4%**		**93,020,985** **22.5%**
PD	5,765,464 8.6%	19,101,481 25.6%	**24,866,945** **17.5%**	22,464,815 57.7%	**47,329,131** **26.2%**		**47,329,131** **11.4%**
DD	29,132,914 43.2%		**29,132,914** **20.5%**		**29,132,914** **16.1%**	232,614,494 100%	**261,747,408** **63.3%**
SMI	10,846,974 16.1%		**10,846,974** **7.6%**		**10,846,974** **6.0%**		**10,846,974** **2.6%**
AODA	299,513 .4%		**299,513** **.2%**		**299,513** **.2%**		**299,513** **.1%**
Other	273,272 .4%		**273,272** **.2%**		**273,272** **.2%**		**273,272** **.1%**
Total	**67,377,129** **16.3%**	**74,571,839** **18.0%**	**141,948,968** **34.3%**	**38,933,821** **9.4%**	**180,902,789** **43.7%**	**232,614,494** **56.3%**	**413,517,283** **100.0%**

Source: Reconciliation schedules

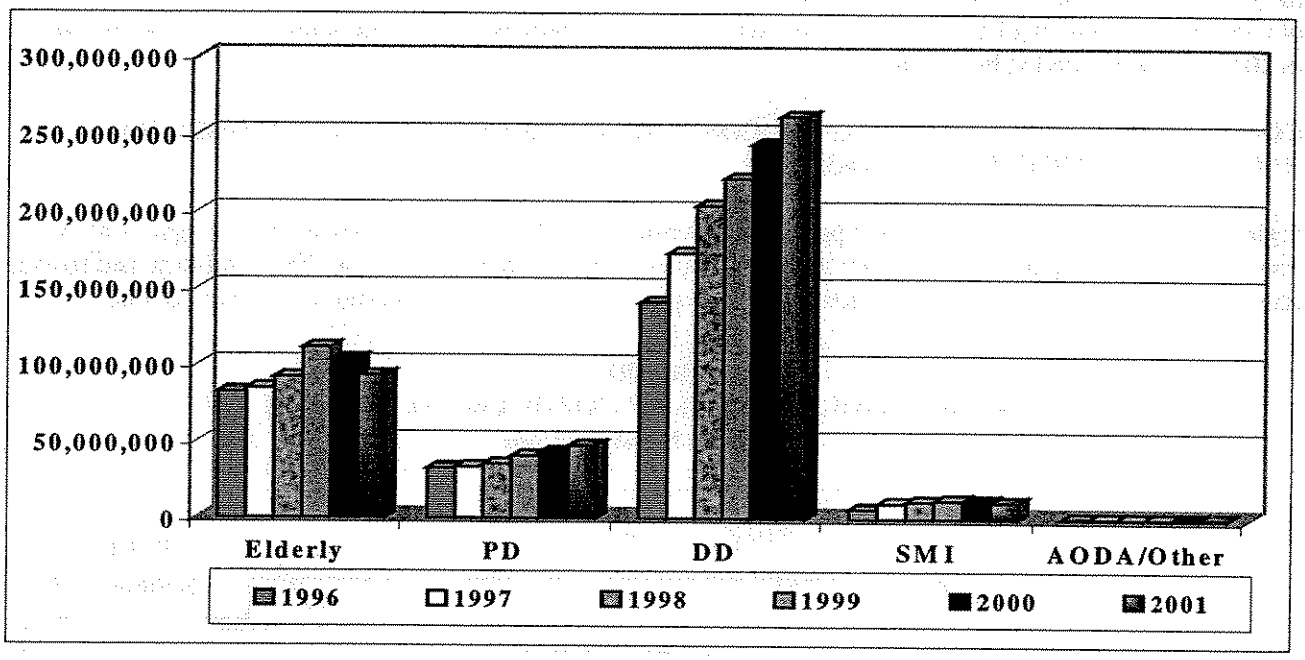
- The elderly received 23% of the funds;
- persons with physical disabilities (PD) received 11% of the funds;
- persons with developmental disabilities (DD) received 63% of the funds;
- persons with severe mental illness (SMI) received 3% of the funds; and
- persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 5
Total COP and Waivers Spending by Target Group



Services for participants are grouped by client characteristics (Figure 6). 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 6
Increase/Decrease in Funding for Community Long-Term Care by Target Group
1996 – 2001



COP-REGULAR

Community Options Program (COP-Regular) general purpose revenue (GPR) is used in the following ways:

- 30.1 percent of the total COP funds were used for services for COP only participants;
- 33.6 percent were used as match to increase services to waiver eligible people by creating more waiver slots;
- 13.9 percent were used for current waiver participants to provide services that could not be paid for with waiver funds;
- 5.6 percent were used for program and service coordination, 1 percent for special projects and 2 percent went into COP risk reserves at the county level;
- 10.5 percent were used to cover the matching share of expenses for those participants whose cost of care exceeds the waiver allowable rates (exceptionally high cost individuals);
- 3.3 percent of COP-Regular funds were used to conduct assessments and develop care plans for COP and Medicaid waiver eligible people.

