

Report to the Legislature

Community Options Program

Community Options Program Waiver

Calendar Year 2014



Wisconsin Department of Health Services
Division of Long Term Care
Bureau of Managed Care
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Introduction: Community Options Program Overview

The Department of Health Services (DHS), Division of Long Term Care, respectfully submits this report pursuant to Wis. Stat. §§ 46.27(11g) and 46.277(5m), which requires summary reporting on state funds appropriated by the Legislature for the Community Options Program. Authorized in 1981, the Community Options Program (COP) provides a home and community-based alternative to nursing home care for frail elders and individuals with disabilities.

The Community Options Program (also known as COP Regular or Classic COP) is entirely state funded and has historically served frail elders, people with physical (PD) or developmental disabilities (DD), and people with serious mental illness (SMI) or substance abuse (AODA). In 1986, Wisconsin received a federal Medicaid Home and Community-Based Services (HCBS) Waiver (MA Waiver) to support frail elders and people with physical disabilities, allowing Wisconsin to obtain federal Medicaid funds for COP at approximately 60% of every dollar spent. This is referred to as the COP Waiver. The document reports on both the COP Waiver and its companion program, the Community Integration Program II (CIP II).

DHS also administers Medicaid HCBS waiver programs for adults with intellectual and developmental disabilities and with traumatic brain injuries, as well as for children with disabilities. Specifically, the Community Integration Program 1A (CIP 1A) and the Community Integration Program 1B (CIP 1B), supports long-term care needs of individuals with developmental and/or intellectual disabilities, in the community. The Brain Injury Waiver (BIW) provided funding to support individuals requiring brain injury rehabilitation. The BIW ended May 1, 2014, and all individuals served with BIW funding were moved to either the CIP 1 or CIP II program, depending upon eligibility. The three Children's Long-Term Support (CLTS) waivers serve children and young adults, under age 22, with developmental and/or intellectual disabilities, physical disabilities, and severe emotional disturbances living at home or in a foster care setting. Children with autism spectrum disorders may be served under the developmental disability waiver or the serious emotional disturbance waiver. Participation in these programs is reported in this document's tables, particularly when COP is a funding source.

With the implementation of Family Care and IRIS (Include, Respect, I Self-Direct), the COP program has been greatly reduced in counties where these reformed programs are operational. In the 57 counties that implemented Family Care and IRIS, COP funding is only available for eligible children and for adults with needs related to severe mental illness or substance abuse. Eligible frail elders and adults with physical or intellectual/developmental disabilities in those counties participate in Family Care or IRIS in lieu of COP. Data for Family Care and IRIS are not included in this report.

Highlights for Calendar Year 2014 include:

- COP and home and community-based waivers served 14,357 people.
- Of COP participants, 39.8% were diagnosed with a developmental or intellectual disability, 35.9% were elderly, and 14.1% had a physical disability. Of the approximately 10.2% remaining, nearly all received services related to mental illness, with under 0.2% participating due to alcohol and/or drug abuse.
- \$283.6 million was expended to serve people in COP and the related Medicaid HCBS waiver programs, excluding Family Care and IRIS.

Participants Served by Target Group

The table below illustrates participants served in 2014 with COP and Medicaid waiver funding, by target group.

Table 1 - Participants Served in 2014 with COP and HCBS Waivers

Client Characteristic	Elderly	PD	DD	MH	AODA /Other	MA Waiver	Waiver w/ COP	Statewide Total
COP-W	511	202	7	5	2	727		
COP-W w/ Supp COP	402	87	4	4			497	
Total COP W	913	289	11	9	2	727	497	1,224
CIP II*	942	524	19	8	4	1,497		
CIP II w/ Supp COP	548	265	3	19	5		840	
Total CIP II	1,490	789	22	27	9	1,497	840	2,337
Total COP-W/CIP II	2,403	1,078	33	36	11	2,224	1,337	3,561
CIP 1A	34	2	216	3		255		255
CIP 1A w/ Supp COP			2				2	2
Total CIP 1A	34	2	218	3	0	255	2	257
CIP 1B**	113	7	590	1		711		
CIP 1B w/ Supp COP	1		9				10	
Sub Total CIP 1B (state matched)	114	7	599	1	0	711	10	721
CIP 1B w/ COP Match	13	3	151	1		168		
CIP 1B/COP Match w/ Supp COP	3		3	1			7	
Sub Total 1B COP match	16	3	154	2	0	168	7	175
CIP 1B/other match sources	175	21	2,122	14	0	2,332		
CIP 1B other match w/ Supp COP	3	1	28				32	
Sub Total CIP 1B all other local match	178	22	2,150	14	0	2,332	32	2,364
Total CIP 1B	308	32	2,903	17	0	3,211	49	3,260
BIW	1	1				2		2
BIW w/ Supp COP		0					0	0
BIW COP Match		0				0		0
BIW other Match	0	0	0			0		0
BIW other Match w/ COP	0	0					0	0
Total BIW and Matching Funds	1	1				2	0	2
Total CIP 1A, CIP 1B, and BIW	343	35	3,121	20	0	3,468	51	3,519
Total Adult Waivers	2,746	1,113	3,154	56	11	5,692	1,388	7,080
COP Only Participants	133	17	36	745	6		937	937
Total COP and Adult Waivers	2,879	1,130	3,190	801	17	5,692	2,325	8,017
Total COP and Adult Waivers (% of Total)	35.9%	14.1%	39.8%	10.0%	0.2%			100%
Total CLTS (based on CLTS Claims)						5,849	491	6,340
Total Participants Served in CY 2014								14,357

