
Family Care for Long-Term Care Service Providers

Responses to Questions from Providers

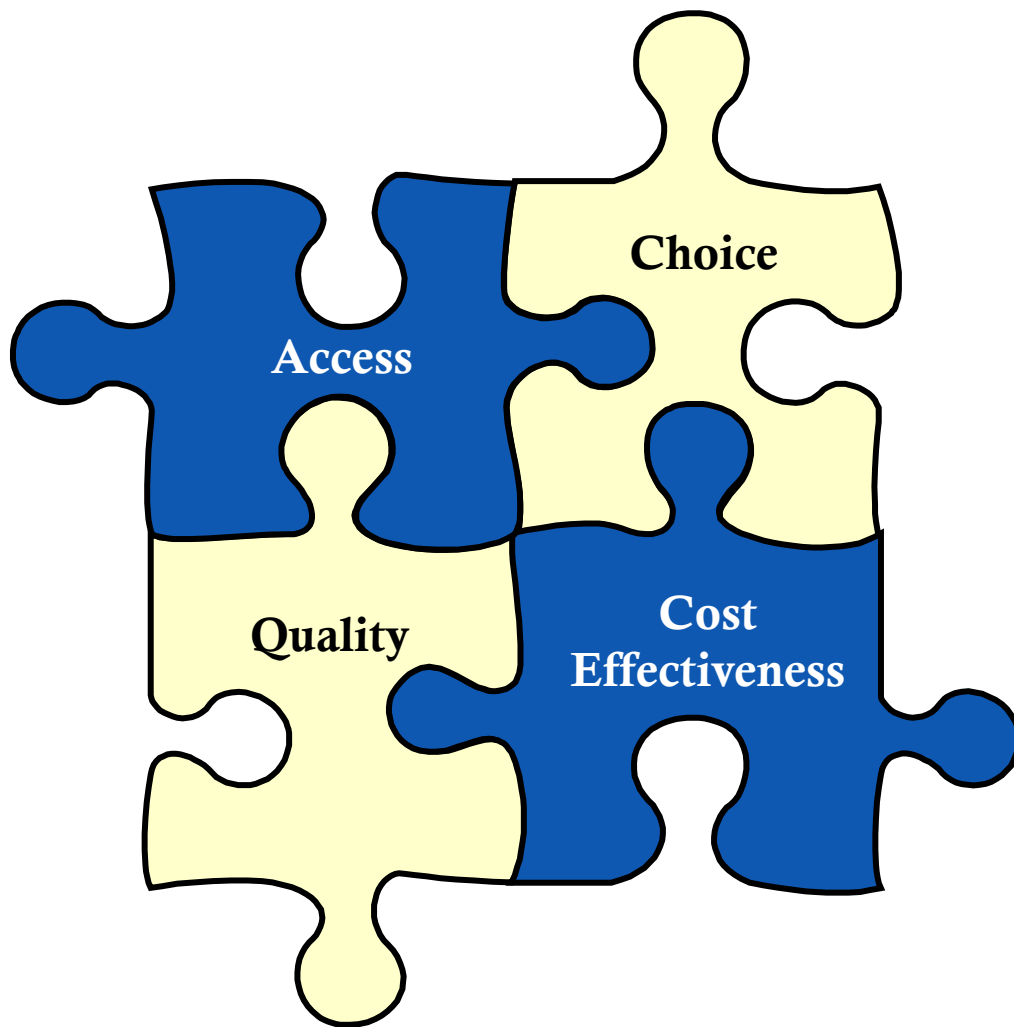


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Family Care Terms

- ADRC - Aging and Disability Resource Center
- CMO - Care Management Organization
- IDT - Interdisciplinary Care Management Team
- MCO - Managed Care Organization
- RAD - Resource Allocation Decision Method
- SDS - Self-Directed Supports

Family Care Program Design

1. What is Family Care and where did it come from?

In the mid-1990s, people began to agree that Wisconsin's long-term support system needed to be redesigned. People were concerned about:

- waiting lists for services;
- the cost of the current system and its complicated rules;
- uneven availability of services; and
- our aging population's growing demand for long-term support.

During the next few years, consumers, advocates, providers, State and local officials, and others worked together to design a new approach to long-term support in Wisconsin. This new approach, named "Family Care," was approved by the Governor and Legislature in 1998. Family Care began serving adults with developmental disabilities, adults with physical disabilities, and frail elders with a long-term support need in 2000. Family Care has two major parts:

- Aging and Disability Resource Centers (ADRCs), which are a single place where anyone can get information and advice about a wide range of resources available in their local communities; and
- Care Management Organizations (CMOs), which manage and deliver the new Family Care benefit, which combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, situation and preferences.

ADRCs are currently operating in 23 counties – Barron, Brown, Calumet, Fond du Lac, Forest, Green, Green Lake, Jackson, Kenosha, La Crosse, Manitowoc, Marathon, Marquette, Milwaukee (serves elders only), Outagamie, Portage, Racine, Richland, Sheboygan, Trempealeau, Waupaca, Waushara, and Wood.

