Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

1 WEST WILSON STREET
MADISON, WI 53703

OPEN MEETING NOTICE

Wisconsin Long Term Care Advisory Council

Tuesday, November 13, 2018

9:30 AM to 3:30 PM
Clarion Suites -- 2110 Rimrock Rd
Madison, WI 53703

AGENDA

9:30 AM Meeting Call to Order
Heather Bruemmer, *Long Term Care Advisory Council Chair*
-Introductions
-Review of agenda and approval of minutes

9:35 AM Department Updates
Curtis Cunningham, *DHS – Assistant Administrator, DMS Long Term Care Benefits and Programs*
Carrie Molke, *DHS – Bureau of Aging and Disability Resources*

10:00 AM Caregiver Initiative for Disability and Older Adults
Lynn Gall*, DHS – Office on Aging*
Lisa Pugh, *State Director, The Arc Wisconsin*

10:30 AM *Break*

10:45 AM Managed Care Rule Appeals and Grievances
Betsy Genz, *DHS – Bureau of Adult Programs and Policy*

11:15 AM MCO Contract Amendment Update
Nate Vercauteren, *DHS – Bureau of Adult Programs and Policy*

11:45 AM Communication Charge Updates
Lisa Strawn*, DHS – DMS Communications*
Cathy Klima*, DHS – DMS Communications*

12:00 PM Comments from the Secretary
Secretary Linda Seemeyer*, Department of Health Services*

12:15 PM Comments from the Public

12:30 PM *Catered Lunch for council members and staff*

1:00 PM LTC Scorecard
Angela Witt*, DHS – Bureau of Long Term Care Financing*

1:45 PM Quality Charge Updates and MCO P4P
Curtis Cunningham, *DHS – Assistant Administrator, DMS Long Term Care Benefits and Programs*
Kevin Coughlin, *DHS – Policy Advisor, DMS Long Term Care Benefits and Programs*

2:15 PM *Break*

2:30 PM LTC Workforce and Retention Guide Website
Annie Yoveff*, DHS – Bureau of Adult Quality and Oversight*
Lindsey Kreitzman*, DHS – Bureau of Adult Quality and Oversight*

3:00 PM Council Business
Heather Bruemmer, *Long Term Care Advisory Council Chair*

3:15 PM Adjourn
Heather Bruemmer, *Long Term Care Advisory Council Chair*

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Wisconsin Long Term Care Advisory Council was first created through the 1999 Wisconsin Act 9 with the responsibility to report annually to the legislature and to the Governor on the status of Family Care and assist in developing broad policy issues related to long-term care services. Wisconsin Act 9 sunset the Council as a legislative council as of July 21, 2001, but the council was reappointed a few months later as an advisory group to the Department on emerging issues in long-term care. The Council has continued to provide guidance to the secretary and make recommendations regarding long-term care policies, programs, and services. More information about the council is available at wcltc.wisconsin.gov.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in another language or in alternate format, you may request assistance to participate by contacting Hannah Cruckson at 608-267-3660 or hannah.cruckson@dhs.wisconsin.gov.

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Wisconsin Long Term Care Advisory Council			Attending: Cindy Bentley, Christine Witt, Denise Pommer, Audrey Nelson, Carol Eschner, Maureen Ryan, Beth Swedeen, Robert Kellerman, Tim Garrity, Amie Goldman, Mary Frederickson, Roberto Escamilla II, Cathy Ley.
Date: 9/11/2018	Time Started: 9:30 a.m.	Time Ended: 3:30 p.m.	
Location: Clarion Suites at the Alliant Energy Center, Madison			Presiding Officer: Heather Bruemmer, Chair

Minutes

Members absent: Sam Wilson, John Sauer.

Others present: Heather Bruemmer, Betsy Genz, Brenda Bauer, Carrie Molke, Cathy Klima, Curtis Cunningham, Dave Varana, Hannah Cruckson, Kevin Coughlin, Ian Ritz, Andy Heidt.

The meeting opened with a moment of silence in remembrance of September 11, 2001.

Meeting called to session

The minutes from the July2018 meeting were unanimously approved on a motion from Amie Goldman, seconded by Maureen Ryan. Draft summaries of the council charges were included in the packets for the current meeting.

Board on Aging

Heather Bruemmer gave the following updates:

Advocacy for 60+ IRIS ombudsman: The Board on Aging and Long Term Care has two IRIS staff serving individuals 60 and older. One Lead Ombudsman and one Ombudsman. The two of them cover the entire state. DHS sent out 4500 letters about our agency IRIS services and we have received a great response. We were appreciative of the Department to send the letters out. Please call our 800 line if you need our services: 1-800-815-0015.

Comment - How many openings on the council? Discussion with the members occurred regarding the vacancies of the Council.

DHS will bring the list during the next meeting with openings. Please spread the word about the vacancies.

Department Updates

Curtis Cunningham, Assistant Administrator of Division of Medicaid Services, Long Term Care Benefits and Programs, gave the following Department of Health Services updates:

EVV - moving forward with developing options.

Children's waitlist - moving forward and eliminating waitlist. Awareness of services and the number of interested is growing. Moving toward 2200 funded.

IMD Rebalancing - 2 years reducing IMD admissions and length of stay. Providing grant funding to innovative practices. Continuing conversation regarding Partnership program expansion.

Comment - Where was the funding going?

Funding will improve ICAs, MCOs system for IMD. Could be coordination, facilitation . Data analysis showed a number of out of county placements. Coordination and communication.

Comment - will there be an RFP?

Going to be an RFP for a small grant. Will send an announcement.

Complex behaviors is one area along with competitive integrated employment.

Quality strategy development will be brought back to the council after input from IRIS advisory committee and data from NCI.

HCBS Conference - WI had four presentations. Value based purchasing for competitive integrated employment. Transitions for LTSS Systems. Betsy presented on the Tribal option implemented in July.

Comment – attendee of HCBS Conference commented that Wisconsin really is the gold standard.

Comment - EVV will be challenging. The communication plan is critical. It will be a heavy lift. Is there a stakeholder engagement plan for the rollout and communication?

Developing stakeholder outreach plan. We are still working on the project structure and charter internally in preparation for the implementation.

Comment - One vendor would do EVV across all programs. Bring your own device? What about BYOD?

Assuming that the member could use their own apparatus or cell phone rather than the state purchasing equipment like that.

Comment - We had a system a number of years ago. We ended up ending BYOD because it was not location specific. Phones were in the home only for that purpose.

Comment - Ohio was a leader in EVV and devices. They had a lot more wifi and hotspots.

There will have to be methods other than requiring hotspots.

Comment - The person who lives at the spot will have a landline if not a hotspot.

Comment - the landline is always there.

Comment - there is a lot of expertise around niche things. There is a lot less tech use in older adults. What makes sense for a very rural group in Wisconsin takes a lot of consideration. Engaging stakeholders early on is a recommendation.

Comment - EVV was used to facilitiate timesheets. Reporting helped electronically finalize timesheets for better timesheet approvals and payments. They had to call within ten minutes if the device was not working.

Comment - Should we bring EVV back to the council?

We will have a vision for the future of the council, so a separate workgroup may be more appropriate. To be determined.

Comment - Will they have a choice about EVV or will they have to do it the way federal requires.

EVV is required for federal funding. It increases over time. One thing we're mindful of is, how do we take something that we have to do and turn it into a benefit? Looking at missed visits, consistency of support workers, electronic billing, we have to do this but how do we make this the best it can be?

Comment - Our workers liked it and they always were paid on time. There weren't any questions and there were a lot of benefits.

Carrie Molke, Director of DHS Bureau of Aging and Disability Resources, gave the following Bureau of Aging and Disability Resources (BADR) updates:

AARP Public Policy Institute. At a national home and community based services conference at the end of August, the following publications were available/discussed by the AARP Public Policy Institute in which Wisconsin is highlighted:

- "The Livability Index 2018: Transforming Communities for All Ages" was just published in June. On page four, you will see Wisconsin highlighted as having "more top-performing communities than any other state". Milwaukee is listed as the 5th best for large cities in the country, Madison as the top performing mid-sized city, and Fitchburg, Sheboygan, and La Crosse take the top three performing small cities. Sun Prairie is also on the small-cities list as #6.
- "Emerging Innovations in Managed Long-Term Services and Supports for Family Caregivers" was published in November, 2017. On page 4, exhibit 2, the Family Care program is highlighted, specifically as it applies to consultation and training for family caregiver benefits.
- "Taking It to the Next level: Using Innovative Strategies to Expand Options for Self-Direction", published in April, 2018. On page 4, and 9-10 the IRIS program is highlighted.
- No Wrong Door: Person and Family Centered Practices in LTSS . Wisconsin's ADRCs are highlighted in a couple different areas within the report.

NASUAD Leadership. The National Association of States United for Aging and Disabilities is an association made up of State Aging Directors and Medicaid LTC Directors. Curtis Cunningham was elected Vice President of the Association this past August.

Accreditation. The Wisconsin Department of Health Services, Division of Public Health is now nationally accredited by the Public Health Accreditation Board (PHAB).

- We learned of this status in late August.
- Wisconsin's Division is now among only 200 health departments (out of 3,000) across the United States to achieve this level of quality.
- According to PHAB: "To receive accreditation, a health department must undergo a rigorous, multi-faceted, peer-reviewed assessment process to ensure it meets or exceeds a specific set of standards and measures. The peer review process provides valuable feedback to inform health departments of their strengths and areas for improvement so that they can better protect and promote the health of the people in the communities they serve."

Aging and Disability Network Conference

- The conference will be held this week (September 13-14, 2018) in the Wisconsin Dells. We are expecting over 500 people.
- This is only the second conference of its kind: whereby it is a joint conference for both the aging and disability networks. In the past, there was an Aging Conference, an ADRC conference, a Physical Disabilities Conference, and a Long-term Care Conference. This conference brings these (and us) together and provides an opportunity to build new relationships and finding new opportunities for partnering on joint initiatives.
- Mary Lazare is the Principal Deputy Secretary of the Administration for Community Living (ACL). She will be giving a keynote address at the conference.
    - In addition, she will be meeting with a small group of ADRC Directors/Tribal Aging Directors (LTCAC members Denise Pommer and Kathy Ley) and ILC Directors (LTCAC member Maureen Ryan), which will provide an opportunity for her to learn about our unique Wisconsin models and engage in discussion with her.
    - ACL is the federal agency that funds Aging programs (e.g. Older Americans Act funding, dementia grants), ILCs, and provides grants to states for ADRCs.