*CIP II counts include Community Relocation Initiative (CRI), CRI-Money Follows the Person (CRI-MFP), Nursing Home Downsizing (NHD), CIP II Tribal, CIP II FC Transfers

**CIP 1B includes Intermediate Care Facilities for Developmental Disabilities/Intellectual Disabilities (ICF-IDD), ICF-IDD/ MFP, CIP 1 Tribal, and CIP 1 Family Care Transfers. This data does not include Family Care and IRIS Medicaid Waivers. Source: 2014 HSRS.

Community Options Program

As indicated in Table 1, the COP and Medicaid HCBS waivers included in the data, combined, served a total of 14,357 people. Below, Table 2 illustrates participants served in 2014 with COP and Medicaid HCBS waiver funding by target group. Similarly, Table 2A describes the number of participants receiving COP funding and the percentages of those populations by target group.

Table 2 - Summary of Total Participants Served by Program By Target Group

Client Characteristic	COP Only	COP-W, CIP II*	CIP 1**, BIW	Subtotal COP Only + Adult Waivers	CLTS (from TPA)	Total Clients
Elderly	133	2,403	343	2,879		2,879
PD	17	1,078	35	1,130		1,130
DD	36	33	3,121	3,190		3,190
MH	745	36	20	801		801
AODA/Other	6	11	0	17		17
CLTS from TPA					6,340	6340
Statewide Total	937 7%	3,561 25%	3,519 24%	8,017 56%	6,340 44%	14,357 100%

*CIP II counts include Community Relocation Initiative (CRI), CRI-Money Follows the Person (CRI-MFP), Nursing Home Diversion (NHD), CIP II Tribal, CIP II FC Transfers.

**CIP 1 includes Intermediate Care Facilities for Developmental Disabilities/Intellectual Disabilities (ICF-IDD), ICF-IDD/ MFP, CIP 1 Tribal and CIP 1 Family Care Transfers. This data does NOT include Family Care and IRIS Medicaid Waivers. See Table 1 for specific breakdown by waiver and those who also received support from COP. Source: 2014 HSRS.

TABLE 2A - Participants Receiving COP Funding by HCBS Waiver/Target Group

Target Group	COP Only	COP-W, CIP II Participants who also received COP	CIP 1, BIW Participants who also received COP	Subtotal COP Only + Adult Waivers w/COP	COP for CLTS	Total People Receiving COP	Percent of Participants Receiving COP by Target Group
Elderly	133	950	20	1,103		1,103	44%
PD	17	352	4	373		373	15%
DD	36	7	191	234		234	10%
SMI	745	23	2	770		770	30%
AODA	6	5		11		11	0%
Children w/ COP					491	491	
Total Participants served in CY 14 who received COP by Program	937	1,337	217	2,491	491	2,982	
Percent of Total Participants (14,357) who received COP	7%	9%	1%	17%	8%	42%	
Total People Served by Program (Table 2)	937	3,561	3,519	8,017	6,340	14,357	

Source: 2014 HSRS.

- 14% of the total participants used COP funding for match.
- 7% of the total participants were served with COP only.
- 84% of the participants who received some COP funding were adults.
- 38% of adults who received some COP funding received COP only.
- 54% of adults who received some COP funding were served in COP-W/CIP II HCBS waivers.
- 9% of adults who received some COP were served in the CIP 1/BIW HCBS waivers.
- 38% of the COP-W/CIP II participants received some COP assistance.
- 6% of the CIP 1/BIW participants received some COP assistance.