Family Care CMOs are currently operating in seven counties - Richland, La Crosse, Fond du Lac, Milwaukee, Portage, Racine, and Kenosha.

2. What are Aging and Disability Resource Centers (ADRCs)?

Aging and Disability Resource Centers (ADRCs) are the first place to go with questions about disability and aging. ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to living with a disability or aging. These centers are friendly, welcoming places anyone can contact to receive information and assistance regarding not only the public benefits that may be available, but all of the programs and services available throughout the area. Individuals, guardians, concerned families or friends, or professionals working with issues related to aging, physical disabilities, developmental disabilities, mental health issues, or substance use disorders, can receive information specifically tailored to each person's situation. ADRC services can be provided at the ADRC, or via telephone or through a home visit, whichever is more convenient to the person seeking help.



Each Aging and Disability Resource Center is required to maintain a resource database that lists service providers in that region. Since only a fraction of the individuals who contact an ADRC are eligible for and enroll in Family Care, many people utilize this information to find providers and obtain needed services with private resources.

3. What services are offered by ADRCs?

ADRCs provide the following services for all consumers, regardless of their condition or their income:

- Information and assistance to the general public about help that is available;
- Long-term care options counseling to help people make the best choices;
- Short-term care management if someone needs help right away;
- Elderly and disability benefits counseling to help people apply for or keep their Medicare, Social Security, or other benefits; and
- Access to the Family Care program. For people who request it, ADRCs will conduct the long-term care functional screen to determine the person's level of need for services and determine if they are eligible for the Family Care program. ADRCs also help people enroll in Family Care.

4. What are Care Management Organizations (CMOs)?

Care Management Organization (CMO) is the name given to the Managed Care Organizations (MCOs) that operate Family Care. The Family Care benefit is available through Care Management Organizations (CMOs). When people refer to Family Care, they usually mean the CMO. A Family Care CMO can be:

- A county; a group of counties acting cooperatively under s. 66.030 Wisconsin Statutes;
- A Family Care district as defined in s. 46.2895 Wisconsin Statutes;
- An HMO or similar organization regulated by the Office of the Commissioner of Insurance;
- A federally-recognized Wisconsin Indian Tribe; or
- A group of any of the above entities working under a contractual agreement.

CMOs provide coordination of health care and long-term care services. CMOs also develop and manage a comprehensive network of long-term care services and support, either through contracts with providers, or by direct service provision by CMO employees. CMOs are responsible for assuring and continually improving the quality of care and services consumers receive.

5. Who is eligible for Family Care?

Aging and Disability Resource Centers serve the general public.

CMOs serve people in three primary target groups who have a long-term care need expected to last for more than 90 days. The three Family Care target groups are:

- Frail Older Adults;
- Adults with Physical Disabilities; and
- Adults with Developmental Disabilities.

Children under 18 and adults whose primary reason for needing services is related to a mental health issue are not eligible for Family Care.

In order to enroll, people must meet both non-financial (or functional) requirements as well as Medicaid financial eligibility requirements.

Non-Financial (Functional) Eligibility

Individuals' functional eligibility for Family Care is determined by the long-term care functional screen. Most Family Care members are at a nursing home level of care, which means that Medicaid would pay for their care in a nursing home or ICF-MR if that is where they wanted to be. There is also a lower level of functional eligibility, the intermediate level of care, but these individuals make up a small part of overall Family Care enrollment.

Financial Eligibility

Medicaid financial eligibility for Family Care is the same as for nursing homes, the home and community-based waiver programs (COP and CIP), and for Partnership. Family Care enrollees must be financially eligible for the Medicaid program as provided for in s. 1915(a) of the Social Security Act. To be financially eligible for Medicaid under this section a person must:

- Have non-exempt assets totaling no more than \$2,000. Examples of exempt assets include items such as the person's home and money set aside for funeral expenses. Non-exempt assets include such items as bank accounts, securities and real property apart from the person's home.;
- Be eligible for Medicaid as a result of eligibility for Supplemental Security Income (SSI) or some other program with categorical eligibility;
- Have income not in excess of 300% of the federal SSI benefit level - \$1,809 in 2006, and pay a cost share; or
- Have income in excess 300% of the federal SSI benefit level and meet "spend down" requirements.

Please see http://dhfs.wisconsin.gov/medicaid1/recpubs/eligibility/book_contents.htm for detailed information on Medicaid eligibility.

6. How does Family Care make the system better?

Family Care builds on the strengths of Wisconsin's rich history of providing services that meet the unique needs of individuals in their homes and communities. Family Care makes the system work better by improving access, choice, quality, and cost-effectiveness.

