

What Will Change?

From the Medicaid Waiver Programs to Managed Long-Term Care

You are currently receiving services that are funded by a Medicaid Waiver program such as the Community Options Program (COP), the Community Integration Program (CIP), or the Brain Injury Waiver (BIW). These programs are changing as managed long term care becomes available in your area. This document provides important answers to questions about this transition and the impact it has on you.

What is managed long-term care?

Managed long-term care is the term used to describe the programs that are now available to provide the full range of long-term care services you may need. These programs are different from the program you are currently in because they coordinate in one flexible benefit all the services that you may need to maintain or improve your health and well-being. By helping you live the way you want to, while being as efficient as possible, we will be able to get more people the services they need and eliminate waiting lists for these services.

There are different types of managed long-term care programs in Wisconsin: Family Care, Family Care Partnership (also known as Partnership) and Program of All-Inclusive Care for the Elderly (also known as PACE). The Family Care program coordinates all of your long-term care services and supports that were previously available through separate programs. Your health and medical care and prescription drugs continue to be covered by Medicare and Medicaid. Partnership and PACE cover all of the long-term care services in the basic Family Care benefit package plus all of your health and medical services and your prescription drugs, all in one package. The program(s) that are available to you will depend on where you live.

Will I have the same services?

The managed long-term care benefit package includes all the services in the current Medicaid Waiver programs (CIP, COP, and BIW) and some of the services funded by your Medicaid Forward card. Managed care organizations, or MCOs, 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 support the outcomes you want to achieve through those services. This may or may not be the exact same services at the exact same level that you currently receive them. Services will NOT be randomly cut, and there are no "across the board" decisions about who gets what services. If you have changes made in your care plan, those changes should result in more personalized, more effective services for you! This is because the type of care planning that occurs in Managed Care is focused on meeting your personal, individualized outcomes. Services that are not effective in supporting your outcomes will likely be discontinued.

It is also important to remember that if your needs or outcomes change over time, your care plan can also change. You don't have to try to include services in your care plan that you don't need today, even if you may need them in the future.

Can I keep the same care manager?

It is possible that you may have a different care manager. The managed care organization(s) will be hiring qualified, professional care managers who will work closely with you to ensure that you have the support that you need to live the kind of life that you would like.

In addition, you will have at least one new member on your care team that you may not have had in the past: a nurse. In Family Care Partnership, you will also have a nurse practitioner and doctor on your team. These individuals will work with you and your care manager to ensure that you experience the best possible health and receive the best possible services.

Will I have the same providers?

This depends on whether your current providers are in the MCO "provider network" and if your care team determines that your current provider can meet your individual outcomes in a cost-effective way.

Most MCOs plan on contracting with all the providers that the county waiver programs used. In Family Care, the number of providers available to members actually grew because the program is required to have providers for all the services covered by the program and have enough in order to offer a choice of providers to its members. You might be able to 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 to you, such as personal care, the MCO must purchase services from whomever you choose as long as that person meets the MCO's requirements and accepts the MCO's payment rate.

For other services, you can choose among the providers in the MCO's provider network. However, the MCO may be able to have a more cost-effective arrangement with one provider than another. In this case, the MCO can offer the most cost-effective way to provide the necessary supports. For example, an MCO might have an arrangement with one home care provider for a daily or overnight rate for services, but contract for hourly services with another home care provider. The daily rate is almost always more economical, and the MCO can limit choice to the most cost-effective way to provide needed support.

If you are currently acting as an employer and hiring your own providers through Self-Directed Supports, you should be able to continue to do so in managed long-term care.