In calendar year 2001, $6,859,773 COP-Regular (GPR) dollars were used to fund the match for CIP 1 so counties could earn additional federal funds for persons with developmental disabilities when the average costs exceeded the allowable reimbursement rate. When COP funding is used in this way it is referred to as "overmatch". In addition, $202,300 of COP-Regular (GPR) dollars were used to fund the match for CIP II so counties could earn additional federal funds for persons who were elderly and/or for persons with physical disabilities when the average costs exceeded the allowable reimbursement rate. Another $3,664,699 of COP-Regular funds were used as match to expand the COP-W program.

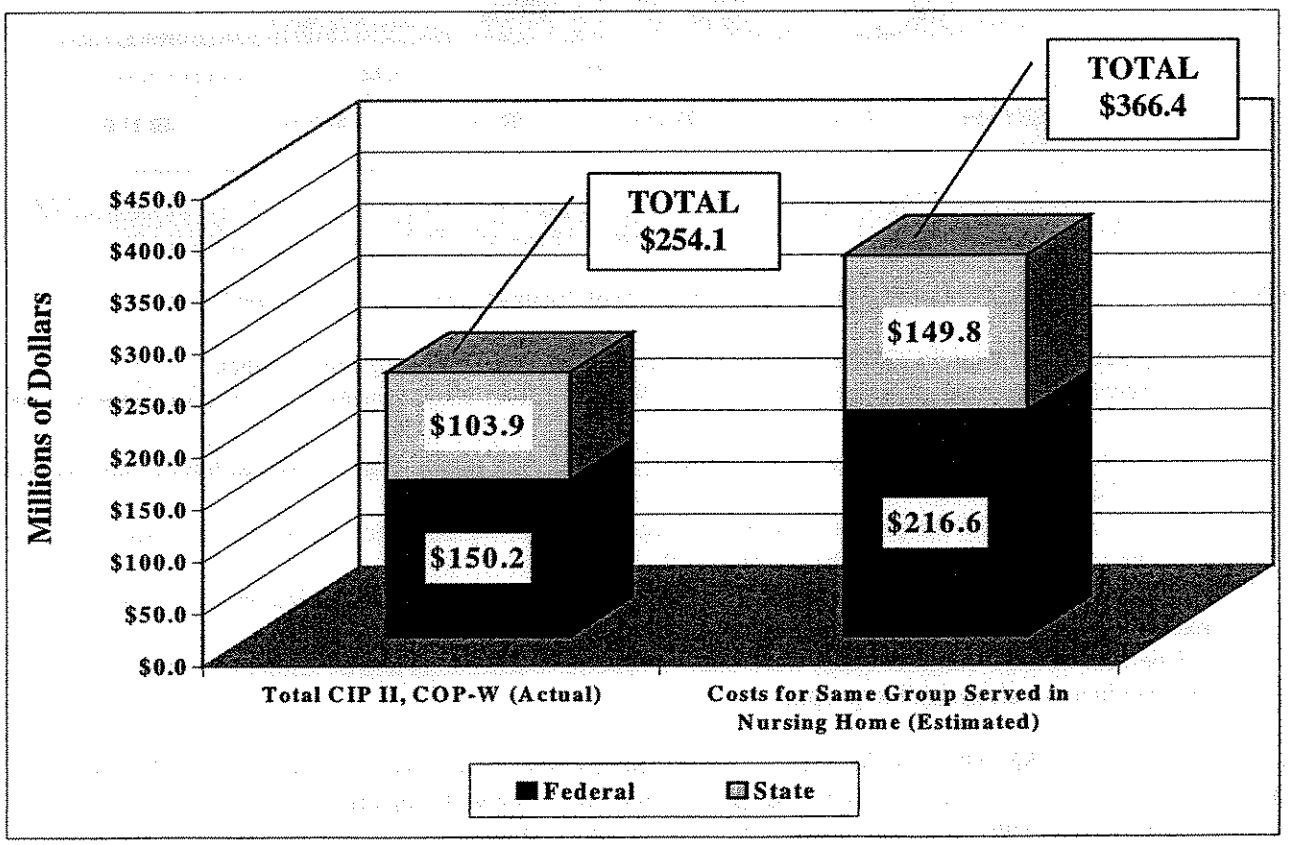
MEDICAID NURSING HOME USE

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. COP has enabled people with long-term care needs to continue to live in their own homes and communities. COP 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. Also, in 2001, CIP II expanded by 232 slots.