Access - Access is improved by assuring people get all the services they need, when they need them. Family Care is an entitlement which means that there are no waiting lists for services. In addition, Family Care coordinates both long-term supports and health care services. Long-term supports include assistance with activities such as eating, bathing, or using the telephone; transportation; and respite for caregivers. Depending on a person's needs, Family Care can help people find health care providers and get the health care services, such as doctor visits, immunizations, and medications, they need.



Choice - Choice is improved by giving people better choices about where they live and what kinds of services and supports they get to meet their needs. Family Care offers choices among a wide range of services provided in individual's homes and communities. Family Care provides a choice of at least two providers of each service and also allows people to self-direct their supports.

Quality - Quality is improved by Family Care's focus on health and quality of life outcomes for each consumer. Outcomes are what is important to a person and helping people achieve their individual outcomes is the goal of the Family Care program. Quality in Family Care means assuring safety and much more; improving health and quality of life.

Cost-Effectiveness - Cost-effectiveness means getting the best results possible for the money spent. Cost-effectiveness is improved by making sure that everyone with a long-term support need gets the right service, in the right amount, at the right time. Our experience operating Family Care during the past six years has demonstrated that this approach to long-term support is cost-effective and therefore sustainable into the future. Family Care focuses on providing the most effective services to meet individual's outcomes. The most effective service is often not the cheapest, but is cost-effective.

The right service, in the right amount, at the right time.

7. What are outcomes and how are they identified?

Quality of life outcomes represent what is important to a person, what is valued by the person, and often are things the person wishes were different in his or her life. Some outcomes may be very simple and others may be more complex.

Helping people achieve their individual outcomes is the goal of Family Care. The Family Care outcome statements on the following page are general statements that guide the Family Care program overall. The examples of individual outcomes show how the general Family Care program outcomes might be stated by an individual person. Family Care helps people reach all of their individual outcomes, including employment outcomes.

The first step in planning Family Care services is for the consumer to discuss with their interdisciplinary care management team (IDT):

- What kind of life they want to live;
- Whether they want to live where they live now or in a different living situation; and
- What kind of support they need to live the kind of life they want.

This step is called the assessment. The assessment helps people identify the real-life personal outcomes that matter to them and the services they need to reach their outcomes.

For years, John went to the same sheltered workshop, but he always wanted to work in a restaurant. With Family Care, he is able to work in a restaurant as a dish washer with supported employment services and is taking cooking classes at the technical college so that he can be promoted and work as a cook in the future.

Family Care Outcome Statements

Example Individual Outcomes

I decide where and with whom I live

- *I want to live by myself in my own apartment*
- *I would like to live with my friend, but I don't want to share a room*

I make decisions regarding my supports and services

- *I want my baths in the evening*
- *I want my sister to help me with my baths*

I decide how I spend my day

- *I want to watch the 10:00 news*
- *I want to take a short walk after lunch*

I have relationships with family and friends

- *I want to have dinner with my boyfriend on Friday nights*

- *I want to go shopping with my friends*

I do things that are important to me

- *I want to go to church*
- *I want to go to concerts in the park*

I am involved in my community

- *I want to volunteer at the humane society*
- *I want to go to the farmers market and see my neighbor's flower stand*

My life is stable

- *I like my life the way it is*
- *I like my routine*

I am respected and treated fairly

- *I want people to take the time to listen to me, even if it takes me longer than other people*
- *I want delivered meals to be kosher*

I have privacy

- *I want to dress myself in my room, even if it takes me a long time*

- *I want my own bathroom*

I have the best possible health

- *I want to manage my diabetes better*
- *I want to quit smoking and need someone to help me get through the tough times*

I feel safe

- *I want a dog who will bark if someone is at the door*

- *I want to hire my own home care workers*

I am free from abuse and neglect

- *I know that I can use the phone to talk to my care manager if someone tries to hurt me*

- *I know that it is not ok to be hurt*

8. Who decides what services consumers get?

Each consumer's individual service plan is determined by their IDT. There will always be at least three people on an IDT – a social worker, a nurse, and the member. In Family Care participants are called members because they are a member of the IDT and the CMO. The contract between the Family Care CMO and the State requires that the social worker and nurse care managers have knowledge of community alternatives for people with developmental disabilities and the full range of long-term support resources.

The job of the IDT is to help members to:

- Identify the member's individual outcomes;
- Develop a service plan that will help the member achieve their outcomes; and
- Make sure the services in the plan are actually provided.

Members should have a chance to be involved in every part of the process, and should get any extra help they need in order to be involved, like someone to read or interpret for them. If the member wants, the other team members will help them to involve family members, friends, an advocate, or other people important to them in the planning process.

If the member has a guardian or an agent under a health care power of attorney, they will be involved in planning along with the member, and will give the legal consent for services. A guardian is responsible for protecting the member's best interests. This includes working with the member and the rest of the planning team to ensure that the member's voice is heard and respected. The CMO should work with guardians or health care agents on how to identify and work toward the personal outcomes the member wants, and on ways to help the member be able to make more decisions for his or herself.

