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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: January 12, 2009

RE: Rereferral of Senate Bill 3

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that Senate Bill 3, relating to: health insurance coverage of treatment for autism spectrum disorders, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the committee on Public Health, Senior Issues, Long-Term Care, and Job Creation. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: January 26, 2009

RE: Rereferral of Senate Bill 10

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that Senate Bill 10, relating to: the income and franchise tax credit that supplements the federal historic rehabilitation tax credit, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the committee on Economic Development. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: April 9, 2009

RE: Rereferral of Senate Bill 160

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that Senate Bill 160, relating to: increasing the amount of the homestead exemption, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the committee on Judiciary, Corrections, Insurance, Campaign Finance Reform and Housing. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: July 6, 2009

RE: Rereferral of Senate Bill 235

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that Senate Bill 235, relating to: limiting disclosure of information gathered by news persons, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the committee on Judiciary, Corrections, Insurance, Campaign Finance Reform, and Housing. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: January 4, 2010

RE: Rereferral of Senate Bill 439

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that **Senate Bill 439**, relating to: adopting Internal Revenue Code provisions related to individual retirement accounts and adopting provisions of the Heroes Earnings Assistance and Relief Tax Act of 2008 for state income and franchise tax purposes, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the committee on Veterans and Military Affairs, Biotechnology, and Financial Institutions. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Jon Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization

3-25-10

MEMORANDUM

TO: Robert J. Marchant
Chief Clerk and Director of Operations

FROM: President Risser

DATE: March 25, 2010

RE: Rereferral of Senate Bill 625

Pursuant to Senate Rule 46 (2) (c), I am writing to direct that Senate Bill 625, relating to: streamlined sales and use tax agreement changes, be withdrawn from the committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue and rereferred to the Joint Committee on Finance. I have obtained the consent of the appropriate chairpersons, as indicated by the signatures below.

Senator Fred A. Risser
Senate President

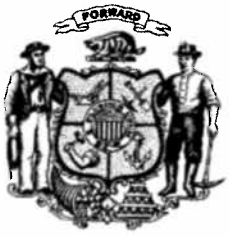
As the chairperson of the committee with jurisdiction over the proposal described above, I consent to the withdrawal of the proposal as described above.

Senator Erpenbach
Chair
Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

As the chairperson of the committee Senate Organization, I consent to the withdrawal of the proposal as described above.

Senator Russ Decker
Chair
Senate Committee on Organization


WISCONSIN STATE LEGISLATURE


FORWARD

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

January 20, 2009

Robert J. Marchant
Senate Chief Clerk
B20 Southeast State Capitol
Madison WI 53702

Patrick E. Fuller
Assembly Chief Clerk
17 West Main Street, Room 401
Madison WI 53703

Dear Mr. Marchant and Mr. Fuller:

The attached report is submitted to the Legislature pursuant to s.46.27 (11g) and s.46.277 (5m) of the Wisconsin statutes, which require the Department of Health Services to submit an annual report for the Community Options Program (COP) and the Home and Community-Based Waivers (COP-W/CIP II). The attached report describes the persons served, program expenditures, and services delivered through the COP, COP-Waiver and CIP II programs in calendar year 2007.

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

Sincerely,

Karen E Timberlake

Karen E. Timberlake
Secretary

Attachment

#Referred to committee on Health, Health Insurance, Privacy, Property Tax Relief, & Revenue

Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2007

Department of Health Services
Division of Long Term Care
Bureau of Long Term Support

Executive Summary

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

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

Report highlights for Calendar Year 2007 include:

- COP and home and community based waivers served a total of 28,430 citizens.
- Half of all individuals served had a developmental disability, approximately 30% of individuals were elderly and 15% of persons had a physical disability. The remaining individuals received services due to a mental illness or alcohol and/or drug abuse.
- $622 million all funds was expended to serve individuals in COP and all waiver programs.
- The *average* daily cost of care for participants in CIP II and COP-W was $75.37. In contrast, the *average* daily cost of care for people in nursing homes, at the same combination of levels of care, was $111.79.
- Sixty-six percent of COP and waiver participants received care in their own homes or apartments; the remaining individuals lived in substitute care residences such as a community-based residential facility, adult family home or child foster care.

Individuals who use waiver services are also eligible for the Medicaid fee-for-service ("card") benefits, and must use the Medicaid card before relying on the waivers to fill gaps in care. Participants in CIP II and COP-W used $89,727,332 in benefits from their Medicaid card. The largest expenditures were for personal care services ($40 million) and home health care ($13 million).

A majority of the participants also had family or friends involved in providing voluntary care. Quality assurance reviews revealed high rates of consumer satisfaction, especially for people living in their own homes.

Table of Contents

LIST OF FIGURES AND TABLES

INTRODUCTION

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

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

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

This report describes the persons served, program expenditures and services delivered primarily through COP, COP-W and CIP II in CY 2007. Information on all waivers has been reported where data was available. Medicaid waiver funding combined with Medicaid card funded services (acute care) and COP provides a comprehensive health care package to recipients, as well as community support services. It is critical that these programs be closely coordinated in order to ensure that the most comprehensive and individualized care is provided. With this kind of coordination, Wisconsin residents are provided with a safe, consumer-controlled alternative to life in an institution. As this report demonstrates, these programs also help contain the costs of providing long-term care to a fragile population.

