

**Long Term Care Program Options Available in
Milwaukee County**

to Individuals 60 Years or Older

(Meet Age Criteria of Department on Aging, except PACE and Family Care Partnership which serve
55+)
2008

1. Program Description	Full Program Name	State Statutory Authority	Target Population	Entitlement (Y/N)?	Statewide or Demo Site(s)?	Consumer Entry Point(s)	Program Summary
<i>PACE & Family Care Partnership</i>	Program of All inclusive Care for the Elderly/ Wisconsin Family Care Partnership Program	PACE is offered as a "state plan" service.	PACE: Frail elderly (age 55+), Family Care Partnership: Frail elderly (age 55+)/ Adults with physical disabilities	No	PACE: Milwaukee Family Care Partnership: Milwaukee, Racine, Dane, Eau Claire, Chippewa, and Dunn.	Private, non-profit agencies	Integrated Medicaid, Medicare funded programs designed to maximize the ability of target populations to remain in the community. Primary, acute and long-term care (LTC) is planned/managed by interdisciplinary teams that include medical & social service professionals. Contractors receive a per member per month payment and assume full risk. Participants in Family Care Partnership must be Medicaid eligible and may also be Medicare eligible. Milwaukee's PACE provider became permanent in 2003. Participant may be Medicaid, Medicare or dually eligible for both Medicaid and Medicare.
<i>Family Care Medicaid</i>	Family Care	s. 46.2805 through s. 46.2895	Frail elderly; physically and/or developmentally disabled adults age 18 or older.	Yes	Milwaukee (Elders only); Fond du Lac, La Crosse, Portage, Richland, Kenosha and Racine Counties.	Aging and Disability Resource Center (Elderlink)	A Medicaid funded (state and federal) program designed to provide long-term care assessments, care plans and services (community and institutionally-based) to functionally and financially eligible persons. Organizations receive a per member per month payment to provide long-term care and some health-related services.
<i>Institutional Medicaid</i>	Institutional Medicaid	s. 49.498	Frail elderly; persons with a physical or developmental disability with significant needs that cannot be addressed in a home setting.	Yes	Statewide	DSS, DHS	Medicaid-funded benefits for people residing in medical institutions (nursing homes, hospitals, etc.), for 30 days or more. Coverage is limited to persons aged 65 and over, or disabled, with significant long-term care needs. Benefits include acute, primary and long-term care services.
<i>CIP-1A</i>	Community Integration Program-1A	s. 46.275	Developmentally disabled under 60 yrs. old, who reside or would enter a State Center without this program.	No	Statewide.	DCP or DHS	A Medicaid-funded (state and federal) program designed to provide community services to persons who are relocated or diverted from the DD Centers. Participants must be Medicaid eligible.
<i>CIP-1B</i>	Community Integration Program-1B	s. 46.278	Developmentally disabled, under 60 years old, who are diverted or relocated from non-Center Intermediate Care Facility for Mental Retardation & certain nursing home beds.	No	Statewide.	DCP or DHS	A Medicaid-funded (state and federal) program designed to provide LTC assessments, care plans and community services to persons who are relocated or diverted from ICFs-MR other than the DD Centers. Participants must be Medicaid eligible.

1. Program Description, cont'd	<i>Full Program Name</i>	<i>State Statutory Authority</i>	<i>Target Population</i>	<i>Entitlement (Y/N)?</i>	<i>Statewide or Demo Site(s)?</i>	<i>Consumer Entry Point(s)</i>	<i>Program Summary</i>
<i>BI Waiver</i>	Brain Injury Waiver	s. 46.278 s. 51.01 (2g)	Adults under 60 yrs. old, who meet the definition of brain injury in s.51.01 (2g)(a) and are diverted/relocated from NH or hospital units designated for brain injury rehabilitation.	No	Statewide	DCP or DHS	A Medicaid funded (state and federal) program designed to provide home and community based services for people with brain injuries who need significant supports.
<i>Non-institutional Medicaid (Medicaid-Fee-for-Service or Card Services)</i>	Medicaid-Fee-For service benefits	s. 49.46	Elderly (65 and older), Blind and Disabled.	Yes	Statewide	For enrollment: County Human Service Departments, County outreach centers, tribal agencies, Aging and Disability Resource Centers where available, or automatic coverage for anyone who receives cash assistance under SSI. Services are provided by Medicaid-certified providers.	Medicaid covers medically necessary acute and long-term care services. Federal regulations define the specific services provided. Beyond the federally required services, Wisconsin covers "optional" services allowed by federal law. Wisconsin Medicaid service coverage is extensive. For Medicaid-eligible people enrolled in Family Care, Medicaid long-term care services are provided through the Family Care benefit only. Acute and primary care services are provided by Medicaid. For a list of Medicaid services in the Family Care benefit package see Section 5 of this chart – Allowable Services and Living Arrangements.
<i>SSI Managed Care</i>	SSI Managed Care	HFS 107.28	Frail elderly; persons with a physical or developmental disability.	No	Milwaukee, Dane, Racine, Kenosha, Waukesha, La Crosse, Buffalo, Trempealeau, Jackson, Monroe and Vernon, Dodge, Jefferson, Winnebago, Waupaca, Outagamie, Calumet, Brown, Manitowoc, Fond du Lac, Sheboygan, Washington, Rock, Ouzakee counties. Scheduled for implementation in 2008: Taylor, Marathon, Clark, Wood, Waushara, Marquette, Green Lake, Shawano, Langlade, Menominee, Oconto.	Automated Health Systems Enrollment Broker.	Care coordinators and a provider network coordinate medical and social services for SSI disabled Medicaid recipients. Care coordinators serve a gatekeeper role. Goals include improving care quality and access. Contractors receive a per member per month payment. Participants must be Medicaid eligible.

