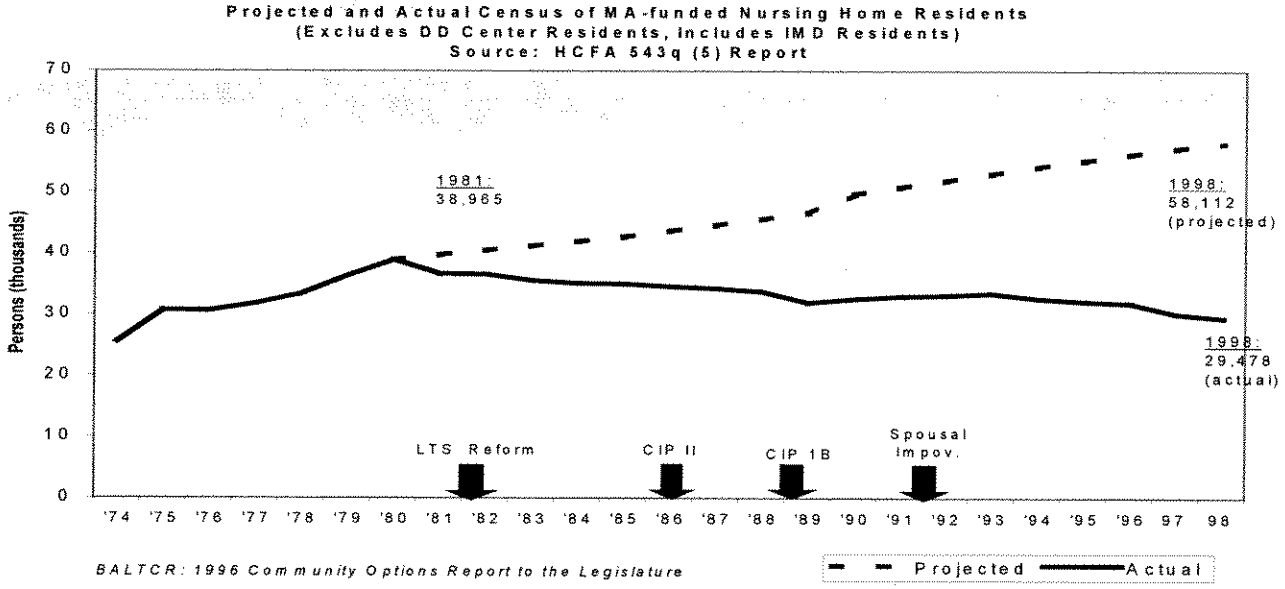
Medicaid Nursing Home Use and Long Term Care Policy Changes

The COP and the Medicaid home and community-based waivers have made possible a lower Medicaid utilization of nursing home beds in Wisconsin. At the same time COP also filled the gaps in unpaid care provided by family and friends. The extra support paid for by COP reduces 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.

The difference between the number of persons projected to be served by Medicaid in nursing homes and the actual number of persons served can be attributed primarily to the three long term support initiatives implemented in the early 1980's. In 1981, Medicaid funding for intermediate levels of care (ICF 3 and 4) was discontinued. A moratorium on new Medicaid-funded nursing home beds also went into effect in 1981. COP was enacted in the same year and was later joined by CIP I and CIP II. Spousal impoverishment provisions enacted in 1989 have increased the number of individuals financially eligible for Medicaid, resulting in an increase in both the projected and actual census of Medicaid-funded nursing home residents between 1989 and 1992.

The figure below depicts the actual number of nursing home residents funded through Medicaid compared to a projection of the number of nursing home residents if the Department of Health and Family Services had not implemented COP and other long term support initiatives.

Projected and Actual Census of Medicaid-Funded Nursing Home Residents



1981 – LTS Reform (COP, ICF 3-4, Bed Cap)
1985 – CIP II
1987 – CIP 1B
1990 – Spousal Impoverishment

Source: Medicaid 543Q Report and LTC Use Rate Projection Methodology
Excludes Developmentally Disabled Centers; Includes Institutions for Mental Disease.

Monitoring and Cost Effectiveness

The COP and COP-Waiver program management, monitoring and attention to program cost effectiveness are carried out in a number of ways. Statutory and other fiscal and programmatic requirements are monitored and addressed by:

- monitoring through the reporting and reconciliation process;
- monitoring through the DHFS audit process;
- monitoring through on-site quality assurance reviews;
- monitoring spending patterns; and
- disallowances taken through recoupment or by non-payment of non-allowed costs.

Guidelines were clarified to re-emphasize the need for counties to review and update policies regarding unusual expenditures. In 1998, counties identified their policies and procedures for unusual expenses. In addition, the Department completed an analysis of the reporting category "Recreation/Other Activities". The findings illustrated that of the people served in the COP and Medicaid waiver programs:

- 551 participants received services in this category (41% of whom were people with developmental disabilities and 22% were elderly).
- expenditures of COP-Regular funds reported as Recreation/Other Activities totaled $370,321, which was 1% of the reported COP-Regular service expenditures or .1% of the COP, COP-W and CIP II waiver funds combined.
- 11 counties spent more than 3% of their COP funds in this category; 37 counties spent nothing.
- $672 per year was the average amount spent by the 551 people; 20 participants received more than $3,000.

Of the 20 participants with high expenditures for Recreational/Other Activities, 10 were miscoded, 5 had extremely challenging conditions, 4 used recreation activities in lieu of paid caregiver respite and 1 was served at the guardian's request. When the COP expenditures for this category were compared to CY 1997, it was found that 56 fewer people received service under the "Recreational/Other" standard program category and $47,252 fewer dollars were spent in CY 1998 than in 1997.

The "Recreation/Other Activities" category for data collection has been redefined to give the Department more accurate data when analyzing spending patterns and service utilization.

Target Groups Served and Significant Proportions

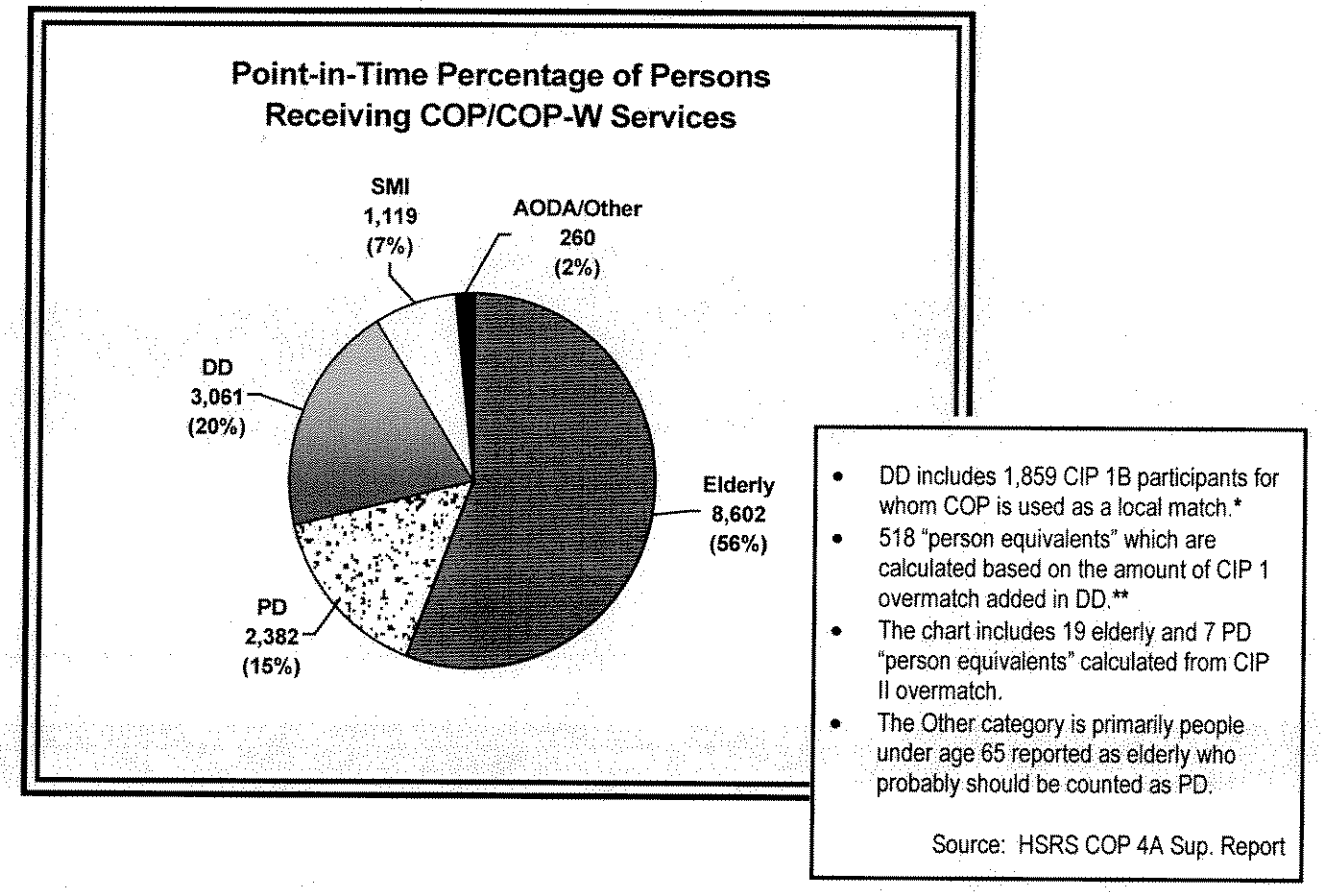
COP and COP-W are intended to serve persons in need of long term support. State statutes require that COP/COP-W serve persons from the major target groups in proportions which approximate the percentages of Medicaid-eligible persons who were served in nursing homes. These percentages are called "significant proportions".

The minimum percentages for significant proportions were initially set in 1984. (A percentage for county discretion was reserved by reducing the elderly minimum.) 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% with 15.8% reserved for county discretion. The current minimum percentages that county COP programs are required to meet for significant proportions are shown below:

Elderly persons	57.0%
Persons with developmental disabilities	14.0%
Persons with physical disabilities	6.6%
Persons with severe mental illness	6.6%
Persons with long term care substance abuse conditions	No % requirement

Figure 1 depicts the percentage of persons from each COP target group who received COP-Regular/COP-W services on December 31, 1998. Statewide, the proportions of persons served exceed the requirements for four of five groups.

Figure 1: COP-Regular/COP-W Participants by Target Group on December 31, 1998



* When COP is used as the matching source of a CIP 1B "slot" the participant is counted on a one for one basis or in the same way COP waiver participants are counted.

** When COP is used in aggregate to provide the matching source for earning federal funds for persons whose cost exceed the allowable rate, (overmatch) several participants may be counted as one (person equivalents) when counting significant proportions.

Table 1 illustrates the history of statewide significant proportions. This table provides point-in-time information on the proportion of persons receiving COP-Regular and/or COP-W services in each target group from 1982 through 1998.