STRUCTURE

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

PARTICIPANTS SERVED BY PROGRAMS

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

TABLE 1 - Participants Served by Programs During 2007 with COP and all Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								**6,735**
Waiver Only	3,360	1,360				4,720		
Waiver/COP	1,612	403					2,015	
CIP II								**4,784**
Waiver Only	1,698	1,557				3,255		
Waiver/COP	931	598					1,529	
Sub Total COP-W/CIP II	**7,601**	**3,918**	**0**	**0**	**0**	**7,975**	**3,544**	**11,519**
CIP 1A	**Elderly**	**PD**	**DD**	**SMI**	**AODA**			**1,325**
Waiver Only	62		1,210			1,272		
Waiver/COP	6		47				53	
CIP 1B Regular								**3,588**
Waiver Only	309		3,176			3,485		
Waiver/COP	17		86				103	
CIP 1B COP Match								**2,154**
Waiver/COP for match only	104		1,915			2,019		
COP match waiver w/other COP	18		117				135	
CIP 1B Other Match								**5,635**
Waiver/other for match	269		5,279			5,548		
Waiver/COP	6		81				87	
Brain Injury Waiver								**229**
Waiver Only	1	134	72	1		208		
Waiver/COP	0	18	3	0			21	
Brain Injury COP Match								**13**
Waiver/COP for match only		8	5			13		
COP match waiver w/other COP								
Brain Injury Waiver Other Match								**95**
Waiver/other for match	1	49	42			92		
Waiver/COP	0	2	1				3	
Sub Total DD Waivers	**793**	**211**	**12,034**	**1**	**0**	**12,637**	**402**	**13,039**
CLTS	**Elderly**	**PD**	**DD**	**SMI**	**AODA**			**1,975**
Waiver Only		19	1,842	103		1,964		
Waiver/COP		0	10	1			11	
CLTS COP Match								**179**
Waiver/COP for match only		40	79	38		157		
COP match waiver w/other COP		6	13	3			22	
CLTS Other Match								**630**
Waiver/other for match		33	413	171		617		
Waiver/COP		3	6	4			13	
Sub Total CLTS Waivers		**103**	**2,363**	**318**		**2,738**	**46**	**2,784**
COP Only Participants	**201**	**67**	**33**	**781**	**6**			**1,088**
Totals by Target Population	**8,595**	**4,297**	**14,430**	**1,102**	**6**	**23,350**	**5,080**	TOTAL: 28,430
% Served by Target Population	**30.2%**	**15.1%**	**50.8%**	**3.9%**	**.02%**	**82.1%**	**17.9%**	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2007 HSRS.

- Total unduplicated participants served in 2007 - 28,430.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 23,350.
- Total Medicaid waiver participants who also received COP funding in CY 2007 – 3,992
- Total participants who received only COP funding (not Medicaid eligible) - 1,088.
- All participants who received either pure COP or COP to supplement waiver funds - 5,080.
- Total participants served with COP and COP-W funds - 11,989

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 28,430 persons. The table below illustrates participants served in 2007 with COP and Medicaid waiver funding by target group.

TABLE 2
Participants Served by Target Group During 2007 with COP and All Waivers

Target Group	COP Only	COP-W	Subtotal COP Only, COP-W	All Other COP Used as Match	CIP II	Subtotal COP Only, COP-W, Other COP, CIP II	CIP 1, CLTS, BIW	GRAND TOTAL
Elderly	201 18.5%	4,972 73.8%	**5,173 66.1%**	1,082 26.0%	1,698 52.2%	**7,953 52.2%**	642 4.9%	**8,595 30.2%**
PD	67 6.2%	1,763 26.2%	**1,830 23.4%**	675 16.2%	1,557 47.8%	**4,062 26.6%**	235 1.8%	**4,297 15.1%**
DD	33 3.0%	0 0%	**33 0.4%**	2,363 56.7%	0 0%	**2,396 15.7%**	12,034 91.2%	**14,430 50.8%**
SMI	781 71.8%	0 0%	**781 10.0**	46 1.1%	0 0%	**827 5.4%**	275 2.1%	**1,102 3.9%**
AODA	6 0.5%	0 0%	**6 0.1%**	0 0%	0 0%	**6 0.04%**	0 0%	**6 0.02%**
Total	**1,088 3.8%**	**6,735 23.7%**	**7,823 27.5%**	**4,166 14.6%**	**3,255 11.4%**	**15,244 53.6%**	**13,186 46.4%**	**28,430 100.0%**

Note: Totals may not equal 100% due to rounding. Source: 2007 HSRS.

- 8,595 or 30% were elderly;
- 4,297or 15% were persons with physical disabilities (PD);
- 14,430 or 51% were persons with developmental disabilities (DD);
- 1,102 or 4% were persons with severe mental illness (SMI); and
- 6 or less than 1% were persons with alcohol and/or drug abuse (AODA)

FIGURE 1
Participants Served by Target Group During 2007 with COP and All Waivers

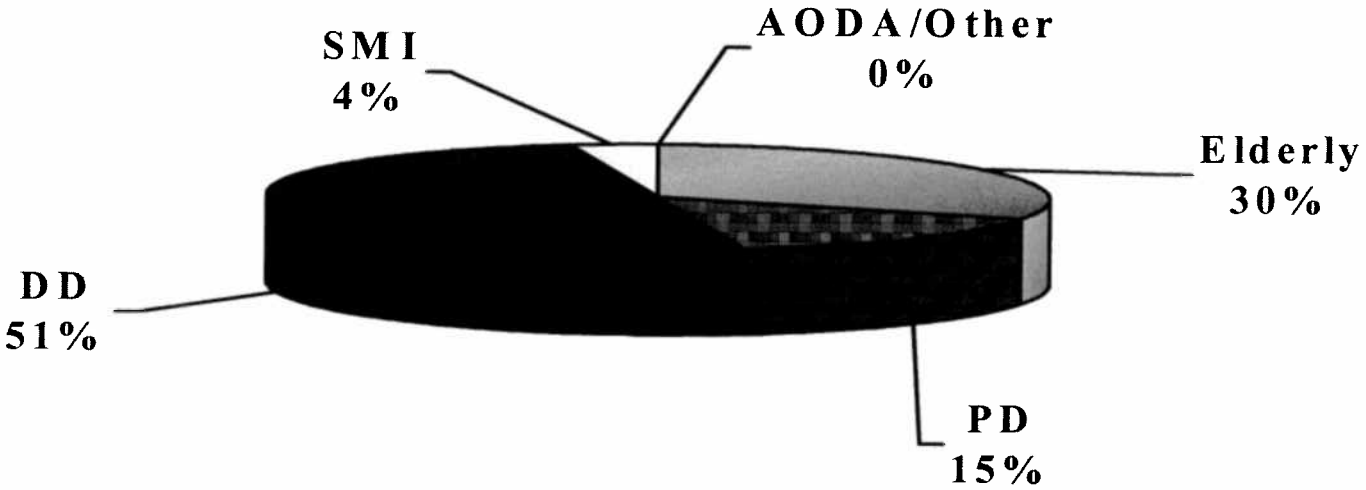


TABLE 3

Participants Served by Programs on December 31, 2007 (Point-In-Time) with COP and All Waivers