Funding Paid for Community Long-Term Care by Target Group/Program in CY 2014

Table 3 - COP and HCBS Waivers

Target Group	COP- Regular	COP-W	Subtotal COP & CW	CIP II (CIP II, CRI,NH Div, CIP II FC transfer, CRI MFP)	Subtotal COP- Regular, COP- W,CIP II	CIP I CLTS*, BIW	TOTAL
Elderly	4,101,659 16.1%	14,465,483 73.59%	18,567,142 41.1%	25,474,743 53.73%	44,041,885 47.59%		44,041,885 15.5%
PD	1,230,681 4.8%	5,192,289 26.41%	6,422,970 14.2%	21,935,346 46.27%	28,358,316 30.64%	4,106,572 2.1%	32,464,888 11.4%
DD	7,029,148 27.6%		7,029,148 15.6%		7,029,148 7.6%	171,348,910 89.7%	178,378,058 62.9%
SMI	13,053,977 51.2%		13,053,977 28.9%		13,053,977 14.1%	15,607,335 8.2%	28,661,312 10.1%
AODA/OTHER	70,662 .3%		70,662 .2%		70,662 .1%		70,662 .02%
Total**	25,486,127 9.0%	19,657,772 6.9%	45,143,899 15.9%	47,410,089 16.7%	92,553,988 32.6%	191,062,817 67.4%	283,616,805 100%

*Children's waivers serve children with a physical disability, a developmental disability, or a mental illness (total all funds paid CLTS = \$72,463,942)

Not included in this table is an additional \$1,255,542 of COP and MA FED that was spent on Family Care expansion (\$143,656) and on CLTS/adult waiver quality assurance and capacity building (\$1,111,886). Source: 2014 HSRS and Reconciliation reports.

Table 3 includes all the dollars paid in CY 14 for COP regular, the COP Waiver, CIP II waiver (which includes the CIP II Community Relocation Program and MFP, CIP II Nursing Home Diversion Program, CIP II Tribal and CIP II Family Care Transfers), CIP I waivers (consisting of 1A, 1B regular/ICF-IDD/MFP, Family Care Transfers, and CIP 1B Tribal), and the Children's Long-Term Support (CLTS) HCBS Waivers. Of the \$191,062,817 shown in Table 3, \$72,463,942 was paid for CLTS and \$118,598,875 was paid for CIP 1 and BIW. The BIW ended May 1, 2014; all individuals served with BIW funding were moved to either the CIP 1 or CIP II program depending upon eligibility.

Assessments, Care Plans, and Individuals Served

Table 4 - Use of COP Regular*

Target Group	COP Only	Supplemental COP (gap filling)	COP used as additional GPR match for waivers	Admin, Special Projects, Risk Reserve	Assessment/ Plans	Total COP Reported
Elderly	2,097,306 14.5%	1,714,301 70%	103,117 1.2%	159,021 14.3%	306,241 24.7%	4,379,985 16.1%
PD	241,456 1.7%	644,741 26%	293,701 3.5%	18,308 1.7%	115,986 13.2%	1,314,192 4.8%
DD	196,412 1.4%	87,068 4%	6,878,337 82.9%	27,092 2.4%	317,217 36.0%	7,506,126 27.6%
SMI	11,884,161 82.0%		1,017,465 12.3%	899,374 81.1%	138,782 15.7%	13,939,782 51.2%
AODA/Other	67,297 .5%			5,102 .5%	3,058 .3%	75,457 .3%
Total	14,486,632	2,446,110	8,292,620	1,108,896	881,284	27,215,542
% of total COP by category	53.2%	9.0%	30.5%	4.1%	3.2%	100.0%

*All amounts shown are in dollars. Source: 2014 HSRS and Reconciliation reports.

People expressing or demonstrating a need for long-term care services receive a functional assessment through the Long Term Care Functional Screen (LTCFS). DHS certified screeners assess each person's unique characteristics, medical conditions, living environment, lifestyle preferences, and goals. The participant (or guardian, if applicable) and care manager, in response to the assessment data, develop a plan of comprehensive services that integrates formal services along with informal and unpaid supports from family, friends, and the community. The care plan also includes individual choices and preferences for the type and arrangement of services. The person's available income and assets are also assessed and the participant may be responsible for contributing toward some or all of the costs for care plan services.

Table 5 illustrates the age distribution within each target group for new adults served in 2014. In 2014, elderly individuals accounted for 533 of new participants. Wisconsin considers participants "new" if services and costs are incurred in the current year, without receiving long-term support services of any type in the previous year. Individuals age 65 and over, regardless of diagnosis, are coded as elderly.