Dementia

- Dementia Awareness Campaign Funding.
    - After a competitive application process, the Alzheimer's Association of WI has been awarded $500,000 to implement a statewide awareness campaign.
    - In addition, this funding will allow the State to move forward with some of the State Plan goals
- Round 1 Dementia Crisis Innovation Grants. A new report will be released this month showing the results/lessons learned from 6 innovation grants. The initiatives were aimed at improving crisis stabilization and response for people with dementia.
- The Dementia State Plan Steering Committee is meeting next week to continue implementation planning for the Plan that is set to begin in 2019.

CMS Waiver

Betsy Genz, Director of DHS Bureau of Adult Programs and Policy

Ms. Genz shared information about waivers in a slide presentation. She then shared the timeline and the importance of each task.

WisCaregiver Careers Updates

Kevin Coughlin, Policy Advisor of DHS Division of Medicaid Services

WisCaregiver Careers is a program through Civil Money Penalty funds and needs to benefit Nursing Homes.

Email at DHSCaregiverCareer@dhs.wisonsin.gov.

Secretary Guidance, Transportation

Carrie Molke, Director of DHS Bureau of Aging and Disability Resources

Ms. Molke shared guidance from the Secretary regarding the council's input about community development and transportation.

Transportation services and Funding

Curtis Cunningham, Assistant Administrator of DHS Division of Medicaid Services, Long Term Care Benefits and Programs

Mr. Cunningham shared information from DHS regarding transportation funding.

Comment - the public policy piece of putting these funding sources together is the most important in addition to local level coordination.

Comment - There needs to be funding for the coordination from a high level.

Comment - At a local level, there will be bubbles if there is not cross-coordination.

Public Comments

Comment - Workforce funding is applauded. It has gone over well to our 400 caregivers. The question is that there is some different contract language regarding bonuses and profit sharing that allows MCOs to determine whether it is reasonable and to take back the funding. That defeats the workforce initiative and we are concerned about it.

Comment - The transportation chart is long coming. When Ian visits this afternoon, compare DOT and DHS spending and ask him to share. DHS has a large stake.

Comment - Would like to echo comments about provider sponsored transportation. Most contracts require transportation. Frequent doctor visits can eat a large amount of funding and that needs to be reflected.

Commute to Careers Grant

Andy Heidt, Department of Workforce Development, shared a presentation about the Wisconsin Fast Forward program.

WisDOT Transit Programs

Ian Ritz, Department of Transportation, shared a presentation about DOT's transit programs.

Community of Practice Workplan

Beth Swedeen, Wisconsin Board for Persons with Developmental Disabilities, shared a presentation about the Community of Practice Workplan.

2019 Charges

Curtis Cunningham led a discussion about the Council's 2019 charges and the following comments were recorded:

Comment - Recommendation to further Transportation.

Comment - DOT seems more policy focused than program focused.

Comment - future guiding principles to use when thinking about regions, models, integration. It has to start there and fit everything in together.

Comment - Does equity fall under vision? Service Delivery Models?

Comment - Start with guiding values in order to avoid silos.

Comment - It needs to be broad. It's already confining thinking by combining the list.

Comment - we should have a futurist.

Comment - Regions didn't just happen.

Comment - Determine what we want it to look like.

Comment - Equity is fundamental, but there are only 2 votes. In our communities, the population has a lower life expectancy.

Comment - These recommendations will continue to evolve.

Comment - Recommendation to add cultural competency as a fourth.

Workforce, long path, transportation, cultural competency.

Comment - are there any department initiatives that would benefit from focus in this council?

Program-level discussion.

Comment - should this council focus on the big vision or should it get involved in the smaller workgroups?

Comment - Under transition of care, add quality of placement and housing.

The meeting was adjourned unanimously.

Prepared by: Hannah Cruckson on 9/11/2018.

These minutes are in draft form. They will be presented for approval by the governmental body on: 11/13/2018

DHS Response to MCO & LTC Council Feedback on Proposed Contract Changes Amendment 1.1.19

(Rows with grey background are required by the federal Managed Care rules)

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	Removed two MCO reporting requirements as DHS does not need information.	Article VIII.J. Change in Providers 1. Required Notifications a. Notice to Department The MCO is required to notify the Department at dhsbmc@dhs.wisconsin.gov within seven (7) calendar days when~~:~~ …. ~~ii. A community residential care provider reports to the MCO that an MCO member has or will be involuntarily discharged.~~	**LTC Council:** Wants DHS to retain this provision. Wants DHS to be notified by MCOs when an involuntary discharge from a residential setting is triggered by an MCO's reduction of a provider's rate. **Response:** DHS will not make this change at this time and will consider exploring this topic (member impact from residential rate reductions).
2.	438.10(d)(3) … Written materials must include taglines in the prevalent non-English languages in the state…	Art. IX.E Accessible Formats and Languages and Cultural Sensitivity *1. Accessible Language* c. Written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices shall include taglines and be available in prevalent non-English languages in the MCO's service area.	**MCO:** Will DHS be providing updated templates? **Response:** Yes. Templates will likely not be ready to implement until mid to late December.
3.	42 C.F.R. § 441.301(c)(4).	Article VIII.G Provider Certification and Standards 1. *Wisconsin Provider Standards* The MCO shall use only providers that meet Department requirements, and a. For waiver services in Addendum VIII.A:~~.;~~ i. meet the provider standards in Wisconsin's approved s. 1915 (c) home and community-based waiver, ii. meet all required licensure and/or certification standards applicable to the service provided, ~~and~~ iii. are enrolled with the Department; ~~or~~ and iv. if newly licensed or certified as a residential provider*, the setting has been determined by the certification agency or the Department to be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4). An exception to this requirement is a setting that was operating prior to March 17,	**MCO:** Is iv. intended to cover both certified and licensed facilities? How does the department intend to determine compliance? **MCO:** Need DHS to provide guidance and direction on steps for MCO to obtain confirmation of provider compliance. Is copy of licensure sufficient, would there be a certification, how would the MCO get this information?

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
		2014 that is subject to heightened scrutiny and is awaiting a determination of compliance from CMS. Any new residential setting must be in compliance with 42 C.F.R. § 441.301(c)(4) before the MCO can use the setting; or b. For State Plan services in Addendum VIII.B and C: i. are certified as providers under Wis. Admin. Code § DHS 105 to provide acute, primary or long term care services specified in Wis. Admin. Code § DHS 107, ii. meet all required licensure and/or certification standards applicable to the service provided, and iii. are enrolled with the Department; or c. Meet the MCO's provider standards that have been approved by the Department. *Members residing in an existing residential setting that has been determined to not be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4) may continue to reside in that setting pursuant to the Department approved MCO member transition plan.	**Response:** The language has been revised to clarify that the requirement applies to newly certified and licensed facilities and that compliance is determined by the certification agency, DHS or CMS (in the case of heightened scrutiny). New language has been added clarifying that MCOs can use a noncompliant setting pursuant to the DHS has approved member transition plan. MCOs confirm compliance by obtaining the DHS compliance letter from the provider. In the future (date uncertain), DHS expects to have a systematic process in place.
4.	Based on past incidents, language is needed to prohibit providers from influencing a member's choice of MCO.	Article VIII. D. Provider Agreement Language … 27. *Prohibited Practice* … c. Marketing/outreach activities as described in Article IX. Section A.5. a-g, page 151, are prohibited. For reference, Article IX.A.5: 5. Prohibited Practices The following marketing/outreach practices are prohibited: a. Practices that are discriminatory; b. Practices that seek to influence enrollment in conjunction with the sale or offering of any other insurance product; c. Direct and indirect cold calls, either door-to-door, email, telephone, text or other cold call marketing activity; d. Offer of material or financial gain to potential members as an inducement to enroll; e. Activities and materials that could mislead, confuse or defraud members or potential members or otherwise misrepresent the MCO, its marketing representatives, the Department, or CMS. Statements that would be	**MCO:** Is DHS asking that our contracted providers adhere to Article IX. Section A.5. a-g?" **Response:** Yes. **MCO:** Concern over restrictions. Suggest modifying Article IX.A.5. f and g to: f. Practices that are reasonably expected to have the effect of denying or discouraging enrollment in an identified Family Care MCO. g. Practices to influence the member to either not enroll in, or to disenroll from, a Family Care MCO.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
		considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that: i. The recipient must enroll in the MCO in order to obtain benefits or in order to not lose benefits; or ii. The MCO is endorsed by CMS, the federal or state government, or other similar entity. f. Practices that are reasonably expected to have the effect of denying or discouraging enrollment; g. Practices to influence the recipient to either not enroll in or to disenroll from another MCO plan;	**Response:** DHS declines these suggestions. For f., providers should not influence members to switch programs or MCOs. For g., this change does not appear to be substantive. MCO would need to provide reason for requested change. **LTC Council:** We believe this provision warrants additional discussion to better understand DHS' intent. **Response:** DHS' intent is to restrict MCO providers from influencing member choice of programs and MCOs.
5.	§438.62 Continued services to enrollees. … (b) The State must have in effect a transition of care policy to ensure continued access to services during a transition from FFS to a MCO, PIHP, PAHP, PCCM or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM or PCCM entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization….	Article IV.C. Monitoring, Coordination, Transition of Care, Discrimination and Dates … 3. *Transition of Care* 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.	**MCO:** Is this a new policy or an existing policy? If existing, clarify where the policy is located. If new, when does the department intend to provide access? **Response:** This is a new policy that formalizes what is, for the most part, existing practice. The policy is being drafted and DHS anticipates sharing it with MCOs in November.
6.	Non-substantive revisions to clarify existing process.	Article III.E. Medicaid Deductibles or Cost Share … 2. *Cost Share or Patient Liability* … c. The MCO is responsible for collecting the members' monthly cost share or patient liability, subject to the	**LTC Council:** 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

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
		following Department policies and procedures:… iii. The system logic that determines a member's patient liability amount can offset either a MCO capitation payment or a Nursing Home Fee-for-Service (NH FFS) claim, but not both. The system will offset whichever of the two transactions that process first. ~~iii. The MCO will not collect a patient liability for the current month from a member who enrolls in Family Care after the 1st of the month if the member is residing in a nursing home and receiving nursing home Medicaid benefits. The member will pay his or her patient liability to the nursing home for the current month and his or her patient liability to the MCO beginning the next month.~~ Generally, when members residing in a NH are enrolled into a MCO and the enrollment includes past months, the NH FFS claim will be offset by the patient liability amount for the past month(s), and the subsequent capitation payment(s) for the past month(s) will not be offset by the patient liability amount. However, this depends on when the NH FFS claim is submitted and processed in the system, so MCOs should monitor the 820 transaction to determine whether or not the patient liability amount was used to offset the capitation payment. If the patient liability amount was used to offset the capitation payment, the MCO should collect the liability amount. The MCO will attempt to collect the patient liability amount from the nursing home when the 820 Report (see Article XV.E) indicates that the capitation payment was offset by the patient liability amount but the member already paid the patient liability to the nursing home. The MCO will pay the patient liability amount to the nursing home when the 820 Report indicates that the capitation payment was not offset by the patient liability amount but the member already paid the patient liability amount to the MCO.	may prove acceptable, we suggest nursing home billers and MCO staff be granted additional time to determine the provision's workability. **Response:** This language does not establish a new process. It simply describes the existing process.
7.	DHS replaced the systems MCOs used to report employment data (Program Participation System (PPS) Employment Outcome Data Reporting System) with the Integrated Exchange System (IES). More frequent reporting is needed to meet DHS employment objectives.	Article XIV.C. Reports: Regular Interval **…** 4. *Quarterly ~~Semi-Annual~~ Employment Data Report* The MCO shall report~~, in its provider agreements, require~~ employment ~~services providers to report employment~~ data quarterly for members who do and do not have a vocational service provider for the months of March, June, September and December ~~in May and November~~ of each year for prepopulated lists of members provided	**MCO:** Anticipates increase in resources needed to implement. **Response:** MCO should address this during the annual business planning process.

