

Family Care: An Overview

A. Applicable Law & Other Resources

- a. Wis. Stat. §§ 46.2805-.2895; Wis. Admin. Code Ch. DHS 10
- b. State's Contracts with Aging Disability Resource Centers and Managed Care Organizations:
 - i. <http://dhs.wisconsin.gov/ltcare/StateFedReqs/FC-RC-CMO-Contracts.htm>
- c. State's Waiver Applications for Family Care:
 - i. <http://dhs.wisconsin.gov/ltcare/Waiver/Index.htm>
- d. Family Care Enrollee Handbook:
 - i. <http://dhs.wisconsin.gov/ltcare/BeingAFullPartner.htm>

B. Introduction

- a. The Family Care Program is designed to help families arrange for appropriate long-term care services for older family members and for adults with physical or developmental disabilities. Wis. Admin. Code § DHS 10.11.
- b. Family Care emphasizes consumer-directed delivery of services. According to the DHS website, its goals include:
 - i. Giving people better choices about where they live and the kinds of services they need to meet their needs;
 - ii. Improving access to services;
 - iii. Improving quality through a focus on health and social outcomes; and
 - iv. Creating a cost-effective system for the future.

C. Family Care is a waiver program.

- a. Two different kinds of waivers and a pre-paid health plan allow the Family Care Program to provide long-term care services through pre-paid "capitated" payments to Managed Care Organizations (MCOs)¹. Each MCO receives a single pre-paid capitated amount of funding for every person who chooses to enroll, and each MCO

¹ Wisconsin Statutes and the Wisconsin Administrative Code refer to these organizations as Care Management Organizations (CMOs), but DHS and the organizations themselves have adopted the term Managed Care Organizations (MCOs).

is responsible for providing any of the services in the Family Care benefit that are needed by an enrollee.

- i. 1915(c) Waivers: Give the Department of Health Services (DHS) the authority to use federal Medicaid funds to provide home and community-based services (HCBS), instead of only institutional care, for people with a level of long-term care need that qualifies for Medicaid funding in a nursing home.
 - ii. 1915(b) Waivers: Give DHS the authority to make the home and community-based services discussed in the 1915(c) Waivers available only to people who are 1) otherwise eligible and 2) enrolled in a MCO. DHS pays the MCO on a pre-paid capitated basis for those services.
 - iii. Pre-paid Health Plan Contract: Allows DHS to contract with MCOs for the other Medicaid long-term care services included in the Family Care benefit (i.e., nursing homes, home health, nursing, personal care, durable medical equipment, disposable medical supplies, and therapies).
- b. Waiver Program Waiting Lists
- i. Eventually, the transition to Family Care will eliminate the current waiting lists for existing waiver programs, such as the Community Options Program (COP-W) and the Community Integration Program (CIP).
 - ii. During the transition period, Aging and Disability Resource Centers (ADRCs) will provide enrollment counseling to those who are on waiting lists, those who are newly eligible for long-term care, and to Family Care members who wish to disenroll from the program.
 - iii. See DHS website for State's memorandum and chart regarding the anticipated implementation of Family Care by county, dated February 18, 2009.

D. Two Main Components

- a. Managed Care Organizations (MCOs)
 - i. MCOs manage and deliver the Family Care benefit. Wis. Admin. Code § DHS 10.41(1)-(2).

- ii. Counties may offer a choice of MCOs or only one. A branch of county government, a private agency, or a mix of public and private agencies, may be certified as a MCO. Wis. Admin. Code 10.42(4).
- iii. MCOs must meet certification standards that include case management capability, adequate availability of providers, MA provider certification, and complaint and grievance processes. MCOs are subject to performance standards and external review of their compliance with those standards.
- iv. MCOs serve all three of the Family Care target groups: people with physical disabilities, people with developmental disabilities, and frail elders.
- v. According to the Family Care statute, a MCO must:
 - 1. Accept enrollment of any person who is entitled to the benefit. Wis. Stat. § 46.284(4)(a).
 - 2. Conduct a comprehensive assessment of each enrollee, including an in-person interview with the enrollee following a standard format as developed by DHS. Wis. Stats. § 46.284(4)(b).
 - 3. Develop a comprehensive plan of care with the involvement of the enrollee, his or her family, or a representative, that reflects the values and preferences of the enrollee. Wis. Stat. § 46.284(4)(c).
 - 4. Provide or contract for the services under the care plan and monitor the delivery of such services. Wis. Stat. § 46.284(4)(d).
 - 5. Provide a mechanism and guidelines for an enrollee's involvement in the arrangement, management, and monitoring of his or her Family Care benefit. Wis. Stat. § 46.284(4)(e).
 - 6. Provide a fee-for-service basis for case management services to persons who are functionally eligible but not financially eligible for the Family Care benefit. Wis. Stat. § 46.284(4)(f).
 - 7. Meet all the performance standards as required by federal law or by rules set by DHS. Wis. Stat. § 46.284(4)(g).
 - 8. Comply with other administrative requirements.

