LeadingAge™ Wisconsin
Better Services for Better Aging

June 26, 2019

Division of Medicaid Services
Bureau of Adult Programs and Policy
Attn: Family Care 1915(c) Waiver Renewal
PO Box 309
Madison, WI 53701-0309
dhsfcwebmail@wisconsin.gov

To: Division of Medicaid Services
From: John Sauer, President/CEO, LeadingAge Wisconsin

Thank you for the opportunity to comment on the State of Wisconsin, Department of Health Services (DHS) renewal of the 1915(c) Family Care waivers. LeadingAge Wisconsin is a statewide association representing non-for-profit and for-profit nursing homes, assisted living facilities and other community-based providers in Wisconsin. In total, the Association represents over 500 nursing home, assisted living, senior housing, and other community-based providers who serve elderly persons and individuals with a disability throughout the state. A large percentage of our members serve Medicaid waiver clients. The following comments pertain to changes in the room and board (R&B) methodology proposed by DHS in its waiver renewal document.

Family Care is structured as a managed care program – the state contracts with managed care organizations (MCOs) and pays them a capitated rate to serve persons who qualify functionally and financially for services. In turn the MCOs contract with individuals and entities to provide home and community-based services. For persons needing assisted living, MCOs negotiate with providers to establish a daily rate to serve persons needing this level of service. Yet for many AL providers, the process of establishing rates with an MCO rarely involves any degree of negotiation as the process most MCOs use to determine member specific rates is, at best, murky.

To provide a level of transparency in the negotiation process, LeadingAge Wisconsin offers the following comments pertaining to the 1915(c) waiver renewal (Our

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Association has provided direct feedback to DHS on these recommendations). We ask that the waiver be modified to require:

1. DHS annually publish the SSI-E, FoodShare (SNAP), and county-specific HUD rates.

2. DHS define the methodology MCOs will use to determine the member's obligation for room and board related costs.

3. Upon request of an AL provider, an MCO must disclose the member's personal obligation for room and board related costs and the amount, if any, the member is paying to cover the cost of care and support. The disclosure must be timely and in advance of any final rate settlement.

4. MCOs must fully disclose to AL providers the process and methodology they use to determine rates associated with care and support. MCOs be required to provide, upon request, member specific data and information used to determine/calculate the MCO offered rate. The disclosure must be timely and in advance of any final rate settlement.

Additionally, LeadingAge Wisconsin is resubmitting comments previously sent to DHS in September and October of 2018 seeking further changes to the Family Care program. Those comments are attached to this email. Our hope is that we will be provided further opportunity to discuss the need for these changes with DHS.

Should you have any questions or need further information on our recommendations and requested changes, please do not hesitate to contact me at 608-255-7060 or jsauer@leadingagewi.org.

Thank you.

Summary highlights of LeadingAge Wisconsin's comments on the Family Care Waiver Renewal June 26, 2019

Room and Board Payments: Effective February 1, 2021, the Family Care waiver renewal will change how DHS and MCOs determine the enrollee's personal obligation to pay for their assisted living room and board costs. The MCOs reportedly would be free to pay the AL facilities a room and board amount that may be different (likely lower) than what is collected from the enrollee. This could result in providers having to "negotiate" an all-inclusive rate with the MCO (That is, the rate would be for both room and board, *and* care and services). We ask that the waiver require:

1. DHS annually publish the SSI-E, FoodShare (SNAP), and county-specific HUD rates.
2. DHS define the methodology MCOs will use to determine the member's obligation for room and board related costs.
3. Upon request of an AL provider, an MCO must disclose the member's personal obligation for room and board related costs and the amount, if any, the member is paying to cover the cost of care and support. The disclosure must be timely and in advance of any final rate settlement.
4. MCOs must fully disclose to AL providers the process and methodology they use to determine rates associated with care and support. MCOs be required to provide, upon request, member specific data and information used to determine/calculate the MCO offered rate. The disclosure must be timely and in advance of any final rate settlement.