Program Category	Elderly	PD	DD	SMI	AODA	Medicaid Waiver Funds Only	Waiver w/Additional COP	Total Served Unduplicated
COP-W								**5,209**
Waiver Only	2,681	1,212				3,893		
Waiver/COP	1,030	286					1,316	
CIP II								**3,832**
Waiver Only	1,442	1,344				2,786		
Waiver/COP	611	435					1,046	
Sub Total COP-W/CIP II	**5,764**	**3,277**				**6,679**	**2,362**	**9,041**
CIP 1A	**Elderly**	**PD**	**DD**	**SMI**	**AODA**			**1,196**
Waiver Only	58		1,097			1,155		
Waiver/COP	2		39				41	
CIP 1B Regular								**3,357**
Waiver Only	288		2,983			3,271		
Waiver/COP	16		70				86	
CIP 1B COP Match								**1,991**
Waiver/COP for match only	93		1,787			1,880		
COP match waiver w/other COP	17		94				111	
CIP 1B Other Match								**5,291**
Waiver/other for match	260		4,960			5,220		
Waiver/COP	3		68				71	
Brain Injury Waiver								**218**
Waiver Only	1	128	70	1		200		
Waiver/COP	0	17	1	0			18	
Brain Injury COP Match								**11**
Waiver/COP for match only		6	5			11		
COP match waiver w/other COP		0	0				0	
Brain Injury Waiver Other Match								**92**
Waiver/other for match	1	48	41			90		
Waiver/COP	0	1	1				2	
Sub Total DD Waivers	**739**	**200**	**11,216**	**1**	**0**	**11,827**	**329**	**12,156**
CLTS	**Elderly**	**PD**	**DD**	**SMI**	**AODA**			**1,835**
Waiver Only		17	1,712	97		1,826		
Waiver/COP		0	8	1			9	
CLTS COP Match								**157**
Waiver/COP for match only		38	70	30		138		
COP match waiver w/other COP		5	11	3			19	
CLTS Other Match								**573**
Waiver/other for match		33	393	138		564		
Waiver/COP		2	5	2			9	
Sub Total CLTS Waivers		**95**	**2,199**	**271**		**2,528**	**37**	**2,565**
COP Only Participants	**166**	**64**	**28**	**685**	**6**			**949**
Totals by Target Population	**6,669**	**3,636**	**13,443**	**957**	**6**	**21,039**	**3,672**	**24,711**
% Served by Target Population	**27.0%**	**14.7%**	**54.4%**	**3.9%**	**0.03%**	**85.1%**	**14.9%**	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2007 HSRS.

ASSESSMENTS, CARE PLANS AND PERSONS SERVED

The Community Options Program lead agencies provide eligible individuals with an assessment and care plan that identifies equipment, home modifications and services that might be available to assist them in their own homes and communities. During the assessment process, a social worker and other appropriate professionals assess each individual's unique characteristics, medical condition, living environment, lifestyle preferences and choices. The individual and the care manager develop a plan for a comprehensive package of services, which integrates and supports the informal and unpaid assistance available from family and friends. This care plan incorporates individual choices and preferences for the type and arrangement of services. Depending upon available income and assets, the individual may be responsible for paying some or all of the costs for services in their care plan. In 2007, 5,913 assessments were conducted, and 3,177 care plans were prepared.

NEW PERSONS

Figure 2 illustrates the target group distribution of the 3,523 new persons served during 2007. The majority of the new participants served in 2007 were individuals who are elderly (age 65+). Clients are considered new if they have services and costs in the current year and no long-term support services of any type in the prior year.

FIGURE 2
New Persons Receiving Services by Target Group in 2007
For COP and All Waivers

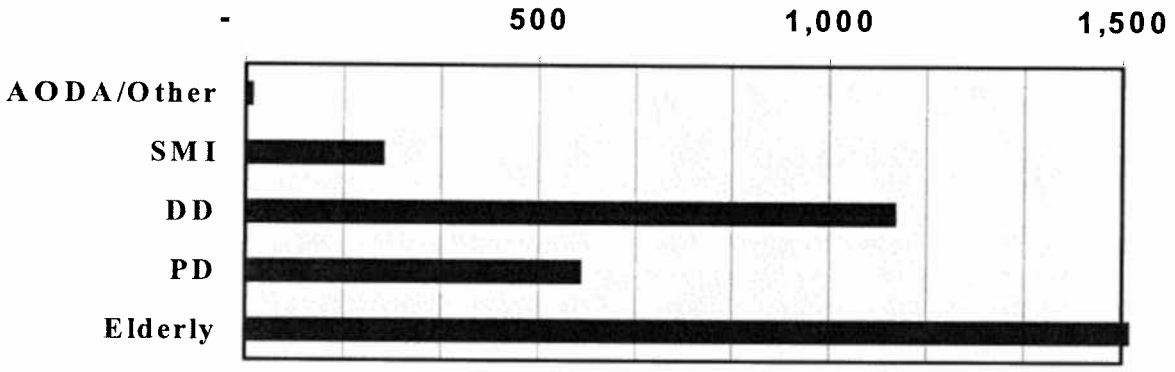


TABLE 4
New Persons Receiving Services by Age in 2007
For COP and All Waivers

	Elderly	PD	DD	SMI	AODA/Other	TOTAL
<18 yrs.	NA	20	338	98	2	458
18 – 64 yrs.	NA	555	777	138	11	1,481
65+ yrs.	1,584	NA	NA	NA	0	1,584
TOTAL	1,584 (45.0%)	575 (16.3%)	1,115 (31.7%)	236 (6.7%)	13 (.4%)	3,523

Source: 2007 HSRS.

PARTICIPANT CASE CLOSURES

Table 5 illustrates the number of participants in each target group who left the program in 2007 for various reasons. Approximately 3,484 or twelve percent of all people participating in COP and all Waivers, were closed for services during 2007. A person's death accounts for about 41 percent of elderly service closures and 27 percent of closures of persons with physical disabilities. Moving to an institution accounts for approximately 21 percent of all closures and was 34 percent of closures for the elderly population. Transferring to Managed Care in 2007 accounts for approximately 31 percent of all closures and was 60 percent for persons with developmental disabilities.

TABLE 5
Reasons for Participant Case Closures for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	784	151	92	17	0	3	1,047
Transferred to or Preferred Nursing Home Care	651	52	23	11	0	0	737
No Longer Income or Care Level Eligible	49	50	52	17	0	0	168
Moved	72	46	87	24	0	0	229
Voluntarily Ended Services	39	23	63	25	0	0	150
Other Funding Used for Services	5	4	11	24	0	0	44
Reside in ICF-MR/IMD Center	2	1	11	2	0	0	16
Medical Issues/Behavioral Challenges	5	3	2	1	0	0	11
Inadequate Service/Support	6	2	0	3	0	0	11
Transferred to Partnership Program/Managed Care	299	235	516	18	0	0	1,068
Other	0	1	0	2	0	0	3
Total Cases Closed (all reasons)	**1,912**	**568**	**857**	**144**	**0**	**3**	**3,484**

Source: 2007 HSRS.

