OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Wisconsin Long Term Care Advisory Council (LTCAC)			Attending: Audrey Nelson, Beth Swedeen, Christine Witt, Cindy Bentley, Darci Knapp, Denise Pommer, Dennise Lavrenz, Janet Zander, John Sauer, Kenneth Munson, Lea Kitz, Mary Fredrickson, Maureen Ryan, Sam Wilson, Shanna Jensen, Stacy Ellingen, Cathy Ley
Date: 7/14/2020	Time Started: 9:30 a.m.	Time Ended: 1:00 p.m.	
Location: Virtual Zoom Meeting			Presiding Officer: Heather Breummer

Minutes

Members absent: none

Others present: Brenda Bauer, Carrie Molke, Curtis Cunningham, Jennifer Speckien, Kevin Coughlin, Lisa Pugh, Suzanne Ziehr, Todd Costello

Meeting called to order

- Heather Bruemmer went through meeting structure and process for public comment
- Audrey Nelson moved to approve the May minutes, Dennise Laverez seconded the motion, the minutes were approve unanimously
- Maureen Ryan moved to approve the July agenda, Janet Zander seconded the motion, the agenda was approved unanimously
- Individuals interested in council membership should send letter of interest to Suzanne.Ziehr@dhs.wisconsin.gov by September 8, 2020. There are currently 5 seats on the council for which terms are expiring. More information can be found on the Council website

Department Updates, presented by Curtis Cunningham and Carrie Molke

Department of Medicaid Services (DMS) updates

- Electronic Visit Verification (EVV)
  - Next public forum is being held online July 29, 2020, from 1:30-3:30 pm
    - This forum will focus on the EVV training plan
  - The soft launch has been rolled back to November 2, 2020
  - Implementation should be completed by January 1, 2021
- IRIS waiver
  - Public comment period has closed
    - Currently in process of reviewing and responding to comments
  - The waiver will be submitted in September 2020
- CARES Funding
  - Providers can apply for funding of costs related to COVID-19 supplies, business loss, personal protective equipment (PPE), etc. for the months of April, May, and June.
- Non-residential Home and Community Based Settings have begun receiving remediation letters

Department of Public Health (DPH) updates

- Continuing to work on Long Path initiative
- Still working with the Caregiver Taskforce
- Health Equity
  - Looking at this as experiencing two (2) public health emergencies at the same time

    - Working on developing a leadership training opportunity to how to look at policies and develop new policies with an equity lens.
        - Possibly to start in fall 2020
    - Examining how to best give power to communities so they can lead the initiates and their voices are heard
- COVID-19
    - Pivoting much of the bureau work to be part of COVID-19 work
    - Developed reconstitution advice and guidance to critical partners
- DPH leadership changes
    - Jeanne Ayers has left the Department of Health Services (DHS), Stephanie Smalley is interim public health administrator

Long Path Update, presented by Carrie Molke

- Went through PowerPoint
- Looking for Council thoughts and guidance on how this can be done in a remote way and what should be modified due to guidance.
- Using Healthy WI Institute Leadership training, from UW Public Health for leader development
- ***Council Suggestions***
    - Chose leaders with the end in mind and what are their roles and responsibility to advance the goals
    - Training piece is important to do right, this is large scale training
        - What is the role and responsibilities of those working on this
        - Be very clear and use data to show how we will be stronger with coordination a
    - Public health organizations invited to training
    - Use clear vision process with counties
    - Include boards of commissioners or steering committees that work with tribes
    - Align with this training with Milwaukee County's activities
    - Send 3-4 specific questions to Council for feedback on before the next meeting
    - Zoom is one method to meet with groups, but doesn't work for everyone
    - Are we silo-ing by separating leaders into different groups
    - Are we marginalizing the population
    - Use community conversations, power mapping, friend of friend of friend calls, small groups

Governor's Taskforce Recommendations, presented by Todd Costello and Lisa Pugh

- Trying to be have a user friendly platform
- Worker registry will be helping, it will be available to families
- Inclusion of kids has been identified
- Will work with state agencies to help refine the costs
- Final vote is on September 10th regarding the taskforce's recommendations