Actuarially Determined Rates: Because the MCOs and DHS have little, if any, data on *providers' actual cost and annual expenditure increases*, the "cost projections" used by the actuaries are underreported. We ask that the federal waiver require the actuarially sound MCO capitation rates reflect projected provider cost increases based on generally accepted cost data and indices.

Medical Loss Ratio (MLR): We proposed that the Family Care waiver establish a mandatory MLR of 85%/15% for MCOs operating under the Family Care program and that all Direct Care Workforce Funding be excluded when calculating the MLR.

Resident Rights and Participant Safeguards: The waiver should require that DHS be notified by the MCO whenever an involuntary discharge from a residential setting is triggered by an MCO's reduction of provider's established reimbursement rate. A resident should have the right to file a grievance and appeal an MCO's action seeking to relocate the resident from her home because the provider is unwilling to accept a

reimbursement rate cut imposed by the MCO. This right should be extended to members even if the MCO is not seeking to terminate a benefit (i.e., assisted living) but is forcing a relocation to another residential setting willing to accept a lower reimbursement rate. Further, DHS should limit any necessary relocation to an assisted living facility to one of close proximity to the resident's current assisted living facility.

Access to Family Care Coverage: The waiver should ensure that providers awaiting DHS' determination of compliance with the federal home and community-based waiver may receive Family Care funding from the MCO, with DHS approval.

MCO Resident Assessments: We ask that the federal waiver require the MCOs to share the Long-Term Care Functional Screen (LTCFS) or other assessment data in order to ensure both the MCOs' and providers' plans of care fully reflect the care and service needs of the residents. Further, the waiver should specify the MCOs are required 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.

Assisted Living Care Management Teams: We ask that the waiver be written in a manner that authorizes the AL care managers to assume the central role in developing and ensuring the residents' care plans are written and followed according to the resident's needs and wishes. While ultimate care management oversight responsibilities could be retained by the MCO staff, we believe resident care management assessment and daily care plan implementation should be a responsibility of the AL staff and the AL should be paid to perform these functions. (Note attempting to address the federal requirement related to "conflict-free care management." See: https://www.medicaid.gov/medicaid/hcbs/downloads/training/conflict-of-interest-hcbs-case-management-july2018.pdf and https://www.leadingage.org/members/conflict-free-case-management-and-adult-day-services)

Dual Eligibles and Alternatives to PACE: We propose that DHS secure a Federal waiver to pool or consolidate Medicare and Medicaid funding and authorize provider-base long-term care organizations to provide care management services to dual eligible individuals. Under this pilot, the organization would be responsible for care management of all acute, primary and long-term care and services. Individuals served under the pilot would be residents and clients residing at the organizations' campus-based locations, including those living in nursing facilities, assisted living facilities and senior housing settings. These persons would not be Family Care members under the MCOs' purview and there would be no capitation of rates or immediate risk-sharing by providers. This structure could avoid "conflict-free care management" restrictions. We are also talking with DHS about a provide-led Partnership program.

Employment Incentives/Health Insurance Coverage: We ask DHS to pursue options under which caregivers receiving BadgerCare benefits would be encouraged to work additional hours without fear of losing their Medicaid-funded health care coverage.

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October 10, 2018

Family Care Waiver Renewal Comments
DHS/DMS/BAPP - Room 518
PO Box 309
Madison, WI 53701-0309
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To: Department of Health Services, Medicaid Waiver Renewal Comments
From: John Sauer, President/CEO, LeadingAge Wisconsin

Subject: DHS Request: Family Care Waiver Ideas

The Department of Health Services (DHS) recently invited LeadingAge Wisconsin to submit ideas about aspects of the Family Care and Family Care Partnership programs that it would like to see added, removed, or changed. To that end, we respectfully submit the following proposals which we believe will improve the quality of care and services available under the Family Care program. Rather, than inundate DHS will details on each suggested item, our goal in submitting this document is to be extended the opportunity to meet with DHS officials to address the merits of the proposals delineated below.

Items for Consideration

- **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 the MCOs and DHS have little, if any, data on *providers' actual cost and annual expenditure increases*, the "cost projections" used by the actuaries are underreported. We ask that the federal waiver require the actuarially sound MCO capitation rates reflect projected provider cost increases based on generally accepted cost data and indices.