<table>
<tr><th>No.</th><th>Reason for Proposed Change</th><th>Language of Proposed Change</th><th>Feedback</th></tr>
<tr><td></td><td></td><td>by DHS. The MCO may choose to require employment services providers to report employment data to them; however, the MCO will be responsible for the uploading and certification of the employment data sent to DHS. ~~The MCO shall report employment data in May and November of each year for pre-populated lists provided by DHS of members who do not have a service provider.~~ The tool the MCO ~~and its providers~~ will use for employment data collection and submission of these reports will be the Integrated Exchange System (IES) through Business Objects~~Program Participation System (PPS)~~.

…

Addendum II

<table>
<tr><th>Report</th><th>Reporting Period</th><th>Due Date</th><th>Submit To</th><th>Contract Reference</th></tr>
<tr><td>Employment Data Report</td><td>~~04/01/18-04/30/18~~

~~10/01/18-10/31/18~~

03/01/19-03/31/19</td><td>~~05/31/18~~

~~11/30/18~~

1st week of July</td><td>~~Program Participation System (PPS)~~
Integrated Exchange System (IES) through Business Objects</td><td>Article XIV.C.4. (page 236)</td></tr>
<tr><td></td><td>06/01/19-06/30/19</td><td>1st week of October</td><td></td><td></td></tr>
<tr><td></td><td>09/01/19-09/30/19</td><td>1st week of January</td><td></td><td></td></tr>
<tr><td></td><td>12/01/19-12/31/19</td><td>1st week of April</td><td></td><td></td></tr>
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<tr><td>8.</td><td>Alignment of contract definition of in lieu of services with the federal definition found in 42 C.F.R. 438.3(e)(2).

§ 438.3 Standard contract requirements.
…
(e)Services that may be covered by an MCO, PIHP, or PAHP.
…

(2) An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu</td><td>Art. VII.A General Provisions
…
8. In Lieu of Services
a. Definition
In lieu of services are a subset of alternate services that the Department has~~, as a general matter,~~ determined are medically appropriate and cost effective substitutes for covered services or settings in Addendum VIII.B for Family Care or Addendum VIII.C for Partnership and PACE; and: ~~in the benefit package, and:~~
i. ~~Which a~~Are offered to a member at the discretion of the MCO; and
ii. ~~Which t~~The member is not required by the MCO to use the alternative service or setting; and ~~agrees to as an alternate service; and~~
iii. ~~For which u~~Utilization and cost are taken into account in setting capitation rates, unless a statute or regulation explicitly requires otherwise.</td><td>LTC Council: 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.

Response: In lieu of services are an alternative means of covering specific state plan services as a waiver service. Member room and board obligation is not a state plan service. Federal law prohibits using waiver funds to supplement room and board.</td></tr>
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No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	of services or settings covered under the State plan as follows: (i) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan; (ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting; (iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and (iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.		
9.	§ 438.400 Statutory basis, definitions, and applicability. … (b)Definitions. As used in this subpart, the following terms have the indicated meanings: Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:	Article XI. B. Definitions As used in this article, the following terms have the indicated meanings: 1. ~~*Action*~~*Adverse benefit determination* a. An "~~action~~adverse benefit determination" is any of the following:	**MCO:** While we understand the general definition and use of adverse benefit determination, can some consideration be made to review this terminology? Not all service changes are adverse to a member, specifically where a member receives services to treat a condition, such as after a fall, and the end of the service is attributed to improvement of the triggering condition.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
			Response: "Adverse benefit determination" is the federally required terminology.
10.	§ 438.400 Statutory basis, definitions, and applicability. … (b)Definitions. As used in this subpart, the following terms have the indicated meanings: Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State. (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	Article XI. B. Definitions As used in this article, the following terms have the indicated meanings: 1. ~~*Action*~~*Adverse benefit determination* a. An "~~action~~adverse benefit determination" is any of the following: i. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care. ii. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VIII~~IX~~, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. iii. The reduction, suspension, or termination of a previously authorized service. iv. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VIII.~~IX.~~ v. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department. vi. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals. vii. The development of a member-centered plan that is unacceptable to the member because any of the following apply. a) The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member. b) The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes. c) The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member. viii. For a resident of a rural area with only one care management organization, the denial of an enrollee's request to exercise his or her right under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network. ix. The involuntary disenrollment of the member from the MCO at the MCO's request~~Notification by the MCO of a decision made in response to a member's appeal that is entirely or partially adverse to the member~~. ~~viii.~~x. The denial of a member's request to dispute a financial liability, including cost sharing, copayments,	**MCO:** General concern throughout, starting in section B, with the shift in which situations can be appealed. With the elimination of the definition of 'Action' and some updated language throughout all decisions appear to now be situations that can be appealed. Previous language clearly distinguished between situations that could be appealed and situations that could be grieved. **Response:** Only the specific items listed under "adverse benefit determination" can be appealed. Anything else is a grievance. Aside from replacing the term "action" with "adverse benefit determination" there hasn't been any change in which situations can be appealed, other than these two (required by federal regulation): viii. For a resident of a rural area with only one care management organization, the denial of an enrollee's request to exercise his or her right under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network. x. The denial of a member's request to dispute a financial liability, including cost sharing,

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	(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.	premiums, deductibles, coinsurance, and other member financial liabilities. … 3. Grievance "Grievance" is an expression of a member's dissatisfaction about any matter other than an "~~action~~adverse benefit determination."	copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
11.	(see #10).	Article XI. B. Definitions As used in this article, the following terms have the indicated meanings: … b. An "~~action~~adverse benefit determination" is not: i. A change in provider; ii. A change in the rate the MCO pays a provider; iii. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.3.a. and b., page 73; or iv. An adverse ~~action~~benefit determination that is the result of a change in state or federal law; however, a member does have the right to a State fair hearing in regard to whether he/she is a member of the group impacted by the change. v. The denial of authorization or payment for a service or item that is not inside of the benefit package specified in Addendum VIIIIX. …… C. Overall Policies and Procedures for Grievances and Appeals … c. A member does not have a right to continuation of benefits: i. When grieving a change in provider that is the result of a change in the MCO's provider network	**MCO:** Language in Section B.1.b lists what is not an adverse determination, but language in section C.6.c.i indicates members can now appeal a change in provider due to contracting, on the basis of dissatisfaction with his/her MCP. General dissatisfaction with an MCP previously had been considered a grievance. **Response:** These are not substantive changes. While a member cannot directly appeal a change in provider, he or she has always been able to appeal his/her dissatisfaction with the MCP. This is not a change.

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		due to contracting changes; however, in such a situation the member does have a right to appeal on the basis of dissatisfaction with her/his MCP.	
12.	§ 438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities. (a) General rule. Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to: (1) Enroll in an MCO, PIHP, or PAHP, must give those beneficiaries a choice of at least two MCOs, PIHPs, or PAHPs. … (b) Exception for rural area residents. (1) Under any managed care program authorized by any of the following, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, or PAHP: (i) A State plan amendment under section 1932(a) of the Act. (ii) A waiver under section 1115(a) of the Act. (iii) A waiver under section 1915(b) of the Act. (2) To comply with this paragraph (b), a State, must permit the beneficiary - (i) To choose from at least two primary care providers; and (ii) To obtain services from any other provider under any of the following circumstances: (A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, or PAHP network.	Article XI. B. Definitions As used in this article, the following terms have the indicated meanings: 1. *~~Action~~Adverse benefit determination* a. An "~~action~~adverse benefit determination" is any of the following: … viii. For a resident of a rural area with only one care management organization, the denial of an enrollee's request to exercise his or her right under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.	**MCO:** Feels B.1.A.viii is limited to PACE/Partnership. 42 CFR § 438.2 primary care is: "customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them." Types of providers listed rarely provide services in the Family Care Benefit Package. Response: DHS disagrees that the provisions are not applicable to Family Care. Although 438.52(b)(2)(i) requires the beneficiary to be permitted to choose from at least two primary care providers, (b)(2)(ii) additionally requires that the beneficiary be permitted to obtain services from any other provider when the service or type of provider is not available within the MCO, PIHP or PAHP network.
13.	438.404(b)(2): Content of notice. The notice	Article XI.C. Overall Policies and Procedures for Grievances and Appeals	**MCO:** Discrepancies noted in language

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	must explain the following: (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. 438.406(b) Special requirements. An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must: … (5)Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).	… 3. Provision of Case File The MCO must ensure that the member is aware that he or she has the right to access his or her case file, free of charge, and to be provided with a free copy of his or her case file. "Case file" in this context means all documents, records and other information relevant to the MCO's adverse benefit determination and the member's appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, functional screen results, any processes, strategies, or evidentiary standards used by the MCO in setting coverage limits and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination. This information must be provided to the member sufficiently in advance of the appeal resolution timeframes described in Article XI.F.5.e and f. … D. Notice of ~~Action~~an Adverse Benefit Determination 4. Content of Notice of ~~Action~~Adverse Benefit Determination The MCO will use the DHS issued notice of ~~action~~adverse benefit determination form (https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm) required in Article XI.D.1. The notice must include the date the notice is mailed or hand -delivered and explain the following: … j. The right of the member to be provided upon request and ~~That the member may obtain,~~ free of charge, reasonable access to and copies of all ~~member~~ documents, records and other information relevant to the adverse benefit determination ~~MCO grievance or appeal, Department review or State Fair Hearing~~ and how to obtain copies. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.	between Section C.3 (page 4) and Section D.4.j. Suggest using same language in both sections. Additionally, suggest qualifying the material to be provided with 'Upon request'. Members have the right to request the information in their record at any time, but the language in both sections appears to require a full member record release for each appeal, as opposed to the information pertinent to the appeal or grievance (specifically language in C.3). Additionally, clarification requested for what the department considers Evidentiary Standards? **MCO:** XI.C.3 Provision of case file – "shall provide". There is no indication that it is upon request only, is it? **Response:** The language in these sections is different because it is based on the text of two different federal regulations: CMS Response to comments on final rule regarding this: "We clarify that the documents and information referenced at §438.404(b)(2) and §438.406(b)(5) are similar; however, it is possible that the enrollee's case file used for the appeal at §438.406(b)(5) could contain additional documents and information that