- vi. Managed Care Units (MCUs)²
 - 1. MCOs may subcontract with MCUs to provide long-term care services outlined in a Family Care enrollee's individual service plan. Currently, MCUs exist only in Milwaukee County.
 - 2. Although MCUs are subcontractors, they are held to the same standards and legal requirements applicable to MCOs. If a MCU fails to comply with the Family Care statute and regulations, an enrollee may hold both the MCU and the MCO legally responsible for the failure. Wis. Admin. Code § DHS 10.43(1).
- b. Aging & Disability Resource Centers (ADRCs)
 - i. ADRCs or "resource centers" are "one-stop shops" where the elderly and individuals with disabilities can access information and advice about community resources, including long-term care.³
 - ii. Pursuant to Wis. Admin. Code § DHS 10.23(2), an ADRC must provide the following services to its target populations:
 - 1. *Information and Referral Services.* Provide information to the general public about services, resources, and programs in areas such as: disability and long-term care related services and living arrangements, health and behavioral health, adult protective services, employment and training for people with disabilities, home maintenance, nutrition, and Family Care. Resource center staff must provide help to connect people with those services and to also apply for SSI, Food Stamps and Medicaid as needed. These services must be provided at hours that are convenient to the public and must be private and confidential.
 - 2. *Advocacy.* Advocacy must be provided to individuals and groups when needed services are not being adequately provided by an organization within the service delivery system.

² Wisconsin Statutes and the Wisconsin Administrative Code refer to these organizations as Care Management Units (CMUs), but DHS and the organizations themselves have adopted the term Managed Care Units (MCUs).

³ Milwaukee County has divided the ADRC into two separate organizations: the Aging Resource Center (ARC) and the Disability Resource Center (DRC).

3. *Long-Term Care Options Counseling.* The resource center must offer consultation and advice about the options available to meet an individual's long-term care needs. This consultation must include discussion of: 1) a review of the person's history, preferred lifestyle, residential setting, and goals; 2) the availability of any long-term care options open to the individual; 3) sources and methods of both public and private payment for long-term care services; 4) factors to consider when choosing among the available programs, services, and benefits; 5) advantages and disadvantages of the various options; and 6) opportunities and methods for maximizing independence and self-reliance. Pre-admission consultation must be offered to individuals with long-term care needs who are entering nursing facilities, community-based residential facilities, adult family homes, and residential care apartment complexes. Counseling must also be available for other people with long-term care needs who request it. Participation in this service is voluntary on the part of any individual.
4. *Benefits Counseling.* Provide accurate and current information on private and government benefits and programs. This includes assisting individuals having problems with Medicare, Social Security, or other benefits.
5. *Emergency Response.* The resource center must assure that clients have someone who will respond to urgent situations that might put someone at risk, such as a sudden loss of a caregiver.
6. *Prevention and Early Intervention.* The resource center must promote effective prevention efforts to keep people healthy and independent. This may include a program to review medications or nutrition, home safety review to prevent falls, or appropriate fitness programs for older people or people with disabilities.
7. *Choice Counseling.* The resource center must provide information and counseling to assist persons who are eligible for the Family Care benefit and their families or other representatives with respect to the

person's choice of whether or not to enroll in a MCO and, if so, which available MCO would best meet his or her needs. Information provided must include:

- a. The availability of mechanisms for self-management of service funding under Wis. Stat. § 46.2804, DHS § 10.44 (2)(d) and (6), through which an enrollee may manage the funding for some or all of his or her own services under the Family Care benefit (i.e., IRIS);
 - b. how to find additional assistance within or outside the resource center, MCO, and the Family Care benefit; and
 - c. opportunities for enrollees in a MCO to do as much for themselves as possible and desired and for full participation in service planning and delivery.
8. *Enrollment Assistance.* The resource center must assist a person found eligible for the Family Care benefit and wishing to enroll in a MCO to enroll in the MCO of the person's choice.
 9. *Disenrollment Counseling.* The resource center must provide information and counseling to assist persons in the process of voluntarily or involuntarily disenrolling from a MCO, including all of the following: 1) information about clients' rights and grievance procedures; 2) advocacy resources available to assist the person in resolving complaints and grievances; 3) service and program options available to the person if the disenrollment occurs; and 4) information about the availability of assistance with re-enrollment.
 10. *Waiting List Management.* The resource center must manage, as directed by DHS, any waiting lists that become necessary under the Family Care rules.
 11. *Access to Benefits Programs.* Resource centers are responsible for overseeing applications and eligibility determinations for the Family Care benefit and for providing access to medical assistance, SSI, state

supplemental payments, and food stamps. Wis. Admin. Code § DHS 10.23(3).

