DRAFT: For Discussion Purposes Only

Possible Strategies to Balance Family Care MCO-Provider Relationships and Negotiating Positions

As most Family Care providers know, contract and rate negotiations between the Managed Care Organizations (MCOs) and the provider community are heavily weighted in favor of the MCO. In cases where the MCO is unwilling to pay what the provider believes is a fair reimbursement level, the provider is generally left with a "take it or leave it" offer from the MCO. If the rate is deemed unacceptable by the provider, the provider is left with either accepting the rate offered by the MCO or following actions that result in the MCO or the provider terminating the Family Care Contract. The latter option could result in the relocation of residents from their home.

The following is a draft of possible options that could be pursued with the Governor, Legislature, and the Department of Health Services (DHS). These options are offered for discussion purposes and, if supported, would need additional clarifications and drafting notes. Further, the options below are generally applicable to assisted living providers or nursing homes, although other providers also could benefit by the proposed changes.

1. **Actuarially Determined Rates:** The actuaries and DHS use the MCOs' prior year encounter data to establish a cost trend that is used to calculate the MCOs' capitation rates for the upcoming year (see: State of Wisconsin, DHS, CY 2018 Capitation Rate Development for the Family Care Program, www.dhs.wisconsin.gov/non-dhs/dms/fc-2018capitationrates.pdf, 12/19/17, pp. 13-15). The encounter data reflects only the costs incurred by MCOs; it does not reflect the actual cost increases incurred by providers. Because many (most) Family Care providers have not received rate increases from the MCOs for several years, the cost projections are thus underreported.

   Proposal: Statutorily require that the actuarially sound MCO capitation rates reflect projected provider cost increases based on generally accepted cost indices.

2. **Medical Loss Ratio (MLR):** Federal law generally set limits (MLR) on how much a large health insurance company is allowed to spend on administrative costs, marketing, and other non-health care-related costs (the MLR is 85% health care/15% administrative). In Wisconsin, the Family Care MCOs do not operate under an MLR expenditure mandate; the statewide MLR for the five MCOS is 83.7%/16.3%, with one MCO reporting a third quarter 2017 MLR of 82.9%/17.1%. www.dhs.wisconsin.gov/publications/p0/p00599-3q-17.pdf (Note: the MCO's MLR as reported above defines administrative expenses as including general administration and overhead, profit/loss and case management expenses).

   Proposal: Statutorily establish a MLR of 85%/15% for MCOs operating under the Family Care program.

3. **Direct Care Workforce Funding Increase:** The 2017-2019 State biennial budget provided over $30.3 million all funds in each of the biennium "to increase the direct care and services portion of the capitation rates to address the direct care-giver workforce challenges in the state." The entire $60.6 million is scheduled to be paid to providers by June 30, 2019.

   Proposal: Ensure the $60.6 million is continued as a separately indentified payment to providers in the next biennium. Further, specify that these workforce caregiver expenses are to be excluded from the MLR calculation as noted above.

4. **Provider and Enrollee Appeal Rights:** The recent efforts by an MCO to impose widespread assisted living rate reductions has demonstrated the provider community has little options other than the "take it, or leave it" option even when faced with steep rate cuts (see prefatory comments above). Neither the facility nor the enrollee (assisted living resident) has a right to appeal an MCO's decision to relocate the resident to another facility that is willing to accept the MCO's rates. DHS has indicated: (1) The facility has the choice of whether or not to contract with the MCO or terminate the contract; and (2) The resident only has the right to appeal an action by the MCO that eliminates a service option; since the MCO will continue to offer an assisted living option to the resident, albeit at a different facility requiring the resident to be relocated, there is no appeal right.

   Proposal: Statutorily grant facilities the right to appeal a decision by the MCO to impose provider rate reductions that are not related to acuity or service reductions (Note: Many issues to review: Would such a provision violate federal MCO regulations/law; Should the provision govern rates in effect for at least one year or more; would unintended consequences result?)

Proposal: Grant residents the statutory right to appeal attempts by the MCO to force a relocation to another assisted living facility solely due to an effort to reduce the rate paid to the a provider. The appeal right would be based on the proposed involuntary transfer of the resident.

5. **MCO Resident Assessments:** Many MCOs rely on the Long-Term Care Functional Screen (LTCFS) or some other internally developed assessment tool to assess the residents' care and service needs. These assessments, in turn, become the basis for how the MCO establishes assisted living rates offered to providers. Providers often are not able to review the data from the assessment tools collected by the MCO for residents. Therefore, providers often question if the MCO or ADRC have fully captured the actual care and service needs of each person assessed (The facility's caregivers in most every instance are able to provide a more accurate assessment than someone with limited daily interaction with the resident).

   Proposal: Require the MCOs to share the LTCFS or other assessment data for assisted living residents.

6. **Change of Condition/Level of Care:** When an assisted living resident experiences a change of condition resulting in a higher acuity level, the provider often requests the MCO for a concomitant rate adjustment. Providers often report of a less than timely response by the MCO.

   Proposal: Require MCOs to update the LTCFS or related assessment tool within 30 days of being notified by the assisted living provider of a resident's change of condition resulting in higher level of care and services.

7. **Nursing Home Medicaid Payments:** The DHS-MCO annual contract states "if the MCO can negotiate such an agreement with providers, the MCO may pay providers less than the Medicaid fee-for-service rate (see: DHS, Division of Medicaid Services - MCO Contract, 1/1/18, www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf, p. 139).

   Proposal: Delete this provision (either via agreement with DHS or by statute).

8. **Nursing Home Retroactive Rate Adjustments:** In 2017-18, some MCOs initially indicated they would not be granting retroactive nursing home rate adjustments for the July 1st rates (Nursing home Medicaid rates are never set prior to July 1st; in fact,

most nursing home rate adjustments are not known until 5 to 8 months after the start of the state fiscal year). After extensive negotiations, the DHS-MCO 2018 contract requires that "Nursing home rates must reflect the annual 2% rate increase that was included in the State's 17-19 biennial budget." (p. 140)

Proposal: Specify in statute that MCOs must grant retroactive nursing home rate increases that are provided under the Medicaid fee-for-service system.

9. **Resident Relocations-- Distance Restrictions:** MCOs seeking to relocate a resident from one assisted living facility to another face no restrictions regarding how far the resident may be relocated from their current home.

   Proposal: Whenever an MCO seeks to relocate an assisted living resident to another facility (after appeals are exhausted and notice has been given) because the MCO-Provider contract is terminated due to the provider's unwillingness to accept a rate cut, limit the relocation to an assisted living facility that is no more than 30 miles from the resident's current assisted living facility. If the assisted living resident has a community spouse, limit the relocation to no more than 10 miles from the community spouse's residence.

10. **Family Care MCO Audit/Report**: The Legislature has not received a Family Care report from the Legislative Audit Bureau since 2011.

    Proposal: Require the Legislative Audit Bureau to report to the Legislature on the Family Care capitation rate setting methodology and process utilized to establish MCO actuarily sound rates and the rates passed on the provider community. Further, require the report to address how the rates reflect the actual costs incurred by the MCO and the providers and what projections are specifically used to estimate future cost increases that will be incurred to provide care and service to the Family Care members. (Note: See Option 1)