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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)

State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

February 17, 2010

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

Patrick E. Fuller
Assembly Chief Clerk
17 West Main Street, Room 401
Madison, Wisconsin 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 2008.

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
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 2008

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

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INTRODUCTION

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

The 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 community-based choices for older people and people with disabilities at a lower cost to the state than institutional choices for long-term care. 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 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.

Highlights for Calendar Year 2008 include:

- COP and home and community based waivers served a total of 27,998 citizens.
- Half of all individuals served had a developmental disability, approximately 29% 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.
- $595 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 $79.09. In contrast, the *average* daily cost of care for people in nursing homes, at the same average level of care, was $115.15.
- Sixty-seven 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.
- During 2008, 5,808 persons transitioned to Managed Care or 21% of the total number served and accounted for 72% of participant case closures.

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 $79,310,887 in benefits from their Medicaid card. The largest expenditures were for personal care services ($37 million) and home health care ($24 million).

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.

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) support 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.

TABLE 1 - Participants Served by Programs During 2008 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								**5,925**
Waiver Only	2,847	1,282				4,129		
Waiver/COP	1,470	326					1,796	
CIP II								**4,864**
Waiver Only	1,810	1,507				3,317		
Waiver/COP	985	562					1,547	
Sub Total COP-W/CIP II	**7,112**	**3,677**				**7,446**	**3,343**	**10,789**
CIP 1A								**1,220**
Waiver Only	69		1,101			1,170		
Waiver/COP	3		47				50	
CIP 1B Regular								**5,497**
Waiver Only	288		5,135			5,423		
Waiver/COP	7		67				74	
CIP 1B COP Match								**1,984**
Waiver/COP for match only	103		1,744			1,847		
COP match waiver w/other COP	18		119				137	
CIP 1B Other Match								**3,408**
Waiver/other for match	326		2,984			3,310		
Waiver/COP	14		84				98	
Brain Injury Waiver								**228**
Waiver Only	4	131	74	1		210		
Waiver/COP	0	15	3				18	
Brain Injury COP Match								**22**
Waiver/COP for match only		7	12			19		
COP match waiver w/other COP		3	0				3	
Brain Injury Waiver Other Match								**79**
Waiver/other for match	4	44	29			77		
Waiver/COP	0	2	0				2	
Sub Total DD Waivers	**836**	**202**	**11,399**	**1**		**12,056**	**382**	**12,438**
CLTS								**2,589**
Waiver Only		118	1,799	657		2,574		
Waiver/COP		0	13	2			15	
CLTS COP Match								**272**
Waiver/COP for match only		61	108	68		237		
COP match waiver w/other COP		10	20	5			35	
CLTS Other Match								**800**
Waiver/other for match		58	524	211		793		
Waiver/COP		0	6	1			7	
Sub Total CLTS Waivers		**247**	**2,470**	**944**				**3,661**
COR Waiver				**4**			**4**	**4**
COP Only Participants	**196**	**63**	**26**	**816**	**5**			**1,106**
Totals by Target Population	**8,144**	**4,189**	**13,895**	**1,765**	**5**	**23,106**	**4,892**	**27,998**
% Served by Target Population	**29.1%**	**15.0%**	**49.6%**	**6.3%**	**<.01%**	**82.5%**	**17.5%**	

NOTE: Participants with a dual diagnosis are counted under the funding program. Source: 2008 HSRS.

- Total unduplicated participants served in 2008 – 27,998.
- Total participants who were served by a Medicaid waiver only (no COP funds) - 23,106.
- Total Medicaid waiver participants who also received COP funding in CY 2008 – 3,786
- Total participants who received only COP funding (not Medicaid eligible) - 1,106.
- All participants who received either pure COP or COP to supplement waiver funds – 4,892.
- Total participants served with COP and COP-W funds - 9,017

PARTICIPANTS SERVED BY TARGET GROUP

The Community Options Program and all the home and community-based waivers combined served a total of 27,994 persons. The table below illustrates participants served in 2008 with COP and Medicaid waiver funding by target group. The COR Waiver is not included in this table.

TABLE 2
Participants Served by Target Group During 2008 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	196 17.72%	4,317 77.10%	**4,513** **67.31%**	1,027 46.20%	1,810 54.57%	**7,350** **60.02%**	794 5.04	**8,144** **29.09%**
PD	63 5.70%	1,282 22.90%	**1,345** **20.06%**	653 29.37%	1,507 45.43%	**3,505** **28.62%**	684 4.34%	**4,189** **14.96%**
DD	26 2.35%	0 0%	**26** **0.39%**	467 21.01%	0 0%	**493** **4.03%**	13,402 85.10%	**13,895** **49.64%**
SMI	816 73.78%	0 0%	**816** **12.17%**	76 3.42%	0 0%	**892** **7.28%**	869 5.52%	**1,761** **6.29%**
AODA	5 0.45%	0 0%	**5** **0.07%**	0 0%	0 0%	**5** **0.04%**	0 0%	**5** **0.02%**
Total	**1,106** **3.95%**	**5,599** **20.00%**	**6,705** **23.95%**	**2,223** **7.94%**	**3,317** **11.85%**	**12,245** **43.74%**	**15,749** **56.26%**	**27,994*** **100.0%**

*The COR Waiver is not included in this table.
Note: Totals may not equal 100% due to rounding. Source: 2008 HSRS.