12. *Elder Abuse and Adult Protective Services*. The resource center is required to identify persons who may need elder abuse or adult protective services and to provide or facilitate access to services for eligible individuals. The resource center may provide elder abuse and adult protective services directly, if a county agency, or through cooperation with the local public agency or agencies that provide the services.
- iii. To assure that persons receive long-term care counseling and eligibility determination services from the ADRC in an environment that is free from conflicts of interest, an ADRC must meet state and federal requirements for organizational independence from any MCO. Wis. Admin. Code § DHS 10.24(4).

E. The Family Care Benefit & Services

a. Access to the Family Care Benefit

- i. For people who request it, ADRCs will administer the Long-Term Care Functional Screen and financial eligibility screen to assess the individual's level of need for services and eligibility for the Family Care benefit.
- ii. Once the individual's level of need is determined, the ADRC will provide advice about the options available to him or her – to enroll in Family Care or a different case management system, if available, to stay in the Medicaid fee-for-service system (if eligible), or to privately pay for services.
- iii. If the individual chooses Family Care, the ADRC will enroll that person in a MCO. The level of need determined by the Long-Term Care Functional Screen also triggers the monthly payment amount to the MCO for that person. MCOs receive a per person per month “capitated” payment to manage care for their members, who may be living in their own homes, group living situations, or nursing facilities.

- b. Service Requirements: Some of the main provisions of the Family Care benefit package are:
- i. *People Receive Services Where They Live.* MCO members receive Family Care services where they live, which may be in their own homes or supported apartments, or in alternative residential settings such as Residential Care Apartment Complexes, Community-Based Residential Facilities, Adult Family Homes, Nursing Homes, or Intermediate Care Facilities for people with developmental disabilities.
 - ii. *People Receive Interdisciplinary Case Management.* Each member has support from an interdisciplinary team that consists of, at minimum, a social worker/care manager and a registered nurse. Other professionals, as appropriate, also participate as members of the interdisciplinary teams. The interdisciplinary team conducts a comprehensive assessment of the member's needs, abilities, preferences, and values with the consumer and his or her representative, if any. The assessment looks at areas such as: activities of daily living, physical health, nutrition, autonomy and self-determination, communication, and mental health and cognition.
 - iii. *People Participate in Determining the Services They Receive.* Members or their authorized representatives take an active role with the interdisciplinary team in developing their care plans. MCOs should provide support and information to assure members are making informed decisions about their needs and the services they receive. Members may also participate in the Self-Directed Supports component of Family Care, in which they have increased control over their long-term care budgets and providers.
- c. Family Care Services Include:
- i. *Long-Term Care Services* that have traditionally been part of the Medicaid Waiver programs or the Community Options Program. These include adult day care, home modifications, home-delivered meals, and supportive home care.
 - ii. *Health Care Services* that include home health, skilled nursing, mental health services, and occupational, physical, and speech therapy. For Medicaid

recipients, health care services not included in Family Care are available through the Medicaid fee-for-service program.

- iii. *Coordination of Primary Health Care.* MCO interdisciplinary teams are supposed to 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.
 - iv. *Services to Help Achieve Employment Objectives.* Services such as daily living skills training, day treatment, pre-vocational services, and supported employment are included in the Family Care benefit package. Other Family Care services such as transportation and personal care also help people meet their employment goals.
 - v. *Other Services.* The MCO is not restricted to providing only the specific services listed in the Family Care benefit package. The MCO interdisciplinary care management team and the member may decide that other services, treatments, or supports are more likely to help the member achieve his or her outcomes, and the MCO could then authorize those services in the member's care plan.
- d. *Note:* There is no actual definition of the "Family Care Benefit" (in terms of required services) contained in the Family Care statute. This information is in the waiver application submitted by Wisconsin. For a complete list of the services that *must* be offered by MCOs, refer to the description of Family Care Benefit Package in the 2009 Family Care Programs Contract, pgs. 174-85.

F. Self-Directed Services (SDS) Option⁴

- a. Enrollees may choose to manage their Family Care budget for the support and services they receive either directly or with the assistance of a person chosen by the enrollee. Wis. Admin. Code § DHS 10.44(6).
- b. DHS must approve each MCO's SDS plan. Wis. Admin. Code § DHS 10.44(6)(c).

⁴ The Self-Directed Services Option is a choice within the Family Care benefit whereas IRIS is a separate program outside of Family Care.

- c. SDS is a progressive concept that enables Family Care enrollees to maintain independence while receiving the services they need through family members, friends, or employees.
 - i. The caregivers chosen by the enrollee may be hired, trained, directed, or paid by the enrollee or by a person chosen by the enrollee.
- d. SDS can be a good option for members who want to craft creative “out-of-the-box” plans to further their goals for self-determination.
- e. For more information, see the Self-Directed Supports (SDS) Resource eLibrary at the following link: <http://cow.waisman.wisc.edu/sdswi.html>.
- f. See also 2009 Family Care Programs Contract, pgs. 47-50.