2021 ADRC Scope of Services, presented by Jennifer Speckien

- Went through Aging and Disability Resource Center (ADRC) Scope of Services document
- Updates aim to make it clear what the role of the ADRC is and isn't in specific situations
- Emergency Preparedness and Response is a new section, previously was one (1) paragraph
- Some shared positions text was more appropriate for the conflict of interest policy
- Staff qualifications and training had sections removed because they were repetitive
- Grievance and appeals will be changing based on information received last week
- Waiver is still in draft form, based on what is in the approved waiver, the contract may be amended

Health Equity and COVID-19, presented by Carrie Molke

- Went through PowerPoint
- Data is for those over 60 years old in Wisconsin
    - Tribes have choice of what to make public or not with data

- DHS is tracking Long-Term Care participants with disabilities and in the future will be able to pull out data on that group regarding COVID-19
- Alzheimer's package was initially broken up by county; a couple years ago had allocations for tribes but learned that tribal members weren't using their allocations
- ***Council suggestions:***
    - Updated county health rankings report came out in spring, would be interesting to see continued and how to better understand our population and how we can be better designed to support the populations to improve health./we all need to be aligned in what we are doing to make a difference
    - Hesitate to use LTCAC to get at health equity, we are largely a very white group. Stakeholders should be primary ones to get the information
    - In some ways we are a qualified group to work on this as we are in the community and working with individuals with disabilities and backgrounds
    - Keep issues in front of us and keep us thinking about it. need to keep challenging us and keep us accountable
    - Important to ask these questions and put these questions on agendas everywhere and whenever it can be
    - Admit we don't know how to do this and ask for input
    - We all go back and have our own sphere of influence so it is good for us to have data and go back and keep this conversation going. We need to really understand what the disconnects are. Many times, there are easy fixes to show the community we are listening and trying.

Public Comment

- Wendy:
    - Thank you for serving WI vulnerable residents. I am rural and don't have broadband so participating is challenging.
    - Dental inequities, the funding for dental providers haven't changed for decades. Appreciate someone looking into it.
    - For IRIS enrollment is a choice. From my perspective, I am seeing state representatives limiting that choice. State representatives should reconsider IRIS being a viable alternative to FC.
        - I am seeing a disuse of use of support brokers. I'm a parent. We were told Support Brokers wouldn't be allowed and if I insisted then it would be a health and safety issue
        - They reduced hours by 80% and I didn't receive a NOA so my son was denied his rights.
        - I was told if someone passed away (guardian) they would go to family care and this would dismantle what was set up.
        - Want the functional screen to be reassessed; it is not funding people properly.
- Bob & Heidi Sheire:
    - Need care teams back face-to-face in Richland Center
    - Hard to breathe with face covering
- Anonymous:
    - I would like to remind you that those of us in rural areas do not have high speed internet and thus these types of forums are either impossible or significantly challenged

Adjourn

- Motion to adjourn by Kenneth Munson, seconded by Christine Witt, The meeting was adjourned unanimously.

Prepared by: Suzanne Ziehr on 7/14/2020.

These minutes are in draft form. They will be presented for approval by the governmental body on: 9/8/2020