Table 5 - New COP and Adult Waiver Participants by Age in 2014

Age Group	Elderly	PD	DD	SMI	AODA/Other	Total
<18 yrs.*	NA	1	9	21		31
18 – 64 yrs.	NA	186	183	158	6	533
65+ yrs.	533	NA	NA	NA	0	533
TOTAL	533 (49%)	187 (17%)	192 (18%)	179 (16%)	6 (<1%)	1,097

*Thirty-one children turned age 18 during the reporting period. Source: 2014 HSRS.

Participant Case Closures

Table 6 illustrates the number of participants in each target group who were closed from programming in 2014. Death accounted for approximately 51% of elderly case closures. The transfer of individuals from COP and waiver services to Family Care, Family Care Partnership, or the IRIS program due to

individuals moving from a legacy waiver county to a Family Care county accounted for approximately 3% of case closures across all target groups.

Table 6 - Reasons for COP and Waiver Participant Case Closures

Reason for Closure	Elderly	PD	DD	SMI	AODA	Other	Total	% of Total
Person Died	354	45	24	5			428	51%
Transferred to Preferred Nursing Home Care	131	18	0	4	0		153	18%
No Longer Income or Level of Care Eligible	24	12	7	4			47	6%
Moved Out of State	20	10	10	8		1	49	6%
Voluntarily Ended Services	20	15	11	11		0	57	7%
Other Funding Used for Services	4		2	11	0	0	17	2%
Ineligible Living Arrangement	20	5	9	3	0	0	37	4%
Inadequate Service/Support	4	12		3	0	0	19	2%
Transferred to Family Care (FC), FC Partnership, or IRIS Program due to county move	11	3	3	11	1	0	29	3%
Other	3	2					5	1%
Total Cases Closed (all reasons)	554	126	104	124	1	2	841	100%

Source: 2014 HSRS.

COP Funding for Exceptional Needs

The statewide COP program also provides funds above county allocations for exceptional needs. Wisconsin Stat. § 46.27(7)(g) grants DHS the capacity to carry forward any COP and COP-W general purpose revenue (GPR) funds allocated but not spent by December 31 of each year into the next fiscal year. Counties can apply for these exceptional funds to support improvement or expansion of long-term community support services for COP-eligible individuals. Services may include:

- Start-up costs for developing needed services for people who are eligible.
- Home modifications for COP or HCBS waiver eligible participants, including ramps.
- Purchase of medical services, medical equipment, or other specially adapted equipment.
- Vehicle modifications.

In 2014, funding was allocated to 15 waiver agencies for exceptional needs in order to serve people with developmental and/or intellectual disabilities, physical disabilities, or frail elders. Beginning January 1, 2014, exceptional expense requests for children were funded through CLTS funds and not COP, so those funds are not included in this report. The funding was used for services and items such as home repairs and modifications, including ramps, mobility lifts, ceiling lifts, roll-in showers, raised toilets, wider hallways and doors, door openers, environmental control systems, adapted mobility equipment such as wheelchairs and scooters not covered by Medicaid, vehicular modifications, and awards for urgent dental work.

Participant Demographic and Service Profiles

Tables 7 through 12 provide participant demographic and service profiles.

Table 7 - COP and Waiver Participants Institutional Relocations and Diversions

Type of Relocation or Diversion	Number	Percent
Diverted from Entering any Institution	6,829	85%
Relocated from General Nursing Home	690	9%
Relocated from ICF/MR	457	6%
Relocated from Brain Injury Rehab Unit	41	<1%
TOTAL	8,017	100%

Note: Some totals may not equal 100% due to rounding. Source: 2014 HSRS.

Table 8 - COP and Waiver Participants by Gender

Gender	Elderly	PD	DD	SMI	AODA/Other	Total Participants	
Female	2,017	574	1,391	363	10	4,355	54%
Male	863	556	1,797	438	8	3,662	46%
TOTAL	2,880	1,130	3,188	801	18	8,017	100%

Note: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2014 HSRS.

Table 9 - COP and Waiver Participants by Age

Age	Elderly	PD	DD	SMI	AODA/Other	Total Participants	
Under 18 years*	0	2	14	33	0	49	1%
18 to < 65 years	0	1,128	3,174	768	18	5,088	63%
65 to < 75 years	1,031	0	0	0	0	1,031	13%
75 to < 85 years	883	0	0	0	0	883	11%
85 years and over	966	0	0	0	0	966	12%
TOTAL	2,880	1,130	3,188	801	18	8,017	100%

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

*Forty-nine children turned age 18 during the reporting period. Source: 2014 HSRS.