G. Eligibility for Family Care Benefits: To be eligible for Family Care, the person must meet functional criteria, financial requirements, and certain general conditions of eligibility such as age and residence. These eligibility criteria are detailed below:

- a. General Conditions: To be eligible for the Family Care benefit, a person must meet all of the following general eligibility conditions:
 - i. *Age*. The person must be at least 18 years of age or attain the age of 18 on any day of the calendar month in which the person applies.
 - ii. *Residency*. The person must be a resident of a county, Family Care district, or service area of a tribe in which the Family Care benefit is available through a MCO. This requirement does not apply to a person who is either of the following:
 - 1. An enrollee who was a resident of the county, Family Care district, or tribal area when he or she enrolled in Family Care, but currently resides in a long-term care facility outside the service area of the MCO under a plan of care approved by the MCO; or
 - 2. an applicant who, on the date that the Family Care benefit first became available in the county, was receiving services in a long-term care facility funded under any of the programs specified under § DHS 10.33(3)(b) administered by that county.

- iii. *Family Care Target Group*. The person must have a physical disability, infirmities of aging or, if the person is a resident of a county that began operating a MCO before July 1, 2001, a developmental disability.
 - iv. *Cost Sharing*. The person must any cost-sharing obligations.
 - v. *Acceptance of Medical Assistance, if Eligible*. If the person is eligible for Medical Assistance, he or she must apply for and accept the Medical Assistance.
 - vi. *Other Non-Financial Conditions*. The person must meet the non-financial conditions of eligibility for Medical Assistance under § DHS 103.03(2)-(9).
- b. The Financial Eligibility Determination (Wis. Admin. Code §§ DHS 10.34-.36; .61-.62)
- i. Resources
 - 1. The Medicaid Eligibility Handbook:
<http://www.emhandbooks.wi.gov/meh-ebd/>
 - 2. State Operations Memorandums:
<http://dhs.wisconsin.gov/em/ops-memos/index.htm>
 - 3. The Medicaid Waivers Manual:
<http://dhs.wisconsin.gov/bdds/waivermanual/index.htm>
 - ii. Asset Limits
 - 1. Generally, the limit is \$2,000 of countable assets for a “single” individual with the same exemptions applicable to Medicaid recipients.
 - a. “Single” means unmarried, legally separated, or, under spousal impoverishment, having been in the program for 12 or more months.
 - iii. Income Limits
 - 1. There are three levels of eligibility. Once a person begins participating in a waiver program, a certain amount of income is protected in order to pay for room, board, and personal expenses. Certain additional deductions from income apply (e.g., medical/remedial expenses) and remaining funds are subject to cost-sharing. Eligible persons are also

protected by spousal impoverishment legislation. *See also* 2009 Family Care Programs Contract, pgs. 42-43.

a. Group A

- i. Group A members are eligible via SSI or a full-benefit Medicaid subprogram, e.g., BadgerCare. These members are financially eligible with no cost share.
- ii. Income Limit for Single Individual = \$533.11 + actual shelter up to \$224.67

b. Group B

- i. Group B members are those not in Group A who have gross income at or below the Categorically Needy Income Limit of \$2,022. Group B members must pay a cost share to the MCO, i.e., a monthly amount a waiver program participant must contribute toward the cost of his or her services.
- ii. The Medicaid Eligibility Handbook (MEH) outlines the procedure for determining the cost-share, including the following exemptions/deductions. *See* MEH § 28.5.1.
 1. Deductions for room, board, and personal expenses, which are collectively referred to as the Personal Maintenance Allowance. The maximum Personal Maintenance Allowance is \$2,022.
 2. Special exempt income as outlined in MEH § 15.7.2.
 3. Exemptions for health insurance premiums and medical/remedial expenses.

c. Group C

- e. Individual has a complicating condition that limits his or her ability to independently meet his or her needs and
 - i. The person requires frequent medical or social intervention to safely maintain an acceptable health or developmental status, or requires changes in service due to intermittent or unpredictable changes in his or her condition, or requires a range of medical or social interventions due to a multiplicity of conditions; and
 - ii. The person has a developmental disability that requires specialized services, or has impaired cognition exhibited by memory deficits or disorientation to person, place, or time, or has impaired decision-making ability exhibited by wandering, physical abuse of self or others, self-neglect, or resistance to needed care.
- iii. Non-Nursing Home Level of Care (formerly Intermediate and Comprehensive non-NH LOC)
 - 1. Long-term or irreversible condition and
 - 2. At risk of losing independence of functional capacity as evidenced by either of the following:
 - a. Inability to safely perform one or more ADL or
 - b. One or more of the following critical IADLs:
 - i. Management of medications and treatments;
 - ii. Meal preparation and nutrition; and/or
 - iii. Money management.
 - 3. *Note:* Family Care enrollees assessed at the Non-Nursing Home Level of Care only receive case management. Their services are limited to Community-Based Medicaid State Plan Services, i.e., Medicaid card services. These services are listed in the 2009 Family Care Programs Contract. See list of the Community-Based Medicaid State Plan