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			were not available at the time of the adverse benefit determination under §438.404(b)(2)." Language has been clarified to indicate that the materials that must be made available to a member who is appealing an adverse benefit determination the materials related to the original adverse benefit determination and any/all documents and information not available at the time of the adverse benefit determination, if any. Language has been clarified to indicate that the MCO must make the member aware of his/her right to access the case file and provide it to the member upon his/her request. If the member has previously requested and been provided with copies of the records/documents/information relevant to his or adverse benefit determination (following receipt of the NOA) then the MCO is only required to provide any additional records/documents/information not previously provided at the time of the adverse benefit determination. By "…any processes, strategies, or evidentiary standards used in setting coverage limits" DHS is referring to the criteria the MCO uses to make its decision, its explanation of the "why" for its decision.
14.	DHS 10.13 Definitions. In this chapter: (1) "Action" means any of the following:	Article XI. B. Definitions As used in this article, the following terms have the indicated meanings:	**MCO:** Suggestion to clarify that appeals for involuntary disenrollment to only go through

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	… (b) Any of the following acts taken by a care management organization: … 7. Termination of the family care benefit or involuntary disenrollment from a CMO. … DHS 10.52 Required notifications. (4) Notification of Due Process and Fair Hearing Rights Clients shall be provided timely and adequate written notification of client rights, including the right to a fair hearing in accordance with s. DHS 10.55, an offer of assistance in preparing a written grievance or fair hearing request and information about the availability of advocacy services to assist the client. Resource centers, county agencies and care management organizations shall provide written notification of due process rights, within timelines established in department contracts, in each instance in which: … (b) A CMO requests or the department approves involuntary disenrollment of an enrollee.	1. ~~*Action*~~*Adverse benefit determination* a. An "~~action~~adverse benefit determination" is any of the following: i. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care. ii. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VIII~~IX~~, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. iii. The reduction, suspension, or termination of a previously authorized service. iv. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VIII.~~IX.~~ v. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department. vi. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals. vii. The development of a member-centered plan that is unacceptable to the member because any of the following apply. a) The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member. b) The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes. c) The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member. viii. For a resident of a rural area with only one care management organization, the denial of an enrollee's request to exercise his or her right under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network. ix. The involuntary disenrollment of the member from the MCO at the MCO's request~~Notification by the MCO of a decision made in response to a member's appeal that is entirely or partially adverse to the member.~~ ~~viii.~~x. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.	State Fair Hearing process, as any decision upheld at a local appeal committee hearing will likely result in a State Fair Hearing, creating a delay in final resolution for the member. **Response:** Out of scope of this amendment. This is not a clarification but rather a suggestion for a policy/procedure change. Ideas such as this should be proposed at the time of contract renewal.
15.	§438.408 Resolution and notification: Grievances and appeals. …	Article XI.H. The State Fair Hearing Process … 2. Time Limits ~~liness of Request~~ for Requesting a Fair Hearing	**MCO:** Time to file an appeal is updated for local appeals but appears to have been missed to update for State Fair Hearings. Additionally,

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	(f) Requirements for State fair hearings—(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination. (i) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. … (2) State fair hearing. The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.	The member must file the request for a fair hearing within forty-five (45) calendar days of one of the types of incidences noted above, or from the date of receipt of written notice from the MCO.	timeframe for Metastar review also appears to have remained unchanged. **MCO:** 42 CFR §438.408(f)(1) states that a fair hearing is available to enrollees only after they have received notice that the MCO is upholding an adverse benefit determination. Thus, enrollees are required to exhaust the MCO appeal process before filing for a State fair hearing. The proposed FCP contract language at Section XI H. 1, second paragraph, does not appear to comply with this requirement, as it states "A member may submit a fair hearing request . . **instead of** or after using the MCO appeal process, the MCO grievance process, or Department review process. . ." (emphasis added) **Response:** DHS must change state statutes to implement the new federally required fair hearing timeframe or require a member to exhaust the MCO level of appeal before requesting a fair hearing. These changes will be made to the contract AFTER the statutes are revised. States are not required to change the 45 day timeframe for a member to request DHS Review.
16.	Inconsistent language.	Article XI.F. MCO Grievance and Appeal Process The MCO grievance and appeal process must meet the following requirements. 1. Assistance in Filing a Grievance or Appeal	**MCO:** Does the department intend this change to mean informal resolution prior to a formal hearing is no longer required?

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		… The MCO should~~must~~ attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the interdisciplinary team and the Member Rights Specialist must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.	**Response:** This change is purely grammatical. The use of 'must' is inconsistent with 'attempt' and 'whenever possible' in the sentence. Nothing has changed in the expectation that the MCO will use best efforts to resolve issues and concerns short of formal hearings when they are able to.
17.	438.420(c) (2) Timing—(i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.	Article XI.B. Definitions As used in this article, the following terms have the indicated meanings: … ~~6. Date of Receipt~~ ~~"Date of receipt" when used in terms of establishing the time during which a member has a right to file a grievance or appeal means five (5) calendar days from the date of mailing of a notice unless the member can demonstrate that the actual date of receipt was later than five (5) calendar days after mailing.~~	**MCO:** Clarification requested around the elimination of previous definition for 'Date of Receipt'. Would like clarification for each situation related to allowed timeframes. Also, there appear to be some missed updates as State Fair Hearing sections still reference date of receipt. **Response:** The new managed care rule changes the clock starting from "date of receipt" to "date on the notice for appeals." For appealing to the MCO, it is 60 calendar days from the date on the notice of action. Since a member can request a grievance at any time, date of receipt is not relevant. The fair hearing decision will have to remain "date of receipt" until the statute can be changed to "date on the notice." (See #15).
18.	438.416 … (b) The record of each grievance or appeal must contain, at a minimum, all of the following information: … (4) Resolution at each level of the appeal or grievance, if applicable	Article XI.I. Documentation and Reporting The MCO must maintain records of member grievances and appeals. Each record must be adequately maintained in an accessible manner and be made available upon request to the State and CMS. The documentation and reporting required in this article regarding grievances and appeals provide the basis for monitoring by the MCO and the Department. The MCO and the Department shall review grievance and appeal information as part of its ongoing monitoring procedures and overall quality management strategies. …	**MCO:** Does the department intend reporting to include a summary of informal resolution as part of Appeal Log reporting? Additionally, does the department intend to make any Appeal Log template changes? If so, when does the department intend to provide updated templates?

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		2. *Content of Grievance and Appeal Records* The record of each grievance or appeal must contain, at a minimum, all of the following information: … g. A summary of the internal review, negotiation or mediation resolution or local grievance and appeal committee decision;	**Response:** What is required to be reported on the appeal log is: if a member's issue is resolved through informal resolution that the MCO provide a summary of what that resolution was. A summary of the informal resolution *process* that led to the resolution is not required. The appeal log is being updated to make the data more useful and insure the MCOs are all reporting the data in the same format. DHS anticipates the revised log will be completed in December and implemented in January.
19.	Integration of required appeal decision templates into contract.	Article XI.D. Notice of ~~Action~~an Adverse Benefit Determination 1. Requirement to Provide Notice of an ~~Action~~Adverse Benefit Determination The MCO must provide written notice of an ~~action~~adverse benefit determination in the situations listed below. The MCO must use the Department and/or CMS issued notice of ~~action~~adverse benefit determination form for the Family Care, Partnership and PACE Programs: https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm. The notice of ~~action~~adverse benefit determination may be mailed or hand delivered. An oral or e-mail notice or reference to information in the member handbook or other materials does not meet the requirement to provide notice of ~~action~~adverse benefit determination. … E. Notification of Appeal Rights in Other Situations 1. Requirement to Provide Notification of Appeal Rights … b. Adverse MCO Grievance or Appeal Decision When~~, as identified in Article XI.B.1.a.viii.,~~ the MCO makes a decision in response to a member's grievance or appeal that is entirely or partially adverse to the member it must on the date of the decision mail or hand deliver a written notification to the member of the reason for the decision and any further grievance or appeal rights. For appeal decisions, the MCO shall use the following Department mandated templates: i. MCO decision is upheld: https://www.dhs.wisconsin.gov/forms/f0/f00232e.doc	**MCO:** Does the department intend to make any changes to any mandated templates – specifically the decision letters (reference Section E.1.b.i-iv, page 12)? Will the Department provide updated required language translations of related state appeal and grievance forms, letters, etc.? When does the department estimate being able to share updated forms, letters, etc. for MCOs to implement in systems? **MCO:** All MCOs use the NOA template from DHS for Family Care and the template the state worked on with CMS to use for Partnership- the Integrated Denial Notice. We will need new updated templates for these notices. The contract changes have links to the old NOAs. **MCO:** A 1/1/19 implementation date provides 90 days for preparation for these changes.