Table 10 - COP and Waiver Participants by Source of Natural Supports

Natural Support Source	Elderly	PD	DD	SMI	AODA/Other	Total Participants	
Adult Child	1,306	143	7	17	6	1,479	18%
Non-Relative	369	232	437	178	3	1,219	15%
Other Relative	494	187	375	125	3	1,184	15%
Spouse	422	182	24	21	0	649	8%
Parent	69	277	2,163	284	2	2,795	35%
No Primary Support	220	109	182	176	4	691	9%
TOTAL	2,880	1,130	3,188	801	18	8,017	100%

Note: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2014 HSRS.

Table 11 - COP and Waiver Participants by Living Arrangement

Living Arrangement	Elderly	PD	DD	SMI	AODA/Other	Total Participants	
Living with Immediate Family	708	417	1,425	126	4	2,680	33%
Living with Others with Attendant Care	533	128	686	215	3	1,565	20%
Living with Others	750	167	585	207	6	1,715	21%
Living Alone	697	263	234	217	4	1,415	18%
Living Alone with Attendant Care	132	103	185	21	1	442	6%
Living with Immediate Family with Attendant Care	35	36	41	3	0	115	2%
Living with Extended Family	16	13	24	6	0	59	1%
Living with Extended Family with Attendant Care	6	1	3	1	0	11	<1%
Transient Housing Situation	3	2	5	5	0	15	<1%
TOTAL	2,880	1,130	3,188	801	18	8,017	100%

Note: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% due to rounding. Source: 2014 HSRS.

Table 12 - COP and Waiver Participants by Type of Residence

Type of Residence	Elderly	PD	DD	SMI	AODA/Other	Total Participants	
Adoptive Home	0	0	8	2	0	10	<1%
Adult Family Home (AFH)	240	82	563	134	3	1,022	13%
Brain Injury Rehab Unit	0	5	1	0	0	6	<1%
Child Group Home	0	0	1	0	0	1	<1%
Community-Based Residential Facility (CBRF)	908	97	154	222	4	1,385	17%
Foster Home	3	1	33	15	0	52	1%
ICF/MR: Not State Center	0	0	0	0	0	0	0
Nursing Home	0	0	0	0	0	0	0
Other Living Arrangement	0	0	0	0	0	0	0
Own Home or Apartment	1,640	924	2,406	401	9	5,382	67%
Residential Care Apartment Complex (RCAC)	78	16	0	0	0	94	1%
Residential Care Center (RCC)	1	0	1	1	0	3	<1%
Shelter Care Facility	1	3	3	4	0	11	<1%
Supervised Community Living	9	2	17	22	0	50	1%
Unknown			1				
TOTAL	2,880	1,130	3,188	801	18	8,017	100%

Note: Participants with a dual diagnosis are counted by first client characteristic as reported to HSRS regardless of funding program. Some totals may not equal 100% because of rounding. Source: 2014 HSRS.

Community Integration Program II and COP-W Services

Participants of the CIP II and COP-W utilize services federally authorized in the DHS-approved HCBS Medicaid waivers and receive services traditionally available to all Medicaid recipients through the Medicaid State Plan (e.g., card services). Whereas the Medicaid State Plan services generally include acute medical care and are provided to all Medicaid recipients eligible for Medicaid card services, waiver services generally focus on community-based supports. Because both types of services are required to support people in community settings, expenditures for medical and community-based supports are combined to determine the total public cost of serving waiver participants.

Federal and Wisconsin statutes require use of Medicaid waiver funds only for expenses not covered by the Medicaid State Plan. In Tables 13, 14, and 15, the Medicaid card services received, Medicaid HCBS waiver services received, total costs for each service, and service utilization rates are outlined. Costs of care, services, and environmental adaptations for waiver participants always include a combination of Medicaid State Plan benefits and Medicaid HCBS waiver benefits. The cross coordination of benefit use is a key component of the COP and waiver programs.

The following tables reflect expenditures for calendar year 2013, the most recent year for which complete data are available:

Table 13 - 2013 Total Medicaid Costs for CIP II and COP-W Recipients

Total CIP II and COP-W Service Costs	\$55,629,964
Total Medicaid Card Service and Nursing Home Costs while in Waiver Status	\$32,525,360
Total 2013 Medicaid Expenditures for CIP II and COP-W Recipients	\$88,155,324

Source: 2013 Federal 372 Report.