2. Administration	<i>Local</i>	<i>State</i>	<i>Federal</i>
<i>PACE & Family Care Partnership</i>	PACE - Community Care Organization (CCO) Family Care Partnership - Community Care Health Plan (CCHP)	* DLTC	*CMS (formerly HCFA)
<i>Family Care</i>	Resource Centers & Care Management Organizations	DLTC	CMS
<i>Institutional MA</i>	Private For-Profit, Private Non-Profit and Government	DLTC	CMS
<i>SSI Managed Care</i>	Private For-Profit	DLTC	CMS
<i>CIP-1A</i>	51, 42/437 Boards, DHS	DLTC BLTS	CMS
<i>CIP-1B</i>	51, 42/437 Boards, DHS	DLTC BLTS	CMS
<i>BI Waiver</i>	51, 42/437 Boards, DHS	DLTC BLTS	CMS

* DLTC = Division of Long Term Care

* CMS= Centers for Medicaid and Medicare Services

* DHCF= Division of Health Care Financing

3. Funding & Reimbursement	<i>Primary Funding Source</i>	<i>Secondary Funding Source(s)</i>	<i>Fee-for-Service or Capitated Rate</i>	<i>Can Recipient of Services under this Program receive LTC Funded through other programs listed here?</i>
<i>PACE & Family Care Partnership</i>	Medicaid Medicare	Exhausted	Capitated	No
<i>Family Care (Medicaid)</i>	Medicaid		Capitated	No. Persons enrolled in Family Care receive all LTC services through that program. MAPP and BadgerCare recipients are eligible for Family Care as long as they are in the Family Care target group and are functionally eligible.
<i>Institutional Medicaid</i>	Medicaid	None.	Fee-for-service	No
<i>SSI Managed Care</i>	Medicaid	Contracted Managed Care Organizations	Capitated	Enrollment in one of several contracted managed care organizations.
<i>CIP-1A</i>	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match.	Fee-for-service per diem	Yes. Local administrative agency may combine CIP-1A funds with COP funds to provide needed care; agencies may not combine CIP-1A funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's CIP 1A funded services.
<i>CIP-1B</i>	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match.	Fee-for-service per diem	Yes. Local administrative agency may combine CIP-1B funds with COP funds to provide needed care; agencies may not, however, combine CIP-1B funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's CIP 1B funded services.
<i>BI Waiver</i>	Medicaid	For costs above the state/federal per diem, counties may contribute 40% (community aids, COP or local taxes) to access additional 60% federal match	Fee-for-service	Yes. Local administrative agency may combine BIW funds with COP funds to provide needed care; agencies may not, however, combine BIW funds with any of the other waiver program funding sources listed here. Further, agencies may not use MA Case Mgmt funds to enhance a person's BIW funded services.