PARTICIPANT TURNOVER RATE

The Community Options Program participants receive services as long as they remain eligible and continue to need services. At the end of 2007, 42 percent of the people eligible for COP and all Waivers had received services for three years or less. The other 58 percent of the people are longer-term participants who received services for more than three years. A notable 6,787 people, or 24 percent have received services for ten years or more.

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

Table 6 illustrates the number of people closed for services during 2007 divided by the caseload size on December 31, 2006 for each target group. The shaded row of Table 6 below shows the turnover rate for each target group. (The "other" category reflects reporting errors which are corrected by January 1, 2008.)

TABLE 6
Calculation of Turnover by Target Group for COP and All Waivers

	Elderly	PD	DD	SMI	AODA	Other	Total
All Persons Served During 2007	8,595	4,297	14,430	1,102	6	0	28,430
Point-in-Time Number of Persons Served on December 31, 2007	6,669	3,635	13,443	958	6	0	24,711
Number of Closures During 2007 (Excludes Transfers to the Family Care Program)	1,613	333	341	126	0	3	2,416
Point-in-Time Number of Persons active on December 31, 2006(Caseload Size)	6,854	3,822	13,454	901	5	0	25,036
Turnover Rate for the Above Case Closures	**24%**	**9%**	**3%**	**14%**	**0%**	**0%**	**10%**

Source: 2006 HSRS.

COP FUNDING FOR EXCEPTIONAL NEEDS

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

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

In 2007, funds for exceptional needs were awarded to 54 counties and served 251 individuals with developmental disabilities, physical disabilities, the frail elderly and children. Awards were made for home repairs and modifications such as ramps, mobility lifts, ceiling lifts, roll-in showers, raised toilets, wider hallways and doors, door openers, environmental control systems and other items. Awards were also made for adapted mobility equipment such as wheelchairs and scooters not covered by Medicaid, van modifications, dental work and autism consultations.

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

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

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

TABLE 7
Individuals and Percentages Used for Monitoring Significant Proportions 2004 - 2007

2004– 2007

Year	Elderly	PD	DD	SMI	AODA	Other	Total
Minimum Percentages	**57.0%**	**6.6%**	**14.0%**	**6.6%**	**0%**		**84.2%**
2007	4,545 45.7%	1,927 19.4%	2,657 26.7%	779 7.8%	38 0.4%	0 0.0%	**9,946** 100%
2006	6,648 51.3%	2,668 20.6%	2,755 21.3%	846 6.5%	39 0.3%	0 0.0%	**12,956** 100%
2005	6,824 51.5%	2,603 19.6%	2,879 21.7%	909 6.9%	19 0.1%	27 0.2%	**13,261** 100%
2004	7,003 49.6%	2,861 20.3%	3,327 23.6%	881 5.2%	23 0.2%	30 0.2%	**14,125** 100%

Note: Counts reflect individuals served with COP and COP-W funding on December 31st of each year with adjustments applied.
Source: 2007 HSRS, Reconciliation Schedules.

These numbers include calculation for COP funding used as overmatch and for county specific variances. This unduplicated count includes individuals whose services are funded with COP Regular, COP-W or CIP IB when COP funding is used to provide the non-federal match to Medicaid Waivers. The numbers include a calculation adjustment to factor in the amount of COP funding that is used as match for services above the CIP I and CIP II rate. (This methodology counts approximately one additional person for every $10,000 of COP regular funds used in this way.)

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 8 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	8,115	3,442	13,095	1,128	48	25,828	91%
African American	140	495	709	112	3	1,459	5%
Hispanic	65	83	242	19	0	409	2%
American Indian/Alaska Native	111	82	129	19	1	342	1%
Asian/Pacific Islander	159	42	168	8	0	377	1%
Unknown	5	0	10	0	0	15	<1%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 9 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	`umber	Percent
Diverted from Entering any Institution	23,567	83%
Relocated from General Nursing Home	2,341	8%
Relocated from ICF/MR	2,284	8%
Relocated from Brain Injury Rehab Unit	237	1%
Other	1	<1%
TOTAL	28,430	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 10 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	6,295	2,204	5,865	578	21	14,963	53%
Male	2,300	1,940	8,488	708	31	13,467	47%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 11 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	98	2,562	291	2	2,953	11%
18 – 64 years	0	4,046	11,791	995	50	16,882	59%
65 – 74 years	2,647	0	0	0	0	2,647	9%
75 – 84 years	3,002	0	0	0	0	3,002	11%
85 years and over	2,946	0	0	0	0	2,946	10%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 12 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	3,851	150	35	11	2	4,049	14%
Never Married	1,636	1,811	13,835	989	28	18,299	65%
Married	1,577	839	167	42	6	2,631	9%
Divorced/Separated	1,395	1,264	192	214	14	3,079	11%
Other	136	80	124	30	2	372	1%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 13 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	4,203	544	25	48	4	4,824	17%
Non-Relative	1,163	787	2,217	296	8	4,471	16%
Spouse	1,193	737	114	29	6	2,079	7%
Parent	118	1,130	9,500	518	10	11,276	40%
Other Relative	1,322	636	1,799	136	13	3,906	14%
No Primary Support	596	310	697	259	11	1,873	6%
Other	0	0	1	0	0	1	<1%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 14 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	2,048	1,585	6,875	330	8	10,846	38%
Living with Others with Attendant Care	1,541	525	3,234	290	20	5,610	20%
Living Alone	2,843	1,010	831	323	10	5,017	18%
Living with Others	1,428	465	2,630	290	10	4,823	17%
Living Alone with Attendant Care	467	287	431	27	2	1,214	4%
Living with Immediate Family with Attendant Care	145	187	201	4	0	537	2%
Living with Extended Family	99	60	129	15	2	305	1%
Living with Extended Family with Attendant Care	17	17	9	2	0	45	<1%
Transient Housing Situation	6	6	4	5	0	21	<1%
Other	1	2	9	0	0	12	<1%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

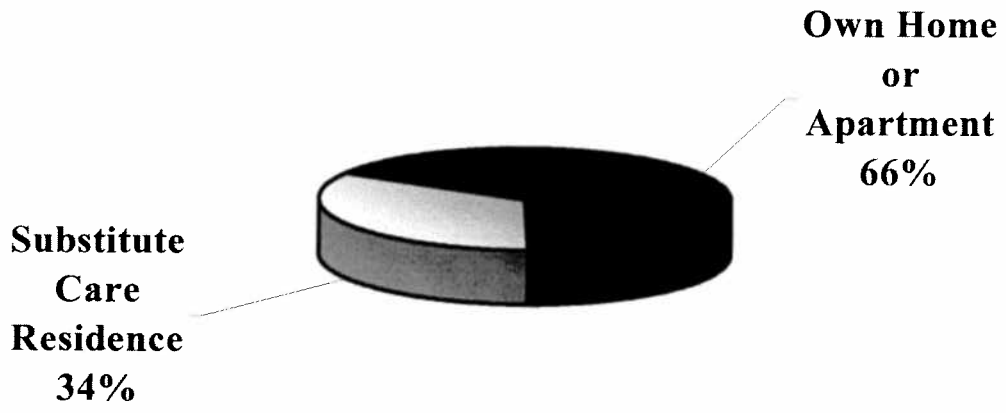
NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