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		ii. MCO decision is reversed: https://www.dhs.wisconsin.gov/forms/f0/f00232d.doc iii. MCO decision is upheld with respect to a service or support that was originally authorized on a temporary (episodic) or trial basis: https://www.dhs.wisconsin.gov/forms/f0/f00232c.doc iv. MCO notification of extension for decision: https://www.dhs.wisconsin.gov/forms/f0/f00232b.doc ~~See Technical Assistance Memo 10-09 (http://www.dhs.wisconsin.gov/ltcare/partners/infoseries/ta10-09.pdf).~~	Will DHS be providing updated templates since all MCOs use them – or will each MCO correct these individually and then get them approved by DHS/CMS? **Response:** DHS is currently revising these forms and anticipates sharing them with MCOs in mid to late December.
20.	438.400(b) Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.	Article XI.B. Definitions As used in this article, the following terms have the indicated meanings: … 4. Grievance and Appeal System The term "Grievance and Appeal System" ~~is used to~~ refer~~s~~ to the overall system the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them. ~~that includes grievances and appeals handled at the MCO level and the DHS level, and access to the State fair hearing process.~~ C. Overall Policies and Procedures for Grievances and Appeals The policies and procedures used by the MCO to resolve~~dispose of~~ grievances and ~~to resolve~~ appeals shall be approved by the Department in initial certification and when any significant change in the MCO's policies and procedures is made.	**MCO:** Would this change in appeal tracking require approval by DHS under XI.C.1.? **Response:** No. XI.C.1 concerns the policies and procedures the MCO uses to resolve grievances and appeals. While DHS requires MCOs to track their grievances and appeals, it does not approve how they track them.
21.	438.424(a). Services not furnished while the appeal is pending. If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives	Article XI.C. Overall Policies and Procedures for Grievances and Appeals … 5. Reversed Appeal Decisions If the MCO appeal process or the Department review process or State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the MCO must authorize or provide the disputed services promptly and ~~within thirty (30) calendar days or~~ as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.~~, whichever is sooner.~~ ~~If, following a State Fair Hearing, an Administrative Law Judge orders the reversal of an MCO's decision to deny,~~	**MCO:** Does this section apply to State Fair Hearing decisions related to functional eligibility? **Response:** Yes.

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	notice reversing the determination.	~~limit or delay services that were not furnished during the appeal, the MCO must authorize or provide the services within the timeframe specified in the hearing decision.~~	
22.	438.406(b)(2) Ensure that the individuals who make decisions on grievances and appeals are individuals- (i) Who were not involved in any previous level of review or decision making nor a subordinate of any such individual	Article XI.F. MCO Grievance and Appeal Process The MCO grievance and appeal process must meet the following requirements. … 2. Grievance and Appeal Decision Makers The MCO must ensure that the MCO grievance and appeal committee is comprised of: a. Individuals who were not involved in any previous level of review or decision making . A subordinate of an individual who was involved in a previous level of review or decision making may not be included in the MCO grievance and appeal committee;	**MCO:** Please clarify the intent of this statement. Could the word "committee" be replaced by the word "hearing" to clarify that IDT staff can participate in the committee, just not in a hearing where their supervisor was involved in a previous level of review? **Response:** IDT staff cannot be on the MCO grievance and appeal committee if they were involved in the decision that the member is appealing or grieving.
23.	438.408(b)(1) Standard resolution of grievances. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.	Article XI.F. MCO Grievance and Appeal Process The MCO grievance and appeal process must meet the following requirements. … 4. MCO Process for Medicaid Grievances … e. Grievance Resolution Timeframe i. The MCO grievance and appeal committee must mail or hand- deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety~~twenty~~ (90~~20~~) calendar~~business~~ days after the date of receipt of the grievance. This timeframe for resolution may be extended by up to fourteen (14) calendar days, up to a total of one hundred and four (104) calendar days if:	**MCO:** Is 90 calendar days correct? It is our understanding that the State is trying to align G&A deadlines with Medicare, however, this does not align with Medicare. **Response:** Yes. The regulation allows for up to 90 calendar days for an MCO to decide a grievance. DHS is giving MCOs the maximum amount of time to render a decision.
24.	438.416 … (b) The record of each grievance or appeal must contain, at a minimum, all of the following information: (3) The date of each review, or, if applicable, review meeting.	Article XI.I. Documentation and Reporting The MCO must maintain records of member grievances and appeals. Each record must be adequately maintained in an accessible manner and be made available upon request to the State and CMS. The documentation and reporting required in this article regarding grievances and appeals provide the basis for monitoring by the MCO and the Department. The MCO and the Department shall review grievance and appeal information as part of its ongoing monitoring procedures and overall quality management strategies. …	**MCO:** What activities will DHS require MCO's to track and provide in our appeal documentation when it is regarding mediation? **Response:** DHS is requiring what is required by the regulation: the dates of any reviews or meetings.

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		1. *Content of Grievance and Appeal Records* The record of each grievance or appeal must contain, at a minimum, all of the following information: … e. The date(s) of any formal or informal reviews or meetings;	
25.	N/A	N/A	**LTC Council:** Add language establishing the right of the member to appeal 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. Delete Article XI. B1. b. i. so that a member could appeal an unwelcomed "change in provider." **Response:** Out of scope of this amendment. This is a suggestion for a policy/procedure change. Ideas such as this should be proposed at the time of contract renewal. Note: A member can appeal a change in provider by appealing on the basis of dissatisfaction with his or her care plan. (See #11). **LTC Council:** 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. **Response:** Out of scope of this amendment. This is a suggestion for a policy/procedure change. Ideas such as this should be proposed at the time of contract renewal. Note: The

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
			Family Care DHS-MCO contract is a Medicaid contract and it would therefore not be appropriate to include in it the member's Medicare appeal rights.
26.	N/A	N/A	**LTC Council** Why did the appeal and grievance timeframes change? **Response:** See 42 CFR §438.408 & §410. The timeframes are changing because the federal regulations governing these timeframes have changed them. **LTC Council:** If a grievance or appeal concerns 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. **Response:** During an appeal, MCOs are required to continue services as they currently exist until the appeal decision is rendered. Therefore, the MCO would not change the residential provider until a decision is rendered.
27.	N/A	Article VIII. D. Provider Agreement Language All provider agreements for member services shall be in writing, shall include the provisions of this subsection, and shall include and comply with any general requirements of this contract that are appropriate to the service. All amendments to provider agreements shall be in writing and signed and dated by both the provider and the MCO.	**MCO:** To require signed amendments for all changes that are mandated for all parties to follow is not manageable and can cause abrasion with providers. **Response:** Out of scope of this amendment. This is a suggestion for a policy/procedure change. Ideas such as this should be proposed at the time of contract renewal.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
28.	§ 438.206 Availability of services. … (c)Furnishing of services. The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements. … (3)Accessibility considerations. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	Article VIII. D. Provider Agreement Language … 32. Accessibility The provider agreement describes how the provider, as appropriate, provides physical access, reasonable accommodations, and accessible equipment to members with physical and/or mental disabilities.	**MCO:** Does the department intend to provide specific requirements by service type or will MCOs need to identify? If MCOs are to identify what guidance does the department intend to provide? **MCO:** Recommend DHS to provide further definition of accessibility requirements by provider type and member need – federal ADA regulations? How does this fit with HCBS requirements? Are they stating that all providers must be accessible? **MCO:** Please provide further information regarding what DHS is requiring for this item. It would seem unreasonably burdensome on both MCOs and providers to require that the contract individually specify specific access and accommodation descriptions for each provider location and service, covering the full range of potential physical and mental disabilities that might be presented. It would be very difficult to adequately address with specific provider contract language. Any such proposed requirement exceeds the requirements of the CFR. **Response:** The Department will change the language to read: 32. Accessibility The provider agreement must contain the

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
			following language: "The provider agrees to provide, as appropriate, physical access, reasonable accommodations, and accessible equipment to members with physical and/or mental disabilities." This will remove the burden of the MCO having to describe specific access and accommodation requirements in its various provider agreements.
29.	§ 438.206 Availability of services. … (c)Furnishing of services. The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements. … (2)Access and cultural considerations. Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.	Article VIII. H. Cultural Competency 1. Cultural Competency and Values … The MCO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds.	**MCO:** Suggest replace attitudes with expectations and removal of interpersonal **Response:** Out of scope of this amendment. This is a suggestion for a new contract change. Ideas such as this should be proposed at the time of contract renewal.
30.	§ 438.206 Availability of services. (a)Basic rule. Each State must ensure that all	Article VIII.I. Access to Providers	**MCO:** What expectations does the department intend MCOs to demonstrate?