- **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 the MLR expenditure mandate;

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the five MCOs under Family Care have a statewide average MLR ratio of 84.4%/15.6%, with one MCO having care and service expenses at 81.8% (Note: the MCOs' MLR as reported defines administrative expenses as including general administration and overhead, profit/loss and case management expenses). We proposed that the Family Care waiver establish a mandatory MLR of 85%/15% for MCOs operating under the Family Care program. Further we propose that the Direct Care Workforce Funding (Budgeted at $60.6 million in 2017-19) be excluded when calculating the MLR. These dollars are passed through to providers and should not be used to overrepresent the percentage of the capitation rate used for care and services.

- **Resident Rights and Participant Safeguards:** The waiver should require that DHS be notified by the MCO whenever an involuntary discharge from a residential setting is triggered by an MCO's reduction of provider's established reimbursement rate. This reporting requirement will help protect the rights of the member and ensure DHS is aware of the MCO's intent to cut provider rates.

  We ask that the waiver emphasize that members have the right to choose from at least two MCOs, whenever possible. The waiver should allow members in rural areas with only one MCO to grieve/appeal actions by the MCO that deny a member's right to obtain out of network services.

  The waiver also should require the MCO to establish a provider network that assures reasonable access to care and services. We wish to avoid situations in which a member is required by the MCO to be placed in or relocated to a residential setting located several miles from their current home. 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. This right should be extended to members even if the MCO is not seeking to terminate a benefit (i.e., assisted living) but is forcing a relocation to another residential setting willing to accept a lower reimbursement rate.

  Under the waiver, when a member files a grievance or appeal of an MCO's decision to relocate the member from one residential setting to another, the relocation should be held in abeyance pending resolution of the matter.

  The waiver should ensure that providers awaiting DHS' determination of compliance with the federal home and community-based waiver may receive Family Care funding from the MCO. In addition, we ask that the waiver include proposed 2019 contract language requiring the MCO "to comply with the DHS transition of care policy to ensure members transitioning to the MCO from FFS Medicaid or transitioning from one MCO to another have continued access to services if the member, in the absence of continued services,

would suffer serious detriment to their health or be at risk of hospitalization or institutionalization."

- **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). We ask that the federal waiver require the MCOs to share the LTCFS or other assessment data in order to ensure both the MCOs' and providers' plans of care fully reflect the care and service needs of the residents. Further, the waiver should specify the MCOs are required 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.

- **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). We ask that the waiver prohibit the MCO from paying providers a rate less than the applicable fee-for-service rate. Further, we ask that the waiver require MCOs to grant retroactive nursing home rate increases that are provided under the Medicaid fee-for-service system.

- **Assisted Living Care Management Teams:** We ask that the waiver be written in a manner that authorizes the AL care managers to assume the central role in developing and ensuring the residents' care plans are written and followed according to the resident's needs and wishes. While ultimate care management oversight responsibilities could be retained by the MCO staff, we believe resident care management assessment and daily care plan implementation should be a responsibility of the AL staff and the AL should be paid to perform these functions.

- **In Lieu of Services**: The waiver should allow MCOs to cover assisted living room and board payments for members with insufficient resources, if doing so is a cost-effective option to relocation to a higher-cost setting.

- **Dual Eligibles and Alternatives to PACE:** We propose that DHS secure a Federal waiver to pool or consolidate Medicare and Medicaid funding and authorize provider-base long-term care organizations to provide care management services to dual eligible individuals. Under this pilot, the organization would be responsible for care management of all acute, primary and long-term care and services. Individuals served under the pilot would be residents and clients residing at the organizations' campus-based locations, including those living in nursing facilities, assisted living facilities and senior housing settings. These persons would not be Family Care members under the MCOs' purview and there would be no capitation of rates or immediate risk-sharing by providers.