COMPARING COP-W PARTICIPANTS' COSTS TO THEIR COSTS IF THEY WOULD HAVE RECEIVED NURSING HOME CARE

Figure 7 illustrates the public costs for participants served with CIP II & COP-Waiver, and compares Medicaid costs for these same participants if they would have been served in a nursing home. The total state and federal costs are compared below if the participants, at the same level of care, were served in a nursing home.

FIGURE 7
Actual Annual 2001 CIP II and COP-W Costs vs. Estimated Care in Nursing Home



The management, monitoring and attention to program cost effectiveness for COP and COP-W are carried out in a number of ways. For additional information on costs of care in the community and in nursing homes, see Table 22 on Page 18.

COP FUNDING FOR EXCEPTIONAL NEEDS

The statewide Community Options Program fund for exceptional needs is part of COP. The Department may carry forward to the next fiscal year, 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 for 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 2001, funds for exceptional needs were awarded to 45 counties. For example, individual awards include "homecoming" funds that allow people to purchase or pay for household furnishings, equipment, security deposits, etc., so they can 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, etc. Awards were also made for adapted mobility equipment such as wheelchairs, walkers and scooters not covered by Medicaid, as well as van modifications.

COP-REGULAR AND COP-W EXPENDITURES

Table 18 (next page) illustrates statewide expenditures and reimbursement of Community Options Program funds for the calendar years 1982 through 2001. Lead agencies are reimbursed at a fixed rate for each assessment and each care plan completed for participants in COP or by any of Wisconsin's Medicaid Home and Community-Based Waivers.

Table 18 also illustrates service funds expended and reimbursed for persons through either COP-Regular or COP-Waiver. This includes COP funds used as match for federally-funded CIP I or CSLA. The COP-W and locally matched CIP I/CSLA service funds are further broken out into the state GPR and federal share of service costs. Table 18 includes the portion of federal funds generated when COP is used as a matching source for CIP I or CSLA locally matched slots. It does not include the federal funds associated with CIP I slots which are funded by state and federal Medicaid dollars (fully funded slots).

NOTES FOR TABLE 18 – COP-REGULAR AND COP-W EXPENDITURES

Column 1: Total costs reported by lead agencies for COP, COP-W and CIP I where COP is used as match.

Column 2: COP funds paid for assessments and care plans. Includes federal assessment funds in 1987-1989.

Column 3: COP funds paid for COP-Regular services. Includes service funds expended for local program administration and COP Alzheimer Service funds.

Column 4: The GPR (state match) portion paid for federally-funded COP-W services.

Column 5: The total amount of GPR funds paid (total of columns 2, 3 and 4).

Column 6: The federal portion of funds paid for COP-W services.

Column 7: The federal portion of funds paid for CIP II, CIP I or CSLA services for which COP funds were used as the state/local match or overmatch. Counties may have additional state and federal revenue for fully funded CIP I or CSLA slots, or for slots matched with local funds other than COP.

Column 8: Includes other federal revenue and revenue for Medicaid-funded case management available to offset state reimbursement of reported costs. Additional revenue may have been applied to reduce county overmatch for costs incurred above the COP contract level. Also includes revenue generated by a county that charges participants for assessment and plan costs.

Column 9: The total amount of federal funds paid (total of columns 6, 7 and 8).

Column 10: The amount listed is assumed to be local Community Aids, county overmatch or other revenue used for COP services based on differences between amounts reported on HSRS and payments amounts.

Column 11: Total paid from all sources (total of columns 5, 9 and 10).

