

County Residency and Transition to Managed Long-Term Care

The purpose of this information bulletin is to provide direction to counties transitioning to managed long-term care on how to handle instances when an individual voluntarily moves to another county or when an individual is placed in another county under a plan of care by a county waiver agency or Family Care MCO. It is the intention of the Division of Long Term Care (DLTC) that anyone who receives long-term care services funded through any of its long-term care programs will be able to experience continuity of care throughout the transition of Family Care expansion. The direction provided in this bulletin builds on long-standing practice and experience in the Division's home and community-based waivers.

1. Individuals who voluntarily move from one county to another

This pertains to individuals who move voluntarily from County A, in which they are being served, to County B. (This move is **NOT** because County A has developed a plan of care that calls for them to be served in a facility or other setting in County B, but because the individual decides to live elsewhere.)

- A. A waiver participant in County A, which is transitioning to managed long-term care (MLTC), voluntarily moves to County B, which is a COP/Waiver county with no wait list for waiver services.
 - The individual should apply for waiver services in County B, through the usual application process of that program.
- B. A waiver participant in County A, which is transitioning to MLTC, voluntarily moves to County B, which is a COP/Waiver county with a wait list for waiver services.
 - DHFS will transfer funding to County B to serve this individual in their waiver program. County B should develop a care plan and submit it to the appropriate DLTC waiver program for approval. Upon approval, DHFS will contract with County B for the care plan. Once the individual reaches the top of County B's wait list, the individual should be served within County B's allocation.
 - County A staff should assist the person in making contact with County B as appropriate.
 - If the individual's needs increased services while he/she is still on the wait list in County B, County B can submit an updated care plan to the appropriate DLTC waiver program for review. Funding to cover cost of approved services will be made available to County B.
 - All funds transferred for the waiver plan of care will be Medicaid waiver funds, subject to rules of the waiver the person will be served under, unless County B makes

other funds available or makes specific arrangements with DHFS for temporary COP-Regular funds. This will affect individuals who may require help with room and board costs.

- C. A waiver participant in County A, which is transitioning to MLTC, voluntarily moves to County B, which is a Family Care county.
- With appropriate assistance from staff in County A, the individual should contact the ADRC in County B and request enrollment in Family Care, Partnership or the SDS waiver. The individual does not need to go on the wait list and is not counted in the monthly wait list enrollment limit for Family Care.
- D. A child who had been served by the CIP/CLTS waiver in County A, which is transitioning to MLTC, voluntarily moves to County B, a COP/Waiver county which has a wait list for children's services.
- County A provides funding for the child's services in County B until the child turns 18. If the child is still on County B's wait list when he/she turns 18, the CIP/CLTS funding from County A will no longer be available. In this case, DHFS will provide funding to cover the cost of approved services to County B **until the child comes to the top of the wait list**, and can be served through County B's own waiver funding. County B should develop a care plan and submit it to the appropriate DLTC waiver program for approval. Upon approval, DHFS will contract with County B for the care plan. Once the individual reaches the top of County B's wait list, he/she should be served within County B's allocation.
- E. A child who had been served by the CIP/CLTS waiver in County A, which is transitioning to MLTC, voluntarily moves to County B, a Family Care county.

The individual will be able to enroll in the Family Care MCO when he/she turns 18, without going on a wait list.

NOTE: The processes described above, under section #1, A-E, is similar to that described in the January 2, 2007 memo titled *Revised Policy and Procedure for Permanent Moves between Family Care Counties and COP/Waiver Counties*. The memo can be found at: <http://dhfs.wisconsin.gov/LTCare/Partners/GeneralMemos.htm>.

There is one major difference between the process described in that memo and the process regarding counties transitioning to MLTC. The 1/2/07 memo says that a person needs to have been continuously enrolled in Family Care for at least six months immediately preceding the date on which he or she moves to a COP/Waiver county in order to have funds made available for waiver services in the new county. **There is no similar six month requirement for waiver participants who voluntarily move from a county transitioning to managed care, to a COP/Waiver county**, in order to have funding for waiver services in their new county of residence.