The member's individual service plan will help them move toward the personal outcomes that they and their team identified in the assessment. The plan must be clear about what services and supports they will receive to achieve their personal outcomes, who is going to provide each service or support, and when each service or support will be provided. The plan will describe things the member will do for his or herself or with help from family or friends.

The CMO is responsible for helping the member achieve their personal outcomes, but also has to consider cost-effectiveness of services and providers. CMOs do this through an exercise called the Resource Allocation Decision (RAD) method. The RAD method is a series of questions that the team will answer for each of the member's outcomes. Answering these questions will help the team determine what services are effective at meeting the member's outcomes and therefore cost-effective.

The RAD Method

1. What is the need, goal, or problem?
2. Does it relate to the person's assessment, service plan and desired outcomes?
3. How could the need be met?
4. Are there policy guidelines to guide the choice of option?
5. Which option does the member (and/or family) prefer?
6. Which option is the most effective in meeting the desired outcome?
7. Of the effective options, which would be most cost-effective?

It is important to remember that the most effective service does not mean the cheapest. To read more about how the RAD method works, go to:

<http://dhfs.wisconsin.gov/LTCare/pdf/RADMethod.pdf>

Members do not have to settle for a service plan that does not help them reach their outcomes, or that gets in the way of an outcome. However, a CMO may choose to provide a service in a less expensive way if the service plan is still effective in helping meet the member's individual outcomes. Members may have to compromise on some of their personal outcomes if reaching them fully, or right away, is so difficult or so expensive that it is not reasonable. If the member and the rest of the team cannot agree, member's have a right to request a different IDT and to file an appeal or grievance.

9. Why does everyone have a nurse on their care management team?

The Family Care program helps people with developmental disabilities have the best health possible by coordinating member's health care and long-term supports. In many cases, health care providers do not understand the unique needs of people with developmental disabilities and, as a result, health care services are not available or effective. People with poor health are far more likely to enter a nursing facility. And, like everyone else, people with disabilities are living longer. The inclusion of a nurse on the IDT will help members get their health care needs met.

During the initial assessment the nurse on the IDT will identify any current health care issues. The nurse can also help prevent new health care issues from emerging by making sure that members get regular exams by a doctor and immunizations, for example. Even if a member doesn't have any current medical problems, the nurse will identify any new problems that develop over time. Finding problems early keeps people healthier. Finding and fixing problems early is often cheaper than the cost of dealing with them later. Everyone in Family Care gets this level of attention from the nurse on their team. Beyond that, involvement of the nurse will depend on the member's individual needs.

10. What services are included in Family Care?

Family Care services include the same long-term support services included in the current Medicaid waiver programs - Community Integration Program (CIP), Community Options Program (COP-W) and Brain Injury Waiver (BIW). Long-term supports provide assistance with activities such as eating, bathing, or using the telephone; transportation; and respite for caregivers. The following long-term support services are included in the Family Care benefit:

- Adaptive aids
- Adult day care
- Adult family home
- Certified Residential Care Apartment Complex (RCAC)
- Children's foster care and treatment foster care (for people between the ages of 17 years nine months and 22)
- Communication aids/interpreter services
- Community-Based Residential Facility (CBRF)
- Consumer education and training

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- Counseling and therapeutic resources
 - Daily living skills training
 - Day services
 - Financial management services
 - Home delivered meals
 - Home modifications
 - Housing counseling
 - Personal emergency response system services
 - Prevocational services
 - Relocation services
 - Respite care
 - SDS support broker
 - Skilled nursing services
 - Specialized medical equipment and supplies
 - Supported employment
 - Supportive home care
 - Transportation
 - Vocational futures planning

Family Care services also include some Medicaid “card” health care services that help people reach their long-term care outcomes. These services include:

- Disposable medical supplies
- Durable medical equipment
- Home health
- Mental health and substance abuse services
- Occupational, physical and speech therapy
- Personal care
- Skilled nursing services
- Nursing facility services

In addition to assuring that people get the health and long-term care services in the Family Care benefit package, the CMO interdisciplinary teams also help members coordinate all their health care, including, if needed, helping members get to and communicate with their physicians and helping them manage their treatments and medications.

Family Care also includes all the services offered by ADRCs. These services, described in Question 3, include information and assistance, options counseling, short-term care management, and benefits counseling.

11. What role does the consumer have in choosing a provider?

For providers who come into the member's home or provide hands-on care, such as personal care and supportive home care, the CMO must purchase services from whomever the member chooses as long as that person meets the CMO's requirements and accepts the CMO's payment rate.

For other services, a Family Care member may choose to receive services from any CMO provider, as long as the services and rates are comparable. However, the CMO may be able to have a more cost-effective arrangement with one provider than another; in this case, the CMO can offer the most cost-effective way to provide the necessary supports. For example, a CMO might have an arrangement with one supportive home care provider for a daily or overnight rate for services, and only contract for hourly services with another supportive home care provider. The daily rate is almost always more economical, and the CMO can limit choice to the most cost-effective way to provide the needed support.