TABLE 18
COP-Regular and COP-W Expenditures

1	2	3	4	5	6	7	8	9	10	11
	Community Options GPR Funds Paid				Federal Funds Paid (matched with COP-Regular fund)					
Year and Total Costs Reported	Assess. And Plans	COP-Regular Services	COP-W GPR Services	Total GPR Paid	COP-W Fed. Paid	CIP II/CIP1 Fed Overage & CIP 1B Fed Match Paid	Other Fed Revenue	Total Fed Paid	Comm. Alds, Overmatch, or Other	Grand Total Paid
2001										
180,838,515	2,202,422	65,174,706	28,082,404	95,459,532	46,489,435	37,679,132	488,491	84,657,058	721,925	180,838,515
2000										
185,469,882	2,159,343	67,219,281	30,296,720	99,675,344	50,482,339	34,098,842	436,354	85,017,535	777,003	185,469,882
1999										
188,779,088	3,076,096	66,662,899	32,132,870	101,871,865	49,257,778	35,321,774	492,151	85,071,703	1,835,520	188,779,088
1998										
167,320,607	2,854,106	63,627,776	26,181,427	92,663,309	42,441,290	30,044,574	516,841	73,002,705	1,654,593	167,320,607
1997										
149,260,716	2,556,110	59,819,203	22,634,789	85,010,102	38,098,122	24,629,387	493,662	63,221,171	1,029,443	149,260,716
1996										
131,974,493	2,194,049	57,948,468	20,997,816	81,140,333	32,170,998	17,183,765	620,566	49,975,329	858,831	131,974,493
1995										
115,684,575	2,264,528	55,507,478	18,057,357	75,829,363	27,550,760	10,863,905	679,487	39,094,152	761,060	115,684,575
1994										
96,792,770	2,009,347	47,806,015	15,075,439	64,890,801	24,085,246	5,492,128	723,866	30,301,240	1,600,729	96,792,770
1993										
83,982,322	2,179,975	44,444,357	13,310,325	59,934,657	20,329,641	1,984,764	673,045	22,987,450	1,060,215	83,982,322
1992										
66,965,400	1,778,355	40,222,689	8,082,092	50,083,136	13,426,855	1,404,418	741,861	15,573,134	1,309,130	66,965,400
1991										
57,295,820	1,481,325	35,818,495	6,867,305	44,167,125	10,939,142	249,841	880,168	12,069,151	1,059,544	57,295,820
1990										
46,825,507	1,619,224	33,758,085	4,312,550	39,689,859	6,322,549		562,287	6,884,836	250,812	46,825,507
1989										
37,172,208	1,353,769	29,931,012	1,962,392	33,247,173	2,873,078		467,675	3,340,753	584,282	37,172,208
1988										
29,921,032	1,263,683	27,738,371	2,678	29,004,912	406,796		441,113	847,909	68,211	29,921,032
1987										
26,648,810	1,451,918	24,832,371		26,234,289				414,520		26,648,809
1986										
20,766,847	1,365,906	19,400,941		20,766,847						20,766,847
1985										
16,083,729	1,875,085	14,108,644		16,083,729						16,083,729
1984										
10,074,947	1,238,231	8,836,716		10,074,947						10,074,947
1983										
3,315,127	832,116	2,483,011		3,315,127						3,315,127
1982										
309,501	110,920	198,581		309,501						309,501

Source: Reconciliation schedules

SERVICE TO PARTICIPANTS WITH ALZHEIMER'S DISEASE INCLUDING OTHER IRREVERSIBLE DEMENTIAS

In 2001, a total of 788 participants were reported as having an Alzheimer's or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's Disease and Parkinson's Disease). Of these 788 individuals, 36 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were $6,594,055.

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 rate of utilization, 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 $109,122,025.

TABLE 19
Total 2001 Medicaid State Plan and Waiver Costs for CIP II and COP-W

Total CIP II and COP-W Service Costs	117,371,993
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	109,122,025
Total 2001 Medicaid Expenditures for CIP II and COP-W Recipients	**226,494,018**

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
2001 Utilization of Waiver Services by CIP II and COP-W Participants

CIP II and COP-W Medicaid Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	90.87	$14,527,136	12.34
Supportive Home Care/Personal Care	98.17	54,153,244	46.27
Adult Family Home	4.03	7,823,091	6.63
Residential Care Apartment Complex	1.33	2,318,189	1.97
Community Based Residential Facility	11.74	20,307,498	17.22
Respite Care	5.64	1,609,989	1.37
Adult Day Care	6.68	3,245,779	2.75
Day Services	1.75	1,197,092	1.02
Daily Living Skills Training	1.63	1,583,003	1.40
Counseling and Therapies	10.47	581,692	.49
Skilled Nursing	3.61	114,524	.10
Transportation	26.32	2,035,464	1.75
Personal Emergency Response System	35.17	1,175,707	1.00
Adaptive Equipment	24.28	1,724,500	1.46
Communication Aids	3.04	73,502	0.06
Medical Supplies	20.54	980,842	0.83
Home Modifications	7.75	1,397,325	1.19
Home Delivered Meals	25.31	2,523,416	2.14
Total Medicaid Waiver Service Costs		**117,371,993**	

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

TABLE 21
2001 Utilization of Medicaid State Plan (Card) Benefits by CIP II and COP-W Participants

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	2.7%	$5,573,764.81	5.1%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	56.2%	2,979,973.24	2.7%
Outpatient Hospital	43.1%	3,536,698.99	3.2%
Lab and X-ray	45.6%	633,768.05	0.6%
Prescription Drugs	75.4%	31,705,231.19	29.1%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	20.3%	3,001,669.91	2.8%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	4.1%	314,161.16	0.3%
Dental Services	14.4%	496,000.48	0.5%
Nursing (Nurse Practitioner, Nursing Services)	0.2%	786,535.46	0.7%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	68.5%	15,106,264.92	13.8%
Personal Care (Personal Care, Personal Care Supervisory Services)	27.5%	32,630,884.55	29.9%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPDST, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	37.2%	12,357,072.41	11.3%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$109,122,025.17**	

Notes: Totals may not equal 100% due to rounding. In 1996, Wisconsin Medicaid restructured CIP II and COP-W Medicaid card service reporting to comply with changes in federal Medicaid reporting requirements.