Services as defined in the Family Care Programs Contract, pgs. 184-85.

iv. The Long-Term Care Functional Screen (LTCFS)

1. The LTCFS is a computer-based program administered by “certified” workers in a face-to-face interview. Worker certification consists of an online course and exams.
2. Applicants may choose to have other individuals present at the LTCFS interview.
3. The process is meant to be objective, so the program does not inform workers why it deems a particular applicant eligible or ineligible.
4. The LTCFS may find an individual eligible in the absence of the requirements found in the Family Care statute based on certain medical interventions as identified in the “Health Related Services” section or if the worker notes that the individual is at “imminent risk of institutionalization.”
5. The level of care determined by the LTCFS also triggers the monthly payment amount to the MCO for that person.
6. According to the LTCFS instructions, whenever the condition of a person in long-term care substantially changes, the LTCFS should be re-run to determine whether the change in condition has affected the appropriate level of care.
7. For a copy of the instructions for the LTCFS, see the following link: <http://dhs.wisconsin.gov/lcCare/FunctionalScreen/LTCFSinstruc-clean.pdf>.
8. For additional information, see the LTCFS website at the following link: <http://dhs.wisconsin.gov/LTCare/FunctionalScreen/>.

H. The Individual Service Plan (ISP)

- a. The MCO, in partnership with the enrollee must develop an individual service plan (ISP) for each member, with the full participation of the member and any family

members or other representatives that the enrollee wishes to participate. Wis. Admin. Code § DHS 10.44(2)(f).

- i. The MCO must provide support, as needed, to enable the enrollee, family members, or other representatives to make informed ISP decisions, and for the enrollee to participate as a full partner in the entire assessment and ISP development process.
 - ii. Family Care members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care. 2009 Family Care Programs Contract, pgs. 34, 37-39.
 - iii. See also 2009 Family Care Programs Contract, pgs. 51-59, for a summary of the process, including the initial comprehensive assessment as well as the ISP process.
- b. Pursuant to Wis. Admin. Code § DHS 10.44(2)(e), MCOs must use assessment protocols as part of the ISP development process, including a face-to-face interview with the enrollee, and comprehensively assess the following:
- i. The needs and strengths of the enrollee in at least the following areas:
 1. Activities of daily living and instrumental activities of daily living;
 2. Nutrition;
 3. Autonomy and self-determination;
 4. Communication;
 5. Mental health and cognition;
 6. Presence of, and opportunities for enhancing, informal supports;
 7. Understanding and exercising rights and responsibilities;
 8. Community integration;
 9. Safety;
 10. Personal values;
 11. Education and vocational activities, including any needs for job development, job modifications, and ongoing support on the job;
 12. Economic resources; and
 13. Religious affiliations, if any.

- ii. Long-term care outcomes that are consistent with the values and preferences of the enrollee in at least the following areas:
 - 1. Safety;
 - 2. Best possible health;
 - 3. Self-determination of daily routine, services, activities, and living situation;
 - 4. Privacy;
 - 5. Respect;
 - 6. Independence;
 - 7. Social roles and ties to family, friends, and community;
 - 8. Educational and vocational activities;
 - 9. Desired level and type of participation in community life; and
 - 10. Spiritual needs and desired participation in religious activities.
- c. The ISP must do all of the following:
 - i. Reasonably and effectively address all of the long term care needs and utilize all enrollee strengths and informal supports identified in the comprehensive assessment;
 - ii. Reasonably and effectively address all of the enrollee's long term care outcomes identified in the comprehensive assessment and assist the enrollee to be as self-reliant and autonomous as possible and as desired by the enrollee;
 - iii. Be cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes; and
 - iv. Be agreed to by the enrollee. Wis. Admin. Code § DHS 10.44(2)(f).
- d. Disagreements Regarding the Individual Service Plan
 - i. If the MCO cannot provide a service that is in the enrollee's ISP, the MCO must authorize receipt of the service from an out-of-plan provider. Wis. Admin. Code § DHS 10.44(3)(d).
 - ii. If the enrollee and the MCO do not agree on an ISP, the MCO must provide a method for the enrollee to file a grievance, request department review, or request a fair hearing. Pending the outcome of the grievance, review, or fair hearing, the MCO must offer its ISP for the enrollee, continue negotiating

with the enrollee, and document the adequacy of the current ISP. Wis. Admin. Code § DHS 10.44(2)(f)(5).

