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# Budget Briefs

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## FAMILY CARE

The biennial state budget act (1999 Wisconsin Act 9), passed by the legislature and signed by Governor Tommy Thompson on October 27, 1999, creates Family Care (FC), a new system for delivery of long-term care to Wisconsin's elderly citizens and persons with physical disabilities. The program will be piloted in 13 counties during the 1999-2001 biennium.

### BACKGROUND

Wisconsin began its redesign of long-term care (LTC) delivery in 1995. Its major objective was to screen persons with physical problems, including the elderly, and, where possible, to provide services that will permit them to remain in their homes or the community rather than being forced into institutional care. In addition, persons of working age were to receive the assistance they needed to maintain employment. A related concern was to combine state and federal funding, including Medical Assistance (MA) and the Community Options Program (COP), into a single source that would permit greater flexibility in programming. 1997 Act 27 authorized the Department of Health and Family Services (DHFS) to test parts of the proposed program. The department contracted with Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, and Trempealeau Counties and the Oneida Tribe for nine pilot projects.

### THE ACT 9 DESIGN OF FAMILY CARE

Act 9 allows DHFS to increase the number and scope of FC pilots and establishes the statutory basis for a permanent FC program. The act does not, however, set a schedule for statewide implementation. Before July 1, 2001, the areas that the department includes in its pilot programs may not encompass the residences of more than 29% of the population eligible for LTC statewide. After that, DHFS may expand the program only to areas that have been authorized and funded by the legislature.

**Resource Centers.** The single-entry point for the FC program is the resource center (RC), which provides counselling and referral services, including assessment of care needs, eligibility and cost sharing determinations, and information about the range of publicly funded LTC options. Nursing homes, community-based residential facilities (CBRFs), adult family homes, and residential care apartment complexes are required to inform prospective residents about available RC services. Hospitals are also required to refer elderly or physically disabled persons who require LTC to RCs before discharge. RCs do not have to perform financial screens for persons who finance their own care and will not be MA-eligible within six months.

**Care Management Organizations.** The second major FC component is the care management organization (CMO), which manages the LTC services on a capitated, risk-based payment system, much like health maintenance organization (HMO) coverage. CMOs may not disenroll any enrollee except under circumstances specified by DHFS, and they are prohibited from encouraging an enrollee to disenroll and switch to MA.

**Family Care Benefits.** The third component of FC programming is the Family Care benefit, which may encompass a variety of alternatives in response to consumer needs and preferences. DHFS is given considerable discretion regarding the coverage it provides under the FC

benefit. Benefits may range from sidewalk shoveling to skilled nursing home care. Presumably, COP and MA benefits, supported-living and supported-work services, nursing homes, residential care apartments, CBRFs, and adult family homes will be included among the options. Those receiving an FC benefit are required to share the costs to the extent that they are able. MA recipients have the option of obtaining MA-funded services outside the CMO on a fee-for-service basis.

**Appeals.** Appeals procedures are provided for various RC or CMO actions including denial of eligibility or entitlement, determination of cost sharing, failure to provide timely services, an unacceptable or insufficient care plan, and termination of benefits.

**Eligibility.** To be eligible for FC, persons must be 18 years of age or older, have infirmities of aging or physical disabilities, and either be financially eligible for MA or demonstrate that their projected care costs exceed their income and asset levels, as defined by law. They must be 1) in a nursing home or receiving publicly funded long-term care and have a terminal or chronic condition; or 2) found functionally eligible at one of two levels — the **comprehensive level** for persons who have long-term or irreversible conditions that are terminal or expected to last at least 90 days and require ongoing care or assistance or the **intermediate level** for persons with those conditions who are at risk of losing independence or functional capacity. (An exception to all these requirements is made for persons with developmental disabilities who live in a pilot area where a CMO is established before July 1, 2001. They are entitled to FC benefits.) Persons who are eligible for, but not entitled to, FC benefits will be placed on waiting lists if funding is insufficient.

**Entitlement.** Generally, a person is entitled to and will receive the FC benefit if he or she is 18 or older, has infirmity of aging or a physical disability, is financially eligible, fulfills any cost-sharing requirements and is also 1) functionally eligible at the comprehensive level or 2) functionally eligible at the intermediate level and MA eligible, in need of adult protective services, in a nursing home, or receiving publicly funded long-term care and has a terminal or chronic condition.

**State Council.** Act 9 creates a 15-member State Council on Long-Term Care, appointed by the governor, which will sunset on July 1, 2001, or the day after publication of the 2001 budget act, whichever is later. The council will assist DHFS in implementing and monitoring the FC program, and it will report annually to the legislature and governor.

## COUNTY ROLE IN FAMILY CARE OPERATIONS

**Family Care Governance.** Act 9 requires that RC and CMO functions within the same pilot, particularly eligibility determinations and care management, must be separated by January 1, 2000. The act provides one solution by allowing the creation of “family care districts” (special districts independent of the state and county), which are authorized to operate the RC or the CMO separately. Act 9 also requires the appointment of local long-term care councils (LTCCs) to guarantee public input regarding the pilot. LTCCs must include a majority of members who are elderly or disabled or their immediate family members or representatives.

**Protection from Competition.** The counties may operate their pilot CMOs without threat of competition until January 1, 2003. A county also will not face any competition in calendar 2003 if its CMO meets prescribed standards, but DHFS may contract with an additional organization to provide FC benefits if the county cannot provide services. Beginning in 2004, CMOs contractors will be chosen on a competitive basis, and selection will focus on quality of care, rather than the lowest bidder.