Table 1: Significant Proportions, December 31, 1982 - 1998

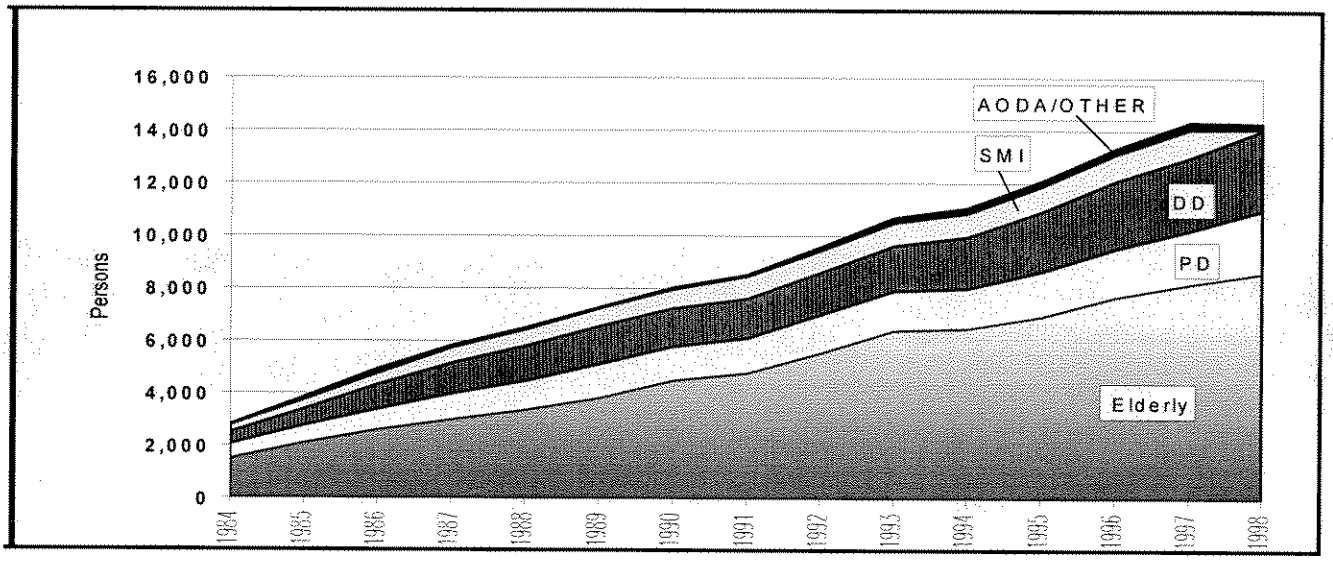
Year	Elderly	PD	DD[1]	SMI	AODA	Other	Total
1998[2]	8,602	2382	3061	1119	27	233	15,424
	55.8%	15.4%	19.8%	7.3%	0.2%	1.5%	100.0%
1997[2]	8,185	2,025	2,792	1,053	30	261	14,346
	57.1%	14.1%	19.5%	7.3%	0.2%	1.8%	100%
1996[2]	7,695	1,829	2,594	988	40	212	13,358
	57.6%	13.7%	19.4%	7.4%	0.3%	1.6	100%
1995	6,949	1,698	2,297	953	43	186	12,126
	57.3%	14.0%	18.9%	8.9%	0.3%	1.5%	100%
1994[3]	6,476	1,528	1,978	878	48	183	11,091
	58.4%	13.8%	17.8%	7.9%	0.4%	1.6%	100%
1993[3]	6,411	1,491	17,534	846	43	170	10,714
	59.8%	13.9%	16.4%	7.9%	0.4%	1.6%	100%
1992[3]	5,548	1448	1,635	818	47	110	9,606
	57.8%	15.1%	17.0%	8.5%	0.5%	1.1%	100%
1991[3]	4,785	1,309	1,532	830	51	39	8,546
	56.0%	15.3%	17.9%	9.7%	0.6%	0.4%	100%
1990[3]	4,492	1,281	1,487	700	58	37	8,055
	55.8%	15.9%	18.5%	8.7%	0.7%	0.5%	100%
1989[3]	3,814	1,289	1,473	660	53	5	7,294
	52.3%	17.7%	20.2%	9.0%	0.7%	0.1%	100%
1988[3]	3,361	1,094	1,365	600	54	39	6,513
	51.6	19.5%	21.0%	10.4%	0.8%	0.6%	100%
1987	2,989	970	1,195	563	63	53	5,833
	51.2%	16.6%	20.5%	9.7%	1.1%	0.9%	100%
1986	2,609	762	956	415	58	131	4,931
	52.9%	15.4%	19.4%	8.4%	1.2%	2.7%	100%
1985	2,098	649	654	329	43	85	3,858
	54.4%	16.8%	17.0%	8.5%	1.1%	2.2%	100%
1984	1,499	541	468	248	30	23	2,809
	53.4%	19.2%	16.7%	8.8%	1.1%	0.8%	100%
1983[4]	1,042	325	160	26	16	19	1,588
	65.6%	20.5%	10.1%	1.6%	1.0%	1.2%	100%
1982[4]	145	31	20	0	2	0	198
	73.2%	15.7%	10.1%	0.0%	1.0%	0.0%	100%

Source: HSRS COP 004A Sup. Report

1. Includes person-equivalents calculated from the use of COP-Regular funds for services above the CIP I and CIP II rate. This calculation is arrived at by dividing the spending above the rate by the statewide COP average per person expenditure. There were 95 person-equivalents in 1993; 247 in 1994; 291 in 1995; 380 DD and 5 PD in CY 1996; 28 ELD, 401 DD and 5 PD in CY 1997; and 19 ELD, 518 DD, and 7 PD in CY 1998.
2. Unduplicated count of persons with services funded by COP-Regular, COP-W, or CIP IB (1,189 for 1996; 1,624 for 1997 and 1,859 in 1998) where COP is used to provide the local match.
3. Unduplicated count of persons with services funded by COP-Regular and/or COP-W.
4. Count of all persons served during the year. Point-in-time data was not available until 1984.

Figure 2: Point-in-Time Count of Persons Receiving COP / COP-W Services December 31, 1984 – December 31, 1998

Figure 2 illustrates the actual number of persons receiving COP-Regular and/or COP-W services on December 31, 1982 to December 31, 1998. There has been steady growth in COP funding for all target groups since 1984. Even as a target group's percentage of the caseload fluctuates, the number of persons served demonstrates steady growth in all target groups.



Source: HSRS 004A Supplement Report

Statewide Expenditures

Table 2 (next page) illustrates statewide expenditures and reimbursement of COP funds for the calendar years 1982 through 1998. 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. See Tables 8 and 9 for county-specific activities and expenditures.

Table 2 also illustrates service funds expended and reimbursed for persons through either COP-Regular or COP-W. 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 2 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).

Table 2: Expenditures in COP-Regular/COP-W, 1982 to 1998

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	CIP2/CIP1 Fed Overage & CIP 1B Fed Match Paid	Other Fed Revenue	Total Fed Paid	Comm. Aids, Overmatch, or Other	Total Paid
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

See next page for column detail.

Notes for Table 2

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 payment amounts.
Column 11	Total paid from all sources (total of columns 4, 9 and 10).

COP Funds Used for Participants with Alzheimer's and Related Dementias

The Community Options Program was changed in 1986 to target some funding for persons with Alzheimer's disease or related dementias that would not otherwise meet level of care eligibility requirements. In the first few years following this change, not all funds allocated for this purpose were spent. Alzheimer's disease was difficult to diagnose at that time. Subsequently, eligibility for these funds was extended to all persons with an Alzheimer's or related diagnosis, regardless of level of care. Beginning in 1996, the special COP Alzheimer's funds were no longer kept separate from COP-Regular funds and counties were no longer required to track this allocation separately. In 1998, a total of 479 participants were reported on HSRS as having an Alzheimer's or related dementia diagnosis. Of these individuals, 408 were functionally eligible for COP, 71 were reported as eligible only by diagnosis, not by level of care.

Table 3 summarizes the use of these legislatively targeted funds, plus additional COP-Regular funds spent for this participant group.

Table 3: Use of COP-Regular Alzheimer's Funds, 1986 - 1998
Includes Other Related Dementias such as Friedrich's Ataxia, Huntington's Disease, and Parkinson's Disease

Year	Allocation	Unspent Carryover	Not Meeting LOC[1] Eligibility		Meeting LOC Eligibility		Total Expenditures
			Persons[5]	Expenditures[2]	Persons[5]	Expenditures[2]	
1998	990,993	n/a	71	61,048	408	2,673,076	2,734,124
1997	990,993	n/a	90	761,457	380	2,357,809	3,119,266
1996	990,993	n/a	171	1,934,930	312	1,287,275	3,222,205
1995	990,993	67,780	193	1,366,978	382	2,240,516	3,607,494
1994	990,993	0	227	1,477,554	317	1,779,178	3,256,732
1993	990,993	0	247	1,523,806	303	1,346,908	2,870,714
1992	990,993	0	258	1,367,453	261	963,633	2,331,086
1991	990,993	0	267	1,276,261	219	809,499	2,085,760
1990	990,993	0	264	1,158,684	257	723,914	1,882,598
1989	1,004,975	150,777	290	854,198	249	603,357	1,457,555
1988	1,028,003	334,356	229	693,647	190	479,978	1,173,625
1987	759,785	362,307	177	397,478	158	416,608	814,086
1986	499,999	n/a[3]	94	194,761	n/a[4]	n/a[4]	194,767

Source: HSRS COP Alzheimer's Report and Allocation Tables (Above table does not include those participants who receive Medicaid waiver funding only.) Some participants who receive waiver funding as well as COP-Regular may be included above.

1. LOC stands for level of care.
2. All COP funds including special COP Alzheimer's allocation.
3. Funds could not be carried over prior to 1987.
4. Because there was no HSRS code for persons with Alzheimer's disease or related dementias prior to 1987, the number of persons with these conditions who met level of care eligibility and COP expenditures could not be determined.
5. In many cases, counties might not report Alzheimer's as one of the client's reported characteristics. Therefore, the number of individuals with an actual Alzheimer's diagnosis may be greater than the number reported here.

In 1998, 375 participants served with Medicaid waiver funds were reported on the HSRS data system with a secondary diagnosis of Alzheimer's or a related dementia. The total expenditures for those participants were $3,184,136. These waiver participants and expenditures are not included in the above table.

COP Assessments, Care Plans and Persons Served

Participation in COP increased steadily from 1982 to 1998. Table 4 illustrates the number of assessments and care plans completed by local COP lead agencies during each calendar year from 1982 to 1998. (See Tables 8 and 9 for county-specific activities and expenditures.) The table also illustrates the number of new persons served and the total number of persons served during each calendar year with COP-Regular and/or COP-W service funds. Since the beginning of COP, on average, approximately one-third of the total persons served each year have been new participants.

Table 4: Number of COP Assessments, Care Plans and Persons Served, 1982 to 1998

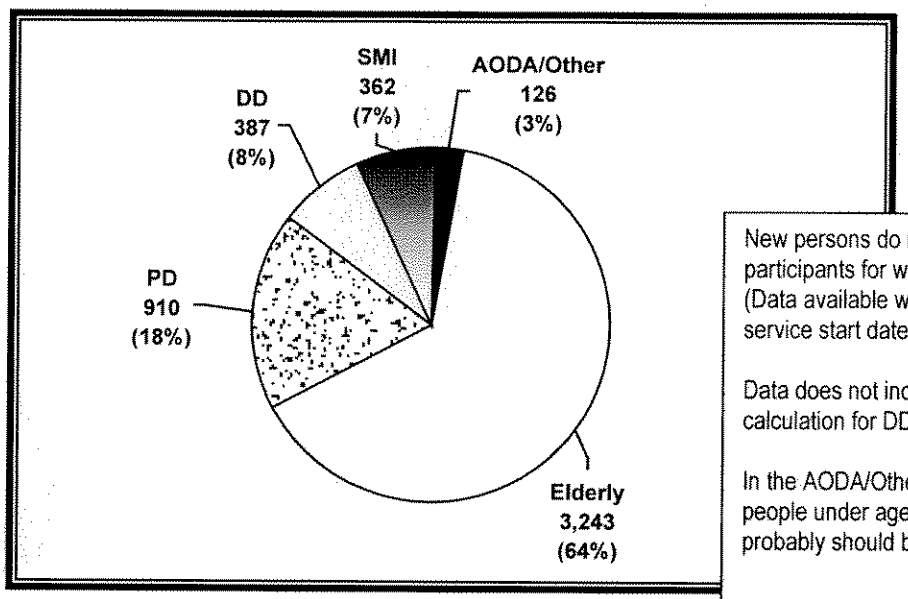
Year	Assessments	Care Plans	New Persons Served During Calendar Year	Total People Served During Calendar Year	Ratio of New Persons to Total Served
1982	712	366	198	198	100%
1983	4,399	2,836	1,399	1,549	90%
1984	6,213	3,893	2,663	3,863	69%
1985	6,674	3,883	2,585	5,233	49%
1986	8,514	4,868	2,954	6,588	45%
1987	7,632	4,998	2,573	7,414	35%
1988	6,754	4,790	2,691	8,202	33%
1989	7,198	5,125	2,939	8,372	35%
1990	8,070	5,744	3,639	10,464	35%
1991	8,301	5,699	3,613	11,320	32%
1992	8,206	5,803	3,470	11,788	29%
1993	9,876	7,348	4,102	13,173	31%
1994	9,288	6,852	3,727	13,600	27%
1995	9,548	7,070	5,113	15,103	34%
1996	9,397	6,662	5,617	16,733	34%
1997	10,539	8,462	5,953	17,062	35%
1998	11,708	9,304	5,028	17,953	28%
Total	133,083	93,703	58,264	n/a	n/a

Source: HSRS COP 004 and 005 Reports

Since 1982:

- more than 133,000 persons have had a COP assessment;
- more than 93,000 persons have benefited from the assistance of a COP care plan; and
- more than 58,000 persons have received community based long term support services.

Figure 4: Percentage of New Persons Receiving COP/COP-W Services During 1998*



New persons do not include 1,859 CIP 1B participants for whom COP is used as local match. (Data available was not able to determine actual service start date of local match participants.)

Data does not include the person equivalent calculation for DD (518), PD (7), and elderly (19).

