
Questions about Family Care for People with Developmental Disabilities

Responses to Questions from Consumers,
Guardians and Families



Table of Contents

Family Care Program Design	3
1. What is Family Care and where did it come from?	3
2. What are Aging and Disability Resource Centers (ADRCs)?	4
3. What services are offered by ADRCs?.....	4
4. How does Family Care make the system better for people with developmental disabilities?	5
5. What are outcomes and how are they identified?	6
6. Who decides what services I get?	8
7. Why does everyone have a nurse on their care management team?.....	10
8. What services are included in Family Care?.....	11
9. Can services under Family Care be self-directed?.....	12
10. How does DHFS focus on quality in Family Care ?	14
11. What if the CMO and I cannot agree on a service plan?	15
Family Care Funding	16
12. How is Family Care funded?.....	16
13. What are Family Care rates?	16
14. How are Family Care rates determined?.....	17
Statewide Family Care Expansion	18
15. When will Family Care expand to my area?.....	18
16. What role do consumers have in Family Care expansion planning?.....	18
17. How will Family Care expansion impact the services my minor child is receiving?.....	19
Transition to Family Care	19
18. How will people transition from waivers or waiting lists to Family Care?	19
19. Can I keep the same care manager?	20
20. Will I have the same services?	20
21. Will I have the same providers?	21
22. What does a person do if their choice for a provider is not in the CMO provider network?	22

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 your disability and aging questions. 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.

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.

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



4. How does Family Care make the system better for people with developmental disabilities?

Family Care builds on the strengths of Wisconsin's rich history of providing services that meet the unique needs of people with developmental disabilities in their homes and communities. Family Care makes the system work better for people with developmental disabilities 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 your 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.

5. 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 you to discuss with your interdisciplinary care management team (IDT):

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

This step is called the assessment. The assessment helps you identify the real-life personal outcomes that matter to you and the services you need to reach your 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*

6. Who decides what services I get?

Your individual service plan is determined by your IDT. There will always be at least three people on your IDT – a social worker, a nurse, and you, 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.

Your IDT includes:

- You
- Social Worker
- Nurse

You can also include family members or others important to you.

The job of the IDT is to help you to:

- Identify your individual outcomes;
- Develop a service plan that will help you achieve your outcomes; and
- Make sure the services in the plan are actually provided.

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

If you have a guardian or an agent under a health care power of attorney, they will be involved in planning along with you, and will give the legal consent for services. A guardian is responsible for protecting your best interests. This includes working with you and the rest of the planning team to ensure that your 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 you want, and on ways to help you be able to make more decisions for yourself.

Your individual service plan will help you move toward the personal outcomes that you and your team identified in the assessment. The plan must be clear about what services and supports you will receive to achieve your personal outcomes, who is going to provide you with each service or support, and when each service or support will be provided. The plan will describe things you are going to do yourself or with help from family or friends.

Nothing about me without me.

The CMO is responsible for helping you achieve your 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 your team will answer for each of your outcomes. Answering these questions will help your team determine what services are effective at meeting your 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?

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

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

You do not have to settle for a service plan that does not help you reach your 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 your individual outcomes. You may have to compromise on some of your personal outcomes if reaching them fully, or right away, is so difficult or so expensive that it is not reasonable. If you and the rest of the team cannot agree, you have a right to request a different IDT. Question 10 describes other options available to you if you have concerns about your care plan.

7. 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 your 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 your IDT will help you get your health care needs met.



During your initial assessment the nurse on your IDT will identify any current health care issues. The nurse can also help prevent new health care issues from emerging by making sure that you get regular exams by a doctor and immunizations, for example. Even if you don't have any current medical problems, the nurse will identify any new problems that develop over time. Finding problems early, keeps you 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 your individual needs.

The nurse on your IDT will help you
achieve the best health possible.

8. 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 (COPW) and Brain Injury Waiver (BIW). Long-term supports provide assistance with activities such as eating, bathing, or using the telephone; transportation; and respite for your 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
- 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.

9. Can services under Family Care be self-directed?

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

SDS is available to all Family Care members. If you choose the SDS option, the CMO 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 any service or support that will work to meet your 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 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 regarding how to care for you and meet your needs.