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68.	1. *Access Standards* The MCO shall demonstrate to the Department that~~ensure~~ all services and all service providers comply with access standards provided in Article VII, Services, page 96 and the access standards in this article.	**MCO:** Further definition needed behind "demonstrating" versus "ensuring" access and is this going to be an expectation for all MCOs that we all adhere to the same criteria or will this vary MCO to MCO? **Response:** The Department has always reviewed the MCO provider networks by file and annual reviews. This required MCOs to provide information to the Department, thus "demonstrating" compliance. Therefore, this language change is not a change in practice.
31.	§438.207 Assurances of adequate capacity and services. (a) Basic rule. The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1). (b) Nature of supporting documentation. Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. (2) Maintains a network of providers that is	Article VIII.I. Access to Providers … 3. ~~*MCO Certification of*~~ *Assuring Adequate Network Capacity* ~~*and Access*~~ ~~By the effective date of this contract, t~~The MCO shall demonstrate to the Department an adequate internal staff and provider capacity to provide the projected membership in the service area with: a. The appropriate range of services to make all services in the benefit package readily available to all members, including those with limited English proficiency or physical or mental disabilities; b. A sufficient number, mix and geographic distribution of providers of all services; ~~b~~c. Access to prevention and wellness services; ~~c. A sufficient number, mix and geographic distribution of providers of all services;~~ d. Specialized expertise with the target population(s) served by the MCO; e. Culturally competent providers (see Section H. of this article) including Indian health care providers; and	**MCO:** Clarification requested about any planned format changes for reporting. Can the department provide updated example templates? **Response:** There is no change to the current process. We are however requiring more detailed information and have created a model reporting document for all MCOs to use. This was sent to all MCOs in July 2018 and the data is under review. **MCO**: The CFR citation for this proposed requirement is 42 CFR §438.206. This CFR section only requires supporting documentation for elements a. and c., but not for elements b., d., e. and f. This proposed language would impose additional reporting obligations on MCOs not required by the regulation.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. (c) Timing of documentation. Each MCO, PIHP, and PAHP must submit the documentation described in paragraph (b) of this section as specified by the State, but no less frequently than the following: (1) At the time it enters into a contract with the State. (2) On an annual basis. (3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including— (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or (ii) Enrollment of a new population in the MCO, PIHP, or PAHP. (d) State review and certification to CMS. After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in §438.68 and §438.206. The submission to CMS must include documentation of an analysis that supports	f. Services that are physically accessible and available on a timely basis. 4. *Frequency of Documentation of Adequate Network Capacity* The MCO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.a and b. at the following times: a. By the effective date of this contract; b. Annually; and c. At any time there has been a significant change (as defined by the Department) in the MCO's operations that would affect the adequacy of capacity and services, including: i. Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of new population in the MCO. The MCO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.c through f. at the following times: a. By the effective date of this contract; and b. Annually.	**Response:** DHS intends the MCO to provide documentation of a. and c. (1) by the effective date of this contract; (2) annually; and (3) at any time there has been a significant change (as defined by DHS) in the MCO's operations that would affect the adequacy of capacity and services, including: changes in MCO services, benefits, geographic service area, composition of or payments to its provider network or enrollment of new population in the MCO. The Department intends the MCO to provide documentation of b. and d-f (1) by the effective date of this contract; and (2) annually. The Department has revised the proposed contract language to reflect this. **MCO:** How does DHS define Enrollment of New Population? **Response:** Enrollment of a new population would occur due to expansion to new counties or the addition of a target group to the program.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network. (e) CMS' right to inspect documentation. The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.		
32.	§438.68 Network adequacy standards. (a) General rule. A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section. (b) Provider-specific network adequacy standards. (1) At a minimum, a State must develop time and distance standards for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist, adult and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental. (viii) Additional provider types when it promotes the objectives of the Medicaid program, as determined by CMS, for the provider type to be subject to time and distance access standards. (2) LTSS. States with MCO, PIHP or PAHP contracts which cover LTSS must develop:	54. *Verification of MCO Network Adequacy and Access~~Demonstrating Capacity~~* The MCO shall annually submit to the Department, in a format specified by the Department, the following information: ~~In demonstrating capacity, the MCO must consider:~~ a. Actual and projected enrollment by target group for each county served by the MCO; b. A description of how the MCO projects the needs for each target group; c. A current listing of all contracted providers that includes, but is not limited to, the following: ~~a. The anticipated MCO enrollment;~~ ~~b. The expected utilization of services, taking into consideration the characteristics and health care needs of the MCO's members;~~ ~~c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the services in the benefit package;~~ ~~d. The numbers of network providers who are not accepting new MCO members;~~ ~~e. 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.~~ ~~5. *Geographic and Timeliness Access Standards*~~	**MCO:** Who would do this? This needs to be a discussion at a higher level for all programs not just FC/PSHIP as this is a requirement for SSI/DA as well. **Response:** The MCO would do this. MCOs should have data on target group utilization of services. This information should be included as part of the annual business plan. **MCO:** Clarification request for this item. Does this section pertain to both Family Care and Pace/Partnership? MCOs do not necessarily know about private pay in all residential settings. **Response:** Yes. This section applies to Family Care, Partnership and PACE. DHS does not require knowledge of private pay, only private room availability. **LTC Council:** We do not support the deletion of I.5. Geographic and Timeliness Access Standards or I.6 Evidence of Adequate Service Capacity.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. (3) Scope of network adequacy standards. Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas. (c) Development of network adequacy standards. (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract. (iv) The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services. (v) The numbers of network providers who are not accepting new Medicaid patients.	~~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.~~ ~~*6. Evidence of Adequate Service Capacity*~~ ~~Evidence of adequate service capacity to serve the MCO membership includes:~~ ~~a. Submission of a provider network listing for all services in the benefit package that includes, but is not limited to, the following:~~ i. Provider or facility name; ii. Provider or facility address(s) including satellite or remote office ~~Exact~~ locations that are contracted with the MCO~~where services are being provided~~; iii. Services being provided (e.g. home health or respite); iv. For Partnership and PACE programs, whether or not physicians and hospitals are accepting new MCO members; v. ~~Upon Department request, w~~Whether or not other network providers are accepting new MCO members; and vi. Verification that providers are credentialed, when appropriate. ~~d~~b. For residential care facilities, ~~evidence of adequate capacity shall include~~ identification of the availability of residential providers offering private rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences. ~~e~~c. As applicable,~~The Partnership and PACE programs must comply with the requirements of the Mental Health Parity and Addiction Equity Act. Partnership and PACE MCOs must submit~~ evidence of compliance with the Mental Health Parity and Addiction Equity Act. ~~requirements at the time of certification.~~	**Response:** The current contract language has not changed, it has been reorganized. **LTC Council:** 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. **Response:** The proposed language does not ease the requirement that the MCO establish a provider network intended to assure reasonable access to care and services **MCO:** DHS should consider traveled services where a provider may have 1 physical location but serves 20 counties in the MCO's network. This is a gap that exists in this process and will hinder the proper measurement of our network and provider capacity. **Response:** DHS is considering these types of services and will be providing more direction as this new review process moves forward. **MCO:** Clarification requested on MCO vs. DHS approval of policies for travel and distance.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	(vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, evisits, and/or other evolving and innovative technological solutions. (2) States developing standards consistent with paragraph (b)(2) of this section must consider the following: (i) All elements in paragraphs (c)(1)(i) through (ix) of this section. (ii) Elements that would support an enrollee's choice of provider. (iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other considerations that are in the best interest of the enrollees that need LTSS. (d) Exceptions process. (1) To the extent the State permits an exception to any of the provider-specific network standards	~~7. *Additional Information for Certification*~~ ~~The Department may require submission of additional information that includes:~~ ~~a. Actual and projected enrollment by target group;~~ ~~b. A description of how the MCO projects the needs for each target group;~~ f~~c~~. ~~MCO~~ DHS approved policies with supporting procedures~~standards~~ for travel and distance times or service delivery timeframes for ~~any~~ the providers of the services listed in the benefit package; g~~d~~. Current policies with supporting procedures for provider selection and retention; and h~~e~~. Other information the Department determines to be necessary for certification of the MCO provider network.	Does the department intend to require separate policies, from provider contracts? How does the department intend to approve travel and distance policies? **Response:** Yes we have requested policies for the 2018 certification regarding how the MCOs are determining if their network providers are available to members considering time and distance, provider availability, and member census. We are currently reviewing this data for the network review and approval.

No.	Reason for Proposed Change	Language of Proposed Change	Feedback
	developed under this section, the standard by which the exception will be evaluated and approved must be: (i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area. (2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66. (e) Publication of network adequacy standards. States must publish the standards developed in accordance with paragraphs (b)(1) and (2) of this section on the website required by §438.10. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.		

Wisconsin Long-Term Care Scorecard

Angela Witt, Integrated Data & Analytics Section Chief
Bureau of Long Term Care Financing (BLTCF)
Division of Medicaid Services (DMS)
November 13, 2018

Wisconsin Department of Health Services

LTC Scorecard

- Provides information on the strengths and weaknesses in Wisconsin's Long Term Services and Supports (LTSS) system
- Modeled after a national scorecard ranking states on LTSS for elderly and physically disabled adults
  - Current national scorecard called "Picking Up the Pace of Change"
  - Available at www.longtermscorecard.org/2017-scorecard
- Includes elderly, physically disabled, and developmentally disabled adults
- Creates opportunity to track progress over time and to inform key initiatives

Dimensions

1. Access
2. Choice of setting and provider
3. Quality of life
4. Support for family caregivers
5. Effective transitions
6. Reform initiatives

Indicators and Data

- Criteria for indicators
  - Measure things that can be impacted by the Department of Health Services (DHS) policy
  - Compared to national metrics, where possible
- Standards for data
  - Available and extractable from existing databases
  - Valid and sustainable over time
  - Applicable and defensible

What's New

- 2016 data
  - Scorecard reflects 2014-2016 data
  - Each indicator features three consecutive years
- No other changes for this edition
  - All indicator definitions are the same
  - No new indicators added
  - No new national comparisons

Dimension 1: Access

1	Access		2014	2015	2016	Progress
	1.1	Percentage of eligible adults on waiting list for long-term care programs	3.3%	3.3%	2.2%	✓
	1.2	Percentage of total LTSS Medicaid funding spent on the care and support of enrollees in Home and Community-Based Services Waivers (HCBS Waivers)—adults	70.2%	72.8%	75.0%	✓

Dimension 2: Choice of Settings and Providers

2	Choice of Settings and Providers		2014	2015	2016	Progress
	2.1	Percentage of eligible Medicaid people enrolled in HCBS Waivers—adults	78.3%	80.2%	81.7%	✓
	2.2	Percentage of managed long-term care (MLTC) and self-directed long-term care (SDLTC) waiver enrollees self-directing services	36.5%	34.9%	34.6%	✗

Dimension 3: Quality of Life, Employment

3	Quality of Life		2014	2015	2016	Progress
	3.1.1	Percentage of adult age 18–64 HCBS Waivers enrollees in the intellectual or developmental disabilities (I/DD) population who are working in any setting.	47.0%	45.2%	43.3%	✗
	3.1.2	Percentage of adult age 18-64 HCBS Waivers enrollees in the I/DD population who are working in a nonworkshop setting	23.0%	23.7%	24.6%	✓
	3.1.3	Percentage of adult age 18-64 HCBS Waivers enrollees in the physical disabilities (PD) population who are working in a nonworkshop setting	3.3%	3.6%	3.6%	-

Employment Trends

- Trends have remained consistent with the addition of 2016 data.
- Overall percentage of enrollees with I/DD working has decreased each year.
- Percentage of enrollees with I/DD working in a non-workshop setting has increased each year.
- Percentage of enrollees with PD has remained flat.

Dimension 3: Quality of Life, Living Situation

3	Quality of Life		2014	2015	2016	Progress
	3.2.1	Percentage of adult HCBS Waivers enrollees reporting they prefer to change their living situation	12.0%	12.2%	12.3%	-
	3.2.2	Percentage of adult HCBS Waivers enrollees reporting they prefer a less restrictive living situation than their current setting	7.0%	7.1%	7.1%	-

Dimension 3: Quality of Life, Enrollees with Natural Supports

3	Quality of Life		2014	2015	2016	Progress
	3.3	Percentage of adult HCBS Waivers enrollees with natural supports	71.1%	72.3%	72.8%	✓

Dimension 4: Support for Families and Other Natural Support Caregivers

4	Support for Families and Other Natural Support Caregivers		2014	2015	2016	Progress
	4.1	Percentage of adults living with family or spouse wherein the family or guardian prefer the person move to another setting	3.9%	4.0%	4.2%	-
	4.2	Percentage of adults living with spouse or family receiving unpaid care who also receive respite	13.3%	13.0%	12.9%	-

Dimension 5: Effective Transitions

5	Effective Transitions		2014	2015	2016	Progress
	5.1	Percentage of nursing home (NH) residents with low care needs	8.9%	8.4%	8.3%	✓
	5.2	Percentage of new NH stays that last 100 days or more	18.0%	17.1%	16.5%	✓
	5.3.1	Percentage of NH residents with dementia who experience potentially burdensome end-of-life transfers	6.9%	7.3%	6.9%	-
	5.3.2	Percentage of HCBS Waivers enrollees with dementia who experience potentially burdensome end-of-life transfers	12.4%	10.9%	10.8%	-