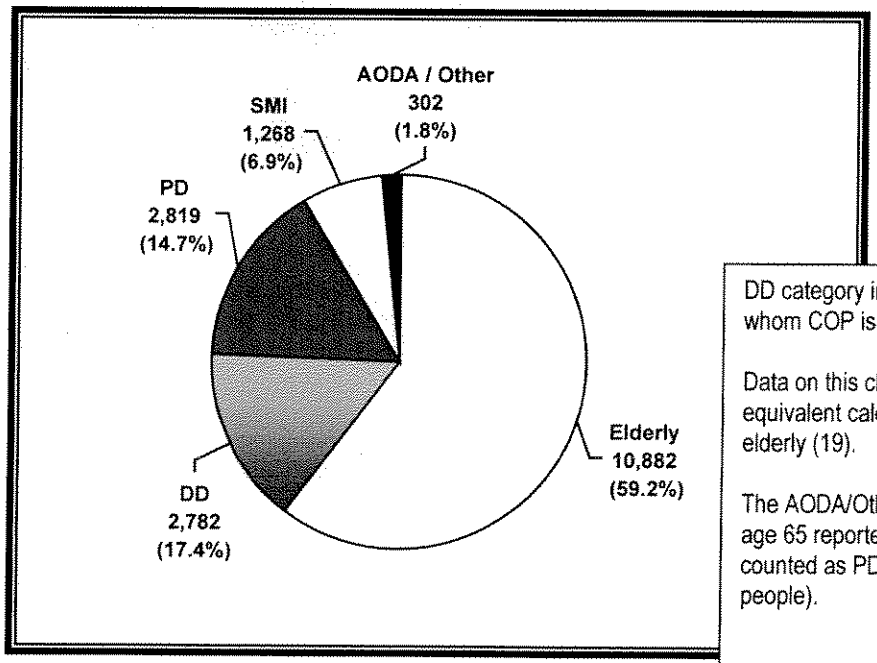
In the AODA/Other category, "Other" is primarily people under age 65 reported as elderly who probably should be counted as PD.

Source: HSRS COP 005 Report

Figure 4 illustrates the target group distribution of new persons served during 1998. In 1998, there was a marked decrease of new people with developmental disabilities who entered the program. The majority of the new participants served in 1998 were elderly

Figure 5 illustrates the target group distribution of all persons served by COP or COP-W in 1998.

Figure 5: Total Participants Served in 1998, COP & COP-W*



DD category includes 1,859 CIP 1B participants for whom COP is used as a local match.

Data on this chart does not include the person equivalent calculation for DD (518), PD (7), and elderly (19).

The AODA/Other category includes people under age 65 reported as elderly who probably should be counted as PD (AODA = 35 people; Other = 267 people).

Source: HSRS COP 04 Sup. Report

* Does not include other waivers.

Participation Rates

Table 5 illustrates the COP participation rate. In 1998, 11,708 assessments were conducted. There were 9,304 care plans developed including 437 care plans for persons who were assessed in a prior year. Approximately 76% of the persons assessed in 1998 also had a care plan developed in 1998. In 1998, 47% of the care plans were also implemented. In 1998, 10% of the people applying for services were placed on a waiting list at the time of the assessment or after the plan was completed.

Table 5: COP Participation Rate for Persons Assessed in 1998

76% of persons having an assessment also had a care plan developed (96% with COP funding and 2% with public or private funds)	47% of care plans were implemented (96% with COP or Waiver funding and 4% with public or private funds)
Of the 1,868 people who did not go on to get a care plan:	Of the 2,089 people who did not go on to services either funded with COP/COP-W or public funds:
16% had services arranged without agency involvement or used other funding	5% had services arranged without agency involvement
25% were placed on the waiting list	32% were placed on the waiting list
29% were ineligible for COP services	11% were ineligible for COP services
7% preferred nursing home care	11% preferred nursing home care
5% died before a plan could be developed	9% died before plan could be implemented
18% had no plan for other reasons	32% did not implement the plan for other reasons

Source: HSRS COP 008 Report

Turnover Rate for Participants

COP participants receive services as long as they remain eligible and continue to need services. In the past, two-thirds of COP and COP-W participants receive services for three years or less, the other one-third continued to be part of the program, some participants for as long as ten years. Given past trends, this is not expected to change.

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%.

Table 6 illustrates the number of cases closed during 1998 divided by the caseload size on January 1, 1998 for each target group for COP and COP-W.

Table 6: COP-Regular and COP-W Turnover by Target Group, 1998

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 1998	10,882	2,819	2,782	1,268	35	267	18,053
Point-in-Time Number of Persons Served on December 31, 1998	8,583	2,375	2,543	1,119	27	233	14,880
Corrected Number of Persons Closed in 1998 (Turnover)	2,299	444	239	149	8	34	3,073
Point-in Time Number of Persons Served on January 1, 1998	8,157	2,020	2,391	1,053	30	261	13,912
Turnover Rate	**28%**	**22%**	**10%**	**14%**	**27%**	**13%**	**22%**

Source: HSRS COP 008 and 004A Sup. Reports

Participant Case Closures

Table 7 illustrates the number of participants in each target group who either died, or moved to a hospital, nursing facility or other institution during 1998. Approximately 22% of all participants' cases were closed during CY 1998. About 39% of elderly case closures and 32% of closures of persons with physical disabilities were due to death. Approximately 33% of all cases that were closed were due to moving to an institution whereas 41% of the elderly cases closed were due to institutionalization.

Table 7: Reasons for Participant Case Closures - COP/COP-W

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	587	152	5	18	0	18	780
Moved to Hospital/Nursing Facility or Other Institution	721	69	6	23	0	27	846
Transferred to Partnership Program	161	10	0	0	0	0	171
No Longer Income or Care Level Eligible	49	23	3	4	0	1	80
Voluntarily Ended Services	85	65	11	43	0	3	207
Other	195	71	19	61	0	2	348
Total Closed (all reasons)	**1,798**	**390**	**44**	**149**	**0**	**51**	**2,432**

Source: HSRS COP 008 Report

Participant Living Arrangements

At the time of a COP or COP-W assessment, most participants reside either in their own home or in the home of family or friends. Community-based residential facilities (CBRF's) and nursing homes or other institutional settings are the next most common residence at the time of assessment. In 1998, the number of assessments conducted for people who lived in a CBRF continued to decrease due to controls on CBRF expenditures which were introduced for COP and COP-W participants in 1996.

- Over 77% of all assessments conducted in 1998 were for people who lived in their home.
- 66% of all assessments conducted were for elderly people.
- 65% of assessments conducted for people living in an institutional setting were for elderly persons.

Living Arrangements at the Time of Assessments

Institutional Living Arrangement	SMI	AODA	Other	PD	DD	Elderly	Total #	Total %
Nursing Home	20	1	1	3	10	14	49	
DD Center				1	46		47	
Mental Health	18	4	9	95	19	446	591	
Brain Injury Institution				5	2		7	
LTC Facility				1	1	23	25	
Brain Injury Hospital				6	4	3	13	
Shelter Care Facility	14		1	2	1	1	19	
Total Institutional Living Arrangement	52	5	11	113	83	487	751	6.5%
Percent of Institutional Arrangement	6.9%	0.7%	1.5%	15.0%	11.1%	64.8%	100.0%	
Percent of Total Assessments (target grp)	8.7%	7.8%	6.4%	5.5%	7.9%	6.4%		

Alternative Living Arrangement	SMI	AODA	Other	PD	DD	Elderly	Total #	Total %
Supervised Apartment	4		1	2	5	11	23	
Adult Family Home	14		2	6	21	18	61	
Group Home - Child					6		6	
CBRF (5-8 beds) & Indep. Apt.	23		9	3	15	86	136	
CBRF (over 8 beds)	21		14	11	9	248	303	
Total Alternative Living Arrangement	62	0	26	22	56	363	529	4.6%
Percent of Alternative Liv. Arrangement	11.7%	0.0%	4.9%	4.2%	10.6%	68.6%	100.0%	
Percent of Total Assessments	10.4%	0.0%	15.2%	1.1%	5.3%	4.7%		

Other Living Arrangement	SMI	AODA	Other	PD	DD	Elderly	Total #	Total %
Other	171	10	25	192	149	767	1,314	11.3%
Percent of Other Living Arrangement	13.0%	0.8%	1.9%	14.6%	11.3%	58.4%	100.0%	
Percent of total Assessments	28.7%	15.6%	14.6%	9.3%	14.2%	10.0%		

Own Home Living Arrangement	SMI	AODA	Other	PD	DD	Elderly	Total #	Total %
Own Home	311	49	109	1,728	762	6,028	8,987	77.6%
Percent of Own Home Living Arrangement	3.5%	0.5%	1.2%	19.2%	8.5%	67.1%	100.0%	
Percent of total Assessments	52.2%	76.6%	63.7%	84.1%	72.6%	78.8%		

Totals of All Living Arrangements	SMI	AODA	Other	PD	DD	Elderly	Total #	Total %
Total Assessments	596	64	171	2,055	1,050	7,645	11,581	*
Percent of All Assessments	5.1%	0.6%	1.5%	17.7%	9.1%	66.0%	100.0%	100.0%

* There were a total of 11,708 assessments conducted in 1998. There were a total 127 assessments for which no living arrangement was shown, either because it was missing or it was for a second assessment for a person already counted in the above total.

Program Activity and Expenditures

The following two tables provide information by county on specific program activities and expenditures.

Table 8 provides information by county on the number of persons receiving assessments, care plans, the number of persons served by program funding as well as those persons who received COP assessments and plans but who were served in the community **without** COP or COP-W funding.

Table 9 illustrates by county reported expenditures and actual payments for the COP and COP-W programs. These payments are broken out further by state and federal amounts.

Table 8: 1998 COP Program Activity by County

Source: COP 004 Supplement, 005 & Reconciliation Schedules

Lead Agencies		Assessments	Case Plans	Participants Served with COP (1)	Participants Served with COP-W (2)	CIP 1B/CSLA Participants COP Match (3)	All Participants Served with COP(4)	Participants Served without COP or COP-W (5)	Total Served in Community (6)
State Totals		**11,707**	**9,304**	**8,419**	**7,775**	**1,859**	**18,053**	**1,204**	**19,257**
ADAMS	DSS	25	16	53	24	3	80	0	80
ADAMS	USB	1	1	2	0	25	27	0	27
ASHLAND	HSD	104	90	36	61	28	125	4	129
BARRON	DSS	82	71	110	36	14	160	0	160
BAYFIELD	USB	74	27	21	60	13	94	17	111
BROWN	DSS	391	222	471	189	45	705	34	739
BUFFALO	HSD	48	25	62	25	10	97	1	98
BURNETT	DSS	20	15	98	13	17	128	2	130
CALUMET	HSD	61	38	25	52	0	77	7	84
CHIPPEWA	HSD	135	59	82	76	38	196	3	199
CLARK	DSS	85	60	30	104	29	163	3	166
COLUMBIA	HSD	102	68	125	51	28	204	45	249
CRAWFORD	HSD	46	26	39	39	14	92	21	113
DANE	CSHSD	430	405	795	379	0	1,174	153	1,327
DODGE	HSD	114	73	52	78	25	155	9	164
DOOR	DSS	52	50	11	61	0	72	0	72
DOOR	DCP	0	0	3	0	13	16	0	16
DOUGLAS	HSD	135	92	165	50	4	219	9	228
DUNN	HSD	23	11	26	62	11	99	3	102
EAU CLAIRE	HSD	111	68	186	192	26	404	26	430
FLORENCE	HSD	7	8	0	33	6	39	0	39
FOND DU LAC	DSS	166	92	117	146	31	294	7	301
FOREST	DSS	16	15	46	7	4	57	5	62
GRANT	DSS	120	99	62	127	46	235	26	261
GREEN	HSD	108	47	71	29	11	111	27	138
GREEN LAKE	HSD	34	14	15	28	5	48	2	50
IOWA	USB	30	13	27	26	18	71	2	73
IRON	HSD	37	26	15	25	9	49	10	59
JACKSON	HSD	55	53	93	47	35	175	21	196
JEFFERSON	HSD	117	117	59	57	60	176	54	230
JUNEAU	HSD	38	28	28	34	11	73	10	83
KENOSHA	AGING	405	399	155	215	9	379	6	385
KEWAUNEE	USB	72	72	112	94	6	212	3	215

