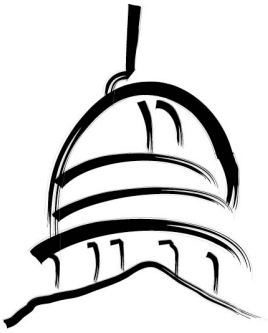
# *Community-Based Long-Term Care Programs*



*Informational Paper 48*

*Wisconsin Legislative Fiscal Bureau*

*January, 2003*

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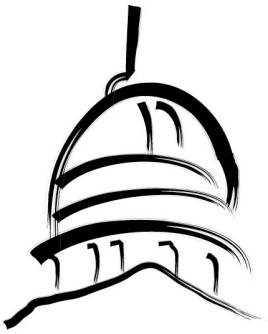

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# *Community-Based Long-Term Care Programs*

**Introduction**

Before 1981, low-income Wisconsin residents who required community-based long-term care services could obtain limited assistance under the state's medical assistance (MA) program and county-administered social services programs. Individuals enrolled in MA could obtain certain "card services," which provide acute care and certain types of long-term care services. However, individuals with care needs that would qualify them for nursing home care frequently require other services that enable them to continue to live in their homes or other community-based setting. As a result, indigent people with long-term care needs often did not have alternatives to MA-funded institutional care in nursing homes.

Chapter 20, Laws of 1981 created the community options program (COP) to expand long-term care options to Wisconsin residents. In addition to supporting a comprehensive set of services, COP screens individuals who are at risk of entering nursing homes to determine whether their long-term care needs can be provided through community-based services.

Initially, COP was funded exclusively with state general purpose revenue (GPR) funds and had no connection to the MA program. However, COP became two distinct programs in the 1987-89 biennium, when the state implemented the COP MA home- and community-based waiver. The first program, which is still funded entirely with state GPR funds, is sometimes referred to as "regular COP" and is hereafter referred to as COP-R to distinguish it from the program administered as an MA home- and community-based waiver program (COP-W). In addition to COP-W, Wisconsin administers several other community-based long-term care programs under a waiver of federal MA rules. These other "waiver programs" fund community-based services to populations not eligible for COP-W services, including people with developmental disabilities and brain injuries.

Counties use COP-R funds to support populations and services that are ineligible for coverage under MA and the MA waiver programs. For example, the MA waiver programs do not cover room and board costs so counties use COP-R funds to support these types of services. Some individuals, including individuals with chronic mental illness and individuals in the early stages of Alzheimer's disease, are not eligible for MA waiver programs but receive services supported by COP-R.

During the past two decades, the state significantly increased funding for community-based long-term care programs. However, the demand for such services has exceeded available funding. Consequently, there are waiting lists for services under these programs, and, for many individuals, nursing home care remains the only long-term care option immediately available to them because under federal law eligible MA enrollees are entitled to services provided by skilled nursing facilities.

The state also funds several pilot programs that provide community-based long-term care services

under a managed care approach. The program for all inclusive care for the elderly (PACE) and the Wisconsin partnership program (WPP) provide both acute health and long-term care services to elderly and disabled people who are eligible for nursing home care. These programs provide comprehensive health care and other supportive services to maintain people in the community at a limited number of sites throughout the state.

In 1998-99, Wisconsin began the Family Care pilot program to consolidate the state's long-term care programs, address the institutional bias of the MA program and eliminate waiting lists for community-based long-term care services. 1997 Wisconsin Acts 27 and 237 authorized the Department of Health and Family Services (DHFS) to begin implementing several pilot programs that served as the foundation for the pilot program created in 1999 Wisconsin Act 9. Act 9 established the two major components of the Family Care program: (a) resource centers that serve as single-entry points for the long-term care system and that provide information, assessments, eligibility determinations and other preliminary services; and (b) care management organizations (CMOs) that manage and provide the Family Care benefit for every person enrolled, under a capitated, risk-based payment system.

In 2001-02, the state spent approximately $1.85 billion (all funds) to provide long-term care services to Wisconsin residents. Of this amount, approximately $1.13 billion (61%) was spent for nursing home care and $0.72 billion was spent for home and community-based long-term care, as shown in Table 1.

**Table 1: Expenditures for Selected Long-Term Care Services -- Fiscal Year 2001-02 (All Funds)**

| | Actual |
|---|---|
| MA Waivers excluding COP-W | $281,201,500 |
| COP-R and COP-W | 135,842,300 |
| MA Personal Care | 104,337,800 |
| Family Care CMOs | 83,720,900 |
| MA Home Health | 59,458,300 |
| PACE/Partnership | 57,808,400 |
| Total | $722,369,200 |
| Total Institutional Care (Nursing Homes) | $1,127,519,300 |
| All Long-Term Care | $1,849,888,500 |

## Medical Assistance Card Services

This section of the paper describes MA card services, including: (a) eligibility; (b) covered services; and (c) service limitations.

### Eligibility

**Non-Financial Criteria.** Although MA is a means-tested program, not all low-income individuals are eligible for MA benefits. MA coverage is available only to a person who is: (a) under 19 years of age; (b) over 65 years of age; (c) blind or disabled; (d) a relative caretaker of a deprived child; or (e) pregnant. Even though children, their families and caretakers may be eligible for MA-supported long-term care services, they rarely use these services. However, because MA enrollees who are disabled, blind or over the age of 65 comprise most users of long-term care services, MA eligibility for these individuals is described below.

In order to be eligible for full MA benefits, a person must be a U.S. citizen or meet criteria for certain classes of aliens. In addition, states are required to cover eligible residents, including migrant workers. In Wisconsin, an individual is considered a resident if he or she is physically present in the state and intends to reside in Wisconsin. Federal law prohibits states from establishing a period of residency before becoming eligible for MA.

**Financial Criteria.** Elderly and disabled individuals may meet MA financial eligibility requirements in two ways. First, federal law requires that any person over the age of 65 or disabled person who is eligible for cash assistance under the federal supplemental security income (SSI) program is categorically eligible for MA and does not have to meet any other financial requirements. If an elderly or disabled person is not eligible for SSI, that person may still be eligible for MA card services if excessive medical expenses cause the individual's net income to fall below "medically needy" income limits.

For both groups, the MA financial standards permit certain deductions and exclusions. The major exclusions for the asset limits include the individual's home, a car with a value of up to $4,500 (or full value if the car is needed for work or medical reasons) and household goods and personal effects. With respect to income for the elderly, blind and disabled groups, one major exclusion is that for earned income, the first $65 per month plus one-half of any additional earned income is excluded from countable income. The calendar year 2002 asset and income limits for categorical and medically needy elderly, blind and disabled individuals that live independently are shown in Table 2.

**Table 2: MA Income and Asset Limits for Aged, Blind and Disabled Individuals -- Calendar Year 2002**

| Group Size | Categorically Needy (SSI) | Medically Needy |
|---|---|---|
| 1 | **Assets:** $2,000 | **Assets:** $2,000 |
| | **Income:** $447 / month + actual shelter cost up to $182 (total of $629) | **Income:** $592 / month |
| 2 | **Assets:** $3,000 | **Assets:** $3,000 |
| | **Income:** $677 / month + actual shelter cost up to $272 (total of $949) | **Income:** $592 / month |

Under the medically needy income standards, an individual can "spend down" to meet the income standard. Although a person may have gross income above the medically needy standard, if medical expenses over a six-month period would reduce available income to below the medically needy income standard, the person is eligible for MA coverage for those additional medical expenses. Thus, "spend down" requires a person to use any income above the medically needy standard for the cost of care, but at that point, MA pays for any additional medical costs.

Divestment restrictions are intended to prevent individuals with adequate resources from avoiding some liability for the cost of their medical care in a medical or nursing facility or other long-term care services that would unnecessarily result in greater state and federal MA costs. In other words, these restrictions are intended to prevent individuals from disposing of their assets for less than market value in order to become eligible for MA. Although these restrictions do not affect eligibility for most MA card services, a person may not be eligible to receive nursing home care and personal care if he or she violates MA divestment restrictions.

Divestment penalties under MA are only applied for divestments made within 36 months (60 months for actions involving trusts) before the person applies for MA or participates in services, whichever is later. If a divestment is made during this "look-back" period, a person loses eligibility for long-term care services for a number of months equal to the amount of the divestment divided by the average monthly cost of nursing home care.

A more thorough description of MA eligibility standards is presented in Informational Paper #42 prepared by the Legislative Fiscal Bureau, entitled "Medical Assistance and BadgerCare."

**Services**

All MA enrollees are eligible for the following MA card services if they need these services.

**Home Health.** Home health agencies provide a variety of services in an individual's home, including: (a) home health services provided by nurses and aides; (b) therapy services provided by physical therapists, occupational therapists and speech and language pathologists; (c) private duty nursing services; (d) respiratory care services; and (e) personal care services.

Home health nursing services are medically necessary, skilled nursing services provided in the home of an individual who requires less than eight hours of direct, skilled nursing services per calendar day. In determining whether or not a service requires the skills of a registered nurse or licensed practical nurse, the complexity of the service, the condition of the enrollee and the accepted standards of medical and nursing practice are considered.

Home health aide services provided in the enrollee's home are services that are needed to maintain the individual's health or to facilitate treatment of his or her medical conditions. These services must include at least one medically necessary, medically-oriented task per visit that a home health aide can safely perform and cannot be safely delegated to a personal care worker. Examples of "medically-oriented tasks" include simple dressing changes and taking vital signs.

Skilled therapy services performed by physical therapists, occupational therapists and speech and language pathologists are covered as a home health service and provided in the enrollee's home under certain conditions. For example, such services must be reasonable and necessary within the context of the enrollee's medical condition, and be considered, under accepted standards of medical practice, specific and effective treatment for the individual's condition or for the restoration or maintenance of an individual's function.

Private-duty nursing services are medically necessary skilled nursing services for an individual who requires eight or more hours of direct, skilled nursing services per day.

Respiratory care services for ventilator-dependent individuals residing at home are eligible home health services. These services must be performed by registered nurses, licensed practical nurses or respiratory therapists.

All home health services must be provided in accordance with orders from the enrollee's physician in a written plan of care. The plan must be reviewed by the physician at least every 62 days or when the enrollee's medical condition changes, whichever occurs first.

Most home health services require prior authorization from DHFS before the MA enrollee receives the service or after the enrollee reaches a specified service threshold. For example, prior authorization is required for all private duty nursing services and for home health visits when the total number of visits by all providers exceeds 30 visits in a calendar year. When a prior authorization request is submitted to DHFS, the services are evaluated based on medical necessity. DHFS can approve, modify or deny a prior authorization request. Enrollees may appeal any prior authorization request that DHFS modifies or denies.

**Personal Care.** Personal care services are medically-oriented activities that assist individuals with activities of daily living and that are necessary to maintain the individual in his or her place of residence. MA enrollees may only receive these services under the written orders of a physician. Covered personal care services include activities of daily living, such as assistance with bathing, toileting, dressing, meal preparation and accompanying an individual to obtain medical diagnosis and treatment.

Once an enrollee receives 50 hours of personal care services in a calendar year, any additional hours may be provided to the enrollee after the provider receives prior authorization. DHFS rules

specify other restrictions relating to personal care services. For example, personal care services do not include supervision of a patient.

**Transportation.** Under Wisconsin's MA program, enrollees may receive three modes of transportation services: (a) ambulance; (b) specialized medical vehicle (SMV); and (c) public common carrier or private motor vehicles.

If an individual requires emergency transportation, he or she may be transported by ambulance, usually to a hospital. In addition, an ambulance may be used to transport an individual to other destinations if he or she has a significant medical condition or a need for medical monitoring that cannot be provided by a common carrier, private motor vehicle or SMV. For example, an individual on a life-support system may be transported by ambulance.

Individuals who are indefinitely disabled or blind and who are unable to take public common carrier or private motor vehicle transportation may use SMVs if the purpose of the trip is to receive covered MA services. An "indefinite disability" is defined by DHFS as a physical or mental impairment that includes an inability to move without personal assistance or mechanical aids, such as a wheelchair, walker or crutches or a mental impairment that prohibits the individual from using common carrier transportation reliably or safely. A physician must prescribe all transportation services provided by SMVs.

Counties, through contracts with common carriers and private motor vehicles, provide transportation services for ambulatory clients. Such services may be provided by buses, trains, taxis and, in rare instances, airplanes. In providing these services, counties must use the least expensive means the individual is capable of using and that is reasonably available at the time the service is required. These services are covered only after a county department of human services approves the service.

All transportation card services may only be used to transport individuals to or from a medical visit.

**Medical Supplies and Equipment.** Certain disposable medical supplies (DMS) and durable medical equipment (DME) prescribed by physicians are covered when they are supplied by particular providers.

Medical supplies are disposable, consumable, expendable or nondurable, medically necessary items with a very limited life expectancy. Examples include dressings, catheters and continence supplies. Payment for medical supplies ordered for a patient in a hospital or nursing home is considered part of the institution's base cost and is therefore not billed directly by the provider.

Durable medical equipment means medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment and prostheses. All DME services, including purchases, rentals and repairs must be prescribed by a physician, podiatrist, nurse practitioner or chiropractor. The item must be necessary and reasonable for treating an illness or injury or for improving the function of a malformed body member. Most DME services, including the purchase of wheelchairs, wheelchair accessories and hospital beds, require prior authorization. In cases where DHFS determines that a piece of equipment will be needed on a short-term basis, equipment is rented, rather than purchased, for the client.

MA card services do not provide coverage for lift chairs, ramps, communication aids or home modifications, such as widening of doorways to accommodate wheelchairs or modifying bathroom or kitchen equipment to accommodate non-ambulatory individuals.

**Mental Health Services.** Wisconsin's MA program provides coverage for a variety of day treatment, outpatient psychotherapy and alcohol

and other drug abuse (AODA) services.

Outpatient psychotherapy services are a covered MA service under certain conditions. For example, a physician must prescribe these services after an individual has had a differential diagnostic evaluation performed by a certified psychotherapy provider. Enrollees may receive services in a provider's office, a hospital or hospital outpatient clinic, an outpatient facility, a nursing home or a school.

Adult medical (mental health) day treatment is a non-residential program in a medically-supervised setting that provides case management, medical care, psychotherapy and other therapies, to alleviate problems related to mental illness. Day treatment services are provided by an interdisciplinary team and may include training in basic living skills, interpersonal skills and problem solving. The intensity and length of services may vary depending on whether the individual requires acute stabilization, rehabilitation or longer term maintenance services. However, MA does not reimburse day treatment in excess of five hours per day. Prior authorization is required for day treatment beyond 90 hours in a calendar year.

Outpatient AODA services are covered by MA when they are prescribed by a physician. In order to qualify for these services, an enrollee must have a complete medical evaluation and the supervising physician or psychologist must develop a treatment plan that relates to behavior and personality changes being sought and the expected outcome of treatment. Services are performed in provider offices, a hospital or hospital outpatient clinic, an outpatient facility, a nursing home or school. Prior authorization is required for both outpatient psychotherapy and AODA treatment services that exceed established limits.

AODA day treatment services are services for individuals with a demonstrated need for structured, intense treatment not available through outpatient counseling. AODA day treatment consists of medically-prescribed treatments provided by AODA and related medical professionals in a non-residential medically-supervised outpatient setting. Services are covered if, after conducting an initial assessment, a qualified medical professional finds that these services are medically necessary and that the enrollee would benefit from treatment. MA does not reimburse treatment services that exceed five hours per day. Prior authorization is required for all AODA day treatment services except the initial assessment.

**Community Support Program.** Community support programs (CSPs) provide individuals with chronic mental illness treatment, rehabilitation and support services. Enrollees receive these services in the community, rather than in institutions or clinics. Covered services include: (a) assessment and treatment planning; (b) services provided to assist individuals in hospitals or nursing homes in making a transition to community living; (c) psychiatric services; (d) medication prescription and administration; (e) symptom management; (f) case management; (g) employment-related skill training; (h) psychosocial rehabilitation; and (i) group therapy. CSP services may be provided by counties or agencies under contract with counties that meet requirements established by rule. Counties are responsible for providing the state matching funds for MA covered CSP services.

**Case Management Services.** Case management services assist individuals in accessing, coordinating and monitoring an array of services, including services covered by MA and those provided under other programs. Case management providers are required to perform a written comprehensive assessment of a person's abilities and needs. Following the assessment, providers develop a case plan to address the needs of the client that would enable him or her to live in the community.

MA enrollees receive case management services from qualified private, nonprofit agencies and

public agencies. MA pays providers a uniform, contracted hourly rate. The MA program pays the federal share of this rate; case management agencies must provide the state MA match by using funding provided through other programs, such as the local tax levy, community aids, community options program, family support program or Alzheimer's caregiver support funds.

Table 3 summarizes the MA card services that individuals who require long-term care services frequently use and describes some of the limitations of these services.

MA enrollees are entitled to receive MA card services and may not be placed on waiting lists for these services. However, an individual's access to these services depends on providers' willingness to accept MA rates. In addition, some services require prior authorization to ensure that individuals receive only the services they need. However, services cannot be denied to an MA enrollee based on the availability of funding. Funding for MA card services is budgeted to meet projected costs. Since all MA card services are funded from the MA benefits appropriations that support all MA-covered services, overspending for some card service may be offset by underspending in other MA service categories.

Table 4 shows spending for MA long-term care card services in each year from 1994-95 through 2001-02. Some of these costs were incurred by individuals with acute care needs that used long-term care services on a temporary basis. The table shows that the growth in these expenditures over the 1994-95 to 2001-02 fiscal years averaged 7.5% per year. During this period, the average growth in spending for personal care and outpatient mental health services was significantly greater, 16% per year and 16.3% per year, respectively.

## MA Community-Based Waiver Programs

Federal law permits states to offer medical and support services that are not covered as MA card services to certain groups of MA enrollees under MA community-based waiver programs. Examples of these services include supportive home care services that are significantly broader in scope than MA personal care services, home modifications, adaptive aids, transportation services to nonmedical destinations, adult day care and supportive services provided by community-based residential facilities (CBRFs) and other services requested by the state and approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which administers the MA program at the federal level.

Potential waiver participants are evaluated to determine the level of care they require, including whether they would otherwise require care in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR). Individuals who meet the level of care requirements must be informed of the availability of the MA-waiver services, but cannot be required to participate in MA-waiver programs. Under federal regulations, MA waiver participants may be either relocated or diverted from institutions.

In order to obtain a federal MA home- and community-based services waiver from CMS, a state must demonstrate that the care it will provide for individuals under the waiver will reduce MA expenditures, or, at a minimum, be cost neutral.

The projected average per capita cost for individuals receiving services under a waiver must not exceed the costs that would have been incurred for the same group of individuals had the waiver not been granted. A state may exclude individuals from the waiver for whom the cost of waiver services is likely to exceed the cost of

| Table 3: Long-Term Care Services Available as MA Card Services | | |
|---|---|---|
| **Service** | **Description** | **Major Limitations** |
| Home Health | Medically necessary nursing and therapy services provided by nurses, nurse aides and therapists. | 1. Care must be provided in home.<br><br>2. Prior authorization by DHFS often required. |
| Personal Care | Medically-oriented activities related to assisting a person with activities of daily living, such as bathing, eating, dressing and toileting. | 1. Does not provide for supervision.<br><br>2. Cannot be used to provide assistance for attendance of social activities (only medical appointments). |
| Medical Supplies and Equipment | Certain disposable medical supplies (DMS) and durable medical equipment (DME) when prescribed by a physician and when supplied by particular providers. | 1. Home modifications, such as ramps, or equipment used to improve functioning, such as computers to aid communication, are not covered. |
| Transportation | Ambulance services when a person requires emergency transportation to a hospital. Also, specialized medical vehicle (SMV) and public common carrier or private motor vehicle services to take person to a medical appointment. | 1. Transportation for non-medical activities are not covered (social activity or working activity). |
| Mental Health Services | Includes outpatient psychotherapy services, adult day treatment, which is a non-residential program providing case management, medical care, psychotherapy and other therapies up to five hours a day, outpatient AODA services, AODA day treatment (up to five hours a day), in-home psychotherapy services for children with severe emotional disturbance (SED), and day treatment for children with SED (up to five hours a day). | |
| Community Support Program (CSP) | A comprehensive program for community-based mental health services for individuals with chronic mental illness. Services include case management services and employment-related skill training. | 1. Not offered by every county. |
| Case Management Services | Assistance in accessing, coordinating and monitoring an array of services, including services covered by MA and services provided under other programs. | 1. Not available to all MA enrollees that need long-term care. Limited to a person who: (a) is over 65 years of age; (b) has a developmental disability; (c) has an HIV infection; (d) has a chronic mental illness; (e) has Alzheimer's disease; (f) is alcoholic or drug dependent; (g) is physically disabled; (h) is a child with severe emotional disturbance; (I) is infected with tuberculosis; (j) is a child eligible for early intervention services; or (k) is a child with asthma; and (l) is a member of a family that has a child at risk of physical, mental, or emotional dysfunction.<br><br>2. Not offered by every county. |

**Table 4: Expenditures for Long-Term Care MA Card Services -- Fiscal Years 1994-95 through 2001-02**

| | 1994-95 | 1995-96 | 1996-97 | 1997-98 | 1998-99 | 1999-2000 | 2000-01 | 2001-02 | Average Annual % Chg. over Entire Period |
|---|---|---|---|---|---|---|---|---|---|
| Personal Care | $36,862,000 | $37,847,700 | $48,370,100 | $62,214,100 | $66,951,700 | $73,576,300 | $101,713,500 | $104,337,800 | 16.0% |
| Home Health | 54,188,000 | 50,408,700 | 49,410,100 | 51,413,800 | 56,026,600 | 59,622,100 | 59,122,500 | 59,458,300 | 1.3 |
| Durable Medical Equipment & Supplies | 35,412,500 | 33,488,500 | 32,311,400 | 29,967,500 | 30,721,700 | 31,596,500 | 33,505,900 | 34,162,700 | -0.5 |
| Non-emergency Transportation | 28,585,300 | 29,681,000 | 31,589,700 | 28,783,900 | 25,800,500 | 24,305,900 | 22,262,500 | 21,130,200 | -4.2 |
| Mental Health | 16,156,800 | 17,660,400 | 19,140,400 | 23,293,900 | 27,663,500 | 34,508,500 | 40,130,400 | 46,633,500 | 16.3 |
| CSP | 7,641,800 | 8,748,300 | 9,726,400 | 12,568,500 | 13,291,000 | 14,326,400 | 17,572,800 | 18,220,200 | 13.2 |
| Case Mgmt. | 8,212,500 | 8,184,800 | 7,484,300 | 9,125,500 | 8,210,000 | 8,288,000 | 9,079,900 | 17,544,500 | 11.5 |
| TOTAL | $187,058,900 | $186,019,400 | $198,032,400 | $217,367,200 | $228,665,000 | $246,223,700 | $283,387,500 | $301,487,200 | 7.5% |
| % Change from Previous Year | 9.8% | -0.6% | 6.5% | 9.8% | 5.2% | 7.7% | 15.1% | 6.4% | |

institutionalization. States must also provide assurances that safeguards are in place to protect the health and welfare of waiver participants.

Waivers are granted for an initial period of three years. CMS usually renews waivers for five-year periods.

Under four federal MA waivers, Wisconsin operates six programs to reduce the number of individuals who would receive long-term care services in nursing homes or institutions. These programs are the community options waiver program (COP-W), the community integration programs (CIP IA, CIP IB and CIP II), the brain injury waiver (BIW) and the community supported living arrangements waiver (CSLA). By administering several different waiver programs, the state can tailor services and county reimbursement rates to the target group or groups served by each program.

There are two MA waiver programs that provide services to elderly and physically disabled individuals -- COP-W and CIP II. Both programs provide the same services, but differ in the requirement for nursing home bed closures and the way new slots are created. COP-W is intended to divert individuals from nursing homes, as well as to relocate nursing home residents, and so, COP-W does not require that a nursing home bed be closed before a new slot is created. DHFS allocates funding the Legislature authorizes for the program to counties to support as many placements as the county can support with its allocation. In contrast, DHFS does not allocate new slots to a county under CIP II unless a nursing home bed is closed. If DHFS provides a county a CIP II slot, it reimburses the county up to $41.86 per day to support services for the individual in that slot.

Individuals who are developmentally disabled receive services under three MA waiver programs: (a) the community integration IA program (CIP IA): (b) the community integration IB program (CIP IB); and (c) the community supported living arrangement (CSLA) waiver. The CIP IA program supports services to individuals who formerly resided at one of the three state centers for the developmentally disabled (Northern Center in the City of Chippewa Falls, Central Center in the City of Madison and Southern Center near the Village of Union Grove). The creation of a CIP IA slot requires that, following a CIP IA placement, a bed at a state center be held vacant for 360 days and then closed. Since individuals relocated from the state centers often have very high-care needs, the state currently reimburses counties up to $225 per

day to provide services for individuals placed under the CIP IA program.

The CIP IB program provides funds to counties to support services for individuals with developmental disabilities who formerly resided at, or were diverted from intermediate care facilities for the mentally retarded (ICFs-MR) other than the three state centers. The state supports and allocates to counties a number of slots that do not require a closed bed, and reimburses counties up to $49.67 per day to fund services for program enrollees. In addition, DHFS may support additional slots when a bed closes at an ICF-MR, and pays an enhanced rate if the facility is closing or has on file a DHFS-approved plan for significant downsizing over five years. If state-supported slots are insufficient, a county may create "locally-supported" slots by supplying the state's 41% match under MA with county funds.

The CSLA program provides an option for individuals to design and manage their own care. Individuals who are developmentally disabled are eligible for CSLA if: (a) the person or guardian, through a person-centered planning process, identifies and chooses the supports and services that best meet the individuals needs; and (b) the individual lives in his or her own home where the setting is controlled by the person or guardian and not a service provider. The CSLA waiver program provides services to both children and adults and is a federal/local match program similar to locally matched slots in CIP IB. Counties may use a variety of funding sources to provide the required local matching funds, including community aids, COP-R funds, funds available under the family support program and county property taxes.

Individuals who are substantially disabled due to a brain injury and receive, or are eligible for, post acute rehabilitation care may receive community services under the brain injury waiver (BIW) program. Counties receive up to $180 per day to provide services for program enrollees. There are a limited number of slots in this program, which DHFS allocates to counties based on individual cases. These slots are reserved for diversions or relocations of individuals from institutions that provide post acute rehabilitation care.

Table 5 summarizes the various MA waiver programs, including target groups, payment rates and other special provisions.

**Eligibility**

Individuals may become eligible for MA waiver programs by meeting both financial and nonfinancial eligibility criteria.

**Nonfinancial Criteria.** In addition to the MA financial eligibility criteria, individuals must meet nursing home level of care requirements in order to qualify for the state's MA waiver programs. The services available under the MA waiver programs are intended to substitute for nursing home care and thus, are only available to individuals who require that level of care**.**

**Financial Criteria.** Several provisions of MA law relating to eligibility for nursing home (institutional) care are also applicable to the MA waiver programs.

*1. Special Institutional Income Limit.* The special institutional income limit enables states to provide nursing home and MA waiver services to individuals with income between 100% to 300% of the applicable SSI payment level. Wisconsin provides coverage to individuals with income up to 300% of the SSI payment, which is $1,656 per month in calendar year 2003. Because Wisconsin provides coverage to the medically needy for nursing home and MA waiver services, this special institutional income limit does not extend coverage beyond individuals who would be eligible under the MA medically needy standard. However, under the waiver programs, the amount of income that can be retained for living expenses, such as rent and food, is greater for someone who qualifies

| Table 5: MA Community-Based Long-Term Care Waiver Programs | | | | |
|---|---|---|---|---|
| **Program/Program Abbreviation** | **Target Group(s)** | **Tied to Closure of Nursing Home Bed?** | **Other Special Provisions** | **Maximum Daily Reimbursement Rate as of January 1, 2003** |
| Community Options Waiver (COP-W) | Elderly and Physically Disabled | No | | Counties are allocated funding, rather than slots. |
| Community Integration II (CIP II) | Elderly and Physically Disabled | Each new slot requires that a nursing home bed be closed. | | $41.86 |
| Community Integration IB (CIP IB) | Developmentally Disabled | The state provides a number of slots that do not require a bed closure but bed closures can create additional slots. | | $49.67 for regular slots but an enhanced rate for certain closed beds. |
| Community Integration IA (CIP IA) | Developmentally Disabled | A new slot can be created only by relocating a resident from one of the state centers and closing a bed at a state center. | | $225 (placements made on and after 7-1-02). |
| Community Supported Living Arrangement (CSLA) | Developmentally Disabled | No | 1. County must supply the state MA match of 41%.<br>2. Recipient / Guardian directed care. | Locally funded. |
| Brain Injury Waiver (BIW) | Brain-Injured | No, but new slots are reserved for diversions or relocations of individuals from post acute rehabilitation care in an institution. | | $180.00 |

under the special institutional income limit than for someone who is eligible for MA services, based on the medically needy criteria.

*2. Spousal Impoverishment*. Spousal impoverishment protections affect legally married couples in cases where one spouse ("the institutionalized spouse") receives nursing home services or services provided under an MA waiver while the other spouse ("the community spouse") does not. The protections allow the community spouse to retain a portion of the couple's income and assets. The spousal impoverishment protections are the same whether the institutionalized spouse receives services in a nursing home or under an MA waiver program.

The amount of assets protected for the community spouse is based on the amount of assets the couple has at the time a married person enters a nursing home or begins receiving MA waiver services. Federal law provides states discretion in establishing the asset protection level, but establishes some limits. Wisconsin's asset limit is in the mid-range of these limits. Wisconsin's spousal asset protection level is the greater of: (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum ($90,660 in 2003). In addition to the assets protected for the community spouse, the institutionalized spouse may retain $2,000 of assets. An individual must expend any countable assets in excess of these protected amounts before he or she can become eligible for MA.

Once the person meets the asset test, he or she must still meet income limits to qualify for MA coverage. One way that the spousal impoverishment provisions protect the community spouse is that only the income that is in the institutionalized spouse's name counts in determining eligibility for MA. Income that is in the name of the community spouse does not have to be used for the cost of care for the institutionalized spouse, nor does it prevent the institutionalized spouse from being eligible for MA-funded long-term care services.

In addition, spousal impoverishment protections may allow the institutional spouse to transfer some income to the community spouse to provide an adequate income for the community spouse. Again, federal law provides states some discretion in the amount that the institutional spouse can transfer, but does establish limits. Wisconsin establishes its income allowance between the federally-established minimum and maximum amounts. Specifically, Wisconsin's income allowance is the sum of: (a) 200% of the federal poverty level ($1,990 per month in 2002); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the state's standard (shelter costs in excess of $597 per month in 2002). In addition, Wisconsin allows an additional transfer of income (up to $497.50 per month in 2002) for each qualifying dependent family member that lives with the community spouse.

The spousal impoverishment protections allow a couple, where one spouse needs long-term care, to retain significantly more resources and income than an individual MA enrollee could retain. Because spousal impoverishment protections are not available to MA enrollees in the community who only receive MA card services, a couple that wishes to receive long-term care for one member only through MA card services is at a significant disadvantage compared to a couple where one member participates in a MA waiver program.

*3. Personal Needs Allowance.* A third way in which the financial criteria for the MA waiver programs differ from the criteria for other MA recipients is that, for individuals who qualify under the special institutional income limit but do not receive SSI, a greater amount of income can be retained for rent, food and other living expenses (the "personal needs allowance") than can be retained by someone who only receives MA card services, based on either categorically or medically needy MA eligibility criteria. In 2003, under the MA waiver programs, the personal needs allowance ranges from $732 to $1,114 per month. The actual personal needs allowance for any individual is calculated as the sum of the following three components: (a) the basic needs allowance of $732 per month; (b) an earned income deduction of the first $65 of earned income plus one-half of the remainder; and (c) an allowance for excess housing costs if such costs are above a certain level ($350 per month in 2003). Both MA card enrollees and MA waiver enrollees can use the earned income deduction, but the excess housing allowance is not available to MA card enrollees and to MA waiver enrollees who spend down. In addition, medically needy recipients (both MA card and MA waiver enrollees) were required to spend down to $592 per month in 2003 after the earned income deduction, an amount that is less than the basic needs allowance of $732 per month.

SSI enrollees are not treated differently with respect to income that can be retained for living expenses, since SSI enrollees are not subject to any cost-sharing for MA, regardless of whether they receive MA card services or participate in an MA waiver program. The SSI program generally allows an enrollee to retain $732 per month plus the earned income deduction for living expenses.

**Services**

Table 6 lists the services that are available under COP-W, CIP IA, CIP IB and CIP II. Unless noted in the table, all of these services are available to clients in each of these MA waiver programs.

Table 6 shows that the MA waiver programs offer some services not provided as MA card services and other services that are broader in scope than the comparable MA card services. In addition to providing services to meet medical concerns, the MA waiver programs include services to: (1) provide supervision (part of supportive home care); (2) address social concerns (adult day care and day services and treatment); and (3) improve independent functioning (adaptive aids, communication aids, daily living skills training, home modifications and transportation to community services for that purpose). The vocational futures program was added as an allowable employment service for COP-W and CIP II participants as of July 1, 2002. The CIP IA and CIP IB waiver programs offer services to enrollees to develop job skills and to obtain employment (prevocational services and supported employment services).

**Funding**

Unlike MA card services and nursing home care, which are entitlements to all individuals who qualify for such services, the amount of MA community-based waiver services available to qualifying individuals is limited by state and county budgets. As a result, eligible individuals can be, and often are, placed on waiting lists for these programs. Depending on the program, availability is limited by the allocation of state-funded slots (or placements) or by the requirement that a nursing home bed be closed before a new slot is created. This section describes funding for services provided under the MA community-based waiver programs, other than COP-W. COP-W funding is discussed elsewhere in this paper.

**CIP IA.** DHFS allocates funding to counties under CIP IA when a resident of one of the three state centers for the developmentally disabled is relocated to the community. When a CIP IA slot is created, a bed must be closed at one of the state centers. In the 2002-03 fiscal year, DHFS provided counties a maximum average per day allowance ranging from $125 for each person relocated from the centers before July 1, 1995 to $225 for each person placed on or after July 1, 2002. For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed for approximately 59% of the difference between the state rate and the actual costs of providing the service as long as the average cost of CIP IA placements statewide does not exceed the average cost of care at the centers, which was estimated to be $382.70 per day in 2001.

As of December 31, 2002, 1,095 individuals were participating in CIP IA. For calendar year 2001, MA expenditures for CIP IA services totaled $64,576,200 (all funds), including $22,924,900 GPR.

The county in which the person relocates receives the CIP IA slot to finance the services in the community. If the CIP IA participant dies, the county retains the CIP IA slot to fund community services to other individuals with developmental disabilities. In order to maximize funding, a county would likely shift higher cost clients to the vacant CIP IA slot, since the maximum rate for CIP IA slots is much higher than the maximum rate for CIP IB slots.

**CIP IB.** A CIP IB slot can be created in three ways. First, the Legislature provides funding to support some CIP IB slots, which DHFS allocates to counties. These slots do not require a closing of an ICF-MR bed.

Second, CIP IB slots may be created following the closure of an ICF-MR bed. Bed closings free up funding that would otherwise be spent for institutional care to instead fund services provided under CIP IB.

In 2002-03, the maximum average per day allowance for state reimbursement under CIP IB is $49.67, although a higher CIP IB rate applies for placements from facilities that close or that file a DHFS-approved plan for significant downsizing or closure within a five-year period. The enhanced

| Table 6: Services Funded by the MA Waiver Programs | |
|---|---|
| **Service** | **Description** |
| Adaptive Aids | Devices, controls, appliances or supplies to enhance a person's ability to perform activities of daily living or to increase independent functioning, such as van lifts or specially adapted locks. |
| Adult Day Care | Services, including personal care, supervision, some meals, medical care, activities to meet physical, social, emotional, health or leisure needs, provided in a group setting for part of the day. |
| Adult Family Home | Care and maintenance above the level of room and board, but limited nursing care, provided to one to four residents by a person whose primary domicile is that residence. |
| Case Management | Locating, managing, coordinating and monitoring all proposed services and informal community supports needed by clients and their families. |
| Communication Aids | Devices or services necessary to help individuals with hearing, speech or vision impairment to communicate. |
| Community-Based Residential Facility (20 Beds or Fewer) | Care, treatment and services above the level of room and board, but limited nursing services, that are provided in facilities with at least five residents unrelated to the owner. Eligible CBRFs are limited to facilities with 20 or fewer beds (COP-W and CIP II), 8 or fewer beds (CIP IA and CIP IB) or facilities that consist entirely of independent apartments. |
| Consumer Directed Supports (CIP IA, CIP IB and CSLA) | Services that provide support, care and assistance to an individual with a disability. |
| Consumer Training and Education (CIP IA, CIP IB, and CSLA | Instruction to develop self-advocacy skills, exercise civil rights and acquire skills to exercise control and responsibility over other support services. |
| Counseling and Therapy | Treatment for a personal, social, behavioral, mental or alcohol or drug abuse disorder to maintain and improve effective functioning. |
| Daily Living Skills Training | Training that includes family maintenance skills, money management, home care maintenance, food preparation and using community resources for clients with inadequate skills in daily living tasks. |
| Day Services and Treatment | Services that are typically provided for four or more hours per day and five days per week in a non-residential setting to enhance social development and the skills of daily living and community living. Primarily intended for individuals with physical and developmental disabilities. |
| Foster Care | Provision of a substitute family for one to four children on a 24-hour basis. |
| Home Delivered Meals (COP-W and CIP-II only) | Provision of meals to homebound individuals at risk of institutional care due to inadequate nutrition. |
| Home Modifications | Modifications to a client's residence to ensure safety, security, accessibility and the maximum degree of independent functioning. |
| Housing Counseling (CIP IA, CIP IB & CSLA only) | Assistance in acquiring housing in the community. |
| Nursing Services (COP-W and CIP-II only) | Medically necessary skilled nursing services not covered as an MA card service. |
| Personal Emergency Response Systems | A direct link to health professionals to secure immediate assistance by the activation of an electronic communications unit in the client's home. |
| Prevocational Services (CIP IA and CIP IB Only) | Teaching and activities to prepare a person for paid or unpaid employment, such as work directions and routines, mobility training, interpersonal skills development and transportation to and from work. |
| Protective Payment or Guard-ianship Services (CIP II and COP-W Only) | Managing the client's money or supervising the client's use of funds. |
| Residential Care Apartment Complex (COP-W and CIP-II only) | Residence for five or more adults that consists of independent apartment and provides not more than 28 hours per week of supportive, personal and nursing services. |
| Respite Care | Short-term services to relieve the person's family or other primary caregiver from daily stress and care demands. |
| Supported Employment Services (CIP IA and CIP IB Only) | Individualized assessments, job development and placement, on-the-job training, performance monitoring and related support and training to enhance employment. |
| Supportive Home Care | Assistance with daily living, attendant care, supervision, assistance with medication and medical procedures which are normally self-administered, mobility and exercise, assistance with grooming, bathing and dressing and chore services. |
| Vocational Futures Planning Services (COP-W and CIP II only) | Identifies barriers to employment, and provides benefits analysis, career exploration, job seeking support, resource team coordination, and ongoing support. |

rate is determined by a formula that is related to the facility's MA reimbursement rate, and the enhanced rate is 10% less if the facility is only downsizing or does not plan to close within a year. For county costs in excess of state reimbursement, federal matching funds can be claimed for costs up to a maximum of the average cost of care in an ICF-MR (estimated to be $134.97 per day in 2001). There were 2,291 state-funded slots budgeted for 2002-03, of which 118 were budgeted at an enhanced rate.

Third, counties can create CIP IB slots by funding the required state MA match for these slots. Counties can use COP-R funds for the state match as well as community aids or local property tax levies. As of December 31, 2002, there were 8,592 CIP IB participants.

In calendar year 2001, MA expenditures for waiver services for CIP IB participants totaled $153,582,200 (all funds), including $19,128,300 GPR.

The allocation of new CIP IB slots depends on how they are created. DHFS allocates new, state-funded slots that do not result from a bed closure to counties based on need. Since a small number of these slots have been authorized in recent years, these slots are reserved for individuals where institutionalization is imminent. DHFS usually provides slots created by bed closings to the county in which the facility is located. There are two exceptions to this rule. First, if the facility is a regional facility, with at least 10% of the residents originating from other counties, DHFS awards these slots to the county of origin based on the proportion of residents from the county. Second, counties with significant unused MA waiver resources do not receive additional slots until they can demonstrate the need for additional resources.

Counties may create as many locally-supported CIP IB slots as they wish. As long as the county provides the state match of 41%, the state will submit the claim for federal matching funds. Because of the availability of federal matching funds, counties have an incentive to use locally supported CIP IB slots whenever possible. Using COP-R funds, community aids or local tax levies to support CIP IB slots expands the number of individuals who can be served by those funds and reduces county waiting lists.

**CSLA.** The community supported living arrangement (CSLA) waiver is a federal/local match program similar to locally matched CIP IB slots. Counties may use a variety of funding sources to provide the required local matching funds, including community aids, COP-R funds, funds available under the family support program and county property taxes. In calendar year 2001, counties expended $800,800 FED and $553,900 in county funds for these services). On December 31, 2002, there were 224 active participants in the program.

**BIW.** The brain injury waiver (BIW) does not require a nursing home bed closing for creation of a new slot. Instead, the number of available slots is established as part of the state budget. In 2002-03, the maximum reimbursement rate provided to counties was $180.00 per day Expenditures under the BIW totaled $13,655,300 (all funds) in calendar year 2001. On December 31, 2002, there were 257 BIW participants.

Because of the limited number of slots, any new or available BIW slots are reserved for MA enrollees who receive care in certified units for brain injury rehabilitation and who will be relocating to the community. Currently, those units are Clearview North at Dodge County Health Care Center in Juneau, Wisconsin and the Neurobehavioral unit at Sacred Heart Hospital in Milwaukee. Because of the limited number of slots, counties may not retain a BIW slot if an enrollee dies.

**CIP II.** CIP II slots can be created following the closing of a nursing home bed. If the bed that is closed is in a private facility, the slot may only be

created if the individual is relocated to the community from the closed bed. However, this relocation requirement does not apply if the total number of closed beds is equal to or less than the number of bed closures projected as part of the state budget. The maximum reimbursement rate on average, for CIP II slots is $41.86 per day for 2002-03. Similar to other MA waiver programs, counties can receive federal matching funds for costs in excess of this maximum. In 2002-03, 2,728 slots were budgeted for counties. In calendar year 2001, MA expenditures for CIP II waiver services totaled $38,933,800 (all funds), including $15,807,100 GPR.

DHFS usually distributes new CIP II slots to the county in which the facility with the closed bed is located. There are two exceptions to this general policy. First, if the facility is a regional facility with at least 10% of the residents originating from other counties, DHFS awards the CIP II slots to the counties of origin based on the proportion of residents from the county at the time of the most recent nursing home survey. Second, a county with significant unused MA waiver resources does not receive additional CIP II slots unless the county demonstrates a need for additional resources. DHFS makes these slots available to other counties until the county where the facility beds closed has used all of its available resources. The new CIP II slots are then awarded as they are freed up in the counties that received the loan slots.

Table 7 provides information on the number of slots and funding provided for these MA waiver programs (except COP-W) for calendar years 1994 through 2001. The table shows that, in recent years, there has been substantial growth in the MA waiver programs.

**Service Restrictions**

Although the services available under the MA waiver programs are more comprehensive than MA card services, some services required by individuals are not available under MA waiver programs. In addition, some restrictions apply to service providers. First, the MA waiver programs cannot fund the costs of room and board, even in cases where an individual is living in a CBRF or adult family home. Recipients must use other income, such as supplemental security income (SSI) payments and social security payments, to support these costs. Second, other items, such as a security deposit for the apartment, telephone and some medical services, cannot be covered under the MA waiver programs. Further, MA waiver services cannot be provided until the person has been certified as eligible under MA or while that individual is still residing in an institution. Consequently, MA funding is not available immediately for certain pre-relocation services, such as home modifications, while the person is in an institution. For someone who requires services immediately, MA funding may not be available, although retroactive payments can be made once MA eligibility is certified. In addition, a variance is required to use COP-W and CIP II funding to support services provided in CBRFs with more than twenty units. However, this restriction does not apply to CBRFs with independent apartments.

General limitations for the MA waiver programs may also preclude some arrangements for the care of the enrollee. For example, these programs cannot fund eligible services provided by spouses or parents. In some cases, the spouse or parent may be an ideal caregiver, but cannot afford to provide the care without compensation. Another restriction is that counties have limits on the average amount of expenditures for program clients. Thus, although a service may be eligible for reimbursement under an MA waiver program, a county may not provide the service if the provision of the service would increase average county costs above this limit.

Several other restrictions apply to the MA community-based waiver programs, as described below.

**Table 7: MA Community-Based Long-Term Care Waiver Programs (Excluding COP-W) Calendar Years 1994 through 2001**

| Program / Target Group | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|---|
| **CIP II** | | | | | | | | |
| Expenditures | $22,500,000 | $20,784,300 | $25,634,100 | $28,436,900 | $28,319,000 | $31,280,000 | $36,119,400 | $38,933,800 |
| Number of Participants | 1,583 | 1,735 | 1,828 | 2,005 | 2,165 | 2,516 | 2,796 | 2,970 |
| Max. Reim. Rate per day | $40.38 | $40.78 | $40.78 | $40.78 | $40.78 | $40.78 | $40.78 | $40.78 |
| **CIP IA** | | | | | | | | |
| Expenditures | $29,346,300 | $34,595,700 | $42,309,000 | $45,716,300 | $55,619,900 | $63,407,100 | $67,125,200 | $70,464,000 |
| Number of Participants | 693 | 795 | 846 | 938 | 1,004 | 1,068 | 1,115 | 1,130 |
| Max. Reim. Rate per day | | | | | | | | |
| Placed Before 7-1-95 | $96.54-$110.82 | $99.43-$115 | $115 / $125 | $125 | $125 | $125 | $125 | $125 |
| Placed 7-1-95 to 6-30-97 | | $150 | $150 / $153 | $153 | $153 | $153 | $153 | $153 |
| Placed 7-1-97 to 6-30-00 | | | | $184 | $184 | $184 | $184 | $184 |
| Placed 7-1-00 to 6-30-01 | | | | | | | $190 | $190 |
| Placed 7-1-01 to 6-30-02 | | | | | | | | $200 |
| **CIP IB** | | | | | | | | |
| Expenditures | $48,722,500 | $73,878,600 | $ 109,520,600 | $139,695,900 | $172,738,900 | $198,498,200 | $212,463,400 | $227,372,100 |
| Number of Participants | 2,270 | 3,848 | 4,806 | 6,098 | 6,397 | 7,424 | 8,849 | 9,299 |
| Max. Reim. Rate per day | $48.33 | 48.33 | $48.33 | $48.33 | $48.33 | $48.33 | $48.33 | $48.33 |
| **CSLA** | | | | | | | | |
| Expenditures | $2,931,900 | $3,594,100 | $137,200 | $618,000 | $757,300 | $1,019,200 | $1,181,300 | $1,354,700 |
| Number of Participants | 346 | 445 | 37 | 90 | 114 | 198 | 219 | 238 |
| **BIW** | | | | | | | | |
| Expenditures | | $996,900 | $3,277,100 | $5,763,100 | $8,614,100 | $10,374,900 | $11,625,800 | $13,655,300 |
| Number of Participants | | 38 | 92 | 132 | 178 | 208 | 216 | 217 |
| Max. Reim. Rate per day | | $150 | $160 | $170 | $180 | $184.19 | $180 | $180 |
| **Total** | | | | | | | | |
| Expenditures | $103,500,700 | $133,849,600 | $180,878,000 | $220,230,200 | $266,049,300 | $304,579,400 | $328,515,100 | $351,779,900 |
| Total Number of Participants | 4,892 | 6,861 | 7,609 | 9,263 | 9,858 | 11,414 | 13,195 | 13,854 |

*CIP II serves elderly and physically disabled individuals; the remaining programs serve developmentally disabled individuals or individuals with brain injuries.

**Limit on Average Expenditures Per Enrollee.** Counties are subject to two limits relating to average expenditures for MA waiver clients. Federal regulations require that MA waiver programs be budget neutral, which restricts the aggregate costs for the waiver program to an amount equal to or less than the costs that would have been incurred if those enrollees received care in an institution. States must demonstrate that expenditures under their MA waiver programs meet this budget neutrality requirement. Federal matching funds are not available for any costs that exceed this limit. Since this federal requirement applies on a statewide basis, one county can exceed the limit if other counties can offset those excess costs.

Since the MA waiver programs serve several target groups, each with different average institutional costs, the limit on average expenditures per client in each waiver program can be different. For instance, the institutional costs of providing services to residents at the state centers is much higher than the costs of providing services to residents at other ICFs-MRs. In addition, because the CIP II and COP-W programs offer services to the same target group -- the elderly and individuals with physical disabilities -- the maximum federal payment limit for both programs is the same ($41.86 per day for waiver and card

services).

In general, the federal restrictions have not been a significant problem for counties. While some counties have exceeded the limits, lower costs in other counties have usually allowed the state to meet the statewide limit and to claim federal matching funds for all county expenditures.

The more important restriction for counties is the state maximum reimbursement rate, which is typically lower than the limit for federal matching funds. For CIP IA, CIP IB, and CIP II, the state provides the state's 41% share of MA costs only for expenditures up to the state's maximum reimbursement rate. If average costs exceed the state maximum rates, counties use their own funds to support 41% of those costs. Counties often exceed the state's maximum reimbursement rates. Counties can use COP funds or community aids and county tax levies to fund the 41% share.

## Community Options Program

This section discusses the GPR-supported community options program (COP-R), including program eligibility, services and restrictions relating to the use of COP-R funds.

### Eligibility

Similar to MA card services and the MA waiver programs, individuals who apply for COP-R funded services must meet both nonfinancial and financial eligibility requirements.

**Non-Financial Eligibility.** In order for a person to receive services supported by COP-R, a person must meet at least one of five nonfinancial eligibility criteria. Specifically, the person must:

1. Require a level of care reimbursable in nursing homes under MA;

2. Meet requirements for participants in Wisconsin's program that assists counties for the cost of care for: (a) individuals who lost MA eligibility prior to July 1, 1989, because the nursing home in which they resided was determined to be institution for mental disease (IMD); and (b) individuals who replace those individuals;

3. Be a current resident of a nursing home or state center for the developmentally disabled, be MA-eligible, and be referred for community care through an inspection of patient care (a federally-required inspection of patient care review referred to as the Interdivisional Agreement 1.67 review);

4. Have a chronic mental illness and be likely to require long-term or repeated hospitalization without long-term, community support services; or

5. Be diagnosed as having Alzheimer's disease or a related illness and needs personal assistance, supervision, social and/or activity therapy services.

An individual must be a resident of Wisconsin for at least six months before he or she is eligible for COP-R services.

There are two groups of individuals that are eligible for COP-R services that are not eligible for MA waiver services: (a) individuals with chronic mental illness; and (b) individuals with early stages of Alzheimer's disease who do not require a skilled nursing level of care. Under the MA waiver programs, a person with Alzheimer's disease is only eligible if he or she requires skilled nursing care.

*Waiver Mandate.* Counties may not use COP-R funds to support waiver allowable services to certain individuals who are eligible for MA waiver services. Specifically, counties may not use COP funds to provide waiver-allowable services to any person: (1) for whom MA waiver services are available; (2) for whom MA waiver services would require less total expenditure of state funds than

would comparable services funded under COP; or (3) who is eligible for and offered MA waiver services, but chooses not to participate in the MA wavier program. These provisions are intended to maximize the total amount of federal MA funding available to the state for community-based long-term care.

The waiver mandate provision requires that counties use MA waiver funds for all waiver-allowable expenses. However, COP-R funds may be used for services that the waiver does not fund and to supplement waiver funding in those instances where the funding provided under the waiver and other available sources are insufficient to support the costs of caring for the individual in the community. In addition, counties may use COP-R funds, for a period of up to 90 days, to provide services to an individual who is eligible for waiver funding while a waiver application is processed for that individual. DHFS guidelines allow counties to exempt an individual from the waiver requirement if the individual's total state share of costs under COP-R is less than the state share of costs under the waiver. A waiver may also be granted if the individual's case plan includes waiver allowable services of minimal cost or if the individual will receive only services that cannot be supported by MA waiver funds.

**Financial Eligibility.** An individual who meets the financial eligibility criteria for MA nursing home care or one of the MA waiver programs also meets the financial eligibility criteria under COP-R. In addition, COP-R provides an alternative financial eligibility test that provides eligibility for other individuals. A person who is likely to become medically indigent within six months by spending excess assets for medical or remedial care qualifies as financially eligible under COP-R.

The formula used by DHFS to implement this six-month spend down provision compares the sum of the individual's assets, after certain exclusions, and the individual's projected income over the next six months, after certain exclusions, with the average cost of nursing home care for six months. If the sum of assets and income is less than the cost of nursing home care, the individual is financially eligible for the COP program. In 2002, DHFS used $29,193 as the average cost of nursing home care for a six-month period ($4,865.50 per month).

Many of the asset and income exclusions used for the COP-R six-month spend down test are similar to exclusions used for MA. However, some differences affect both the eligibility determination and the enrollee's cost-sharing responsibility. Under COP-R:

a. An individual does not have to deplete his or her assets immediately. Instead, one-sixth of the value of assets above the exclusion level is added to available resources for computing the enrollee's cost share.

b. Enrollees may exclude an additional $5,000 in assets.

c. The monthly income that may be excluded for general living expenses is $659 for a personal allowance, $497.50 for a dependent, and any special non-medical expenses specified in the county's cost-sharing plan. Allowances for non-medical expenses by counties varies; some counties do not allow any deductions, while other counties allow deductions for property taxes, insurance payments, high shelter costs and other items. Under MA waivers, the allowance is the sum of $732, a portion of earned income equal to $65 plus one-half of the amount in excess of $65, and a special housing amount if housing expenses exceed $350. In total, the sum of these three items cannot exceed $1,114.

Although COP-R is not part of MA, MA spousal impoverishment and the divestment provisions apply. Thus, the spouse of an individual receiving COP-R services can benefit from the same income and asset allowances applicable under the MA waiver programs. In addition,

applicants for COP-R services are subject to the same divestment restrictions that apply to the MA waiver programs. A county is required to use spousal impoverishment and divestment information in calculating financial eligibility and cost-sharing under COP-R. This requirement may be waived if: (a) the transferred resource has no current value; or (b) the county determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred resource in the calculation of the amount of cost-sharing required.

Individuals who meet other criteria, but not the financial eligibility criteria, may still receive county-purchased or county-provided services, but these clients may be required to pay 100% of the costs of these services. These clients are not generally identified as COP-R clients. Other individuals with income above a certain level are expected to share in the cost of services provided. However, DHFS guidelines require counties to annually redetermine the financial eligibility of these individuals.

COP-R has broader financial eligibility requirements than MA-supported services, since COP-R eligibility can be met by not only satisfying the MA financial requirements, but also by satisfying the alternative requirement that the person would be eligible for MA within six months if he or she were to enter a nursing home. This additional financial criterion often allows an individual to qualify sooner for assistance under COP-R than under one of the MA waiver programs.

**Services**

Because COP-R is supported entirely with state funds, program services are not subject to the restrictions that apply to the MA waiver programs, including COP-W. Wisconsin's statutes define COP services in a very general way as "long-term care support services." Consequently, counties may use these funds to support any services necessary to implement a community-based living arrangement for an individual, subject to the following restrictions:

(1) No state funds may be used to purchase land or construct buildings;

(2) No state funds may be used to provide services for an individual who resides in an institution (other than for acute or recuperative stays of 30 days or less), unless a variance is granted by the county long-term support planning committee or DHFS; and

(3) No state funds may be used for care provided in a CBRF facility that is larger than 20 beds unless a variance is granted by DHFS or the CBRF consists entirely of independent apartments.

Services typically funded under COP-R include: (1) supportive home care; (2) care at a community-based care and treatment facility; (3) case management; (4) community support program services; (5) day services or nonmedical day treatment; (6) adult day care; (7) care in an adult family home; (8) counseling; and (9) respite care. However, counties may use COP-R funds for other services. In contrast, COP-W funds may only be used for the services listed in Table 6.

Individuals who are eligible for funding under the MA waiver programs are also eligible to receive services supported by COP-R. In general, COP-R funds are used to supplement funding for MA waiver clients in three areas: (1) to provide pre-relocation funding; (2) to purchase services that cannot be funded under the waivers; and (3) to supplement funding provided under the MA waiver programs.

COP-R funds may be used to develop assessments and case plans for applicants for MA waiver services to determine if community care is feasible for these individuals, since the MA waiver programs do not cover the costs of assessments

and case plans conducted prior to determination of the person's eligibility for waiver services. Counties may also use COP-R funds to initiate services while a future waiver client is still residing in an institution, for a period of up to 90 days. For example, counties may use COP-R funds to pay the security deposit on an apartment, to install a telephone, to purchase furnishings or to make housing modifications before a person's moves to the apartment.

Counties may also use COP-R funds to provide services for individuals who are relocated or diverted under the MA waiver programs to provide services that cannot be funded under these programs. Generally, these services include room or board expenses, certain medical supplies and care provided by a spouse or parent of a minor. (Some MA waiver programs have additional restrictions on the use of waiver funds for specified services.) Finally, COP-R funding may be used to supplement MA waiver funding in those instances where the total amount provided under the waiver, together with other available sources of funding, is insufficient to support the costs of providing community-based services.

Of the $67.3 million GPR expended for COP-R services in calendar year 2001, counties expended $9.3 million to provide services not covered under the MA waiver programs and $20.3 million for individuals not eligible for the MA waiver program. In addition, counties expended $19 million to fund the required 41% match for locally-supported slots under CIP IB and CSLA and $7.1 million to fund 41% of the costs in excess of the state maximum reimbursement rate for MA waiver programs. Since $26.1 million was used to support MA waiver services, these funds generated approximately $37.7 million in matching federal funds. COP-R funds are used to support the costs of assessments and case plans for any person requesting them ($2.2 million in 2001).

**Program Restrictions**

**Significant Numbers Requirement.** State law requires counties to provide noninstitutional community alternatives for a "significant number" of people in each of the COP-R client groups. This requirement was enacted in response to concerns that some client groups were underserved by COP-R, particularly people with developmental disabilities and chronic mental illness. DHFS is required to determine what constitutes a "significant number" of people for each county.

For the 2002 calendar year, DHFS required counties to allocate COP-R funds to serve a minimum number of clients in the following eligible groups: (a) elderly, 57%; (b) developmentally disabled, 14%; (c) physically disabled, 6.6%; and (d) chronically mentally ill, 6.6%. People with substance abuse problems are also a target population under COP-R, but counties are not required to allocate COP-R funds for this population. Originally, DHFS made this determination based on county size and on the statewide proportion of individuals from each target group that received MA-supported services in a nursing home or state center for the developmentally disabled. However, 1993 Wisconsin Act 16 directed DHFS to annually redetermine these figures, based on changes in the state population of eligible individuals and the purposes for which increased funds, if any, are appropriated by the Legislature.

Act 16 also authorized DHFS to grant variances to the "significant numbers" requirement on a county-by-county basis if: (a) the county has disproportionately lengthy waiting lists for certain target groups; or (b) demographic or other data demonstrates that a county's population is significantly at variance with the statewide proportion of individuals from each COP-R and COP-W target group receiving MA in a nursing home. DHFS may also grant a variance to the

significant numbers requirement if, based on county documentation, it finds that an unusual or emergency circumstance exists and compliance with this requirement would be contrary to the program's purpose. This variance applies only for the calendar year for which it is granted.

Rather than develop specific client group numbers for each county, DHFS has developed "significant numbers" guidelines that apply to all counties. DHFS determines compliance with the "significant numbers" requirement by a point-in-time measurement of each county's COP-R and COP-W caseload.

Table 8 presents statewide information on the number of people served in each COP client group on December 31, 2001, and compares the percentage of individuals served in each client group to the "significant numbers" percentages. For purposes of compliance with the "significant numbers" requirement, clients served with COP-R and COP-W funds are counted on December 31st of each year. The total number of clients served shown in Table 8 is less than the total shown in Table 11 because Table 8 presents point-in-time data, which does not include turnover in the program during the calendar year. To provide counties with the flexibility to exceed the "significant numbers" percentages, the total of the percentages is less than 100%.

Table 8 shows that, in 2001, most of the significant numbers requirements were met on a statewide basis. The decrease in the proportion of elderly individuals served is largely due to the implementation of Family Care - especially in Milwaukee County. Before 1990, DHFS did not apply sanctions to counties that failed to meet this requirement. However, provisions in 1989 Wisconsin Act 31 required DHFS to earmark funding for counties that failed to meet the significant numbers requirement. Beginning January 1, 1990, DHFS was required to earmark a portion of a county's increased COP-R and COP-W allocation for services to each COP client group for which the county failed to meet the requirement. Counties with annual service allocations of less than $185,000 are exempt from this earmarking provision.

**Table 8: Total Number of Person Served with COP-Rand COP-W Funds by Disability Group as of December 31, 2001**

| | Number | Actual Percent | "Significant Numbers" Percentages |
|---|---|---|---|
| Elderly* | 6,422 | 53.6% | 57.0% |
| Developmentally disabled | 2,476 | 20.7 | 14.0 |
| Physically disabled | 2,024 | 16.9 | 6.6 |
| Chronically mentally ill | 967 | 8.1 | 6.6 |
| Chemically dependent and others | 97 | 0.7 | 0.0 |
| Total | 11,986 | 100.0% | 84.2% |

*All individuals over 65, regardless of primary disability, are counted as elderly.

DHFS may release earmarked funds at any time during the year that a county meets, and demonstrates ongoing compliance with, the "significant numbers" requirement for the underserved client groups. A county can have the earmarked funds released by either: (a) meeting the significant percentage requirements for three consecutive months; or (b) spending at least the amount the county expended in the previous year, plus the earmarked amount on the target group. Counties may appeal a DHFS decision to earmark funds for purposes of compliance with significant numbers requirements.

In 2001, DHFS earmarked $1,141,382 for 44 counties that were out of compliance with the "significant numbers" requirement. However, no funds were earmarked for this purpose in calendar year 2002. Variances were granted to counties since new funding was targeted at reducing waiting lists. Counties that were out of compliance, however, were required to submit plans of correction to address underserved groups.

**CBRF Size Limit.** State law limits the use of MA waiver funds for services in a CBRF to CBRFs with twenty or fewer beds under COP-W and CIP-

II and eight or fewer beds under CIP IA and CIP IB or to CBRFs that are entirely composed of independent apartments, with a few exceptions. This restriction reflects a concern that larger CBRFs may represent more of an institutional setting, and that, given the limited amount of funding available for MA-waiver programs, services provided by larger CBRFs should not be funded by programs that support home and community-based care. MA funding for care in small CBRFs is available through the waiver programs, but support is generally not provided for large CBRFs (20 or more beds). COP-R, COP-W, and CIP II funding is available to support care in CBRFs with twenty or more beds in limited situations. A disadvantage of using COP-R for CBRF care for someone who would otherwise be eligible for a MA waiver program is that the service would be entirely funded with GPR, rather than on a 41% GPR/59% FED cost-sharing basis.

**Residential Care Apartment Complexes (RCACs).** When RCACs were created in the 1995-97 biennial budget act as another type of residential provider of long-term care services, there were concerns about how the availability of RCAC services would affect public costs for long-term care. To address these concerns, the act restricted the use of public funding for services in a RCAC. Residents of RCACs who are eligible for MA can receive the various MA card service if the service is provided from a certified MA provider. However, MA enrollees that live in RCACs may only use the COP-W and CIP II MA waiver programs to support services not covered as MA card services. Further, funding under the COP-W and CIP II programs for RCAC services cannot exceed 85% of the statewide MA reimbursement rate for nursing home care only (the cost of room and board is excluded). In calendar year 2003, this rate is $73.50 per day. In addition, COP-R funds may not be used to support services to individuals who reside in RCACs, but such individuals can obtain services provided under Family Care.

**Limit on Aggregate Average COP Costs.** COP-R expenditures are limited on an aggregate basis to the average monthly amount the state would expect to pay under the MA program if these clients were residents of nursing homes. DHFS annually determines this amount on a statewide basis. In 2002, DHFS determined that the average monthly cost to the state for MA-funded nursing home care was $1,253 per person. (Because this is an average, some clients can receive services that exceed $1,253 per month). Counties may request a variance to this limit. DHFS may grant a variance if the actual statewide average monthly cost for COP-R funded care is less than the average monthly cost to the state for MA-funded nursing home care.

Under COP-W, the state must demonstrate that federal MA expenditures will not exceed amounts that would have been incurred had COP-W clients instead been served in nursing homes. To implement this restriction, DHFS limits average county expenditures per COP-W recipient to $41.86 per day.

**Requirement to Serve High-Cost Clients.** DHFS may require a county to reserve funding for clients with high costs of care if the county continuously fails to serve such clients. The Department enforces this provision by requiring, for all counties with at least 25 COP-R and COP-W clients, that at least 20% of the county's caseload include individuals with high costs of care. This provision is intended to ensure that counties serve a population that is similar to the population in nursing homes and other institutionalized settings. For 2002, a client with high costs of care was defined as a person whose total cost of community care was greater than $2,506 per month, or twice the average state cost of MA-funded nursing home care. Total cost of care may include room and board, COP funds, MA community waiver funds, community aids and services to the elderly under Title III of the Federal Older Americans Act. Room and board may be included even if they are paid by other sources, such as SSI.

**Review of High Cost-of-Care Cases.** Each

county can establish a monthly cost per client threshold for COP-R services. This threshold is intended to serve as a point at which a client's service plan received review by the county for possible modification. The threshold amount cannot be lower than the average total cost of care in a nursing home, less the supplemental security income rate.

**Targeted Funding for Alzheimer's Clients.** 1985 Wisconsin Act 29 expanded eligibility for COP-R services to include individuals diagnosed with Alzheimer's disease who require levels of care equivalent to personal or residential care in a nursing home. Beginning in calendar year 1986, a portion of COP funding was earmarked to provide services to this group. 1987 Wisconsin Act 27 expanded eligibility for these earmarked funds to include all individuals diagnosed with Alzheimer's disease who are eligible for COP-R services. Counties are also required to identify the service needs of individuals with Alzheimer's disease and their caregivers and to describe, in their COP plans, the programs and services which would be provided to meet the needs of these individuals. Beginning in 1996, in order to simplify budgeting, DHFS consolidated the Alzheimer's allocation into the general COP-R allocation. However, counties are still required to report their expenditures for this group. In 2001, 455 individuals with Alzheimer's disease or a related dementia were served under COP. Approximately $3 million was expended to provide services to this group.

**Carry-Forward Provisions.** At the request of a county, DHFS is required to carry forward up to 10% of the COP amount allocated to a county in a calendar year that is not expended or encumbered so that these funds can be used by the county in the following calendar year. As a result of 1999 Wisconsin Act 9, counties can alternatively place up to 10% of the COP allocation into a risk reserve, but any deposits in a risk reserve would reduce by an equal amount the 10% carryover limit. Counties are prohibited from using "carry forward" funds for administrative or staff costs (defined as any expense which is not part of a direct service to a client), although carryover funds can be used to fund costs that are associated with implementation of COP-W. Risk reserve funds can be used to: (a) defray the costs of COP services; (b) meet the costs of a county-operated CMO; (c) transfer funds to a Family Care district, if approved by the county board; and (d) fund COP administrative costs, if approved by DHFS. In 2002, $4,262,700 of unexpended funds budgeted in 2001 were carried forward by DHFS at the request of counties.

DHFS may also carry forward any remaining funds allocated to counties, but not expended or carried forward for counties, for the improvement or expansion of long-term, community support services for clients with high costs of care or for payments to counties for planning and implementation of Family Care resource centers or CMOs. High-cost funds may be used for such services or activities as specialized training for providers of services to high-cost clients, start-up costs for developing needed services, home modifications and purchase of medical equipment.

**COP Waiting List Procedures.** The statutory requirement that counties provide assessments, case plans and COP-R services to eligible individuals only extends to the limits of state and federal COP funds allocated to counties by DHFS. For this reason, counties must provide a client with the opportunity to be placed on a waiting list if an assessment or case plan is not feasible because the county has expended all funds available for these activities. A client may be placed on a waiting list if: (a) the county has expended all COP service funds or reasonably projects that all COP funds are committed to current COP participants; or (b) the client is a member of a target group for which the county has established a waiting list for the purposes of meeting minimum significant proportions requirements for other target groups.

Counties are required to indicate, in their county COP plans, procedures for placing individuals on waiting lists. At a minimum, DHFS

guidelines require counties to make an offer of an assessment. If the offer is accepted, counties must complete the assessment before the applicant is placed on the waiting list. If the offer is not accepted, the county must do the following before the applicant is placed on the waiting list:

• Complete a COP functional screen for each applicant;

• Document that the county has made an initial determination that the applicant is financially eligible for COP or MA -waiver services; and

• Document that there has been a personal contact with the applicant.

In January and February of each year, DHFS compiles county COP waiting list data from plans counties are required to submit to DHFS by December 31 of each year. The data compiled by DHFS includes a point-in-time count of the number of individuals on county COP waiting lists. Before 1995, the point-in-time date was September 30 of each year. In 1996, DHFS changed the reference date to December 31. Table 9 presents information on the number of individuals on county waiting lists in each year from 1990 through 2002.

**Table 9: Number of Individuals on County COP Waiting Lists***

| Year | Number |
|---|---|
| 1990 | 2,444 |
| 1991 | 3,660 |
| 1992 | 4,952 |
| 1993 | 6,348 |
| 1994 | 8,549 |
| 1996 | 8,834 |
| 1997 | 8,270 |
| 1998 | 9,189 |
| 1999 | 10,829 |
| 2000 | 11,353 |
| 2001 | 9,478** |
| 2002*** | 8,739 |

*The 1996 through 2002 figures reflect the count as of December 31, while the 1994 and prior year figures reflect the number as of September 30 of each year.
**The Family Care benefit became available in 2001 resulting in significant waiting list reductions.
***Number of individuals on wait lists as of October 31, 2002.

**Assessments, Case Plans and Other Preliminary Services**

Individuals may not be aware of their options for receiving long-term care, whether community-based care would be suitable for them, or how to obtain community-based services. COP-funded assessments and case plans enable individuals to obtain this information. COP assessments and case plans are available to any individual who seeks these services, regardless of whether he or she is eligible for publicly-funded services. However, some individuals may be required to support a portion of the costs of assessment and case planning services.

**COP Assessments.** Counties are required to conduct assessments with staff who can determine the needs of the individual being assessed and who know the availability of alternatives to nursing home placement within the county. The county department or aging unit is also required to coordinate the involvement of representatives from the county departments, health service providers and the county commission on aging in the assessment activities, as well as the individual being assessed and his or her family members or guardians. Although counties retain some flexibility in selecting individuals to conduct the assessments, DHFS is required to encourage counties to employ public health nurses to assist in the process.

*Assessment Scope.* The assessment is designed to provide information relating to: (1) the person's functional abilities and disabilities, both medical and social; and (2) the noninstitutional community services that would be necessary to enable the person to live or continue to live in the community. Although these factors are used to determine eligibility for COP services, not all of the program

eligibility determinations are made at the time of the assessment.

The assessment may also gather information regarding a person's income. Although an individual does not need to meet an income test to receive an assessment, income eligibility must be verified for a person to receive COP-funded services. Such information is needed for the county to determine whether to charge a fee for the COP assessment and eligibility for services.

As part of the assessment, county staff must provide an explanation of the potential community alternatives to the individual and the person's family or guardian. COP-R guidelines require that the assessment include a face-to-face discussion with the applicant and his or her guardian, if any.

Each county is required to adopt a uniform assessment procedure, which is usually a list of questions regarding various aspects of the client's status. Information collected through this assessment instrument becomes the basis for future determinations. The factors that these instruments must take into consideration are discussed below.

*Functional Ability and Disability*. The COP assessment measures a person's functional abilities and disabilities. This assessment differs somewhat from other assessments, such as nursing home level of care determinations, because it takes into account social, as well as medical factors. If the client elects to continue the COP process, this information becomes the basis for determining what community-based arrangements would be necessary to permit the person to live in a noninstitutional setting.

DHFS COP guidelines stress that the assessment process should include a comprehensive review of the person's functional disabilities in the following areas: physical health, activities of daily living, emotional functioning, cognitive functioning, communication, capacity for self-care and social participation. In addition, the COP assessment collects information on the individual's informal support systems, physical environment, economic resources and personal preferences.

*Assessment of Community Alternatives.* The assessment also includes an investigation to determine what community-based long-term care services could serve as an alternative to institutional placement. This part of the assessment includes information on services that could be provided and supports that are already available to the client, including the potential for assistance from family and friends. Information collected from this part of the assessment becomes the basis for determining whether a noninstitutional community arrangement is feasible.

*Assessment Determinations.* Once an assessment is complete, a decision must be made as to whether or not to proceed to a case plan. If the results of the assessment indicate that community living is feasible, financially viable and preferred by the person or his or her guardian, a case plan is developed. A feasibility determination takes into account the person's preferences for community services and whether these services are currently, or potentially available in the person's environment. Counties are required to document, in the assessment, the reasons why a community arrangement is not found feasible for a person who has received an assessment. In addition, counties are required to explain the reasons a community arrangement is not feasible to the person and his or her family or guardian.

*Notification of Assessment Approval or Denial***.** Counties are required to notify COP applicants of approval or denial for an assessment within 30 calendar days from the date the individual applies for COP services. If a county denies a request for an assessment, its notification must include the reason for denial. If the county approves an assessment, it must conduct the assessment within 45 calendar days of application, except in emergency situations. Emergency situations include instances in which a person is at risk of

long-term nursing home placement and will be discharged from a hospital within 72 hours, emergency nursing home admission, sudden loss of a primary caregiver and other situations defined by a county. In emergency situations, the person must receive a direct contact, by phone or face-to-face, within 72 hours of applying for COP-R services or being referred to the county COP-R program. If the emergency is an emergency nursing home admission, an assessment must be conducted within 10 days of admission.

**Case Plans.** Case planning is an intermediate step in the COP process between the assessment and the actual provision of services. As is the case for assessments, all individuals, regardless of their income, are eligible for a case plan, although counties may establish a sliding fee scale for the plan. Consequently, county COP staff may assist individuals who have sufficient private financial resources to locate and arrange the community supports necessary to live in the community, although the services themselves would be paid from the client's own resources.

Case planning is intended to arrange a specific, individualized set of resources for the client. Counties are encouraged to find resources from whatever sources are available that best meet an individual's needs, instead of attempting to serve individuals through a standard set of programs or resources.

At the case planning stage, various potential funding sources are organized. The statutes require that counties use other funding sources available for long-term care services in coordination with COP-R funds in preparing a case plan. The DHFS guidelines direct counties to seek other funding sources first, with COP funds to be used only after other available sources have been expended to the greatest extent possible (the exception to this provision is that COP-R funds must be used before family support program funds). Other funding sources that are frequently used in conjunction with COP-R funds are community aids funds, county aging funds and MA funding.

Each case plan includes the following information:

1. The types of services preferred by the client and those necessary to maintain the client in a community setting;

2. Who will provide each of the services and whether or not the service is a paid service;

3. How often each of the services will be provided;

4. Where the services will be provided;

5. Beginning and, if known, ending dates of service delivery;

6. Services provided by the family and other informal support;

7. Funding source and amount of each service;

8. Identification of the case manager who will be responsible for day-to-day monitoring of service delivery and for ongoing client contact; and

9. The means by which the case plan will be monitored to assure that the objectives of the case plan are met.

In addition, COP case plans also take into account the client's ability to pay for necessary community services. Finally, the individual's case file must include documentation that the client has reviewed and approved the case plan.

A case plan must be completed before COP services are provided. In emergencies, counties may provide COP-funded services before a case plan is completed if direct contact with the client has been made and an assessment has been initiated. However, the case plan must be

completed within 30 days of the beginning of services.

**Eligibility for Assessments and Case Plans.** A person is eligible for an assessment funded under COP-R if he or she is: (1) seeking or about to be admitted to a nursing home; (2) already residing in a nursing home and wants to be assessed and receive long-term community-based support services; (3) chronically mentally ill and is in need of long-term community-based support services to avoid long-term or repeated hospitalization; and (4) diagnosed as having Alzheimer's disease and who meets the level of care requirements equivalent to personal or residential care.

Counties are not required to assess eligible individuals if certain conditions apply. An assessment is not required for:

1. Emergency admissions to a nursing home for long-term care as determined by a physician, except that an assessment must be conducted within 10 days of the admission;

2. Private pay patients who waive the assessment, unless they would be eligible for MA within six months of being assessed;

3. Any person who is readmitted to a nursing home from a hospital within six months of being assessed;

4. Current residents of nursing homes who are eligible for, but choose not to receive, an assessment;

5. Any person who enters a nursing home for recuperative care (defined as a stay of 90 days or less);

6. Any person who enters a nursing home for respite care (defined as care provided for a period of 28 days or less for the purpose of temporarily relieving the caregiver from daily caregiving duties);

7. Any person who seeks admission to, or is about to be admitted to the Wisconsin Veterans Home at King who requests that the assessment be waived;

8. A person who is admitted to a nursing home from another nursing home, unless the person requests an assessment and funds are available to conduct the assessment;

9. A person who refuses to release the information necessary to conduct the assessment or who is paying privately for services and who does not want to be assessed; and

10. Any person if a county has expended all funds available for conducting assessments.

If the assessment indicates that community-based services are feasible, financially viable and preferred by the person or the person's guardian, the county is required to develop a case plan for the person as long as there are available state and federal funds.

Eligibility for a COP assessment or case plan is not dependent on an individual's income or financial resources, but an individual with adequate income or other resources may be required to contribute to the cost of the assessment. Counties may charge a fee for a COP assessment or case plan based on the person's ability to pay. Any such fee must be based on the uniform fee schedule established by DHFS. DHFS applies the same cost-sharing provisions to assessments and case plans as it applies to COP-R services. Currently, funds appropriated for assessments and case plans are based on a cost assumption of $147 per assessment and $184 per case plan.

**Budgeting**

Although COP provides funding based on a number of budgeted slots and rates, counties are not required to serve a number of individuals equal to the budgeted number of slots. Instead,

counties receive allocations of funding under COP-R and COP-W, which they can spend at a rate per person that is greater or less than the budgeted slot rate.

**Budgeted Rates.** The budgeted rate for assessments and case plans are currently $147 and $184, respectively, and reflect past time studies that document the actual costs of conducting assessments and case plans. If actual average expenditures by a county for assessments or case plans are less than the budgeted rates, the county may retain the full amount, provided that the excess funds are expended for other COP-R or COP-W services. If the average cost per assessment and case plan exceeds the budgeted rate, the county cannot use COP-R or COP-W funds for that excess expense. However, these excess costs can be billed as part of the 7% allowed for administrative costs or to the MA program as case management costs, which are funded on a 59% FED / 41% county basis.

COP-R and COP-W services are reimbursed at actual cost, to the extent that funding is available. The budgeted rates shown in Table 10 are based on statewide average costs for COP-R and COP-W services in the year before the slot was created. As a result, there are four different budgeted rates, depending on when the slot was created. Slots created at an earlier date are budgeted at a lower rate. To the extent that current average costs are higher than these budgeted rates, fewer individuals will be provided services than the number of placements for which funding is budgeted.

**Table 10: Budgeted Rates for Assessments, Case Plans and COP and COP-Waiver Services – 2001-03 Biennium**

| | COP-R | COP-W |
|---|---|---|
| Assessments | $147 | $147 |
| Case Plans | 184 | 184 |
| Placements Before July 1, 1939 | 459 | 712 |
| Placements From July 1, 1993 to July 1, 1997 | 596 | 723 |
| Placements From July 1, 1997 to July, 1, 1999 | 769 | 723 |
| Placements After July 1, 1999 | 802 | 770 |

Because of the federal requirement that the average cost of care under COP-W and CIP-II not exceed the average cost of nursing home care, DHFS limits average spending by a county for COP-W and CIP-II services to $41.86 per day. If average daily costs exceed this amount counties are responsible for covering the excess costs.

**Administrative Costs.** Counties may use up to 7% of COP-W and COP-R funds they receive for administrative services. A county may request a temporary variance to this limit, provided that the increased funds are used to: (a) improve implementation and management of COP; (b) implement a county-administered, MA-funded personal care program; or (c) develop the curriculum and defray extra administrative costs for the initial implementation of a program of ongoing training for COP agency staff. In 2001, DHFS granted variances to the limit on administrative costs to five counties for COP-R and six counties for COP-W.

**Budgeted Placements.** Overall, each county attempts to serve as many eligible individuals from its COP-R and COP-W funding allocations as possible. If actual costs per placement exceed the budgeted rates, a county would serve fewer individuals than the budgeted number of placements.

In 2002-03, $175,206,700 ($130,320,800 GPR and $44,885,900 FED is budgeted for COP-R and COP-W services), $20,983,000 GPR of which is budgeted for Family Care. However, counties have historically spent more, on average, than the budgeted rates and have not supported as many placements as the budgeted number would indicate.

**Transfer of State Funding from Nursing Homes to COP.** 1993 Wisconsin Act 469 established a mechanism whereby funding

initially budgeted for MA program benefits could be transferred, subject to the review of the Joint Committee on Finance, to the GPR appropriation to support COP-R and COP-W services if there was a decline in the utilization of nursing home beds by MA enrollees. Under these provisions, the amount of funding transferred would equal the decline in MA patient days in the most recently completed fiscal year, multiplied by the average daily cost to the state of care in such facilities. However, the provisions created in Act 469 were repealed by 1995 Wisconsin Act 27.

1997 Wisconsin Act 27 reestablished the potential funding transfer from MA to COP, although the mechanism for establishing the transfer amount differed from the Act 469 provision. The Act 27 provisions did not establish a formula for the transfer amount, but instead, allowed DHFS to make that determination. In addition, the amount recommended by the Department was not subject to review by the Joint Committee on Finance, although DHFS was still required to file a report with the Committee. There was no statutory deadline for this report.

1999 Wisconsin Act 9 made three modifications to these transfer provisions. First, no transfer can occur if the transfer would reduce the balance in the MA appropriation below an amount necessary to ensure that the appropriation will end the current fiscal year or the current fiscal biennium with a positive balance. Second, Act 9 modified the condition that would trigger a required DHFS proposal to transfer funds to COP to specify that the utilization of nursing home beds must be less than estimates used in budget determinations by the Governor, Legislature and Joint Committee on Finance. Finally, Act 9 required that the annual report, prepared by DHFS and submitted to the Joint Committee on Finance on the utilization of nursing home beds, include a discussion and detailed projection of the likely balances, expenditures, encumbrances and carryover of

**Table 11: COP R and COP-W Program -- Clients Served and Total Expenditures**
**Calendar Years 1984 through 2001**

| | Clients | | | | Expenditures | | | |
|---|---|---|---|---|---|---|---|---|
| Year | COP-R | COP-W* | Total | % Change | COP-R** | COP-W | Total | % Change |
| 1984 | 3,863 | 0 | 3,863 | 149.4 | $10,074,900 | $0 | $10,074,900 | 203.9% |
| 1985 | 5,233 | 0 | 5,233 | 35.5 | 15,983,700 | 0 | 15,983,700 | 58.7 |
| 1986 | 6,588 | 0 | 6,588 | 25.9 | 20,766,800 | 0 | 20,766,800 | 29.9 |
| 1987 | 7,414 | 0 | 7,414 | 12.5 | 26,233,300 | 0 | 26,233,300 | 26.3 |
| 1988 | 8,202 | 0 | 8,202 | 10.6 | 29,002,100 | 690,600 | 29,692,700 | 13.2 |
| 1989 | 8,372 | 837 | 9,209 | 12.3 | 31,284,800 | 4,835,500 | 36,120,300 | 21.7 |
| 1990 | 8,622 | 1,842 | 10,464 | 13.6 | 35,377,300 | 10,645,100 | 46,022,400 | 27.4 |
| 1991 | 8,508 | 2,812 | 11,320 | 8.2 | 37,714,900 | 17,806,400 | 55,521,300 | 20.6 |
| 1992 | 8,740 | 3,048 | 11,788 | 3.8 | 41,580,700 | 21,509,000 | 63,089,700 | 13.6 |
| 1993 | 9,118 | 4,055 | 13,173 | 6.1 | 46,624,300 | 33,639,900 | 80,264,200 | 27.2 |
| 1994 | 9,178 | 4,422 | 13,600 | 3.2 | 49,815,400 | 39,160,700 | 88,976,100 | 10.9 |
| 1995 | 9,894 | 5,207 | 15,103 | 11.1 | 57,772,000 | 45,608,100 | 103,380,100 | 16.2 |
| 1996 | 10,862 | 5,871 | 16,733 | 10.8 | 60,142,500 | 53,168,800 | 113,311,300 | 9.6 |
| 1997 | 10,129 | 6,933 | 17,062 | 2.0 | 62,375,500 | 60,732,900 | 123,108,400 | 8.6 |
| 1998 | 10,278 | 7,775 | 18,053 | 5.8 | 66,481,900 | 68,622,700 | 135,104,600 | 9.7 |
| 1999 | 9,452 | 8,524 | 17,976 | -0.4 | 69,739,000 | 81,390,600 | 151,129,600 | 11.9 |
| 2000 | 9,105 | 7,992 | 17,097 | -4.9 | 69,378,600 | 80,779,100 | 150,157,700 | -0.6 |
| 2001*** | 8,529 | 6,786 | 15,315 | -10.4 | 67,377,100 | 74,571,800 | 141,948,900 | -5.5 |

* Includes clients who receive only COP-W funded services (No regular COP).
** GPR only. COP-W expenditures include both GPR and federal funds.
***Family Care began in 2001 which accounted for the significant enrollment and expenditure declines from 2000 to 2001.

appropriated amounts under MA. For the 2001-02 fiscal year, DHFS determined that the actual utilization of nursing homes was 1.2% less than budgeted, resulting in a savings of $4.7 million GPR. However, DHFS did not recommend any transfer due to concerns that a transfer would result in a deficit in the MA appropriation.

**History of COP Funding**. Table 11 provides information on the number of individuals served and the level of COP-R and COP-W expenditures in calendar years 1984 through 2001. The figures in Table 11 include expenditures for assessments and case plans, as well as county administrative costs.

**Table 12: COP/COP Waiver Services -- Average Monthly Costs -- Calendar Year 1984 through 2001**

| | COP-R | | COP-W / CIP II | |
|---|---|---|---|---|
| Year | Amount | % Change | Amount | % Change |
| 1984 | 327.33 | 2.83 | | |
| 1985 | 360.10 | 10.01 | | |
| 1986 | 329.19 | -8.58 | | |
| 1987 | 403.42 | 22.55 | | |
| 1988 | 374.42 | -7.19 | $765.59 | |
| 1989 | 478.84 | 27.89 | 697.45 | -8.90% |
| 1990 | 527.43 | 10.15 | 695.93 | -0.22 |
| 1991 | 595.75 | 12.95 | 723.31 | 3.93 |
| 1992 | 642.62 | 7.87 | 743.08 | 2.73 |
| 1993 | 687.00 | 6.91 | 777.15 | 4.58 |
| 1994 | 755.15 | 9.92 | 818.82 | 5.36 |
| 1995 | 769.00 | 1.83 | 833.72 | 1.82 |
| 1996 | 820.00 | 6.63 | 840.41 | 0.80 |
| 1997 | 802.00 | -2.20 | 856.67 | 1.93 |
| 1998 | 811.00 | 1.12 | 836.30 | -2.38 |
| 1999 | 860.00 | 6.04 | 908.66 | 8.65 |
| 2000 | 872.00 | 1.40 | 966.00 | 6.31 |
| 2001 | 907.00 | 4.01 | 1,039.00 | 7.56 |

The figures in Table 12 show the average monthly cost of COP-R and COP-W services, excluding the costs of assessments, case plans and administration. The cost figures for COP-W includes CIP II participants, since both programs serve the same target group and counties shift individuals between the two programs to optimize reimbursement levels. The monthly costs listed in Table 12 do not include MA personal care services and other MA card long-term care services. Consequently, the figures in Table 12 do not reflect the total costs of long-term care services for individuals who receive community-based services.

**County Allocation Procedures.** The statutes do not specify a formula DHFS must use to distribute COP funds to counties. In general, the Department's policy has been to allocate most COP funds using each county's share of total funding under the community aids formula. The community aids formula allocates funds based on three factors, each weighted equally: (1) each county's proportionate share of the state's MA caseload; (2) each county's relative rank on an urban-rural scale, in which very urban and very rural counties receive enhanced allocations; and (3) each county's full value of taxable property per capita.

Although DHFS has allocated most COP funding increases by using the historical community aids formula share, it has also used other criteria to allocate COP funding increases. For instance, additional COP-W funding provided in 2002 was allocated in a slightly different manner, with 1/3 of the funding allocated based on the community aids formula and 2/3 of the additional funding distributed based on the number of elderly and physically disabled adults on waiting lists. In addition, DHFS reserved approximately $126,700 in 2001 and $152,529 in 2002 for the expansion of disability benefits specialists located in resource centers as part of the Family Care initiative. Actual COP allocations to counties for calendar year 2003 are provided in Appendix I. These figures reflect allocations after projected transfers to Family Care CMOs.

DHFS provides counties separate allocations for assessments, case plans, COP-R and COP-W services. Counties may transfer unspent funds

from the assessment and case plans allocations to fund COP-R and COP-W services, with the approval of the DHFS. However, funds provided for services may not be transferred to another allocation.

**Administration**

COP is administered at the state level by the DHFS Division of Supportive Living, Bureau of Aging and Long-Term Care Resources and at the local level by county human services agencies or departments on aging.

**State Administration.** DHFS is responsible for developing overall program guidelines, which it develops in consultation with representatives of counties, hospitals, nursing homes and recipients of long-term community support services. These guidelines address: (1) cost-effectiveness; (2) program scope; (3) feasibility; and (4) program impact on the quality and appropriateness of services. The guidelines provide counties with as much flexibility as is feasible to develop programs that respond to local needs.

In addition, DHFS reviews and approves county COP plans, the selection of a county department to administer the program and periodically monitors the implementation of the program. Finally, DHFS evaluates the cost effectiveness of the program, the ability of the program to provide alternatives to institutional care and the reasons why any agency may find that community arrangements are not feasible for an individual.

**County Administration.** Each county board designates a lead agency or joint lead agencies to administer COP, appoints the long-term support planning committee and reviews and approves, disapproves or amends the COP plan prepared by the planning committee. Each board is required to provide community services for a significant number of people in each target population group and identify the needs of people with Alzheimer's disease and their caregivers. Finally, each board is required to establish policies to ensure that the program uses existing county resources and personnel to the greatest extent practicable and that the program enhances discharge planning from hospitals.

**Long-Term Support Planning Committee.** The statutes require that each county's planning committee be composed of people who represent: elderly, developmentally disabled, physically disabled, chronically mentally ill individuals, and individuals with chronic alcohol or other drug abuse problems. In addition, each committee must include two elected officials and representatives from county agencies responsible for health, social services, Chapter 51 services and aging programs.

The primary function of the long-term support planning committee is to prepare a county COP plan. This plan, which requires both county board and state approval, describes the proposed program, available services, procedures for coordination with other county agencies, hospitals, nursing homes and providers of community services, procedures for coordinating COP funds with state and federal aging funds and community aids funds, methods for monitoring implementation, methods for community outreach and services and programs to be provided to meet the needs of people with Alzheimer's disease.

**Lead Agency or Joint Lead Agencies.** The county board may select the social services agency, the Chapter 51 board, the human services agency, a health and human services director or a county aging unit as the lead COP agency. In addition, the county board may designate any of these agencies as joint lead agencies for COP if a single joint COP plan is developed and submitted to DHFS. The lead agency is the primary administrative agency at the county level and is responsible for developing the assessment process, providing case management services and providing or arranging community-based services for COP-eligible clients.

The lead agency is also required to coordinate the involvement of the county's social services agency, Chapter 51 board, aging unit and health services providers.

*Appeal Process for COP Services.* Counties are required to establish a grievance procedure under which a person who is denied COP services, or whose services are reduced or terminated, may appeal the decision. These individuals may request a hearing from DHFS under its administrative hearing process. However, the statutes specify that a request for a hearing may not be granted if services are denied because a county does not have adequate funding.

## Family Care

Family Care is a pilot program intended to change the manner in which state residents receive long-term care services. The program replaces other long-term care programs available in participating counties as the means of consolidating eligibility and services.

The pilot program was created to address several problems in the current system. One concern is that the current system consists of too many programs, each with its own eligibility standards and services. A second criticism of the current system is that it encourages individuals to receive institutional care because nursing home care under MA is an entitlement, while the amount of funding budgeted for the MA waiver programs and COP-R is limited to the amounts provided for these programs, resulting in waiting lists for community-based long-term care programs. Family Care also expands long-term care options by reducing barriers to the use of CBRFs and other types of facilities.

It is hoped that Family Care will improve the long-term care system by: (a) delivering services under a managed care system with a strong monitoring system and performance expectations; (b) increasing flexibility in the provision of services and providing case management services to coordinate long-term care with acute care services; and (c) increasing the amount of information consumers have to enable them to make informed decisions.

Family Care provides services to elderly individuals, physically disabled adults, and adults with developmental disabilities. Children and individuals with chronic mental illness may not participate in the Family Care pilot program.

Family Care includes two major components. First, resource centers provide information, assessments, eligibility determinations, and other preliminary services. Resource centers provide potential long-term care users with information so that they are aware of the alternatives to nursing homes that may be more satisfying or cost effective. In areas where a resource center is established, nursing homes and other long-term care facilities must inform and refer prospective residents of the facility to the resource center before admitting that person.

Second, care management organizations (CMOs) provide the Family Care benefit for every person enrolled under a capitated, risk-based payment system. The benefit provides a comprehensive and flexible range of long-term care services, including the types of services currently available under COP, the MA community-based waiver programs, and the MA fee-for-service program. Examples of services provided under the Family Care benefit include supportive living services, supportive employment services, adult day care, respite care, supportive home care, residential services, nursing home care, personal care, home health and therapy services. These services are examples of services that participating CMOs must provide. In addition, any CMO may provide other services needed by enrollees. However, a CMO's capitation rate is not increased

if it provides additional services.

The Family Care benefit does not provide acute care services, such as hospital care or physician care, which enrollees continue to receive on a fee-for-service basis. Although acute care is not provided by the CMO, the CMO's case managers are required to coordinate acute care to ensure the enrollee's total health care needs are met.

In addition to providing benefits to individuals who meet a nursing home level of care standard, Family Care serves individuals with fewer long-term care needs, but who are at risk of losing their independence or functional capacity unless they receive some assistance. There are two capitation rates CMOs may receive: (a) a comprehensive rate to support services for enrollees who meet a nursing home level of care standard; and (b) an intermediate level rate to support services for enrollees who do not meet that standard. The intermediate level is intended to support services for people who previously received some long-term care funded supported by the county or received some MA card services, such as personal care or home health care.

The 1997-99 biennial budget act authorized DHFS to conduct a pilot project to test the resource center concept. Currently, nine counties are operating resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau). The 1997-99 budget adjustment act expanded the pilot program to test the CMO concept. As of January 1, 2003, Fond du Lac, La Crosse, Milwaukee, Portage and Richland Counties serve as CMOs.

MA enrollees in Family Care pilot counties have three long-term care options: (a) nursing home care supported by MA; (b) enrollment in Family Care; or (c) the limited long-term care services available as MA card services, such as personal care and home health care.

Before January 1, 2003, DHFS could only contract with counties and tribes to operate CMOs. Now, other entities can serve as CMOs under certain circumstances. CMOs are required to monitor and report a number of measures, such as the rate of hospitalization, so that their performance can be assessed. CMOs must meet performance standards that are part of the CMO contract.

**Eligibility**

**Non-Financial Eligibility**. Each Family Care enrollee must be at least 18 years of age and have a primary disability that is something other that mental illness, substance abuse or developmental disability, although individuals with developmental disabilities may participate in counties (or tribes) where a CMO operated before July 1, 2003.

To be eligible for Family Care, a person must meet one of the following three functional eligibility criteria:

a. The person's functional capacity is at the comprehensive level, which is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance or supervision.

b. The person's functional capacity is at the intermediate level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others;

c. The person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by DHFS, funded under COP, MA community-based waivers, the

Alzheimer's family caregiver support program, community aids or other county funding documented by the county.

The comprehensive level of functional capacity is approximately equivalent to a nursing home level of care under MA. The distinction between comprehensive and intermediate levels is important, since it may affect whether a person is entitled to Family Care services

**Financial Eligibility**. A person is financially eligible for Family Care if, as determined by DHFS or its designee, the person: (a) is eligible for MA and accepts MA unless he or she is exempt from the acceptance under DHFS rules (Family Care MA); or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rule (Family Care Non-MA).

Because of the alternative financial eligibility criteria, an individual that is not financially eligible for MA may be eligible for Family Care. A person can begin receiving Family Care services before that person's assets are reduced to the MA limits of $2,000 (individuals) or $3,000 (couples) because only one-twelfth of countable assets are used in the financial eligibility/cost-sharing test. Family Care allows more liberal deductions for assets and income than MA. Family Care allows a deduction for countable assets of either $9,000 (for nursing home, CBRF, or Adult Family Home residents), or $12,000 (for individuals who reside in their own home or in residential care apartment complexes (RCACs)), compared to the $2,000 or $3,000 exclusion under MA.

Further, Family Care provides a monthly deduction for earned income that is equal to the first $200 of earned income plus two-thirds of earned income in excess of $200, whereas MA allows a deduction of $65 plus one-half of earned income in excess of $65. Family Care also allows a slightly higher personal needs allowance of $65 per month for individuals in nursing homes, CBRFs, and adult family homes, compared to the personal allowance of $45 allowed for MA nursing home residents. The personal needs allowance under Family Care for individuals in their own home or RCAC has the same minimum and maximum levels as under the MA waiver programs ($732 to $1,114 per month in 2003), although Family Care calculates the allowance differently, based on the sum of shelter costs, the maximum food stamp allotment for a household of one and a clothing allowance determined by DHFS.

Family Care enrollees, including both MA-eligible and MA-ineligible enrollees, are required to share in program costs. If an enrollee is MA-eligible, the cost-share is identical to that required under MA community waiver cost share rules. Non MA-eligible participants have a cost-share based on the alternative financial eligibility test described above, which requires the person to contribute to the cost of care any countable income and assets in excess of the non-MA Family Care exclusions outlined above.

**Entitlement.** A primary goal of the Family Care program is to eliminate waiting lists for community-based long-term care. In order to achieve this goal, Family Care provides "entitlement" to certain groups. A person is entitled to the Family Care benefit through enrollment in a CMO if he or she meets eligibility requirements, fulfills any applicable cost-sharing requirements and: (a) is functionally eligible at the comprehensive level; (b) is functionally eligible at the intermediate level and is eligible for MA; (c) is functionally eligible at the intermediate level and is determined to be in need or protective services or protective placement; (d) has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, the person first applies for eligibility for the Family Care benefit within 36 months after the date on which the Family Care benefit is initially available

in the person's county of residence, and on the date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or had been receiving for at least 60 days, under a written plan of care, long-term care services funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county; or (e) has a primary disabling condition that is a developmental disability and is a resident of a county or tribe that has operated a CMO before July 1, 2003.

Within each county and for each client group, entitlement first applies on the effective date of a contract under which a CMO accepts a capitated payment. However, during the first 24 months after this date, the CMO is provided a phase-in period to build the capacity to serve all entitled individuals in that county. A person who is eligible for Family Care but who is not entitled to receive the Family Care benefit can be put on a waiting list for services even after the phase-in period for building capacity. However, while waiting for enrollment, a person who is eligible but not entitled to Family Care services may purchase services from a CMO.

Appendix II to this paper compares the eligibility requirements Family Care with the other long-term care programs described in this paper for calendar year 2003.

**Resource Centers**

**Services.** Resource centers provide "one-stop shopping" for information, assessments, eligibility determinations and other preliminary services relating to long-term care. These services allow an individual to explore the feasibility of home- or community-based long-term care, similar to a COP assessment. However, resource centers do not develop detailed case plans as this function is performed by CMOs. Private pay individuals that are functionally, but not financially, eligible for Family Care have the right to purchase case management services from the CMO at the rate paid by MA.

Resource centers must provide the following services.

- *Information and Assistance.* The resource center must provide information to the public about services, resources and programs in areas such as disability and long-term care related services and living arrangements, health and behavioral health, adult protective services, employment and training for people with disabilities, home maintenance, nutrition and the Family Care benefit.

- *Long-Term Care Options Counseling.* Resource centers must offer long-term care options counseling to anyone who is referred for, or requests, the functional screen. Resource centers are required to provide pre-admission consultation to all individuals entering nursing homes, CBRFs, adult family homes and RCACs to provide objective information about the cost-effective options available to them. The current resource center contract requires that counseling be conducted at a location preferred by, and at a time convenient to, the person. Counseling cannot be limited to the resource center location, but must be available in the person's place of resident or other setting, such as a hospital.

- *Benefits Counseling.* Resource centers must ensure that individuals from all of the target populations they serve have access to benefit specialists for counseling on private and government benefits and programs, including assisting individuals when they have problems with Medicare, Social Security or other benefits. The benefit specialists can be staff of the resource center or another organization.

- *Emergency Response.* Resource centers must assure that people are connected with someone who will respond to urgent situations that might

put someone at risk, such as a sudden loss of a caregiver. A resource center must assure prompt responses to emergency calls, 24 hours a day.

- *Prevention and Early Intervention*. Within the limits of available funding, resource centers must provide prevention and intervention services to keep people healthy and independent. Examples of these services include a program to review medications or nutrition, a home safety review to prevent falls and appropriate fitness programs.

- *Access to the Family Care Benefit*. For individuals interested in the Family Care benefit, a resource center must conduct a functional and financial eligibility determination. If the person is eligible for the Family Care benefit, the resource center must provide assistance about the options available to the individual-- to enroll in Family Care, stay in the MA fee-for-service system (if eligible), or to privately pay for services. If the person chooses Family Care, the resource center must enroll that person into a CMO.

- *Access to SSI, Medicaid and Food Stamps.* Resource centers must establish a DHFS-approved plan to ensure that people who contact or are referred to the resource center have access to MA, SSI and food stamps. Resource centers must establish procedures to ensure coordination and referral with other relevant agencies to ensure that an eligibility determination is completed.

- *Elder Abuse and Adult Protective Services.* Resource centers are required to identify individuals who may need elder abuse or adult protective services and who are provided access to services for elder abuse and adult protective services through cooperation with respective county agencies.

- *Outreach and Public Education.* Although not required by statute, the current resource center contract requires that each resource center develop and implement an ongoing program of marketing and outreach to the target populations, community agencies and service providers to inform them of the availability of resource center services.

- *Transitional Services.* Resource centers are required to provide transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system.

Although all the services described above would typically be provided by resource centers, current law allows DHFS to contract with a resource center to perform only a portion of these services. Currently, all nine of the operating resource centers provide all of the services listed above.

**Eligibility and Cost-Sharing.** In addition to members of the target population, the general public may obtain information from resource centers. Physicians, hospital discharge planners or other professionals who work with elderly or disabled individuals can use the information services resource centers provide. Each resource center must offer long-term care counseling, the long-term functional screen and financial screen to any individual over the age of 17 years and nine months who has a disability or condition requiring long-term care that is expected to last at least 90 days and who: (a) is referred to the resource center by a nursing home, CBRF, adult family home or a RCAC; (b) requests access to the Family Care benefit; or (c) contacts or is referred to the resource center and appears to have a significant long-term care need. A resource center can limit its target population to a subset of the groups eligible for Family Care. Eight of the nine current resource centers include all groups eligible for Family Care among their target population. The resource center in Milwaukee County targets services to elderly individuals, exclusively.

Resource centers must provide all of their services, including conducting functional screen, eligibility determinations and individual counseling, free-of-charge. Since the CMO, rather

than the resource center, is responsible for developing individual service plans, an individual with higher income or resources may not obtain case planning free under the Family Care program. However, a private pay individual is entitled to purchase case management services from the CMO at the MA rate.

**Establishment and Governing Structure of Resource Centers.** A resource center cannot be established unless it signs a contract with DHFS. Until July 1, 2001, only counties, tribes, the Great Lakes Inter-Tribal Council or Family Care districts created by a county could contract with DHFS to establish a resource center. Since July 1, 2001, DHFS has been permitted to contract with private, nonprofit organizations if: (a) a county board declines in writing to apply for a contract to operate a resource center; or (b) a county agency or Family Care district applies for a contract but fails to meet required standards for operating a resource center. Counties and tribes can jointly operate a resource center.

Each resource center must have a governing board that reflects the ethnic and economic diversity of the area served by the resource center. At least one-fourth of the members of the governing board must be older individuals with physical or developmental disabilities or their family members, guardians or other advocates.

Beginning January 1, 2001, counties operating both a CMO and a resource center must create a structural separation between the resource center and the CMO of at least the eligibility determination and enrollment counseling functions. This structural separation can be achieved by creating a Family Care district to operate either the CMO or the resource center or by some other means if approved by DHFS.

**Family Care Pre-Admission Requirements**. Nursing homes, CBRFs, adult family homes and RCACs are required to inform prospective residents of the services of the resource center, the Family Care benefit and the availability of functional and financial screens if the DHFS Secretary has certified that a resource center is available for the target group under which the potential resident would be categorized. For individuals seeking admissions to these facilities and for individuals who are discharged from hospitals, the facility is required to refer these individuals to a resource center for a pre-admission consultation if: (a) the person is at least 65 years of age or has a developmental or physical disability; and (b) the person's disability or condition is expected to last at least 90 days.

A referral is not required if the Secretary has not certified that a resource center is available or if one of the following applies: (a) the person has received a screen for functional eligibility within the previous six months: (b) the person is entering the institution only for respite care; (c) the person is an enrollee of a CMO; or (d) a person is being readmitted to a nursing home, CBRF, adult family home or RCAC from a hospital. If a facility violates either of these requirements, it may be required to pay a fine of up to $500 for each violation.

When a person is referred to a resource center for a pre-admission consultation, the resource center staff contacts the individual shortly after the referral and explains the purpose of the pre-admission consultation. The staff responds to any questions from the referred individual, explains Family Care, and offers to conduct the long-term care functional screen and the financial declaration. An individual has the right to decline the functional screen or any other part of the pre-admission consultation process. Private pay individuals, unless they are expected to become eligible for MA within six months, are not required to provide financial information as part of the pre-admission consultation process.

**Funding**

Two separate entities provide direct services under Family Care. Resource centers provide the

preliminary services of providing information, screening, eligibility determinations and enrollment. For Family Care enrollees, the CMOs develop an individualized service plan and provide long-term care service under the Family Care benefit. Resource centers are reimbursed under a different mechanism than are the CMOs.

**Funding of Resource Centers.** The resource center contract assigns a number of responsibilities to the resource center. The contract allows the resource center to be reimbursed for its costs in carrying out these required functions. However, the contract limits the total payment to the resource center. If actual costs exceed this limit, the resource center is responsible for those costs. Thus, the resource center assumes some financial risk in carrying out its functions. However, this payment limit may be increased if DHFS approves the increase. As an incentive to test new methods to improve long-term care, resource centers can apply for "prevention grants" to test programs aimed at preventing events such as improper nutrition, contributing to a decline in functional ability. Table 13 lists the maximum contract amounts for the current nine resource centers for calendar year 2002.

Since the resource centers perform a number of functions that were previously performed under different programs, part of the funding used to support resource centers is transferred from other programs. In 2001-02, the costs of operating resource centers totaled $4.8 million (all funds).

**Funding of CMOs.** Entitlement for the benefit, within each county and for each client group, first applies on the effective date of a contract under which a CMO accepts a capitated payment. Within 24 months after this date, DHFS must assure that sufficient capacity exists to provide the Family Care benefit to all entitled enrollees in that county. Although the phase-in of capacity provision permits CMOs to have waiting lists during the first two years of operation, after that period of capacity building, the Family Care benefit must be provided immediately when the person's eligibility has been confirmed and that person is a member of one of the entitlement groups. Because of these provisions, the Family Care benefit is not limited for most groups. In contrast, enrollment and services provided under COP and the MA waiver programs are limited by the funding or the maximum number of slots budgeted for these programs.

CMOs are paid a specified amount per month for each enrollee. There are two payment rates corresponding to the two levels of functional eligibility: (1) a comprehensive rate, which is paid for the care of enrollees that meet a nursing home level of care standard; and (2) an intermediate rate, which is paid for the care of enrollees with a lower level of care need. These rates are intended to fund all long-term care costs, but not acute care costs. These rates were developed based on an analysis of historical costs to serve individuals in the community under the COP and MA waiver programs, including long-term care MA card services.

**Table 13: Resource Centers -- Populations Served and Maximum Calendar Year 2003 Contract Amounts**

| | Target Group(s) | | | CY 2003 | |
|---|---|---|---|---|---|
| County | Elderly | Adult Phy. Dis. | Adult Dev. Dis. | Contract Amount | Prevention Grant |
| Fond du Lac | x | x | x | $789,000 | $0 |
| Jackson | x | x | x | 328,700 | 0 |
| Kenosha | x | x | x | 1,099,500 | 265,800 |
| La Crosse | x | x | x | 1,086,700 | 0 |
| Marathon | x | x | x | 936,100 | 381,900 |
| Portage | x | x | x | 666,500 | 0 |
| Richland | | x | x | 327,800 | 0 |
| Trempealeau | x | x | x | 311,800 | 0 |
| Milwaukee | x | | | 3,381,500 | 237,800 |
| TOTAL | | | | $8,927,600 | $885,500 |

**Table 14: CMO Capitation Rates, Enrollments and Expenditures**

| | Target Groups | | | Capitation Rates CY 2003 | | | |
|---|---|---|---|---|---|---|---|
| County | Elderly | Phys. Dis. | Dev. Dis. | Comprehensive | Inter. | Enrollment Sept. 2002 | Proj. FY 03 Expenditures |
| Fond du Lac | x | x | x | $1,945 | $657 | 900 | $17,400,000 |
| La Crosse | x | x | x | 1,802 | 657 | 1,200 | 19,700,000 |
| Portage | x | x | x | 2,368 | 657 | 3,700 | 25,500,000 |
| Milwaukee | x | | | 1,768 | 657 | 600 | 82,300,000 |
| Richland | x | x | x | 1,976 | 657 | 300 | 6,400,000 |
| TOTAL | | | | | | 6,700 | $151,300,000 |

The average historical costs were adjusted for anticipated inflation, an administrative cost adjustment and a managed care discount.

Table 14 lists the CMO payment rates for the 2003 calendar year. The capitation rates differ by county to reflect the past experience of long-term care clients in that county. The calendar year 2003 rates at the comprehensive level vary from a low of $1,768 per month in Milwaukee County to a high of $2,368 per month in Portage County. The intermediate rate is the same for all five CMOs -- $657 per month. The prospective payment rates shown in Table 14 will be adjusted retrospectively if the care levels of the actual enrollees differ from the levels assumed under the prospective rates. The retrospective adjustments will be based on the historical costs of actual enrollees with the same adjustments as used for the prospective rates.

In 2001-02, payments to CMOs totaled $100.2 million. As of August 31, 2002, the number of individuals enrolled in the five pilots totaled 6,500, including 6,300 MA eligible and 200 non-MA eligible enrollees. It is expected that CMO payments for 2002-03 will total approximately $151.3 million (all funds). Table 14 summarizes these cost estimates by county.

**Program Requirements**

Providers that offer services covered under Family Care must meet a number of requirements. This section describes some of these requirements.

**CBRF and RCAC Care.** One of the services in the long-term care benefit package that must be provided to enrollees at the comprehensive level of care, if consistent with the individual service plan (ISP), is CBRF care. Unlike the MA waiver programs and COP, Family Care does not limit CBRF coverage to care in small CBRFs. As long as the CBRF care is appropriate and meets other general standards, such as cost effectiveness, CBRF care must be provided, even in large CBRFs. Although Family Care is intended to increase availability of home- and community-based long-term care, the program is also intended to meet the preferences of the Family Care enrollee, and to provide services in the most appropriate setting.

Family Care also supports care RCAC if the care is consistent with the person's ISP and meets other general standards, such as cost effectiveness. Under Family Care, there is no upper limit on the reimbursement level, as there is for services provided under the COP-W and CIP II programs, which limit reimbursement to 85% of the average cost of nursing home care.

**Separation of Resource Center and CMO Functions.** A risk-based payment system that is based on the functional level of the person creates a potential conflict of interest if the functional screen and eligibility determination is done by the same entity that provides the service. A financial

incentive exists for the entity to classify individuals at a higher level of care need to generate a higher monthly payment or to discourage participation by individuals viewed as too costly relative to the payment rate. Federal regulators have raised concerns about this potential conflict and, as a result, the Family Care legislation includes provisions to incorporate and mandate separation.

To achieve this separation, the statutes provide for the creation of a special purpose district, termed a Family Care district, that is separate and distinct from, and independent of, the county. Although a Family Care district may be created by one or more counties, only up to 25% of the board members of the Family Care district can be elected or appointed officials or employees of the county or counties that created the district. A Family Care district can operate either the resource center or the CMO. The Family Care district can only perform the critical functions of the resource center (functional screen/enrollment counseling) that create the potential conflict. Counties may use mechanisms other than the Family Care district to achieve the necessary separation, as long as the mechanism is approved by DHFS. However, the statutes do not specify what alternative mechanisms counties may use.

**Competition for the CMO Function.** Federal MA regulations require that MA enrollees be provided choice for the provision of services. However, under Family Care, choice is limited because community-based long-term care will eventually only be provided under the Family Care program and COP and the MA waiver programs will no longer be available for individuals who require long-term care. In this situation, although a phase-in period is allowed, federal regulations require that the CMO contract be opened to competition to provide an incentive for the CMO to provide the best combination of services, quality and cost. Although counties have historically provided community-based long-term care services, counties will eventually need to compete with other entities for that contract.

The statutes initially require DHFS to only contract with a county or Family Care district if the county elects to operate a CMO and the CMO organization meets specified requirements. A county-operated CMO was not subject to any competition in calendar years 2000, 2001 and 2002. In calendar year 2003, a county-operated CMO will not need to compete for the CMO function as long as it demonstrates that it is meeting performance standards. If a county cannot demonstrate the capacity to serve all entities in the service area, DHFS can contract with an additional organization to provide the Family Care benefit in 2003. Beginning in calendar year 2004, CMO contracts will be selected on a competitive basis, with the focus on quality of care, rather than the lowest bidder.

**Quality and Performance.** As under any risk-based managed care system where a provider receives a monthly capitation payment, the provider has a financial incentive to limit services. Since revenues are based on the monthly payment and are not tied to the level of services, any reduction to services results in a reduction in costs without any corresponding reduction in revenues. This concern may be greater if the recipient has the choice of only one CMO and there is no alternative program for community-based long-term care services.

Because of this negative financial incentive, the Family Care program includes a number of features to ensure quality care. Before signing a contract, state law requires that the potential CMO be certified as having an adequate network of providers, expertise in the provision of long-term care services, a range of supported living arrangements, and meet a number of other requirements. Further, each CMO must have both an informal and formal grievance process under which the Family Care enrollee can contest the adequacy of services, the type of living arrangement offered, whether the services offered are responsive to the enrollee's preferences, the timeliness of services, and other matters.

CMOs are also required to have a quality assurance/quality improvement plan that provides for systematic data collection of performance and member results for identified goals and outcomes. This plan must be submitted to DHFS and approved before the effective date of the contract. Annually, the CMO must set new goals and objectives, based on findings from quality assurance and improvement activities. DHFS may perform off-site and on-site audits of the CMO. DHFS may also require that the CMO achieve minimum levels of performance on specific measures DHFS establishes. In addition, DHFS plans to contract for external quality reviews. The CMO contract requires that the CMO be informed of any deficiencies discovered by a quality review and submit a corrective action plan to DHFS within 60 days. The corrective action plan must be approved by DHFS.

The CMO contract requires that the CMO file a number of reports that allow DHFS to monitor the CMO in a number of areas. Annually, the CMO is required to submit a complaint and grievance report that contains a log of complaints and grievances, as well as a summary that contains an analysis of the trends the CMO has experienced regarding the types of grievances and complaints the CMO receives, and which of the CMO's providers are subject of complaints or grievances. Each month, CMOs are required to submit CMO quality indicators that include such measures as the percent of members who voluntarily disenroll, the percent of members who have used paid staff chosen by the enrollee, the percent of members who are relocated into the community from an institutional setting and the percent of members who live in their own home or apartment.

Annually, the CMO is required to submit a financial audit that must include testing of compliance with program requirements, as well as financial requirements identified in DHFS audit guidelines.

**Administration and Oversight**

The following section describes the administration and oversight of the Family Care program.

**DHFS.** DHFS has a number of duties in administering the Family Care program. First, DHFS must request from the federal Department of Health and Human Services any waivers of federal MA laws necessary to permit the use of federal moneys to provide the Family Care benefit to MA recipients, and DHFS is required to implement any waiver that is approved and consistent with state law. However, regardless of whether a waiver is approved, DHFS is authorized to implement operation of resource centers, CMOs and the Family Care benefit, and to: (a) establish, in geographic areas determined by DHFS, a pilot project under which DHFS contracts with a county, a Family Care district, a tribe or band or the Great Lakes Inter-Tribal Council, Inc. or with any two or more of these entities, to operate a resource center; and (b) contract with counties, tribes or bands under a pilot project to demonstrate their ability to manage all long-term care programs and administer the Family Care benefit as a CMO. DHFS is required to prescribe and implement a per person monthly rate structure for costs of the Family Care benefit and to develop risk-sharing arrangements in contracts with CMOs, in accordance with applicable state laws and federal statutes and regulations.

In order to maintain continuous quality assurance and quality improvement for resource centers and CMOs, DHFS is required to: (a) prescribe by rule and by contract and enforce performance standards for resource centers and CMOs; (b) use performance expectations that are related to outcomes for individuals in contracting with CMOs and resource centers; (c) conduct ongoing evaluations of the long-term care system; (d) require that quality assurances and quality

improvement efforts be included throughout the long-term care system; (e) ensure that reviews of the quality management and service delivery of resource centers and CMOs are conducted by external organizations and make information about specific review results available to the public; (f) require by contract that resource centers and CMOs establish procedures under which an individual who applies for or receives the Family Care benefit could register a complaint or grievance and procedures for resolving complaints and grievances; (g) prescribe criteria to assign priority equitably on any necessary waiting lists for individuals who are eligible for, but not entitled to, the Family Care benefit.

The DHFS Secretary must certify to each county, nursing home, CBRF, adult family home and RCAC the date on which a resource center that serves the area of the county or facility is available to provide a functional and financial screen. To facilitate the phase-in or services of resource centers, the DHFS Secretary may certify that the resource center is available for specified groups of eligible individuals or for specified facilities in the county.

DHFS is required to promulgate as rules the following: (a) standards for performance by resource centers and for certification of CMOs, including requirements for maintaining quality assurance and quality improvement; (b) criteria and procedures for determining functional eligibility, cost sharing and entitlement for benefits; and (c) procedures and standards for hearings. The rules for eligibility must be substantially similar to eligibility criteria for COP services.

**State Council on Long-Term Care.** 1999 Wisconsin Act 9 created a 15-member Council on Long-Term Care to assist DHFS in developing broad policy issues relating to long-term care, including the implementation of Family Care. Act 9 provided that the Council would terminate on July 1, 2002, or on the day after publication of the 2001-03 biennial budget act. On July 21, 2001, the Council on Long-Term Care terminated. However, in early September, 2001, all of the members of the council were reappointed to advise DHFS on broad policy issues related to the Family Care program and other long-term care services. Two additional members were also added to the council to represent children with long-term care needs and individuals with mental health concerns.

**Resource Centers.** A resource center cannot be created until an entity has contracted with DHFS to operate a resource center. Before July 1, 2001, DHFS could only contract with counties, Family Care districts, tribes or the Great Lakes Inter-Tribal Council to operate a resource center. Currently DHFS is able to contract with private, nonprofit organizations if: (a) a county board declines in writing to apply for a contract to operate a resource center; or (b) a county agency or Family Care district applies for a contract but fails to meet required standards for operating a resource center.

A county board or county executive can decide whether to authorize one or more county departments or an aging unit to apply to DHFS for a contract to operate a resource center, and if so, which to authorize and what client groups to serve. The county board or county executive can also decide whether to create a Family Care district or apply to DHFS for operating a resource center. Counties and tribes may submit joint applications.

Each resource center must have a governing board that reflects the ethnic and economic diversity of the area served by the resource center. At least one-fourth of the members of the board must be older individuals with physical or developmental disabilities or their family members, guardians or other advocates.

Resource centers are required to provide services within the entire geographical area prescribed for the resource center by DHFS. Within six months after the Family Care benefit is available to all eligible individuals in the resource center area, the resource center must provide

information on resource center services and Family Care benefits to all elderly and physically disabled individuals who are residents of nursing homes, CBRFs, adult family homes and RCACs. Further, the resource center must provide a functional and financial screen to any resident in a nursing home, CBRF, adult family home or RCAC who requests a screen and to anyone seeking admission to one of these institutions if the DHFS Secretary has certified that a resource center is available to the person and facility. A resource center must assure that emergency calls to the resource center are responded to promptly, 24 hours per day.

**Care Management Organizations.** An entity can function as a CMO only if DHFS certifies that it meets a number of requirements and if the entity contracts with the DHFS to serve as a CMO.

A county board or county executive can decide whether to authorize one or more county departments or an aging unit to apply to DHFS for a contract to operate a CMO, and if so, which to authorize and what client groups to serve. The county board or county executive can also decide whether to create a Family Care district to apply to DHFS to operate a CMO. The governing body of a tribe or band or the Great Lakes Inter-Tribal Council can apply to operate a CMO for tribal members. Counties and tribes may submit joint applications.

Except for pilot counties established before July 1, 2001, a single entity cannot operate both a resource center and a CMO. However, a county can operate a resource center and establish a Family Care district to operate the CMO. Further, a county can operate a CMO while the Family Care district operates the resource center. A tribe can establish two separate corporations whose governing boards do not share any single individual in which one corporation operated the CMO while the other operated the resource center. DHFS can approve an alternative method to achieve this separation.

A pilot county established before July 1, 2001, may operate both a resource center and a CMO until January 1, 2001. After this date, there must be structural separation of at least the eligibility determination and enrollment counseling functions from the CMO by establishing a Family Care district or an alternative method approved by DHFS.

Each CMO must have a governing board that reflects the ethnic and economic diversity of the area served by the resource center. At least one-fourth of the members of the Board must be older individuals with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the CMO's enrollees.

In order to be certified as a CMO, an entity must demonstrate that it has an adequate provider network to provide the full range of services in a range of living situations that are available under Family Care and that the CMO has a qualified staff that has expertise in the area of long-term care and community resources. CMOs may subcontract with providers on a capitated basis and limit the profits of providers with which they subcontract. DHFS is required to review any subcontracts, including rates, to ensure that the contract terms protect service access and financial viability of the CMO. DHFS may require contract revisions.

CMOs must accept the requested enrollment of any person entitled to the Family Care benefit and if funding is available, accept the requested enrollment of any person eligible for the Family Care benefit. During the first two years of operation, each CMO is provided a phase-in period to build the necessary capacity to serve all individuals entitled to the Family Care benefit. The CMO is required to conduct a comprehensive assessment for each enrollee, including an in-person interview, using a standard format developed by DHFS, and with the enrollee's family or guardian, if appropriate, develop a comprehensive care plan reflecting the enrollee's

values and preferences. CMOs may not disenroll any enrollee except under circumstances specified by DHFS by contract. Any involuntary disenrollment is not effective until DHFS has reviewed and approved it. A CMO may not encourage any enrollee to disenroll in order to obtain long-term care services under the MA fee-for-service system.

As noted above, the CMOs are subject to performance standards in their contract and must submit reports and data to DHFS. CMOs must also implement internal quality improvement and quality assurance processes that meet DHFS standards prescribed by rule, and must cooperate with external quality assurance reviews, as well as submit an annual independent financial audit to DHFS.

DHFS may, by contract, impose solvency protections that DHFS determines are reasonable and necessary to retain federal financial participation. The current contract requires that the CMO must provide solvency protections through a cash reserve and through any other means acceptable to DHFS, including without limitation, aggregate reinsurance, lines of credit or parent guarantees. The required minimum reserve amount is set for the contract term and based upon the projected annual capitation payment as agreed upon by DHFS and the CMO.

DHFS may provide risk-sharing for CMOs and the current CMO contract offers sharing of both losses and savings with the CMO. Risk-sharing is offered for up to three years, but the contract states that DHFS intends to discourage risk-sharing beyond that time period. The schedule for the sharing of losses/savings is provided in Table 15. Richland County is the only county eligible for risk sharing in calendar year 2003.

**Table 15: CMO Risk-Sharing Option**

| Loss/Savings Ranges | CMO | State | Federal |
|---|---|---|---|
| < 2% | <100% | 0% | 0% |
| 2% to 10% | 50% of non-federal share | 50% of non-federal share | 58.92% of total |
| > 10% | 100% | 0% | 0% |

**Family Care Districts.** County boards may create a special purpose district, termed a "Family Care district," which is separate, and distinct, and independent of the state and the county. County boards of two or more counties may create a multi-county Family Care district. A Family Care district can operate a resource center or a CMO, but not both. The purpose of the Family Care district is to provide a mechanism to avoid potential conflicts of interest that would exist if the same entity performed both the functions of a resource center and a CMO.

The members of the governing board of the Family Care district are appointed by the county board, county administrator or county executive. However, not more than 25% of the board members can be elected or appointed officials or employees of the county or counties that created the Family Care district. All board members must be residents of the Family Care district and board members must reflect the ethnic and economic diversity of the area of the Family Care district. At least one-fourth of the board members must be either representative of the client group(s) that will be served by the district or be family members, guardians or other advocates of such individuals. A single-county Family Care district would have 15 members in the board, while a multi-county district would have an odd number of members of at least 15 but no more than 21 members.

Family Care districts are provided a broad range of powers necessary and convenient to carry out the operation of a resource center or CMO, such as the authority to enter into contracts, hire and pay employees and buy property. However, Family Care districts are prohibited from issuing bonds or levying a tax or assessment. Family Care districts are subject to many of the same

requirements covering other public entities, such as open records laws and open meeting laws; however, they may also benefit from many of the advantages afforded public entities, such as exemption from local property taxation and the state corporate income and franchise taxes, as well as the right to participate in the Wisconsin Retirement System.

**Long-Term Care Councils.** In a county, or contiguous counties, that participate in the Family Care pilot program, the county board or county administrator must appoint a local long-term care council (LTCC). In counties in which a LTCC is established, the COP planning committee is dissolved and the LTCC assumes the duties of the COP planning committee. Any band or tribe that intends to operate a resource center or CMO must also establish a LTCC.

A LTCC that serves a single-county area consists of 17 members, at least nine of whom must be elderly, physically disabled, developmentally disabled or their immediate family members or other representatives. The age or disability represented by these nine members must correspond to the proportion of individuals receiving long-term care in this state who are elderly, or have a physical or developmental disability. The remaining member must include providers of long-term care services, individuals residing in the county with recognized ability and demonstrated interest in long-term care and up to three members of the county board of supervisors or other elected officials. A LTCC that serves an area of two or more counties would have 23 members, at least 12 of which would be consumer representatives. The LTCC may include up to four members of the county boards of supervisors or other elected officials, but if there are more than four counties served, the number of county elected officials could increase to allow at least one county official from each participating county. A LTCC council appointed by a tribe, band or by the Great Lakes Inter-Tribal Council, Inc., would consist of 21 members, at least 11 of whom would be consumer representatives, while up to three members of the governing board of the tribe, band or the Great Lakes Inter-Tribal Council, Inc. could be appointed to the LTCC.

Members of the LTCC serve three-year terms. No member can serve more than two consecutive terms. The county must provide training to the consumer members of the LTCC to enable them to participate effectively and the county must provide compensation for reasonable expenses associated with membership participation. At the first meeting of the LTCC, members must elect a chairperson, a secretary and other officers as necessary. The chairperson presides at all meetings when present and countersigns all actions taken by the LTCC.

A LTCC must do all of the following:

a. Develop the initial plan for the structure of the resource center and the CMO, including recommendations to the county board (or other governing board of tribe) and to DHFS on all of the following: (1) whether the county (tribe) should exercise its right of first selection to operate a resource center or CMO and how the operation should proceed; (2) whether the county should create a Family Care district to operate a resource center or a CMO; (3) whether local organizations other than the county (or tribe) should serve as alternatives or in addition to county-operated entities to operate a resource center or a CMO; and (4) if applicable, how county-operated functions should interact with a resource center or CMO that is operated by an Indian tribe or band.

b. Under criteria prescribed by DHFS in consultation with the state Council on Long-Term Care, evaluate and determine whether additional CMOs are needed in the area and if so, recommend this to DHFS;

c. Advise DHFS regarding applications for initial certification or certification renewal of CMOs, including providing recommendations for

organizations applying for certification or recertification, and assist DHFS in reviewing and evaluating the applications;

d. Receive information about and monitor complaints from individuals served by the CMOs concerning whether the numbers of providers of long-term care services used by the CMOs are sufficient to ensure convenient and desirable consumer choice and provide recommendations to DHFS;

e. Review initial plans and existing provider networks of any CMO to assist the CMO in developing a network of service providers that includes a sufficient number of accessible, convenient and desirable services;

f. Advise CMOs about whether to offer optional acute and primary health care services and, if so, how these benefits should be offered;

g. Review the utilization of various types of long-term care services by CMOs;

h. Monitor the pattern of enrollments and disenrollments in the CMOs;

i. Identify gaps in services, living arrangements and community resources and develop strategies to build local capacity to serve older individuals and individuals with physical or developmental disabilities;

j. Perform long-range planning on policy for older individuals and individuals with physical or developmental disabilities;

k. Annually review interagency agreements between the resource center and CMOs and make recommendations, as appropriate, on the interaction between the resource center and CMOs to assure coordination among them;

l. Annually review the number and types of complaints and grievances about the long-term care system by individuals who receive or may receive care under the system, to determine if a need exists for system changes, and recommend system or other changes, if appropriate;

m. Identify potential new sources of community resources and funding for needed services for the elderly and disabled;

n. Support long-term care system improvements to the elderly and disabled;

o. Annually report to DHFS concerning significant achievements and problems in the local long-term care system; and

p. Advise on whether the county-operated CMO met the performance standards in 2002 and whether DHFS should contract with an additional CMO in 2004.

DHFS is required to consult with the LTCC before soliciting applications for CMOs when there is open competition for the function in calendar year 2004 and later. Finally, the county and LTCC, rather than just the county, must agree in writing in order for DHFS to contract for a non county-operated CMO in the period of protection against competition.

## Other MA Managed Care Programs

This section of the paper describes other MA managed care programs that provide long-term care services to enrollees.

**Program for All Inclusive Care for the Elderly (PACE)/ Wisconsin Partnership Program (WPP)**. The PACE and WPP programs are managed care programs that provide both acute health and long-term care services to elderly and disabled individuals whose care needs would make them eligible for placement in a nursing home. These programs provide a comprehensive system of

health care and other supportive services to maintain people in the community.

There are two major differences between the PACE and WPP programs. First, PACE requires enrollees to attend a day health center on a regular basis in order to receive many services. In contrast, WPP focuses on providing comprehensive services in the participants' home while offering voluntary enrollment in adult day care. Second, PACE requires that the client's primary physician be a physician who is a member of the PACE organization, while WPP attempts to retain the client's current primary physician by recruiting that physician to the WPP organization. The PACE and WPP sites are paid a monthly capitation rate for each person served, and are at risk if costs for needed services exceed the capitation rate.

There is currently one PACE site in Wisconsin, Community Care for the Elderly (CCE) in Milwaukee County, which began operating in 1989. CCE also operates one of four WPP sites along with Eldercare, the Community Living Alliance, and the Community Health Partnership. Eldercare of Dane County began operating the program in 1996. In addition, the Community Living Alliance (CLA) of Dane County began operating a WPP site that exclusively enrolls disabled individuals under 65 years of age in 1991. Finally, in 1997, Community Health Partnership (CHP) began operating a multi-county WPP program serving both younger disabled individuals and elderly individuals residing in Eau Claire, Chippewa, and Dunn Counties. The WPP program is also expanding into Racine County. Current enrollment for all of the PACE and WPP sites totaled 1,187 individuals in November, 2002.

The PACE/WPP programs are voluntary, and are available to individuals that are eligible for both MA and Medicare (dual eligibles). In addition to the monthly capitation rate under MA, PACE/WPP sites receive a monthly payment under Medicare for acute care services. The capitation rates provide for normal fee-for-service coverage, as well as psychological services.

*PACE/WPP Programs.* Enrollment in the PACE/WPP programs are controlled by contract with the entities that operate the five sites in Wisconsin. Each contract specifies a maximum enrollment for the site. Table 16 lists annual average enrollment levels for the PACE/WPP programs in each fiscal year since 1997-98.

Capitation rates vary by site and are based on an actuarial study of the costs to serve similar individuals under the fee-for-service system. The estimated cost under the fee-for-service system is discounted 5% to reflect an expectation that managed care will reduce costs. For 2002, the MA capitation rate for the elderly ranged from $2,819.28 per month for CHP to $2,873.50 per month for CCE. Capitation rates for the disabled tend to be higher and varied from $3,512.23 per month for CHP to $3,804.02 per month for CLA. Table 16 lists total annual MA costs for the PACE/WPP sites since 1997. These cost do not include acute care costs.

## Summary

Currently, most publicly-funded, comprehensive community-based long-term care is provided through MA waiver programs and COP-R, supplemented by long-term care services available as MA card services. In 2001-02, spending for these programs totaled approximately $731 million (all funds), which represented approximately 39.3% of all community-based long-term care expenditures in that year.

During the past decade, Wisconsin began pilot programs to provide long-term care services through managed care. First, the PACE/WPP programs were created to provide both acute and long-term care under a capitated, risk-based system at a limited number of sites throughout the

state.

In the mid-1990s, DHFS began a major initiative to redesign the entire long-term care system to achieve several goals, including the consolidation of multiple programs, increasing the types of services available to individuals who require long-term care, increasing accountability from providers and eliminating waiting lists for services. This effort led to the creation of the Family Care pilot program in 1999 Wisconsin Act 9. Nine counties currently operate resource centers and five of those counties operate care management organizations provide the comprehensive Family Care benefit. In the 2002-03 fiscal year, CMOs will receive an estimated $107.5 million in capitation payments. Most of the funding to support these capitation payments will be transferred from other long-term care programs from which enrollees had been receiving long-term care services, including MA and COP.

**Table 16: PACE/WPP Enrollment and Expenditures -- Fiscal Years 1997-98 through 2001-02**

| Site | Target Group | Program | 1997-98 | 1998-99 | 1999-00 | 2000-01 | 2001-02 |
|---|---|---|---|---|---|---|---|
| **Enrollment (Monthly Average over Year)** | | | | | | | |
| CCE | Elderly | PACE/WPP | 414 | 490 | 557 | 651 | 693 |
| Elder Care | Elderly | PACE*/WPP | 197 | 262 | 300 | 375 | 408 |
| CLA | Phy. Dis. | WPP | 57 | 92 | 130 | 165 | 205 |
| CHP | Eld. & Phy. Dis | WPP | 39 | 104 | 174 | 238 | 320 |
| Total | | | 707 | 948 | 1,161 | 1,429 | 1,626 |
| **Capitation Rate (Monthly Rate at end of Fiscal Year)** | | | | | | | |
| CCE | Elderly | PACE/WPP | $2132 | $2,429 | $2,438 | $2,660 | $2,874 |
| Elder Care | Elderly | PACE*/WPP | 2,177 | 2,465 | 2,465 | 2,779 | 2,819 |
| CLA | Phy. Dis. | WPP | 2,866 | 3,281 | 3,522 | 3,782 | 3,804 |
| CHP | Elderly | WPP | 2,072 | 2,219 | 2,374 | 2,668 | 2,819 |
| | Phy. Dis. | WPP | 2,594 | 2,977 | 3,359 | 3,425 | 3,512 |
| **Expenditures** | | | | | | | |
| CCE | Elderly | PACE/WPP | $10,577,500 | $13,556,100 | $16,501,600 | $7,584,200 | $9,789,000 |
| Elder Care | Elderly | PACE*/WPP | 5,247,400 | 7,409,800 | 9,782,700 | 20,603,900 | 22,506,500 |
| CLA | Phy. Dis. | WPP | 1,926,500 | 3,356,000 | 5,492,700 | 8,674,400 | 11,664,600 |
| CHP | Eld. & Phy. Dis | WPP | 1,017,900 | 2,908,300 | 5,495,600 | 11,984,400 | 14,135,600 |
| Total | | | $18,769,300 | $27,230,200 | $37,272,600 | $48,846,900 | $58,095,700 |

Note: Enrollment and expenditure amounts are approximate.
* The Elder Care PACE program closed in April, 2001.

## APPENDIX I

## Estimated COP Allocations -- Calendar Year 2002

| County | COP-R All GPR | COP-W GPR | COP-W FED | COP-W Total | GPR for COP-R & COP-W | Total All Funds COP-R & COP-W |
|---|---|---|---|---|---|---|
| Adams | $271,722 | $158,838 | $224,551 | $383,389 | $430,560 | $655,111 |
| Ashland | 346,623 | 279,744 | 395,477 | 675,221 | 626,367 | 1,021,844 |
| Barron | 460,809 | 297,723 | 420,894 | 718,617 | 758,532 | 1,179,426 |
| Bayfield | 270,445 | 195,579 | 276,492 | 472,071 | 466,024 | 742,516 |
| Brown | 2,540,427 | 1,776,451 | 2,511,386 | 4,287,837 | 4,316,878 | 6,828,264 |
| Buffalo | 230,009 | 153,166 | 216,532 | 369,698 | 383,175 | 599,707 |
| Burnett | 236,996 | 158,913 | 224,657 | 383,570 | 395,909 | 620,566 |
| Calumet | 258,985 | 164,459 | 232,497 | 396,956 | 423,444 | 655,941 |
| Chippewa | 651,274 | 359,857 | 508,733 | 868,590 | 1,011,131 | 1,519,864 |
| Clark | 455,808 | 318,989 | 450,958 | 769,947 | 774,797 | 1,225,755 |
| Columbia | 709,547 | 469,529 | 663,778 | 1,133,307 | 1,179,076 | 1,842,854 |
| Crawford | 256,807 | 153,773 | 217,390 | 371,163 | 410,580 | 627,970 |
| Dane | 5,198,232 | 2,916,442 | 4,123,003 | 7,039,445 | 8,114,674 | 12,237,677 |
| Dodge | 618,651 | 365,762 | 517,081 | 882,843 | 984,413 | 1,501,494 |
| Door | 219,264 | 120,181 | 169,901 | 290,082 | 339,445 | 509,346 |
| Douglas | 865,018 | 405,405 | 573,125 | 978,530 | 1,270,423 | 1,843,548 |
| Dunn | 389,193 | 224,320 | 317,123 | 541,443 | 613,513 | 930,636 |
| Eau Claire | 947,224 | 591,090 | 835,630 | 1,426,720 | 1,538,314 | 2,373,944 |
| Florence | 76,265 | 49,175 | 69,519 | 118,694 | 125,440 | 194,959 |
| Fond du Lac | 564,513 | 0 | 0 | 0 | 564,513 | 564,513 |
| Forest | 178,073 | 90,791 | 128,352 | 219,143 | 268,864 | 397,216 |
| Grant | 612,250 | 277,154 | 391,815 | 668,969 | 889,404 | 1,281,219 |
| Green | 392,817 | 178,271 | 252,023 | 430,294 | 571,088 | 823,111 |
| Green Lake | 137,443 | 98,115 | 138,706 | 236,821 | 235,558 | 374,264 |
| Iowa | 218,333 | 120,115 | 169,808 | 289,923 | 338,448 | 508,256 |
| Iron | 120,620 | 74,800 | 105,745 | 180,545 | 195,420 | 301,165 |
| Jackson | 263,331 | 198,296 | 280,333 | 478,629 | 461,627 | 741,960 |
| Jefferson | 590,681 | 326,675 | 461,824 | 788,499 | 917,356 | 1,379,180 |
| Juneau | 284,289 | 192,888 | 272,688 | 465,576 | 477,177 | 749,865 |
| Kenosha | 1,720,408 | 1,492,873 | 2,110,489 | 3,603,362 | 3,213,281 | 5,323,770 |
| Kewaukee | 225,138 | 218,716 | 309,201 | 527,917 | 443,854 | 753,055 |
| LaCrosse | 478,315 | 0 | 0 | 0 | 478,315 | 478,315 |
| Lafayette | 211,593 | 142,529 | 201,495 | 344,024 | 354,122 | 555,617 |
| Langlade | 313,392 | 135,336 | 191,326 | 326,662 | 448,728 | 640,054 |
| Lincoln | 239,506 | 188,161 | 266,005 | 454,166 | 427,667 | 693,672 |

## APPENDIX I (continued)

## Estimated COP Allocations – Calendar Year 2002

| County | COP-R All GPR | COP-W GPR | COP-W FED | COP-W Total | GPR for COP-R & COP-W | Total All Funds COP-R & COP-W |
|---|---|---|---|---|---|---|
| Manitowoc | $803,073 | $531,300 | $751,104 | $1,282,404 | $1,334,373 | $2,085,477 |
| Marathon | 1,157,524 | 1,076,112 | 1,521,310 | 2,597,422 | 2,233,636 | 3,754,946 |
| Marinette | 483,341 | 313,563 | 443,287 | 756,850 | 796,904 | 1,240,191 |
| Marquette | 151,067 | 150,154 | 212,274 | 362,428 | 301,221 | 513,495 |
| Menominee | 148,238 | 99,979 | 141,341 | 241,320 | 248,217 | 389,558 |
| Milwaukee | 8,619,684 | 3,033,955 | 4,289,132 | 7,323,087 | 11,653,639 | 15,942,771 |
| Monroe | 425,926 | 226,699 | 320,487 | 547,186 | 652,625 | 973,112 |
| Oconto | 331,406 | 168,732 | 238,538 | 407,270 | 500,138 | 738,676 |
| Oneida | 388,542 | 154,547 | 218,485 | 373,032 | 543,089 | 761,574 |
| Outagamie | 1,295,927 | 874,472 | 1,236,250 | 2,110,722 | 2,170,399 | 3,406,649 |
| Ozaukee | 482,555 | 368,030 | 520,288 | 888,318 | 850,585 | 1,370,873 |
| Pepin | 136,872 | 64,474 | 91,148 | 155,622 | 201,346 | 292,494 |
| Pierce | 382,401 | 152,122 | 215,056 | 367,178 | 534,523 | 749,579 |
| Polk | 447,658 | 301,896 | 426,793 | 728,689 | 749,554 | 1,176,347 |
| Portage | 210,952 | 0 | 0 | 0 | 210,952 | 210,952 |
| Price | 264,876 | 216,922 | 306,665 | 523,587 | 481,798 | 788,463 |
| Racine | 2,390,168 | 981,005 | 1,386,856 | 2,367,861 | 3,371,173 | 4,758,029 |
| Richland | 123,310 | 0 | 0 | 0 | 123,310 | 123,310 |
| Rock | 2,012,291 | 1,160,400 | 1,640,469 | 2,800,869 | 3,172,691 | 4,813,160 |
| Rusk | 196,561 | 222,404 | 314,415 | 536,819 | 418,965 | 733,380 |
| St. Croix | 421,787 | 238,919 | 337,762 | 576,681 | 660,706 | 998,468 |
| Sauk | 456,397 | 347,810 | 491,702 | 839,512 | 804,207 | 1,295,909 |
| Sawyer | 232,740 | 133,092 | 188,153 | 321,245 | 365,832 | 553,985 |
| Shawano | 383,451 | 456,499 | 645,357 | 1,101,856 | 839,950 | 1,485,307 |
| Sheboygan | 1,236,091 | 651,133 | 920,513 | 1,571,646 | 1,887,224 | 2,807,737 |
| Taylor | 204,800 | 153,050 | 216,368 | 369,418 | 357,850 | 574,218 |
| Trempealeau | 536,036 | 387,111 | 547,263 | 934,374 | 923,147 | 1,470,410 |
| Vernon | 204,620 | 233,714 | 330,404 | 564,118 | 438,334 | 768,738 |
| Vilas | 251,247 | 195,448 | 276,307 | 471,755 | 446,695 | 723,002 |
| Walworth | 683,453 | 552,520 | 781,103 | 1,333,623 | 1,235,973 | 2,017,076 |
| Washburn | 250,219 | 146,505 | 207,116 | 353,621 | 396,724 | 603,840 |
| Washington | 660,547 | 425,626 | 601,712 | 1,027,338 | 1,086,173 | 1,687,885 |
| Waukesha | 3,544,582 | 1,803,100 | 2,549,060 | 4,352,160 | 5,347,682 | 7,896,742 |
| Waupaca | 607,392 | 318,253 | 449,917 | 768,170 | 925,645 | 1,375,562 |
| Waushara | 234,197 | 327,336 | 462,758 | 790,094 | 561,533 | 1,024,291 |
| Winnebago | 1,707,153 | 1,031,478 | 1,458,211 | 2,489,689 | 2,738,631 | 4,196,842 |
| Wood | 780,118 | 522,518 | 738,689 | 1,261,207 | 1,302,636 | 2,041,325 |
| Oneida Tribe | 104,366 | 78,987 | 111,665 | 190,652 | 183,353 | 295,018 |

## APPENDIX II

## Eligibility Requirements for Long-Term Care Services
## Calendar Year 2003

| | MA Card Services | MA Community-Based Waiver | COP-R | Family Care |
|---|---|---|---|---|
| Eligible Groups | 1. Elderly<br>2. Blind or disabled<br>3. Families with dependent children<br>4. Certain pregnant women and children | 1. Elderly. (COP-W/CIP II)<br>2. Physically disabled (COP-W/CIP II)<br>3. Developmentally disabled (CIP IA, CIP IB, CSLA)<br>4. Brain-Injured (BIW) | 1. Elderly<br>2. Blind or disabled<br>3. Chronic mental illness<br>4. Alzheimer's or related disease | 1. Elderly<br>2. Physically Disabled adults<br>3. Adults with developmental disabilities in counties where CMO begins before July 1, 2003 |
| Eligibility of Non-Citizens | Lawfully admitted for permanent residence except if admitted after 8/22/96 subject to five-year ineligibility period. Groups exempt from five-year period include: (a) Cuban/Haitian; (b) veteran or active member of US Armed Forces; (c) refugees and asylees; (d) Amerasians; and (e) certain American Indians. | Same as for MA card services | No restrictions | Same as for MA card services |
| Residency | Current Wisconsin resident | Current Wisconsin resident | Wisconsin resident for the last six months | Current Wisconsin resident of a county where the Family Care benefit is available |
| Other Non-Financial Requirements | | Care requirements equivalent to someone qualifying for care in a skilled nursing facility.<br><br>Disability determination needed for non-elderly. | Meets one of the following requirements:<br>1. Qualifies for MA nursing home care;<br>2. Chronic mental illness and needs care to avoid repeated hospitalizations; or<br>3. Alzheimer's disease and requires care equivalent to nursing home providing personal care and activity therapy. | Meets one of the following requirements:<br>1. Long-term condition expected to last at least 90 days or requiring on-going care, assistance or supervision (nursing home level of care).<br>2. Long-term condition putting individuals at risk of losing independence or capacity (intermediate LOC).<br>3. Long-term condition and was receiving public long-term care when Family Care began. |

## APPENDIX II (continued)

## Eligibility Requirements for Long-Term Care Services
## Calendar Year 2003

| | MA Card Services | MA Community-Based Waiver | COP-R | Family Care |
|---|---|---|---|---|
| Asset Limitation<br><br>(for couple category, it is assumed that only one spouse needs services) | Individual: < $2,000<br><br>Couple: < $3,000<br><br>Excluded assets:<br>1. Home<br>2. One vehicle<br>3. Household goods and personal effects<br>4. Assets related to burial | Individual: <$2,000<br><br>Couple: <$53,000 to $90,660<br><br>Excluded assets:<br><br>Same as for MA card services | Individual: <$5,000<br><br>Couple: < $50,000 to $90,660<br><br>Excluded assets:<br><br>Same as for MA card services | FC-MA: Same as for MA Community-Based Waivers<br><br>FC Non-MA: Available income and available 12-month resource allocation must be less than the cost of actual services in individual's care plan<br>Excluded assets:<br><br>Individual:<br>In own home/RCAC -- $12,000<br>In CBRF/NH, or AFH -- $9,000<br>Other same as for MA Community-Based Waiver |
| Income per month that can be retained after cost-sharing<br><br>(for couple category, it is assumed that only one spouse needs services) | SSI Eligible:<br>Individual: $635.78<br>Couple: $961.05<br><br>Medically Needy (Spenddown)<br>Individual: $592<br>Couple: $592<br><br>Income deductions (applies to both groups)<br><br>1. First $65 plus ½ of earned income<br>2. $20 disregard, and<br>3. Health insurance premiums and other out-of-pocket medical expenses. | SSI-E Eligible<br>Individual: $731.77<br>Couple: $1,306.41<br><br>Medically Needy<br><br>Individual: $591.67<br><br>Special Income Limit (Gross Income <$1,656)<br>Personal Maintenance Allowance: $732 to $1,114<br><br>Income deductions (applies to all three groups):<br><br>1. First $65 plus ½ of earned income<br>2. $20 disregard<br>3. Health insurance premiums and other out-of-pocket medical expenses and<br>4. Excess housing costs (special income limit group only. The sum of the earned income and excess housing deduction cannot exceed $350.) | Individual: $666<br>Spouse (COP) $1,484<br>Spouse (Non-COP) $2,266<br><br>Six Month Resource Allocation:<br><br>Adults: $29,193<br>Children: $87,054<br><br>Income deductions:<br><br>1. First $65 plus ½ of earned income<br>2. $20 disregard<br>3. Health insurance premiums and other out-of-pocket medical expenses, and<br>4. County approved non-medical expenses. | FC MA: Same as for MA Community-Based Waivers<br><br>FC Non-MA: Same as above<br><br>Cost share equal to available income and available 12-month resource allocation less same personal maintenance allowance and income deductions for MA Community-Based Waivers<br><br>Income deductions:<br><br>1. First $200 plus two-thirds of earned income<br>2. Other deductions same as for MA Community-Based Waivers |