Under certain circumstances, a consumer may choose a provider not included in the CMO's network. For example, if the existing network cannot meet the need on a timely basis or does not include the required expertise, a member may choose another provider that meets CMO requirements. With any provider, the member must obtain prior authorization before receiving services.

12. What does Self-Directed Supports (SDS) mean in Family Care?

Self-directing services may offer members a way to have more control over their services and supports. In Family Care, self-directed support (SDS) means that the member chooses to buy their services with the money the CMO gives them, instead of the CMO buying them for the member.

SDS is available to all Family Care members. If a member chooses the SDS option, the CMO will make resources (including a budget) available to them based on what it would have spent if it managed those services. Members can then use that budget amount to buy any service or support that will work to meet their personal outcomes, even if the service or provider is not part of the CMO's benefit package. Each CMO has its own plan for offering self-directed supports. Each CMO must:

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

Members can choose to self-direct all or only part of their services. For example, a member could choose to self-direct services that help them stay in their home or help them find and keep a job, and use their IDT to manage services aimed at other outcomes in their plan.

SDS is not available for residential living arrangements, and may be limited for some other kinds of services, including durable medical equipment and disposable medical supplies.

If a member chooses to get involved in SDS, their IDT will:

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

The CMO may put limits on the SDS option, if it finds that:

- The member is not staying within available resources;
- The member has used resources in a way that is illegal;
- The member has used resources in a way that is too much of a risk to health and safety; or
- Someone else is making decisions for the member that are not based on what the member wants.

The CMO must tell the member what they need to do to remove those limits, and tell them about their right to file a grievance or ask for a hearing.

13. How does DHFS focus on quality in Family Care?

Quality is one of the main goals of Family Care. One of the most important ways that DHFS focuses on quality is to focus on each member's individual outcomes. The interdisciplinary team (IDT) will help member's identify the outcomes that they want in their life. These will be based on what is important to them, such as where they want to live, how they spend their day and how they are involved in their community.

The IDT must also check on how well services support the member's outcomes on an ongoing basis. Because of this focus on individual outcomes, each Family Care member plays an important role in quality by being an active member of their IDT. The CMO, ADRC and DHFS also have important roles in focusing on quality in Family Care.

Each CMO monitors the quality of services and the quality of the work the IDT does with each member. Each CMO also has special projects each year that help them meet people's needs in special areas. Management of diabetes, improving ability of members to remain in their own homes and improving treatment for members with depression are some examples of these special projects.

ADRCs focus on quality in Family Care by giving consumers clear and unbiased information about the long-term care services available to them. Changes proposed for Family Care will give ADRCs a bigger role in monitoring quality in Family Care. ADRC boards will review whether CMOs in their area have enough providers, determine if there is good coordination between the ADRC and CMOs and monitor complaints.

DHFS has a detailed contract with each CMO and ADRC. The contracts list all the things the CMO and ADRC must do. One of the things CMOs must do is look into problems and fix them. The CMO must also report some problems called critical incidents to the State. DHFS monitors how well each CMO and ADRC does what is in their contract and requires them to improve when necessary. Also, remember that before Family Care can be offered by a CMO, the CMO must be certified by DHFS, to make sure that they will be able to do all the things in the contract.

In addition, federal law requires DHFS to hire an outside reviewer called an External Quality Review Organizations (EQRO) to review the quality of CMOs. The Department and the EQRO make certain that everyone's outcomes are being met in a number of ways, including:

- Monitoring of signs that indicate how well the CMO is doing its work;
- Reviewing policies and procedures, provider networks, care plans, and appeals and grievances; and
- Interviewing members, providers, and CMO staff.

Everyone in Family Care focuses on quality so that member's get the best possible services and supports tailored to their individual needs and preferences.

Statewide Family Care Expansion

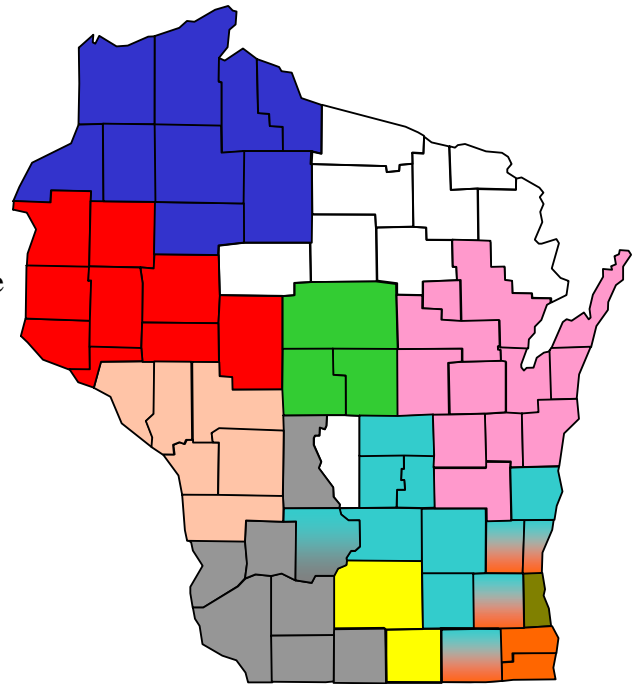
14. When will Family Care expand to my area?

