

Community Options Program and Medicaid Home and Community Based Waivers



A PROFESSIONAL'S GUIDE



Webcast: Community Options Program and Medicaid Home and Community Based Waivers

Competency/skill – Understand main features and components of the Community Options Program and Medicaid Home and Community Based Waivers.

Objectives:

1. Describe the goals of the Community Options Program and the RESPECT values.
2. Explain a “waiver”.
3. List the target group, eligibility requirements and funding source for CIP IA, CIP IB, CIP II, COP-W and the Brain Injury Waiver.
4. Discuss the variety of services included in the home and community based waivers.
5. Describe how a service plan is developed and what it contains.

Sample discussion questions:

1. The process of applying for publicly funded long-term care can be confusing for consumers. Role play how you would explain the process to consumers and their families.
2. What happens after eligibility for a program has been determined?
3. Describe the assessment process?
4. What are the common services provided to consumers who receive long-term care via a waiver?
5. Role play how you would describe the role of a care manager to consumers and their families.

COMMUNITY OPTIONS PROGRAM

And Medicaid Home and Community Based Waivers

The Birth
of the program. . .



On December 8, 1981 the group of professionals, who volunteered to develop and implement the Community Options Program, stated:

“...we can assist disabled people to create or preserve environments and experiences which make lives whole and meaningful.”



And it was the unspoken dream of countless disabled and aged individuals and their families.

A system was changed. A system that encouraged institutional long term care and...



...that “placed the needs of buildings and bureaucracies above the needs of persons.”



The goals pursued by the community options program now include:

- independence,
- dignity,
- self-determination and
- least restrictive environment or *people choose where they live*

RESPECT

- Relationships between participants care managers and providers.
- Empowerment to make choices.
- Services to meet individual needs.
- Physical and mental health services are intended to help people achieve their best level of health and functioning.
- Enhancement of participation reputation.
- Community and family participation.
- Tools for self-determination.

What is a Waiver

- The “waiver” refers to a waiver of the federal Medicaid rules. These rules generally restrict the use of Medicaid funds to primary and acute care.
- Before the waivers came along, Medicaid funds for long-term care were primarily directed to institutional care such as nursing homes.
- The federal waivers allow Medicaid money to go where it could not go before... **to fund home and community-based**

Community Integration Program 1A (CIP 1A)

- Target group:
 - ✓ Persons of any age with a developmental disability who are **relocated or diverted** from a state center
- Eligibility:
 - ✓ Meet Medicaid waiver financial eligibility criteria, and
 - ✓ Pass the long-term care functional screen (LTC FS) with a DD 1a, 1b, 2 or 3 level of care
- Funding source:
 - ✓ Allocated as “slots,” about 42% state GPR funds and 58% federal Medicaid funds

Community Integration Program 1B (CIP 1B)

- Target group:
 - ✓ Persons of any age with a developmental disability who are **relocated or diverted** from nursing homes or ICF's-MR (other than the state centers)
- Eligibility:
 - ✓ Meet Medicaid waiver financial eligibility criteria, and
 - ✓ Pass the LTC FS with a DD 1a,1b, 2 or 3 level of care
- Funding source:
 - ✓ Allocated as slots, about 42% state GPR or local dollars and 58% federal Medicaid funds

Community Integration Program II (CIP II)

- Target group:
 - ✓ Frail elders
 - ✓ Persons with a physical disability
 - ✓ May also serve persons with a developmental disability who do not need active treatment and who meet an eligible level of care
- Eligibility:
 - ✓ Must meet Medicaid waiver financial eligibility criteria
 - ✓ Pass LTC FS with a nursing home equivalent level of care (1 or 2) and have long term care needs
- Funding source:
 - ✓ About 42% state GPR and 58% federal Medicaid funds
 - ✓ Dollars are allocated as slots and are often tied to nursing home relocations

Community Options Program-Waiver (COP-W)

- Target group:
 - ✓ Frail elders
 - ✓ Persons with a physical disability
 - ✓ May also serve persons with a developmental disability who do not need active treatment and who meet an eligible level of care
- Eligibility:
 - ✓ Must meet Medicaid waivers financial eligibility criteria
 - ✓ Pass the LTC FS with a nursing home equivalent level of care (1or 2) and have long-term care needs
- Funding source:
 - ✓ About 42% state GPR and 58% federal Medicaid funds
 - ✓ Provided as an allocation

COP-W and CIP II are the same federal home and community based waiver under section 1915c of the Social Security Act.