Table 8: 1998 COP Program Activity by County

Source: COP 004 Supplement, 005 & Reconciliation Schedules

Lead Agencies		Assessments	Case Plans	Participants Served with COP (1)	Participants Served with COP-W (2)	CIP 1B/CSLA Participants COP Match (3)	All Participants Served with COP(4)	Participants Served without COP or COP-W (5)	Total Served in Community (6)
LACROSSE	HSD	188	162	142	293	46	481	7	488
LAFAYETTE	HSD	22	14	22	29	1	52	8	60
LANGLADE	DSS	75	47	48	71	16	135	6	141
LINCOLN	DSS	92	64	74	70	21	165	10	175
MANITOWOC	HSD	123	67	162	118	21	301	18	319
MARATHON	DSS	178	56	92	189	38	319	2	321
MARINETTE	HSD	116	31	58	91	21	170	4	174
MARQUETTE	DSS	39	22	27	31	8	66	0	66
MENOMINEE	HSD	27	13	30	31	5	66	4	70
MILWAUKEE	DHSS	1,084	1,006	427	477	347	1,251	72	1,323
MILWAUKEE	AGING	3,173	2,982	1,221	1,321	64	2,606	14	2,620
MONROE	HSD	84	79	108	68	21	197	12	209
NORTHERN PINES	USB	0	0	4	0	14	18	0	18
OCONTO	HSD	56	56	40	48	25	113	21	134
ONEIDA	DSS	110	96	156	19	18	193	42	235
ONEIDA	TRIBE	10	0	4	18	3	25	0	25
OUTAGAMIE	HSD	184	75	120	116	24	260	6	266
OZAUKEE	DSS	43	35	44	41	9	94	1	95
PEPIN	HSD	50	41	25	49	8	82	3	85
PIERCE	HSD	94	60	54	53	2	109	7	116
POLK	DSS	30	29	98	3	10	111	4	115
PORTAGE	HSD	107	68	70	99	27	196	23	219
PRICE	HSD	48	34	52	72	14	138	6	144
RACINE	HSD	376	243	356	111	56	523	26	549
RICHLAND	DSS	71	50	50	37	10	97	25	122
ROCK	HSD	217	203	278	113	0	391	34	425
ROCK	DD BD	28	28	7	0	68	75	29	104
RUSK	DSS	55	39	47	45	23	115	7	122
ST. CROIX	HSD	86	29	36	95	4	135	14	149
SAUK	HSD	137	101	68	96	9	173	70	243
SAWYER	HSD	33	32	23	87	18	128	10	138
SHAWANO	DSS	145	101	59	118	0	177	0	177
SHAWANO	DCP	9	9	18	0	24	42	2	44
SHEBOYGAN	HSD	120	72	102	114	24	240	45	285
TAYLOR	HSD	38	34	28	60	28	116	2	118

Table 8: 1998 COP Program Activity by County

Source: COP 004 Supplement, 005 & Reconciliation Schedules

Lead Agencies		Assessments	Case Plans	Participants Served with COP (1)	Participants Served with COP-W (2)	CIP 1B/CSLA Participants COP Match (3)	All Participants Served with COP(4)	Participants Served without COP or COP-W (5)	Total Served in Community (6)
TREMPEALEAU	DSS	124	73	74	97	29	200	0	200
VERNON	HSD	14	12	45	44	3	92	0	92
VILAS	DSS	39	27	65	39	10	114	5	119
WALWORTH	HSD	127	107	152	115	9	276	41	317
WASHBURN	DSS	85	46	57	57	0	114	0	114
WASHINGTON	DSS	125	44	75	104	11	190	6	196
WAUKESHA	HSD	296	269	231	250	45	526	9	535
WAUPACA	HSD	87	63	79	54	21	154	24	178
WAUSHARA	DSS	94	82	36	30	0	66	1	67
WAUSHARA	USB	8	5	14	0	6	20	0	20
WINNEBAGO	DSS	199	186	126	310	77	513	53	566
WOOD	DSS	17	12	123	72	27	222	21	243

1. Includes all participants who are opened as a COP participant on the HSRS LTS module regardless of any other funding source.
2. Counts participants who receive only COP-W funds (no COP). Totals reflect unduplicated counts.
3. COP provides only the GPR match. No other COP funding is provided during the year.
4. All participants who received services with COP and/or COP-W funding.
5. Participants who received a COP assessment and/or care plan, but who were served in the community with funding other than COP or COP-W.
6. Total people served with COP, COP-W and/or funding other than COP or COP-W.

Lead agency designations:

DCP – Department of Community Programs. Administers funding for persons with developmental disabilities and persons with severe mental illness.
DOA – Department of Aging. Administers funding for elderly persons.
DSS – Department of Social Services. Administers funding for programs for the elderly and persons with physical disabilities.
HSD – Human Service Department. Administers funding for programs for the elderly and persons with disabilities.
USB – Unified Services Board. Administers funding for persons with developmental disabilities and persons with severe mental illness.
DD Board – Developmental Disabilities Board. Administers funding for persons with developmental disabilities.
Oneida Tribe – Administers funding for the elderly, persons with physical disabilities, persons with developmental disabilities, and persons with severe mental illness.
Northern Pines USB – Provides services for persons with developmental disabilities and persons with severe mental illness in Barron, Burnett, Polk, Rusk and Washburn counties.

Table 9: CY 1998 Costs Reported and Reimbursed by County

Source: COP and COP-Waiver Reconciliation Schedules

Lead Agencies		COP-Regular Costs Reported	COP-Regular Dollars Paid	COP-W Costs Reported	COP-W GPR/State Funds Paid	Total GPR/State Funds Paid	COP-W Federal Paid	Additional Federal Dollars Earned when COP is used for CIP 1B Match & CIP II or CIP I Overmatch	Total All Federal Paid	Total
State Totals		68,408,725	66,481,882	72,122,228	26,181,427	92,663,309	42,441,290	30,044,574	72,485,864	165,149,173
ADAMS	DSS	165,614	165,614	391,299	113,573	279,187	230,250	19,710	249,960	529,147
ADAMS	USB	113,254	112,957	0	0	112,957	0	101,552	101,552	214,509
ASHLAND	HSD	331,192	282,832	443,540	180,203	463,035	260,990	233,248	494,238	957,273
BARRON	DSS	529,114	476,784	852,820	232,594	709,378	501,821	95,708	597,529	1,306,907
BAYFIELD	USB	244,870	244,870	582,365	154,191	399,061	342,678	146,237	488,915	887,976
BROWN	DSS	2,765,668	2,601,142	3,345,300	1,148,829	3,749,971	1,968,458	734,118	2,702,576	6,452,547
BUFFALO	HSD	225,055	224,461	256,492	105,566	330,027	150,927	85,170	236,097	566,124
BURNETT	DSS	230,457	224,509	296,985	112,801	337,310	174,754	101,471	276,225	613,535
CALUMET	HSD	344,256	311,174	357,567	127,486	438,660	210,401	47,910	258,311	696,971
CHIPPEWA	HSD	559,285	544,881	754,308	269,670	814,551	443,854	268,143	711,997	1,526,548
CLARK	DSS	396,788	392,813	584,694	240,646	633,459	344,049	213,896	557,945	1,191,404
COLUMBIA	HSD	695,809	666,959	943,131	266,600	933,559	554,962	260,036	814,998	1,748,557
CRAWFORD	HSD	255,407	250,849	299,151	122,746	373,595	176,028	93,084	269,112	642,707
DANE	CSHSD	5,929,414	5,926,683	5,300,102	2,168,475	8,095,158	3,118,713	1,629,590	4,748,303	12,843,461
DODGE	HSD	645,791	645,791	508,530	200,654	846,445	299,232	307,748	606,980	1,453,425
DOOR	DSS	111,015	90,271	184,195	75,810	166,081	108,385	0	108,385	274,466
DOOR	DCP	157,029	147,581	0	0	147,581	0	190,074	190,074	337,655
DOUGLAS	HSD	730,412	722,491	1,212,985	257,453	979,944	713,751	214,426	928,177	1,908,121
DUNN	HSD	475,599	415,794	361,769	146,964	562,758	212,874	243,761	456,635	1,019,393
EAU CLAIRE	HSD	1,653,592	1,594,583	1,032,106	404,629	1,999,212	607,317	427,448	1,034,765	3,033,977
FLORENCE	HSD	51,996	51,979	149,209	40,048	92,027	87,798	17,997	105,795	197,822
FOND DU LAC*	DSS	1,201,007	1,188,140	739,444	304,214	1,492,354	435,231	484,141	919,372	2,411,726
FOREST	DSS	151,820	147,760	183,088	67,591	215,351	109,447	40,216	149,663	365,014
GRANT	DSS	657,990	647,773	673,198	168,352	816,125	396,126	255,697	651,823	1,467,948
GREEN	HSD	362,434	359,757	242,312	89,444	449,201	142,582	75,975	218,557	667,758
GREEN LAKE	HSD	159,861	157,982	165,118	52,632	210,614	97,160	33,503	130,663	341,277
IOWA	USB	260,486	256,194	182,811	75,240	331,434	107,571	159,599	267,170	598,604
IRON	HSD	132,509	129,940	106,751	43,936	173,876	62,815	87,722	150,537	324,413
JACKSON	HSD	666,460	288,629	412,481	138,671	427,300	242,714	664,901	907,615	1,334,915
JEFFERSON	HSD	585,259	580,528	558,126	228,896	809,424	328,416	428,145	756,561	1,565,985
JUNEAU	HSD	277,690	271,868	166,431	68,499	340,367	97,932	104,590	202,522	542,889

Table 9: CY 1998 Costs Reported and Reimbursed by County

Source: COP and COP-Waiver Reconciliation Schedules

Lead Agencies		COP-Regular Costs Reported	COP-Regular Dollars Paid	COP-W Costs Reported	COP-W GPR/State Funds Paid	Total GPR/State Funds Paid	COP-W Federal Paid	Additional Federal Dollars Earned when COP is used for CIP 1B Match & CIP II or CIP I Overmatch	Total All Federal Paid	Total
KENOSHA	DOA	1,768,969	1,766,683	1,873,152	691,497	2,458,180	1,102,209	380,085	1,482,294	3,940,474
KEWAUNEE	USB	322,886	322,030	532,385	167,906	489,936	313,269	3,433	316,702	806,638
LACROSSE*	HSD	1,317,811	1,314,548	1,516,179	577,785	1,892,333	893,997	586,355	1,480,352	3,372,685
LAFAYETTE	HSD	227,562	225,780	171,226	70,472	296,252	100,754	104,337	205,091	501,343
LANGLADE	DSS	293,746	290,119	440,153	102,393	392,512	258,997	142,627	401,624	794,136
LINCOLN	DSS	322,444	319,004	370,464	103,466	422,470	217,990	74,320	292,310	714,780
MANITOWOC	HSD	776,189	768,744	749,845	308,617	1,077,361	441,228	239,036	680,264	1,757,625
MARATHON	DSS	1,313,106	1,312,562	1,787,377	538,843	1,851,405	1,051,738	562,886	1,614,624	3,466,029
MARINETTE	HSD	413,174	412,860	618,734	202,723	615,583	364,079	214,583	578,662	1,194,245
MARQUETTE	DSS	212,579	212,126	269,148	86,105	298,231	158,373	76,742	235,115	533,346
MENOMINEE	HSD	96,005	96,005	197,489	71,394	167,399	116,208	52,990	169,198	336,597
MILWAUKEE	DHSS	8,090,379	8,046,068	4,574,853	1,776,718	9,822,786	2,691,958	7,856,844	10,548,802	20,371,588
MILWAUKEE	DOA	8,974,633	8,883,576	14,677,632	5,739,031	14,622,607	8,636,686	2,164,386	10,801,072	25,423,679
MONROE	HSD	488,924	425,254	429,163	130,204	555,458	252,530	209,744	462,274	1,017,732
NORTHERN PINES	USB	104,703	82,240	0	0	82,240	0	0	0	82,240
OCONTO	HSD	418,638	317,453	376,881	96,774	414,227	221,766	333,651	555,417	969,644
ONEIDA	DSS	427,589	416,849	323,922	108,040	524,889	190,604	132,874	323,478	848,367
ONEIDA TRIBE		245,544	117,873	453,068	43,277	161,150	266,597	103,940	370,537	531,687
OUTAGAMIE	HSD	1,338,045	1,338,045	1,677,462	527,364	1,865,409	987,060	434,088	1,421,148	3,286,557
OZAUKEE	DSS	489,998	488,750	651,875	193,371	682,121	383,580	150,235	533,815	1,215,936
PEPIN	HSD	225,518	130,709	134,692	48,564	179,273	79,256	150,940	230,196	409,469
PIERCE	HSD	394,946	390,204	276,457	87,724	477,928	162,674	238,146	400,820	878,748
POLK	DSS	462,818	457,164	565,403	204,381	661,545	332,698	83,854	416,552	1,078,097
PORTAGE*	HSD	724,005	700,871	603,416	244,784	945,655	358,632	264,813	623,445	1,569,100
PRICE	HSD	308,283	263,860	464,379	173,292	437,152	273,252	156,305	429,557	866,709
RACINE	HSD	2,833,046	2,808,860	1,163,590	478,904	3,287,764	684,685	1,061,990	1,746,675	5,034,439
RICHLAND*	DSS	230,623	230,623	208,031	80,491	311,114	127,540	102,915	230,455	541,569
ROCK	HSD	1,613,762	1,594,681	1,586,072	652,788	2,247,469	933,285	0	933,285	3,180,754
ROCK	DD BD	759,959	759,509	0	0	759,509	0	1,028,121	1,028,121	1,787,630
RUSK	DSS	293,255	247,794	436,119	135,520	383,314	256,623	133,064	389,687	773,001
ST. CROIX	HSD	461,986	443,194	766,584	152,981	596,175	451,077	182,815	633,892	1,230,067
SAUK	HSD	527,455	499,084	484,878	199,564	698,648	285,314	188,070	473,384	1,172,032