In the February 2006 State of the State Address, Governor Jim Doyle announced the goal to expand the Family Care program statewide during the next five years. As a first step toward achieving this goal, with a grant from the federal government, DHFS has awarded grants to ten groups to carry out intensive planning activities. These planning groups include county governments and private agencies working in partnership. They are planning for regional CMOs to operate Family Care and working to develop regional ADRCs.

Starting January 2007, the Family Care program expanded to Kenosha and Racine Counties as the first step in this statewide expansion. The Wisconsin Partnership Program is also available in both of these counties. See expansion announcement for more information at <http://dhfs.wisconsin.gov/LTCare/expansionJan07.htm>

Before Family Care can be offered in new areas, more CMOs and ADRCs need to be created. The local planning groups are thoughtfully planning to do this. This planning includes many tasks, including finding new providers to serve the people already on waiting lists. It takes time to put all these pieces into place. More information about the planning in each region, including contact information, is available at DHFS's website:

<http://dhfs.wisconsin.gov/managedltc/stakeholders/index.htm>



15. What role do providers have in Family Care expansion planning?

The voice of stakeholders has been and will continue to be key to the successful expansion of Family Care. The local planning groups are required to include consumers and other stakeholders in the local planning efforts to help determine the best way to set-up Family Care in that region. Information about the efforts to create CMOs and ADRCs in each region, including contact information and websites, is available at DHFS's website:

<http://dhfs.wisconsin.gov/managedltc/stakeholders/index.htm>

A statewide Comprehensive Systems Change Committee also gathers input about State and local long-term care policies, practices, and reform proposals. This committee advises DHFS and the Wisconsin Council on Long Term Care Reform. More information about the committee is available on this website:

<http://www.wcltc.state.wi.us/stakeholders.htm>

16. How will Medicaid providers get information about when Family Care is starting in their area?

DHCF will provide information to providers via the Medicaid Updates when Family Care starts in different areas of the state. The information Medicaid providers need is in the Family Care Guide, which can be found at: <http://dhfs.wisconsin.gov/medicaid2/handbooks/familycare/index.htm>

17. How will Family Care expansion impact the services minor children are receiving?

When Family Care begins in a new area, all minor children under age 18 will continue to receive services through the children's long-term support system, as long as they continue to remain eligible.

At age 17 years 9 months, anyone may be screened for eligibility for Family Care at the local ADRC. If the person is eligible for Family Care he or she will be offered options counseling by ADRC staff and given the option to enroll.

At age 18, young adults who are eligible for Family Care are no longer eligible for children's long-term support services because they have the option to enroll in the Family Care program without delay.

18. How will people transition from waivers or waiting lists to Family Care?

Before anyone can enroll in a new Family Care CMO, the CMO must be "certified" by DHFS to make sure that all the right pieces are in place, such as having enough providers in the network and enough nurses for the IDTs. After the State certifies a new CMO, people who need long-term supports will be enrolled.

People currently receiving services or on waiting lists will be contacted when Family Care begins in their area.

There are three groups of potential members for each new Family Care CMO. One group is the people currently receiving Medicaid waiver services (CIP, COP-W and BIW). This group will be enrolled during the first six to eight months that the new Family Care CMO is in operation, a few people each month. People on waiting lists are the second group of new Family Care members. They will be enrolled during the first two years the new Family Care CMO is in operation. The third group includes people who ask for long-term support services for the first time during the first two years the CMO is in operation. They will also be enrolled during the same two year period as people on waiting lists. Consumers can talk to their ADRC about when enrollment in Family Care will be offered to them.

People currently receiving services or on a waiting list will be personally notified when Family Care comes to their county. They will receive information about how enrollment in Family Care will personally impact them. A team of State staff is dedicated to working with the local CMO and the county care managers to ensure that the transition is as seamless as possible for consumers.

Family Care Funding

19. How is Family Care funded?

Consumer advocates and others involved in long-term care reform, from the beginning of the CIP and COP programs, have said that it could be a much more cost-effective use of available funding to serve people, not in institutions, but in the community, where they prefer to live. They thought that, given a choice, people would choose the less costly community option. Family Care offers people that choice.

Family Care pools all the funding currently in the system for long-term care. This includes money that funds the current Medicaid waiver programs (CIP, COP-W, and BIW) the Community Options Program, and some Medicaid “card” services such as institutions and personal care. Family Care combines all the federal, State, and county funds associated with these programs.