- 8,144 or 29% were elderly;
- 4,189 or 15% were persons with physical disabilities (PD);
- 13,895 or 50% were persons with developmental disabilities (DD);
- 1,761 or 6% were persons with severe mental illness (SMI); and
- 5 or less than 1% were persons with alcohol and/or drug abuse (AODA)

FIGURE 1
Participants Served by Target Group During 2008 with COP and All Waivers

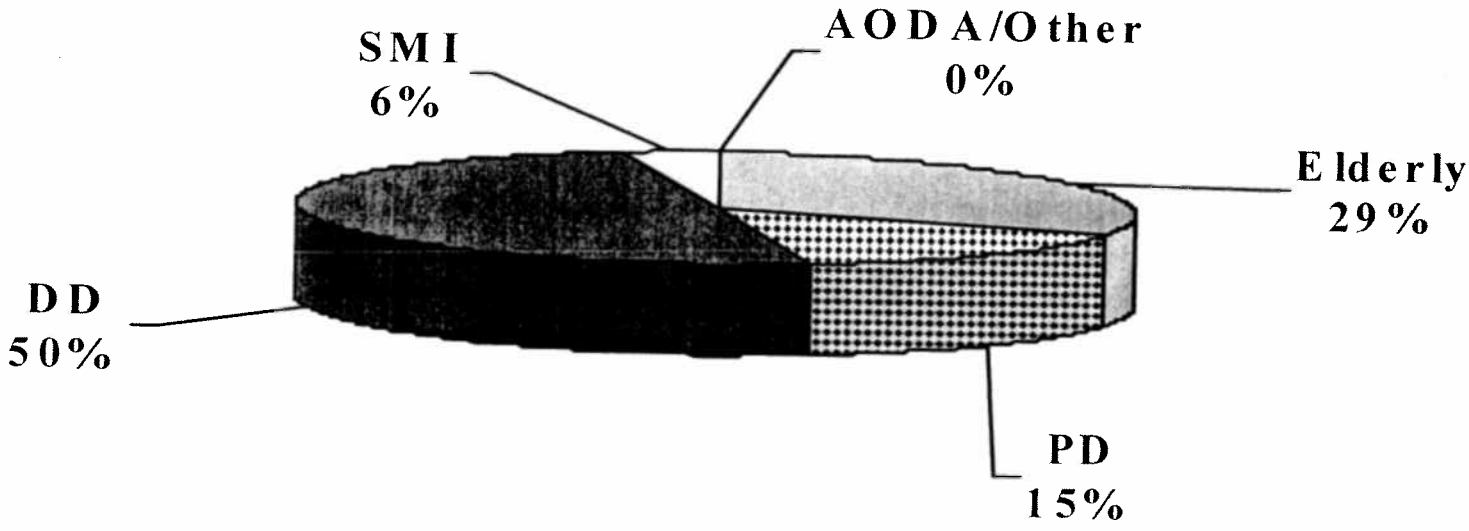
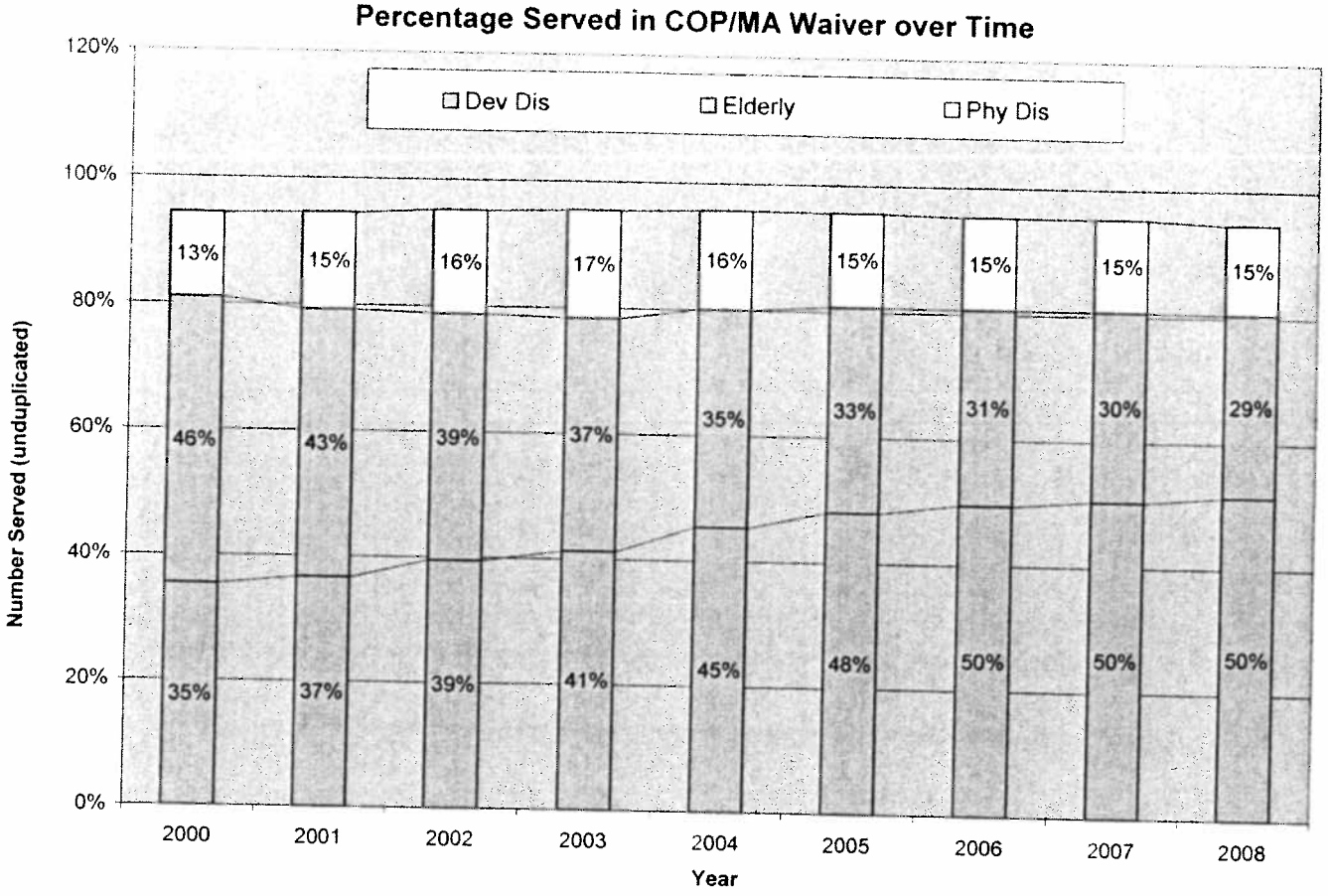


FIGURE 2



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 2008, 4,636 assessments were conducted, and 2,676 care plans were prepared.

NEW PERSONS

Figure 3 illustrates the target group distribution of the 3,376 new persons served during 2008. The majority of the new participants served in 2008 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 3
New Persons Receiving Services by Target Group in 2008
For COP and All Waivers

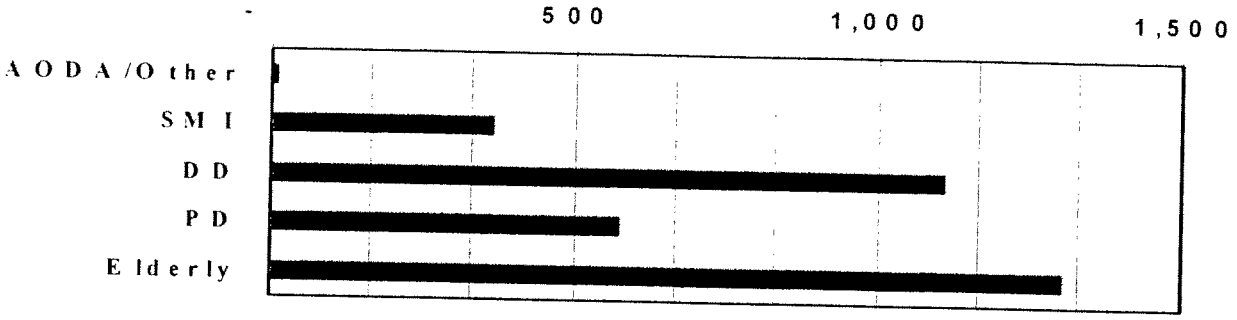


TABLE 3
New Persons Receiving Services by Age in 2008
For COP and All Waivers

	Elderly	PD	DD	SMI	AODA/Other	TOTAL
<18 yrs.	NA	63	617	188	0	868
18 – 64 yrs.	NA	515	497	177	13	1,202
65+ yrs.	1,306	NA	NA	NA	0	1,306
TOTAL	1,306 (38.7%)	578 (17.1%)	1,114 (33.0%)	365 (10.8%)	13 (.4%)	3,376

Source: 2008 HSRS.

PARTICIPANT CASE CLOSURES

Table 4 illustrates the number of participants in each target group who left the program in 2008 for various reasons. Approximately 8,077 or thirty two percent of all people participating in COP and all Waivers, were closed for services during 2008. A person's death accounts for about 22 percent of elderly service closures and 14 percent of closures of persons with physical disabilities. Moving to an institution accounts for approximately 8 percent of all closures and was 16 percent of closures for the elderly population. Transferring to Managed Care in 2008 accounts for approximately 72 percent of all closures and was 88 percent for persons with developmental disabilities.

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

	Elderly	PD	DD	SMI	AODA	Other	Total
Person Died	735	161	118	7	0	0	1,021
Transferred to or Preferred Nursing Home Care	536	60	21	6	0	0	623
No Longer Income or Care Level Eligible	36	39	65	21	0	0	161
Moved	31	34	66	17	0	0	148
Voluntarily Ended Services	38	31	63	36	0	1	169
Other Funding Used for Services	6	6	25	23	0	0	60
Reside in ICF-MR/IMD Center	0	0	7	0	0	0	7
Ineligible living arrangement	15	4	17	15	1	1	53
Inadequate Service/Support	2	4	14	2	0	0	22
Transferred to Partnership Program/Managed Care	1,973	789	2,950	81	8	7	5,808
Other	2	0	3	0	0	0	5
Total Cases Closed (all reasons)	**3,374**	**1,128**	**3,349**	**208**	**9**	**9**	**8,077**

Source: 2008 HSRS.

PARTICIPANT TURNOVER RATE

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 5 illustrates the number of people closed for services during 2008 divided by the caseload size on December 31, 2007 for each target group. The shaded row of Table 5 below shows the turnover rate for each target group. Please note: turnover in 2008 included transfers to Family Care and Partnership.

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

	Elderly	PD	DD	SMI	AODA	Total
All Persons Served During 2008	8,144	4,189	13,895	1,761	5	27,994
Point-in-Time Number of Persons Served on December 31, 2008	4,753	2,788	10,974	1,214	19	19,748
Number of Closures During 2008(Includes Transfers to the Family Care Program)	3,374	1,128	3,349	208	9	8,077
Point-in-Time Number of Persons active on December 31, 2007Caseload Size)	6,669	3,635	13,443	958	6	24,711
Turnover Rate for the Above Case Closures	**51%**	**31%**	**25%**	**22%**	**n/a**	**33%**

Source: 2008 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 or Waiver eligible participants including ramps;
c) purchase of medical services and medical equipment or other specially adapted equipment; and
d) vehicle modifications.

In 2008, funds for exceptional needs were awarded to 54 counties and served 265 individuals with developmental disabilities, physical disabilities, the frail elderly and children. Awards were made for 85 home repairs and modifications including 30 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, 40 vehicle modifications and dental work (10 awards).

PARTICIPANT DEMOGRAPHIC AND SERVICE PROFILES

TABLE 6 - COP and All Waiver Participants by Race/Ethnic Background

PARTICIPANTS BY RACE/ETHNIC BACKGROUND	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Caucasian	7,728	3,275	13,144	1,268	49	25,464	91%
African American	100	482	688	116	3	1,389	5%
Hispanic	44	79	244	21	0	388	1%
American Indian/Alaska Native	118	82	135	22	1	358	1%
Asian/Pacific Islander	149	40	181	11	1	382	1%
Unknown	5	0	12	0	0	17	<1%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 7 - COP and All Waiver Participants who Relocated/Diverted from Institutions

RELOCATED/DIVERTED	Number	Percent
Diverted from Entering any Institution	23,238	83%
Relocated from General Nursing Home	2,379	8%
Relocated from ICF/MR	2,156	8%
Relocated from Brain Injury Rehab Unit	225	1%
Other	0	0%
TOTAL	27,998	100%

NOTE: Some totals may not equal 100% due to rounding. Source: 2008 HSRS.

TABLE 8 - COP and All Waiver Participants by Gender

PARTICIPANTS BY GENDER	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Female	5,917	2,067	5,828	620	27	14,459	53%
Male	2,227	1,891	8,576	818	27	13,539	47%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 9 - COP and All Waiver Participants by Age

PARTICIPANTS BY AGE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Under 18 years	0	146	2,863	418	3	3,430	12%
18 – 64 years	0	3,812	11,541	1,020	51	16,424	59%
65 – 74 years	2,541	0	0	0	0	2,541	9%
75 – 84 years	2,792	0	0	0	0	2,792	10%
85 years and over	2,811	0	0	0	0	2,811	10%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 10 - COP and All Waiver Participants by Marital Status

PARTICIPANTS BY MARITAL STATUS	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Widow/Widower	3,601	131	33	14	1	3,780	14%
Never Married	1,599	1,808	13,880	1,130	32	18,449	66%
Married	1,461	770	169	48	7	2,455	9%
Divorced/Separated	1,351	1,173	188	216	12	2,940	10%
Other	132	76	134	30	2	374	1%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 11 - COP and All Waiver Participants by Natural Support Source

PARTICIPANTS BY NATURAL SUPPORT SOURCE	Elderly	PD	DD	SMI	AODA/ Other	Total Participants	
Adult Child	3,991	497	20	44	6	4,558	16%
Non-Relative	1,084	748	2,141	300	9	4,282	15%
Spouse	1,096	663	109	31	5	1,904	7%
Parent	125	1,143	9,736	651	13	11,668	42%
Other Relative	1,290	623	1,787	152	13	3,865	14%
No Primary Support	558	284	610	260	8	1,720	6%
Other	0	0	1	0	0	1	<1%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 12 - COP and All Waiver Participants by Living Arrangement

PARTICIPANTS BY LIVING ARRANGEMENT	Elderly	PD	DD	SMI	AODA Other	Total Participants	
Living with Immediate Family	1,897	1,541	7,170	446	14	11,068	40%
Living with Others with Attendant Care	1,421	485	3,124	290	17	5,337	19%
Living Alone	2,658	953	834	319	7	4,771	17%
Living with Others	1,481	473	2,533	304	12	4,803	17%
Living Alone with Attendant Care	454	252	418	33	2	1,159	4%
Living with Immediate Family with Attendant Care	123	169	172	5	0	469	2%
Living with Extended Family	92	59	131	20	2	304	1%
Living with Extended Family with Attendant Care	11	16	11	2	0	40	<1%
Transient Housing Situation	6	8	4	3	0	21	<1%
Other	1	2	7	0	0	10	<1%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

TABLE 13 - 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	2	81	24	0	107	<1%
Adult Family Home (AFH)	691	221	2,793	140	7	3,852	14%
Brain Injury Rehab Unit	0	9	1	0	0	10	<1%
Child Group Home	0	1	4	0	0	5	<1%
Community Based Residential Facility (CBRF)	2,166	402	1,567	294	21	4,450	16%
Foster Home	0	11	226	130	2	369	1%
ICF/MR: Not State Center	0	0	0	0	0	0	0%
Nursing Home	2	1	0	0	0	3	<1%
Other Living Arrangement	0	0	0	0	0	0	<1%
Own Home or Apartment	5,018	3,266	9,691	819	24	18,818	67%
Residential Care Apartment Complex (RCAC)	245	30	0	2	0	277	1%
Residential Care Center (RCC)	0	0	2	3	0	5	<1%
Shelter Care Facility	1	1	4	2	0	8	<1%
State DD Center	0	0	0	0	0	0	0%
Supervised Community Living	20	14	34	24	0	92	<1%
Unknown	1	0	1	0	0	2	<1%
TOTAL	8,144	3,958	14,404	1,438	54	27,998	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: 2008 HSRS.

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

FUNDING OF COMMUNITY LONG-TERM CARE BY TARGET GROUP

A total of $594,546,372 (federal waiver and state funds) was spent in 2008 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 20 percent of the overall total. The COR Waiver is not included in this table. These figures do not include funds spent under the fee-for-service (non-waiver) Medicaid program.

TABLE 14
COP and All Waivers
Funding of Community Long-Term Care by Target Group in 2008*

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	8,785,967 16%	47,584,703 71%	**56,370,670 47%**	40,649,769 50%	**97,020,439 48%**		**97,020,439 16%**
PD	4,220,796 8%	19,815,726 29%	**24,036,522 20%**	40,325,866 50%	**64,362,388 32%**	1,928,065 <1%	**66,290,453 11%**
DD	28,466,688 54%		**28,466,688 23%**		**28,466,688 14%**	376,545,723 96%	**405,012,411 68%**
SMI	11,662,860 22%		**11,662,860 10%**		**11,662,860 6%**	14,471,007 4%	**26,133,867 5%**
AODA	76,724 <1%		**76,724 <1%**		**76,724 <1%**		**76,724 0.0%**
Other	12,478 0.0%		**12,478 0.0%**		**12,478 0.0%**		**12,478 0.0%**
Total	**$53,225,513 9%**	**$67,400,429 11%**	**$120,625,942 20%**	**$80,975,635 14%**	**$201,601,577 34%**	**$392,944,795 66%**	**$594,546,372 100%**

Source: 2008 HSRS and Reconciliation Schedules.
*The COR Waiver is not included in this table.
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 11% of the funds;
- Persons with developmental disabilities (DD) received 68% of the funds;
- Persons with severe mental illness (SMI) received 5% of the funds; and
- Persons with alcohol and/or drug abuse (AODA) or other conditions received less than 1% of the funds.

FIGURE 5
Total COP and Waivers Spending by Target Group

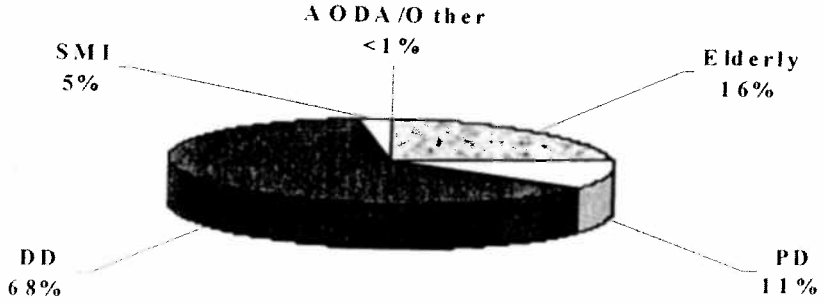
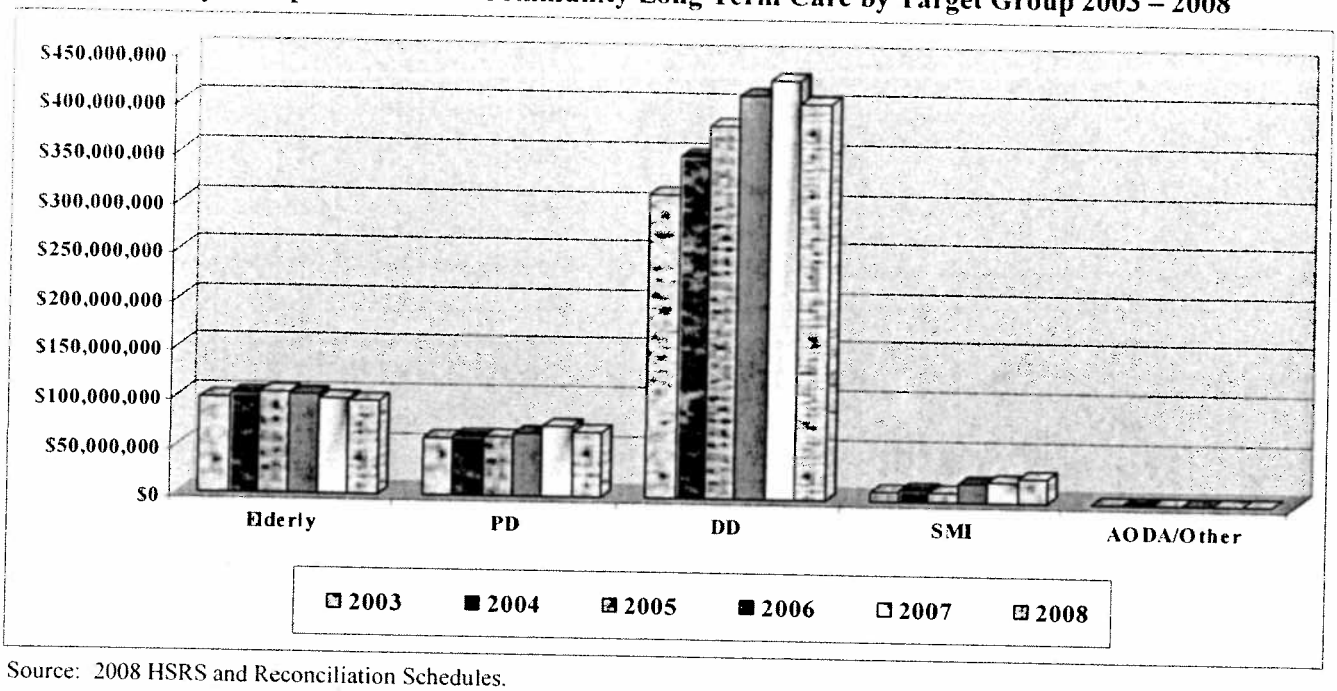


Figure 6 illustrates spending for participants by target groups. The "elderly" category includes all persons age 65 or older regardless of type of disability. All other participants are younger than 65. All participants have a need for a level of care equivalent to a nursing home care level.

FIGURE 6
History of Expenditures for Community Long Term Care by Target Group 2003 – 2008



Source: 2008 HSRS and Reconciliation Schedules.

HOW COP-REGULAR IS USED
Table 15 – Use of COP Regular

Target Group	COP Only	Supplemental COP (gap filling)	Additional GPR Match for Waivers	Admin, Special Projects, Risk Reserve	Assessments And Plans	Total Percent of COP-R Reported
Elderly	13.6%	55.0%	7.5%	22.8%	47.4%	16.5%
PD	3.2%	29.7%	4.1%	8.8%	28.0%	7.9%
DD	2.7%	14.3%	85.1%	18.8%	19.1%	52.6%
SMI	80.0%	1.0%	1.8%	46.9%	5.3%	21.9%
AODA/Other	0.6%	0.0%	0.0%	0.6%	0.3%	0.2%
TOTAL	23.0%	11.1%	57.3%	4.5%	4.0%	99.1%
Costs Reported*	$13,838,236	$6,694,803	$34,431,221	$2,701,188	$2,386,147	$60,051,595*

*Note: Reflects allowable costs reported on HSRS; however, actual reimbursement was $53,255,512.

- 23 percent of the total COP-Regular funds were used for services for COP only participants, 80 percent of whom are persons with a severe mental illness.
- 11 percent of COP-Regular was used for current waiver participants to provide services that could not be paid for with waiver funds.
- 4 percent was used for program and service coordination.
- 4 percent of COP-Regular funds were used to conduct assessments and develop care plans.

$34.4 million was used as match to serve more people or for increased service costs for existing participants. Of the funds used for additional match, $29.7 million was used for persons with developmental disabilities. For persons who are elderly or have physical disabilities, $3.6 million of COP-Regular funds were used as match to expand the COP-W program and $110,592 COP-Regular funding was used to fund the match for CIP II federal dollars when average costs exceeded the allowable reimbursement rate. In addition, $1.7 million of COP-Regular funding was used to provide support for the new Children's Long Term Support waiver.

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 16, 17 and 18. The total cost of Medicaid fee-for-service card costs for these waiver participants was $79,310,886.

TABLE 16
2008 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	$152,959,627
Total Medicaid Card Service Costs for CIP II and COP-W Recipients	$ 79,310,886
Total 2008 Medicaid Expenditures for CIP II and COP-W Recipients	**$232,270,513**

Source: 2008 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 17
2008 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	100.00	$19,860,485	12.98
Supportive Home Care/Personal Care	74.24	50,121,060	32.77
Adult Family Home	5.35	12,883,854	8.42
Residential Care Apartment Complex	3.47	4,362,503	2.85
Community Based Residential Facility	27.00	48,646,310	31.80
Respite Care	3.74	1,237,637	0.81
Adult Day Care	4.16	2,152,638	1.41
Day Services	2.09	1,607,495	1.05
Daily Living Skills Training	1.02	568,020	0.37
Counseling and Therapies	3.29	605,730	0.40
Skilled Nursing	2.09	281,787	0.18
Transportation	25.06	2,072,314	1.35
Personal Emergency Response System	37.44	1,095,691	0.72
Adaptive Equipment	14.06	1,515,511	0.99
Communication Aids	1.16	45,561	0.03
Housing Start-up	.82	123,991	0.08
Vocational Futures Planning	.01	2,063	<.01
Medical Supplies	23.05	1,134,753	0.74
Home Modifications	3.37	1,379,896	0.90
Home Delivered Meals	24.02	2,933,990	1.92
Financial management Services	6.85	328,338	0.21
Total Medicaid Waiver Service Costs		**$152,959,627**	

Note: Totals may not equal 100% due to rounding. Source: 2008 Federal 372 Report.

TABLE 18
2008 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%	10,539	.01%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	79.5%	3,758,996	4.7%
Outpatient Hospital	44.6%	1,823,006	2.3%
Lab and X-ray	18.3%	495,798	0.6%
Prescription Drugs	64.2%	7,635,127	9.6%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	34.4%	2,457,074	3.1%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	9.42%	415,961	0.5%
Dental Services	19.1%	508,738	0.6%
Nursing (Nurse Practitioner, Nursing Services)	1.1%	9,814,695	12.4%
Home Health, Supplies & Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	17.0%	6,491,012	8.2%
Personal Care (Personal Care, Personal Care Supervisory Services)	37.04%	37,677,298	47.5%
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)	78.8%	8,222,643	10.4%
Total Medicaid State Plan Benefit Costs for Waiver Recipients		**$ 79,310,887**	

Notes: Totals may not equal 100% due to rounding. Source: 2008 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 19 below indicates total public funds on an average daily basis for nursing home and waiver care.

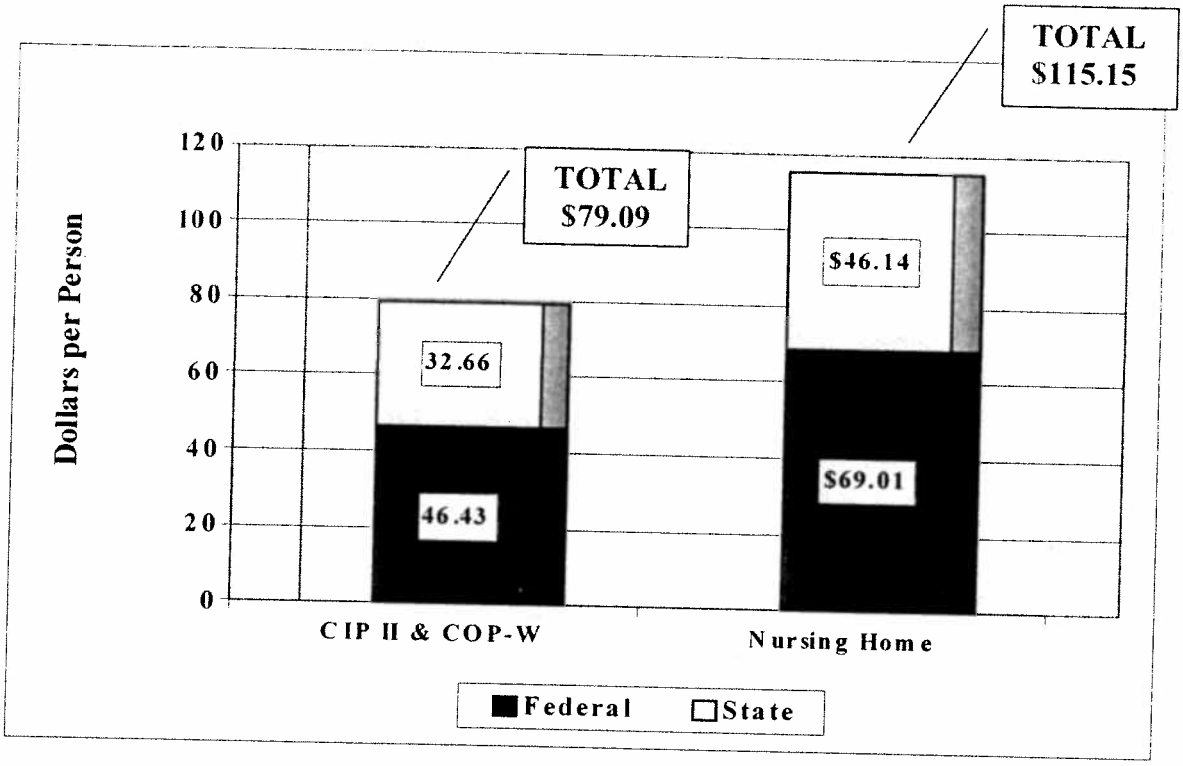
TABLE 19
2008 Average Public Costs for CIP II & COP-W Participants vs. Nursing Home Residents
Average Cost per Person per Day

Year	Cost Category	Community Care Costs			Nursing Home Costs			Difference		
		Total	State / County	Federal	Total	State / County	Federal	Total	State / County	Federal
2008	Medicaid Program Per Diem	$50.24	$20.13	$30.11	$110.88	$44.43	$66.45			
	Medicaid Card	27.24	10 92	16.32	4.27	1.71	2.56			
	Medicaid Costs Subtotal[2]	$77.48	$31.05	$46.43	$115.15	$46.14	$69.01	$37.67	$15.09	$22.58
	COP – Services w/Admin.	1.22	1.22	0.00	n/a[3]	n/a[3]	n/a[3]			
	COP – Assessments & Plans	0.39	0.39	0.00	n/a[3]	n/a[3]	n/a[3]			
	Total	**$79.09**	**$32.66**	**$46.43**	**$115.15**	**$46.14**	**$69.01**	**$36.06**	**$13.48**	**$22.58**

Source: 2008 HSRS and 2008 Federal 372 Report.

When all public costs are counted, expenses for CIP II and COP-W participants averaged $79.09 per person per day in 2008, compared to $115.15 per day for Medicaid recipients in nursing facilities, with the same level of care needs. On average, the per capita daily cost of care in CIP II and COP-W during 2008 was $36.06 or 31 percent less than the cost of nursing home care.

FIGURE 7
CIP II & COP-W vs. Nursing Home Care in 2008
Average Public Costs per Day



Source: 2008 Federal 372 Report

Appendix A

PERFORMANCE STANDARDS

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

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

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

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

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

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

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

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

RESPECT performance standards are measured by the extent to which:

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

Appendix B

DEFINITIONS OF COMMUNITY LONG-TERM CARE PROGRAMS

COMMUNITY OPTIONS PROGRAM (COP):

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

Funding: GPR/State = 100%

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

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

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

COMMUNITY INTEGRATION PROGRAM II (CIP II):

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

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

COMMUNITY INTEGRATION PROGRAM IA (CIP IA):

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

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

COMMUNITY INTEGRATION PROGRAM IB REGULAR (CIP IB):

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

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

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

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

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

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

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

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

BRAIN INJURY WAIVER:

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

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

Appendix C

QUALITY ASSURANCE AND IMPROVEMENT OUTCOMES

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

PROGRAM INTEGRITY

On-site monitoring reviews were conducted for a random selection of 320 cases in 2008. 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, 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: *80 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: 65 per*cent 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: 91 *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: 72 *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: 84 *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: 79 *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. Disallowances were taken where retroactive corrections could not be implemented. The total disallowance within those 17 counties was **$46,591**.

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 2008, 227 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 20 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 20
Program Quality Results

SATISFACTION CATEGORY	PERCENTAGE OF POSITIVE RESPONSES
Care manager is effective in securing services	96%
Good communication with care manager	97%
Care manager is responsive	96%
Active participation in care plan	98%
Satisfaction with in-home workers	98%
Substitute care services are acceptable	97%
Satisfaction with substitute care living arrangement	89%

Source: 2008 Quality Monitoring Reviews.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

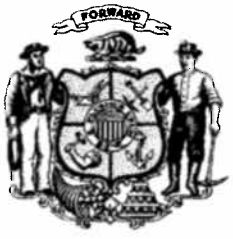
The information collected from various quality assurance efforts was incorporated into a variety of ongoing quality improvement projects. Examples of those activities are listed below:

- 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

February 25, 2010

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 2009, Southern Wisconsin Center and Central Wisconsin Center have relocated 9 center residents into the community under the CIP program. There were no employee layoffs as the result of these placements. However, the Department redeployed 24 employees into other vacant positions dedicated to providing care to persons who continue to reside at the Center.

Sincerely,

Karen E Timberlake

Karen E. Timberlake
Secretary

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

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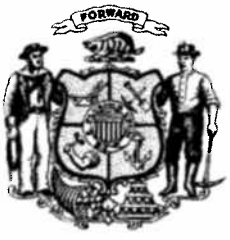

State of Wisconsin • DEPARTMENT OF REVENUE

2135 RIMROCK ROAD • P.O. BOX 8933 • MADISON, WISCONSIN 53708-8933 • 608-266-6466 • FAX (608) 266-5718 • http://www.revenue.wi.gov

Jim Doyle
Governor

Roger M. Ervin
Secretary of Revenue

May 20, 2010

Honorable Jon Erpenbach, Chair
Committee on Health, Health Insurance,
Privacy, Property Tax Relief, and Revenue
Room 8 South State Capitol
PO Box 7882
Madison WI 53708-7882

Honorable Jon Richards, Chair
Committee on Health and Healthcare Reform
Room 118 North State Capitol
PO Box 8953
Madison WI 53708-8953

Re: Clearinghouse Rule 10-005

Dear Senator Erpenbach and Representative Richards:

Enclosed for your review is a germane modification to Clearinghouse Rule 10-005. This modification is made at the request of the Association of Wisconsin Surgery Centers, Inc. The modification consists of amending Tax 1.17(5)(c), renumbering Tax 1.17(5)(d) to (f), and creating Tax 1.17(5)(d) and (e).

Sincerely,

Roger M. Ervin
Secretary of Revenue

RME:DSK
e:rules\117 Committees – Germane Modification

Enclosure

(5)(c) The assessment shall be paid electronically on or before June 1 of each year in a manner prescribed by the department.

(d) At the discretion of the department, an ambulatory surgical center that is unable to timely pay the assessment due June 1, 2010, may be granted an extension of the due date to June 22, 2010. This extension is only available for the payment that is due June 1, 2010. A determination by the department to not grant an extension is final and is not subject to review under ch. 227, Stats.

(e) Failure to pay the assessment by the due date, including any extension, shall result in a penalty of $500 per day calculated from the day after the due date up to, but not including, the date the assessment is received by the department, subject to a maximum penalty equal to the amount of the assessment. Payment of the penalty under this paragraph does not relieve the ambulatory surgical center from the responsibility of paying the assessment.

(f) The department may require estimated pre-payment of the assessment, in a manner prescribed by the department. The department shall notify ambulatory surgical centers at least 90 days before the first estimated pre-payment is due.

E:Rules/117 Germane Modification