Dimension 6: Reform Initiatives, NHs

6	Reform Initiatives		2014	2015	2016	Progress
	6.1.1	NH utilization: Percentage of elderly, blind, or disabled Medicaid enrollees using nursing home care	9.9%	9.1%	8.7%	✓
	6.1.2	NH occupancy: Percentage of licensed beds occupied	80.5%	79.0%	76.4%	

Dimension 6: Reform Initiatives, Intermediate Care Facilities

6	Reform Initiatives		2014	2015	2016	Progress
	6.2.1	Intermediate care facility utilization: Percentage of I/DD enrollees using intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs)	1.4%	1.2%	1.3%	-
	6.2.2	ICF/IID occupancy: Percentage of licensed beds occupied	84.8%	90.4%	88.9%	

Dimension 6: Reform Initiatives, Inpatient Behavior Health

6	Reform Initiatives		2014	2015	2016	Progress
	6.3.1	Inpatient behavioral health utilization: Percentage of HCBS Waivers enrollees and fee-for-service (FFS) institution residents using inpatient behavioral health care	1.6%	1.6%	1.5%	-
	6.3.2	Inpatient behavioral health utilization: Percentage of HCBS Waivers enrollees and FFS institution residents with dementia using inpatient behavioral health care	1.3%	1.4%	1.4%	-

Next Steps

- Further LTC use
  - Continued work on LTC quality strategy
  - Add 2017 data in 2019
- Additional updates expected in 2019
  - Continue work on additional infographics and/or interactive displays
  - Continue work on separate scorecard for children's programs
- Possible future updates
  - How else do we measure access after the waitlist indicator is zero?
  - How and when do we incorporate NCI data?
  - Maybe 2019, maybe later

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WISCONSIN DEPARTMENT of HEALTH SERVICES

Curtis Cunningham

Long Term Care
Benefits & Programs

Pay for Performance

2019

2019 Pay for Performance

- Member Survey
- Competitive Integrated Employment
- Assisted Living Community Incentive

Member Survey

- Criteria and questions same as 2018
- 0.25% of Withhold
- 0.20% of Incentive

3

Pay for Performance Questions

Question	Previous Question	2018 & 2019 Question
1	**How often do you get the help you need from your Care Team?** Frequency Scale: Always; Usually; Sometimes; Never	**How often do you get the help you need from your Care Team?** Frequency Scale: Never; Rarely; Sometimes; Very Often; Extremely Often
2	**Do you participate in making decision about your Care Plan?** Frequency Scale: Yes; No	**How involved are you in making decisions about your Care Plan?** Frequency Scale: Not at All; A Little; Somewhat; Very; Extremely
3	**Does your Care Plan include all/most/some/none of the things that are important to you?** Frequency Scale: All of the things that are important to you**;** Most of things that are important to you**;** Some of the things that are important to you**;** None of the things that are important to you; Don't know	**How much does your Care Plan include the things that are important to you?** Frequency Scale: Not at All; A Little; Somewhat; Quite a Bit; A Great Deal
4	**Overall, how would you rate the supports and services you receive?** Frequency Scale: Excellent; Very Good; Good; Fair; Poor	**How well do the services you receive meet your needs?** Frequency Scale: Not at All; A Little; Somewhat; Very; Extremely

4

Benchmarks and Targets

- DHS used MCOs' past results from the previous member satisfaction survey to select thresholds for minimum performance standards and target performance benchmarks.
- Minimum Performance Standard: The minimum performance standards are set on the percentage of positive responses the MCO receives. Positive responses include the top two responses out of the five possible responses for each question.

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Benchmarks and Targets

- Target Performance Benchmark: The target performance benchmarks are set on the percentage of top responses the MCO receives. Top responses include only the most positive response available for each question
- MCOs are only considered to have met a threshold if their response percentage, rounded to the first digit after the decimal point, is equal to or greater than the threshold.

6

Competitive Integrated Employment Withhold Criteria

Plan Review Process:

Initial plan submitted by MCO to DHS on 1/4/2019

1. Must meet at least six of the eight rationale listed below to be eligible for resubmission.
2. If six of the criteria are met, feedback by the state CIE panel will be provided and the MCO will be given a one-time opportunity to resubmit the plan within two weeks.
3. Upon initial submission, plans not meeting at least six of the eight criteria below will not be eligible for resubmission.

In order to receive the withhold, MCOs must have:

- An approved plan by DHS
- All eight criteria must be met for an approved plan
- An approved plan is required in order to be eligible for the incentive.

- Plan template remains the same

CIE Incentive Step One

Step One: Discussion with Members(90%)

1. Currently working in CIE
2. Interested in working in CIE
   a) Interested in working in CIE and know their desired career path
   b) Interested in working in CIE but unsure of their desired career path
3. May be interested in working in CIE
4. Not interested in working in CIE
5. Currently in hospice, medically compromised or a hospital/institutional setting

CIE Incentive Step Two

Step Two: Follow up activities(90%)

1. Currently working in CIE
2. Interested in CIE
   a) Know desired career
   b) Unsure of desired career
3. May be interested in CIE

Initial Criteria 18-64

Target Group	18-64 YO	Employed	Not Employed	% Interested in CIE
IDD	19423	2646	16777	8389
PD	9069	253	8816	882
Total	28492	2899	25593	9271

New Criteria 18-45

Target Group	18-45 YO	Employed	Not Employed	% Interested in CIE
IDD	11149	2006	9143	4572
PD	1387	108	1279	128
Total	12536	2114	10422	4700

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Dates CIE

1. Members included will be from one point in time 11/1/18
2. All work completed will be counted even if member disenrolls
3. If member disenrolls and no work completed the member will be removed from list.

12

Assisted Living Community Incentive Step One DQA

The incentive would be a two prong approach giving an incentive to the MCO based on the number of members who are residing in:

- An ALC that qualifies for an "Abbreviated DQA Survey" and is compliant with HCBS settings rule. ACLs who qualify for an "Abbreviated DQA Survey" have a standing of good regulatory compliance from DQA. To qualify for an abbreviated survey an ALC must be:
  - Licensed for 3 years and
  - Have no enforcement action in 3 years and
  - Have no substantiated complaints in 3 years

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Step One ALC WCCEAL

- An ALC who is a member of Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) in "good standing", is compliant with HCBS settings rule and qualifies for Abbreviated DQA survey. WCCEAL is a volunteer public/private collaborative which requires an ALC to implement a provider association's department-approved QA/QI program, report quality structure, process, and outcome data on a quarterly basis, participate in the resident satisfaction survey and comply with all membership rules.

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Assisted Living Community Incentive Step Two

- On a date to be determined by DHS, DHS will request that each MCO submit the following information for any member living in an ALC on that date:
  - Member Name
  - Member ID
  - Name of ALC that member is living at on that date
  - DQA license number for the ALC
- DHS will provide template

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Assisted Living Community Incentive Step Three

DHS will determine the incentive for the MCOs using the following reports:

- DQA report showing ALCs that qualify for an abbreviated survey
- WCCEAL report showing ALCs in "good standing"
- MCO report showing members residing in ALCs
- HCBS Residential Settings report showing ALCs in non-compliance
- DMS reports for validation

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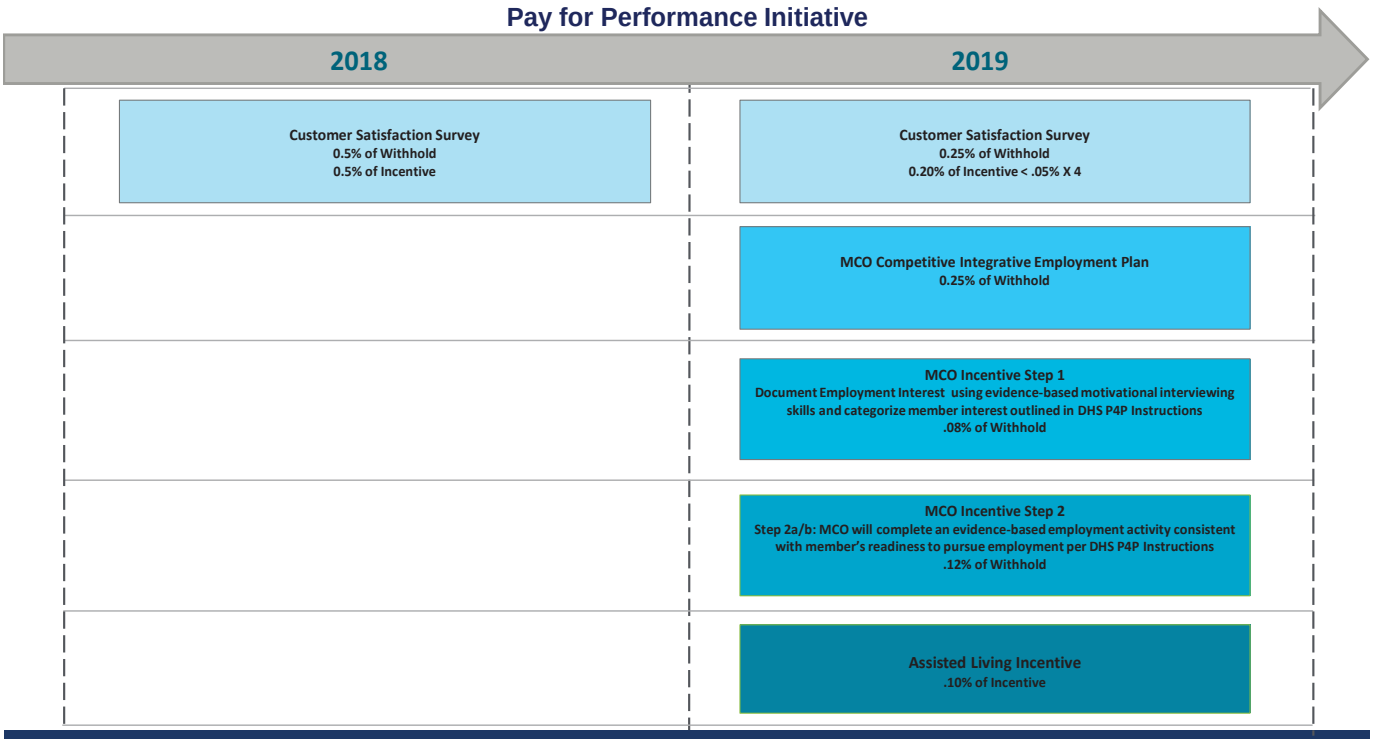
Assisted Living Community Incentive

Incentive .1% of P4P budget

- MCOs will receive an incentive of &--- for each member living in an ALC that meets the abbreviated DQA survey criteria
- $---incentive for each member that meets the WCCEAL criteria.
- If the calculation exceeds or is significantly below .1% of the capitation rate ($2,100,000) DHS will prorate up or down the per member incentive payment amount



Discussion

LTC Council Charges

July 2016 – December 2018

Council Charge Stages

We have been moving through each 2016-2018 charge based on the following steps:

1	**Topic Intro**
2	**Topic Presentation in Depth**
3	**Workgroups Discussion**
4	**Draft Summary**
5	**Final Summary**
6	**Secretary Response**
7	**Workgroups Deep Dive (DD)**
8	**Next Steps**
0	**Updates**

During the period of July 2016 to December 2018, Secretary Seemeyer is charging the Long Term Care Advisory Council (LTCAC) with the following:

Workforce: Develop strategies and data metrics to address workforce shortages in the long-term care system.

