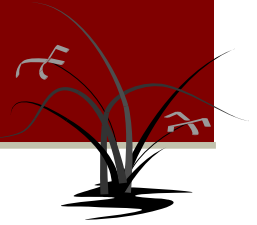


RESOURCE CENTERED



Technical Assistance for Wisconsin Aging and Disability Resource Centers
Department of Health Services, Office for Resource Center Development (ORCD)

This bulletin updates and replaces Resource Centered Bulletin 08-3, dated September 30, 2008.

Topic: Enrollment Counseling

Enrollment Counseling is an important service of the Aging and Disability Resource Center (ADRC). Resource Center specialists assist individuals who are found eligible for publicly funded long-term care to select a benefit package: Family Care, Family Care Partnership (also known as Partnership), Program of All-Inclusive Care for the Elderly (also known as PACE) and IRIS.

This bulletin will provide tools and resources to support the delivery of long-term care enrollment counseling in your Aging and Disability Resource Center (ADRC). ADRCs are encouraged to make copies of key information to give to individuals who are considering their publicly funded long-term care options.

Note: This information is also intended for waiver care managers who may be providing enrollment counseling during a counties transition to new long-term care programs.

Inside This Bulletin

- [Enrollment Counseling: How to Prepare](#)
- [Enrollment Counseling: A Guide for ADRC Specialists](#)
- [A Guide for People who are on a Waiting List](#)
- [Sample Notice to Individuals on a Waiting List](#)
- [What is an Aging and Disability Resource Center?](#)
- [What is the Long-Term Care Functional Screen and How is It Used?](#)
- [Which Long-Term Care Program is Best for Me?](#)
- Tell Me More About... [Family Care](#), [Family Care Partnership](#), [Program of All-Inclusive Care for the Elderly \(PACE\) Self-Directed Supports in Managed Care](#) and [IRIS](#) (5 Fact Sheets)
- [Key Questions: Highlighting differences between options for self-direction in Family Care and IRIS](#)
- [Interdisciplinary Teams in Family Care & FC Partnership](#)
- [Key Differences between Family Care & FC Partnership](#)
- [What Will Change From the Medicaid Waiver Programs to Managed Long-Term Care](#)
- [What Will Change From the Medicaid Waiver Programs to IRIS \(Include, Respect, I Self-Direct\)](#)
- [Covered Services in WI's LTC Programs](#)
- [Family Care Benefit Packages: NH & non-NH LOC](#)
- [Non-Nursing Home Level of Care Benefit Options](#)
- [Managed Care Organization \(MCO\) Options](#)
- [The Enrollment Counselor's Quick Guide to MC Acronyms](#)

Enrollment Counseling Tools and Model Forms

The following documents are included in this "Resource Centered" Bulletin:

[Enrollment Counseling: How to Prepare.](#) This document provides helpful information describing best practices for ways staff can prepare to provide enrollment counseling.

[Enrollment Counseling: A Guide for ADRC Specialists.](#) This document is written for ADRC Specialists who counsel people about their long-term care options. It is a step-by-step process guide that takes you from the initial contact with the person through the discussion about long-term care programs and enrollment. This guide also serves as an outline on how the samples, diagrams, and fact sheets found in this bulletin might be used in the counseling process.

[**A Guide for People who are on a Waiting List.**](#) This chart provides an overview of the steps that individuals can expect to go through when enrolling in a new long-term care program.

[**Sample Notice to Individuals on a Waiting List.**](#) This sample letter can be used to notify individuals in advance that you will be contacting them to discuss their option to participate in a new long-term care program. This letter is directed to individuals who are on a waiting list for publicly funded long-term care. An additional letter directed to individuals who are currently receiving publicly funded long-term care through existing waivers is available on the Department's website at <http://dhs.wisconsin.gov/managedLTC/transition>.

[**What Is an Aging and Disability Resource Center?**](#) Because the system and options that are available to meet people's long-term care needs have changed since the individual's name was placed on a waiting list, they may not be aware of what an ADRC is and how it might help them. This sheet could be used to provide individuals with basic information that explains an ADRC.

[**What Is the Long-Term Care Functional Screen and How Is It Used?**](#) Some people may need to have an updated long-term care functional screen. This document describes what a functional screen is and describes how it is used.

[**Which Long-Term Care Program Is Best for Me?**](#) One of the key differences between the program options is the degree to which a person's long-term and/or health care is coordinated. This chart asks a person to decide "which statement describes you" and, based on the individual's responses, leads the counselor to the program that the person might prefer so that more information can be provided.

[**Tell Me More about...Family Care.**](#) This document highlights some key facts about the Family Care program for those individuals who are interested in learning more about this program.

[**Interdisciplinary Teams in Family Care.**](#) This document describes who is on an interdisciplinary team and what they do in Family Care. A diagram is provided that shows a visual example of what someone's team might look like.

[**Tell Me More about...Family Care Partnership.**](#) This document outlines the key program information about the Family Care Partnership program for those interested in learning more.

[**Interdisciplinary Teams in Family Care Partnership.**](#) This document describes who is on an interdisciplinary team and what they do in Family Care Partnership. A diagram is provided that shows a visual example of what someone's team might look like in this program.

[**Tell Me More about...Program of All-Inclusive Care for the Elderly \(PACE\).**](#) This document outlines key program information about Program of All-Inclusive Care for the Elderly (PACE).

[**Interdisciplinary Teams in Program of All-Inclusive Care for the Elderly \(PACE\).**](#) This document describes who is on an interdisciplinary team and what they do in PACE. A diagram is provided that shows a visual example of what someone's team might look like in this program.

[Key Differences between Family Care and Family Care Partnership.](#) When an individual has the option to participate in either a Family Care or Family Care Partnership program, this document might be used to highlight the key differences between the two programs.

[What Will Change from the Medicaid Waiver Programs to Managed Long-Term Care?](#) Some case managers or ADRC staff will be providing enrollment counseling to individuals who are current Medicaid Waiver participants. If an individual is interested in a managed long-term care program, this document provides important answers to questions that he or she may have about their transition such as, will I have the same services, care manager and providers?

[What Will Change from the Medicaid Waiver Program to IRIS \(Include, Respect I Self-Direct\)](#)

Some case managers or ADRC staff will be providing enrollment counseling to individuals who are current Medicaid Waiver participants. This document is designed to be used during enrollment counseling to provide important answers to questions about IRIS.

[Tell Me More about...Self-Directed Supports in Managed Care.](#) For individuals who are interested in learning more about the Self-Directed Supports option within either Family Care or Family Care Partnership, this document outlines key information.

[Tell Me More about...IRIS \(Include, Respect, I Self-Direct\).](#) This document highlights key information about IRIS for those individuals interested in this program.

[Key Questions: Highlighting differences between options for self-direction in Family Care, Partnership, PACE and IRIS.](#) This document answers key questions that highlight differences between self-directing one's services and supports in managed care and IRIS (Include, Respect, I Self-Direct).

[Covered Services in Wisconsin's Long-Term Care Programs.](#) This chart compares the long-term and health care services that are covered in Wisconsin's long-term care programs: Family Care, Partnership, PACE, IRIS, and Medicaid fee-for-service programs.

Family Care Benefit Packages: Nursing Home and Non-Nursing Home Level of Care. Pertaining to the Family Care program only, people who meet a non-nursing home level of care (formerly called an "intermediate" level of care), may be able to receive certain Medicaid State Plan services. This information shows the different benefit packages as they apply to people who are either at the nursing home or non-nursing home level of care that might be useful when providing enrollment counseling to people whose level of care does not qualify them for full benefits under Family Care. IRIS requires persons have a nursing home level of care.

- [Family Care Benefit Packages: Nursing Home and Non-Nursing Home Level of Care](#)
- [Non-Nursing Home Level of Care Benefit Options](#)

[Managed Care Organization \(MCO\) Options.](#) This chart may be useful when individuals have more than one Managed Care Organization (MCO) available in their area. The chart, when completed, will contain contact information, type of plan, geographic service area, care management caseload size, years of experience with various target groups, and a link to MCO quality information.

[The Enrollment Counselors Quick Guide to Acronyms.](#) This document lists the acronyms that are used throughout this document, and are commonly used in printed materials or everyday conversations when discussing publicly funded long-term care. This guide is intended to be a quick reference for enrollment counselors to refer to if necessary.

Other Useful Resources

Options Counseling Orientation. The Department of Health Services (DHS) has made available to each ADRC a “Long-Term Care Options Counseling Toolkit” that provides key information to assist in building the skills and knowledge necessary to provide options counseling. Sections of the toolkit may be helpful for staff to review when preparing to provide enrollment counseling. The toolkit includes webcasts that provide an introduction to publicly funded long-term care in Wisconsin and an overview of managed long-term care. The kit also includes a video that provides an overview of long-term care options counseling, a communication module to support staff training, and a series of webcasts to provide information on other critical subjects.

[“Being a Full Partner in Family Care.”](#) Members of Family Care and Family Care Partnership have a right to be a full partner in deciding what they need and want from their health and long-term support services, and in planning how those services will be provided. This booklet provides useful information about what it means to be a partner in a managed care program, describes what “outcomes” are and why they matter, discusses how care decisions are made, what self-directed supports in managed care means, and other useful information. ADRCs or others providing enrollment counseling should provide a copy of this document to each enrollee or prospective enrollee.

[“Questions about Family Care for People with Developmental Disabilities.”](#) This document was developed in response to questions about Family Care that came from consumers, guardians and families. While written for people with developmental disabilities, much of the information is relevant to any long-term care consumer regardless of target group.

[“IRIS \(Include, Respect, I Self-Direct\) Participant Handbook.”](#) This handbook provides key information to help the individual learn about IRIS, creating a support and service plan, arranging services, supports and goods as well as introducing the role of the Independent Consultant Agency, Independent Consultants and the Financial Service Agency.

Contact Information & Training Requests

If you have any questions about the materials or information found in this bulletin, you can contact your ADRC liaison at the Department of Health Services, Office for Resource Center Development, or send an e-mail to: DHSRCteam@wisconsin.gov.

Enrollment Counseling: How to Prepare

Aging and Disability Resource Centers (ADRCs) together with Long-term Support (LTS) agencies are charged with the responsibility to provide enrollment counseling. During enrollment counseling, staff from the ADRC and LTS agency educate people about the available long-term care options. Through this process, an individual decides which option is best for him/her.

Preparation

The following list provides helpful information about how staff can prepare to provide enrollment counseling.