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



If you choose to get involved in SDS, your IDT will:

- Explain the variety of choices available to you in SDS;
- 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.

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

- You are not staying within 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 health and safety; or
- Someone else is making decisions for you that are not based on what you want.

The CMO must tell you what you need to do to remove those limits, and tell you about your right to file a grievance or ask for a hearing.

10. 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 your individual outcomes. Your interdisciplinary team (IDT) will help you state the outcomes that you want in your life. These will be based on what is important to you, such as where you live, how you spend your day and how you are involved in your community.

Your IDT must also check on how well your services support the outcomes you want 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 your services and the quality of the work the IDT does with you. 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 you clear and unbiased information about the long-term care services available to you. 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 that you get the best possible services and supports tailored to your needs and preferences.

11. What if the CMO and I cannot agree on a service plan?

You and your team may not always be able to agree about whether a service will achieve your personal outcomes, or about whether a kind of support you want is worth the cost. You and your team should talk it through, probably using the Resource Allocation Decision method. If you and the team still do not agree on a plan, the CMO has to show in writing that the plan:



- Reasonably and effectively addresses the needs and personal outcomes identified in the assessment;
- Does not significantly hurt your chances of achieving an outcome, at least in the long term;
- Considers your needs and personal outcomes, as well as cost and the services the CMO has available; and
- Was developed after working with you to try to think of a plan that would work for both you and the CMO. This should include offers by the CMO to find or develop other ways to meet your personal outcomes that you and the CMO might be able to agree to.

Family Care gives you several choices if you have a concern about your service plan. These choices and processes are the same for every Family Care CMO. A grievance or appeal is a way for you to say that you are unhappy with something about the CMO. You can:

- File a grievance or appeal with the CMO;
- File a grievance or appeal with the Wisconsin Department of Health and Family Services (DHFS) which is the agency that contracts with the CMO for Family Care services; and
- Ask for a State fair hearing.

You can choose to use any of the three ways listed above to file a grievance or appeal. You can use these methods together or at different times.

If you decide to file a grievance or appeal with the CMO or DHFS and do not get what you want, you can still ask for a State fair hearing. For most kinds of concerns you can also go straight to a State fair hearing. If you do ask for a State fair hearing, a person who works with DHFS will talk with you and the CMO to see if you can agree on a compromise before the hearing. This may help, and does not delay the hearing unless you agree to a delay.

Each CMO has someone whose job it is to help members with grievances and appeals called a Member Rights Specialist. The ADRC may also help you make sure your needs and outcomes are being addressed.

Family Care Funding

12. 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, COPW, 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.

13. 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 provides all the services each member needs. Some people’s care plans will cost more than the rate and some will cost less.



The Family Care rate is not a limit - maximum or a minimum - on the dollar value of your care plan. The value of the services you receive will be determined by what services are necessary to meet your individual outcomes. You will work with your IDT to develop a specific plan for you that includes the services you need to meet your personal outcomes in the most effective and, therefore, cost-effective way.

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

14. 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. Therefore, other things being equal, a CMO with a larger proportion of adults with developmental disabilities would always receive a higher rate, because services for these adults cost more than they do for elders or adults with physical disabilities.

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 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.

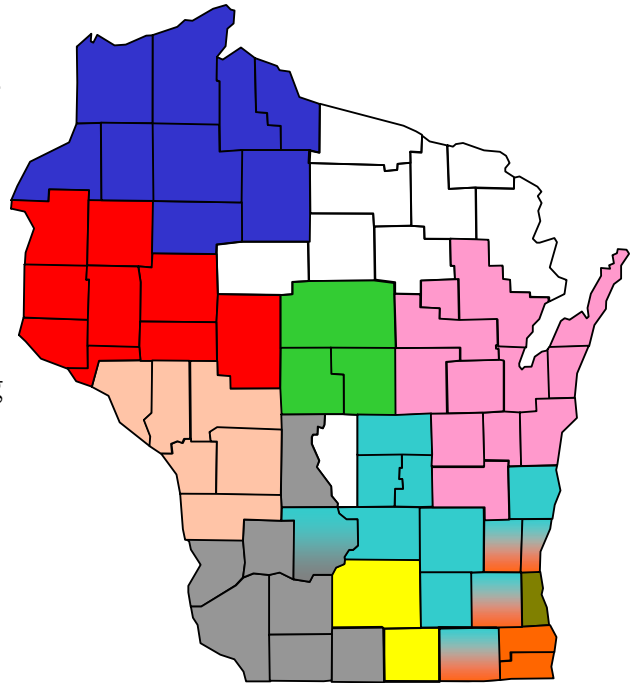
It is important to understand that the amount of services Family Care members receive does not change when the CMO's rate changes. Service amounts change when a member's needs change or new outcomes are identified.