- Provide advice and guidance regarding how to measure workforce shortages by provider type.
- Provide advice and guidance on required financial reporting related to assessing workforce shortages.
- Provide advice and guidance to ensure that Medicaid contractors are maintaining quality of care.

Quality: Explore the development and use of quality metrics to analyze the long-term care system and service outcomes, including:

- Provide advice and guidance to determine what metrics should be utilized to assess the effectiveness of the entire long-term care system.
- Provide advice and guidance on a long-term quality strategy to be deployed at every level of the long-term care system.

Communications: Develop plans to communicate to all long-term care stakeholders. Responsibilities will include:

- Ensuring consistent messaging to all entities in the long-term care system.
- Ensuring that policies are being accurately communicated to consumers.
- Ensuring the Department of Health Services is receiving accurate consumer feedback.

Community Development: Develop strategies to keep people safe and healthy in the community to prevent and delay the need for long term care services by:

- Looking at strategies to prevent individuals from going into residential setting before necessary.
- Ensuring that individuals in residential settings are in the right setting for their acuity needs.
- Providing advice and guidance on prevention strategies that should be developed to delay the need for long term care services.

Workforce

Develop strategies and data metrics to address workforce shortages in the long-term care system.

- Provide advice and guidance regarding how to measure workforce shortages by provider type.
- Provide advice and guidance on required financial reporting related to assessing workforce shortages.
- Provide advice and guidance to ensure that Medicaid contractors are maintaining quality of care.

Secretary Response

Based on the council's feedback, the Secretary offered the following guidance:

1. The Secretary will engage with the Wisconsin Department of Workforce Development (DWD) and identify strategies for DHS and DWD to address the above guidance together.

2. The Secretary instructs the council:
   - to identify innovative practices that reduce demands on workforce to serve member needs such as transportation, grocery, remote care, and telehealth/e-health.
   - to review current Home and Community Based Services (HCBS) waiver benefits and advise on what amendments or waiver language changes would be necessary to implement innovative practices and reduce workforce demands.
   - to identify methods that should be used to measure provider costs relative to reimbursement.
   - to advise on strategies for workforce retention.
   - to include workforce quality of care measures with the council's quality charge.

Workforce Charge Stages

The council followed the following steps toward resolving the Workforce charge:

Sep '16	**Overview of the State's Labor Force**	**Dennis Winters**	2 Topic Presentation in Depth
Sep '16	**Workforce Discussion Workgroups**	**Council**	3 Workgroups Discussion
Nov '16	**Workforce Draft Summary**	**Curtis Cunningham**	4 Draft Summary
Jan '17	**Final Workforce Summary**	**Curtis Cunningham**	5 Final Summary
Mar '17	**Secretary guidance regarding Workforce**	**Curtis Cunningham**	6 Secretary Response
May '17	**MCO Provider Networks and Workforce presentations**	**CommunityLink, Care Wisconsin**	8 Next Steps
May '17	**DHS Caregiver Career Program Civil Money Penalty Grant**	**Kevin Coughlin**	8 Next Steps
Jul '17	**LTC Workforce and Employment**	**Becky Kikkert**	8 Next Steps
Jul '17	**Next Steps Regarding LTC Workforce**	**Curtis Cunningham**	8 Next Steps
Mar '18	**Discuss workforce demands and innovative solutions**	**Council**	7 Workgroups Deep Dive
Mar '18	**Discuss workforce recruitment and retention strategies**	**Council**	7 Workgroups Deep Dive
Nov '18	**LTC Worker recruitment and retention resources**	**Annie Yoveff and Lindsey Kreitzman**	8 Next Steps

Quality

Explore the development and use of quality metrics to analyze the long-term care system and service outcomes, including:

- Provide advice and guidance to determine what metrics should be utilized to assess the effectiveness of the entire long-term care system.
- Provide advice and guidance on a long-term quality strategy to be deployed at every level of the long-term care system.

Secretary Response

Based on the council's guidance, the Secretary instructs the council:

1. To continue the DMS Long Term Care overall quality strategy to identify measures and to establish a pay-for-performance program to incentivize quality. The strategy includes:
   - Scan: existing measures and initiatives.
   - Select measures from Scan to use in overall strategy.
   - Add measures we need but don't have (including information technology (IT) and contract issues).
   - Use measures to improve quality: pay for performance (P4P) and public reporting.
2. To make public materials and information as effective and usable as possible and to coordinate these recommendations with the communication charge of the Long Term Care Advisory Council.

Quality Charge Stages

May '17	**NCI Data**	**Angela Witt**	0 Updates
Jul '17	**NCI Custom Questions**	**Angela Witt**	0 Updates
Sep '16	**Quality Scorecard**	**Angela Witt**	0 Updates
Sep '16	**Quality Strategy**	**Curtis Cunningham**	1 Topic intro
Nov '16	**Presentation: National Core Indicators**	**Mary Lou Bourne**	2 Topic Presentation in Depth
Nov '16	**Quality Discussion Workgroups**		3 Workgroups Discussion
Jan '17	**Quality Summary**	**Curtis Cunningham**	4 Draft Summary
Mar '17	**Final Quality Summary**	**Curtis Cunningham**	5 Final Summary
May '17	**Secretary response regarding Quality**	**Curtis Cunningham**	6 Secretary Response
Jan '18	**Nursing Home Quality and Oversight Updates**	**Otis Woods**	0 Updates
Jan '18	**2017 LTC Scorecard**	**Angela Witt**	0 Updates
Jan '18	**Council Discussion – LTC Quality Measures**		3 Workgroups DD
Jul '18	**NCI Data and Custom Questions**	**Angela Witt**	0 Updates
Nov '18	**Quality Charge Updates and MCO P4P**	**Kevin Coughlin and Curtis Cunningham**	7 Next Steps

Communication

Develop plans to communicate to all long-term care stakeholders. Responsibilities will include:

- Ensuring consistent messaging to all entities in the long-term care system.
- Ensuring that policies are being accurately communicated to consumers.
- Ensuring the Department of Health Services is receiving accurate consumer feedback.

Secretary Response

Based on the council's guidance, the Secretary instructs the council and DHS to:

1) Review and revise the Medicaid Long Term Care communications channels such as the Medicaid Long Term Care website to improve the intuitiveness, readability, and user-friendliness of content for targeted audiences.
2) Develop a strategy to more frequently share long-term care updates with and solicit informal feedback from members and the community, such as through virtual town halls, webcasts, or conference presentations.
3) Adopt more robust change management strategies to communicate program and policy changes.
4) Develop a distribution list for Governor-appointed and DHS Secretary-appointed long-term care boards, committees, and councils, and enroll council chairs in order to improve communication between councils.
5) Explore development of more robust direct communication channels for program and policy updates, such as creating distribution lists that automatically enroll members.

Communication Charge Stages

Nov '16	**Communications Introduction**	**Curtis Cunningham**	1 Topic intro
Jan '17	**Communications Discussion Introduction**	**Karen Kopetskie**	2 Topic Presentation in Depth
Jan '17	**Communications Discussion Workgroups**	**Kevin Coughlin**	3 Workgroups Discussion
Mar '17	**Draft Communications Summary**	**Curtis Cunningham**	4 Draft Summary
May '17	**Final Communications Summary**	**Curtis Cunningham**	5 Final Summary
Jul '17	**Secretary response regarding Communication**	**Curtis Cunningham**	6 Secretary Response
May '18	**Further Communication updates and Web Persona Development**	**Cathy Klima**	7 Workgroups Deep Dive
Nov '18	**Communication updates**	**Cathy Klima and Lisa Strawn**	0 Updates

Community Development

Develop strategies to keep people safe and healthy in the community to prevent and delay the need for long term care services by:

- Looking at strategies to prevent individuals from going into residential setting before necessary.
- Ensuring that individuals in residential settings are in the right setting for their acuity needs.
- Providing advice and guidance on prevention strategies that should be developed to delay the need for long term care services.

Secretary Response

Based on the council's guidance, the Secretary instructs the council:

- To invite DOT to meet with the Council to share program information and to solicit input.
- Develop an inventory of DHS funding and/or programs that provide or pay for transportation, and make that available to the Council;
- Obtain a listing of local transportation coordinating committees and promote these local input and coordination opportunities on the DHS website.
- To clarify what MCOs and IRIS providers are required to do to meet the transportation needs of its members.
- Review care plans for MCO members and IRIS participants to ensure transportation needs are identified in the plan.
- Develop quality measures related to transportation for older adults and people with disabilities.

Community Development Charge Stages

Jan '17	**Keeping People Safe and Healthy in the Community**	**Carrie Molke**	1 Topic intro
Mar '17	**Keeping People Safe and Healthy in the Community – Demographics in depth**	**Carrie Molke**	2 Topic Presentation in Depth
Mar '17	**Keeping People Safe and Healthy in the Community – Discussion Workgroups**	**Carrie Molke**	3 Workgroups Discussion
May '17	**Draft Community Development Summary**	**Curtis Cunningham**	4 Draft Summary
Jul '17	**Final Community Development Summary**	**Carrie Molke**	5 Final Summary
Sep '17	**Secretary response regarding Community Development**	**Carrie Molke**	6 Secretary Response
Sep '17	**Community Development next steps discussion**	**Carrie Molke**	8 Next Steps
Nov '17	**Community Development, Transportation presentations**	**Carrie Porter, Tim Sheehan, Amber Mullett**	2 Topic Presentation in Depth
Nov '17	**Community Development, Transportation Discussion Workgroups**	**Carrie Molke**	3 Workgroups Discussion
Jan '18	**Community Development, Transportation discussion summary**	**Amber Mullett**	4 Draft Summary
Mar '18	**Community Development, Transportation discussion summary**	**Carrie Molke**	5 Final Summary
Jul '18	**Secretary response regarding Transportation**	**Carrie Molke**	6 Secretary Response