An independent study of Family Care found that the program kept people healthier, maintained their level of functioning and reduced the need for institutional care. As a result, people with similar needs required, on average, much less funding than those served in institutions, or CIP and COP. These savings allow the State to offer an entitlement to home and community-based services through Family Care. Entitlement means everyone with a long-term support need will receive services. This is why there are no waiting lists for long-term support services in counties where Family Care is available.

20. What are Family Care rates?

In Family Care, “rate” is the term for the amount of the money paid monthly to each CMO by the State for each member enrolled in the CMO. This is also called a capitation payment. The CMO pools all the funding received for its members on a monthly basis from the State and purchases all the services each member needs.

Some people’s care plans will cost more than the Family Care rate and some will cost less.

The Family Care rate is not a limit - maximum or a minimum - on the dollar value of a member's care plan. Some people's care plans will cost more than the rate and some will cost less. The value of the services each member receives will be determined by what services are necessary to meet their individual outcomes. Each member will work with their IDT to develop a specific plan that includes the services they need to meet their personal outcomes in the most effective and, therefore, cost-effective way.

21. How are Family Care rates determined?

Each CMO receives its own single Family Care rate based on the costs and characteristics of its members. The rate is based on the:

- Actual costs of services provided to every Family Care member in the previous year; and
- Functional information from the long-term care functional screen for every member enrolled in the CMO.

The rate the CMO gets is recalculated each year.

Because the rate is based on individual information, it reflects individual differences and accounts for things such as the lack of availability of natural supports or the relatively higher cost of supporting people with developmental disabilities in the community.

The rates also reflect regional variation in costs including wages of long-term care workers. For example, wages in urban areas are often higher than wages in rural areas, and the rates would be adjusted to reflect such a difference. The rates also include an annual adjustment for inflation.

The federal government requires that the State provide CMOs with enough money for the CMO to fully meet the needs of all of its members. DHFS contracts with independent actuaries who must verify that each individual CMO's rate is appropriate.

It is important to understand that the amount of services Family Care members receive does not change when the CMO's rate changes. Service amounts change when a member's needs change or new outcomes are identified.

22. How are service provider rates determined?

Each CMO establishes rates with the providers in its network. In establishing provider subcontracts, the CMO will seek to maximize the use of available resources, provide quality services, and control costs. Quality and cost control measures can include:

- Using different reimbursement amounts for different specialties;
- Using different reimbursement amounts for different practitioners in the same specialty; and
- Establishing measures that are designed to maintain quality of service consistent with the CMO responsibilities to serve members.

The CMO may not pay more than Medicaid fee-for-service rates for care services unless the state Department of Health and Family Services approves a higher level of payment. Each CMO will negotiate rates with providers of waiver services.

23. Will annual Cost of Living Adjustments (COLAs) be provided?

CMOs generally renew contracts with providers annually. CMOs may provide cost of living increases in their provider payments, but that is determined in the contract negotiations between the CMO and the provider.

24. Will the Allowable Costs Policy remain in effect?

In subcontracting with and paying providers, the CMO is not subject to ss. 46.036 (3) and (5m) Stats., which refer to allowable costs. Typically, CMOs negotiate fixed unit rates with providers based on the individual needs of their members and the market cost to purchase the required service.

25. Will Family Care CMOs pay for bed holds?

Typically, providers negotiate rates with CMOs that recognize the fixed costs of temporarily empty beds.

26. Will Family Care pay for room and board?

The Federal Government expressly prohibits the use of Medicaid funds for room and board. Family Care is a Medicaid program and as such the residential services in the benefit package exclude the cost of room and board.

27. Will Family Care allow providers to testify in public or at government forums about the adequacy of reimbursement rates?

We are not aware of any entity prohibiting providers from speaking publicly about the reimbursement rates they receive from a CMO. Please inform the Department if you are aware of specific circumstances in which this is occurring.

As peoples needs and outcomes
change, their service plan can change.

Family Care Service Providers

28. Who gets to be a service provider in Family Care?

CMOs are required to have at least two providers of every service in their provider “network.” They use a variety of methods to solicit providers. Where applicable, CMOs follow their county rules for competitive bidding. CMOs can limit their provider network. In practice, the Family Care CMOs have contracted with most of the providers that the county has contracted with for the waiver programs.

The DHFS contract with the CMO requires that:

- If the CMO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision; and
- The CMO provider network selection must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

29. What if I am not interested in contracting with a Family Care CMO?

When Family Care is implemented in an area, the State contracts directly with the CMO for the provision of services for frail elders, adults with physical disabilities, and adults with developmental disabilities in that area. After a transition period, the State will terminate contracts with the counties for the CIP and COP waiver programs for those populations. Therefore, the counties will no longer contract directly with providers for waiver services. If you want to continue to provide waiver services to members of a CMO, you must enter into a contract with the CMO.