- Read and thoroughly understand the Resource Centered Document on Enrollment Counseling
- Watch the webcast on enrollment counseling:
<http://dhs.wisconsin.gov/lcicare/Generalinfo/Webcast/adrcwebcastLTCEnroll.htm>
- Familiarize yourself with the benefit packages:
 - Family Care
 - Partnership
 - Program of All-Inclusive Care for the Elderly (PACE)
 - IRIS (Include, Respect, I Self-Direct)
- Learn about the organizations that will be authorizing or coordinating publicly funded long-term care in your area. Invite representatives from the MCO and ICA to your office to share information about their organization and approach to the delivery of services.
- Familiarize yourself with the member handbooks for Family Care, Partnership, PACE and IRIS.
- Learn about and understand appeals and grievance procedures for each program option.
- Familiarize yourself with the financial implications that may impact the individual's decisions. Understand and be prepared to explain:
 - Cost share
 - Spend down
 - Co-pay
 - Estate recovery

This is a link to the Medicaid handbook: www.emhandbooks.wi.gov/imm/imm.htm
- Learn the enrollment process by reviewing and discussing your ADRC enrollment plan.
- Learn the systems and steps taken to complete the enrollment transaction: use of PPS for centralized enrollment processes, use of PPS for IRIS referral, who gets notified, how, forms to complete.
- Develop a packet of information to take to home visits. Include materials from the Enrollment Counseling technical assistance documents, MA application, member handbooks, brochures, and other publications.

Training

ADRCs and LTS agencies are encouraged to develop a plan for how to train staff so they are comfortable talking with consumers about these new programs. The plan may include such things as:

- Discussing any of the above material at a staff meeting
- Role playing enrollment counseling at a staff meeting
- Shadowing someone (even if in a neighboring ADRC) who is experienced in enrollment counseling
- Having two staff do home visits as a team: one has the lead, the other gives feedback
- Having co-workers, supervisor or experienced enrollment counselor mentor staff new to the activity.
- Scheduling a training on enrollment counseling with the Office for Resource Center Development

If you have questions contact the Office for Resource Center Development at DHSRCTeam@wisconsin.gov.

Enrollment Counseling: A Guide for ADRC Specialists

This guide is written for Aging and Disability Resource Specialists who will be providing enrollment counseling to individuals on a waiting list for long-term care services. The steps outlined in this guide follow those found in the [Guide for People who are on a Waiting List](#) and shows how the supporting documents contained in this bulletin can be used in the enrollment counseling process.

Before Contacting Consumers: *Sending a “Heads Up”*

- Prior to calling individuals on the waiting list, you may want to alert them in advance that you will be contacting them to discuss their option to participate in a new program.
- Send a notice to explain who you are, where you’re from, and why you will be calling. You might want to use the [Sample Notice to Individuals on a Waiting List](#). Doing this may calm any fears a person may have about answering a call from a strange person, talking about themselves, or asking questions on the call.
- With the notice, you might also want to send information about what an Aging and Disability Resource Center is. See [What is an Aging and Disability Resource Center](#) for a model document that you can use for this purpose.
- In preparation, you will also want to check Forward Health interChange for the individual’s Medicaid status and long-term care functional screen to learn the individual’s level of care.

Step 1: Good News!

Delivering Good News (via telephone)

- Next, contact an individual who has been on a waiting list for long-term care services. The system and options available to meet their long-term care needs have changed since the individual’s name was placed on the list. The person may have been waiting a short period of time, or may have been waiting for years. The individual may not have received or read the notice you sent, and may never have heard of an Aging and Disability Resource Center until you make contact with them.
- Introduce yourself and explain who you are. Explain what an Aging and Disability Resource Center (ADRC) is and how you will be helping them. You might wish to use the [What is an Aging and Disability Resource Center](#) for ideas on how to describe what services you offer.
- Explain that the reason for your call is to inform the person that new long-term care programs are available that might be able to get them the help they have been waiting for. Remember that you are delivering good news! You may be the recipient of a few cheers, enjoy them. ☺

- Ask if the person would like you to visit his or her home to continue your conversation; if so, schedule a home visit. If not, ask if the person would feel more comfortable meeting in another place or continue talking over the phone.

Step 2: Having a Conversation

Getting to Know the Person and Discovering Individual Needs and Preferences

- Find out how the person is doing! Discuss what kind of help the person might need and begin to explore their service preferences.
- Provide individuals with an overview of the steps they will go through when enrolling in a new long-term care program. This lets them know what to expect. You might use [*A Guide for People Who Are on a Waiting List*](#) to provide this overview and help guide the conversation.
- If you will be providing enrollment counseling to someone who is a current Waiver participant, modify the information you provide.
- Double-check to make sure that the individual and/or the family understands the process.
- Answer any questions throughout the conversation.
- If you haven't already, you'll need to confirm that the individual is functionally eligible for long-term care programs. The long-term care functional screen should accurately reflect the person's functional condition. Depending on changes in the individual's condition, how old the screen is, an update or a new screen may be necessary. At a minimum, a new screen should be done if it is more than a year old. If appropriate, you could share the [*What is the Long-Term Care Functional Screen and How is It Used*](#) information sheet if the individual has questions about what it is and how it's used.

Talking about Long-Term Care Options and Selecting a Program

- With the individual's needs and preferences in mind, review potential services or benefits that may be available to the individual.
- Explain managed long-term care options, IRIS and services available through the Medicaid card.
- Explore which long-term care option is best for this person. Consider how the individual feels about having health and medical care managed and drug coverage coordinated, in addition to long-term care. Discuss how much independence the person would like in managing their own support and services.
- Resource materials to help explain the different programs and key differences between them include:
 - [*Which Long-Term Care Program is Best for Me?*](#)
 - [*Tell Me More about...Family Care*](#)
 - [*Tell Me More about...Family Care Partnership*](#)
 - [*Tell Me More about...Program for All-Inclusive Care for the Elderly \(PACE\)*](#)
 - [*Key Differences between Family Care, Partnership and PACE*](#)
 - [*Tell Me More about...Self-Directed Supports in Managed Care*](#)
 - [*Tell Me More about...IRIS \(Include, Respect, I Self-Direct\)*](#)

- [Key Questions: Highlighting differences between options for self-direction in Family Care, Partnership, PACE and IRIS](#)
- [Covered Services...in Wisconsin's Long-Term Care Programs](#)
- (Note: Pertaining to the Family Care program only, if the individual meets a non-nursing home level of care (formerly called an "intermediate" level of care), the person may be entitled to receive certain services under the Family Care program. See: [Family Care Benefit Packages: Nursing Home and Non-Nursing Home Level of Care](#) and [Non-Nursing Home Level of Care Benefit Options](#) for a listing of services that may be available to affected individuals.)
- Remember to provide only as much information as the person can absorb. It is recommended that several conversations will be held with the individual.
- In some areas, individuals may have a choice of more than one managed care organization. You might wish to use the [Managed Care Organization \(MCO\) Options](#) to provide more specific detail about the person's local managed care options.
- For individuals who choose to participate in IRIS, the Self-Directed Supports (SDS) Waiver, you will need to complete an IRIS referral and connect the individual to the Independent Consultant Agency.
- The consumer compares and selects the program that is best for him or her.

Step 3: Applying

Updating Medicaid Records/Financial Considerations

- Gather medical remedial information if appropriate.
- Provide the Income Maintenance (IM) worker with pertinent information.
- Use centralized processing if applicable.
- Educate people about their cost share amount if appropriate.

Step 4: Enrolling

Last Steps

- If the individual's financial eligibility information was up-dated, share information about the eligibility status (cost-share).
- Find out when the individual would like to enroll or begin services.
- If a person chose a managed long-term care option, complete the [enrollment form](#). Communicate with and provide information to Income Maintenance and the managed care organization (MCO).
- If a person chose IRIS, document their choice using the IRIS authorization form and PPS (Program Participation System). Provide information to Independent Consultant Agency.

Step 5: Services Begin!

Services!

- If the individual chose to enroll in a managed long-term care program, a care team will be assigned to the person. The team will work with the individual to plan and coordinate their care.
- If the person chose to enroll in IRIS, he or she will select and meet with the independent consultant to develop their own support and service plan.
- Remind people that they can change their mind and reconsider their choice at any time.
- Services can finally begin!

A Guide for People Who Are on a Waiting List

for Publicly Funded Long - Term Care

You have been waiting for long-term care services.

Step 1: Good News!

A friendly person from an Aging and Disability Resource Center, or "ADRC," will contact you with good news! New long-term care programs are available that might be able to get you the help that you've been waiting for! The ADRC specialist will talk with you about your option to take part in a new program.

Step 2: Having a Conversation

The ADRC specialist is there to help! He/She wants to find out how you are doing and discuss what kind of help you may need, as well as discuss what options are available to get you that help!

The ADRC specialist can meet you in your home if you would like. There is a lot to learn! They will explain the different programs that are available, make sure you are functionally eligible, help you compare your options, and help you select the option that is best for **you**.

Step 3: Applying

After you select the option that is best for you, it might be necessary to apply for Medicaid, or if you've already done that, you might need to update your records. The ADRC specialist will connect you with a county worker who will help with this. This can be done in person, over the Internet, by phone, or by mail. Please note, sometimes people are required to help pay a share of the cost of the services they receive. If this is necessary, it will be discussed with you.

Step 4: Enrolling

Next, the ADRC specialist will contact you again to discuss the results of your application. An estimated date of when you will start getting help will be set.

Step 5: Services Begin!

After all the paperwork is completed, a person from the organization you've selected will contact you. That person will work with you in planning and coordinating your care. You are well on your way to getting the help you need!



Jim Doyle
Governor

Karen E. Timberlake
Secretary



State of Wisconsin
Department of Health Services

DIVISION OF LONG TERM CARE

1 WEST WILSON STREET
PO BOX 7851
MADISON WI 53707-7851

Telephone: 608-266-2000
FAX: 608-266-2579
TTY: 888-241-9432
dhs.wisconsin.gov

SAMPLE

Notice to Individuals on a Waiting List

(Word Fillable Version)

Date:

From: **Add the Name of County Official Here**

To: All adult persons on a waiting list for long-term care services from the Community Options Program Waiver (COP-W), Community Integration Program (CIP), Brain Injury Waiver (BIW), and Children's Long Term Support (LTS) Waiver Programs

We are writing to you because you are on a waiting list for long-term care services from the Community Options Program Waiver (COP-W), Community Integration Program (CIP), Brain Injury Waiver (BIW), or you are a young adult who is over 18 years waiting for services from the Children's LTS Waiver. We are pleased to inform you that new programs will be available to all eligible adults who have been waiting for long-term care services. The new programs are called Family Care, **Partnership, Program of All-Inclusive Care for the Elderly (PACE)** and IRIS (Include, Respect, I Self-Direct).

When your name gets close to the top of the waiting list, a person from the Aging and Disability Resource Center of **Insert Name of County here** will be contacting you to explain your options and help you select a program that best meets your needs. Here is some information about the transition to these new long-term care programs.