Proposed January 2021 DHS-MCO Amendment Language		
No.	**Summary of Proposed Change**	**Language of Proposed Change**
1.	Existing contract definition of "acute and primary care benefit package" needs to be revised in light of changes made to Addendum VIII.C. in January 2020.	Article I … 3. **Acute and Primary Care Benefit Package:** ~~the~~ services covered ~~identified~~ in Addendum VII~~I., Benefit Package Service Definitions, Section~~ C~~.~~ that are not also included ~~identified~~ in Addendum VII~~I., Benefit Package Service Definitions, Section~~ B.
2.	Removing contract language allowing MCOs to reduce or waive cost share and replacing with requirement that MCOs inform members of cost share reduction process	Article III.D.2.c.iv. iv. If a member fails to pay the cost share or patient liability as billed by the due date, the MCO will: a) Contact the member to determine the reason for nonpayment. b) ~~Determine whether the cost share or patient liability presents an undue hardship for which the MCO is willing to waive some or the entire obligation.~~ b) Remind the member that non-payment may result in loss of eligibility and disenrollment. c) Attempt to convince the member to make payment or negotiate a payment plan. d) Offer the member assistance with financial management services or refer the member for establishment of a representative payee or legal decision maker if needed. e) If all efforts to assist the member to meet the financial obligation are unsuccessful, refer the situation to the income maintenance agency for ongoing eligibility determination and the ADRC for options counseling f) For a member with a cost share, inform the member that if he or she is having a financial hardship, he or she may file an Application for Reduction of Cost Share with the Department, requesting that it be reduced or waived (see Addendum VIII.10.). The MCO shall also offer to assist the member in completing and submitting the Application.
3.	Typo in citation	Article XIV.D. Reports: As Needed The MCO agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information previously reported by the MCO to the Department. The MCO shall report each such change in information as soon as possible, but not later than thirty (30) calendar days after the effective date of the change. Changes in information covered under this section include all of the following: • Any change in information relevant to Article XIII.H, Ineligible Organizations, page 235. • Article XIII~~., MCO Administration,~~ G., Required Disclosures, page 231
4.	Typo in citation	Article XI.E.3.c. Other Adverse Benefit Determinations A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.~~vii. viii.~~ v.-viii. On the date it becomes aware of any such adverse benefit determination, the MCO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations."
5.	Need to clarify process for MCOs if a member files an oral appeal but does not follow up with a written appeal	Article XI. F.5. c. Acknowledgement of Appeal Receipt The MCO must provide written acknowledgement ~~in writing~~ of receipt for~~of~~ each appeal. The MCO~~'s written acknowledgement~~ must use the ~~include~~ Department issued template language in its written acknowledgment, which includes ~~providing~~ the date ~~by which~~ the MCO will make a decision on the member's appeal and ~~explaining~~ that the member can request a State Fair Hearing if the MCO does not provide the member with its decision by that

		date. Additionally, for oral appeals, the MCO must include a written summary of the member's appeal request. The acknowledgement must be provided to the member, person acting on the member's behalf, or the member's legal decision maker, if applicable;~~,~~ and it must be mailed or hand delivered within five (5) business days of the date of receipt of the appeal. See Article XI.F.5.a.i. for a description of individuals who may be authorized to submit an appeal. d. Procedures i. ~~An appeal may be filed~~ A member can request an appeal ~~either~~ orally or in writing ~~with the MCO~~. The MCO must document all appeals – oral or written – to establish the earliest possible filing date for the member. When an MCO receives an oral appeal, it must make all reasonable efforts to have the member follow-up with a written, signed appeal. This requirement is met when a member signs and returns the oral appeal summary that was included with the acknowledgment of receipt. If after reasonable effort the MCO is unable to obtain the member's signature, it should adjudicate the oral appeal within the 30-day deadline. ii. When processing expedited appeal requests, the MCO is not required to seek written follow-up from the member. Upon receipt, the expedited appeal should be adjudicated within its limited timeframe. ~~However, for standard appeals, the individual must follow an oral filing with a written, signed appeal. In order to establish the earliest possible filing date for the appeal, the MCO must document all appeals whether received orally or in writing. The MCO will process oral requests for expedited appeals without requiring further action of the member.~~
6.	Need to correct typo	Art. VIII.D.23 *Authorization for Providing Services* 23. The provider agreement directs the provider on how to obtain information that delineates the process the provider follows to receive authorization for providing services in the benefit package to members. The ~~provider~~ MCO agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.
7.	Removing requirement that when a member files a grievance on an MCOs request to extend the timeframe for a service authorization the service authorization is automatically denied	Article V.K.9. *Timeframe for Decisions* The IDT staff shall make decisions on direct requests for services and provide notice as expeditiously as the member's health condition requires. a. Standard Service Authorization Decisions i. For Family Care and Partnership, standard service authorization decisions shall be made no later than fourteen (14) calendar days following receipt of the request for the service unless the MCO extends the timeframe for up to fourteen (14) additional calendar days. If the timeframe is extended, the MCO must send a written notification to the member no later than the fourteenth day after the original request The notification of extension must inform the member that: a) The member may file a grievance if dissatisfied with the extension, ~~in which case the extension will be considered a denial,~~ and b) The member may contact the Member Rights Specialist for assistance.
8.	Removing duplicate language	Article XI: **E. Notification of Appeal Rights in Other Situations** *1. Requirement to Provide Notification of Appeal Rights* The MCO must provide members with written notification of appeal and grievance rights in the following circumstances. **a.** Change in Level of Care from Nursing Home to Non-Nursing Home Members whose level of care changes from the nursing home level of care to the non-nursing home level of care must receive a written notice that clearly explains the potential impact of the change, the

