State of Wisconsin - Department of Health Services - Division of Medicaid Services
Family Care | Partnership | PACE Technical Assistance Series
P-01048-10-06
Revised: 02/2024, 11/2011, 4/2011; Issued: 7/21/2010

Technical Assistance for When a Residential Provider Rate Change or Termination in Contract Results in a Move for a Member

Purpose: This document gives direction to managed care organizations (MCOs) when an impasse in rate negotiations with a residential provider results in the provider declining to serve a member, and the member needing to relocate.

I. Introduction

Some members require the support of an adult family home (AFH), community-based residential facility (CBRF), or residential care apartment complex (RCAC). In those situations, the MCO must assure these residential settings provide services that adequately support the member's needs and long-term care outcomes, as identified in the individual's member-centered plan.

MCOs negotiate rates and contracts with residential providers. The Wisconsin Department of Health Services (DHS) recognizes that, in some instances, residential providers may be unwilling or unable to contract at a rate the MCO determines is adequate to support a member. When the MCO and provider reach an impasse in rate negotiations, the member will need to relocate to a new home or residential setting.

Take note that moves may occur due to an MCO's proposal to change a future resident rate, or due to a provider's decision to no longer accept the MCO's rate. This technical assistance document addresses both situations.

II. General Overview of DHS Review

A residential move is a significant event for the member. The MCO must assure the member and/or legal decision maker are informed of the potential need for relocation as soon as the MCO recognizes the situation, but no less than 30 days before the move. MCOs must provide early notification and ongoing communication with the DHS oversight team (OST) to assure collaboration throughout the process with members, providers, and advocates for a smooth transition for any member who needs to relocate.

III. Process When the MCO Will Conduct Residential Provider Rate Realignments

A. Member communication and notification requirements

1. Interdisciplinary team (IDT) staff must maintain initial and ongoing (via phone or face to face) communication with the member/legal decision maker throughout the relocation process. Initial discussions must explain that:
   a. The MCO and residential provider have failed to reach an agreement in rate negotiations.
   b. The MCO will provide other possible residential options for the member/legal decision maker's consideration.
   c. The IDT will continue to support the member's choices and long-term care outcomes with appropriate services.
   d. IDT staff will assure that the member/legal decision maker is a full participant in identifying and choosing other residential options.
   e. IDT staff will make it clear to the member/legal decision maker that the member will not be forced to move from the current residence until a new residential location is secured, even if finding new services takes longer than 30 days.

2. DHS approved written notification must be provided to the member/legal decision maker to include the information in A.1., as well as:
   a. The date IDT staff spoke with the member/legal decision maker regarding the potential need to relocate.
   b. A statement acknowledging that a move is a significant event for the member.
   c. A statement identifying that the current residential provider is required to send the member a discharge notice at least 30 days before any termination of the placement.
   d. A description of resources for additional assistance including contact information for the MCO's member rights specialist (MRS), independent advocacy organizations (for example, Board on Aging and Long Term Care and Disability Rights Wisconsin), and the Division of Quality Assurance.
   e. Information on how to request a hearing before the Department of Administration, Division of Hearings and Appeals if the new member-centered plan requires the member to live in a place that is unacceptable to the member.

B. The MCO will provide the following written information to the OST

1. The provider information.
2. The number of members affected.
3. A draft of the notice the MCO intends to send to the current residential provider.
4. A draft of the letter the MCO intends to send to members of the potential need to move.
5. MCO transition plan: this transition plan is to be updated weekly on a spreadsheet to reflect the progress of each member's relocation plan, and the OST will evaluate the spreadsheet each week. The transition plan will include:
   a. Member's name
   b. Legal decision maker's name, when applicable
   c. County of responsibility
   d. Member's target group
   e. Type of current facility
   f. All options being considered
   g. Indication whether the member is protectively placed

h. Indication whether the member has a risk plan, approved restrictive measure, and/or behavior support plan
i. Identification of challenges or special needs to consider for next placement
j. Any additional comments, concerns, or issues
k. The name, facility type, and address of new home that member will be moving to
l. The planned date to move
m. Identified dates for the 14 day and 30-day post-relocation visits
n. Status summary of both the 14 day and 30-day post-relocation visits
o. If applicable, notice and date of disenrollment from the MCO

C. Communication plans

1. Upon receipt of the MCO's written documentation, the OST will establish reoccurring meetings between the MCO and OST to discuss progress pre- and post-member move. If the Chapter 50 Resident Relocation process is initiated, the MCO shall participate in the state resident relocation team meetings. See below.
2. Meetings will include review of the initial information from the MCO and ongoing updates regarding:
   a. An explanation on how the MCO is assuring the health and safety needs of each resident.
   b. Transition planning and indication that the new residential provider will adequately support the member's long-term care outcomes.
   c. Evidence that the member/legal decision maker has been appropriately involved in choosing a new residential setting.