If you are a provider of Medicaid card services, you could continue to provide fee-for-service Medicaid services for non-Family Care members. However, the CMO will be responsible for all the card services in the Family Care benefit for its members. Medicaid providers are responsible for verifying recipients’ eligibility before providing services. Information about Family Care for Medicaid providers can be found in the Family Care Guide at:

<http://dhfs.wisconsin.gov/medicaid2/handbooks/familycare/index.htm>

30. How do I know whether to bill Medicaid or the CMO?

For people enrolled in Family Care, DHCF will not pay providers directly for services included in the Family Care benefit. CMOs will contract with and pay providers directly. CMOs will only pay providers for services that they have authorized. For people not enrolled in Family Care, Medicaid card services providers will continue to bill DHCF. Information about Family Care for Medicaid providers can be found in the Family Care Guide at: <http://dhfs.wisconsin.gov/medicaid2/handbooks/familycare/index.htm>

31. What is a Provider Network Developer?

Each CMO will have at least one person, called a Provider Network Developer, in charge of contracting with providers and monitoring the performance of those providers. The Provider Network Developer is

the person with whom providers will interact with in negotiating rates and contract language, and in solving any problems that arise during the course of the contract.

32. Who do I contact if I have a problem?

The Family Care Provider Network Developer will be your primary contact. Your contract with the CMO may instruct you to contact other Family Care staff directly based on the nature of the problem. For example, you would probably be instructed to contact the care manager for care delivery issues, a special system may be used for after hours emergencies, or billing related inquiries may be directed to the financial staff.

33. What is the process for provider appeals?

The CMO must provide written notification to providers of CMO payment/denial determinations. Providers can appeal to the CMO within sixty (60) calendar days of the initial denial or partial payment.

The CMO has forty-five (45) calendar days from the date of receipt of the request for reconsideration to respond in writing to the provider. If the CMO fails to respond within that time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from DHFS. All appeals to DHFS must be submitted in writing within sixty (60) calendar days of the CMO's final decision.

34. How does my contract with the Family Care CMO relate to licensure and certification requirements?

Family Care providers are subject to all applicable licensing and certification requirements.

The state contract with the CMO specifies that the CMO shall use only providers that:

- Meet the provider standards in Wisconsin's Family Care home and community-based waivers and are consistent with any applicable DHFS policies and procedures, including the use of certified RCACs and certified adult day care; or
- Are certified by the Medicaid program for those services in the LTC benefit package that would have been provided under Medicaid fee-for-service; or
- Meet the CMO's provider standards, which are approved by the State.

In addition, the CMO shall perform, or require providers to perform, criminal background checks on people paid to provide services to a member in accordance with HFS 12, Wis. Adm. Code.

35. What is Pre-Admission Consultation (PAC)?

Family Care legislation (enacted October 27, 1999) requires certain long-term care facilities (nursing homes, community-based residential facilities, adult family homes, and residential care apartment complexes) to refer individuals seeking admission to these facilities to an aging and disability resource center.

In turn, the ADRC is required to offer pre-admission consultation (PAC) and a functional eligibility screen to the referred individual, if appropriate.

The purpose of PAC is to ensure that an individual who is about to enter a residential facility has access to information about the full range of available long-term care options, and has the opportunity to discuss with a knowledgeable professional which options would be most appropriate and cost-effective for him or her. In the counties that offer the Family Care benefit, PAC will also provide individuals with an opportunity to determine whether they are eligible for Family Care. More information about PAC is available on the DHFS website at:

<http://dhfs.wisconsin.gov/LTCare/ProgramOps/Pre-Admission.HTM>

Changes in PAC requirements are included in the 07-09 biennial budget bill. The provisions are described on page 32 of the bill which is available at:

http://www.legis.state.wi.us/2007_State_Budget/07-1716_1.pdf

36. How does Family Care make the system better for providers?

Family Care makes the system better for providers in a number of ways.

- ADRCs will provide information and counseling about home and community-based services to private pay consumers at no cost to the provider.
- The entitlement to home and community-based services provided by Family Care means more business for providers.
- Large providers of waiver services currently contract with numerous counties. Because most CMOs will be regional and serve people in multiple counties, the number of entities larger providers contract with will be reduced.
- The dedicated Provider Network Developer position allows the CMO to be responsive to providers' concerns related to rates, contract language, and any problems that arise during the course of the contract.

37. What can providers do to get ready for Family Care?

There are a number of ways that providers can be good business partners with CMOs. These include:

- Participating in local planning consortia to share your expertise about the people you serve;
- Learning about what it means to be member-centered and learning about Family Care's focus on quality of life outcomes for each consumer;
- Learning about how Family Care IDTs work, so you are ready when they begin to engage you in the care planning process;
- Being ready to contract with a new type of organization that will be positioned to address your cost considerations; and
- Offering services that help the CMO manage both quality and cost; and
- Developing new services based on the individual needs and preferences of consumers in your area.



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