		member's right to request a functional eligibility re-screening, the member's right to appeal with the MCO and the member's right to request a State Fair Hearing following the MCO's appeal decision or the MCO's failure to issue a decision within the timeframes specified in Article XI.F.5.e and f. The MCO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or member's legal decision maker~~. The MCO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or a member's legal decision maker.~~ The MCO must mail or hand deliver the Department issued notice of change in level of care form https://www.dhs.wisconsin.gov/library/f-01590.htm when the MCO administers a long-term care functional screen that results in a reduction of the member's level of care from "nursing home" to "non-nursing home," as identified in Article XI.B.1.a.i.
9.	Adding Enrollment and Disenrollment Plan for Publicly Funded Long-Term Care Programs to resource addendum	Addendum VIII. Materials Cited in This Contract & Other Related Communications 78. Enrollment and Disenrollment Plan for Publicly Funded Long-Term Care Programs, F-00366 https://www.dhs.wisconsin.gov/publications/p02320.pdf
10.	Adding Partnership specific appeal and grievance forms to list of DHS mandated templates due to DSNP integration requirements	Article XI.E.1. b. Adverse MCO Grievance or Appeal Decision When 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, T~~t~~he MCO shall use the following Department mandated templates: i. MCO decision is upheld: https://www.dhs.wisconsin.gov/library/f-00232e.htm ii. MCO decision is reversed: https://www.dhs.wisconsin.gov/library/f-00232d.htm iii. MCO notification of extension for decision: https://www.dhs.wisconsin.gov/library/f-00232b.htm iv. Partnership Dual Eligible SNP appeal decision letter <add link when form is complete> ~~iii.~~v. Partnership Dual Eligible SNP Expedited Grievance Rights (add link when form is complete>
11.	Adding requirement for MCOs to provide members with third party records relied upon to make a service authorization decision when member requests records for an appeal	Article XI.C. 4. *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, third party records the MCO relied upon to make a service authorization decision, 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.
12.	P4P 2021 initiative	*redlines are based on the original 2020 contract language

Article XVIII.E.2.

Competitive Integrated Employment

a. Competitive Integrated Employment (CIE) Withhold Criteria

Each MCO will have 0.25% of its calendar year 2021 capitation rate withheld to be returned based on the MCO's performance maintaining its number of members employed in CIE.

Each MCO's 2021 Quarter 1 and Quarter 4 IES Employment Wage Data will be used to evaluate the P4P results. Any member who has worked during at least one month in the quarter is counted in that review period. DHS will round each MCO's percentage result to the first digit after the decimal point.

~~Each MCO will submit a completed Department created spreadsheet to DHSLTCEmployment@dhs.wisconsin.gov by January 31, 2020 to be eligible for the withhold payment. The template will list any MCO members employed in CIE in the month of January 2020. The MCO will update the January 2020 spreadsheet to list its members employed in CIE as of December 31, 2020, and submit the updated spreadsheet to DHSLTCEmployment@dhs.wisconsin.gov by January 31, 2021.~~

1. The MCO will receive 0.25% of its capitation if 90.0 – 100.0% of its members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 ~~January 2020~~ are employed in CIE in Quarter 4 of 2021 ~~December 2020~~.

2. The MCO will receive 0.125% of its capitation if 80.0 – 89.9% of its members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 are employed in CIE in Quarter 4 of 2021. ~~January 2020 are employed in CIE in December 2020.~~

The MCO will not receive any capitation return if less than 80% of its members aged 18-45 years who were employed in CIE in Quarter 1 of 2021 are employed in CIE in Quarter 4 of 2021. ~~January 2020 are employed in CIE in December 2020.~~

b. CIE Incentive Criteria

Each MCO is eligible to receive up to 0.10% of its capitation rate as an incentive payment only if the MCO received the full or partial withhold payment under 0.a. and increases its number of members employed in CIE in 2021~~0~~.