Table 14 - 2013 CIP II and COP-W Service Utilization and Costs

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Number of Participants	Cost	Percent of Total Waiver Costs
Care Management	99%	3,195	\$8,126,490	15%
Supportive Home Care/Personal Care	61%	1,987	\$16,108,018	29%
Adult Family Home	6%	197	\$4,655,779	8%
Residential Care Apartment Complex	3%	92	\$1,507,037	3%
Community-Based Residential Facility	29%	945	\$17,425,316	31%
Respite Care	4%	114	\$308,479	<1%
Adult Day Care	4%	118	\$623,042	1%
Day Services	2%	55	\$405,771	<1%
Daily Living Skills Training	<1%	7	\$21,284	<1%
Counseling and Therapies	4%	116	\$268,634	< 1%
Skilled Nursing	< 1%	30	\$65,256	< 1%
Transportation	24%	793	\$703,334	1%
Personal Emergency Response System	35%	1,149	\$318,339	<1%
Adaptive Equipment	15%	492	\$423,621	<1%
Communication Aids	<1%	18	\$4,177	< 1%
Housing Start-up	<1%	-	-	< 1%
Vocational Futures Planning	<1%	-	-	< 1%
Medical Supplies	30%	981	\$499,799	<1%
Home Modifications	4%	116	\$368,676	<1%
Home-Delivered Meals	24%	777	\$975,652	2%
Financial management Services	12%	403	\$166,874	< 1%
Administrative Costs			\$2,654,406	
Total Medicaid Waiver Service Costs and Actual Number of Unduplicated Participants		3,240	55,629,964	100%

Note: Totals may not equal 100% due to rounding. Source: 2013 HSRS and Final Reconciliation.

Table 15 - 2013 CIP II and COP-W Medicaid Card Service Utilization

CIP II and COP-W Service Categories	Rate of Participant Utilization (%)	Number of Participants	Cost	Percent of Total Waiver Costs
Inpatient Hospital	47%	1511	3,209,451	10%
Physician (Physician Services, Clinic Services – including outpatient Mental Health)	82%	2,644	2,773,206	9%
Outpatient Hospital	9%	305	799,104	2%
Lab and X-ray	13%	409	109,695	<1%
Prescription Drugs	52%	1673	1,815,964	6%
Transportation (Ambulance and Non-Emergency Specialized Motor Vehicle)	10%	313	108,694	<1%
Therapies (Physical Therapy, Speech and Hearing Therapy, Occupational Therapy, Restorative Care Therapy, Rehabilitative Therapy)	5%	151	81,871	<1%
Dental Services	12%	373	85,056	<1%
Nursing (Nurse Practitioner, Nursing Services)	< 1 %	0	-	<1%
Home Health, Supplies and Equipment (Home Health Therapy, Home Health Aide, Home Health Nursing, Enteral Nutrition, Disposable Supplies, Other Durable Medical Equipment, Hearing Aids)	58%	1,895	3,999,857	12%
Personal Care (Personal Care, Personal Care Supervisory Services)	33%	1,078	13,052,450	40%
All Other (Other Practitioners Services, Family Planning Services, HealthCheck/EPSTD, Rural Health Clinic Services, Home Health Private Duty Nursing—Vent, Other Care, Hospice, Community Support Program)	39%	1,260	6,490,012	20%
Case Management			-	
Total Medicaid State Plan Benefit Costs for Waiver Recipients	100%	3,240	32,525,360	100%

Note: Totals may not equal 100% due to rounding. Source: 2013 HSRS and Final Reconciliation.

Appendix A: Performance Standards

In order to ensure the goals of COP are met, person-centered performance outcomes valued by COP participants are incorporated into the acronym RESPECT:

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

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

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

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

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

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

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

RESPECT performance standards are measured by the extent to which:

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

Appendix B: Definitions

Community Options Program (COP):

The Community Options Program, administered by DHS, is managed by local county agencies and delivers community-based services to Wisconsin citizens in need of long-term assistance. The program began as a demonstration in eight counties in 1982 and expanded, statewide, in 1986 (*Funding: 100 % GPR/State*).

Community Options Program-Waiver (COP-Waiver or COP-W):

A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities demonstrating long-term needs and who would otherwise be eligible for Medicaid reimbursement in a nursing home (*Funding: Approximately 40% GPR/State, budgeted separately with COP GPR/state funds; approximately 60% federal funding*).

Community Integration Program (CIP II)

A Medicaid-funded waiver program that provides community services to the elderly and persons with physical disabilities after a nursing home bed is closed. (*Funding: Approximately 40% GPR/State [state Medicaid funding]; approximately 60% federal Medicaid funding*).