4. Eligibility	<i>Non-financial eligibility</i>	<i>Functional eligibility</i>	<i>Cost sharing?</i>	<i>Spend down?</i>	<i>Asset Limit</i>	<i>State Approval of care plan required?</i>
<i>PACE & Family Care Partnership</i>	Medicaid non-financial eligibility	Long-term care Functional screen eligibility.	Yes, if monthly income minus deductions is above \$817 , but at or below \$1,911 .	Yes, if gross monthly income is greater than \$1,911 and gross monthly income minus the following monthly expenses or minus the cap. Is less than or equal to \$591.67: •Work related expenses • Health insurance premiums, and •Medical remedial expenses (including cost of waiver services)	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	No
<i>Family Care</i>	Medicaid non-financial eligibility	Determined by long-term care functional screen: Nursing Home LOC, Comprehensive, Intermediate,	Yes, if monthly income minus deductions is above \$817 but at or below \$1,911 .	Yes, if gross monthly income is greater than \$1,911 and gross monthly income minus the following monthly expenses is less than or equal to \$591.67: •Work related expenses • Health insurance premiums, •Court Ordered fees and •Medical remedial expenses	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	No
<i>Institutional Medicaid</i>	Medicaid non-financial eligibility	Level of Care = Developmentally Disabled -1,2, or 3 Intermediate Care Facility-1,2, Skilled Nursing Home or Intensive Skilled Nursing as determined by Office of Quality Assurance.	Yes, after certain allowances for certain expenses, e.g. health insurance premiums, support obligation, personal needs allowance, etc.	No	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	No
<i>CIP-IA</i>	Medicaid nonfinancial eligibility	LTC-FS Eligibility DD-1, 2 or 3	Yes, if monthly income minus deductions is above \$817, but at or below \$1,911.	Yes, if gross monthly income is greater than \$1,911 and gross monthly income minus the following monthly expenses is less than or equal to \$591.67: •Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	Yes
<i>CIP-IB</i>	Medicaid nonfinancial eligibility	LTC-FS Eligibility DD-1, 2 or 3	Yes, if monthly income minus deductions is above \$817, but at or below \$1,911.	Yes, if gross monthly income is greater than \$1,911 and gross monthly income minus the following monthly expenses is less or equal to \$591.67: •Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	Yes
<i>BI Waiver</i>	Medicaid nonfinancial eligibility	Level of care as determined by BLTS	Yes, if monthly income minus deductions is above \$817, but at or below \$1,911.	Yes, if gross monthly income is greater than \$1,911 and gross monthly income minus the following monthly expenses is less than or equal to \$591.67: •Work related expenses • Health insurance premiums, and • Medical remedial expenses (including cost of waiver services)	\$2000. If spousal impoverishment protections apply, community spouse asset share: \$104,400 maximum (plus \$2000).	No

4. Eligibility, continued	<i>Non-financial eligibility</i>	<i>Functional eligibility</i>	<i>Cost sharing?</i>	<i>Spend down?</i>	<i>Asset Limit</i>	<i>State Approval of care plan required?</i>
<i>Non-Institutional Medicaid</i>	Yes, based on federal requirements	Not for overall eligibility or delivery of most services. All services must be medically necessary.	Medicaid copayments on most, but not all, services. Copays do not apply to children under 18 years old, and nursing home residents.	For people who do not currently meet the financial eligibility requirements, Medicaid has a deductible (spend down) determined on a six-month basis. Potential eligibles can meet the deductible through prepay, incurring medical expenses or having unpaid medical bills not previously used to meet a Medicaid deductible.	There is no asset limit for "family Medicaid." SSI-related Medicaid has an asset limit of \$2,000 for a single person and \$3,000 for a couple.	Not for overall eligibility or delivery of some services. Some services require prior authorization that includes review of the plan of care.
<i>SSI Managed Care</i>	Medicaid non-financial eligibility	No. If NH level of care should not sign up for SSI Managed Care.	No	No	SSI-related Medicaid has an asset limit of \$2,000 for a single person and \$3,000 for a couple.	No

