

Common Questions: Family Care and Chapters 51 and 55

Background:

Family Care is a program model that includes two core components: Aging and Disability Resource Centers (ADRCs) that provide information, assessment and referral and Managed Care Organizations (MCOs) that provide Medicaid funded long-term support services. While either of these core components may be operated by county governments, neither is vested with the responsibility for activities assigned to counties under Chapters 51 and 55 of Wisconsin Statutes. Any county government that contracts with the state Department of Health and Family Services to operate either an ADRC or MCO retains its responsibility under these statutes and must maintain sufficient staff resources to carry out (or contract for) the assessment, case management and court work involved.

Both ADRCs and MCOs, regardless of whether they are county operated, carry out activities that have been managed and staffed for many years by county Human Services, Social Services and Boards under Wis. Stats. 51.42. Implementation of Family Care may result in reassignment of county staff from their former organizational location to:

- an ADRC, MCO, or some other unit of county government; or
- work as care managers under a county contract with a private MCO or Long-Term Care district.

In counties where Family Care has been implemented, individuals in need of adult protective services or treatment may come to the attention of county staff in a variety of ways. When this need becomes apparent to staff of either an ADRC or MCO, regardless of whether the ADRC or MCO are publicly or privately operated, staff is obligated under contract with DHFS and, in some instances, the requirements of their professional licensure, to report their observations to the county agency responsible under Chapters 51 or 55.

Common Questions:

Q1: In Family Care counties, who pays for court-related work and any mental health, AODA or adult protective services that have been court ordered for adults with long-term support needs?

A: Statutory responsibility for court-related work and the cost of any long-term support services that are court ordered is no different in counties with Family Care than it is in counties with COP and Medicaid waiver programs. Court orders under Chapters 51 and 55 specify services to be provided by the county of residence for long-term support consumers and that county is responsible for engaging the consumer in the service delivery system that exists in that county. If the consumer is a MCO member, services that are part of the MCO's covered services are provided by the MCO and care management for those services is provided by the MCO.

Q2: Which court ordered services are covered by Family Care?

A: Services that are within the Family Care service package will be Family Care funded after the consumer becomes a Family Care member. The Family Care benefit package includes:

- Adaptive aids, communication aids, medical supplies, home modifications
- Home health, therapies, nursing, personal care, supportive home care
- Residential services, nursing home care
- Transportation, daily living skills training, supportive employment
- Nutrition services, including home delivered meals
- Emergency response system services (Lifeline, for example)
- Respite care, adult day care, day services
- Mental health and AODA services not provided by a physician (including, for example, CSP and outpatient mental health/counseling provided by a psychologist or other non-physician therapist)
- Care management

Any Family Care service may be court ordered and will be paid for by the Family Care care management organization (MCO) once the individual who is subject to the order is enrolled in Family Care.

See <http://dhfs.wisconsin.gov/LTCare/Generalinfo/Benpackage.htm> for a list of services included in the Family Care benefit package.

Q3: Which court ordered services are not covered by Family Care?

A: Court ordered services that are not part of the Family Care benefit package will not be paid for by Family Care. Examples of services that are not included in the Family Care benefit package include:

- Inpatient care, including mental health or AODA treatment in a hospital or Institute for Mental Disease (IMD) for individuals between the ages of 18 and 65 years of age
- Outpatient treatment by a psychiatrist or physician
- Prescription medication

Of course, all Family Care enrollees are Medicaid eligible. Under Medicaid fee-for-service provisions, many additional acute and primary health care services are covered for Family Care members, including services by a Medicaid certified physicians and medications covered by Medicaid.

Q4: After Family Care is implemented in a county, how do county agencies pay for court ordered services that are not included in the Family Care benefit package?

A: Within Family Care counties, county agencies are purchasing or providing services that are not covered by Family Care by maximizing their use of Medicaid card-covered services or using community aids, social services block grant or local funding.

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Q5: May MCOs select who they will enroll in Family Care, thereby reducing their responsibility to serve members with court ordered services that may require costly or complicated care plans?

A: No. ADRCs, in conjunction with local Economic Support Agencies, determine who is eligible for Family Care and MCOs are informed of the enrollment. The MCO is not able to select which individuals the MCO will serve. Family Care MCOs are directed by their contract with DHFS to provide enrollees with “*court ordered treatment if it is a service in the LTC benefit package for which the MCO would be the primary payer and the member has been court ordered into placement or services through Chapter 51 or 55 of the Wisconsin Statutes*”¹. MCOs also may not disenroll members who are eligible for and need Family Care benefits and who become subject to court ordered services or treatment after enrollment. In all cases, involuntary disenrollments must be approved by DHFS.

Q6: Must all long-term support consumers for whom services have been court ordered under Chapter 51 or Chapter 55 enroll in Family Care if Family Care has been implemented in the responsible county?

A: Not if the only services that are ordered by the court are available as Medicaid card-covered long-term support services outside the Family Care program. Acceptance of any services that are needed by the consumer and within the Family Care benefit package, **but not court ordered**, are voluntary.