It is proposed that 3 to 5 organizations located in relatively close proximity to each other be allowed to participate in the Provider-Based Care Management (PBCM) pilot. This would be necessary to achieve the population size required to implement an effective pilot. In essence, the PBCM would operate like an Accountable Care Organization, with gain-sharing opportunities provided. If the PBCM operators successfully managed their residents' care cost-effectively and with desirable outcomes, DHS would share the combined Medicare-Medicaid savings with the providers. The idea is to test whether campus-based providers can effectively managed care and services, without the overhead expenses and complexity associated with MCOs.

- **Employment Incentives/Health Insurance Coverage:** While perhaps beyond the scope of the Family Care waiver renewal, we ask DHS to pursue options under which caregivers receiving BadgerCare benefits would be encouraged to work additional hours without fear of losing their Medicaid-funded health care coverage. Allowing caregivers to take on additional hours and still receive BadgerCare benefits would help address the direct care workforce coverage facing all long-term care providers.

We very much appreciate the opportunity to submit our comments on the Family Care waivers and look forward to discussing our proposals with the Department. Should you have any questions or comments on these issues, please do not hesitate to contact me at 608-255-7060 or jsauer@leadingagewi.org.

Thank You.

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September 28, 2018

Nate Vercauteren, Program & Policy Analyst - Advanced
Family Care Policy and Federal Relations
Bureau of Adult Long Term Care Services
State of Wisconsin Department of Health Services
1 West Wilson Street, Room 527
Madison, WI 53703

Hannah Cruckson, Project Coordinator
Long Term Care Benefits and Programs
Division of Medicaid Services Administrator's Office
1 West Wilson Street, Room 550
Madison, WI 53703

Dear Mr. Vercauteren and Ms. Cruckson:

Thank you for the opportunity to comment on the proposed Family Care contract and Grievances and Appeals documents. We have reviewed these documents and look forward to discussing them at the November 11, 2018 meeting of the Department of Health Services (DHS) Long-Term Care Advisory Council to learn more about the intent and application of the various proposed provisions.

With that said, we do wish to offer a few observations and comments on each document:

Proposed Contract Changes Amendment 1.1.19

- Article VIII. J. 1. A. ii (page 3): The proposed change would delete the provision that requires the MCO to notify DHS when: "A community residential care provider reports to the MCO that an MCO member has or will be involuntarily discharged." We strongly encourage DHS to retain this provision. DHS should be notified by the MCO whenever an involuntary discharge from a residential setting is triggered by an MCO's reduction of provider's established reimbursement rate. This reporting requirement will help protect the rights of the member (enrollee) and ensure DHS is aware of the MCO's intent to cut provider rates.

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- Article VIII. G. iii. (Page 4): We support the added language to ensure that providers awaiting DHS' determination of compliance with the federal home and community-based waiver may received Family Care funding from the MCO.

- Article VIII. Provider Network, I. Access to Providers/Monitoring Access to Services (Pages 7-9): The proposed language would make several changes to the contract which appear to weaken the requirement that MCOs verify the adequacy of its provider network. We do not support deleting these provisions. For example, the proposed changes would **delete** provisions requiring the MCO to annually report to DHS the following information:
    - The geographic location of providers and MCO members, considering distance, travel time, the means of transportation ordinarily used by MCO members, and whether the location provides physical access for members with disabilities.
    - The MCO shall develop standards for geographic access and timeliness of access to services in the benefit package and monitor the performance of providers in relation to those standards.
    - Evidence of adequate service capacity to serve the MCO membership including: Submission of a provider network listing for all services in the benefit package….
    - Evidence of adequate capacity for residential care…

  Although other suggested contract provisions could possibly mitigate the impact of removing the above provisions, as a whole, it would appear the proposed language would ease the requirement that the MCO establish a provider network intended to assure reasonable access to care and services. We wish to avoid situations in which a member is required by the MCO to be placed in or relocated to a residential setting located several miles from their current home.

- Article VIII. D. Provider Agreement Language, 27. Prohibited Practice (Page 11): The proposed language states that "Marketing/outreach activities as described in Article IX. Section A.5. a-g, page 151, are prohibited." We believe this provision warrants additional discussion to better understand DHS' intent. Our goal is to preserve providers' right to communicate issues with members related to Family Care contracts and MCO decisions that could impact continued stay in a residential setting.