Brain Injury Waiver (BIW)

- Target group:
 - ✓ Persons who have sustained any injury to the brain regardless of age of onset, whether mechanical or infectious in origin and including brain trauma, brain damage or traumatic brain injury, the result of which constitutes a substantial impairment to the individual and is expected to continue indefinitely. Includes injury vascular in nature that occurs prior to age 22 but does not include alcoholism, or dementia.
 - ✓ Persons who meet the definition and who are receiving treatment in or are eligible for treatment in a designated brain injury rehabilitation unit
 - ✓ Meet Medicaid waiver financial eligibility criteria
- Funding source:
 - ✓ About 42% state or local match dollars and 58% federal Medicaid dollars, allocated as “slots.”

What Does the Waiver Provide?

- Medicaid waiver funds are only available for certain home and community based services - services provided to **prevent institutionalization**.
- Wisconsin’s approved waivers cover virtually all of the services CMS allows. Services include care management, adaptive aids, respite, supportive home care, home modifications, adult family homes, CBRF’s, RCAC’s, personal emergency response systems, transportation, and more.



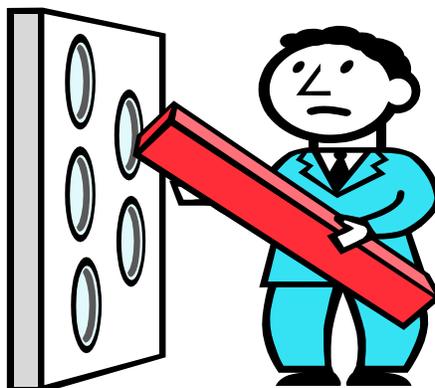
Are There **LIMITS** to the Use of Medicaid Waiver Dollars?



Yes, waiver funds may not be used

- For services not included in the state's approved home and community based waiver plan
- For services already available in the state's regular Medicaid program
- To pay the spouses of participants or the parents of minors who are participants
- To pay for services during a period of time the person resides in an institution (with the exception of personal emergency response systems and some care management)
- To pay for rent or room and board costs

With the community options program consumers can expect a common sense approach to long-term care.



Depending on the local ADRC access plan either the ADRC or . . .



. . . the county Community Options agency will gather basic information and schedule a time to meet with a consumer in order to offer an assessment. Following the assessment the assigned care manager in the community options agency will put together a plan of care.

Once Eligibility for a Program Is Determined, What Happens Next?

■ The waiver applicant receives an assessment to determine his/her long term care needs and preferences.

Provider: This is generally a county social worker, who may complete the assessment with the help of a nurse. An Assessment will include questions about the physical, medical, environmental, financial and social components of an applicant's life. Needs and wants are also a part of this review.

Participant: (Consumer) Will provide information as needed. The participant is encouraged to express all of his/her concerns regarding living in a community setting.

NOTE: A spouse, son, daughter or other relative or supporting person is welcome to be a part of this process.

Long-Term Care Plans

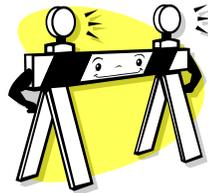
A **service plan** is derived from the assessment and identifies the supports and services to meet the person's needs, preferences, and desired outcomes.

Provider: Will discuss the conclusions from the assessment. A summary of the needs that were identified as necessary is documented. Services and providers to meet those needs are proposed.

Participant: Will express his/her preferences for providers and will indicate how much independence is desired within the limits of individual health and safety.