- **Why are these programs changing?**
The State and the counties have been working hard to improve Wisconsin's long-term care system. The new programs are designed to maintain or improve the quality of these programs and serve more people. These programs are different because they coordinate in one flexible benefit all the services that a person may need to maintain or improve their health and well-being. By helping people live the way they want to, while being as efficient as possible, we will be able to get more people the services they need and eliminate waiting lists for these services.
- **What will happen to the current programs?**
As Family Care, **Partnership, PACE** and IRIS become available in **insert the name of your County**, the COP-W, CIP, and BIW programs will be discontinued. Also, the Children's Waiver program will no longer serve people age 18 and older. This is because they will be replaced by the new programs.
- **Who will operate the new programs?**
Until now, the State contracted with counties to provide the services of the COP-W, CIP, Brain Injury Waiver and the Children's LTS Waiver locally. **Starting _____**, the State will contract with **insert the name of the Managed Care Organization(s) here** to provide the new managed care programs in **insert name of your county(ies) here**. IRIS is managed by the State through contracted agencies referred to as the Independent Consultant Agency (ICA) and the Financial Service Agency (FSA).

- **What choices will I have about getting long-term care services?**
In the COP-W, CIP, or BIW, you were likely to be eligible for only one long-term care program. In the new system, if you are eligible, you will be able to choose from two-three programs! A person from the Aging and Disability Resource Center (ADRC) will contact you and help you through the process of becoming eligible and explaining the choices you have about enrolling in a new program. The ADRC specialist will explain all your choices to you so you can make the best decision for yourself.
- **Will my family or guardian still be able to help me?**
Yes. Your family, guardian, or others will still be able to help develop your care plan if you enroll in any of these programs.
- **What do I need to do?**
You do not need to do anything! The Aging and Disability Resource Center will contact you when your name gets close to the top of the wait list. They will give you all the information you need to make your decisions and start getting the help you have been waiting for!
- **Who should I call if I have questions or concerns about the upcoming changes?**
If you'd like more information now, you can call the Aging and Disability Resource Center to ask any questions or discuss any concerns you might have. The phone number is ***insert the ADRC phone number, website address, or e-mail here.***

Thank you for your cooperation as this important transition takes place. We believe that these new programs will be successful in getting people the help that they need and the results they expect from their long-term care services.

What is an Aging and Disability Resource Center?

What are Aging and Disability Resource Centers?

Aging and Disability Resource Centers, or ADRCs, offer the general public a single entry point for information and assistance on issues affecting older people, and people with disabilities regardless of their income. These resource centers are welcoming and convenient places for you and your family to get information and access to a wide variety of services. Services can be provided through the telephone, in the resource center, or in your own home.

What kind of services can I get from an ADRC?

The types of services that an ADRC has to offer include: information and assistance, long-term care options counseling, benefits counseling, emergency response, prevention and early intervention, and access to publicly funded long-term care programs such as Family Care, Family Care Partnership, and IRIS (Include, Respect, I Self-Direct).

What is Information and Assistance?

Information and assistance specialists in the ADRC provide you with information about services, resources, and programs in areas such as disability and long-term care, living arrangements, health and wellness, adult protective services, employment and training for people with disabilities, home maintenance, nutrition and publicly funded programs. ADRC specialists can help to connect you with services and can help you apply for Supplemental Security Income (SSI), FoodShare, and Medicaid as needed. You can call the resource center about a wide variety of topics from home care to hospice services, from legal issues to Alzheimer's care, from job help to education.

What is Long-Term Care Options Counseling?

Options counselors offer information and help to evaluate the options that are available to meet your long-term care needs. An options counselor discusses factors to consider when making long-term care decisions. ADRCs provide this service to the general public and to all individuals with long-term care needs who are entering nursing homes and assisted living facilities. The ADRC Specialist provides objective information to help you plan to meet your needs and consider how to best spend your personal resources.

What is Benefits Counseling?

Elderly or disability benefit specialists can provide you with accurate and current information about private and government benefits and programs that you may be entitled to. They help to sort through the maze of benefits, the varying eligibility requirements and application processes. Benefit specialists can also help when people run into problems with Medicare, Social Security, and other benefits.

What is enrollment counseling?

Individuals who meet certain financial, non-financial and functional eligibility requirements will choose from different publicly funded programs to meet their long-term care needs. Staff from the ADRC will help provide information about these different programs, what services may be available and how services are arranged. This service is called enrollment counseling. The goal of enrollment counseling is to help inform you about your options so you can make decisions about which program is best for you. Please know you can change your mind and reconsider your choice at any time.

What if I have an emergency related to my long-term care needs or services?

If you call the ADRC with a health related emergency, the resource center is there to help connect you with someone who will respond to your urgent situation. For example, if someone experienced a sudden loss of a caregiver, they may need emergency help to keep them safe. The ADRC can help connect you with resources immediately.

Can I learn about ways to maintain my health and wellness from an ADRC?

The ADRC promotes effective prevention to keep you healthy and independent. In collaboration with public and private health and social service partners in the community, the ADRC offers both information and intervention activities that focus on reducing the risk of disability. For example, the ADRC can talk to you about strategies to make sure you are taking all of your medications when you need to, or ways to improve your nutrition. ADRC staff can help you think about home safety to prevent falls, or consider appropriate fitness programs for older people or people with disabilities.

Can I enroll in a publicly funded long-term care program through the ADRC?

Yes. In fact, ADRCs are the “entry-way” to publicly funded long-term care programs. The resource center would first help assess your level of need for services and make sure that you are eligible. The ADRC provides information about all the options available to you and will help you select the best option. If you are eligible and choose to enroll in a long-term care program, the ADRC will help you take your next steps.

What is the “Long-Term Care Functional Screen” and How Is It Used?

What is the long-term care functional screen?

The functional screen is used by staff to determine your eligibility for many of Wisconsin’s Long Term Care programs. It used to gather information about whether you need help, and to what extent, in doing the activities of your everyday life.

What sort of “activities” does the tool gather information about?

The long-term care functional screen looks at many of the common activities of daily life such as bathing, getting dressed, brushing your teeth and hair, using the bathroom, walking, and eating. It also looks at activities that you may or may not be able to do for yourself such as meal preparation, managing your medications, managing your money, and using the telephone. In addition, the screen includes questions about behavior, physical diagnoses, medically-oriented tasks, transportation needs, and employment. Information is also gathered about mental health concerns and substance abuse and other conditions that might impact your need for help.

How will the information I share be used?

The functional screen has multiple purposes. First, the functional screen was designed to be an objective way to determine the long-term care needs of elders and people with physical or developmental disabilities. This is important, because the functional screen is used to determine whether the type of help you need qualifies you for long-term care services. The long-term care functional screen also calculates the monthly budget allocation for all persons who choose the IRIS option.

Who administers the screen?

Only experienced professionals who have taken a training course and have passed a certification exam can administer the screen.

Will my information be kept confidential?

Yes. Any information collected for the screen or during the screening process is confidential.

Am I required to have a long-term care functional screen?

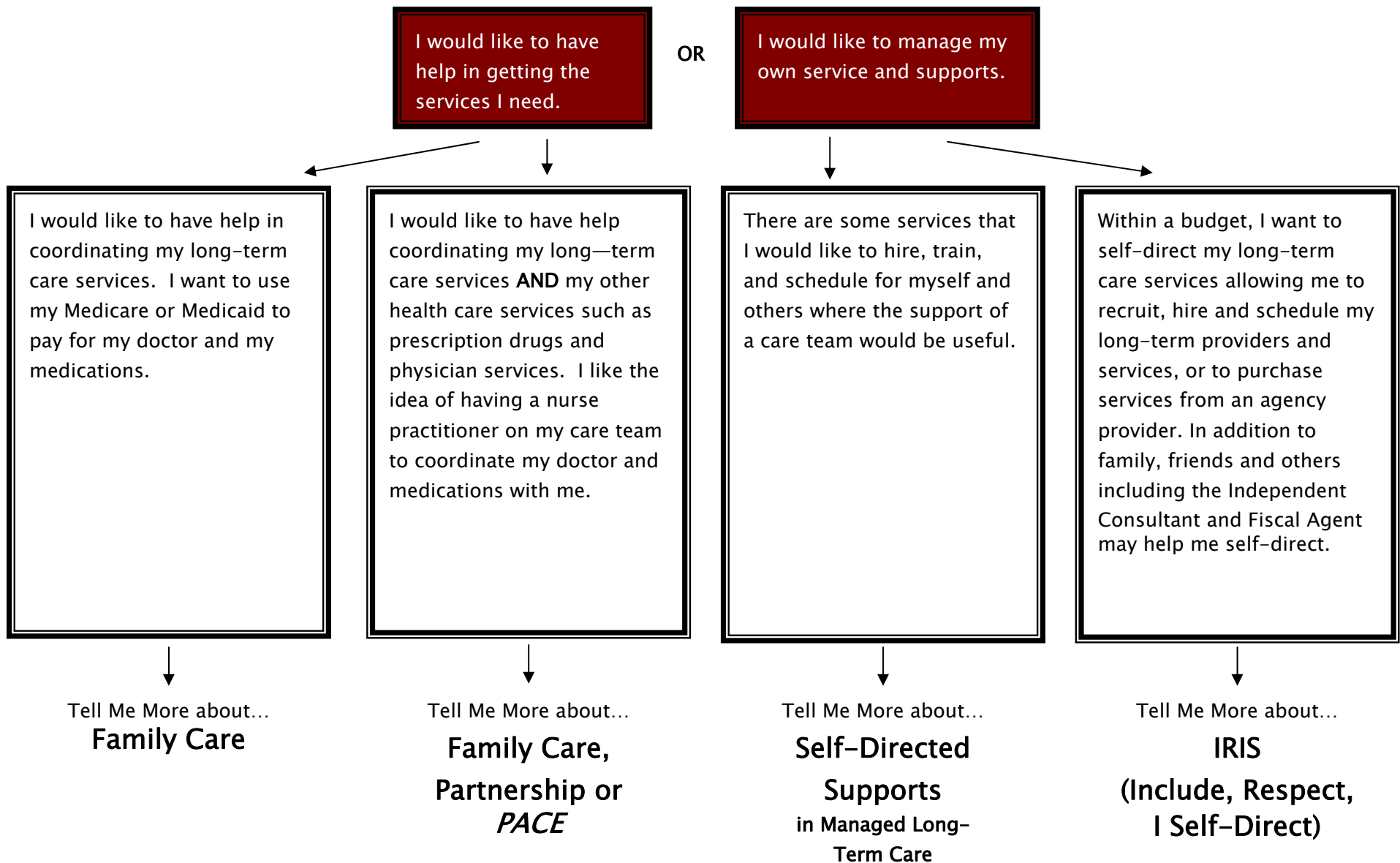
The functional screen is voluntary, but it is required in order to enroll in one of Wisconsin’s long-term care program since the screen is used to make sure you are eligible.

If I do not like the results of the screen what can I do?

If you have reason to believe that an error has occurred in your functional eligibility determination, you have a right to appeal. The appeals and grievance processes will be shared by your local ADRC at the time the functional screen is done.

Which Long-Term Care Program is Best for Me?