3. The MCO will receive 0.10% of its capitation rate if it increases its members in CIE by at least 4.0% in 2021~~0~~.

4. The MCO will receive 0.05% of its capitation rate if it increases its members in CIE by 2.0% to 3.9% in 2021~~0~~.

The Department will validate the information contained in the ~~spreadsheets provided under~~ IES Employment Wage Data Mart

		with the Unemployment Insurance Data provided by the Department of Workforce Development. ~~2.a. The Department will determine each MCO's increase in number of members employed in CIE based on the validated information contained in the spreadsheets.~~
13.	Adding CIE definition from currently published memo	Article I. 22. **Competitive Integrated Employment (CIE):** Work performed on a full-time or part-time basis; compensated not less than the applicable state or local minimum wage law (or the customary wage), or if self-employment, yields income comparable to persons without disabilities doing similar tasks; the worker should be eligible for the level of benefits provided to other employees; the work should be at a location typically found in the community; where the employee with a disability interacts with other person who do not have disabilities and are not in a supervisory role, and; the job presents opportunities for advancement. The minimum criteria that must be met for employment to qualify as CIE for purposes of the Quarterly Employment Data Report described in Article XIV.C.5. and the CIE Pay for Performance initiative described in Article XVIII.E.2. include all of the following: 1. Compensation a) Wage Employment: Paid at state minimum wage (or local minimum wage if a local ordinance sets the minimum wage higher than the state minimum wage) or higher; or b) Self-Employment: Yields income comparable to persons without disabilities doing similar tasks, and for those self-employed at least one (1) year, the income, when calculated on a per hour worked basis, is at least state minimum wage or the customary wage for that type of employment. 2. Location The work location must be a location typically found in the community: a) Excludes locations leased, owned and/or operated by contracted service providers or other entities for the primary purpose of employing and/or providing prevocational or vocational training/rehabilitation to people with disabilities. 3. Interactions When at the work location, the employee with a disability routinely interacts with co-workers and customers/patrons who do not have disabilities to the same extent as a worker without disabilities filling the same or similar position would interact with co-workers and customers/patrons who do not have disabilities. Co-workers and customers/patrons do not include supervisors or provider agency staff providing supported employment or personal care supports to the employee with a disability. 4. Individualized Position The person is employed or self-employed in a distinct position. This means: a) The person is not sharing a job with another person(s) with disabilities that the business would consider to be one job. b) The person is not working in a team (side by side; same work schedule; identical or virtually identical tasks and duties).

		c) People working in teams of 2 to 8 are considered to be in Group Community Employment, not CIE. This exclusion applies regardless of the service title and billing code used for waiver-funded supports needed to work. 5. Employer of Record CIE assumes that in the vast majority of cases the employer of record will be the business or organization that: a) Operates the location(s), typically found in the community (as defined above), where the individual engages in paid work; and b) Benefits directly from the work done by the person with a disability. The only exceptions to this expectation are when: c) The business or organization does not typically act as employer of record for other employees without disabilities; or d) The business or organization is a government entity and/or a unionized workplace. In these two documented situations, the employer of record may be a provider of services.
14.	Fixing citation typo in Addendum VII.B.	Addendum VII. B. 11. Nursing home stays as defined in Wis. Admin. Code DHS § 107.09 (nursing home, institution for mental disease (IMD) and ICF-I/ID facility). Inpatient services are only covered for IMD nursing home residents under the age of 21 years or age 65 or older, except that services may be provided to a 21 year old resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21. This exception only applies until the person's 22nd birthday. Nursing home services include coverage of 95% of the MCO's nursing home daily rate for MCO members who are in hospice and reside in nursing homes, excluding those members who are receiving nursing home hospice respite services for less than 5 day stays in a nursing home. For members at the non-nursing home level of care nursing home services are coverable only if re-screening results in a change to a nursing home level of care or the member's most recent Minimum Data Set (MDS) assessment in the nursing home indicates that the services are Medicaid reimbursable. See Article ~~VI~~ VII.B.2.b. and c.
15.	Adding requirement for MCOs to notify counties of at risk members and need to coordinate services with a county due to protective placement or emergency mental health services	Article V. N. Requirement to Notify Counties of At-Risk Members: 1. If an MCO identifies risk factors for a member that indicate a need to coordinate planning efforts or provide information to a county human services agency, the MCO will do the following: a. Send the Family Care Member County Notification Form F-02558 https://www.dhs.wisconsin.gov/forms/f02558.docx to: i. The county of residence/responsibility on record, and ii. To the county where the person lives (if different). b. When appropriate or requested, work with the receiving county and any relevant providers in the development of a behavior support plan, a crisis plan, or other community safety plans.