2. Individuals who are placed by a county agency in another county, under a plan of care developed by the agency in the “sending” county

This pertains to situations where an individual is placed by one county, County A, in another county, County B, under a plan of care by the waiver agency (or another county agency) of County A. This includes situations where the individual has court-ordered services, and situations where the services are not court-ordered. If the person is in County B because that is where his/her care and treatment is being provided by County A, this is not considered a voluntary move, as described above.

The Department’s intent is to have policy and practice regarding out of county placements for counties transitioning to MLTC be consistent with what the practice has been for waivers and mental health/substance abuse services, and consistent with the DHFS Residency Manual.

A. A waiver participant in County A, which is transitioning to MLTC, is placed in a specialized residential setting in County B, under a plan of care developed and funded by County A’s waiver program. (It does not matter whether the person is protectively placed or not – the salient fact is that he/she was placed under a plan of care by County A’s waiver program.)

- When County A transitions to MLTC, the individual must be offered enrollment in the available managed care programs (e.g., Family Care, PACE/Partnership) and MCOs serving County A, or in the SDS waiver when it becomes available in County A, as part of the transition of County A waiver participants to managed care. This person must be offered the same choices as other waiver participants in County A. This is true whether County B is a COP/waiver county, or a Family Care county.
- If the person enrolls in an MCO serving County A, that MCO will need to make arrangements for the individual’s current placement in County B to continue, or work with the individual and his/her representatives to relocate the person.
- These waiver participants, who have been placed out of county by County A, which is transitioning to managed care, should be included in County A’s initial and final transition plan, according to policy and requirements in Information Bulletin # 5.

Questions about these issues can be addressed to the DHFS central office contact on county residency issues:

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608/261-7812
[hendrch@dhfs.state.wi.us](mailto:hendrhc@dhfs.state.wi.us)

In addition, DHFS Area Administration staff can be contacted for preliminary and non-binding interpretation of residency issues.

Waiver Participant Residency Status in Counties (“County A”) Transitioning to Managed Long-Term Care

1. Voluntary Moves	
Waiver participant in County A voluntarily moves to County B, a COP/Waiver county:	
A. There is no wait list for waiver services in County B.	Person applies for services in County B.
B. There is a wait list for waiver services in County B.	DHFS will transfer funding to County B to serve the person until he/she reaches the top of the wait list, when he/she should be served within County B’s allocation.
C. Waiver participant in County A voluntarily moves to County B, a Family Care county.	Person should contact the ADRC in County B and receive options counseling about whether to enroll in Family Care or the SDS waiver. Does not go on the wait list and is not counted in the monthly wait list enrollment limit for Family Care.
D. Childrens’ Waiver participant in County A voluntarily moves to County B, a COP/Waiver county with a wait list for children’s services. County A’s waiver program provides funding for the child’s services in County B until the child turns 18. Child is still on County B’s wait list when he/she turns 18, and CIP/CLTS funding from County A is no longer available.	When the child turns 18, DHFS will transfer funding to County B to serve the person until he/she reaches the top of the wait list, when he/she should be served within County B’s allocation.
E. Childrens’ Waiver participant in County A voluntarily moves to County B, a Family Care county. County A’s waiver program provides funding for the child’s services in County B until the child turns 18.	When the child turns 18, he/she can enroll in County B’s Family Care program without going on a wait list.
2. Out of County Placements	
Waiver Participant in County A is placed in County B under County A’s plan of care. County B is a COP/Waiver county.	When County A transitions to MLTC, person receives options counseling and chooses whether to enroll in MCO serving County A, or in the SDS waiver when it becomes available in County A.
Waiver Participant in County A is placed in County B under County A’s plan of care. County B is a Family Care county.	When County A transitions to MLTC, person receives options counseling and chooses whether to enroll in MCO serving County A, or in the SDS waiver when it becomes available in County A.