Which statement best describes YOU...



What is Family Care?

Family Care is an innovative program that provides a full range of long-term care services, all through one flexible benefit program. To understand Family Care, it helps to know what “Long-Term Care” is. Long-term care is any service or support that a person may need as a result of a disability, getting older, or having a chronic illness that limits the ability to do the things that people need to do throughout the course of their day. This includes things such as bathing, getting dressed, making meals, going to work, and paying bills. There are a variety of services and supports available in Family Care that can help people do these things independently or with the support of someone else.

How Does Family Care Work?

People Receive Interdisciplinary Care Management.

Sometimes people don’t know exactly what they need, what’s available, or where to go to get the care and services that can help. Coordinating your own services can be overwhelming! When you participate in a Family Care program, a team of people come together to help you identify what sort of assistance you might need and work with you to arrange your long-term care services. You are an active participant on the team that also includes, at a minimum, a care manager and a registered nurse. You can choose to include a family member or loved one on your team. Sometimes people also choose other professionals, such as a personal care worker, to participate as team members as well. In Family Care, this team is called an “interdisciplinary team.”

People Participate in Determining the Services They Receive.

The first step in planning Family Care services is for you to discuss with your team the kind of life you want to live, whether you want to live where you live now or in a different place, and what kind of support you need to live the kind of life you want. This step is called the assessment.

The services that you will receive are then outlined in a “Care Plan.” Team members support you in developing your plan by providing information that you need to make informed choices about the care you receive. Your care plan will help you move toward the personal outcomes that you and your team identified in the assessment.

People Choose Service Providers from a Comprehensive Network.

Members of Family Care select their long-term care providers from a “provider network.” Managed Care Organizations or MCOs (which are the agencies that provide the Family Care benefit to people)

are required to have providers for all the services covered by the program and have enough to give members a choice about how they receive their services.

People Receive the Services They Need Through One Benefit.

Sorting through multiple government funding programs to discover what you're eligible for and what's covered (or not) can be confusing and exhausting. The good news is that Family Care pays for the long-term care services, individualized for you in your care plan, through one benefit.

People Receive Services that Best Achieve the Results They Desire.

The success of the Family Care program is best measured by the real-life results or the outcomes you get from the services you receive. "Quality of Life Outcomes" in Family Care represent what is important to you in your life.

The following statements are the "Quality of Life Outcomes" that the Family Care program strives for. YOU define what these outcome statements mean to you and your life. Helping you achieve your personal outcomes is the goal of Family Care:

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

Interdisciplinary Teams in Family Care



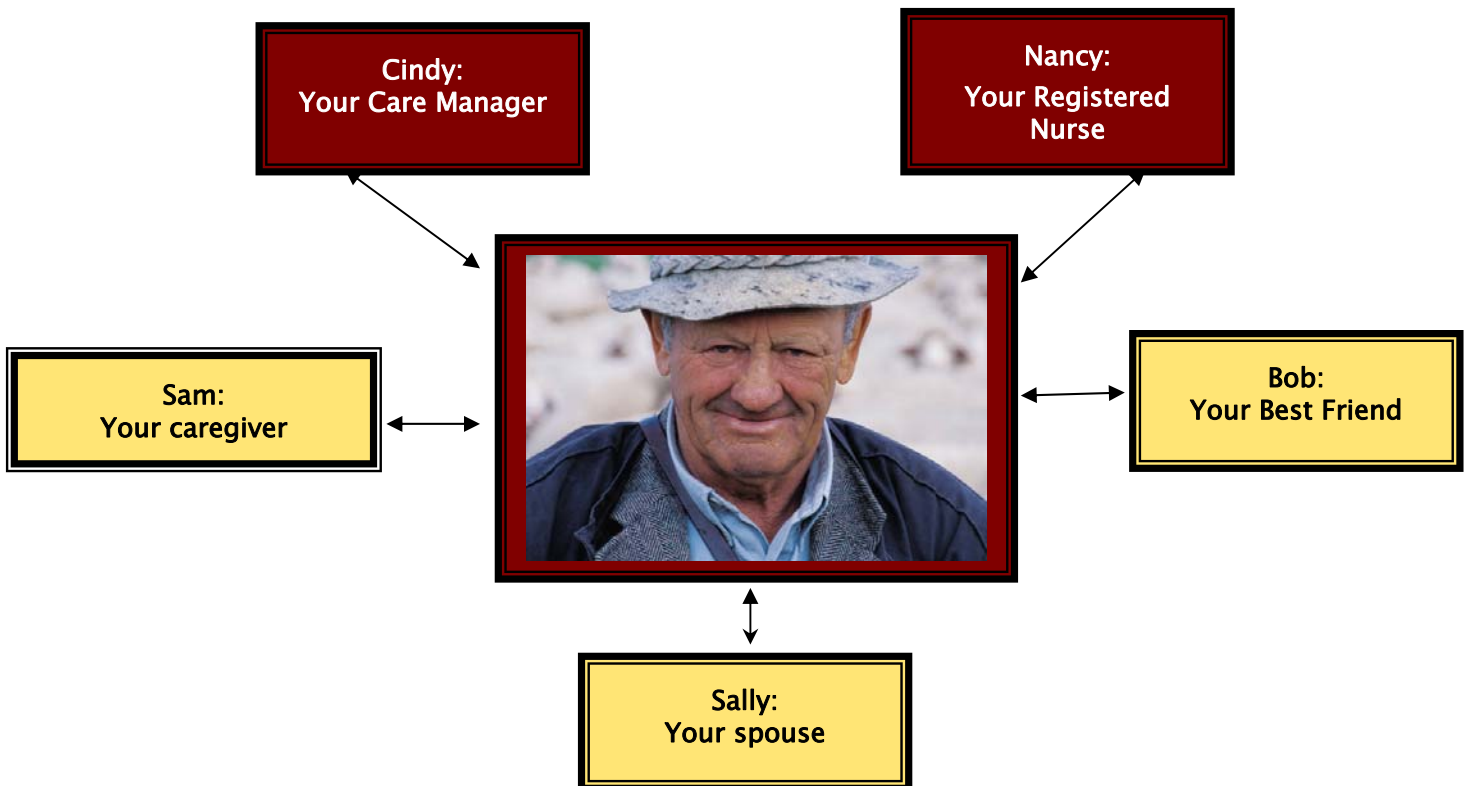
Who is on your interdisciplinary team?

When you participate in a Family Care program, a team of people come together to help you identify what sort of assistance you might need and work with you to arrange your long-term care services. You are an active participant on the team that also includes, at a minimum, a care manager and a registered nurse. You can choose to include a family member or loved one on your team. Sometimes people also choose other professionals to participate as team members as well. In Family Care, this team is called an “interdisciplinary team.”

What does your interdisciplinary team do?

The team completes an assessment of your needs and develops a plan for services to meet those needs. The services outlined in your plan are individualized for you and focus on the most effective and cost-effective way to meet your needs and personal outcomes. The care manager and registered nurse authorize payment for your services, and monitor the quality of the services you receive.

Here’s an example of an interdisciplinary team in Family Care. The person in the center picture represents you. The individuals in the lightly shaded boxes were personally selected by YOU to participate on your team:



What is Family Care Partnership?

Family Care Partnership, also known as Partnership is an innovative program that provides a full range of long-term care, health and medical services, and prescription drugs to enable you to live as independently as possible.

Long-term care is any service or support that you may need as a result of a disability, getting older, or having a chronic illness that limits the ability to do the things that you need to do throughout the course of your day. This includes things such as bathing, getting dressed, making meals, going to work, paying bills, and much more. There are a variety of services and supports available in Partnership that can help people do these things independently or with the support of someone else.

Partnership also covers your health and medical services, which includes the services of a physician, nurse practitioner, physician assistant, or other qualified medical professional. Health promotion, disease prevention, health maintenance, and patient education are also provided. In addition, Medicaid and Medicare drug services are all provided by the Family Care Partnership organization. Members do not need to have a separate Medicare Part D drug plan.

By coordinating your long-term care, health, medical care, and prescription drugs all together, this program is convenient and efficient for its participants.

How Does Partnership Work?

People Receive Interdisciplinary Care Management.

Sometimes people don't know exactly what they need, what's available, or where to go to get the care and services they need. Coordinating your own health, medical, and long-term care services can be overwhelming! When you participate in a Partnership program, you receive the support of a care team that is trained to provide care management for both health and medical conditions, in addition to your long-term care needs.

You are an active participant on the care team that also includes, at a minimum, a Partnership doctor, a nurse practitioner, a care manager and a registered nurse. You can choose to include a family member or loved one on your team. Sometimes people also choose other professionals to participate as team members as well. In Partnership, this team is called an "interdisciplinary team." The interdisciplinary team plans, delivers, and oversees your care across all settings, from your home to the hospital.

People Participate in Determining the Services They Receive.

The first step in planning Partnership services is for you to discuss with your team the kind of life you want to live, whether you want to live where you live now or in a different place, and what kind of support you need to live the kind of life you want. This step is called the assessment.

The services that you will receive are then outlined in a “Care Plan.” Team members support you in developing your plan by providing the information you need to make informed choices about the care you receive. Your care plan will help you move toward the personal outcomes that you want for your life and that your team identified in the assessment.

People Choose Service Providers from a Comprehensive Network.

Participants of Partnership select their long-term care and health care providers from a “provider network.” Managed Care Organizations or MCOs (which are the agencies that provide the Partnership benefit to people) are required to have providers for all the services covered by the program and have enough to give members a choice about how they receive their services.

In addition to selecting your long-term care providers through the provider network, in Partnership, you also select your physician from a network. Having physicians in a network ensures that your health care and long-term care services are coordinated in the way that the program is designed. You will have the opportunity to remain with your physician if he or she is in the MCO’s provider network.

If you join a Partnership program, medication coverage is also integrated into the benefit. Members of Partnership receive their prescription medications at Partnership pharmacies. Medicare enrollees no longer need a separate Medicare Part D drug plan.

People Receive the Services They Need Through One Benefit.

Sorting through multiple government funding programs to discover what you’re eligible for and what’s covered (or not) can be confusing and exhausting. The good news is that Partnership pays for your long-term care, health and medical services and prescription drugs that would otherwise be available through various Medicare and Medicaid programs. This includes pharmacy services so that participants can receive their prescription and some over-the-counter medications conveniently.

People Receive Services that Best Achieve the Results They Desire.

The success of the Partnership Program is best measured by the real-life results or the outcomes you get from the services you receive. “Quality of Life Outcomes” in Partnership represent what is important to you in your life.