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 spent per capita on an average daily basis for nursing home and waiver care. It also indicates the breakdown between federal spending and state and/or county spending for each funding source.

TABLE 22
2001 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
2001	Medicaid Program Per Diem	$31.04	$12.69	$18.35	$84.56	$34.58	$49.98			
	Medicaid Card	30.36	12.42	17.94	12.24	5.00	7.24			
	Medicaid Costs Subtotal[2]	$61.40	$25.11	$36.29	$96.80	$39.58	$57.22	$35.40	$14.47	$20.93
	COP – Services w/Admin.	2.41	0.99	1.42	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.49	0.20	0.29	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.11	0.04	0.07	unk.	unk.	unk.			
	Other	1.08	0.44	0.64	n/a[4]	n/a[4]	n/a[4]			
	Total	$67.20	$27.48	$39.72	$96.90	$39.62	$57.28	$29.70	$12.14	$17.56

When all public costs are counted, expenses for CIP II and COP-W participants averaged $67.20 per person per day in 2001, compared to $96.90 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 2001 was $29.70 less than the cost of nursing home care, compared to a difference of $26.22 in 2000.

TABLE 23
2000 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
2000	Medicaid Program Per Diem	$29.01	$11.92	$17.09	$79.44	$32.64	$46.80			
	Medicaid Card	26.66	10.96	15.70	10.82	4.45	6.37			
	Medicaid Costs Subtotal[2]	$55.67	$22.88	$32.79	$90.26	$37.09	$53.17	$34.59	$14.21	$20.38
	COP – Services w/Admin.	1.54	1.54	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.36	0.36	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	3.42	1.41	2.01	0.12	0.00	0.12			
	Community Aids	0.04	0.02	0.02	unk.	unk.	unk.			
	Other	3.13	0.17	2.96	n/a[4]	n/a[4]	n/a[4]			
	Total	$64.16	$26.38	$37.78	$90.38	$37.09	$53.29	$26.22	$10.71	$15.51

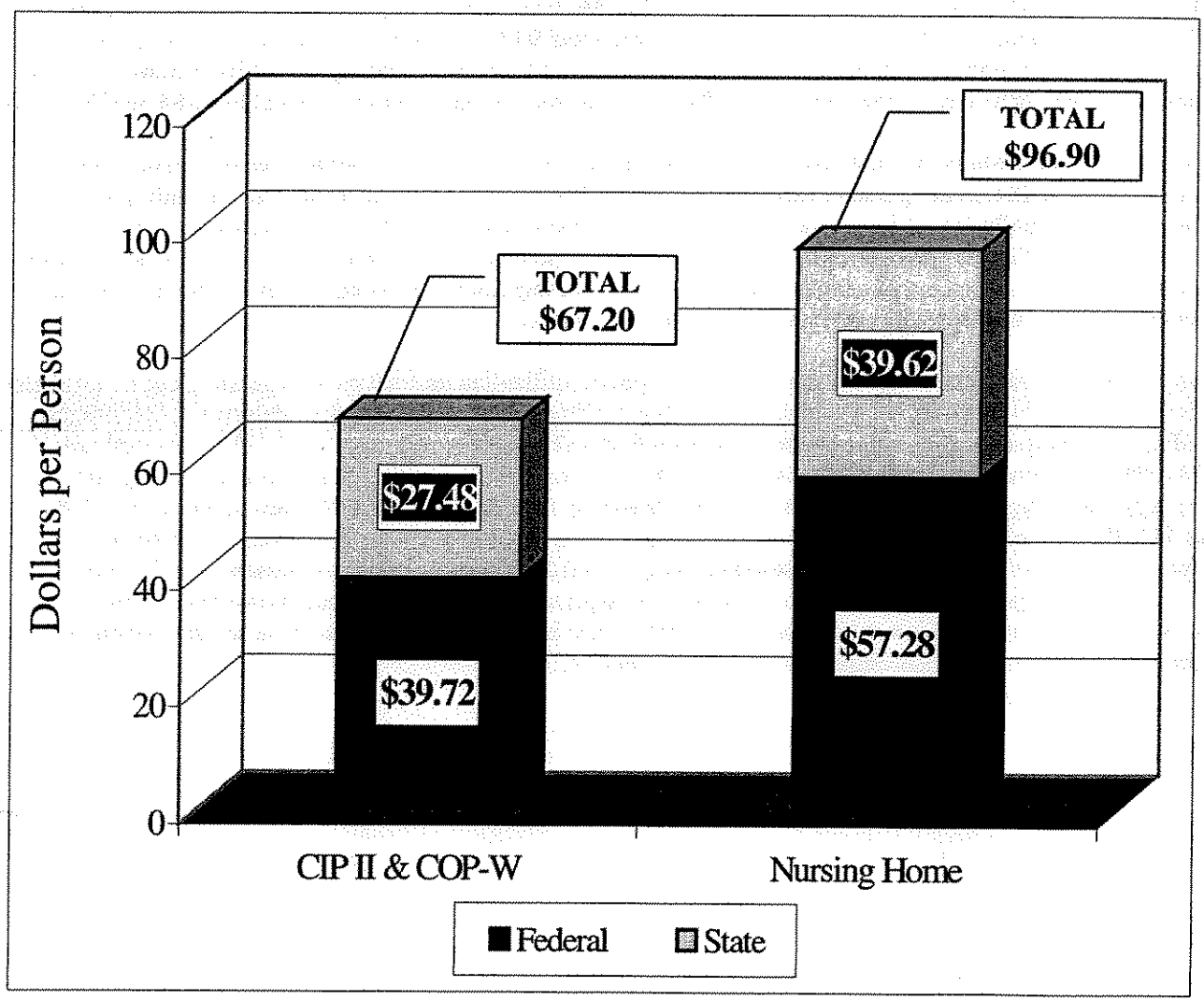
The following footnote references are for Table 22 and Table 23:

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.
4. This category applies only to community care.

COST EFFECTIVENESS

A total of 3,781,399 service days were provided to 12,508 CIP II and COP-W participants during 2001. Therefore, the total public cost of care for waiver participants in 2001, based on actual days of service, was $254,110,013 ($67.20 per day for 3,781,399 days). If the 12,508 individuals had spent the same 3,781,399 days in nursing homes at the average daily public cost for nursing home care, the total cost of serving them in 2001 would have been $366,417,563 ($96.90 per day for 3,781,399 days). The total public spending on behalf of these individuals is estimated to have been $112,307,550 less than if they had resided in nursing homes for the same length of time. Figure 8 below compares actual average daily per capita costs.

FIGURE 8
CIP II & COP-W vs. Nursing Home Care in 2001
Average Public Costs per Day



CARE LEVEL AND ITS SIGNIFICANCE FOR THE COST COMPARISONS

The cost differences evident in the previous comparisons (Table 22), 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 2001, 71 percent of CIP II and COP-W participants were rated at the intermediate care facility (ICF) level and 29 percent were rated at the skilled nursing facility (SNF) level. Corresponding figures for persons residing in nursing homes during 2001 were 12 percent ICF and 88 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 Health Care Financing Administration, the actual 2001 nursing home Medicaid per diem for ICF residents was approximately $66.28. For SNF residents the Medicaid per diem was approximately $85.33. 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 (71 percent ICF and 29 percent SNF), estimated costs to Medicaid for nursing home care would have been $649,926,871 instead of $765,351,848. Given that there were 9,051,339 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 2001, this level of total Medicaid spending would have translated to an average per diem across care levels of $71.80 (Table 24), instead of the previously calculated $84.56 (Table 22).

Assuming the same Medicaid card costs and other expenses, the average daily public cost of nursing home care would have been $84.14 per person (Table 24), instead of $96.90 as reported in Table 22. The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $16.94 instead of $29.70. This represents a difference of 25 percent, compared to 44 percent. Table 24 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.

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 12,508 waiver participants had spent the same 3,781,399 days residing in nursing homes, they would have incurred total public costs of $318,166,912 ($84.14 per day for 3,781,399 days), compared with the $254,110,013 they incurred while residing in the community. Assuming equivalent care level proportions, then, total public spending for CIP II and COP-W participants during 2001 was $64,056,899 less than the predicted cost of nursing home care for a comparable group. This figure is 13 percent less than the $366,417,563 estimated using actual 2001 data, but it still represents a difference in total public costs of 20 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.