TABLE 15 - COP and All Waiver Participants by Type of Residence

PARTICIPANTS BY TYPE OF RESIDENCE	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Adoptive Home	0	3	78	14	0	95	33%
Adult Family Home (AFH)	712	244	2,979	138	7	4,080	14%
Brain Injury Rehab Unit	0	16	6	0	0	22	<1%
Child Group Home	0	1	5	0	0	6	<1%
Community Based Residential Facility (CBRF)	2,282	439	1,595	293	22	4,631	16%
Foster Home	0	12	222	91	2	327	1%
ICF/MR: Not State Center	0	0	0	0	0	0	0%
Nursing Home	1	1	1	0	0	3	<1%
Other Living Arrangement	0	1	0	0	0	1	<1%
Own Home or Apartment	5,321	3,386	9,427	713	21	18,868	66%
Residential Care Apartment Complex (RCAC)	253	25	0	2	0	280	1%
Residential Care Center (RCC)	0	0	3	3	0	6	<1%
Shelter Care Facility	0	0	3	6	0	9	<1%
State DD Center	0	0	0	0	0	0	0%
Supervised Community Living	25	16	32	26	0	99	<1%
Unknown	1	0	2	0	0	3	<1%
TOTAL	8,595	4,144	14,353	1,286	52	28,430	100%

NOTE: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2007 HSRS.

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



FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $622,254,352 (federal waiver and state funds) was spent in 2007 through the Community Options Program and all long-term care Medicaid Home and Community-Based Services Waivers. As a publicly-funded and managed program for community long-term care, COP-Regular contributes about 9 percent of the overall total. COP-Regular and COP-Waiver together contribute 21 percent of the overall total. [These figures do not include funds spent under the fee-for-service (non-waiver) Medicaid program.]

TABLE 16
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2007

Target Group	COP-Regular	COP-W	Subtotal COP-Regular, COP-W	CIP II	Subtotal COP-Regular, COP-W, CIP II	CIP 1, CLTS, BIW*	GRAND TOTAL
Elderly	10,920,241 20%	54,319,473 70%	**65,239,714 49%**	33,505,411 43%	**98,745,125 47%**		**98,745,125 16%**
PD	5,584,435 10%	22,838,870 30%	**28,423,305 22%**	44,233,362 57%	**72,656,667 34%**	1,037,183 <1%	**73,693,850 12%**
DD	26,662,550 49%		**26,662,550 20%**		**26,662,550 13%**	400,529,048 97%	**427,191,598 69%**
SMI	11,492,324 21%		**11,492,324 9%**		**11,429,324 6%**	10,977,984 3%	**22,470,308 3%**
AODA	141,171 <1%		**141,171 <1%**		**141,171 <1%**		**141,171 0.0%**
Other	12,300 0.0%		**12,300 0.0%**		**12,300 0.0%**		**12,300 0.0%**
Total	**$54,813,021 9%**	**$77,158,343 12%**	**$131,971,364 21%**	**$77,738,773 13%**	**$209,710,137 34%**	**$412,544,215 66%**	**$622,254,352 100%**

Source: 2007 HSRS and Reconciliation Schedules.
Children's waivers serve children with a physical disability, a developmental disability and those children who have a severe mental illness.

- The elderly received 16% of the funds;
- Persons with physical disabilities (PD) received 12% of the funds;
- Persons with developmental disabilities (DD) received 69% of the funds;
- Persons with severe mental illness (SMI) received 3% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 4
Total COP and Waivers Spending by Target Group

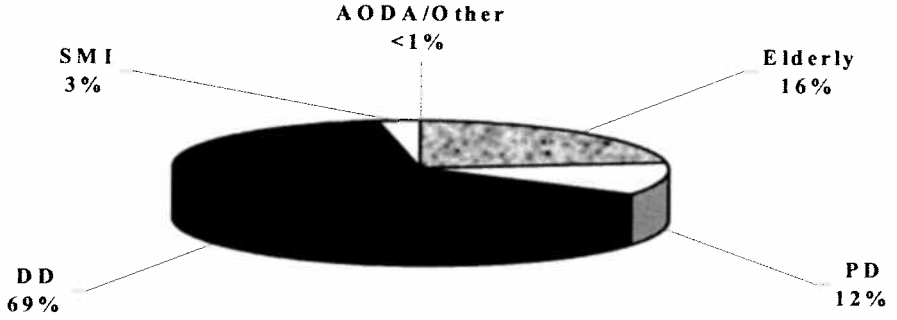
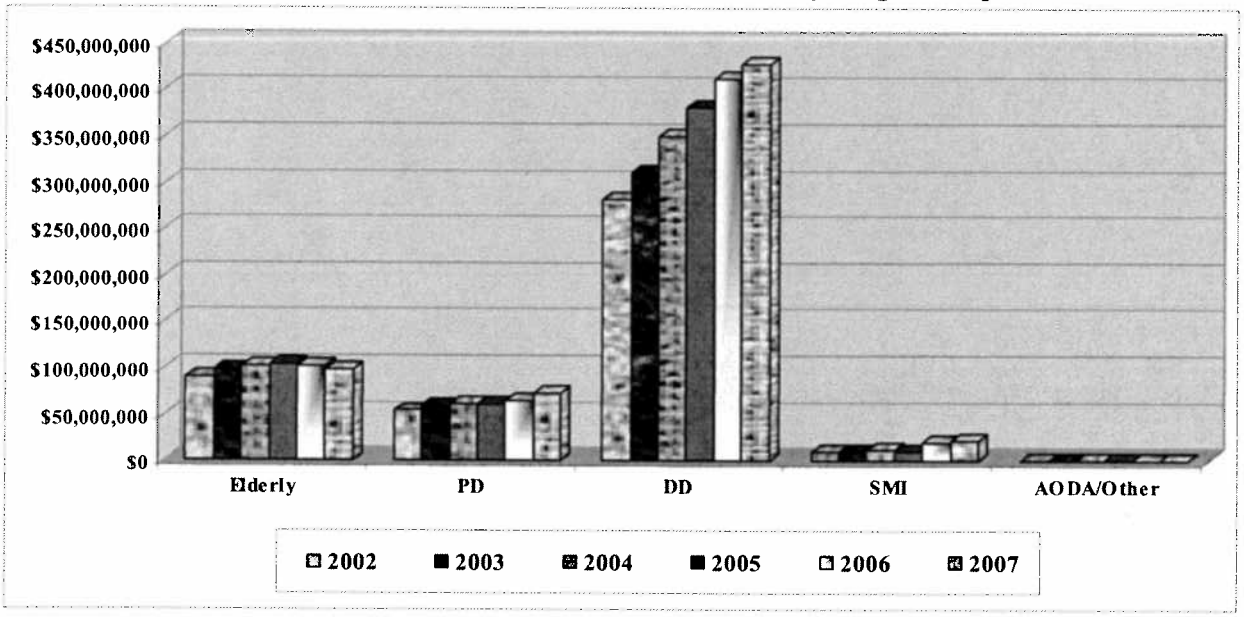