5. Allowable Services and Living Arrangements	<i>Allowable Services</i>	<i>Allowable Living Arrangements</i>
<i>Family Care Partnership & PACE</i>	Comprehensive Medicaid, Medicare, and HCBW	All, within operation under protocol.
<i>Family Care</i>	<p>The list can be found at: http://dhfs.wisconsin.gov/Medicaid2/handbooks/familycare/appendix4.htm</p> <p>Case Management provided by case management agencies.</p> <ul style="list-style-type: none"> • Home Care Services provided by home health agencies, personal care agencies, independent nurses, and respiratory therapists. <ul style="list-style-type: none"> - Home health aide services. - Personal care - Skilled nursing (including independent nursing services). <ul style="list-style-type: none"> ▪ Intermittent (less than eight hours per day). ▪ Private duty nursing (eight or more hours per day). ▪ Respiratory care. - Occupational and physical therapy, and speech and language - Pathology services (refer to therapy services). • Mental Health/Substance Abuse and Related Services provided by mental health providers, day treatment programs, community support programs. <ul style="list-style-type: none"> - Mental health and substance abuse services. <ul style="list-style-type: none"> ▪ Except those services provided by a physician. ▪ Except those services provided in an inpatient hospital setting. - Day treatment (mental health and substance abuse) in all settings. - Child/adolescent mental health day treatment. - Community Support Program services. <ul style="list-style-type: none"> ▪ Except when provided by a physician. ▪ Except non-psychiatric medication and treatment services. ▪ In-home intensive psychotherapy. ▪ In-home autism treatment. • Nursing Facilities – all nursing facility stays (including Intermediate Care Facility for People with Mental Retardation and Institution of Mental Disease). <ul style="list-style-type: none"> ▪ Except lab and radiology ancillary services. ▪ Except NF services are not available for persons at the intermediate LOC. • Supplies and Equipment provided by any provider. <ul style="list-style-type: none"> - Disposable Supplies <ul style="list-style-type: none"> ▪ Except supplies used in a hospital or physician clinic, including enteral nutritional products. - Durable medical equipment (DME) purchased or rented in all settings. <ul style="list-style-type: none"> ▪ Except for hearing aids, hearing aid accessories, hearing aid batteries, and assistive listening devices. ▪ Except for prosthetics. - Orthotics (purchase and repair). 	<p>In addition to natural residential settings (own home or apartment), individuals may reside in other appropriate settings, such as:</p> <ul style="list-style-type: none"> • CBRFs: there are no size limits for elderly and persons with physical disabilities. Developmentally disabled adults may be served in CBRFs of 4 beds or less (up to 8 beds with a variance). • Certified RCACs, ▪ Nursing Homes, ICFs/MR, Extended care facilities.

5. Allowable Services and Living Arrangement, cont'd	Allowable Services	Allowable Living Arrangements
	<ul style="list-style-type: none"> ▪ Therapy Services provided by therapy and speech and language providers. <ul style="list-style-type: none"> - Occupational therapy. <ul style="list-style-type: none"> ▪ Except those services provided by physicians in clinic settings. ▪ Except those services provided in an inpatient hospital setting. - Physical therapy. <ul style="list-style-type: none"> ▪ Except those services provided by physicians in clinic settings. ▪ Except those services provided in an inpatient hospital setting. - Speech and language pathology services. <ul style="list-style-type: none"> ▪ Except those services provided by physicians in clinic settings. ▪ Except those services provided in an inpatient hospital setting. • Transportation provided by specialized medical vehicle providers. • Individualized home and community-based waiver services. The Family Care benefit package includes all services available in the Medicaid Home and Community Based Waivers and Medicaid nursing home and long-term care "card" services such as home health and personal care. In addition, Family Care CMOs can opt to provide other services if they are effective in achieving members' outcomes. See Long Term Options in Fond du Lac, La Crosse, Portage and Richland, Section 5, for a listing of the Family Care Benefit Package, and also: http://dhfs.wisconsin.gov/Medicaid2/handbooks/familycare/appendix4.htm 	
CIP-1A	Card services except case mgt. (which is covered by the waiver). Services specified in approved waiver include: -Adult Day Care -Respite Care - Institutional Respite -Supportive Home Care -Day Services—Case Management/Service Coordination -Pre-Vocational Services -Daily Living Skills Training -Personal Emergency Response System -Counseling & Therapeutic Services -Supported Employment (excludes supported employment & pre-vocational services for diverted persons) -Community Aids -Home Modification - Adult Family Home -Adaptive Aids -CBRF -Children's Foster Home - Transportation	-Natural residential settings. -Community based substitute care up to 4 beds (with waivers, up to 8 beds for adults)
CIP-1B	Same as CIP-1A.	-Natural residential settings. -Community based substitute care up to 4 beds (with waivers, up to 8beds for adults)
BI Waiver	Card services except case management (which is covered by the waiver). Services specified in the approved waiver include: -Case Management - Supportive Home Care -Respite Care -Adult Day Care -Prevocational Services - Home Modification -Personal Emergency Response System—Communication Aids -Counseling & Therapeutic Resources -Alternate Living Arrangements (Adult Family Home, CBRF, Children's Foster Home) -Daily Living Skills Training -Day Services -Transportation -Institutional Respite -Supported Employment - Adaptive Aids	-Natural residential settings -Community based substitute care up to 4 beds (with waivers up to 8 beds for adults).
Institutional Medicaid	All Medicaid acute and primary care services. The long term care services that are covered by Family Care and listed above are not covered for Family Care enrollees.	<ul style="list-style-type: none"> • Nursing Homes • Intermediate Care Facility for a person with Mental Retardation (ICF/MR) • Hospitals
SSI- Managed Care	All Medicaid covered services, except Targeted Case Management, chiropractor, Family Planning, CSP, and Crisis Intervention.	Natural residential settings; up to 90 days in NH