D. Discharge planning with current and new residential provider and member/legal decision maker

1. The MCO will assure the member's preferences and long-term care outcomes are identified and supported from one provider to the next.
2. The MCO will mitigate, to the extent possible, relocation stress syndrome and transfer trauma. (See information about relocation stress syndrome and transfer trauma in the Chapter 50 Resident Relocation Manual https://www.dhs.wisconsin.gov/relocation/index.htm and incorporate suggestions into the planning and moving process for each resident.)

E. Post-relocation review

1. IDT staff will meet with the member/legal decision maker in the new residential setting at 14 and 30 days after the move to ensure the member is adjusting to the new living arrangement. The MCO should continue to monitor for relocation stress syndrome.
2. Upon DHS request the MCO will:
   a. Provide updates to the OST following the 14-day and 30-day post-relocation visits regarding member transition, changes in condition, or signs of relocation stress syndrome.
   b. Notify OST of any care plan changes and add to the weekly updates.

F. Determine the number of members affected

1. If less than five residents are affected, the MCO will provide the following information to the OST:

a. The reason the provider indicated it will no longer accept the MCO's contracted rate.
b. A copy of the provider's 30-Day notice sent to the MCO.
c. Follow the rest of the process outlined above in section III for "When the MCO Will Conduct Residential Provider Rate Realignments."

2. If five or more members will have to relocate from one location, the provider must submit a Chapter 50 resident relocation plan to DHS before any relocation activities may take place. The MCO shall:
   a. Notify the OST immediately to communicate this relocation to the DHS relocation coordinator.
   b. Provide the OST with the reason the provider indicated it will no longer accept the MCO's contracted rate.
   c. Follow the process for "Chapter 50 Resident Relocations" below.

IV. Chapter 50 Resident Relocation Process

Chapter 50 of the Wisconsin State Statutes applies when a community-based residential facility, skilled nursing facility, or facility serving people with developmental disabilities is closing, changing its type or level of services, or changing its means of reimbursement accepted and will relocate at least five residents.

A provider must submit a resident relocation plan to DHS for approval prior to any relocation activities taking place. (Note: Refer to the Resident Relocation Manual for the plan requirements and submission instructions.) Once the relocation plan is approved by DHS, the date of closure, change of type or level of services, or change of means of reimbursement accepted may not be earlier than 90 days from the date of approval if 5-50 residents will be relocated or 120 days from the date of approval if more than 50 residents will be relocated.

Once a facility resident relocation plan is approved, a relocation team will be established by the state relocation coordinator.

A. The MCO shall:
   1. Verify with the OST that the provider has an approved resident relocation plan before any relocation activities occur.
   2. If occurring because the provider will no longer accept the MCO's contracted rate, also provide documentation listed above: "When A Provider Decides to No Longer Accept the MCO's Current Rate" (B)(1-5)(a-n).
   3. Actively participate on the relocation team by attending regularly scheduled relocation team meetings.
   4. Work in conjunction with the provider to develop a relocation plan for the resident by:
      a. Convening an initial relocation planning meeting with each resident, to also include facility staff, and decision-maker/family to develop a relocation plan that describes what steps will be taken to assist the member in exploring options for alternate living arrangements (including referrals, tours, exchanges of information, and assessments).
      b. Making referrals, arranging assessments and tours in conjunction with providers, and exchanging information as appropriate.

c. Convening a discharge planning meeting once a new residence is selected by the member. This will include the resident, decision-maker/family, and service providers, including the new provider, to develop a discharge plan that details the final steps to be taken to safely relocate and support the member during transfer.
d. Making follow-up calls and visits to assure the success of the relocation and to work out any problems or issues that may be occurring in the new setting.

5. Provide updates to the relocation team during relocation team meetings, including all of the above information as well as dates of meetings, list of items or issues important to the member or guardian, planning progress, and whether the IDT staff is seeing signs or symptoms of relocation stress syndrome.
6. Complete a 14-day and 30-day post-move staffing at the new residence to discuss the member's adjustment status, changes in condition, or signs of relocation stress syndrome.
7. If indicated, provide a 30-day post-move update to the state relocation coordinator and/or involved OST representative.

Reference Materials:

See information on relocation stress syndrome, also called transfer trauma, in the Chapter 50 Relocation Manual or on the Board on Aging and Long Term Care website:

- Resident Relocation Manual: Section VII, Relocation Stress Syndrome/Transfer Trauma https://www.dhs.wisconsin.gov/publications/p01440.pdf
- Board on Aging and Long Term Care (BOALTC) https://longtermcare.wi.gov/Pages/Home.aspx
- Disability Rights Wisconsin (DRW) https://disabilityrightswi.org/program/family-care-and-iris-ombudsman-program
- Wis. Stat. Ch. 50 https://docs.legis.wisconsin.gov/statutes/statutes/50.pdf