		c. Update the information on form F-02558 if the member's address or other essential information changes, and provide that information to the county. d. If the member lives in a residential setting, provide a copy of the notification form to the member's residential provider agency. e. If a member moves voluntarily to a county in which the MCO does not operate, follow the Change Routing Notification process in Article V.M.b. f. In instances in which the individual's county of legal residency comes into question, or when the individual does not provide written consent for the MCO to provide this notification form to the county, the MCO will convey only the necessary information to ensure appropriate service coordination, as defined in Wis. Stat. § 46.22(dm), about the individual to the appropriate county or state agency involved in residency determinations and/or in the coordination of services.
16.	Removing requirement that an SDS worker signs a provider agreement directly with the MCO	VIII.N.2.f. There is a properly executed provider agreement ~~between the MCO and the relative or legal guardian~~.
17.	Adding requirement for MCOs to reimburse members for cost share or patient liability amounts already paid but later found to be incorrectly calculated	Art. III D. Medicaid Deductible or Cost Share …… 2. Cost Share or Patient Liability d. The MCO shall reimburse members for cost share or patient liability amounts that were collected by the MCO that need to be returned to the member. i. The income maintenance agency or the Department will retroactively adjust the member's cost share amount in CARES. Once the MCO is informed of retroactive adjustment of the member's cost share or patient liability, the MCO must reimburse the member for the incorrectly collected cost share or patient liability amount within 30 calendar days. ii. If the cost share retroactive adjustment is within the past 365 days, FHiC will adjust the MCO's capitation payment. If the retroactive adjustment is more than 365 days, the MCO may need to contact the Department via the enrollment discrepancy mailbox for an adjustment in capitation payment (see Article IV.0.5.a.).
18.	Removing requirement for MCOs to have directed plans of correction in SOD review process because DQA no longer requires the plans	Article XIII D. 2. Quality Monitoring of Providers Regulated by the Division of Quality Assurance (DQA) Each MCO shall have a system for monitoring the quality of subcontracted DQA-regulated provider services. The MCO must: a. Establish mechanisms to monitor the performance of DQA-regulated provider services to ensure member health and welfare and provider compliance with member-care-related provisions of the subcontract on an ongoing basis. b. Identify provider deficiencies or areas for improvement (inclusive of monitoring statements of deficiency (SOD) issued by the Department of Health Services, Division of Quality Assurance). i. The MCO shall have specific SOD review processes in place to address SODs with significant enforcement action, such as: ~~directed plan of correction~~ Provider visit verification, no new admission orders, impending revocations, repeat citations, immediate jeopardy with unresolved

2019 MCO Pay for Performance Results

July 14, 2020

Jasmine Bowen, Quality Assurance Program Specialist
Bureau of Adult Programs and Policy

Purpose of Pay for Performance

Pay for Performance (P4P) is a value-based payment system in which MCOs are incentivized to achieve goals or objectives pertaining to quality. It is an outcomes-based initiative that uses data collection and analysis to drive continuous improvement.

MCO P4P Initiatives

2018	2019	2020	2021
Satisfaction Survey	Satisfaction Survey	Satisfaction Survey	Satisfaction Survey
	Competitive Integrated Employment	*CIE P4P suspended due to COVID-19	Competitive Integrated Employment
	Assisted Living Communities	Assisted Living Communities	Assisted Living Communities

Satisfaction Survey
P4P Questions

1	How often do you get the help you need from your Care Team?
2	How involved are you in making decisions about your Care Plan?
3	How much does your Care Plan include the things that are important to you?
4	How well do the services you receive meet your needs?

Responses range on a 1 - 5 Likert scale (Not at All; A Little; Somewhat; Very; Extremely)

Satisfaction Survey
2019 Results

MCO	**Withhold (0.5%)** "Very" or "Extremely" Satisfied	**Incentive (0.2%)** Only "Extremely" Satisfied
Inclusa (Family Care)	4/4	4/4
Community Care, Inc. (Family Care)	4/4	4/4
Lakeland Care, Inc. (Family Care)	3/4	0/4
My Choice Family Care (Family Care)	2/4	0/4
iCare (Partnership)	2/4	0/4
Care Wisconsin (Partnership)	1/4	0/4
Community Care, Inc. (Partnership)	1/4	0/4
Care Wisconsin (Family Care)	0/4	0/4