TABLE 24
2001 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
2001	Medicaid Program Per Diem	$31.04	$12.69	$18.35	$71.80	$29.36	$42.44			
	Medicaid Card	30.36	12.42	17.94	12.24	5.00	7.24			
	Medicaid Costs Subtotal[2]	$61.40	$25.11	$36.29	$84.04	$34.36	$49.68	$22.64	$9.25	$13.39
	COP – Services w/Admin.	2.41	0.99	1.42	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.49	0.20	0.29	n/a[3]	n/a[3]	n/a[3]			
	SSI	1.71	0.70	1.01	0.10	0.04	0.06			
	Community Aids	0.11	0.04	0.07	Unk.	unk.	unk.			
	Other	1.08	0.44	0.64	n/a[4]	n/a[4]	n/a[4]			
	Total	$67.20	$27.48	$39.72	$84.14	$34.40	$49.74	$16.94	$6.92	$10.02

TABLE 25
2000 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

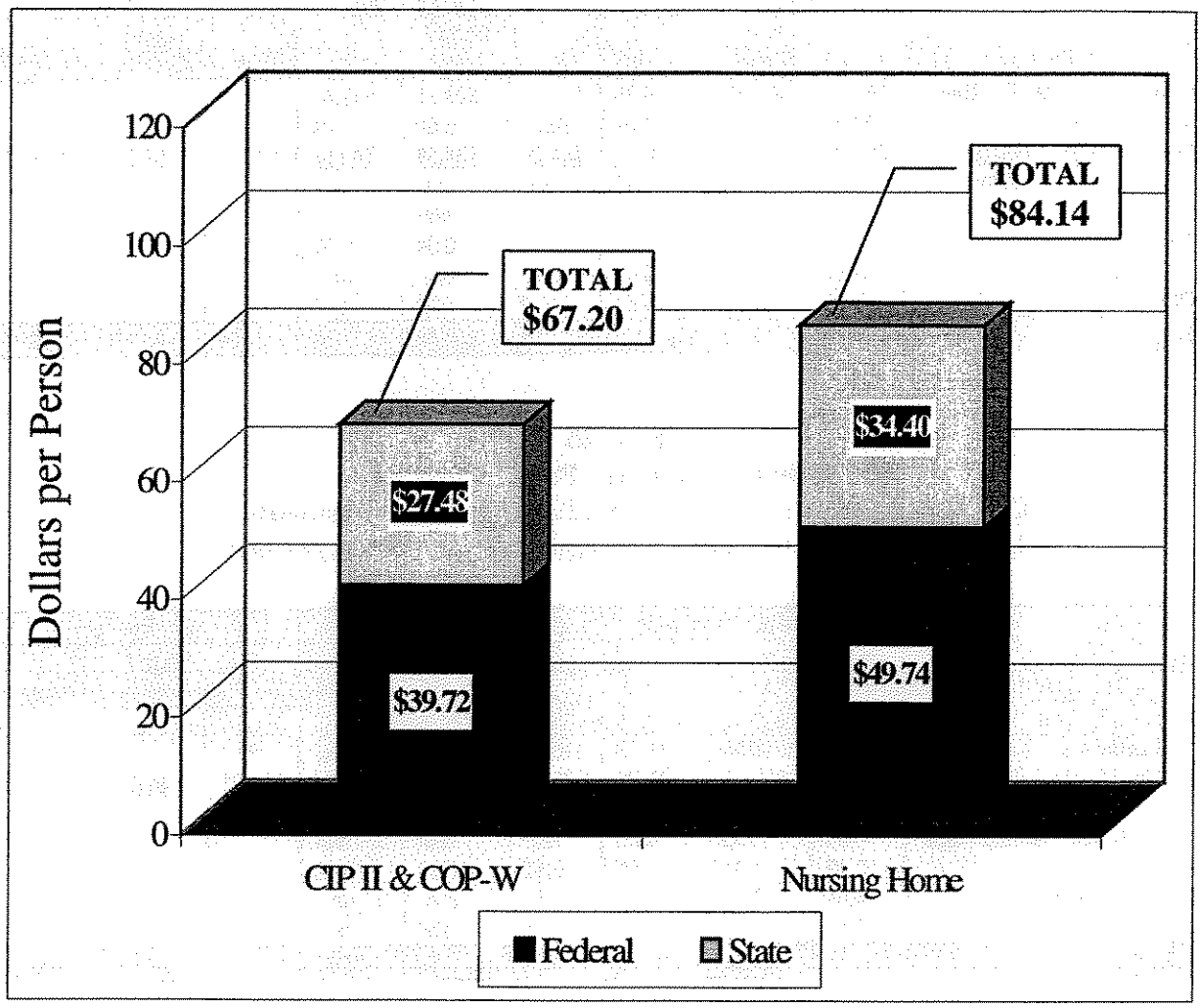
Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2000	Medicaid Program Per Diem	$29.01	$11.92	$17.09	$68.86	$28.30	$40.56			
	Medicaid Card	26.66	10.96	15.70	10.82	4.45	6.37			
	Medicaid Costs Subtotal[2]	$55.67	$22.88	$32.79	$79.68	$32.74	$46.94	$24.01	$9.86	$14.15
	COP – Services w/Admin.	1.54	1.54	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.36	0.36	0.00	n/a[3]	n/a[3]	n/a[3]			
	SSI	3.42	1.41	2.01	0.12	0.00	0.12			
	Community Aids	0.04	0.02	0.02	unk.	unk.	unk.			
	Other	3.13	0.17	2.96	n/a[4]	n/a[4]	n/a[4]			
	Total	$64.16	$26.38	$37.78	$79.80	$32.79	$47.01	$15.64	$6.41	$9.23