The following statements are the “Quality of Life Outcomes” that the Partnership program strives for. When you participate in the program, YOU define what these outcome statements mean to you and your life. Helping you achieve your personal outcomes is the goal of Partnership:

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

Interdisciplinary Teams in Family Care Partnership

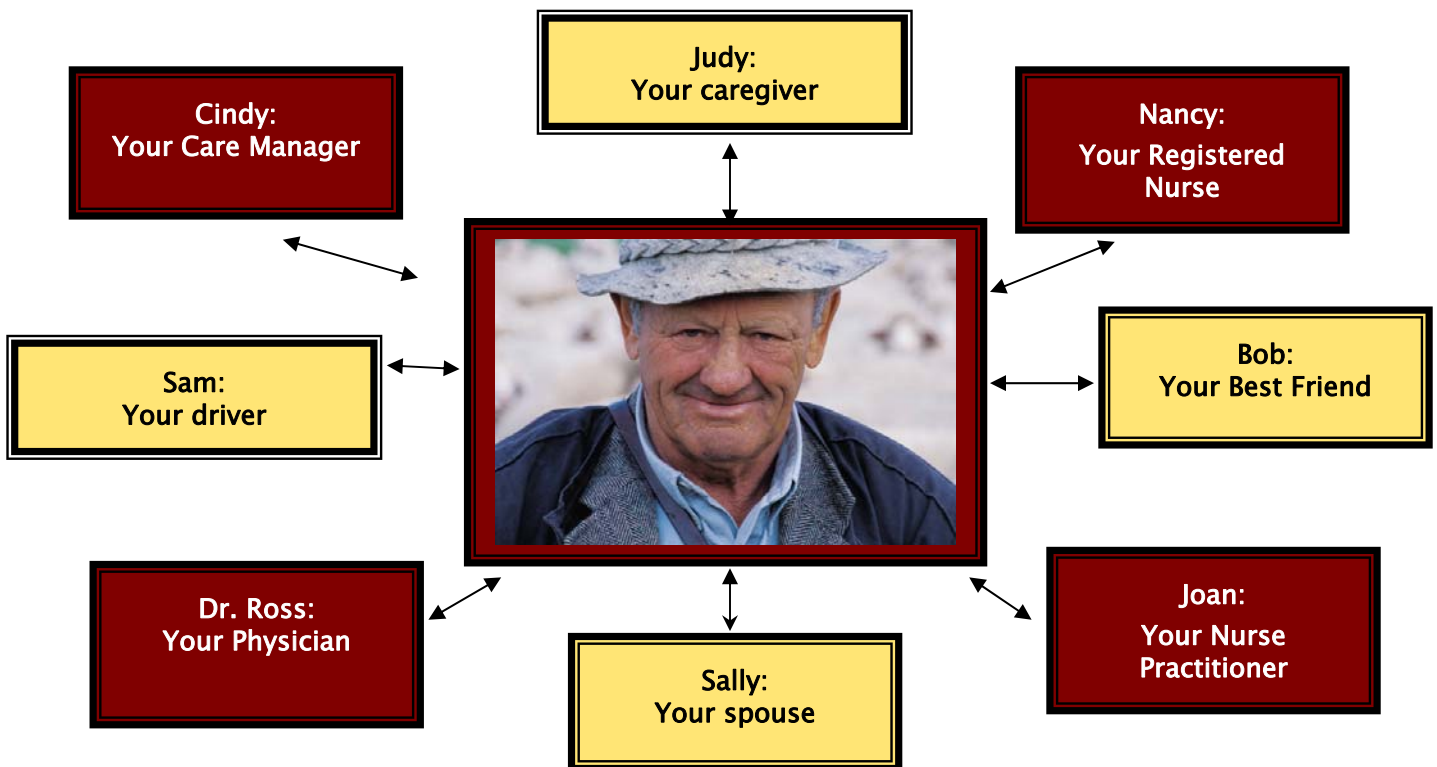
Who is on your interdisciplinary team?

When you participate in a Family Care Partnership program, also known as Partnership, a team of people come together to help you identify what sort of assistance you might need and work with you to arrange your long-term and health and medical services. You are an active participant on the team that also includes, at a minimum, a Partnership doctor, a nurse practitioner, a care manager and a registered nurse. You can choose to include a family member or loved one on your team. Sometimes people also choose other professionals, such as a personal care worker, to participate as team members as well. In Partnership, this team is called an “interdisciplinary team.”

What does your interdisciplinary team do?

The interdisciplinary team plans, delivers, and oversees your care across all settings, from your home to the hospital. The team completes an assessment of your needs and develops a plan for services to meet those needs. The services outlined in your plan are individualized for you and focus on the most effective and cost-effective way to meet your needs and personal outcomes. The care manager, registered nurse, and nurse practitioner authorize payment for your services, and monitor the quality of the services you receive.

Here’s an example of an interdisciplinary team in Partnership. The person in the center picture represents you. The individuals in the lightly shaded boxes were personally selected by YOU to participate on your team:



Tell Me More about...

Program of All-Inclusive Care for the Elderly (PACE)

What is the Program of All-Inclusive Care for the Elderly?

Program of All-Inclusive Care for the Elderly, also known as PACE, is an innovative program that provides a full range of long-term care, health and medical services, and prescription drugs to enable you to live as independently as possible.

Long-term care is any service or support that you may need as a result of a disability, getting older, or having a chronic illness that limits the ability to do the things that you need to do throughout the course of your day. This includes things such as bathing, getting dressed, making meals, going to work, paying bills, and much more. There are a variety of services and supports available in PACE that can help people do these things independently or with the support of someone else. Some of these services may be provided at the PACE Center, if you choose to attend the Center.

PACE also covers your health and medical services, which includes the services of a physician, registered nurse, physician assistant, or other qualified medical professional. Health promotion, disease prevention, health maintenance, and patient education are also provided. In addition, Medicaid and Medicare drug services are all provided by the Managed Care organization which operates PACE. You do not need to have a separate Medicare Part D drug plan.

By coordinating your long-term care, health and medical care, and prescription drugs all together, this program is convenient for you and efficient in its operation.

How Does PACE Work?

People Receive Interdisciplinary Care Management.

Sometimes it's hard to know exactly what you need, what's available, or where to go to get the care and services you need. Coordinating your own health, medical and long-term care services can be overwhelming! When you participate in PACE, you receive the support of a care team that is trained to provide care management for both health and medical conditions, in addition to your long-term care needs.

You are an active participant on the care team that also includes, at a minimum, a PACE doctor (or community doctor), a registered nurse, a care manager, PACE center coordinator, home care coordinator, physical therapist, occupational therapist, recreational therapist and a dietitian. You

can choose to include a family member or loved one on your team. Sometimes people also choose other professionals to participate as team members as well. In PACE, this team is called an “interdisciplinary team.” The interdisciplinary team plans, delivers, and oversees your care across all settings, from your home to the hospital.

People Participate in Determining the Services They Receive.

The first step in planning PACE services is for you to discuss with your team the kind of life you want to live, whether you want to live where you live now or in a different place, and what kind of support you need to live the kind of life you want. This step is called the assessment.

The services that you will receive are then outlined in a “Care Plan.” Team members support you in developing your plan by providing the information you need to make informed choices about the care you receive. Your care plan will help you move toward the personal outcomes that you want for your life and that your team identified in the assessment.

People Choose Service Providers from a Comprehensive Network.

Participants in PACE select their long-term care and health care providers from a “provider network.” Managed Care Organizations or MCOs (which are the agencies that provide the PACE benefit to people) are required to have providers for all the services covered by the program and have enough to give members a choice about how they receive their services.

In addition to selecting your long-term care providers through the provider network, in PACE, you also select your physician from the physicians who work for the PACE program or one of their community physicians. Having physicians in a network ensures that your health care and long-term care services are coordinated in the way that the program is designed.

If you join a PACE program, medication coverage is also integrated into the benefit. Members of PACE receive their prescription medications at PACE pharmacies. If you have Medicare, you no longer need a separate Medicare Part D drug plan. You will have no co-pays or deductibles for medications if you enroll in PACE.

People Receive the Services They Need Through One Benefit.

Sorting through multiple government funding programs to discover what you’re eligible for and what’s covered (or not) can be confusing and exhausting. The good news is that PACE pays for your long-term care, health and medical services and prescription drugs that would otherwise be available through various Medicare and Medicaid programs. This includes pharmacy services so that you can receive your prescription and some over-the-counter medications conveniently.

People Receive Services that Best Achieve the Results They Want.

The success of PACE is best measured by the real-life results or the outcomes you get from the services you receive. “Quality of Life Outcomes” in PACE represent what is important to you in your life.

The following statements are the “Quality of Life Outcomes” that the PACE program strives for. When you participate in the program, YOU define what these outcome statements mean to you and your life. Helping you achieve your personal outcomes is the goal of PACE:

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

Interdisciplinary Teams in Program of All-Inclusive Care for the Elderly (PACE)

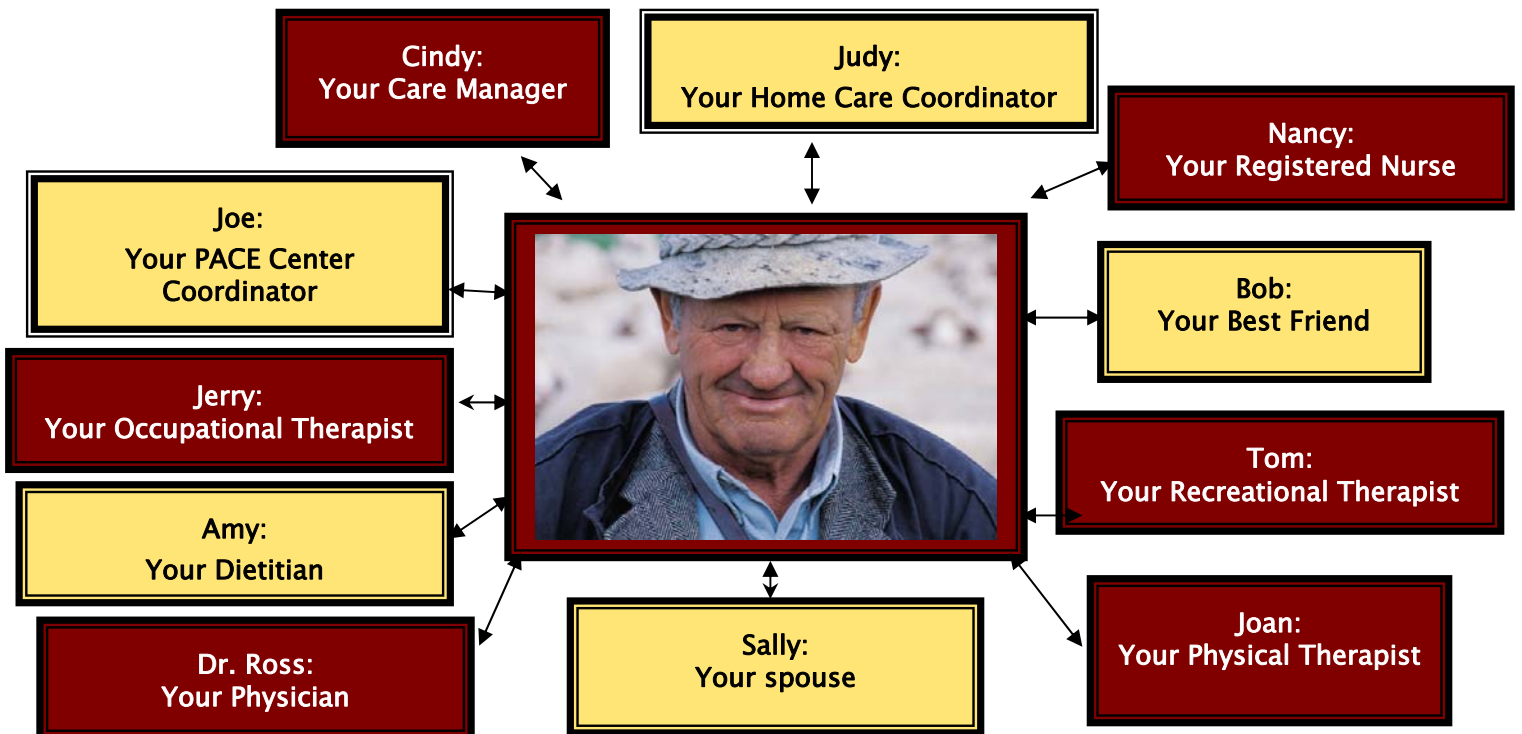
Who is on your interdisciplinary team?