Satisfaction Survey
Comparing 2018 to 2019

% “Very” or “Extremely” Satisfied

Question	FC	FCP	PACE
Q1. How often do you get the help you need from your Care Team?	2018: 66.8% 2019: 67.4%	2018: 64.3% 2019: 66.2%	2018: 82.2% 2019: 78.5%
Q2. How involved are you in making decisions about your Care Plan?	2018: 77.3% 2019: 78.5%	2018: 75.2% 2019: 73.4%	2018: 79.6% 2019: 70.0%
Q3. How much does your Care Plan include the things important to you?	2018: 79.5% 2019: 79.3%	2018: 75.6% 2019: 72.6%	2018: 87.7% 2019: 82.1%
Q4. How well do the supports and services you receive meet your needs?	2018: 82.0% 2019: 82.5%	2018: 79.2% 2019: 76.5%	2018: 89.1% 2019: 86.0%

Competitive Integrated Employment
Overview

Step 1 (Withhold)

- MCOs submitted a comprehensive, unified five-year plan to advance CIE.

Step 2 (Incentive 1)

- MCOs submitted documentation of CIE conversations with 90% of its members age 18-45 to gather level of employment interest (e.g. currently working in CIE, interested in working in CIE, may be interested in working in CIE, or not interested in working in CIE)

Step 3 (Incentive 2)

- MCOs submitted documentation of follow-up employment activities intended to support members in maintaining employment, identifying employment interests and opportunities, or successfully gaining employment (e.g. job coaching, shadowing/career exploration, assistance with DVR referral process)

Competitive Integrated Employment
2019 Results

MCO	Withhold (0.25%): MCO Plan	Incentive 1 (0.08%): CIE Conversations	Incentive 2 (0.12%): CIE Follow-Up Activities
All MCOs	Met	Met	Met

The 2020 CIE P4P initiative has been suspended due to the effect of COVID-19 on rate of unemployment; however MCO employment leads continue to meet with DHS on a bi-monthly basis to problem solve issues related to employment during COVID-19.

The CIE P4P initiative will resume in 2021, with objectives to maintain at least 90% of members in CIE to receive the full withhold (or 80% to receive half the withhold) and increase number of members in CIE by 4% for the full incentive (or 2% for half the incentive).

Assisted Living Communities
Overview

The initiative is focused on incentivizing MCOs to improve quality of care provided at Assisted Living Communities (ALCs) in their provider network. ALCs include three facility types:

- Community-based residential facilities (CBRFs)
- Certified residential care apartment complexes (RCACs)
- 3-4 bed adult family homes (AFHs)

Assisted Living Communities
Overview

Incentive 1 Category

Members in an ALC that:

- Is compliant with the Home and Community-Based Services settings rule
- Qualifies for an abbreviated DQA survey

Assisted Living Communities
Overview

Incentive 2 Category

Members in an ALC that:

- Is compliant with the Home and Community-Based Services settings rule
- Qualifies for an abbreviated DQA survey

+

- Is a member of the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) in good standing
- Has a rate of less than three falls with injury per 1,000 occupied bed days during CY 2019.

Assisted Living Communities
2019 Results

	iCare	LCI	CCI	Inclusa	All
# Members in Incentive 1 Category (HCBS and DQA abbrev. survey)	43 (33.3%)	658 (33.9%)	1596 (37.5%)	1850 (38.9%)	4147 (37.4%)
# Members in Incentive 2 Category (HCBS, DQA abbrev. survey, WCCEAL, and falls measure met)	8 (6.2%)	129 (6.6%)	351 (8.2%)	386 (8.1%)	874 (7.9%)
# Members in Neither Category	78 (60.5%)	1153 (59.4%)	2309 (54.3%)	2525 (53.0%)	6065 (54.7%)
# Total Members in ALCs (MCO data submissions as of 12/31/2019)	129 (100%)	1940 (100%)	4256 (100%)	4761 (100%)	11086 (100%)

Assisted Living Communities
2019 Results

	iCare	LCI	CCI	Inclusa	All MCOs
Incentive 1 Earnings	$10,368.94	$158,668.92	$384,856.52	$446,105.62	$1M
Incentive 2 Earnings	$9,153.32	$147,597.25	$401,601.83	$441,647.60	$1M
Total Earnings	$19,522.26	$306,266.17	$786,458.35	$887,753.22	$2M

In Person Survey (IPS) - includes people with intellectual and developmental disability (IDD)
Aging and Disability Survey (AD) - includes people with physical disabilities and older adults (age 65+)

Wisconsin Highlights 2018-19

This summary highlights results that changed from 2017-18 to 2019 and notable areas of interest for NCI IPS and NCI-AD surveys. The full survey results for 2018-19 are available online. For IPS, the national report is released first and can be found at https://www.nationalcoreindicators.org/survey-reports/. For AD, the state report is released first and can found at https://nci-ad.org/upload/state-reports/WI_2018-2019_NCI-AD_state_report_FINAL.pdf.