Figure 5 illustrates spending for participants by target groups. The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 5
History of Expenditures for Community Long Term Care by Target Group 2002 – 2007



Source: 2007 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED
Table 17 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	15.0%	56.6%	11.1%	12.7%	54.5%	19.9%
PD	4.4%	32.7%	6.5%	4.4%	26.5%	10.2%
DD	3.4%	10.5%	81.4%	19.2%	15.5%	48.6%
SMI	76.3%	0.2%	1.0%	62.9%	2.9%	21.0%
AODA/Other	0.9%	0.0%	0.0%	0.8%	0.6%	0.3%
TOTAL	22.4%	12.6%	55.1%	4.9%	4.9%	100.0%
Costs Reported*	$13,128,107	$7,384,168	$32,217,972	$2,894,766	$2,866,728	$58,491,741*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was $54,813,021.

- 22 percent of the total COP-Regular funds were used for services for COP only participants, 76 percent of whom are persons with a severe mental illness. The federal waiver is currently being developed for the long-term care needs of this group.
- 13 percent of COP-Regular was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 5 percent was used for program and service coordination including one percent for special projects.
- 5 percent of COP-Regular funds were used to conduct assessments and develop care plans.

$32 million was used as match to serve more people or for increased service costs for existing participants. Of the funds used for additional match, $26 million was used for persons with developmental disabilities: of that amount, $5.9 million was used to fund the match for CIP I so counties could earn additional federal funds when the average costs exceeded the allowable rate. When COP funding is used in this way it is referred to as "overmatch." For persons who are elderly or have physical disabilities, $4.9 million of COP-Regular funds were used as match to expand the COP-W program and $772,593 COP-Regular funding was used to fund the match for CIP II federal dollars when average costs exceeded the allowable reimbursement rate. In addition, $1 million of COP-Regular funding was used to provide support for the new Children's Long Term Support waiver.

PARTICIPANTS WITH ALZHEIMER'S DISEASE AND RELATED IRREVERSIBLE DEMENTIAS

In 2007, a total of 1,342 people using funds from the COP, COP-W and CIP II programs were reported as having an Alzheimer's disease or related dementia diagnosis (e.g., Friedrich's Ataxia, Huntington's disease and Parkinson's disease). Of these 1,342 individuals, 3 qualified for the program by diagnosis alone. The total expenditures for participants with Alzheimer's or other irreversible dementia were $15,621,880.

CIP II AND COP-W SERVICES

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

State statutes require use of Medicaid waiver funds only for expenses not covered in the Medicaid program. The Medicaid card services received, the waiver services provided, the total costs for each service and the service utilization rates are outlined in tables 18, 19 and 20. The total cost of Medicaid fee-for-service card costs for these waiver participants was $89,727,332.

TABLE 18
2007 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	$161,193,171
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$ 89,727,332
Total 2006 Medicaid Expenditures for CIP II and COP-W Recipients	**$250,920,503**

Source: 2007 Federal 372 Report.

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

TABLE 19
2007 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Waiver Costs
Care Management	98.22	$21,733,265	13.48
Supportive Home Care/Personal Care	74.09	52,611,480	32.64
Adult Family Home	5.21	12,786,250	7.93
Residential Care Apartment Complex	3.19	4,712,664	2.92
Community Based Residential Facility	26.23	50,646,852	31.42
Respite Care	3.92	1,396,469	0.87
Adult Day Care	4.32	2,635,629	1.64
Day Services	2.14	1,759,399	1.09
Daily Living Skills Training	1.03	790,601	0.49
Counseling and Therapies	3.32	709,965	0.44
Skilled Nursing	2.11	254,779	0.16
Transportation	24.96	2,129,668	1.32
Personal Emergency Response System	38.09	1,253,480	0.78
Adaptive Equipment	15.20	1,647,841	1.02
Communication Aids	1.21	62,109	0.04
Housing Start-up	.95	114,217	0.07
Vocational Futures Planning	.00	0	0.00
Medical Supplies	22.35	1,150,142	0.71
Home Modifications	3.16	1,387,320	0.86
Home Delivered Meals	23.83	3,040,974	1.89
Financial management Services	6.68	370,067	0.23
Total Medicaid Waiver Service Costs		**$161,193,171**	

Note: Totals may not equal 100% due to rounding. Source: 2007 Federal 372 Report.

TABLE 20
2007 CIP II and COP-W Medicaid Card Service Utilization

Medicaid State Plan Benefits Categories	Rate of Participant Utilization (%)	Cost	Percent of Total Card Costs
Inpatient Hospital	3.0%	$5,391,585	6.0%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	72.5%	3,972,630	4.4%
Outpatient Hospital	52.2%	2,350,441	2.6%
Lab and X-ray	57.1%	816,155	0.9%
Prescription Drugs	58.1%	7,807.357	8.7%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	39.0%	2,530,825	2.8%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	6.2%	272,863	0.3%
Dental Services	15.8%	447,777	0.5%
Nursing (Nurse Practitioner, Nursing Services)	0.6%	1,522,570	1.7%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	70.5%	12,968,941	14.5%
Personal Care (Personal Care, Personal Care Supervisory Services)	69.1%	39,755,294	44.3%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSDT, Rural Health Clinic Services, Home Health Private Duty Nursing – Vent, Other Care, Hospice, Community Support Program)	45.0%	11,890,894	13.3%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$ 89,727,332**	

Notes: Totals may not equal 100% due to rounding. Source: 2007 Federal 372 Report.