Table 9: CY 1998 Costs Reported and Reimbursed by County

Source: COP and COP-Waiver Reconciliation Schedules

Lead Agencies		COP-Regular Costs Reported	COP-Regular Dollars Paid	COP-W Costs Reported	COP-W GPR/State Funds Paid	Total GPR/State Funds Paid	COP-W Federal Paid	Additional Federal Dollars Earned when COP is used for CIP 1B Match & CIP II or CIP I Overmatch	Total All Federal Paid	Total
SAWYER	HSD	223,020	214,270	482,544	121,188	335,458	283,941	148,612	432,553	768,011
SHAWANO	DSS	210,441	201,726	781,589	321,683	523,409	459,907	2,533	462,440	985,849
SHAWANO	DCP	214,342	209,351	0	0	209,351	0	171,900	171,900	381,251
SHEBOYGAN	HSD	1,175,218	1,168,997	852,575	350,899	1,519,896	501,677	479,395	981,072	2,500,968
TAYLOR	HSD	247,893	245,969	285,148	99,112	345,081	167,788	124,423	292,211	637,292
TREMPEALEAU	DSS	559,016	556,292	739,950	265,429	821,721	435,405	266,454	701,859	1,523,580
VERNON	HSD	271,022	271,022	313,530	127,246	398,268	184,489	94,814	279,303	677,571
VILAS	DSS	228,541	222,462	322,801	106,954	329,416	190,993	75,103	266,096	595,512
WALWORTH	HSD	693,549	642,766	910,109	374,578	1,017,344	535,531	439,527	975,058	1,992,402
WASHBURN	DSS	193,055	187,153	346,607	87,427	274,580	203,952	7,097	211,049	485,629
WASHINGTON	DSS	610,058	605,745	637,854	248,940	854,685	375,329	226,580	601,909	1,456,594
WAUKESHA	HSD	2,659,399	2,649,428	3,221,735	1,130,676	3,780,104	1,895,749	1,377,421	3,273,170	7,053,274
WAUPACA	HSD	578,054	572,743	506,414	173,426	746,169	297,987	291,534	589,521	1,335,690
WAUSHARA	DSS	198,124	198,124	439,045	174,464	372,588	258,345	0	258,345	630,933
WAUSHARA	USB	123,792	123,354	0	0	123,354	0	92,794	92,794	216,148
WINNEBAGO	DSS	1,823,144	1,809,460	1,597,827	657,625	2,467,085	940,201	812,190	1,752,391	4,219,476
WOOD	DSS	841,905	783,870	999,450	322,281	1,106,151	588,101	254,192	842,293	1,948,444
FAMILY CARE DEMO		12,439	12,439	18,113	18,113	30,552	*	*	*	30,552**

* Federal matching dollars included in above totals for appropriate counties.

** This number only represents the GPR dollars. Federal matching dollars included in above totals for appropriate counties.

COP Funding for Exceptional Needs

The statewide COP fund for exceptional needs was created as part of the original design of COP. The authority for this fund is Wisconsin Statute s. 46.27(7)(g). The department may carry forward to the next fiscal year, COP and COP-W GPR funds allocated but not spent by December 31. These exceptional funds may be allocated for the improvement or expansion of long term community support services for clients. Services may include:

a) specialized training for providers of services for the benefit of the COP target groups;
b) start-up costs for developing needed services for eligible target groups;
c) home modifications for COP eligible participants; and
d) purchase of medical equipment or other specially adapted equipment.

The limitations and rules are:

- only COP Lead Agencies may request and receive funds;
- all requests must be approved by the county LTS Planning Committees;
- a county is limited to $50,000 per year;
- requests are for one-time grants only;
- if funds cause a county to exceed the allowable COP or Waiver rate/average, the rate is waived automatically;
- funds may be expended only for the purpose for which they are granted;
- reporting and verification of the expenditure is required at year end;
- COP funding for exceptional needs are matched with federal funds whenever possible to expand the resources; and
- COP may be used only as the funding of last resort.

In 1998, funding for exceptional needs was awarded to 34 counties. Examples of individual awards include "homesteading" funds to enable people to move from an institution to the community such as furnishing, making security deposits, etc. Awards were made for home modifications such as ramps, elevators, stair lifts, overhead track lifts, roll in showers, raised toilets, lowered cabinets and fixtures, grab bars, widening hallways and doors, door openers automatic controls for windows, lights and temperature, adapted beds and chairs. Awards were also made for adapted mobility equipment such as wheelchairs, scooters and carts not covered by Medicaid as well as van modifications.

In 1998, some awards were made for expansion and start up costs for county agencies. During 1998, county agencies were struggling to increase their capacity to serve increasing numbers of people, to meet the demands for complex data requests and reporting requirements, and to recruit and retain a quality work force. New mandates on spending requirements for the COP funds required more detailed tracking of funds between long term care programs. County agency awards included: temporary start-up costs for agency staff, start-up funding for county Medicaid Personal Care Agencies, funding for the development of Adult Family Homes, computer equipment and upgrades including software, funding to transition participants from sheltered workshops to supported employment in the community and funding for recruitment and retention of home care workers and volunteers. Demand for funding for exceptional needs continues to exceed available dollars. Small, one-time investments are cost-effective ways to make home care plans successful and to secure adequate providers of service.

PART II

Medicaid Home and Community Based Services Waivers

Community Options Program Waiver (COP-W)
Community Integration Program II (CIP II)

Report to the Legislature

CY 1998

Introduction

The following report is submitted to the Legislature pursuant to s. 46.277(5m) of Wisconsin statutes and describes calendar year 1998 services in Wisconsin's Home and Community Based Services Waivers, CIP II and COP-W. CIP II and COP-W provide Medicaid funding for home and community-based care for elderly and persons with physical disabilities who have long term care needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

CIP II and COP-W, combined with Medicaid card services, provide a comprehensive health care package to CIP II and COP-W recipients. In addition, it is critical that these programs be closely coordinated with the State's Community Options Program in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, CIP II and COP-W provide Wisconsin residents who are elderly or who have physical disabilities 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.

County Participation and State Administration

Since February 1997, CIP II and COP-W have been administered by the newly created Bureau of Aging and Long Term Care Resources in the Division of Supportive Living, which resulted from the merger of the former Bureau of Long Term Support and the former Bureau on Aging.

County participation in these waiver programs was mandated effective January 1, 1990, and all counties are actively participating. Individual service plans are developed for each applicant by the appropriate county agency and submitted for approval to the state as required by the state's approved waiver application. Each service plan is reviewed to ensure that the proposed plan of care meets all federal specifications, is comprehensive, individualized, and guarantees the health, safety, and welfare of the program participant. The state oversees the activities of an outside vendor, The Management Group, Inc., to monitor these safeguards and to ensure compliance with program requirements by county agencies. A description of the compliance monitoring procedures and results follow.

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 and satisfaction, and program quality. The information obtained is provided as feedback to local and state agencies to promote quality improvement. These quality assurance activities include:

- waiver manual directives, clarifications and related technical assistance;
- review of all new applications for the program for accuracy and quality of the care plan, and a review of that care plan annually thereafter;
- on-site reviews of a random sample of records for compliance and program integrity;
- home interviews with a random sample of program participants; and
- assessments of local long term support system quality assessments and quality improvement projects in selected counties.

Program Integrity

On-site monitoring reviews were conducted for 467 cases in 1998. The reviews went well beyond the traditional federal requirements, which identify only payment errors, in an effort to gain in-depth information on program operation and policy interpretation. For all criteria monitored, 96% compliance was verified. A summary of the monitoring categories and findings follows:

Category: Financial Eligibility
Monitoring Components:
- Medicaid financial eligibility as approved in state plan
- Cost share
- Spenddown

Findings: 98% of factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spenddown. These areas will be emphasized in technical assistance activities.

Category: Non-financial Eligibility
Monitoring Components:
- Health form
- Functional screen

Findings: 96% overall compliance was calculated. No major areas of non-compliance were identified under this category, although some cases showed a deficit in documentation.

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

Findings: 94% of factors were in compliance. In a small percentage of 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 all case management contacts made or waived as allowed in state plan
- Care providers were appropriately trained and certified
- Services met necessary standards

Findings: 92% of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category.

Category: Billing
Monitoring Components:
- Services accurately billed
- Case management provided and billed
- Only waiver allowable providers billed
- Residence in waiver allowable settings during billing period

Findings: 97% compliance was found in these categories. A process has been implemented to assist in improving billing accuracy. Reports are being generated which will assist local agencies in identifying and correcting such errors throughout their caseloads.

Category: Substitute Care
Monitoring Components:
- Currently licensed
- Only waiver allowable costs calculated and billed

Findings: 99% overall compliance was found. Documentation or charging errors due to room and board versus care and supervision were evidenced in a few cases. Although insignificant in the error rate, substitute care has proven to be a challenging area for service providers and will be addressed with technical assistance efforts.

Corrective Action

A written report of each monitoring review was provided to the director of the local agency responsible for implementation of 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 one 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 13 instances, disallowances were taken where retroactive corrections could not be implemented. The average disallowance within those 13 counties was $821. Disallowances were taken in areas such as 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 1998, of the 467 cases monitored 418 participants were interviewed and responded to 22 questions regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded. Questions and responses are summarized under the following seven categories:

The factors studied regarding case 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 alternate care settings were:

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

Questions and responses are summarized under the following seven categories:

Satisfaction Category	Percentage of Positive Responses
Good communication with care manager	98%
Case manager is effective in securing services	97%
Case manager is responsive	97%
Active participation in care plan	96%
Satisfaction with in-home workers	96%
Alternate care services are acceptable	90%
Satisfaction with alternate care living arrangement	85%

Quality Improvement Projects

The information collected from these quality assurance efforts is 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.
- Develop issue specific technical assistance documents.
- Conduct statewide training in the areas of: Fiscal Management; Advanced Care Manager/Economic Support Training; and Plan Development and Care Management Techniques.
- Utilize enhanced data collection and reporting formats to identify target areas for monitoring and technical assistance.
- Produce and distribute case specific fiscal reports containing potential correctable reporting errors.
- Review certification and recertification procedures to identify more efficient and effective practices.
- Conduct enhanced interviews to determine customer satisfaction.

Participant Demographic Profile

In 1998, CIP II and COP-W provided funding for home and community-based services to 12,895 elderly and persons with physical disabilities with long term care needs. This compares with 11,791 persons served in 1997 and 10,670 served in 1996. Since 1990, the census of persons served has increased on average 15.8% annually (see Table 1).

Table 1
CIP II and COP-W Program Growth, 1990 – 1998

Year	CIP II & COP-W Participants	Growth from Previous Year
1990	4,079	n/a
1991	5,501	+ 34.9%
1992	6,129	+ 11.4%
1993	7,625	+ 24.4%
1994	8,326	+ 9.2%
1995	9,369	+ 12.5%
1996	10,670	+ 13.9%
1997	11,791	+ 10.5%
1998	12,895	+9.4%

Table 2
1998 CIP II and COP-W Participant Demographic Profile

Age	Number	Percent
Under 21 years	56	0.4
21 – 64 years	3,532	27.4
65 – 74 years	2,777	21.5
75 – 84 years	3,752	29.1
85 years and over	2,778	21.5

Gender	Number	Percent
Female	9,187	71.2
Male	3,708	28.8

Race/Ethnic Background	Number	Percent
Caucasian	11,097	86.0
African American	1,230	9.5
Hispanic	211	1.6
American Indian	191	1.5
Asian/Pacific Islander	157	1.2
Unknown	9	<0.1

Marital Status	Number	Percent
Widowed	5,064	39.3
Married	3,088	23.9
Divorced/Separated	2,227	17.3
Never Married	1,970	15.3
Unknown	546	4.2

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

The demographic characteristics of CIP II and COP-W participants are described in Table 2. The living arrangements and other characteristics of 1998 participants are profiled in Table 3.

Table 3
1998 CIP II and COP-W Participant Service Profile

Level of Care	Number	Percent
Intermediate Care	8,043	62.4
Skilled Nursing	4,852	37.6

Target Group	Number	Percent
Elderly	9,307	72.2
Disabled	3,588	27.8

Prior Living Arrangement: New Waiver Recipients in 1998	Number	Percent
Diverted from Nursing Facility	2,090	88.5
Relocated from Nursing Facility	270	11.5

Prior Living Arrangement: Waiver Recipients Enrolled before 1998	Number	Percent
Diverted from Nursing Facility	9,741	92.5
Relocated from Nursing Facility	793	7.5

Current Living Arrangement	Number	Percent
Private Home or Apartment	10,331	80.1
Community Based Residential Facility (CBRF)	822	6.4
Adult Family Home	316	2.4
Supervised Apartment / Supported Living / RCAC	242	1.9
Unknown/Not Reported	1,184	9.2

Primary Source of Natural Support	Number	Percent
Adult Child	4,856	37.7
Spouse	2,505	19.4
Other Relative	1,697	13.2
Non-Relative	1,693	13.1
No Primary Support	1,228	9.5
Parent	754	5.8
Unknown/Not Reported	162	1.2

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

CIP II and COP-W Service Use and Costs

CIP II and COP-W 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 card 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.