When you participate in the Program of All-Inclusive Care for the Elderly, also known as PACE, a team of people come together to help you identify what sort of assistance you might need and work with you to arrange your long-term care, health and medical services. You are an active participant on the team that also includes, at a minimum, a PACE doctor or doctor from the community, a care manager, a registered nurse, physical therapist, occupational therapist, recreational therapist, dietitian, PACE center coordinator and home care coordinator. You can choose to include a family member or loved one on your team. Sometimes people also choose other professionals, such as a personal care worker, to participate as team members as well. In PACE, this team is called an “interdisciplinary team.”

What does your interdisciplinary team do?

The interdisciplinary team plans, delivers, and oversees your care across all settings, from your home to the hospital. The team completes an assessment of your needs and develops a plan for services to meet those needs. The services outlined in your plan are individualized for you and focus on the most effective and cost-effective way to meet your needs and personal outcomes. The interdisciplinary team authorizes payment for your services, and monitors the quality of the services you receive.

Here’s an example of an interdisciplinary team in PACE. The person in the center picture represents you. Some of these individuals personally selected by YOU to participate on your team:



Key Differences between Family Care, Partnership and PACE

The following document describes three key differences between the Family Care, Partnership and PACE Programs. These are the general categories of services that are integrated into the benefit (long-term care services and health care services), the composition of the interdisciplinary team, and specific services that are covered in the provider network.

SERVICE INTEGRATION

Family Care	Partnership and PACE
<p>Partial Integration. The Family Care program integrates home and community-based services, institutional care (such as nursing home care), Medicaid personal care, home health, and other services that were previously funded separately. Family Care does NOT pay health care costs (acute/primary care) such as hospital stays, emergency room visits, medications, and doctor visits. Family Care participants use Medicare and Medicaid to purchase these health care services.</p>	<p>Full Integration. The Partnership and PACE programs integrate a person's long-term care services and health and medical care services (primary and acute care), and prescription medications. Therefore, all home and community based services, institutional care (such as a nursing home), physician services, hospital stays, medications, and all other medical care is integrated into the Partnership and PACE benefit.</p>

INTERDISCIPLINARY TEAM COMPOSITION

Family Care	Partnership and PACE
<p>At a minimum, the service coordination team includes a registered nurse, social worker, and the member. Members may choose to include family members, loved ones, and other professionals to participate on their team.</p>	<p>In Partnership, at a minimum, the service coordination team includes a nurse practitioner, registered nurse, social worker, the member, and a physician. Members may choose to include family members, loves ones, and other professionals to participate on their team.</p> <p>In PACE, the service coordination team includes a registered nurse, care manager, PACE center coordinator, home care coordinator, PACE or community physician, therapists (occupational, physical and recreational) and a dietitian. Members may choose to include family members, loves ones, and other professionals to participate on their team.</p>

COVERED SERVICES and the PROVIDER NETWORK

Family Care	Partnership and PACE
<p>Long-Term Care Services. A person’s long-term care services are covered by Family Care. (See the “Covered Services” chart for more information.)</p> <p>Primary Care Services (including services for acute and chronic conditions). Family Care does not pay for primary care services. Members use their own physician and use their Medicaid Forward card to pay for their primary care services. Members obtain prescription drugs through their Medicare (Part D) and/or Medicaid (or SeniorCare) coverage. The interdisciplinary team can assist an individual in communicating with and coordinating primary care providers and services.</p>	<p>Long-Term Care Services. A person’s long-term care services are covered by Partnership and PACE. (See the “Covered Services” chart for more information.)</p> <p>Primary Care Services (including services for acute and chronic conditions) are integrated in the Partnership and PACE benefit that is managed by the care team along with long-term care services. In Partnership, members use physicians who are in the MCO’s provider network that may include the member’s current physician. In PACE, members use physicians that are employed by the MCO or under contract. Members obtain prescription drugs through Partnership and PACE. Those who join a Partnership or PACE program do not use SeniorCare or any other Medicare Part D provider, since medication coverage is also integrated into the benefit. Individuals who choose PACE do not pay co-pays or deductibles for their medications.</p>

Helping People Decide: Key Questions

1. How do you feel about having a team of people coordinating all of your long-term care services **and** your health care services?
2. Do you have multiple diagnoses with complex chronic disease or conditions? Have you had to go into the hospital multiple times? Do you take a lot of medications? Do you have a diagnosis of End Stage Renal Disease? If so, you are ineligible to enroll in Partnership, unless you are enrolling in a Managed Care Organization (MCO) that has a federally authorized exemption to this rule. Only one MCO, Community Care Inc., has a federally authorized exception to enroll individuals with End Stage Renal Disease at this time. Note: Individuals with End Stage Renal disease may enroll in PACE.
3. If you are interested in Partnership, is your physician a part of the provider network? If not, you could contact the MCO to see if it is possible for your physician to join the network. If not, does it matter to you? If you are interested in PACE, is your physician employed by PACE or one of their community physicians? If not, does it matter to you?

4. If you participate in a particular program, which hospital will you be able to use? Can you select your own? Does it matter to you?

5. If you are interested in Partnership or PACE, are your medications included in the formulary? If not, is a comparable (generic) drug available? How would the local Partnership MCO or PACE ensure that you get the medications that you need?

What Will Change?

From the Medicaid Waiver Programs to Managed Long-Term Care

You are currently receiving services that are funded by a Medicaid Waiver program such as the Community Options Program (COP), the Community Integration Program (CIP), or the Brain Injury Waiver (BIW). These programs are changing as managed long term care becomes available in your area. This document provides important answers to questions about this transition and the impact it has on you.

What is managed long-term care?

Managed long-term care is the term used to describe the programs that are now available to provide the full range of long-term care services you may need. These programs are different from the program you are currently in because they coordinate in one flexible benefit all the services that you may need to maintain or improve your health and well-being. By helping you live the way you want to, while being as efficient as possible, we will be able to get more people the services they need and eliminate waiting lists for these services.

There are different types of managed long-term care programs in Wisconsin: Family Care, Family Care Partnership (also known as Partnership) and Program of All-Inclusive Care for the Elderly (also known as PACE). The Family Care program coordinates all of your long-term care services and supports that were previously available through separate programs. Your health and medical care and prescription drugs continue to be covered by Medicare and Medicaid. Partnership and PACE cover all of the long-term care services in the basic Family Care benefit package plus all of your health and medical services and your prescription drugs, all in one package. The program(s) that are available to you will depend on where you live. ***(OR: In insert the name of your County, you have the option to participate in insert the name of the program(s) available locally and only describe that program. If PACE is available in your area, describe that program as well. Link to [Word document](#) to insert your county and program information).***

Will I have the same services?

The managed long-term care benefit package includes all the services in the current Medicaid Waiver programs (CIP, COP, and BIW) and some of the services funded by your Medicaid Forward card. Managed care organizations, or MCOs, can also provide additional services not in the Medicaid benefit package if they meet the member's individual outcomes and are cost-effective.

You will get the services you need at the level you need them to cost-effectively support the outcomes you want to achieve through those services. This may or may not be the exact same services at the exact same level that you currently receive them. Services will NOT be randomly cut, and there are no "across the board" decisions about who gets what services. If you have changes made in your care plan, those changes should result in more personalized, more effective services for you! This is because the

type of care planning that occurs in Managed Care is focused on meeting your personal, individualized outcomes. Services that are not effective in supporting your outcomes will likely be discontinued.

It is also important to remember that if your needs or outcomes change over time, your care plan can also change. You don't have to try to include services in your care plan that you don't need today, even if you may need them in the future.

Can I keep the same care manager?

It is possible that you may have a different care manager. The managed care organization(s) will be hiring qualified, professional care managers who will work closely with you to ensure that you have the support that you need to live the kind of life that you would like.

In addition, you will have at least one new member on your care team that you may not have had in the past: a nurse. In Family Care Partnership, you will also have a nurse practitioner and doctor on your team. These individuals will work with you and your care manager to ensure that you experience the best possible health and receive the best possible services.

Will I have the same providers?

This depends on whether your current providers are in the MCO "provider network" and if your care team determines that your current provider can meet your individual outcomes in a cost-effective way.

Most MCOs plan on contracting with all the providers that the county waiver programs used. In Family Care, the number of providers available to members actually grew because the program is required to have providers for all the services covered by the program and have enough in order to offer a choice of providers to its members. You might be able to choose a new provider that wasn't available to you in the past!

For providers who come into your home or provide hands-on care to you, such as personal care, the MCO must purchase services from whomever you choose as long as that person meets the MCO's requirements and accepts the MCO's payment rate.

For other services, you can choose among the providers in the MCO's provider network. However, the MCO may be able to have a more cost-effective arrangement with one provider than another. In this case, the MCO can offer the most cost-effective way to provide the necessary supports. For example, an MCO might have an arrangement with one home care provider for a daily or overnight rate for services, but contract for hourly services with another home care provider. The daily rate is almost always more economical, and the MCO can limit choice to the most cost-effective way to provide needed support.

If you are currently acting as an employer and hiring your own providers through Self-Directed Supports, you should be able to continue to do so in managed long-term care.

What Will Change?

From the Medicaid Waiver Programs to IRIS (Include, Respect, I Self-Direct)

You are currently receiving services that are funded by a Medicaid Waiver program such as the Community Options Program (COP), the Community Integration Program (CIP), or the Brain Injury Waiver (BIW). These programs are changing as long-term care reform occurs in your area. This document provides important answers to questions about this transition and the impact it has on you.

What is IRIS?