Community Integration Program 1A (CIP 1A):

A Medicaid-funded waiver program that provides community services to persons with developmental and/or intellectual disabilities who are relocated from the state centers for the developmentally disabled. (*Funding: Approximately 40% GPR/State, budgeted separately with COP GPR/state funds; approximately 60% federal funding*).

Community Integration Program 1B Regular (CIP 1B):

A Medicaid-funded waiver program which provides community services to persons with developmental and/or intellectual disabilities who are relocated or diverted from nursing homes and intermediate care facilities—intellectually/developmentally disabled (ICFs-I/DD) other than the state centers for the developmentally disabled. (*Funding: Approximately 40% GPR/State, budgeted separately with COP GPR/state funds; approximately 60% federal funding*).

Community Integration Program 1B (CIP 1B)/Local Match:

A Medicaid-funded waiver program that provides community services to persons with developmental and/or intellectual disabilities who are relocated or diverted from nursing homes and ICFs-MR other than the state centers for the developmentally disabled. (*Funding: Approximately 40% GPR/State [Community Aids, county match, or COP funds]; approximately 60% federal Medicaid funding*).

Children's Long-Term Support Waiver (CLTS-WAIVER):

A Medicaid-funded waiver program that serves children and individuals under age 22 diagnosed with a developmental disability, physical disability, or a severe emotional disturbance. CLTS waivers provide funds that enable individuals to be supported in the community. (*Funding: Approximately 40% GPR/State [state Medicaid, Community Aids, county match, or COP funds]; approximately 60% (federal Medicaid funding)*).

Brain Injury Waiver (BIW):

A Medicaid-funded waiver, serving a limited number of individuals with brain injuries who require significant supports in the community. The person must receive or be eligible to receive post-acute rehabilitation services in a nursing home or hospital certified by Wisconsin Medicaid as a special unit for brain injury rehabilitation. The program began January 1, 1995, and ended on May 1, 2014. All individuals served with BIW funding were moved to either the CIP 1 or CIP II program, depending upon eligibility. (*Funding: Approximately 40% GPR/State, budgeted separately with COP GPR/state funds; approximately 60% federal funding*).

Appendix C: Quality Improvement Activities and Outcomes

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

Program Integrity: Record Reviews

Onsite county monitoring reviews were conducted for a random selection of 190 cases in 2014. Reviewers looked at records to ensure compliance with waiver requirements. Where errors were identified, corrective action plans were implemented. For all criteria monitored, percent compliance with the waiver requirements was verified. A summary of the monitoring categories and findings are as follows:

- **Financial Eligibility**

Monitoring Components included:

- Medicaid financial eligibility as approved in state plan
- Cost share calculated appropriately
- Spenddown calculated appropriately

Findings: 97% of the factors monitored indicated no deficiency. Errors were detected in more complex areas of calculation, such as billing. The deficiencies are being addressed with corrective action plans, training, and technical assistance.

- **Functional Eligibility**

Monitoring Component: Functional eligibility determined/re-determined on a timely basis

Findings: 92% of factors monitored demonstrated compliance with eligibility. No instances of incorrect eligibility determination were identified under this category; however, documentation errors were found and corrected.

- **Service Plan**

Monitoring Components:

- Individual service plan (ISP) developed and reviewed with participant
- Services waiver allowable
- Services appropriately billed

Findings: 87% of factors were in compliance. In a small percentage of the cases, incorrectly identified services or the omission of identified services within the ISP was noted. Only the inclusion of non-allowable costs resulted in negative findings and a disallowance of state/federal funding.

- **Service Standards And Requirements**

Monitoring Components:

- Waiver-billed services met necessary standards and identified needs
- Care providers appropriately trained and certified

Findings: 69% of factors were documented as error free. Documentation deficits accounted for many of the negative findings under this category. Disallowances were taken when standards were not met.

- **Billing**

Monitoring Components:

- Services accurately billed
- Only waiver-allowable providers billed
- Residence in waiver-allowable settings during billing period

Findings: 74% compliance was found in these categories. Disallowances were taken for areas of noncompliance.

- **Substitute Care**

Monitoring Component: Only waiver-allowable costs calculated and billed

Findings: 78% of relevant files showed compliance with the documentation requirements. Technical assistance and training is being provided. Disallowances were taken for areas of noncompliance.

Program Integrity: Home Visits

Of the 190 record reviews completed, 163 included home visits. Reviewers used the results of their home visits and interviews with participants to determine the extent to which the program was meeting the goals outlined within the RESPECT philosophy.