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

In addition to Medicaid-funded services, many waiver participants receive other public funds that can be used to help pay for long-term care costs. To provide an adequate comparison of the cost of serving persons through the Medicaid waiver versus the cost of meeting individuals' long-term support needs in nursing homes, an analysis of total public funding used by each group was completed. Table 21 below indicates total public funds on an average daily basis for nursing home and waiver care.

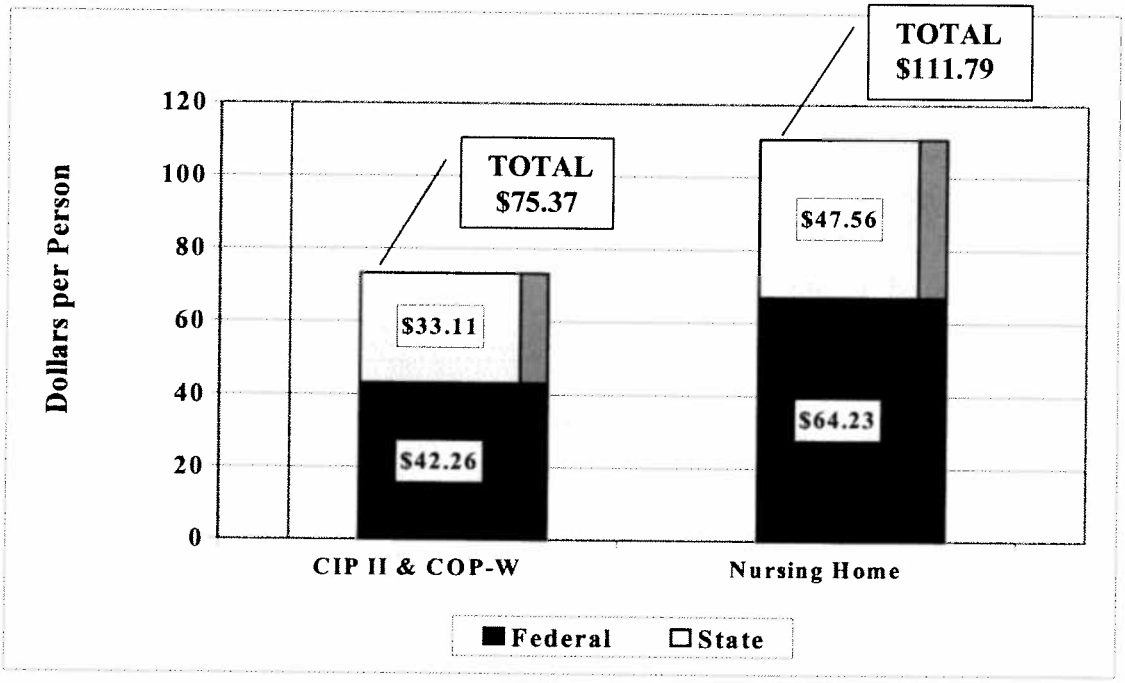
TABLE 21
2007 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

		Community Care Costs			Nursing Home Costs			Difference		
Year	Cost Category	Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2007	Medicaid Program Per Diem	$47.25	$20.10	$27.15	$105.84	$45.03	$60.81			
	Medicaid Card	26.30	11.19	15.11	5.95	2.53	3.42			
	Medicaid Costs Subtotal[2]	$73.55	$31.29	$42.26	$111.79	$47.56	$64.23	$38.24	$16.27	$21.97
	COP – Services w/Admin.	1.70	1.70	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.12	0.12	0.00	n/a[3]	n/a[3]	n/a[3]			
	Total	**$75.37**	**$33.11**	**$42.26**	**$111.79**	**$47.56**	**$64.23**	**$36.42**	**$15.49**	**$20.93**

Source: 2007 HSRS and 2007 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged $75.37 per person per day in 2007, compared to $111.79 per day for Medicaid recipients in nursing facilities, with the same level of care needs. On average, then, the per capita daily cost of care in CIP II and COP-W during 2007 was $36.42 less than the cost of nursing home care.

FIGURE 6
CIP II & COP-W vs. Nursing Home Care in 2007
Average Public Costs per Day



Source: 2007 Federal 372 Report.

Appendix A

PERFORMANCE STANDARDS

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

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

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

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

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

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

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

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

RESPECT performance standards are measured by the extent to which:

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

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

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

Funding: GPR/State = 100%

COMMUNITY OPTIONS PROGRAM-WAIVER (COP-WAIVER OR COP-W):
A Medicaid-funded waiver program which provides community services to the elderly and persons with physical disabilities who have long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home.

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

COMMUNITY INTEGRATION PROGRAM II (CIP II):
A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities *after a nursing home bed is closed.*

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

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):
A Medicaid-funded waiver program that provides community services to persons with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

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

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

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

COMMUNITY INTEGRATION PROGRAM IB (CIP IB)/LOCAL MATCH:
A Medicaid-funded waiver program which provides community services to persons with developmental disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the State Centers for the Developmentally Disabled.

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

CHILDREN'S LONG TERM SUPPORT WAIVERS (CLTS-WAIVER):
A Medicaid-funded waiver program that serves children and persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance. CLTS waivers provide funds that enable individuals to be supported in the community.

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

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

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

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

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

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 488 cases in 2007. The reviews went well beyond the traditional federal requirements, which only identify payment errors, in an effort to gain in-depth information on program operation and policy interpretation. Where errors were identified, corrective action plans were implemented. For all criteria monitored, 89 percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

Category: FINANCIAL ELIGIBILITY

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

Findings: 90 *percent of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as cost share and spend down. These areas have been emphasized in training and technical assistance activities. A disallowance occurred if the cost share was included in the expenses billed to the waiver.*

Category: NON-FINANCIAL ELIGIBILITY

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

Findings: 91 *percent overall compliance with eligibility was measured. No instances of incorrect eligibility determination were identified under this category, although some cases failed to contain sufficient documentation.*

Category: SERVICE PLAN

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

Findings: 92 *percent of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.*

Category: SERVICE STANDARDS AND REQUIREMENTS

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

Findings: 85 *percent of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken if standards had not been met.*

Category: BILLING

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

Findings: 93 *percent compliance was found in these categories. Disallowances were taken.*

Category: SUBSTITUTE CARE

Monitoring Components:
- ✓ *Contracting requirements have been met*
- ✓ *Only waiver allowable costs calculated and billed*

Findings: 95 *percent overall compliance was found. Documentation or errors due to room and board versus care and supervision were evidenced in a few cases. Residential care has proven to be a challenging area for services providers and is being addressed with technical assistance and training. Disallowances were taken.*

CORRECTIVE ACTION

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

Where a deficiency correlated with ineligibility, agencies were instructed to correct their reimbursement requests. In addition, agencies were required to develop a plan to modify their practices. In **24** instances, disallowances were taken where retroactive corrections could not be implemented. The total disallowance within those 19 counties was **$133,329**.