Waiver services used by CIP II and COP-W participants in 1998 accounted for 57% of the total costs to Medicaid of serving those participants. The remaining 43% of costs were incurred through participants' use of the Medicaid card to secure medical services, including prescription drugs, physician services, hospital services, home health services, and other medical care. The waiver services provided, their rate of utilization, and the total costs for each service are outlined in Table 4 below. Table 5 presents the same information for Medicaid card services utilized by 1998 program participants. Table 6 combines waiver and card costs to show the total cost to Medicaid of providing services to all 12,895 CIP II and COP-W program participants in 1998.

Table 4
1998 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
Case Management	97.8	$12,399,743	12.6
Supportive Home Care	85.9	72,585,436	73.9
Respite Care	4.6	1,496,622	1.5
Habilitation	5.1	1,508,993	1.5
Adult Day Care	7.9	3,755,176	3.8
Transportation	18.4	1,449,809	1.5
Home Modification, Adaptive Equipment and Communication Aids	50.8	4,995,875	5.1
Total Medicaid Waiver Service Costs		**$98,191,654**	

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

Table 5
1998 CIP II and COP-W Medicaid Card Service Utilization

Medicaid Card Service Category	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	2.8	$4,568,580	6.2
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	55.7	2,012,352	2.7
Outpatient Hospital	43.5	2,782,362	3.8
Lab and X-ray	46.1	435,551	0.6
Prescription Drugs	83.4	15,382,083	21.0
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	45.1	2,988,798	4.1
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	3.8	231,921	0.3
Dental Services	12.9	308,171	0.4
Nursing (Nurse Practitioner, Nursing Services)	0.1	408,790	0.6
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	56.9	12,146,009	16.6
Personal Care (Personal Care, Personal Care Supervisory Services)	32.6	17,202,090	23.5
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)	35.7	14,721,246	20.1
Total Medicaid Card Service Costs for Waiver Recipients		**$73,187,953**	

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.

Table 6
1998 Total Medicaid Costs for CIP II and COP-W

Total CIP II and COP-W Service Costs	$98,191,654
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$73,187,953
Total 1998 Medicaid Expenditures for CIP II and COP-W Recipients	**$171,379,607**

Total 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, some of which are used to help pay 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 7 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 7
Average Daily Public Costs by Funding Source,
CIP II and COP-W Participants vs. Nursing Home Residents

Cost Category	CIP II & COP-W			Nursing Home		
	Total	State / County	Federal	Total	State / County	Federal
Medicaid *	$48.02	$19.76	$28.26	$90.01	$36.79	$53.22
COP – Regular	1.25	0.51	0.74	n/a	n/a	n/a
SSI	4.11	1.90	2.21	0.11	0.00	0.11
Community Aids	0.09	0.04	0.05	unk.	unk.	unk.
Other	0.78	0.32	0.46	n/a	n/a	n/a
Total	**$54.25**	**$22.53**	**$31.72**	**$90.12**	**$36.79**	**$53.33**

* Total Medicaid expenses, including card costs.

When all public costs are counted, expenses for CIP II and COP-Waiver participants averaged $54.25 per person per day in 1998, compared to $90.12 per day for Medicaid recipients in nursing facilities. On average, then, the per capita daily cost of care in CIP II and COP-Waiver during 1998 was $35.87 less than the cost of nursing home care, compared to a difference of $25.21 in 1997. (Table 8). This represents a difference of 40%, compared with 29% in 1997.

Table 8
Average Public Costs for CIP II and COP-W Participants and 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
1997	Medicaid Program Per Diem	$28.18	$11.56	$16.62	$70.74	$29.03	$41.71			
	Medicaid Card	24.97	10.25	14.72	8.67	3.56	5.11			
	Other Medicaid[2]	n/a[4]	n/a[4]	n/a[4]	6.30	1.59	4.71			
	Medicaid Costs Subtotal[3]	$53.15	$21.81	$31.34	$85.71	$34.18	$51.53	$32.56	$12.37	$20.19
	COP – Regular	0.99	0.97	0.02	n/a[5]	n/a[5]	n/a[5]			
	SSI	4.75	1.95	2.80	0.14	0.00	0.14			
	Community Aids	0.07	0.05	0.02	unk.	unk.	unk.			
	Other	1.68	0.13	1.55	n/a[6]	n/a[6]	n/a[6]			
	Total	**$60.64**	**$24.91**	**$35.73**	**$85.85**	**$34.18**	**$51.67**	**$25.21**	**$9.27**	**$15.94**

Year	Cost Category	Community Care Costs			Nursing Home Costs[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
1998	Medicaid Program Per Diem	$27.51	$11.32	$16.19	$74.04	$30.47	$43.57			
	Medicaid Card	20.51	8.44	12.07	9.38	3.86	5.52			
	Other Medicaid[2]	n/a[4]	n/a[4]	n/a[4]	6.59	2.46	4.13			
	Medicaid Costs Subtotal[3]	$48.02	$19.76	$28.26	$90.01	$36.79	$53.22	$41.99	$17.03	$24.96
	COP – Regular	1.25	0.51	0.74	n/a[5]	n/a[5]	n/a[5]			
	SSI	4.11	1.90	2.21	0.11	0.00	0.11			
	Community Aids	0.09	0.04	0.05	unk.	unk.	unk.			
	Other	0.78	0.32	0.46	n/a[6]	n/a[6]	n/a[6]			
	Total	**$54.25**	**$22.53**	**$31.72**	**$90.12**	**$36.79**	**$53.33**	**$35.87**	**$14.26**	**$21.61**

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. Other Medicaid represents Intergovernmental Transfer (IGT) payments spread across all Medicaid nursing home patient days, although IGT payments are paid only to county and municipal nursing homes.
3. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
4. This category applies only to nursing home care.
5. Nursing home residents are not eligible for the Community Options Program.
6. This category applies only to community care.

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. As shown in Table 3 on page II-5, 62.4 percent of 1998 CIP II and COP-W program participants were rated at the intermediate care (ICF) level and 37.6 percent were rated at the skilled nursing (SNF) level. Corresponding figures for persons residing in nursing homes during 1998 were 16.2 percent ICF and 83.8 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 1998 nursing home per diem for ICF residents was approximately $70.89. For SNF residents the per diem was approximately $74.65. 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 (62.4 percent ICF and 37.6 percent SNF), estimated costs to Medicaid for nursing home care would have been $723,783,334 instead of $741,127,186. Given that there were 10,009,662 Medicaid-funded days of nursing care at the ICF and SNF levels combined in 1998, this level of total Medicaid spending would have translated to an average per diem across care levels of $72.31, instead of the previously calculated $74.04. Assuming the same Medicaid card costs and other expenses, the average daily public cost of nursing home care would have been $88.39 per person, instead of $90.12 as reported in Table 8 (page II-10). The difference between average daily per capita waiver costs and average nursing home costs, therefore, would have been $34.24 instead of $35.87. This represents a difference of 5 percent[1], compared to 24 percent in 1997, and 22 percent in 1996. Table 9 (page II-13) presents estimated daily per capita public costs and the waiver/nursing home cost comparisons shown in Table 8 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 1998 waiver participants had spent the same 3,568,166 days residing in nursing homes, they would have incurred total public costs of $315,390,193 ($88.39 per day for 3,568,166 days), compared with the $193,573,005 they incurred while residing in the community. Assuming equivalent care level proportions, then, total public spending for COP-W/CIP II participants during 1998 was $121,817,188 less than the predicted cost of nursing home care for a comparable group. This figure is 5 percent[2] less than the $128,346,931 estimated using actual 1998 data, but it still represents a difference in total public costs of 5 percent[3] 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.

[1] Equal to ($35.87 - $34.24) / $35.87 = 4.5%, rounded to 5%.
[2] Equal to ($128,346,931 - $121,817,188) / $128,346,931 = 5.1%, rounded to 5%.
[3] As calculated in Footnote #1.

Table 9
Estimated Average Public Costs for CIP II and COP-W Participants and 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
1997	Medicaid Program Per Diem	$28.18	$11.56	$16.62	$64.42	$26.44	$37.98			
	Medicaid Card	24.97	10.25	14.72	8.67	3.56	5.11			
	Other Medicaid[2]	n/a[4]	n/a[4]	n/a[4]	6.30	1.59	4.71			
	Medicaid Costs Subtotal[3]	$53.15	$21.81	$31.34	$79.39	$31.59	$47.80	$26.24	$9.78	$16.46
	COP – Regular	0.99	0.97	0.02	n/a	n/a[5]	n/a[5]			
	SSI	4.75	1.95	2.80	0.14	0.00	0.14			
	Community Aids	0.07	0.05	0.02	Unk.	Unk.	Unk.			
	Other	1.68	0.13	1.55	N/A[6]	N/A[6]	N/A[6]			
	Total	**$60.64**	**$24.91**	**$35.73**	**$79.53**	**$31.59**	**$47.94**	**$18.89**	**$6.68**	**$12.21**

Year	Cost Category	Community Care Costs			Nursing Home Costs*[1]			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
1998	Medicaid Program Per Diem	$27.51	$11.32	$16.19	$72.31	$29.76	$42.55			
	Medicaid Card	20.51	8.44	12.07	9.38	3.86	5.52			
	Other Medicaid[2]	n/a[4]	n/a[4]	n/a[4]	6.59	2.46	4.13			
	Medicaid Costs Subtotal[3]	$48.02	$19.76	$28.26	$88.28	$36.08	$52.20	$40.26	$16.32	$23.94
	COP – Regular	1.25	0.51	0.74	n/a[5]	n/a[5]	n/a[5]			
	SSI	4.11	1.90	2.21	0.11	0.00	0.11			
	Community Aids	0.09	0.04	0.05	unk.	unk.	unk.			
	Other	0.78	0.32	0.46	n/a[6n]	n/a[6]	n/a[6]			
	Total	**$54.25**	**$22.53**	**$31.72**	**$88.39**	**$36.08**	**$52.31**	**$34.14**	**$13.55**	**$20.59**

* 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 (e.g., in 1998, if SNF=37.6% and if ICF=62.4%). In nursing homes during 1998, 16.2% of residents were rated at an ICF level, and 83.8% 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. Other Medicaid represents Intergovernmental Transfer (IGT) payments spread across all Medicaid nursing home patient days, although IGT payments are paid only to county and municipal nursing homes.
3. Medicaid reporting is subject to subsequent adjustments due to a 12-month claims processing period.
4. This category applies only to nursing home care.
5. Nursing home residents are not eligible for the Community Options Program.
   This category applies only to community care.

A total of 3,568,166 service days were provided to 12,895 CIP II and COP-Waiver participants during 1998. Therefore, the total public cost of care for waiver participants in 1998, based on actual days of service, was $193,573,005 ($54.25 per day for 3,568,166 days). If the same individuals had spent the same number of days in nursing homes at the average daily public cost for nursing home care, the total cost of serving them in 1998 would have been $321,563,120 ($90.12 per day for 3,568,166 days). In other words, total public spending on behalf of these individuals is estimated to have been $127,990,114 less than would have been the case had they resided in nursing homes for the same length of time. By comparison, total spending was estimated at $82,132,189 less in 1997 and $73,854,161 less in 1996.

Figures 1 and 2 illustrate these cost differences. **Figure 1** compares actual average daily per capita costs, and **Figure 2** compares total waiver costs with estimated nursing home costs for the same days of care.