- C. Monitoring, Coordination, Transition of Care, Discrimination and Dates; Transitions of Care (Pages 11-12): The Association strongly supports inclusion of the proposed language stating: The MCO shall comply with the Department's transition of care policy to ensure that members transitioning to the MCO from FFS Medicaid or transitioning from one MCO to another have continued access to services if the member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or

institutionalization." The language is essential to preserving the health and well-being of the member.

- Article XVI. Mediciad Deductibles or Cost Share (Page 15): These provisions establish a process to determine if the MCO or the nursing homes is responsible for collection of a member's patient liability. The provision states the entity that first initiates the transaction is responsible. While this process may prove acceptable, we suggest nursing home billers and MCO staff be granted additional time to determine the provision's workability.

- Article VII. A. 8. In Lieu of Services (Page 17): We seek clarification on how the "in lieu of" provisions might be able to ensure assisted living room and board payments for members with insufficient resources.

- Article III. D5 (Page 17): We support the provision requiring the MCO to assist members with Medicare coverage choices, including Medicare Advantage Plan election periods.

Grievances and Appeals

Our prefatory comment related to the review of this document is that we would benefit greatly from the opportunity to directly discuss with DHS the proposed grievance and appeals processes and related timeframes modifications. Overall, it appears the proposed changes would provide added protections for members and, therefore, we are generally supportive of these modifications.

- XI. B Definitions. Adverse benefit determination (Pages 1-2 and related provisions contained throughout the document): We support the members' right to pursue grievances and file appeals for denials or limited authorizations, including "requirements for medical necessity, appropriateness, *setting* or effectiveness of a covered benefit." (emphasis added) Of great importance to the provider community is establishing the right of the member to file a grievance and appeal MCO determinations and actions when the MCO seeks to relocate the resident from her home because the provider is unwilling to accept a reimbursement rate cut imposed by the MCO. We ask that the contract be clarified to assure these protections for the member. This right should be extended to members even if the MCO is not seeking to terminate a benefit (i.e., assisted living) but is forcing a relocation to another residential setting willing to accept a lower reimbursement rate. We further ask that Article XI. B1. b. i. be deleted so that a member could appeal an unwelcomed "change in provider." In addition, we want to ensure the right to file a grievance and an appeal process for members that may be denied a Medicare covered and necessary service (e.g., physical therapy) while residing in a nursing facility.

- XI. B Definitions. Rural Areas/Disenrollment (Page 2 and throughout the document): The proposed change would allow members in rural areas with only one MCO to grieve/appeal actions by the MCO that deny a member's right to obtain out of network services. Other provisions would allow the member to grieve/appeal the involuntary disenrollment of the member from the MCO. We support these proposed changes and encourage DHS to consider adding these protections statewide.

- Other general provisions: We support the proposed added language: Requiring the MCO to continue a member's benefits even if a previously authorized time period or service limit is reached during the course of the appeal process; Ensuring that the MCO grievance and appeal committee is comprised of individuals who were not involved in any previous level of review or decision making and the language adding that a subordinate of such an individual may also not be a part of the grievance and appeal committee; and requiring the grievance and appeal decisionmakers to take into account all comments, documents, records, and other information submitted by the member or the member's legal representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

- Timeframes: The document would make several changes to the timeframes under the grievance and appeals processes. In general, the timeframes appear to be extended, giving the member additional time to file a grievance/appeal and allowing more time for the MCO and others to make decisions on these matters. We look forward to learning more about why these timeframes are proposed to change. One change that should be considered: If the contested issue involves a grievance or appeal of an MCO's decision to relocate the member from one residential setting to another, the relocation should be held in abeyance pending resolution of the matter.

Again, thank you for the opportunity to review the Proposed Contract Changes Amendment and the Grievance and Appeals documents. We ask that you consider modifying the proposed DHS contract changes as we have suggested above. Should you have any comments or questions on our suggested changes, please do not hesitate to contact me at 608-255-7060 or jsauer@leadinagewi.org.

I look forward to discussing these provisions and the DHS' recommendations at the November 11th meeting of the Advisory Counsel.

Sincerely,

John Sauer
President/CEO

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)