The following footnote references are for Table 24 and Table 25:

* Nursing home program per diems have been calculated assuming that the proportion of residents rated at the SNF and ICF care levels was the same as that reported for Medicaid Waiver participants in each of the respective years. The figures shown thus represent not actual costs but the costs that would have been incurred had the assumed SNF/ICF proportions prevailed. In nursing homes during 2000, 13 % of residents were rated at an ICF level, and 87% were SNF.

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.
4. This category applies only to community care.

FIGURE 9
CIP II & COP-W vs. Nursing Home Care in 2001
Adjusting for Level of Care
Estimated Average Public Costs per Day



Appendix A

PERFORMANCE STANDARDS

A state leadership committee established the framework for assessing quality in the Community Options Program. 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)

COMMUNITY SUPPORTED LIVING ARRANGEMENTS (CSLA-WAIVER):
A Medicaid-funded waiver program that serves the same target group as CIP IB. CSLA provides funds that enable individuals to be supported in their own homes. The program began as a demonstration in some counties in 1992 and was expanded statewide January 1, 1996.

Funding: GPR/State = Approximately 40% (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 471 cases in 2001. 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, 90 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: 95 *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 corrective action plans and technical assistance activities.*

Category: NON-FINANCIAL ELIGIBILITY

Monitoring Components:
- ✓ *Health form*
- ✓ *Functional screen*

Findings: 91 *percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases showed a deficit in documentation that was remedied. Systems of enhanced internal quality control have been implemented in those agencies with documentation issues.*

Category: SERVICE PLAN

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

Findings: 85 *percent of factors were in compliance. In a small percentage of the cases, timely ISP review, omission of identified services within the ISP, or 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: 86 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Corrective action plans were implemented where warranted.*

Category: BILLING

Monitoring Components:
- ✓ *Services accurately billed*
- ✓ *Only waiver allowable providers billed*
- ✓ *Residence in waiver allowable settings during billing period*

Findings: 88 *percent compliance was found in these categories. A process has been implemented to assist in improving billing accuracy. Reports are generated, when available, to assist local agencies in identifying and correcting such errors throughout their caseloads. Corrective action plans were implemented where warranted.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Currently licensed*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: 87 *percent overall compliance was found. Documentation or charging errors due to room and board versus care and supervision were identified in a few cases. A training module has been developed to assist in clarifying this complex area of policy. Corrective action plans were implemented where warranted.*

CORRECTIVE ACTION

A written report of each monitoring review was provided to the director of the local agency responsible for implementing the waiver participant's service plan. The reports cited any errors or deficiencies and required that the deficiency be corrected within a specified period of time, between 1 and 90 days. Follow-up visits were conducted to ensure compliance when written documentation was insufficient to provide assurance. Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. All agencies complied by modifying their practices and acknowledging the deficiencies.

In 2001, a total of 37 agencies were monitored, 33 with full reviews and 4 with reviews of newly implemented internal recertification systems. In 17 instances, disallowances were taken from counties where retroactive corrections could not be implemented. The average disallowance within those 17 counties was $3,736. Disallowances were taken in areas including billing of non-allowable services, data entry errors, lack of documentation for billed services, billing during a period of ineligibility for waiver services, and inaccurate collection of cost share.

PROGRAM QUALITY

During 2001, 471 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 26 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 26
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	97%
Good communication with care manager	96%
Care manager is responsive	99%
Active participation in care plan	95%
Satisfaction with in-home workers	96%
Substitute care services are acceptable	94%
Satisfaction with substitute care living arrangement	91%

QUALITY IMPROVEMENT PROJECTS

The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. An overview of those projects is 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. Quarterly, 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, Advanced Care Manager/Economic Support Training, Resource Allocation Decisions, Personal Outcomes, and Automated Functional Screen;
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance, including a reporting system for technical assistance requests and responses;
- Produce and distribute case specific fiscal reports containing potentially correctable reporting errors;
- Review certification and recertification procedures to identify more efficient and effective practices;
- Conduct enhanced interviews to determine customer satisfaction; and
- Enhance an internal question and answer system to ensure consistency by the reviewers/Bureau of Aging and Long Term Care Resources staff.

Irene Anderson and Kate Fitzgerald prepared this report with assistance from the staff in the Bureau of Aging and Long Term Care Resources and HSRS programming staff. We gratefully acknowledge the efforts of County Community Options Program Lead Agencies to report COP activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to:

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