e. Reviews of the Individual Service Plan

- i. Pursuant to Wis. Admin. Code § DHS 10.44(2)(j)(5), MCOs must review each enrollee's ISP and adjust services if indicated by the review, as follows:
 1. Whenever a significant change occurs in the enrollee's health, functional capacity, or other circumstances;
 2. When requested by the enrollee, the enrollee's representative, the enrollee's primary medical provider, or an agency providing services to the enrollee;
 3. As often as necessary in relation to the stability of the enrollee's health and circumstances, *but not less than every 180 days*.

f. Analyzing Cost-Effectiveness

- i. The Resource Allocation Decision (RAD) Method is standardized decision-making process designed by DHS. It was designed to assist MCOs with balancing costs and outcomes. DHS requires MCOs to either use the RAD method as their service authorization process or use an alternative method that has been approved by DHS. Currently, all MCOs use the RAD method to authorize services.
- ii. The RAD method consists of a series of questions that an enrollee and his or her Family Care interdisciplinary team discuss to identify personal outcomes and match those outcomes with the right services and supports.
- iii. The RAD method instructions state that "cost-effective" does not necessarily mean "least expensive." In other words, enrollees do not have to settle for service plans that do not help them reach their outcomes.
- iv. For additional information, see DHS guidance on RAD Method at the following link: <http://dhs.wisconsin.gov/LTCare/ProgramOps/RAD.HTM>.
 1. *Note:* DHS's guidance on the RAD Method can be attached to a hearing brief to better explain the analysis to ALJs. In particular, note that "cheapest" is not a consideration and case workers should start

with the requested outcome, not the requested service, when analyzing a member's request.

I. Advocacy & Appeals

a. Sources of Law

i. Family Care Statutes and Regulations

1. The Family Care statutes are found at Wis. Stats. §§ 46.286 – 46.288, with corresponding regulations at Ch. DHS 10 of the Wisconsin Administrative Code.

ii. Medicaid Statutes and Regulations – Family Care applicants and enrollees are entitled to all of the due process protections available to Medicaid participants.

1. The federal Medicaid statutes are found at 42 USC §§ 1396 et seq., with corresponding federal regulations at 42 C.F.R. §§ 430-439.
2. The state Medicaid statutes are found at Wis. Stats. §§ 49.43-49.499, with corresponding regulations at §§ DHS 101-108 of the Wisconsin Administrative Code.

b. Grievances, Appeals, & Requests for Fair Hearings

i. Notice of Adverse Action

1. Before the services of Family Care enrollees are denied or reduced, they must receive written notice of the intended action. Wis. Admin. Code § DHS 10.52(2)(b)(1)-(9); 42 C.F.R. § 431.201.
 - a. The MCO must give the enrollee notice of any intended adverse action at least *ten days* prior to the date of the intended action. Wis. Admin. Code § DHS 10.52.
 - b. *See also* 2009 Family Care Programs Contract, p. 40.
2. The notice should include all of the following, if applicable:
 - a. The effective date of the intended action (although not required by Family Care regulations, it is basic due process to include it);

- b. The action the county agency, ADRC, or MCO will be taking, and the effect that this action will have on services the enrollee currently receives;
 - c. The reasons for the intended action;
 - d. Any laws that support the intended action;
 - e. The enrollee's right to file a grievance or appeal, to request a department review, and to request a fair hearing;
 - f. Information on how to file a grievance or appeal and how to request a fair hearing;
 - g. The enrollee's right to appear in person in front of the ADRC, agency, or MCO that will be resolving the issue;
 - h. Information regarding agencies that can assist the enrollee with a grievance, department review, or fair hearing; and
 - i. The enrollee's right to review free copies of his or her record for the appeals process and an explanation of how to request copies. *See also* 42 C.F.R. § 431.242.
3. Continuing Benefits Pending Appeal (*See also* Wis. Admin. Code § HA 3.05(5).)
- a. Enrollees must also receive notice of their right to have the services they currently receive continue during the grievance, department review, or fair hearing process. Wis. Admin. Code § DHS 10.52(2)(b)(7).
 - b. *Enrollees must submit their request for continued services pending the appeal prior to the effective date of the intended action.* Wis. Admin. Code § DHS 10.56.
 - c. MCOs cannot deny a request to continue services. Wis. Admin. Code § DHS 10.56(1)-(2).
 - d. *Note:* The enrollee is responsible for the cost of the services received during the appeals process if the outcome of the appeal is not favorable to the enrollee. However, if DHS determines that the person would incur a "significant and

substantial financial hardship” as a result of repaying the cost of the provided services, it may waive or reduce the enrollee's liability. Wis. Admin. Code § DHS 10.56(3).

