MCO-Provider (LeadingAge Wisconsin)
Family Care Operations Workgroup
November 14, 2016
DeForest, WI

1. **Issue: Names and Contact Information--** LeadingAge Wisconsin Recommendation: Each MCO should be required to share with their providers the names and contact information for members of the MCO's care management teams. Sharing this information would greatly improve MCO-Provider communications.

   Workgroup Response: It is the expectation that the MCOs will keep the provider informed of each member's (Family Care enrollee) care manager (team/IDT) and create a process to update this contact information. An acknowledged best practice is for the MCO to notify the provider at the same time it notifies the member of a change in her/his assigned care manager. This notification is frequently done via electronic communication. MCOs should also make available to the provider the contact information of the case manager's immediate supervisor.

2. **Issue: Care Management Assignments**-- LeadingAge Wisconsin Recommendation: MCOs should assign only 1 or 2 care management teams to a facility. Consistent assignment of a care management team to a particular facility would help build stronger relationships and improve communications between the team and the residents and staff of the facility. Assignment of multiple care management teams to a single facility is inefficient, costly and confusing to all parties.

   Workgroup Response: MCOs and providers acknowledge that it may be difficult to assign only a few care management teams to a single facility in situations where: (a) the member has an established relationship with a care manager prior to being admitted to the facility; (b) the member's stay at the facility is expected to be relatively short; or (c) the MCO has experienced a significant increase in member enrollment. Further, more than one or two care managers may be assigned to a facility because of a need for particular skill set that may not be present with the currently-assigned care managers (e.g., bilingual services or behavioral management skills). Many MCOs prefer to have two care management teams for each facility for their own quality assurance systems.

   It was agreed, however, that the MCOs should make every reasonable effort to narrow the number of care managers assigned to a single facility. Generally speaking, "fewer is better."

3. **Issue: Reasonable Expectation and Communications--** LeadingAge Wisconsin Recommendation: MCO care management teams should articulate in advance their reasonable expectations of the facility regarding access to information, residents and staff. Providing a written statement on MCO expectations would help the facility staff

more efficiently use its limited resources when addressing the needs of the care management team.

Workgroup Response: The Workgroup generally agreed that, excluding issues related to provider payments for care and services, much of the tension between the MCOs and the provider community could be better addressed through improved communications. The following points were made:

- The MCO-DHS contract requires care managers to meet face-to-face with the member at least quarterly and for the six-month and annual reviews. Outside of these meetings, care manager-member contacts may be accomplished via telephone.
- Facility visits by care managers related to annual member reviews or care conferences should be scheduled and announced in advance (the exception may be visits conducted in response to a member complaint or follow-up to documented care concerns or visits that do not require facility staff time).
- Care managers should notify the facility in advance what member information should be available at the in-facility meeting and, to the extent possible, the MCO and facility care conferences should be coordinated by each party to avoid redundant meetings and improve efficiencies. The MCO and provider should be fully aware of the staff (disciplines) that are requested to be present at the meeting.
- The best practice is for the facility to provide care managers electronic access to the member's care plan; producing extensive resident-related paper reports is most often unnecessary and not recommended due to storage and security concerns.
- Care managers should immediately inform the facility staff upon entering the facility. Facilities should inform the MCO of the facility's "check-in" process (this may be particularly important for assisted living facilities which often do not have a "front desk"). Also, care managers should inform the facility when they have concluded their visit and are leaving the building. The exception to this "check-in, check-out policy" is when the member requests confidentiality or the nature of the visit precludes advance notice by the MCO.
- MCOs should provide their Case Management contact listing to providers. Also, providers can call the MCO main number to obtain the contact information of a care manager's supervisor.
- Identified care and services issues are best addressed by the facility, MCO and the member. The best practice is to timely, directly and cooperatively confront these issues. Care managers are expected to work with the provider to address quality issues before contacting DQA, except in the most serious circumstances where regulatory expectations supersede.
- MCO and providers propose meeting with DHS representatives (DQA and DLTC) to discuss the MCOs' contractual obligations to review and respond to DQA-issued Statements of Deficiencies (SODs). In some instances, providers are required to report incidents to the MCO that are not considered reportable to DQA or, conversely, are already being reported to and investigated by DQA. In

either case, MCOs and providers are concerned about redundant or unnecessary reporting requirements and the resources required to address these contractual obligations. DHS should be asked to clarify its reporting expectations and to evaluate the cost and need for duplicative systems.