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

PROGRAM QUALITY

During 2007, 488 randomly selected participants responded to 22 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

The factors studied regarding care management services were:
- ❑ Responsiveness to consumer preferences
- ❑ Quality of communication
- ❑ Level of understanding of consumer's situation
- ❑ Professional effectiveness
- ❑ Knowledge of resources
- ❑ Timeliness of response

The factors studied for in-home care were:
- ❑ Timeliness
- ❑ Dependability
- ❑ Responsiveness to consumer preferences

The factors studied for persons living in substitute care settings were:
- ❑ Responsiveness to consumer preferences
- ❑ Choices for daily activities
- ❑ Ability to talk with staff about concerns
- ❑ Comfort

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

Table 22
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	94%
Good communication with care manager	93%
Care manager is responsive	92%
Active participation in care plan	94%
Satisfaction with in-home workers	91%
Substitute care services are acceptable	88%
Satisfaction with substitute care living arrangement	88%

Source: 2006 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

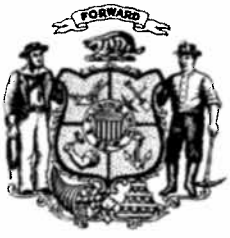
The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- Quarterly completed review and corrections of valid Medicaid numbers.
- Utilized enhanced data collection and reporting formats to identify target areas for local monitoring, training and technical assistance.
- Produced and distributed case specific fiscal reports containing potential correctable reporting errors.
- Continued revisions to Medicaid Waivers Manual and made available to local agencies via the Department's website
- Revised COP Waiver Basics Manual and made available to local agencies via the Department's website
- Provided training and technical assistance on the Long Term Care Functional Screen
- Began revising outcomes measurement tool.
- Developing a data base of decisions made through the Hearings and Appeals process.
- Developing a link to the Division of Quality Assurances data on findings in alternate care facilities.

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

Irene Anderson
Bureau of Long Term Support
Division of Long Term Care
Wisconsin Department of Health Services
P.O. Box 7851
Madison, WI 53707-7851
Phone: (608) 266-3884
Fax: (608) 267-2913
E-mail: irene.anderson@wisconsin.gov

WISCONSIN STATE LEGISLATURE



State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

April 6, 2009

Patrick E. Fuller
Assembly Chief Clerk
17 West Main Street, Suite 401
Madison, Wisconsin 53703

Robert J. Marchant
Senate Chief Clerk
Room B20 Southeast State Capitol
Madison, Wisconsin 53702

Dear Mr. Fuller and Mr. Marchant:

The Community Integration Program (CIP) for residents of State Centers was created by 1983 Wisconsin Act 27. According to s. 46.275 of the Wisconsin statutes, this program is intended:

> ...to relocate persons from the state centers for the developmentally disabled into appropriate community settings with the assistance of home and community-based services and with continuity of care. The intent of the program is also to minimize its impact on state employees through redeployment of employees into vacant positions.

Under Wisconsin statutes s. 46.275(5m), the Department is required to submit an annual report to the Joint Committee on Finance and to the Chief Clerk of each house of the Legislature describing the program's impact during the prior calendar year on state employees, including the Department's efforts to redeploy employees into vacant positions and the number of employees laid off.

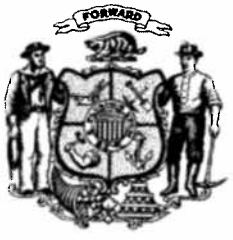
During calendar year 2008, Southern Wisconsin Center and Central Wisconsin Center relocated 20 center residents into the community under the CIP program. The Department was able to reduce positions and funding for calendar year 2008 without employee layoffs and without redeploying employees into vacant positions.

Sincerely,

Karen E. Timberlake
Secretary

#Referred to committee on Health

WISCONSIN STATE LEGISLATURE



Esser, Bridget

From: Laundrie, Julie
Sent: Monday, May 11, 2009 9:13 AM
To: Esser, Bridget; Johnson, Kelly
Subject: FW: Food Safety in Healthcare

Julie Laundrie
Office of Senator Jon Erpenbach
608-266-6670 cell 608-772-0110

From: Marchant, Robert
Sent: Monday, May 11, 2009 8:51 AM
To: Laundrie, Julie
Subject: FW: Food Safety in Healthcare

Julie—

Wow. Two forwarded emails in one day. Weird.

I am sending this one on to you because it appears to relate to the health committee.

Rob

From: Thomas Sullivan [mailto:tsullivan@beloitmemorialhospital.org]
Sent: Saturday, May 09, 2009 9:13 AM
To: Marchant, Robert
Subject: Food Safety in Healthcare

May 9, 2009

Dear Senator Marchant:

On behalf of the Wisconsin Dietary Managers Association, I would like to submit the following recommendations regarding the regulations for the dietary department of Wisconsin's Long Term Care Facilities. Certified Dietary Managers currently play a very important role within the dietary service department. In the absence of a full-time registered dietitian, it is the certified dietary manager who is responsible for the day-to-day operation of the dietary services area and the implementation of nutritional assessments.

Certified dietary managers are experienced, educated and trained professionals who can address the nutritional needs of our state's nursing home residents. Therefore, it is our position that all nursing home food service supervisors should be certified. Currently, DHS Administrative Code (DHS 132.63) only requires that the director of food service take the dietary manager's course- not be certified. We feel this is a grave injustice to our elderly population and feel it is time for a change.

There are currently 495 Dietary Managers Association members, 99% of whom are certified. These

individuals have taken and passed a 255-question certification examination offered by the Certifying Board for Dietary Managers. Forty-five hours of continuing education credits per three-year period are required to maintain certification. With the continuous changes in the delivery of health care, we feel these continuing education courses are vitally important. Based on the experience, education and training of the Certified Dietary Manager, we submit the enclosed regulation changes for you to consider.

Without a full-time dietitian, we believe that only certified dietary managers have the education, training and experience to provide a safe and healthy dietary services department that can adequately address the needs of Wisconsin's long term care patients.

Please accept the proposed changes to recognize the CDM credential. I look forward to working with you to make these changes in the state regulations.

Sincerely,

Thomas J. Sullivan CDM CFPP
President, Wisconsin Dietary Managers Association
Executive Chef, Nutrition Services
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