Figure 1
CIP II & COP-W vs. Nursing Home Care - Average Public Costs per Day 1998

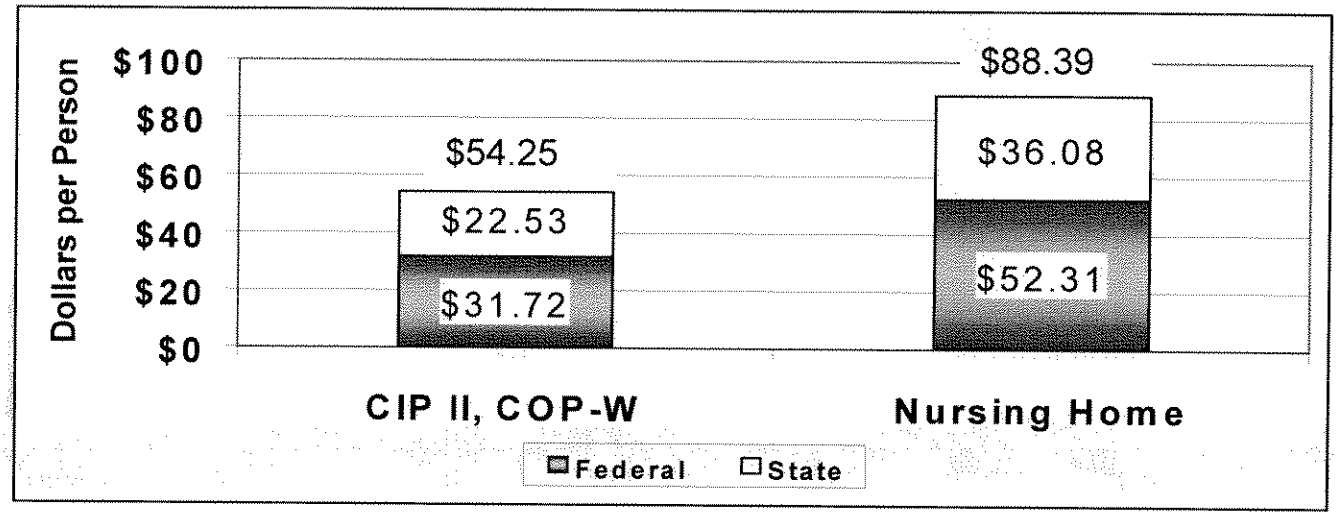
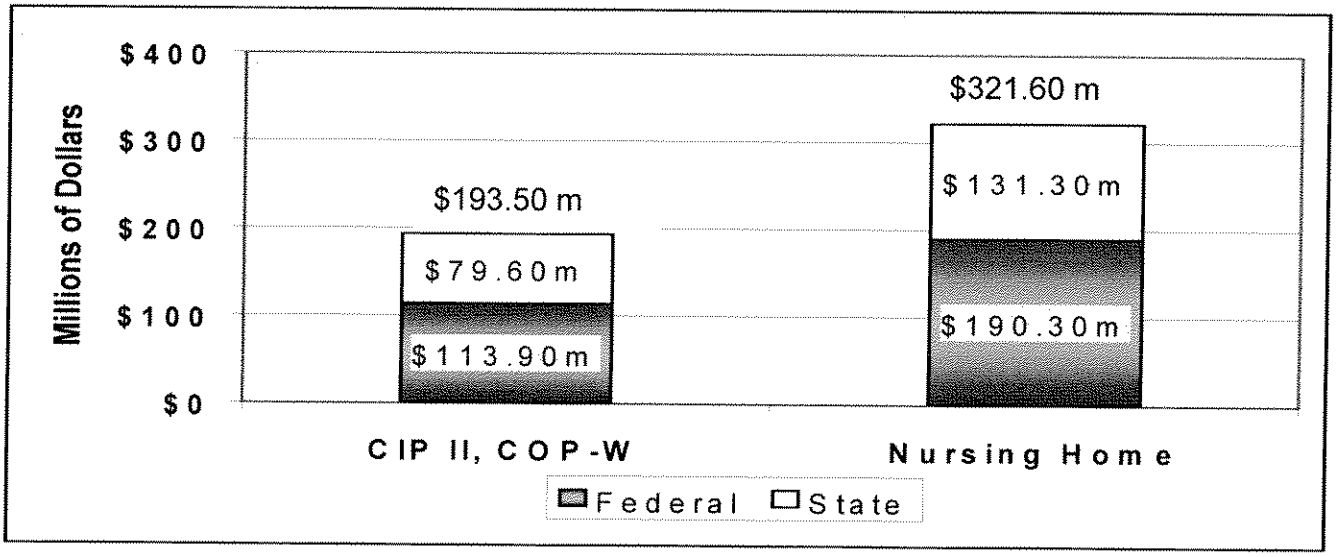


Figure 2
Actual Annual 1998 CIP II and COP-W Costs vs. Estimated Care Costs
If CIP II and COP-W Participants Received Care in Nursing Homes



APPENDIX A

CIP II and COP-W Cost Study

Report to the Legislature

CY 1998

Table A
Detail of Average Public Costs for CIP II and COP-W Participants and Nursing Home Residents

Average Cost per Person per Day, CY 1998

Year	Note #	Cost Category	Community Care Costs			Nursing Home Costs[1]			Difference		
			Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
1998	1	Medicaid Program Per Diem	$27.51	$11.32	$16.19	$74.04	$30.47	$43.57			
	2	Medicaid Card	20.51	8.44	12.07	9.38	3.86	5.52			
	3	Other Medicaid	N/A[3]	N/A[3]	N/A[3]	6.59	2.46	4.13			
		Medicaid Costs Subtotal[2]	$48.02	$19.76	$28.26	$90.01	$36.79	$53.22	$41.99	$17.03	$24.96
	4	COP – Regular	1.25	0.51	0.74	N/A[4]	N/A[4]	N/A[4]			
	5	SSI	4.11	1.90	2.21	0.11	0.00	0.11			
	6	Community Aids	0.09	0.04	0.05	Unk.	Unk.	Unk.			
	7	Other	0.78	0.32	0.46	N/A[5]	N/A[5]	N/A[5]			
		TOTAL	**$54.25**	**$22.53**	**$31.72**	**$90.12**	**$36.79**	**$53.33**	**$35.87**	**$14.26**	**$21.61**

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. This category applies only to nursing home care.
4. Nursing home residents are not eligible for the Community Options Program.
5. This category applies only to community care.

Notes to Table A, Detail of Average Public Costs for CIP II and COP-W Participants and Nursing Home Residents, Average Cost per Person Per Day, CY 1998

1. Medicaid Program Per Diem Payments: Data are from the HCFA Form 372 Report. This report is prepared by a special Wisconsin Medicaid/EDS computer run from the Medicaid claims payment system. The figures represent the average Medicaid net payment per day made to nursing homes for nursing home cases and to counties for CIP II and COP-W expenses. See Table A.1.

2. Medicaid Card Costs: This report is prepared by a special Wisconsin Medicaid/EDS computer run from the Medicaid claims payment system. The term "Medicaid Card Costs" refers to those Medicaid-funded services which a qualified recipient obtains by presenting his or her Medicaid card. Home care, prescription drugs, and hospital care are the primary card services obtained by CIP II and COP-W participants. Hospital services, physician services, and prescription drugs are among the services most frequently obtained by nursing home residents.

3. Other Medicaid Expenses: This category only applies to nursing home care. It refers to the special provision in state law which permits counties to obtain matching funds from certain other allowable Medicaid expenses, provided the county pays the non-federal share (otherwise referred to as the Intergovernmental Transfer program). See Table A.2.

4. Regular Community Options Program Expenditures: Supplemental COP spending across all Medicaid Home and Community-Based Waiver recipients the reported expenditures on the Human Services Reporting System (HSRS), as summarized in the 1998 9D Report. See Table A.3 for detail.

5. Supplemental Security Income (SSI): A sample of 5% of 1998 waiver participants (equal to 645 participants) was used to determine the percentage who receive SSI payments and, among those participants who did, how many qualified for the SSI-E payment level. Data was obtained for 620 participants based on an original sample of 645 CIP II and COP-W participants. See Tables A. 4 through A.6.

   A portion of Medicaid nursing home residents receive a monthly SSI personal needs allowance. In this analysis, it is calculated across all Medicaid nursing home residents. Average SSI personal needs allowance payments received by participants in 1998 were derived from federal SDX tapes. See Tables A.7 and A.8.

6. Community Aids: The same sample of 645 CIP II and COP-W participants was used to identify the amount of community aids funding indicated in the average participant's individual service plan. Data was obtained for 620 participants based on an original sample of 645 CIP II and COP-W participants. Various studies have indicated that planned expenditures tend to be higher than actual expenditures. "Community Aids" refers to all block grant and similar aids provided to counties for local community services. See Tables A.9 and A.10.

7. Other: For persons residing in the community, other expenses may include food stamps, congregate meals, energy assistance, respite funds, DVR funds, etc. Data was obtained for 620 participants based on an original sample of 645 CIP II and COP-W participants. See Tables A.11 and A.12.

Table A.1
Medicaid Payments for CIP II and COP-W Participants and Residents of SNF/ICF Facilities, 1998

	CIP II and COP-W	Nursing Facilities
A. Medicaid Per Diems		
1. Service Payments	$98,191,654	$741,127,186
2. Days of Service	3,568,166	10,009,662
3. Average Payment per Day	$27.51	$74.04
B. Medicaid Card Services		
1. Total Card Payments	$73,187,953	$93,957,232
2. Days of Service	3,568,166	10,009,662
3. Average Payment Per Day	$20.51	$9.39

Source: Wisconsin Medicaid/EDS reports and 1998 HCFA 372 Report.

Table A.2
Calendar Year Data for Nursing Home Intergovernmental Transfer (IGT) Program

Calendar Year	Gross Expenditure	Federal Funds Awarded	Net County/State Costs	Total Medicaid Statewide Days of Nursing Home Care**	Average Cost per Person per Day		
					Federal	County	Total
1985	$25,633,988	$4,823,400	$21,810,588	12,787,577	$0.38	$1.71	$2.09
1986	27,191,087	3,823,101	23,367,986	12,625,554	0.30	1.85	2.15
1987	* 30,588,289	5,715,002	24,873,287	12,507,927	0.46	1.99	2.45
1988	24,408,847	7,715,001	27,794,957	12,326,812	0.63	2.25	2.88
1989	39,528,323	7,714,998	31,813,325	11,557,801	0.67	2.75	3.42
1990	39,657,322	10,822,731	28,834,591	11,694,128	0.93	2.46	3.39
1991***	39,971,830	12,972,651	25,999,179	11,875,795	1.09	2.19	3.38
1992 ***	39,830,572	15,834,150	23,996,422	12,044,019	1.31	2.00	3.31
1993 ***	52,682,503	19,434,150	33,248,353	11,172,256	1.74	2.98	4.72
1994 ***	60,735,948	38,460,537	22,275,411	10,648,912	3.61	2.09	5.70
1995 ***	70,347,467	38,410,000	31,937,467	10,607,523	3.62	3.01	6.63
1996 ***	75,601,880	38,400,000	37,201,880	10,491,248	3.66	3.55	7.21
1997 ▲	63,414,760	47,426,503	15,988,257	10,076,450	4.71	1.59	6.29
1998	66,202,032	41,492,138	24,709,894	10,051,775	4.13	2.46	6.59

* Interpolated from previous and succeeding years' data.

** Excludes state DD centers and Institutions for Mental Disease. Source: Annual HCFA Form 372 Reports, Section IX, B.1.

*** Amounts incorporate an additional amount from the Nursing Home Appeal Award portion of the FFP Program.

▲ Beginning in 1997, a revised method was used to calculate Gross Expenditure, Federal Funds Awarded, and Net County/State Costs. Sources: Medicaid Nursing Home Intergovernmental Transfer Program; 1998 HCFA 372 Report.

Note: Although the per diem cost is calculated based on all Medicaid nursing home patient days, Intergovernmental Transfer (IGT) payments are paid only to county and municipal nursing homes.

Table A.3
COP Service Costs for Medicaid Home and Community-Based Waiver Participants, 1998

	Net Supplemental COP $	Net Supplemental COP Days of Service	COP Cost per Day for Participants Who Received Waiver & Supplemental COP	Total Days of Service (Net Supplemental COP Days + Net Waiver Days)	COP Cost per Day for All Waiver Participants
CIP II	$1,160,747	122,197	$9.50	815,976	$1.42
COP-W	$4,968,148	413,708	$12.01	3,241,388	$1.53
CIP 1A	$167,651	27,387	$6.12	383,353	$0.44
CIP 1B*	$1,266,556	279,568	$4.53	1,641,657	$0.77
CSLA*	$88,146	3,226	$27.32	21,041	$4.19
Brain Injury	$56,279	5,518	$10.20	63,834	$0.88
Total All Waivers	**$7,707,527**	**851,604**	**$9.05**	**$6,167,249**	**$1.25**

Calculations are based on data from the 1998 9D Report. Includes the total count of Medicaid Home and Community-Based Waiver participants in CY 1998.

* CIP 1B and CSLA include all COP match participants and costs.

Table A.4
Number of CIP II and COP-W Participants Receiving SSI and Other Sources of Income in 1998

Target Group	Private or Social Security only	SSI (Duplicated)	SSI-E (Duplicated)	Total Unduplicated Participants **
Elderly	293	55	124	466
Disabled	75	21	62	154
Total	**368**	**76**	**186**	**620**

* Of the 252 sample participants who received SSI or SSI-E funding, 10 received funding of both types

** Data provided for 620 participants based on an original sample of 645 CIP II and COP-W participants.

Table A.5
Average State Share of Public Income Received by CIP II and COP-W Participants in 1998 (Payment per Day)

Target Group	Private or Social Security only	SSI	SSI-E	Average State Share of SSI
Elderly	$0.00	$2.25	$4.93	$1.65
Disabled	$0.00	$3.27	$5.10	$2.64
Total	**$0.00**	**$2.48**	**$4.99**	**$1.90**

* Data provided for 620 participants based on an original sample of 645 CIP II and COP-W participants.