Statewide Family Care Expansion

15. 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.

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>



16. What role do consumers have in Family Care expansion planning?

The voice of consumers has been and will continue to be key to 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 in each region, including contact information, is available at DHFS's website: <http://dhfs.wisconsin.gov/managedltc/stakeholders/index.htm>

Consumers also have a voice in the on-going oversight of Family Care. Each CMO and ADRC must have consumer representatives on their governing boards. At least one-fourth of the members of the CMO and ADRC governing boards must be consumers or their family members, guardians or other advocates.

A statewide Committee on State and Local Stakeholder Participation 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>

17. How will Family Care expansion impact the services my minor child is receiving?

When Family Care begins in a new area, all minor children, under 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 they 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. However, children who have a diagnosis of Severe Emotional Disturbance may continue to be served by the children’s waiver until age 22.



Transition to Family Care

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.

There are three groups of potential members for each new Family Care CMO. One group is the people currently receiving Medicaid waiver services (CIP, COPW 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. You can talk to your ADRC about when enrollment in Family Care will be offered to you.

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.

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

19. Can I keep the same care manager?

This depends on how the new Family Care CMO is created in your area. In the original Family Care counties, the case managers in the waiver program became the Family Care case managers. In Racine and Kenosha counties, Community Care, a private non-profit organization, is the CMO. Community Care has contracted with the same case management agencies that those counties relied on for case management. Several other local planning consortia are discussing developing multi-county operated CMOs. Case managers might remain the same in these areas as well.

That said, we cannot guarantee that you will have the same care manager. It is possible that a CMO could choose not to use county case managers. In those instances, if the CMO does not hire your particular care manager, your care manager would change. Remember, in addition to your care manager, you will also have a nurse on your team.

20. Will I have the same services?

The Family Care benefit package includes all the services in the current Medicaid waiver services (CIP, COP and BIW). CMOs 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 meet your personal outcomes. This may or may not be the exact same services at the exact same level that you currently receive.



You may have heard about the Family Care pilots “reworking” care plans. “Reworking” care plans refers to the outcome-based care planning process that is described in Questions 5 and 6. For most waiver consumers who moved into Family Care and had changes in their service plan, those changes resulted in more personalized, more effective services.

As your needs and outcomes change, your service plan can change.

We understand that you may be concerned that your services will be cut. In Family Care, services will not randomly be cut and there are no across the board decisions about who gets what services. The focus in Family Care is on individualized planning to meet your individual outcomes. Services that are not effective will probably be discontinued.

It is important to remember that if your needs or outcomes change over time, your service plan can also change. You don’t have to try to include services in your care plan that you don’t need today, but you may need some day.

21. Will I have the same providers?

This depends on whether your current providers are in the CMO’s provider network and if your IDT determines that your current provider can meet your individual outcomes in a cost-effective manner. If you are currently acting as an employer through Self-Direct Supports you should be able to continue to do so in Family Care. In practice, the Family Care CMOs have contracted with most of the providers that the county contracted with for the waiver programs. The number of providers available to members has actually grown in Family Care because the CMOs are required to have providers for all the covered services and offer a choice of providers. You may 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, such as personal care and supportive home care, the CMO must purchase services from whomever you choose as long as that person meets the CMO’s requirements and accepts the CMO’s payment rate.

For other services, you can choose among the providers in the CMO’s provider network. 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

You will have more providers to choose from.

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.

22. What does a person do if their choice for a provider is not in the CMO provider network?

Members can request a provider who is not in the provider network and the CMO must consider the request. A member's request for a provider outside the network should be honored by the CMO when network providers:

- Do not have the capacity or specialized expertise to meet the need;
- Cannot meet the need on a timely basis; or
- Are located in geographic locations or buildings that make transportation or physical access an undue hardship to the member.





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