- An MCO's response to provider concerns related to level and scope of care/services identified at a member's care conference will be addressed on a timely basis, or at a minimum per contract expectations: 72 hours for immediate health and safety focus, or within 14 days if provider is making a request on behalf of the member.

4. **Issue: LTC Functional Screen Input**-- LeadingAge Wisconsin Recommendation: For persons who already reside in an assisted living or nursing facility and are seeking to enroll in Family Care, the Aging and Disability Resource Centers (ADRC) should be required to contact the facility (assisted living or nursing facility) to assist the ADRC in completing the person's Long-Term Care Functional Screen (LTCFS). Failure to utilize the facility's direct knowledge of the resident's care and service needs often results in an inaccurate resident assessment.

   Workgroup Response: It was noted the MCOs have no input on the completion of the LTCFS before a person is enrolled in Family Care; this is the sole responsibility of the ADRC. Although ADRCs are required by DHS to ask the direct care provider for input (consider the provider's resident assessment and care plan) as it completes and submits a prospective enrollee's LTCFS, that requirement quite often is unmet. Once the person is deemed eligible for Family Care, the ADRC and MCO may meet to review possible LTCFS discrepancies. Since the Screen is used by DHS as the basis of the MCOs' capitation rates (and then used by many MCOs to set provider payment rates), the MCOs are interested in ensuring the initial Screen accurately captures the person's care and services needs. The Workgroup recommends that the ADRCs, MCOs and providers meet to review how the providers' first-hand knowledge of the members' needs are captured by the screeners and fully reflected in the LTCFS.

   After the LTCFS is completed by the ADRC, and the member has enrolled, the MCO is responsible for updates based on the members' changing needs and conditions. The MCOs will share their members' screen with the providers upon request and if permission to share the screen results is granted by the member.

5. **Issue: Prior Authorizations**-- LeadingAge Wisconsin Recommendation: DHS should review the MCOs' prior authorization (PA) requirements and procedures to ensure the MCOs have in place an accurate, transparent and verifiable process, thereby avoiding the need for providers to resubmit PA requests and documentation (the Lakeland Care District MCO reportedly has an excellent PA process).

   Workgroup Response: The Workgroup agreed that prior authorization concerns are somewhat isolated and should be addressed outside the Workgroup's activities. Several provider representatives did express concerns that verbal PAs from their MCOs

were not followed by written PAs, which the MCO representatives stated should be standard practice. Also, providers should have their own tracking process for tracking requests for authorization.

6. **Issue: Claims Processing**-- LeadingAge Wisconsin Recommendation: DHS and the applicable MCOs should review the claims processing performance of WPS, the company that reportedly processes claims for 5 of the eight MCOs. Attendees noted WPS often will provide only partial payment for services provided to a resident with little explanation or documentation. Reportedly, WPS will offset provider claims to reflect adjusted charges/payments for other Family Care residents served by the facility, without any written basis for these adjustments.

   Workgroup Response: It was generally agreed both by the MCOs and providers that the WPS claims processing system is in need of significant improvement. The process of reconciling claims and payments is extremely difficult to complete and providers are unnecessarily forced to expend scarce staff resources to secure reimbursements for care/services. Providers recommended claims be submitted and paid using an "umbrella code" to allow claims for a member to be paid under a consolidated claim, not according to each type of service that is provided (e.g., speech, occupational and physical therapies) as is done when providers bill Medicare. The MCO representatives agreed to take these concerns to their leadership for further review and consideration.

7. **Issue: Disenrollment and Medicaid Payments--** LeadingAge Wisconsin Recommendation: DHS should review why there sometimes is a gap between the time a nursing home resident chooses to disenroll from Family Care and when the Medicaid fee-for-service payments begin for this resident.

   Workgroup Response: The sense of the Workgroup is that disenrollment of a member from the Family Care program should not cause a delay in Medicaid nursing home payments for this individual (Medicaid eligibility is already verified because Family Care enrollment is the same). The providers will gather more information on when Medicaid payment delays might occur for these individuals. It was unclear if a delay could result from mid-month disenrollments and "patient share" payments that occur at the first of the month.

November 29, 2016