Table A.6
Average Federal Share of Public Income Received by CIP II and COP-W Participants in 1998 (Payment per Day)

Target Group	Private or Social Security only	SSI	SSI-E	Average Federal Share of SSI
Elderly	$0.00	$3.71	$4.73	$1.74
Disabled	$0.00	$8.22	$6.28	$3.62
Total	**$0.00**	**$4.74**	**$5.27**	**$2.21**

Table A.7
Number of Medicaid-Funded Nursing Home Residents Receiving SSI in 1998

Year	No SSI	Some SSI *	Total **
CY 1998	27,321	2,157	29,478

* Average monthly number of Medicaid nursing home residents who received SSI during CY 1998.

** One-day count of Medicaid nursing home residents, December 31, 1998. *Wisconsin Nursing Homes and Residents 1998*, page 30, WI DHFS, Division of Health Care Financing, Bureau of Health Information.

Table A.8
Average SSI Amount Received by Medicaid-Funded Nursing Home Residents in 1998 (Payment per Day)

Year	No SSI	Some SSI	Total
CY 1998	$0.00	$1.52	$0.11

Table A.9
Number of CIP II and COP-W Participants Receiving Community Aids in 1998

Target Group	No Community Aids	Some Community Aids	Total *
Elderly	464	2	466
Disabled	153	1	154
Total	**617**	**3**	**620**

* Data provided for 620 participants based on an original sample of 645 CIP II and COP-W participants.

Table A.10
Average Community Aids Cost per CIP II and COP-W Participant in 1998 (Payment per Day)

Target Group	No Community Aids	Some Community Aids	Total
Elderly	$0.00	$14.18	$0.08
Disabled	$0.00	$21.00	$0.12
Total	**$0.00**	**$15.89**	**$0.09**

Table A.11
Number of CIP II and COP-W Participants Receiving Additional State or Federal Funding in 1998

Target Group	None	DVR	Fuel Assistance	Food Stamps	Congregate Meals	Section 8 Housing Subsidy	Other *	Total **
Elderly	380	1	39	47	6	13	2	466
Disabled	117	5	10	13	0	11	0	154
Total	**497**	**6**	**49**	**60**	**6**	**24**	**2**	**620**

* Other includes such federal sources as federal housing loans and subsidies, AFCSP, social service support, and state and county sources such as county levy and state funds to counties for social services.

** Data provided for 620 participants based on an original sample of 645 CIP II and COP-W participants.

Table A.12
Average State and Federal Share of other Services Received by CIP II and COP-W Participants in 1998 (Payment per Day)

	Target Group	None	DVR	Fuel Assistance	Food Stamps	Congregate Meals	Section 8 Housing Subsidy	Other *	Total
Federal	Elderly	$0.00	$0.00	$0.14	$0.09	$0.01	$0.24	$0.01	$0.50
	Disabled	$0.00	$0.53	$0.05	$0.08	$0.00	$0.80	$0.00	$1.45
	Total Federal	$0.00	$0.13	$0.12	$0.09	$0.01	$0.38	$0.01	$0.74
State	Elderly	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.01
	Disabled	$0.00	$0.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.14
	Total State	$0.00	$0.04	$0.00	$0.00	$0.01	$0.00	$0.00	$0.04
Federal & State	Elderly	$0.00	$0.00	$0.14	$0.09	$0.02	$0.24	$0.01	$0.51
	Disabled	$0.00	$0.67	$0.05	$0.08	$0.00	$0.80	$0.00	$1.59
	Total Federal & State	$0.00	$0.17	$0.12	$0.09	$0.02	$0.38	$0.01	$0.78

* Other includes such federal sources as federal housing loans and subsidies, AFCSP, social service support, and state and county sources such as county levy and state funds to counties for social services.

Sue Liegel and Irene Anderson 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:

Sue Liegel
Bureau of Aging and Long Term Care Resources
1 West Wilson Street, Room 450
P.O. Box 7851
Madison, WI 53707-7851
Phone: (608) 266-9755
Fax: (608) 267-2913
E-mail: liegesk@dhfs.state.wi.us

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 14, 1999

The Honorable Brian Burke
Senate Co-Chair, Joint Committee on Finance
Room 316 S, State Capitol
Madison, WI 53702

The Honorable John Gard
Assembly Co-Chair, Joint Committee on Finance
Room 315 N, State Capitol
Madison, WI 53702

Dear Senator Burke and Representative Gard:

As a follow-up to my March 24 testimony, I am submitting the enclosed package of technical corrections for DHFS items in the Governor's Biennial Budget with the concurrence of the Department of Administration. Some of these items may also be included in the statewide list of technical corrections submitted by DOA because they were identified earlier by DOA staff. For your convenience, I am including all technical corrections for DHFS items in this package. I would appreciate your favorable consideration of these technical corrections. Please contact the agency staff person listed on each item if you have questions regarding an item.

Sincerely,

Joe Leean
Secretary

cc: Bob Lang, LFB
Charlie Morgan, LFB
Mark Bugher, DOA
Jennifer Kraus, DOA

Technical Corrections
April 14, 1999

1. **Statutory and Non-Statutory Language Corrections**

   A. Family Care

   B. MA Purchase Plan

   C. Tuberculosis

   D. Supervised Release for Sexually Violent Persons

   E. Mental Health Services Contracting

   F. IMD Funding Transfer

   G. Prostate Cancer

   H. SACWIS Implementation Date

2. **Funding and Budget Authority Corrections**

   A. 2% State Operations Lapse Reductions: SSI Administrative Funding

   B. 2% State Operations Lapse Reductions: DPH positions

   C. AIDS/HIV Insurance Program

   D. TANF Funded WIC Administration

   E. MA Estate Recovery Changes

   F. Account for DCTF project position cuts as CIP cuts

   G. Brighter Futures

   H. Milwaukee Child Welfare

   I. Social Worker Salary Increase

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 21, 1999

Family Care
DIN 5802

Description of Change

Make various technical corrections to the statutory language provisions of Family Care, including the MA purchase plan.

Explanation

See attached.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
0		0			

Agency: DHFS
Agency Contact: Fredi Bove, 266-2907
Lorraine Barniskis, 267-5267
Tom Hamilton, 266-9304

Family Care: Technical Amendments to Governor's Request

Topic: Resource Center contracting
(AB-133, p. 606, lines 1-4 and 9-13)

s. 46.283 (2) (c) should be deleted.

s. 46.283 (2) (b) should be rewritten to read something like:

> 46.283 (2) (b) After June 30, 2001, subject to approval of necessary funding, the department may contract to operate a resource center with counties, family care districts, the governing body of a tribe or band or the Great Lakes inter-tribal council, inc., or under a joint application of any of these, or with a private nonprofit organization if the department determines that the organization has no significant connection to an entity that operates a care management organization and if any of the following applies:
>
> Explanation:
> Technical amendment. These two paragraphs are redundant and somewhat conflicting. (We have already discussed this with Debora Kennedy. Richard Megna has also discussed this with her.)

Topic: General eligibility requirements (AB-133 p. 618, lines 20-24)

Revise the introductory paragraph on eligibility for the Family Care benefit to read:

> **46.286 Family care benefit. (1)** ELIGIBILITY. Except as provided in sub. (1m), a person is eligible for, but not necessarily entitled to, the family care benefit if the person is at least 18 years of age; ~~does not have a primary disabling condition of mental illness, substance abuse or developmental disability~~ has a physical disability as defined in s. 15.197 (4) (a) 2. or infirmities of aging as defined in s. 55.01 (3); and meets all of the following criteria:
>
> Explanation:
> As originally drafted, the language could be interpreted to exclude persons who do have a disabling condition that is related to a physical disability or aging that does require long-term care, but who also have a mental illness, substance abuse problem or developmental disability. The proposed amendment is intended to extend eligibility to all those who have a serious physical disability or who have a disabling condition related to advanced age (including those who also have other disabilities). (Persons whose primary disabling condition is a developmental disability are also eligible in counties operating CMO pilots prior to July 1, 2001.)

Topic: Eligibility; grandfathering

(AB-133 page 619, lines 11-15)

Amend s. 46.286 (1) (a) 2. (intro.) to read:

2. The person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application and, on the date that the family care benefit became available in the person's county of residence, the person was a resident in a nursing home or ~~was~~ had been receiving for at least 90 days, under a written plan of care, long-term care services, as specified by the department, that were funded under any of the following:

Explanation:
As written, this provision would allow a county to add individuals to its Community Aids or county-funded program caseload for a very short time and entitle them to the Family Care benefit. The proposed amendment is intended to assure that people receiving these services are eligible for and entitled to Family Care, while removing any incentive to include individuals who would not otherwise be served by the county in these programs.

Topic: Non-financial eligibility requirements
(AB-133, page 620, lines 3-7)

Amend s. 46.286 (1) (b) 1. a. to read:

a. The person would qualify for medical assistance except for financial or disability criteria, and the projected cost of the person's care plan, as calculated by the department or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by rule by the department.

Explanation:
The first phrase of this provision was meant to assure that Family Care eligibility requirements would include non-financial requirements similar to Medicaid's, such as citizenship or specified alien status. As drafted, it has the unintended effect of adding the Social Security Act disability definition as a requirement, when Family Care already has a functional disability requirement. This would slow down the eligibility process, add costs, and exclude some non-elderly people who were intended to be covered by Family Care.

Topic: Department access to client records

The bill currently provides [s. 46.2895 (9)] that, with several exceptions, records of the Family Care District that contain personally identifiable information about its clients may not be disclosed without the client's informed consent. One of the exceptions is "to comply with s. 49.45 (4)." The cited provision is the Department's authority to access the records of Medicaid recipients. We believe that this provision is not sufficient to assure that the Department have access to the records of all Family Care enrollees and applicants, including those who are not Medicaid-eligible and those who are served by a Resource Center or CMO other than a Family Care District. Please include a broader provision that prohibits all Resource Centers and all CMOs from disclosing records that contain personally identifiable information about their clients not connected with the department's administration of ss. 46.2805 to 46.2895.

Topic: Add cross-reference related to Medicaid eligibility

Amend s. 49.46 (1) (a) 14. to read:

Any person who would meet the financial and other eligibility requirements for home or community-based services under s. 46.27 (11), ~~or~~ 46.277, or under the family care benefit if a waiver is in effect under s. 46.281 (1) (c) but for the fact that the person engages in substantial gainful activity under 42 USC 1382c (a) (3), if a waiver under s. 49.45 (38) is in effect or federal law permits federal financial participation for medical assistance coverage of the person and if funding is available for the person under s. 46.27 (11) or 46.277 or under the family care benefit .

Explanation:
The Family Care legislation includes several changes to Chapter 49 to assure that people eligible for the new Home and Community-based Waiver [1915 (c) waiver] for Family Care will also be eligible for Medicaid card services. One such reference was missed, and this amendment would include it.

Topic: Hearings (AB-133 page 623, lines 4-5)

Amend s. 46.287 (2) (a) 1. (intro.) to read:

1. (intro.) Except as provided in subd. 2., a client may contest any of the following applicable matters by filing, within 45 days of the failure of a resource center or care management organization to act on the contested matter within time frames established by the department or within 45 days of receipt of notice of ~~the~~ a contested ~~matter~~ decision, a

written request for a hearing that shall be held under procedures for hearing these disputes that are prescribed by the department by rule:

Explanation:
A client would not receive notice of all of the listed matters that can be contested. For example, a client may request a hearing for "failure to provide timely services and support items that are included in the plan of care."

Note:
The Legislative Fiscal Bureau has inquired whether the hearing under this section were intended to be through the Department of Administration's Division of Hearings and Appeals. That was our intent and we will draft required rules to specify it. If others feel that it would be preferable to amend the statutory language at this time, we would be supportive.

Amend s. 46.287 (2) (b) to read:

(b) An enrollee may contest ~~a~~ any decision, omission or action of a care management organization regarding the type, amount or quality of the enrollee's services under the family care benefit, other than those specified in par. (a) 1. d. to f., or may contest the choice of service provider. In these instances, the enrollee shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute. If the dispute is not resolved to the satisfaction of the enrollee, he or she may request a hearing under the procedures specified in par. (a) 1. (intro.).

Explanation:
As written, the language appears to limit the rights of enrollees to request a fair hearing, after review by the Department's contract monitors, to only certain kinds of CMO decisions. It would not appear to cover, for example, a CMO's failure to provide required notification of rights or release of confidential information without informed consent. The proposed amendment is meant to clarify this language.

Topic: Rule-making requirements (AB-133 page 624, lines 14-15)

Delete 46.288 (2).

Explanation: