Chapter II: Administration

2.01 County Board of Supervisors

A. Responsibility

The County Board of Supervisors shall have the following responsibilities:

1. Create an Interagency Long-Term Support Planning Committee with responsibilities as specified in Section 2.02;

2. Appoint the members of the Committee in accordance with Section 2.02;

3. Designate a Community Options lead agency or joint agencies in accordance with Section 2.03;

4. Establish policies to be followed that ensure that the program uses existing county resources and personnel to the greatest extent possible; and,

5. Approve and submit the county Community Options Plan.

B. Delegation

County Board responsibilities may be delegated to the county executive or administrator in those counties that are covered under Chapter 59 of the Wisconsin Statutes.

2.02 Interagency Long-Term Support Planning Committee

A. Membership

At a minimum, the committee shall consist of:

1. At least five (5) members must be consumers receiving long-term community support services or a relative or guardian of such a consumer. At least two (2) of the consumer representatives must be actual recipients of long-term community support. Each of the following groups must be represented:

   a. Persons who are frail elderly;
   b. Persons with physical disabilities,
   c. Persons with developmental disabilities,
   d. Persons with chronic mental illness,
   e. Persons with chemical dependence;

2. At least two elected county officials;

3. At least one representative from the county health department;

4. At least one representative from the county department of social services under §46.215 or §46.22;

5. At least one representative from the county community department(s) created under §51.42 or §51.437;

6. At least one representative from the county commission on aging;

7. In counties that have a human service department, at least one (1) representative from that agency.

B. Additional Members Recommended

The statute establishes basic minimum representation on the committee but also requires coordination and consultation with other public and private providers of long-term support services. Representatives of service providers are appropriate additional members of the Interagency Long-Term Support Planning Committee. The department recommends that a representative from the areas listed below be included on the committee:

1. Home health agency;

2. Hospital, particularly discharge planners;

3. Nursing home;

4. Consumer advocacy organizations and/or consumer self-help organizations;

5. Physician, especially one who has a relationship with the county medical society;

6. An additional consumer representing persons with Alzheimer's disease or other irreversible dementias

C. Existing Committee

An existing county committee may be the Interagency Long-Term Support Planning Committee provided that the membership meets the criteria in this section.

D. Chairperson

The committee must have a chairperson. The selected chairperson may not be a staff person from the Community Options lead agency.

E. Responsibility

The committee must be an ongoing committee that meets at least quarterly. The Interagency Long-Term Support Planning Committee shall have the following responsibilities:

1. Develop and approve the county Community Options Plan and annual Community Options Plan Update, including a plan for the funds available through the: Community Options base allocation, Community Options carryover, Community Options-Waiver and CIP II;

2. Monitor, on a regular basis, the implementation and operation of the county's Community Option Program to assure compliance with applicable statutes, guidelines, procedures and the prudent management of limited funds;

3. Develop the Community Options Uniform Eligibility and Cost-Sharing Plan;

4. Develop any special county policies for Community Options (see 2.04 K, 5.04 A 11, 5.05 E, 5.06 A 3, 5.08 D, 5.10 C and 5.12);

5. Implement Community Options statutory responsibilities for persons with Alzheimer's disease and other related dementias, as specified in §46.27(3)(h) and §46.27(4)(c)7;

6. Plan for use of federal Medicaid care management funds in Community Options;

7. Develop plans and requirements for quality assurance, including client satisfaction, self-evaluation of care plan development, cost effective service utilization and the care manager's role (see Section 2.03 D 12);

8. Annually review and approve required interagency agreements;

9. Annually review and approve or deny requests for variances to service limitations;

10. Annually review reasons for denial of Community Options services, appeals or grievances, and any remedial actions taken as a result of grievances;

11. Ensure coordination of Community Options with Chapter55, Independent Living Centers, Interdivisional Agreement 1.67, and 51 department prescreening of nursing home admissions of mentally ill persons and persons with developmental disabilities (§51.42(3)(ar)13., §51.437(4m)(L) and §50.05(2r));

12. Ensure coordination of Community Options and the Medicaid community waivers in ways which maximize Community Options dollars by developing plans and requirements for the use of Medicaid community waiver program funds in lieu of regular Community Options funding whenever possible;

13. Ensure coordination of Community Options and the Medicaid Personal Care benefit provided by a county agency or an Independent Living Center;

14. Serve as a forum to coordinate various long-term support programs within the county (e.g., Medicaid community waivers. Family Support Program, Community Support Program); and,

15. Be part of the local grievance process if so designated in the county Community Options Plan.

2.03 Lead Agency

A. Selection of Lead Agency

The county board shall designate a Community Options lead agency or joint lead agencies to administer the program. The Community Options lead agency(ies) shall be either:

1. A county department of social services.

2. A §51.42, §51/437 or combined community services department.

3. A director of institutions and departments under §46.23.

4. A human services department as defined in §46.21.

5. A county aging unit as defined in §46.81(l)(a). Designation of a County Aging Unit as the Community Options lead agency or joint lead agency requires department approval under the statutes (§46.27(3)(b)6).

Since the department regards this as primarily a matter of local discretion, the only criterion for approval shall be documentation that the aging unit possesses the administrative and programmatic capacity to administer Community Options services, or has an acceptable plan to develop such capacity.

6. Any of the above agencies jointly. "Joint lead agencies" means separate agencies within a single county which have separate state/county contracts for Community Options.

   A lead agency subcontracting for some or all Community Options-funded services with another county agency does not constitute "joint lead agencies," however, the effects of such arrangements are similar. Nothing in these requirements restrict a lead agency from subcontracting with other agencies.

   Joint lead agencies shall consolidate their activities into a single Community Options plan. Regardless of whether single or joint Community Options lead agencies are designated, a single Interagency Long-Term Support Planning Committee and a single, comprehensive long-term support plan for the county will still be required.

   If joint lead agencies are designated, the selected agencies must represent the fixed points of responsibility for all Community Options applicants in the target group(s) they are designated to serve. For example, Community Options services provided to developmentally disabled persons may not be split between the department of community services and social services department; one of the agencies must represent the single fixed point of responsibility for all developmentally disabled Community Options recipients.

B. County Board Resolution

Existing county board resolutions passed prior to July 1989 will be honored with regard to the designation of Community Options lead agencies or joint lead agencies. If the county does not wish to make any change it does not need to submit a new resolution.

If a county wishes to change its designation of Community Options lead agency or agencies, it must do so by submitting to the Bureau of Long Term Support a new county board resolution which identifies the designated agency or agencies and the Community Options target groups for which the agency will serve as the fixed point of responsibility.

C. Special Considerations for Joint Lead Agencies

If joint lead agencies are selected to administer Community Options, the county will be required to:

1. Establish separate budgets for each agency as well as a county- wide Community Options budget summary if a county does not wish to establish separate budgets it should adopt subcontracting procedures rather than establishing joint lead agencies;

2. Explain who is responsible and how staffing for the county Interagency Long Term Support Planning Committee will be accomplished;

3. Explain how HSRS reporting and fiscal management will be accomplished; and,

4. Explain how intake and services delivery will be coordinated especially for supportive home care and MA personal care.

The above items will be required in the annual county Community Options Plan and do not need to be part of the county board resolution designating joint lead agencies.

D. Responsibility

The minimum responsibility of the lead agency(ies) is to:

1. Organize assessment activities;

2. Coordinate involvement in the assessment process of the department of social services, 51 board(s). Independent Living Centers, health service providers, hospital discharge planners, county commission on aging, the person assessed and her/his family or guardian;

3. Arrange service contracts;

4. Ensure that long term community services are necessary to meet an assessed need and COP is used as the funding of last resort (except for Family Support);

5. Provide for ongoing care management, periodic care plan review and follow-up services;

6. Apply the Community Options Uniform Eligibility and Cost-Sharing Plan;

7. Apply the program to current residents of nursing homes;

8. In addition to the requirement to plan to meet the needs of all Community Options age and disability target groups, plan to meet the needs of persons with Alzheimer's disease and other irreversible dementias and persons eligible for admission to an institute for mental disease;

9. Coordinate the program with other programs and service systems, such as Community Support Programs, Chapter 55 protective services, Interdivisional Agreement 1.67, and Medicaid community waivers;

10. Maintain required interagency agreements;

11. Ensure appropriate program reporting, billing, and budget reconciliation in compliance with the requirements of Chapter HSS 73 and these Guidelines;

12. Implement quality assurance procedures, including establishing a process for periodic self-evaluation of the care management function which examines outreach and access to the program, ensuring assessments are thorough and involve appropriate professionals, appropriateness of care plans based on the assessment, ongoing monitoring of services including an internal process of reviewing the approval of funding for extraordinary services, and monitoring the workload of care managers;

13. Serve as the fixed point of responsibility for all Community Options applicants in the Community Options target group(s) for which the agency is designated;

14. Serve as the fiscal agent (see Section 2.12) and develop the policies and procedures specified under Chapter HSS 73.07 - 73.09 for recipients of COP-funded supportive home care or respite care who directly receive funds to hire service providers; and,

15. Provide or arrange for a program of ongoing training for agency staff who are responsible for the performance of duties in the Community Options Program, and include a description of the plan for such training in the annual county Community Options Plan Update.

E. Interagency Agreements

Interagency agreements are required to ensure coordination of Community Options with other agencies providing community-based services.

1. One interagency agreement must be between the department of social services and the 51.42/.437 community departments), and must describe the mutual roles which allow for a coordinated completion of Community Options assessments, care planning, care management, service provision, allocation of funds, and other procedures. This agreement must also specify how coordination will be achieved with the Community Support Program, Medicaid waivers, Medicaid-funded care management. Chapter 55,I.A. 1.67, and Pre-Admission Screening/Annual Resident Review for persons with developmental disabilities or mental illness. Milwaukee County and Human Service Departments are exempt from this requirement (but must develop an intra-agency agreement on 51 department prescreening). Joint lead agencies must also address these issues in their interagency agreement.

2. The second agreement shall be between the Community Options lead agency and the county aging unit. This agreement must address coordination of Community Options with the Elder Abuse Reporting System, Title Ill-funded services (e.g., meals on wheels). Community Options-funded services to persons with Alzheimer's disease and other related dementias, and the Alzheimer's Family and Caregiver Support Program. If the lead agency is a Human Services Department that includes the county aging unit, it is exempt from this requirement.

3. An additional interagency agreement is required for joint lead agencies which identifies clear roles and responsibilities for: major program activities; decision making regarding expenditures of Community Options funds; cost-sharing, billing and collecting for services delivered; receipt, disbursement and accounting of Community Options funds; transfer of Community Options funds between agencies during the year; signing the Community Options contract with the department; required program and fiscal reporting; responding to grievances and appeals; and defining each agency's relationship to the Interagency Long-Term Support Planning Committee.

2.04 Use of Funds

A. Reimbursement Rates

The department repays lead agencies for allowable Community Options expenditures.

1. Assessments and care plans are reimbursed at flat unit rates determined by the department. If actual expenditures by the county for an individual assessment or care plan are less than the amount reimbursed, the county may retain the reimbursed amount provided the excess funds are expended for other Community Options purposes. Such funds received by a county must be expended during the calendar year in which they were earned; they may be used only for assessments, care plans, services or administrative costs in the Community Options, Community Options-Waiver or CIP II programs. Current rates are communicated to counties annually in the state/county contract. See Appendix C for current maximum rates. Reimbursement is calculated as follows:

   a. Assessments are reimbursed at rates determined by a department specified time study, up to a maximum (see Appendix C for current maximum reimbursement);
   b. Care plans are reimbursed at a flat rate (see appendix C for current rate).

2. Services are reimbursed at actual cost, within the limits of Section 2.04 E.

3. Subcontractors may be paid at rates established by the lead agency within the department's Allowable Cost Policy.

B. Transfers

With prior notice to the department, funds allocated for assessments and care plans may be transferred to the county's service allocation if the county reasonably projects that the funds transferred would otherwise remain unspent at the end of the year. Any, or all of such funds which have been transferred may be returned to the assessment and care plan allocation later in the year.

Funds allocated for services may not be transferred to the assessment or care plan allocation.

C. Administration

No more than seven (7) percent of service funds may be used for program administration, unless a variance is granted by the department (see 5.12 B 4). In accordance with county policy, expenses of Interagency Long-Term Support Planning Committee members may be reimbursed as an administrative expense.

D. High Cost Funds

Lead agencies may request "high cost funds" from the department. Such funds are generally used for the purchase of one-time high cost services or equipment needed by an individual. In addition, high cost funds may be used for services or equipment which will help the lead agency improve its ability to provide services to high cost participants. Improving the county's ability to access federal long-term support funds is an example. Requests for high cost funds are submitted to the Bureau of Long Term Support and are considered on a case-by-case basis. Further information on accessing high cost funds and prioritized uses of high cost funds can be obtained through the DSL Memo Series.

E. Allowable Average Community Options Service Cost

1. **Services to Individuals**. Reimbursement for ongoing services to an individual may not exceed the average monthly Medicaid payment for nursing home care, unless the lead agency grants an exemption under Section 5.09 B for one of the following circumstances:

   a. The person is under age 22,

   b. The person is ventilator dependent,

   c. The lead agency has determined that:

      1) The cost of providing nursing home care for the person would exceed the cost of care in the community,

      2) nursing home care is not available for the person, or

      3) public funding is not available for nursing home care for the person.

2. **Lead Agency Allowable Average Cost**. Unless a variance is granted under Section 5.12B, year-end reimbursement of

service and administrative expenditures to a lead agency is limited to the state share of the average monthly Medicaid payment for nursing home care.

The department shall establish the average monthly Medicaid payment for nursing home care for each calendar year and communicate it to lead agencies in the state/county contract. See Appendix C for the current average monthly payment for nursing home care.

F. Requirement to Serve Persons With “High Cost” Service Plans

At least 20% of the lead agency's Community Options and Community Options-Waiver recipients at any point in time must be "high cost" participants. "High cost" participants are defined as those whose "total cost" of community care is greater than twice the allowable cost average. The department shall establish this limit and communicate it to counties annually in the state/county contract (see Appendix C for the current funding level considered "high cost"). Counties with Community Options service caseloads of fewer than 25 people on December 31 of the previous calendar year are exempt from this requirement.

"Total cost" of care may include room and board, Community Options funds, Medicaid community waiver funds, community aids, and Title III. Room and board may be included even if they are paid by other sources, such as SSI and SSI-E. It does not include services which are paid by the person's Medicaid card (e.g., Medicaid home health care).

At the county's discretion non-Community Options participants served in the community under the Community Options-Waiver and CIP II may be taken into account toward meeting this requirement.

G. County Service Expenditure Maximum

A county may establish an absolute maximum expenditure limit above the service expenditure review threshold only if the county's expenditures exceed the allowable average Community Options service cost (see Section 2.04 E), and the department has denied a variance (see Section 5.11 B). Written approval of the Interagency Long-Term Support Planning Committee and the Bureau of Long Term Support is required to establish a maximum.

H. Hospital Link Pilot Projects

1. **Purpose**. Community Options funds are allocated under §46.271 for projects to improve coordination and linkages

with hospital discharge planning. In addition to funds for administrative development of these projects, the department may reserve some service funds for use in these projects. The primary purpose of these projects is intervention to prevent people from being unnecessarily place in nursing homes for long term care when they are discharged from hospitals.

2. **Project Selection**. Projects are selected by the department from applications submitted by lead agencies. Criteria for selection under this competitive process are described in the Request for Proposals sent to all lead agencies.

3. **Use of Funds**.

   a. **Administrative funds**. Administrative funds awarded to lead agencies may be used only as approved by the department in accordance with the purposes and conditions described in §46.271 of the statutes, the Request for Proposals issued by the department to solicit applications for these funds, and the lead agency's application for these funds, including any subsequent revisions to the application agreed to by the lead agency and the department.

   b. **Service funds**. COP and COP-W service funds allocated specifically for hospital link projects may be used only for services for persons otherwise eligible for Community Options who are referred through the approved hospital link process established by the lead agency. As long as these funds remain available to the lead agency, they must remain dedicated to this purpose and are subject to these limitations. In addition to any service funds allocated specifically for these projects, a lead agency may chose to reserve a portion of its general COP and/or COP-W service allocation to serve older people with long term care needs who are being discharged from hospitals.

4. **Reporting**. Participants served under a hospital link project must be identified in the Human Services Reporting System (HSRS) as directed by the department. This reporting requirement remains in effect as long as any COP and/or COP-W service funds allocated specifically for a hospital link project remain available to a lead agency. In addition, the department may require a lead agency awarded hospital link

project funds to submit narrative and/or budget reports regarding the design and operation of the project, participants served, and other information that will assure accountability for funds and assist in evaluating department and lead agency policies for these project.

5. **Plan**. A lead agency which receives hospital link project funds shall include a description of its project in its Community Options Plan.

I. Limitations on the Use of Community Options Funds

No Community Options service funds may be used:

1. To purchase land or build buildings;

2. To provide care or services in an institution to non-residents unless a variance is granted (see Section 5.12);

3. For community-based services to persons residing in an institution unless discharge is planned within 90 days and a variance is granted, or unless such services are provided during acute or recuperative stays of not more than 30 days (see Section 5.12);

4. For care in a Community-Based Residential Facility (CBRF) except as allowed in Section 2.04 M;

5. For services to any individual who is subject to the Medicaid community waiver use requirement (see Section 2.04 L), but who refuses an offer of such services;

6. To purchase services or equipment that: (a) are not directly a response to documented need in a COP participant's assessment and care plan; (b) are not a cost-effective means of meeting a documented need; or (c) can be paid for with other funds;

7. To purchase services for any individual who has not resided in Wisconsin for at least 180 consecutive days before applying for or receiving Community Options services (See Section 4.04 C).

J. Purchase of Equipment Amortization

Any Community Options funds used for one time purchase of equipment or adaptive aids for an individual participant are exempted under certain conditions from the normal purchase

of service amortization requirements of the allowable cost policies. See Allowable cost Policy Manual for details. (1998 Revision)

K. Carryover of Community Options Funds

Lead agencies may carry forward unexpended Community Options funds from one calendar year to the succeeding calendar year. Up to 10% of the lead agency's base Community Options allocation including Community Options-Waiver match allocations may be carried forward. Lead agencies may not, however, deny applicants or participants needed services if Community Options service funds remain uncommitted to current recipients unless the lead agency receives department approval to do so.

Use of carryover funds is subject to the approval of the Interagency Long-Term Support Planning Committee and the department. A plan for the use of such funds must be submitted to the department by July 1 of the following year.

Carryover funds may be used for any Community Options purpose except general administrative or administrative staff costs. They may be used for such purposes only if those costs are directly related to administration of the Community Options-Waiver and are approved by the department.

"General administrative or administrative staff costs" are defined as any expense which is not part of a direct service to a recipient of care. Such costs do not include:

1. Conducting assessments or developing care plans;
2. Providing care management;
3. Providing direct care, such as hands-on supportive home care;
4. Training supportive home care or respite workers; or,
5. Paying fiscal agent costs or unemployment, social security, worker's compensation or related taxes.

L. Required Prior Use of Medicaid Community Waivers (Waiver Mandate)

Whenever possible as described in this section, CIP I, CIP 11 or COP-W Medicaid Community-Based Services Waiver funds must be used in lieu of Community Options funds to provide services to an individual. §46.27(6r)(a)

1. **Required Use**: Regular Community Options funds may not be used for any Medicaid community waiver allowable service for any participant receiving Community Options services if:

   a. The participant is waiver-eligible, unless the persons is exempted in paragraph 5; and

   b. The lead agency has Medicaid community waiver resources available. (Medicaid community waiver resources are deemed available if the lead agency has allocated waiver resources which are uncommitted or has regular Community Options funds available to create a locally matched waiver slot.)

2. **Scope**: The mandate applies to all participants who are eligible for or become eligible for Medicaid community waiver services. For any participant who, through a spend down or other means becomes waiver-eligible at a later date, the mandate applies at the time eligibility occurs and a Medicaid community waiver application must be completed and processed. Community Options funds may continue to be used until waiver resources become available.

3. **Waiver-Eligibility Determination Required**: If the person is potentially waiver-eligible, a waiver application must be initiated unless the lead agency documents evidence that the applicant is ineligible for the Medicaid community waiver or is otherwise exempt from the mandate. Acceptable evidence of Waiver-ineligibility could be:

   a. The person does not meet Medicaid community waiver level of care requirements;

   b. The person does not meet Medicaid community waiver financial eligibility as determined by the lead agency Economic Support Unit or the Community Options Eligibility and Cost-Sharing Worksheet;

   c. The person does not meet other program eligibility, e.g., the person is an illegal alien; the person is denied a disability determination by the Division of Health Care Financing Disability Determination Bureau; the person is aged 22 to 64, has a diagnosis of mental illness and is not otherwise considered appropriate for care in and

admission to a nursing home or ICF-MR at a level of care reimbursable under Medicaid;

d. The person will have Medicaid card costs, as determined by BLTS or its contract agent, in excess of the maximum allowable for participation in the Community Options-Waiver, CIP I or CIP II; or,

e. The person's care plan is to reside in a living arrangement which is appropriate to meet assessed needs but is not allowable under Medicaid community waivers (i.e., CBRF larger than 8 beds).

4. Availability of Resources: Medicaid community waiver resources are deemed available if:

   a. The lead agency has a vacant CIP I or CIP II slot for which the participant is eligible; or,

   b. The Community Options-Waiver match allocated by the state is not fully committed to current participants; or,

   c. The lead agency has regular Community Options funds available to match available Medicaid community waiver slots thus applying the mandate to those funds as well.

5. Exemptions: The following are exempted from the mandate:

   a. Any person for whom a Medicaid community waiver application is being processed may receive Community Options-funded services for up to 90 consecutive days after initial services begin provided that within the first ten (10) calendar days after services begin:

      1) A referral for a Medical Assistance application is made to the county Economic Support Unit, unless the person is already receiving Medical Assistance in the community (including SSI recipients);

      2) For CIP II and Community Options-Waiver applicants, completion of a Community Options functional screen signed by a nurse or social worker, or for CIP I, initiation of a PPOC; and,

      3) An initial Community Options individualized service

plan is completed. This plan may be revised when finalizing the Medicaid community waiver packet.

b. Any person whose total state share of costs under regular Community Options would be less than the state share (41% of the total) under the Medicaid community waiver. For such an exception to apply, the lead agency must enter the following documentation into the participant's record:

   1) State Community Options costs with the Medicaid community waiver (regular Community Options costs plus 41% of waiver costs);

   2) State Community Options costs without the Medicaid community waiver;

   3) State savings (#2 is less than #1).

c. Any person whose total cost of care for Community Options-funded services is less than $ 100 per month may be exempted from the waiver mandate by the lead agency with no cost-effectiveness documentation required. (Whenever a spouse or parent of a minor receives regular Community Options payments to provide services, subtract the cost of such payments from total costs of care to determine if the remaining cost is less than $100).

d. Any person who will receive only services (other than care management) or equipment which are not waiver allowable, including direct payments for care to a spouse or parent of a minor.

e. For the COP-Waiver or CIP II, any child who has not reached the age of eighteen, however, upon reaching age eighteen the mandate becomes operative. Children are not exempt from the CIP I waiver mandate.

f. Any single parent of minor children whose income places them in category C (medically needy) of the Medicaid community waiver cost-sharing worksheet.

6. **Mixed Uses of Regular Community Options and Medicaid Community Waivers**: Regular Community Options funds must be used in concert with Medicaid Community waiver funds whenever any of the following applies:

a. The equipment, services or providers required by the recipient are not waiver-allowable (e.g. certain attendant care provided by a spouse or parent of a minor, all services while the recipient is hospitalized, etc.); or,

b. Additional funds to current recipients are required to supplement costs exceeding the allowable Medicaid Community waiver rate or state match allocation. Lead agencies are encouraged to request a rate variance on any of the Medicaid community waivers in order to increase the lead agency average before committing regular Community Options funds to supplement Medicaid community waiver rates.

7. **Applications or Service Agreements**: Each lead agency shall incorporate into its signed Community Options applications, or service agreements signed by all recipients, language which requests and authorizes the lead agency to seek Medicaid reimbursement for any and all costs which are covered by Medicaid or Medicaid community waivers. The language shall also contain a statement that in electing to receive Community Options services the recipient has been offered a choice between available nursing home care and Community Options services.

8. **Denials**: The denial of Community Options services to persons to whom the required use of Medicaid community waiver funding applies but who decline such funding shall not be appealable under Chapter 227.

9. **Recipients as Employers**: In counties which permit regular Community Options or supportive home care recipients to function as employers of their supportive home care or respite care workers, the county shall also permit recipients of such waiver-funded services to function as employers if they are determined capable of doing so. In such cases the county shall adopt procedures which will enable recipients to function as employers, for purposes of direction and control of providers, with the exception that Medicaid community waiver funds may not be paid to a recipient or any other third party. Medicaid community waiver funds may be paid only to the service provider or to a fiscal intermediary who then pays the service provider. (See Medicaid Community Waivers Manual for further information on supportive home care services provided by the Medicaid community waivers.)

M. Purchasing Services for Residents of CBRFs

Community Options funds may be used for a resident of a CBRF only in accordance with this section.

1. Limit on funding for residents of CBRFs.

   a. A lead agency shall establish a limit to the amount from its annual allocations for COP and COP-W (including federal COP-W matching funds) it will spend for community based services to participants who reside in CBRFs. The lead agency shall establish a separate such limit for participants in CIP II. (Community based services include all services funded by COP/COP-W or CIP II). The county-determined maximum amount is to include expenses in all types of CBRFs, including those comprised of independent apartments and those with a dementia care program. The limits may be expressed either as a specific dollar amount or as a percentage of the allocations, and shall be incorporated into the county Community Options Plan subject to approval by the Interagency Long Term Support Planning Committee. Whenever COP is used as match for any other Medicaid Waiver for a person residing in a CBRF, only the COP funds are counted in the expenditure total.

   b. Community Options service funds must be used for a person in his or her own home or apartment unless one of the following applies: (A county may establish more restrictions than those listed below, subject to DHFS approval.)

      1) Services are provided in an adult family home or in a CBRF consisting of independent apartments.
      2) Services to persons with Alzheimer's disease are provided in a CBRF that has a dementia care program.
      3) Services are provided in other CBRFs where all of the following conditions have been met:

         a) A COP assessment has been completed prior to the CBRF admission even for those who are paying privately.
         b) In-home options have been discussed, evaluated and found to be feasible. Determination that in-home care is infeasible must be made in accordance with administrative rule, HSS 73.

c) The CBRF is a person's preferred residence.
d) The CBRF provides quality services in a quality environment.
e) The CBRF is cost-effective.

c. If a county is at or above the applicable limit, additional CBRF residents applying for the program are ineligible, and reimbursement will not be provided, unless an exemption has been granted according to established policy.

1) Individual applicants may be granted an exception by the department in accordance with the hardship provisions of administrative rule HFS 73.

2) A lead agency may be granted an exception by the department for an individual's service costs from being counted towards its limit on funding for services for residents of CBRFs if it documents that the applicant has been diagnosed as terminally ill (a medical prognosis that the individual's life expectancy is less than 12 months) by a physician and hospice services can be provided in the CBRF. Exceptions expire under any of the following circumstances:

a) The participant no longer resides in the facility where the exception was granted.
b) The facility can no longer meet the participant's needs.
c) The lead agency can accommodate the cost of services to the participant within its limit on funding for services for residents of CBRFs.

d. The Department shall determine if a county engages in a pattern of inappropriate use of these funds. Use of these funds will be considered inappropriate if a Department review finds that the county's implementation of the admission assessment, the determination of infeasibility, preference, quality and cost-effectiveness shows a pattern which is inconsistent with statutory intent and Department criteria, and/or does not achieve the desired outcome of maximizing home care. (Specific criteria regarding inappropriate use are covered in DSL Numbered Memo series.)

2. No variance is required to continue to use Community Options service funds for a person who, prior to January 1, 1996, received COP service funds while residing in a CBRF larger than 8 beds, as long as that person continues to reside in that specific facility as licensed on December 31, 1995. (These persons are grandfathered in regardless of whether a variance may have been required in the past.) If a variance was required for the person to reside in the facility prior to January 1, 1996, the lead agency shall maintain a copy of the variance that was in effect on December 31, 1995 in the participant's case record.

   A variance is required to use Community Options funds for a participant who, on or after January 1, 1996, enters a CBRF licensed for more than eight (8) beds. Except that no variance is required for an elderly participant who will reside in a facility certified by DSL as consisting entirely of "independent apartments" (see Appendix Z), occupied by not more than two unrelated individuals. Variances are granted in accordance with Section 5.12 B 2.

   A variance may be granted for a participant to reside in any size CBRF if the facility was licensed prior to July 29, 1995. No variance may be granted for a participant to reside in a CBRF licensed on or after July 29, 1995 for more than 20 beds.

3. Care and services purchased from a licensed CBRF or Adult Family Home on behalf of a participant are subject to §46.036 Wisconsin Statutes and Section 3 of the department's Allowable Cost Policy Manual.

4. A lead agency may set a maximum unit rate which it will pay for services provided in a CBRF or Adult Family Home as long as the rate does not have the effect of eliminating availability of services in any facility class. This rate may not exceed the actual cost of services permitted under the Allowable Cost Policy. In addition, this rate may not be higher than the rate charged to private pay residents of the facility unless an exception is approved by the County Interagency Long Term Support Planning Committee.

5. As a part of the contract for services with a CBRF or Adult Family Home, a lead agency may specify special requirements a facility must meet in providing services to

individual(s) whose cost of care is funded through Community Options. Counties are not required to contract with facilities that are unable or refuse to meet these special requirements.

6. Lead agencies are not required to contract with or seek a variance to purchase services from any CBRF for which a size variance is required (see Section 5.12 B 2).

2.05 Cost-Sharing in Community Options

A. Services

Depending upon his/her available income and assets, an applicant/participant may be required to share in the cost of any community services identified in the care plan. Either the Community Options Cost-Sharing Worksheet or Medicaid Community Waiver Eligibility and Cost-Sharing Worksheet is used to determine an individual's cost-sharing obligation (see Section 2.05 E).

B. Assessments or Care Plans

With approval of the Interagency Long Term Support Planning Committee, a lead agency may establish a policy to apply cost-sharing to assessments and/or care plans. A lead agency may not charge more than the agency's state approved reimbursement rates (see Appendix C) for an assessment or care plan. Medicaid recipients are exempted from cost-sharing for assessments or care plans. A participant's share of the cost of an assessment or care plan is determined using the Community Options Cost-Sharing Worksheet. A lead agency must inform an applicant of the amount of any cost-sharing obligation prior to providing the assessment and/or care plan.

The lead agency shall report any revenue from cost-sharing for assessments and/or care plans on its CARS reports. (At the end of the calendar year, this revenue will be applied towards the lead agency's reported expenses for assessments and care plans before reimbursement is made for these services from allocated Community Options funds for assessments and care plans.)

C. Lead Agency Requirements

Lead agencies are required to:

1. Participate in the Community Options Uniform Eligibility and Cost-Sharing Plan (See the Community Options Uniform Cost-Sharing Plan, revised annually);

2. Establish ability to pay provisions equal to 100% of the

amount determined by the Community Options Cost-Sharing Worksheet;

3. Identify non-medical expenses which may be deducted in determining a participant's ability to pay;

4. Identity other programs, if any, to which cost-sharing will be applied;

5. Decide, with approval of the Interagency Long Term Support Planning Committee, whether to apply cost-sharing to assessments and care plans;

6. Determine cost-sharing for each applicant/participant;

7. Use funds collected through cost-sharing to pay for long-term community support services in accordance with this section.

D. Participant Requirements

An applicant or his/her guardian is required to:

1. Sign a statement disclosing all income and assets available for the support of the applicant and attesting that the disclosure of available income and assets is complete and accurate.

2. Pay any required cost-sharing as determined by the lead agency.

E. Determination of Cost-Sharing

1. **Community Options Participants**. Cost-sharing for Community Options participants who do not receive Medicaid community waiver services is determined by using the annually updated Community Options Cost-Sharing Worksheet (see Appendix D). Fees collected under these cost-sharing arrangements must be used to pay for long-term community support services for persons who are eligible for Community Options.

2. **Participants In Both Community Options and a Medicaid Community Waiver**. Community Options participants who also receive services through a Medicaid community waiver use only the Medicaid Community Waiver Eligibility and Cost-Sharing Worksheet. In this situation there is no ability to pay for Community Options-funded services. Cost-sharing is determined at 100% on Medicaid community waiver services

only, and fees received must be applied toward the individual's expenses in the Medicaid community waiver program (see the Medical Assistance (MA) Community Waivers Manual).

F. Private Pay

Persons who are not financially eligible for Community Options-funded services are not considered Community Options participants except for conducting assessments and care plans. If the lead agency has established a policy approved by the Interagency Long Term Support Planning Committee to apply cost-sharing to assessments and care plans, private pay persons are responsible to pay the approved cost of a Community Options assessment or care plan. If such persons choose to pay for community-based services, they are responsible for the full cost of any services.

2.06 Estate Recovery in Community Options

The department may recover the cost of services provided to a participant after she/he reaches age 55 from his/her estate after the participant dies. The lead agency is responsible to:

1. Notify applicants and participants of the potential estate recovery at the time of intake, prior to placement on any waiting list, and as part of an offer of services.

2. Gather and keep current information from applicants and participants necessary to assist the department in estate recovery. A lead agency must:

   a. Complete an Estate Recovery Program Disclosure Form for each participant who is age 55 or older, and for each participant who becomes 55 years of age after initially receiving services;

   b. Update the Estate Recovery Program Disclosure Form for any participant who experiences a substantial change in her/his estate (e.g., an inheritance);

   c. Return a copy of each completed Estate Recovery Program Disclosure Form to the Division of Health Estate Recovery Program;

   d. Retain a copy of each completed Estate Recovery Program Disclosure Form in the participant's case record.

2.07 Confidentiality

A. Release of Information

Consent to share information with others shall be obtained from applicants before or during the Community Options assessment.

B. County Form

The very nature of the Community Options program implies the necessity for coordinative efforts on behalf of the applicant/participant. Thus, the county's release of information form should include agencies that are commonly used in the assessment/care plan steps of the program. A release of information form must be completed for each Community Options participant and maintained in the person's file. The form must contain these items:

1. Name of the program releasing information;
2. Name or title of the person or organization to which disclosure is to be made;
3. Purpose or need for disclosure;
4. Extent or nature of information to be disclosed;
5. Name of the applicant/participant;
6. Time period during which the consent is effective;
7. Date on which the consent is signed;
8. Signature of the applicant/participant or parent/ guardian; and,
9. A statement which indicates that the applicant/ participant may revoke consent.

2.08 Community Options as “Gap-Filling”

Community Options service funds are intended to be used in direct partnership with private income, SSI-E payments and all state, federal and county funds which are available for long-term support community services, including Medicaid community waiver funds.

2.09 Funding of Last Resort

Community Options service funds are the funding of last resort. Where other programs, other than the Family Support Program, are also defined as funding of last resort, they are to be used before COP funds. All other traditional and non-traditional funding sources, except Family Support Program funds, must be investigated and used as part of the funding package before a determination that a "gap" exists and that COP funds are necessary.

If a “gap” exists because of the need for an extraordinary service or item which is not funded by other sources, the county must still explore voluntary contributions or informal supports. With approval of the Interagency Long Term Support Planning Committee, a county may establish written policy and/or protocol relating to the use of COP funds for extraordinary or atypical services. (See Section 5.10)

Where funds which typically would be used to meet the identified need are committed to existing participants, or with reasonable documentation are projected to be fully expended prior to the end of the year, then a determination may be made that a gap exists.

2.10 Conflict of Competing Interests

Each county's Community Options Plan must contain a policy that will minimize conflict of interest. The county policy must protect against any conflict of interest inherent whenever service providers are involved in assessment or care plan development.

2.11 Significant Proportions

A. Generic Intent

The Community Options program must be generic. County assessments, care plans and services must be designed to be available to all five age or disability groups. Children, persons eligible for admission to an institute for mental disease, and persons with Alzheimer's or other related dementias are served within the Community Options target groups.

B. Target Groups and Minimum Requirement

To ensure that the program remains generic, each county's Community Options and COP-Waiver caseload is required to consist of a significant proportion of persons from each of the major target groups. The minimum significant proportion

Percentages each county must maintain are adjusted annually by the department to reflect:

1. Changes in the state population of persons eligible for Community Options; and,
2. Purposes for which increased funds, if any, are appropriated by the legislature.

See Appendix C for the current year required minimum significant proportions percentages.

C. Measuring Compliance

In determining significant proportions, all recipients who receive Community Options- or Community Options-Waiver-funded services are counted. Persons who receive no Community Options- or Community Options-Waiver-funded services are not counted. Recipients of CIP I or II waiver-funded services who also receive regular Community Options funds are counted. CIP I and CIP II recipients who receive no regular Community Options funds are not counted except as part of a department approved variance (see Section 2.11 G). All persons age 65 and over who receive Community Options or Community Options-Waiver service funds, regardless of their primary disability, are counted as frail elderly.

The department will measure compliance with significant proportions requirements by a point-in-time count of all persons receiving Community Options service funds. If the county believes that the point-in-time was unrepresentative, a quarterly point-in-time average may be substituted.

The department will assess all county efforts to serve persons within significant proportions including review of coordination with hospital discharge, and nursing home prescreening and relocation efforts such as the 51 department responsibilities under §51.42(3)(ar)13 and §51.437(4m)(L).

As an alternative to measuring compliance by a point-in-time count of persons served, a county may request approval to split COP/COP-W state GPR service funds by target group, provided:

1. The minimum percentage of funds for each group must be at least equal to the significant proportions minimums. If current spending for any one group is below the minimum, the county may apportion base funding according to current spending if it assigns future allocations and increases in a way

which will raise the relevant target group(s) up to the minimum over a period of time judged reasonable by the Department.

2. Assessment and case plan funds will be apportioned by the Department according to a standard formula for each target group.

3. The county may propose splitting out funds for one target group and counting persons for other target groups if the Bureau of Long Term Support finds the plan to be workable.

D. Enforcement and Earmarking

For counties which do not meet the minimum significant proportion for any target group, the department will earmark service allocation increases for the underserved group(s) until such time as the minimum proportion is attained. A county's total service allocation includes regular Community Options and Community Options Alzheimer's service funds, and Community Options-Waiver match.

Counties with total service allocations below $185,000 per year are exempt from earmarking. However, the department may require a county to adopt a plan to achieve a greater degree of compliance.

Compliance with significant proportions, whether funds will be earmarked and the amount of earmarking is based on the most recent accurate data available to the department. Following an initial notice of earmarking, counties will be given an opportunity to appeal the proposed earmarking by demonstrating that the data used by the department is incorrect and the county is meeting significant proportions. In addition, at any time during the year, counties may appeal to the department that special circumstances exist which make earmarking unnecessary or counter-productive. Such appeals will be considered by the department on a case-by-case basis.

E. County Use of Earmarked Funds

Earmarked funds may be completely released at anytime during the year that a county meets, and demonstrates ongoing maintenance of, the required minimum significant percentage for the target groups that were designated as underserved. Such release is conditional upon approval by the Bureau of Long Term Support, in writing, in response to a county's written request. Once earmarked funds are released, the may be used to provide services for any Community Options target group.

Earmarked funds that are not released may still be earned by lead agencies.

F. Plan of Correction

When a plan of correction is required, it is subject to approval by the department. The plan of correction shall include goals and an annual timetable, intended to increase the probability of meeting significant proportions. As part of this plan, counties must request technical assistance to overcome problems in meeting the requirement. This request is made to the OSF Regional Office Area Administrator. The Area Administrator contacts the appropriate bureau or office age/disability specialists to jointly analyze the issues and offer assistance to the county.

G. Significant Proportions Variance

Variances to the significant proportions requirement in the Community Options statute (§46.27(3)(e)) may be granted in the circumstances described in §46.27(3g) and this section. The department shall determine the type of information for which the county is required to provide documentation in order to support its request for a variance. The department will set the duration, terms and conditions of any variance. As part of a variance, the department may require a plan of correction. In many instances, a variance will also remove or reduce any requirements for the earmarking of funds.

For each variance request, approval of the county Interagency Long Term Support Planning Committee is required. Notification to the county social services department, human services department, 51 boards and county aging unit is also required. Requests due to emergency or unusual circumstances may be submitted prior to Planning Committee action. For more information about applying for variances see DSL Memo Series 94-14. The types of variances and procedures for requesting them are:

1. **Emergency/Unusual Circumstances**: A county may apply to the Bureau of Aging & Long Term Care Resources at any time for a variance due to emergency or unusual circumstances. Examples of unusual circumstances include: nursing home resident relocations due to bed closures; implementation of Hospital Link or other long term support initiatives.

2. **Demographic Differences**: A county may apply to the OSF regional Office Area Administrator if it has demographic or other data which demonstrates that within the county's population of COP-eligible persons, the proportion of persons in one or more target groups is significantly different from the statewide proportion of persons receiving Medicaid-funded long term care services in nursing homes.

3. **Waiting Lists**: A county may apply to the OSF Regional Office Area Administrator if it has disproportionately lengthy waiting lists for services in regular COP or COP-W for one or more target groups. A county requesting such a variance must demonstrate that its wait list data are accurate, its wait list procedures conform to Community Options Guidelines, and its procedures for applicants to access the program are fair and effective for all target groups.

2.12 Requirement to Serve As Fiscal Agent

A. Requirement

Wisconsin Statutes §46.27(5)(i) requires Community Options lead agencies to serve as fiscal agents or to contract with vendors to do so for purposes of paying required unemployment compensation (UC) contributions on behalf of participants who directly receive Community Options funds to hire supportive home care or respite care providers. Under UC law, such contributions are required whenever the participant pays $1,000.00 or more in cash wages to one or more providers during any calendar quarter of the current or previous year.

The level of services an individual receives may not be reduced to compensate for increased costs of fiscal agent activities unless the requirements of Section 5.10 E are met. The lead agency is expected to use the increase in Community Options allocations, or increases in revenues (e.g., MA care management revenue), to meet any increase in costs due to fiscal agent or UC requirements before serving new persons.

B. Status as Employer

Wisconsin Statutes §108.02(13)(k) specifies that when Community Options funds are paid to the participant and the county or fiscal intermediary functions as fiscal agent for UC contributions, the lead agency shall not be considered under the UC law as the employer of the home care provider. This blanket protection also applies when Community Options funds are paid by the lead agency or fiscal intermediary to the service provider rather than to the participant. In this situation, the fiscal agent

arrangement is optional, but failure to act as agent leaves the lead agency open to being designated the UC employer should the provider file an unemployment claim.

C. Required Procedures

The lead agency or fiscal intermediary shall perform the following duties on behalf of the participant:

1. Pay all state and federal UC taxes incurred by the participant as a result of services funded in whole or in part through Community Options funds paid to the participant; and,

2. Receive, review, complete and submit all forms, reports and other documents required under the state UC Act (Chapter 108) or the federal unemployment tax act; and,

3. Serve as the representative of the participant in any investigation, meeting, hearing or appeal involving a UC issue in which the participant is a party.

D. Waiver of Fiscal Agency

The participant may make an informed, knowing and voluntary election to waive the right to a fiscal agent. The waiver may pertain to all or part of the fiscal agent responsibilities. The waiver must be in writing and signed by the participant or the participant's representative. The participant assumes responsibility for all fiscal agent responsibilities waived for the period during which the waiver is in effect. Waivers may be rescinded by the recipient in whole or in part at any time.

E. Reimbursement

The cost of UC and fiscal agent activities should be considered part of the service cost for each participant. For ease of administration, however, the lead agency may elect to pay all or part of these costs as part of the program management expense subject to the normal 7% limit on total management costs (see Section 2.04 C).