IRIS (Include, Respect, I Self-Direct) is a Medicaid long-term support Self-Directed Waiver Program. In this new program you and anyone else you choose to help are in charge of making the decision about which supports and services you would like to use. The Aging and Disability Resource Center (ADRC) will tell you your monthly budget allocation amount.

This program is different from the program you are currently in because you plan your own supports and services within your assigned budget. The supports and services that you select will help you live the way you want to. You will select an independent consultant whose job it is to make sure your plan is written, only includes qualified providers and does not exceed the amount of your budget. You can apply to the Department for an adjustment to your budget, if you and your independent consultant conclude an adjustment is needed. You decide how to define quality of your services, and the goods and services you select must be able to connect to the personal outcomes that matter to you. You may not purchase goods or services that are illegal or considered experimental. Your health and medical care and prescription drugs continue to be covered by Medicare and Medicaid. A state contracted financial services agent pays your providers for you from your budget.

Will I have the same services?

The IRIS long-term care benefit package includes all the services in the current Medicaid Waiver programs (CIP, COP, and BIW) and also the new service “customized goods and services” which is a service that allows you to purchase non traditional supports and services with your budget. You will get the services you choose at the level you need them to cost-effectively support the outcomes you want to achieve through those services. This may or may not be the exact same services at the exact same level that you currently receive. Services will NOT be randomly cut, and there are no “across the board” decisions about who gets what services. If you decide you would like to make changes in your support and service plan you can. This is because the type of planning that occurs in IRIS is focused on meeting your personal, individualized outcomes. The cost of services that you choose may not exceed your monthly individual budget amount.

Can I keep the same care manager/support and service coordinator?

In IRIS, the ADRC will refer you to the statewide independent consultant organization, which helps you select an independent consultant. The independent consultant will be especially respectful of honoring your choices in how you arrange and manage your supports and services. This person will assist you if you want them to. He or she may help you in some ways that your former care manager/support and service coordinator did, but they will not direct your plan. That is your job. You may also have friends, relatives, or a guardian assist you as much as you desire.

Will I have the same providers?

You may select from any qualified provider– so if you would like to continue with your current provider and they remain otherwise qualified, yes. The cost of the provider’s services must fit within your budget amount. Remember, you determine if your current provider can meet your individual outcomes in a cost-effective way. You will be able to choose a new provider that wasn’t available to you in the past!

If staff or a paid attendant is part of your plan, you may select an agency, you may become the employer, or you may engage a co-employment agency to help you manage them. The state contracted financial services agency handles all of the payroll functions and makes sure criminal background checks are completed.

Are there any limits on how I spend my individualized budget amount?

Expenses may be incurred only for services included in your approved care plan. The state (through the independent consultant) may put limits on your self-directed supports options if:

- You are not staying within your available resources;
- You have used resources in a way that is illegal;
- You have used resources in a way that is too much of a risk to your health and safety; or
- Someone else is making decisions for you that are not based on what you want.

Tell Me More about... **Self-Directed Supports in Managed Care**

This document specifically discusses the Self Directed Support option that is available in Wisconsin's managed long-term care programs: Family Care, Family Care Partnership, and PACE. If you would like additional information on these managed long-term care programs, please ask your Aging and Disability Resource Center specialist for more information.

What is Self-Directed Supports in Managed Care?

Self-directing your services may offer you a way to have more control over your services and supports. In Family Care, Family Care Partnership and Program of All-Inclusive Care for the Elderly (PACE), which are “managed long-term care” programs, the Managed Care Organization, or MCO, will make resources (including a budget) available to you based on what it would have spent if it managed those services. You can then use that budget amount to buy the services and supports that will work to meet your personal outcomes.

How Does Self-Directed Supports in Managed Care Work?

Anyone Can Choose the Managed Care Self-Directed Supports Option

The Self-Directed Supports option is available to all Family Care, Family Care Partnership and PACE members.

Each MCO Has a Plan for Self-Directed Supports

Each MCO has its own plan for offering self-directed supports. Each MCO must:

- Have a way for you to authorize payment to providers with your available budget and keep track of how much remains available;
- Have a way for you to choose and hire your own support workers, who could be family, friends, or neighbors; and
- Have a way for you to train and supervise your own support workers in how to care for you and meet your needs.

People Have a Choice About What Services They Self-Direct

You can choose to self-direct all or only part of your services. For example, you could choose to self-direct your personal care services or those providers that help you find and keep a job, and use your interdisciplinary care team to manage services aimed at other outcomes in your plan.

If you choose to get involved in self-directed supports, your interdisciplinary team will:

- Explain the variety of choices available to you;
- Work with you to assess your needs;
- Determine the amount of resources available to you; and
- Keep track of whether you are staying within your available resources and meeting your needs for health and safety.

Budget Limits

The MCO may put limits on the self-directed supports option if it finds that:

- You are not staying within your available resources;
- You have used resources in a way that is illegal;
- You have used resources in a way that is too much of a risk to your health and safety; or
- Someone else is making decisions for you that are not based on what you want.

The MCO will tell you what you need to do to avoid these limits and about your right to file an appeal or grievance or ask for a hearing.



What is IRIS?

Self-directing your services offers you a way to have control over your long-term care services and supports. In IRIS, you are provided with an individualized budget (based on your individualized needs), that you use to buy your own services and supports. Participants of the IRIS program decide what services, supports and goods they need, when to schedule services, who to select to provide services and supports, and where to receive them.

How Does IRIS Work?

Anyone Can Choose IRIS

The IRIS option is available to anyone in a county where Family Care is operational who meets eligibility requirements for Wisconsin long-term care programs.

Purchase Services Within an Individualized Budget Amount

The amount of funding available for your plan will be determined by the results of a tool called the “Long-Term Care Functional Screen.” A worker at the Aging and Disability Resource Center will ask you questions about your abilities, strengths and needs. He or she will enter the information you provide into the functional screen, and the screen will calculate the amount of money that you can use to create your plan for how to meet your long-term care needs. Potential clients in IRIS may apply to the Department for an adjustment to their initial budget, if they are unable to develop a support and service plan with their independent consultant within the initial budget amount.

Receive Home and Community-Based Services

Participants of IRIS can purchase a wide array of home and community based long-term care services that are covered in the IRIS service package. You will be able to use your Medicaid card for other Medicaid covered services.

Plan Your Own Care

Initially, each person who chooses to participate in IRIS will select and meet with an independent consultant (who is contracted for by the State of Wisconsin) to receive an in-depth orientation about the program. You, and any other person providing assistance to you with self direction, will then develop your support and service plan that describes the type of supports and services you need. After you develop your plan, the consultant will review it to be sure that it is consistent with the services that are covered by the program and that it addresses your health and safety. The

consultant will also ensure that necessary paperwork is completed and will refer you to sources for assistance as needed.

Coordinated Payment to Providers

An IRIS participant has access to the IRIS Financial Services Agency at no cost to him or her. This agency takes care of money issues like payroll, taxes, and other employer-related financial paperwork requirements. The Financial Services Agency makes payments to people you employ and to businesses or providers where you purchase other goods and services after you authorize payment.

Self-Direct Your Own Support and Services

IRIS is a program that allows you to direct your own services and supports. IRIS recognizes that you are the decision-maker in your life, including determining how to spend your days and the types of support or assistance you need. IRIS is grounded in the core values of self-determination. These values include:

- Freedom to decide how you want to live your life;
- Authority over a specific budget;
- Support to organize resources in ways that are life enhancing and meaningful to you;
- Responsibility for the wise use of public dollars and recognition of the contribution you make to your community; and
- Confirmation of the important role of self-advocates.

Key Questions:

Highlighting differences between options for self-direction in Family Care/Partnership/PACE and IRIS

This document answers key questions that highlight differences between self-directing one's services and supports in Family Care, Partnership and Program of All-Inclusive Care for the Elderly (PACE), and IRIS (Include, Respect, I Self-Direct).

Key Question: How much of my services can I self-direct?

Family Care/Partnership/PACE (Managed Long-term Care)	IRIS (Include, Respect, I Self-Direct)
<p>Individuals who select Family Care, Partnership or PACE can also choose to self-direct some of their services and supports. The Managed Care Organization (MCO) will continue to manage any services the individual does not choose to self-direct. Please note that family, friends and others may help.</p>	<p>Individuals who select IRIS self-direct all of their long-term care services and supports. Family, friends, their independent consultant, a broker and others may help.</p> <p>The individual will also be able to access services and supports available through the Medicaid Card and include these services in their support and service plan.</p>

Key Question: How is a service and support plan developed?

Family Care/Partnership/PACE (Managed Long-term Care)	IRIS (Include, Respect, I Self-Direct)
<p>During the assessment process, individuals identify the services and supports they would like to self-direct. Based on what it would otherwise pay for that set of services, the MCO's interdisciplinary care management team designates an amount of money the individual can use to pay for services and supports. Individuals create a "SDS Plan" that outlines how they will direct those services and supports. This "SDS Plan" is approved by the individual's care management team.</p> <p>The interdisciplinary care management team will continue to manage any services and supports the individual does not choose to self-direct.</p>	<p>The ADRC or waiver case manager informs individuals of their monthly budget allocation during enrollment counseling. Within their monthly budget allocation, individuals with the help of a chosen Independent Consultant create their own plan of services and supports. The Independent Consultant Agency (ICA) approves the support and service plan. Individuals have access to a wide range of services including a new service option called "Customized Goods and Services." Individuals may apply to the Department for adjustments to their budget amount if they are not able to develop a cost effective support and service plan with the assistance from the ICA within their initial monthly budget allocation amount.</p>

Key Question: How are services paid?

Family Care/Partnership/PACE (Managed Long-term Care)	IRIS (Include, Respect, I Self-Direct)
A fiscal intermediary uses dollars allocated by the Managed Care Organization to pay all claims that are listed on the individual’s SDS plan after the individual authorizes the payment.	The IRIS Financial Services Agency (FSA) pays all claims that are listed on the service and support plan after the individual authorizes the payment.

Key Question: Can my family and friends be paid to provide care?

Family Care/Partnership/PACE (Managed Long-term Care)	IRIS (Include, Respect, I Self-Direct)
The individual can select their own workers, including family, friends and neighbors. These individuals must meet qualification requirements including background checks and attending any required in training.	The individual can select their own workers, including family, friends and neighbors. These individuals must meet qualification requirements including background checks and attending any required in training.

Key question: Do I have to hire my workers directly?

Family Care/Partnership/PACE (Managed Long-term Care)	IRIS (Include, Respect, I Self-Direct)
The individual can employ workers directly or may use a co-employment agency that would offer help with recruiting, screening, hiring, training and firing workers. Individuals may also purchase services and supports through an agency.	The individual can employ workers directly or may use a co-employment agency that would offer help with recruiting, screening, hiring, training and firing workers. Individuals may also purchase services and supports through an agency.