- e. If the enrollee changes his or her mind about continuing services pending the appeal, he or she may contact the MCO to discontinue the services.

ii. MCO Grievances & Appeals

1. A member must file a grievance, appeal, and/or request for a fair hearing within *forty-five calendar days* of the receipt of the notice of the intended action. Within that time, any of these filings may be made separately or concurrently.
 - a. The 45-day time limit tolls separately for receipt of the initial notice and receipt of an adverse grievance/DHS review decision. *See* 2009 Family Care Programs Contract, pg. 74. In other words, a member has 45 days after each of these events to submit an appeal.
 - b. *Note:* Although the member has 45 days to file an appeal, his or her benefits will be continued only if he or she files a request for continued benefits prior to the effective date of the intended action.
 - c. According to Wis. Admin. Code § HA 3.05(3)(b), the default is 45 days *from the effective date of the action*, but a different time limit for a hearing request may be specified by state statute or administrative rule. The Family Care administrative rules specify 45 calendar days *from receipt of the notice*.
2. The MCO grievance/appeal process consists of an informal evidentiary hearing in front of a grievance committee. The committee must include at least one fellow Family Care enrollee. 2009 Family Care Programs Contract, pg. 71.

3. MCOs must dispose of appeals within 20 business days of the date they receive an initial appeal request. *See Family Care Program Contract, pgs. 71-72.*
4. Member Rights Specialists, Member Advocates, & MCO Advocacy Services
 - a. MCOs must provide a member rights specialist and designate a MCO employee to serve as a member “advocate” within the agency. These functions may be assigned to the same MCO employee.
 - b. Member Rights Specialists should assist members with understanding their rights and filing requests for MCO-level appeals, DHS reviews, and/or fair hearings with the Division of Hearings and Appeals.
 - c. Member Advocates should assist members with issues or concerns relating to their care management or service providers.
 - d. *Member Rights Specialists and Member Advocates will not advocate for members in grievances or accompany them at fair hearings.*
 - e. *See 2009 Family Care Programs Contract, pgs. 66-67.*
5. Pursuant to 42 C.F.R. § 431.232, if the decision of the local evidentiary hearing (i.e., MCO grievance or appeal) is adverse to the applicant or recipient, the agency must:
 - a. Inform the applicant or recipient of the decision;
 - b. Inform the applicant or recipient that he or she has the right to appeal the decision to the state agency, in writing, within 15 days of the mailing of the notice of the adverse decision;
 - c. Inform the applicant or recipient of his or her right to request that the appeal be a *de novo* hearing; and
 - d. Discontinue services after the adverse decision (unless the member requests a state fair hearing within 10 calendar

days from when the MCO mails an adverse MCO decision, per the Family Care Program Contract).

iii. Department of Health Services Reviews

1. MetaStar, Inc., the Family Care external quality review organization, acts as the designated agent for DHS. MetaStar will investigate and analyze the facts surrounding the member's appeal in an attempt to resolve concerns and problems informally. *Note:* A DHS Review is not a formal appeal option, only a general review of the MCO's decision.
2. DHS is required to complete its review within 20 days of receiving a request from a client, unless the client and DHS agree to an extension of time.
3. There is also a concurrent review process whenever DHS is informed that a Family Care applicant or enrollee has requested a fair hearing under Wis. Admin. Code § DHS 10.55(1)(d)-(g) before an Administrative Law Judge (ALJ) from the Division of Hearings and Appeals (DHA). Wis. Admin. Code § DHS 10.54.
4. To request a DHS review, contact:
DHS Family Care Grievances
c/o MetaStar
2909 Landmark Place
Madison, WI 53713
Fax: (608) 274-8340
E-Mail: famcare@dhfs.state.wi.us
Family Care Grievance Hotline: 1-888-203-8338
5. See also the 2009 Family Care Programs Contract for a description of the appeal process, pgs. 68-73.

iv. Fair Hearings

1. Applicants or enrollees may contest the following without first filing a grievance by submitting a written request for a hearing under Wis.

Stat. § 277.44 to the Division of Hearings and Appeals (DHA) (Wis. Stat. § 46.287):

- a. Failure to provide timely services and support items that are included in the plan of care;
 - b. Reduction of services or support items under the Family Care benefit;
 - c. Development of plan of care (individual service plan) that is unacceptable because the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee or the plan of care provides care, treatment, or support items that are insufficient to meet the enrollee's needs, are unnecessarily restrictive, or are unwanted by the enrollee; and
 - d. Involuntary disenrollment from MCO (*See Family Care Programs Contract, pg. 74*).
2. In order to contest any other decision, omission, or action, an applicant or enrollee must first file a grievance and/or a request for review by DHS. Wis. Stat. § 46.287(2)(b); Wis. Admin. Code § DHA 10.55(2).
 3. *Note:* Unless the applicant or recipient specifically requests a *de novo* hearing, the state agency hearing may consist of a review by the agency hearing officer of the record of the local evidentiary hearing to determine whether the decision of the local hearing officer was supported by substantial evidence in the record. 42 C.F.R. § 431.233.
 4. Fair Hearings are conducted by ALJs employed by the DHA. Requests for a fair hearing must be submitted in a writing mailed or faxed to DHA.
 5. To request a fair hearing with DHA, contact:
Family Care Request for Fair Hearing
c/o Division of Hearings and Appeals
5005 University Avenue, Suite 201
P.O. Box 7875