ALLOWABLE SERVICES



ALLOWABLE SERVICES

**Adaptive Aids-
Vehicle Related Adaptive Aids
Adult Day Care
Adult Family Home
Care Management/Support
Communication Aids
Community Based Residential
Counseling and Therapeutic Services
Daily Living Skills Training
Adults Day Services
Home-Delivered Meals
Home Modifications
Housing Counseling**

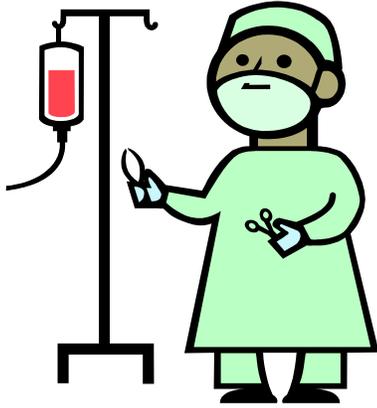


ALLOWABLE SERVICES



**Nursing Services
Personal Emergency Response System
Relocation Related – Housing Start-up
Relocation Related Utilities
Residential Care Apartment Complex
Respite Care
Residential
Institutional
Home-based
Other Setting
Special Medical and Therapeutic Supplies
Specialized Transportation
Support & Service Coordination
Supportive Home Care
Vocational Futures Planning**

Putting It All Together



- Health care services are funded by Medicaid (and may include Medicare or other health insurance programs).
- Long-term care services are funded by appropriate Waiver or other funding source.
- *Only **one** Waiver funding source* may be used to serve the person.

Care Managers help consumers to understand their service plan:



Three things to keep in mind when using Waiver funding:

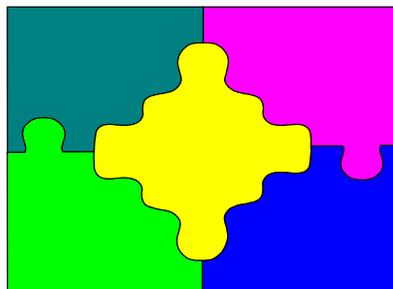
1. Medicaid card services have to be used **first**, and
2. Waiver funds **must** be used when waiver eligibility is present and the services are waiver allowable, and
3. COP may only be used to fill gaps for services **not covered** by Medicaid or the waivers

Also, Keep in Mind That Every Support Does Not Need to Be a Paid Service....



- Utilize informal supports like family, friends, and neighbors whenever possible
- Find volunteer services that are available in the community
- Tap into other community resources or other funding sources like churches, civic organizations, support groups, etc.

So, As the Pieces of the Service Plan Start to Come Together



The service plan will look something like this...

INDIVIDUAL SERVICE PLAN
for Joe Participant

SPC Code	Service Type	Provider	Unit Cost	Units of service	Daily Costs	Funding Source
604	Care Mgmt.	Fox Co DHHS	\$60/hr	2hrs/mo	\$3.95	COP-W
104	Supportive Home Care	Quality Home Care Inc.	\$18/hr	2hrs/day	\$35.63	COP-W
	Personal Care	Quality Home Care Inc.	\$28/hr	4hrs/week	\$17.15	MEDICAID
	Help with finances, errands, companionship	Family members and neighbor	-----	-----	----	Volunteer
106	Energy Assist.	BP Electric	\$90.00/mo Budget Plan			COP

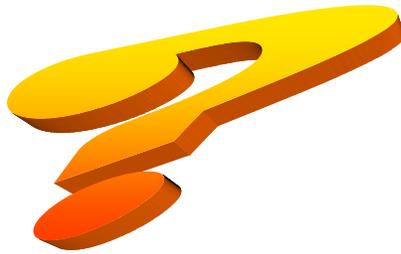
The consumer can expect regular contacts:

Care management contacts are required in the Community Options Program *unless* a participant asks to have this requirement waived.

Provider: Meets directly with the participant as needed, but at least once every three months. Satisfaction with the long-term care plan is discussed. If changes are necessary or desired, a new care plan will be developed.



Participant: Keeps the contact information readily available for his/her manager and initiates a contact when changes in his/her situation occur.



Where do I go to obtain
more information?

http://www.dhfs.state.wi.us/ltc_cop/COP_contacts/COUNTIES.HTM

http://www.dhfs.state.wi.us/ltc_cop/COP.HTM

This document was developed under grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government.

Wisconsin Department of Health & Family Services
Division of Disability & Elder Services
Bureau of Aging & Disability Resources
PDE-45 (9/06)