Care managers identify a participant's health status and care needs

Findings: average 96% compliance. A certified screener met with the participant and his/her family or other support system to complete the functional screen at least annually. The care manager assured that the person was followed by a medical professional in the year reviewed.

Care managers create or arrange for appropriate services to support and not supplant the help available from family, friends, and the community.

Findings: average 95% compliance. The individual service plan (ISP) addresses all the participant's assessed needs and is reviewed and updated at least every six months, but more often as needed. The participant (and legal representative if applicable) was informed of their right to choose among waiver-allowable services (e.g., in-home vs substitute care services).

Care managers monitor the performance of service providers.

Findings: average 68% compliance. Documentation exists in the record to show that providers were licensed or certified as required, met training requirements for services not requiring licensure/certification, had a signed Waiver Provider Agreement on file, and provided services that were on the ISP and met the standards as outlined in the Medicaid Waivers Manual. Improved documentation of provider requirements will be a focus area for corrective action.

Services respond to individual needs.

Findings: average 94% compliance. The ISP addresses the individual's assessed needs as identified by the corresponding functional screen. The ISP is updated throughout the year as needed.

Participant preferences and choices are honored.

Findings: average 99% compliance. Participants could choose their services. Knowledgeable care managers listened and responded to participant preferences and choices, and addressed participant concerns.

Participants are satisfied with the services delivered.

Findings: average 99% compliance. Participants were satisfied with the care-management services they received as well as with the in-home (e.g., supportive home care) services received.

Participants are able to maintain a home of their choice and participate in community life.

Findings: average 99% compliance. Participants make their own decisions about their living arrangement and feel connected to their community.

Corrective Action

Following completion of the record reviews and home visits, site monitoring visits include a face-to-face summary meeting and submission of a written report, which is provided to the local agency director responsible for waiver implementation. The report provides details to the agency about identified health or safety issues and whether action is needed at the local level. The report also cites errors or deficiencies, noting that corrective action must occur within a specified period of time. The monitoring includes follow-up visits to ensure compliance when written documentation insufficiently provides assurance. Results from consumer outcomes and satisfaction surveys are included in the written report with intent to present an overview of the county system and identify trends in service areas.

In instances where a deficiency correlated with ineligibility, DHS requires agencies to correct reimbursement requests. In addition, agencies develop a plan to modify their practice. Disallowances occur when retroactive corrections cannot be implemented.

Program Quality

During 2014, 190 randomly-selected participants responded to 16 questions during in-person interviews regarding satisfaction with waiver services. Both direct responses and reviewer assessments of those responses were recorded.

- **Factors examined regarding care management services included:**
 - Responsiveness to consumer preferences
 - Quality of communication
 - Level of understanding of consumer’s situation
 - Knowledge of resources
 - Timeliness of response
- **Factors examined for in-home care included:**
 - Timeliness
 - Dependability
 - Responsiveness to consumer preferences
- **Factors examined for individuals residing in substitute care settings included:**
 - Responsiveness to consumer preferences
 - Choices for daily activities
 - Ability to talk with staff about concerns
 - Comfort

Table 16 combines and summarizes the findings of the survey.

Table 16 - Program Quality Results

Satisfaction Category	Percentage of Positive Responses
Choice of services	98%
Connected to the community	99%
Care manager is responsive	99%
Feels safe	99%
Satisfaction with in-home workers	99%
Substitute care services are acceptable	99%
Satisfaction with living arrangement	99%

Positive Responses include responses for which the Satisfaction Category was either achieved or in progress. Source: 2014 Quality Monitoring Reviews (based on CY14 participant interviews and a review of CY 13 records)

Continuous Quality Improvement Projects

DHS analyzed and combined quality improvement data that informs ongoing quality improvement projects:

- Quarterly validation of Medicaid numbers.
- Enhanced data collection and reporting formats which identify target areas for local monitoring, training and technical assistance.
- Production and distribution of case specific fiscal reports containing potential, correctable reporting errors.
- Provision of training and technical assistance on the Long Term Care Functional Screen.
- Provision of training and technical assistance on the management of complex funding sources.
- Maintenance of a database of Hearings and Appeals decisions.
- Maintenance of a database of registered service providers with/without provider agreements.

We gratefully acknowledge the efforts of county COP lead agencies to report COP and waiver activities and expenditures completely and accurately, since this information is the foundation for the data compiled in this report. Questions may be directed to DHSBMC@dhs.wisconsin.gov.