Enrollment in Family Care is always voluntary. If a person who has a court appointed legal guardian and court ordered long-term support services is unwilling to enroll in Family Care, it becomes the responsibility of his or her guardian to approve enrollment. The county agency may wish to petition the court to replace any guardian who refuses to enroll his or her ward in court ordered long-term support services.

Q7: Does DHFS anticipate changing statutory language to release counties from funding Family Care services that are court ordered?

A: Not at the present time. The design of Family Care, with ADRCs and Economic Support determining eligibility and enrollment, prevents adverse selection and strong contract language prevents inappropriate disenrollment.

¹ See DHFS Health and Community Supports Contract – 2007, pg. 48, at <http://dhfs.wisconsin.gov/LTCare/StateFedReqs/cy07MCOcontract.pdf>

Q8: When petitioning for court ordered services, should county agencies request an order for Family Care?

A: No, petitions should specify services to be provided, not programs, in order to maximize the responsible county's funding flexibility.

Q9: Must counties maintain capacity to case manage services for long-term support consumers who are subject to court ordered services who are not eligible for or enrolled in Family Care?

A: Yes. Counties must maintain capacity (provided or contracted) for case management to individuals whose services are court ordered and not within the Family Care benefit package. However, within counties where Family Care has been implemented, this work may be performed by staff of Aging and Disability Resource Centers and is generally rare and of limited duration as it relates to long-term support services.

Q10: Is the ADRC or MCO responsible to provide and pay for services to the court, e.g., assessments to determine the need for adult protective services (APS), volunteer guardians, petitioning for APS orders or guardianship?

A: No. Services to the court related to adult protective services and guardianship remain the responsibility of the county APS system. However, counties may establish contracts or memoranda of understanding with ADRCs to perform these activities.

Q11: Does the Department of Health and Family Services contract with ADRCs or MCOs make them responsible for recruiting, training and managing volunteer guardians?

A: No. However, any county that operates an ADRC may choose to assign these responsibilities to its ADRC. Under no circumstances should MCO staff perform these duties when the individual in need of a guardian is an enrollee in the MCO's Family Care program.

Q12: Is the MCO responsible for paying court ordered guardianship fees or stipends to volunteer guardians on behalf of enrollees?

A: No. Guardianship fees are not included in the Family Care benefit package. If possible, guardianship fees should be paid out of each enrollee's personal funds. This may reduce the amount that MCOs are able to collect from enrollees toward room and board costs. Enrollees that are subject to cost sharing receive an exemption for guardianship fees when financial eligibility and cost sharing are calculated by Economic Support.

Payment of fees to guardians for their services by any MCO may be perceived as or may result in influencing decision making by a guardian about services in the care plan or advocacy on the part of the guardian for the enrollee with the MCO.

The contribution of local funds that any county is required to make toward Family Care when managed long-term care is implemented in that county will be reduced by the amount of fees paid to guardians by that county in 2005. The Department will also work with both ADRCs and MCOs to develop strategies to reduce the dependence on paid volunteer guardians.

The Department recommends that when Family Care is implemented in any county, the county agency responsible for adult protective services execute a memorandum of understanding with the Family Care MCO that describes the expectation for the MCO to work with the enrollee's family and informal supports to identify a volunteer guardian who does not require a stipend.

Q13: Does a MCO continue to receive capitation payments for an individual residing in a nursing home IMD (such as Trempealeau County Health Center's 76-bed unit) or a hospital IMD (such as Winnebago or Mendota Mental Health Institute or the Brown County Mental Health Center)?

A: No. When a person whose age is between 21 and 65 is admitted to an IMD, he or she loses Medicaid eligibility and capitation payments cease. The capitation payment will resume when the individual is discharged and re-enrolled in Family Care.

Q14: What incentive does a MCO have to engage in discharge planning for an individual who has entered an IMD?

A: As a matter of general policy and program design, it is expected that the MCO will work actively toward discharge planning and the return of the individual to the most integrated setting appropriate to his or her needs. The Department will include new language in the next contract with Family Care MCOs that will require them to have a Memorandum of Understanding in place with all counties within their service areas addressing expectations for discharge planning in these situations.

Q15: Does Family Care solve the dilemma faced by many counties when they have fully expended all of their community aids, social services block grant and local funding and must provide non-Medicaid-covered court ordered services to adults?

A: No. The implementation of Family Care in any county does not resolve the existing difficulty faced by county agencies without available resources when courts order services that are not within the Family Care benefit. When all court ordered services are within the Family Care benefit, and the consumer enrolls in Family Care, the entitlement nature of Family Care means that the county bears no financial responsibility for the ordered services.

Questions about the information presented in this document may be addressed to Kathleen Luedtke, Comprehensive Systems Change Manager, at the Department of Health and Family Services by telephone at 608-267-4896 or email at luedtka@dhfs.state.wi.us.