Madison, WI 53707-7875

Fax: 608-264-9885

Phone: 608-266-3096

TTY: 608-264-9853

6. According to Wis. Admin. Code § DHS 10.55(3) and Wis. Stat. § 44.287, an enrollee must file a request for a fair hearing within the following time limits:
 - a. A Family Care client must request a fair hearing within 45 days after receipt of notice of a decision in a contested matter, or after an ADRC or a MCO has failed to respond within time frames specified by Chapter DHS 10 or the Department. Receipt of notice is presumed within 5 days of the date the notice was mailed.
 - b. A hearing request will be considered filed on the date of actual receipt by the DHA, or the date of the postmark, whichever is earlier.
 - c. Fair hearings requests may also be filed by fax. Faxed requests are considered received when the transmission is complete. However, if transmission is completed between 5:00pm and midnight, one day will be added to the transmission date.
 - i. *Note:* If sending a fair hearing request via fax and a deadline is imminent, call DHA to confirm receipt of the faxed request to ensure that the request was received. A late request will be dismissed.
7. The petitioner or his or her representative has a right to inspect the records relevant to the grievance, department review, or fair hearing and to receive copies of these documents free of charge. Wis. Admin. Code § DHS 10.52.(3)(b)(9); 42 C.F.R. 431.242.
8. DHA will send all parties a notice of hearing and an ALJ will conduct a hearing, unless:

- a. The client withdraws the request in writing;
 - b. The hearing is resolved to the petitioner's satisfaction;
 - c. The petitioner voluntarily withdraws from the MCO;
 - d. The petitioner abandons the hearing by failing to appear in person or by an authorized representative, without good cause;
 - e. An informal resolution is proposed that is acceptable to the petitioner and the petitioner agrees in writing to the resolution and/or withdraws the hearing request; or
 - f. An informal resolution acceptable to the petitioner appears imminent and the petitioner requests rescheduling of the hearing. If the informal resolution that was anticipated is not acceptable to the petitioner a new hearing will be rescheduled promptly. (Wis. Admin. Code § DHS 10.55(5)((a))
9. DHA must issue a hearing decision within 90 days of the receipt of the request for a fair hearing. (Wis. Admin. Code § DHS 10.55(5)(b)(2))
- a. In a *de novo* hearing, the decision must:
 - i. Specify the reasons for the decision; and
 - ii. Identify the supporting evidence and regulations.
42 C.F.R. § 431.244.
10. See also 2009 Family Care Programs Contract, pgs. 74-77.

J. Related Programs

- a. IRIS (“Include, Respect, I Self-Direct”)
 - i. The Centers for Medicare & Medicaid Services (CMS) requires Wisconsin to provide all long-term care consumers with a choice of providers. Competing MCOs or an alternative such as the Wisconsin Partnership Program each meet that requirement. However, some Family Care counties have only one MCO and do not have access to the Wisconsin Partnership Program. For these

counties, CMS mandates that Wisconsin offer an alternative to the Family Care Program. The result is IRIS.

- ii. The IRIS program permits individuals to self direct all of their long-term care needs.
- iii. IRIS is only available in Family Care counties—but it is available in all Family Care Counties, not just those in which there is only one MCO and no Wisconsin Partnership Program. *In practice, many ADRCs have neglected to inform potential enrollees of this option.*
- iv. While a Family Care enrollee may choose to self direct some or all of his or her individual service plan, an IRIS participant must self direct all of his or her services.

1. For additional information, see the following link:

<http://dhs.wisconsin.gov/lcicare/Generalinfo/iris.htm>.

b. Wisconsin Partnership Program

- i. The Wisconsin Partnership Program is a comprehensive program of services for older adults (age 55 and older) and people with physical disabilities. Recipients must be Medicaid eligible and may also be Medicare eligible.
- ii. The Program integrates health and long-term support services, and includes home and community-based services, physician services, and all medical care. Services are delivered in the participant's home or in a setting of his or her choice.
- iii. Contractors receive capitated per member reimbursements using Medicare and Medicaid funds. Providers use the combined capitation rates to meet recipients' long-term and acute care needs. Available services include some that are not covered by normal fee-for-service Medicaid or Medicare, such as case management services and on-going psychological services.
- iv. For more information, see the following link:
<http://dhs.wisconsin.gov/wipartnership/2pgsum.HTM>.