Covered Services

...in Wisconsin's Long-Term Care Programs

The following chart is a **partial** listing of long-term care and health related services. The chart indicates whether the service is included in the specific program's benefit package. The services that a person actually receives are based on assessed needs and other program specific requirements. Some services may require prior authorization.

Long-Term Care Service	Family Care*	Family Care Partnership (and/or PACE)*	IRIS**	Medicaid "Forward" Card
Home Health or Personal Care	Included	Included	Use your Medicaid "Forward Card" to purchase this service	Included
"Supportive Homecare" <i>This includes assistance with daily activities and tasks such as eating and grooming, and assistance with household tasks, for example, meal preparation, laundry and house cleaning.</i>	Included	Included	Included	
Nursing Home	Included	Included	Use your Medicaid "Forward Card"	Included
Assisted Living/Residential Care Services	Included	Included	Included	
Adult Day or Respite Care	Included	Included	Included	
Home Delivered Meals	Included	Included	Included	
Home Modifications	Included	Included	Included	
Transportation	Included	Included	Included	Included
Hospice	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use you Medicare and/or Medicaid "Forward Card" to purchase this service	Included
Physical, Speech or Occupational Therapy	Included	Included	Use your Medicaid "Forward Card"	Included
Wheelchairs and other equipment	Included	Included	Use your Medicaid "Forward Card"	Included
Adult diapers, gloves, and other medical supplies	Included	Included	Use your Medicaid "Forward Card"	Included
Mental health or drug and alcohol treatment	Included	Included	Use your Medicaid "Forward Card"	Included
Daily Living Skills Training	Included	Included	Included	
Communication Aids/Interpreter	Included	Included	Included	
Employment services	Included	Included	Included	
Customized goods and services			Included	

Health Care Services	Family Care*	Family Care Partnership (and/or PACE)*	IRIS**	Medicaid "Forward" Card
Physician Services	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare first
Hospitalization	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare first
Prescription Medications	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare Part D first
Dental Care	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare first
Foot Care: Podiatry	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare first
Vision (including eye glasses)	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included	Use your Medicare and/or Medicaid "Forward Card" to purchase this service	Included, but use your Medicare first

*With the help of an interdisciplinary team, participants in a Family Care or Family Care Partnership also known as Partnership program choose their long-term care providers (and their health care providers in Family Care Partnership) from the network offered by the Managed Care Organization (MCO).

**IRIS participants purchase services, supports and goods within an individualized budget amount. Participants make purchases and hire service providers directly, or with the help of an employment agency.

Note: Individuals who have a diagnosis of **End Stage Renal Disease** are ineligible to enroll in Partnership, unless these individuals are enrolling in a Managed Care Organization (MCO) that has a federally authorized exemption to this rule. Only one MCO, Community Care Inc., has a federally authorized exception to enroll individuals with End Stage Renal Disease at this time. Individuals who have a diagnosis of End Stage Renal Disease may enroll in PACE.

Note: **Estate Recovery** provisions apply for Family Care, Partnership and IRIS. Estate Recovery provisions do not apply for PACE. In addition, individuals who choose PACE do not pay prescription co-pays or deductibles.

Family Care Benefit Packages: Nursing Home and Non-Nursing Home Level of Care

NURSING HOME LEVEL OF CARE	NON-NURSING HOME LEVEL OF CARE
Interdisciplinary Care Management	Interdisciplinary Care Management
Community-Based Medicaid State Plan Services*	Community-Based Medicaid State Plan Services*
<ul style="list-style-type: none"> • AODA Day Treatment Services (in all settings) • Durable Medical Equipment, except hearing aids and prosthetics • Home Health • Medical Supplies • Mental Health Day Treatment Services (in all settings) • Mental Health Services, except physician or inpatient • Nursing (including respiratory care, intermittent and private duty) • Occupational Therapy (except inpatient) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Specialized Medical Supplies • Speech and Language Pathology Services (except inpatient) • Medicaid Transportation except ambulance and common carrier 	<ul style="list-style-type: none"> • AODA Day Treatment Services (in all settings) • Durable Medical Equipment, except hearing aids and prosthetics • Home Health • Medical Supplies • Mental Health Day Treatment Services (in all settings) • Mental Health Services, except physician or inpatient • Nursing (including respiratory care, intermittent and private duty) • Occupational Therapy (except inpatient) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Specialized Medical Supplies • Speech and Language Pathology Services (except inpatient) • Medicaid Transportation except ambulance and common carrier
INSTITUTIONAL MEDICAID STATE PLAN SERVICES*	INSTITUTIONAL MEDICAID STATE PLAN SERVICES
<ul style="list-style-type: none"> • Nursing Facility including ICF-MR and IMD (For IMDs, coverage is for adults under age 25 or 65 and older) 	Not applicable
HOME AND COMMUNITY-BASED WAIVER SERVICES	HOME AND COMMUNITY-BASED WAIVER SERVICES
<ul style="list-style-type: none"> • Adaptive aids • Adult Day Health • Adult residential care: 1-2 bed adult family homes • Adult residential care: 3-4 bed adult family homes • Adult residential care: CBRF • Adult residential care: RCAC • Children's foster homes/treatment foster homes • Communication aids • Consumer education and training 	Not applicable

- Consumer-directed supports (SDS) support broker
 - Counseling and therapeutic resources
 - Day Habilitation
 - Day services for children
 - Education
 - Environmental accessibility adaptations (Home modifications)
 - Financial management services
 - Home delivered meals
 - Housing counseling
 - Personal Emergency Response Systems (PERS)
 - Prevocational Services
 - Relocation services
 - Respite
 - Specialized medical equipment and supplies
 - Supported Employment
 - Supportive home care
 - Transportation (Specialized transportation)
 - Vocational futures planning
- Self-directed supports (SDS) can be used to direct any service

**Please note: Family Care managed care organizations are able to provide cost-effective alternatives to the listed Medicaid card services.*

Non–Nursing Home Level of Care Benefit Options

Individuals, who are eligible at the non–nursing home level of care, have access to two benefit options: Family Care and the Medicaid State Plan. Help to coordinate available services through an interdisciplinary care management team is only available through Family Care. Institutional Medicaid State Plan Services (Nursing home care and ICF–MR services) or home and community based (waiver) alternative services are not noted in this chart, since this service is not available to people who do not have a nursing home level of care. Individuals who are eligible at the non–nursing home level of care also need to meet non–financial and financial eligibility criteria for Medical Assistance. Note: An expanded financial eligibility criterion is not applicable.

COMMUNITY–BASED MEDICAID STATE PLAN SERVICES

Family Care	Medicaid State Plan
<ul style="list-style-type: none"> • AODA Day Treatment Services (in all settings) • Durable Medical Equipment, except hearing aids and prosthetics • Home Health • Medical Supplies • Mental Health Day Treatment Services (in all settings) • Mental Health Services, except physician or inpatient • Nursing (including respiratory care, intermittent and private duty) • Occupational Therapy (except inpatient) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Specialized Medical Supplies • Speech and Language Pathology Services (except inpatient) • Medicaid Transportation except ambulance and common carrier • Interdisciplinary care management (including a social worker and a registered nurse)* 	<ul style="list-style-type: none"> • AODA Day Treatment Services (in all settings) • Durable Medical Equipment, except hearing aids and prosthetics • Home Health • Medical Supplies • Mental Health Day Treatment Services (in all settings) • Mental Health Services, except physician or inpatient • Nursing (including respiratory care, intermittent and private duty) • Occupational Therapy (except inpatient) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Specialized Medical Supplies • Speech and Language Pathology Services (except inpatient) • Medicaid Transportation except ambulance and common carrier

**Please note: Family Care managed care organizations are able to provide cost–effective alternatives to the listed Medicaid card services.*

Managed Care Organization (MCO) Options

This chart (See [Word Version](#)) may be useful in providing enrollment counseling to people in areas where more than one Managed Care Organization is available. The categories found in the chart provide consumers with more detailed and factual information about each MCO that may be useful when weighing their options.

Service Detail	<i>Insert name of MCO</i>	<i>Insert Name of MCO</i>	<i>Insert Name of MCO</i>
MCO Address, Phone Numbers & e-mail			
MCO Website Address			
Type of Plan (Family Care, Family Care Partnership, PACE)			
Legal Status (Public, Private Non-Profit or For-Profit)			
Years of Experience with Each Target Group			
Geographic Service Area			
ADRC(s) in Service Area			
Care Management Caseload Size			

Service Detail	<i>Insert name of MCO</i>	<i>Insert Name of MCO</i>	<i>Insert Name of MCO</i>
Member Advocate Contact Information & Resources			
Provider Network References & Contact Information			
MCO Quality Information			

Health Care Services *This section is applicable if the MCO offers a Family Care Partnership or PACE benefit.*

Service Detail	<i>Insert name of MCO</i>	<i>Insert name of MCO</i>	<i>Insert name of MCO</i>
Hospitals Affiliated with Plan			
Location of Urgent Care Facilities			
Total Number of Primary Care Physicians			
Medicare Prescription Drug Plan Coverage			

Acronyms



Alphabet soup anyone? The following acronyms are used throughout this document, and are commonly used in printed materials or everyday conversations when discussing long-term care programs. This guide is intended to be a quick reference for enrollment counselors to refer to if necessary. While these acronyms are commonly used for those in the human services profession, it is important for enrollment counselors to remember to try to avoid using them when having conversations with consumers. ☺

ADRC	Aging and Disability Resource Center
BIW	Brain Injury Waiver
CIP (1A, 1B, II)	Community Integration Program
CLTS	Children's Long Term Support Waivers
CM	Care Manager (also referred to as support and service coordinator, or case manager)
CMO	Care Management Organization (a term often used to describe a Managed Care Organization in Family Care)
COP-W	Community Options Program-Waiver
DHS	Department of Health Services
FC	Family Care (a managed care program)
FCP	Family Care Partnership (a managed care program)
FSA	IRIS Financial Service Agency
I&A	Information and Assistance
ICA	IRIS Independent Consultant Agency
IDT	Interdisciplinary Team
IM	Income Maintenance (also referred to as Economic Support (ES))

IRIS	Include, Respect, I Self-Direct (A long term care program)
ISP	Individualized Service Plan
LOC	Level of Care
LTC	Long-Term Care
LTCFS	Long-Term Care Functional Screen
LTS	Long-Term Support
MA	Medicaid (also referred to as Medical Assistance and Title 19)
MC	Managed Care (or Managed Long-Term Care)
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NH	Nursing Home
OC	Options Counselor (may also be referred to as an Enrollment Counselor)
ORCD	Office for Resource Center Development
PACE	Program of All-Inclusive Care for the Elderly (a managed care program)
SDS	Self-Directed Support(s)
SSI	Supplemental Security Income
SSI-E	SSI Exceptional Expense Supplement

For additional information on common acronyms, you can go to:
<http://dhfs.wisconsin.gov/data/glossary.asp>