Access to Transportation

Results related to access to transportation worsened in both surveys with a decrease in people "getting to places when they want to do things outside their homes." In 2017-18, each survey had 78% positive responses, which decreased in 2018-19 to 68% for AD and 71% for IPS. Further, IPS results for "having a way to get to places they need to go" decreased from 92% to 87%.

The surveys showed the most common response was "other" when asked about "reasons they don't have transportation." Of the reasons captured in the survey options, barriers related to location were more common (e.g. no rides coming to the person or going where they want to go) than timing issues, (e.g. no rides on the day or at the time needed).

Community Inclusion, Participation, and Leisure

An approximate ten percent decrease was noticed from year to year regarding being "able to go out and do the things they like to do in the community" (74.9% to 66.4%) and being "able to go out and do the things they like to do in the community as often as they want" (75.3% to 64.2%) for people with IDD. NCI-AD results for similar questions dropped including, "people being as active in the community as they'd like (46% to 44%)," and "doing things they enjoy outside their homes as much as they want (65% to 57%)."

The most common barrier to community inclusion in NCI-AD is health limitations, while transportation led in IPS. Both surveys, however, mention these barriers as well as the cost of activities and having limited help with staffing/personal assistance.

Choice and Decision Making

An increase is noticed between years for respondents who "can choose the people they live with" (30.9% to 39.2%) and a slight decrease for respondents who "can decide their daily schedule" (59.7% to 57.8%) for IPS.

AD state averages remained similar for respondents "who can eat their meals when they want to" (73-74%) and "who can get up and go to bed when they want to" (88-89%).

Rights and Respect

For both years of IPS data, at least 97% of respondents report, “having a place to be alone”, 85% report “others letting the person know before entering the bedroom”, and (89-92%) can “use the phone and internet whenever they want.”

18-19 AD results report a state average of 84% for the “proportion of people whose paid support staff treat them with respect. 17-18 AD data report 88% for the same indicator. In IPS, this indicator was 93% in 2017-18 and decreased to 89% in 2018-19, which was significantly below the NCI IPS national average of 93%.

Self-Directed Supports

For IPS, a slight increase in utilizing self-directed supports from 33% to 36.4% occurred between years. The 2018-19 result is significantly above the national average of 12% and the second-highest percentage of states participating in NCI IPS that year. In addition, people “having enough help deciding how to utilize their budget and supports” fell (94.1% to 85.6%), along with “information about budget/services being easy to understand” (80.6% to 69.6%). An increasing proportion of survey participants self-directing said family members or friends (47% to 56%) or a care manager (9% to 10%) made “decisions about how their budget for services is used”; however, those who said they hire or manage their staff also increased (56% to 62%).

For AD, the percentage of those utilizing self-directed supports is similar at 35-36%. The NCI-AD survey does not ask additional questions about decision-making and help within self-directed supports options.

Work

The IPS Work domain saw an increase in people with a paid job in the community from 16% to 21%; note that Dane County was not included in 2017-18 during its transition, and then was included again in 2018-19. In AD results, only 2% overall had a paying job in each year, although this is higher for people with PD at 3-6% depending for the group and year.

IPS results also showed a decrease in the percent of people who would like a paid job in the community from 42% to 34%. AD results on this question varied by group, with 45-49% of people with physical disability wanting a job if not currently employed.

COVID-19 Impacts on National Core Indicators (NCI) In Person Survey (IPS) and National Core Indicators – Aging & Disabilities (NCI-AD) in 2019-20 and 2020-21

2019-20 Surveys

Data collection was well underway for 2019-20 NCI-AD surveys and had recently begun for IPS when the COVID-19 pandemic hit Wisconsin. Following the declaration of a public health emergency due to the COVID-19 pandemic, DHS directed that in person surveying activities be suspended on March 16th. National organizations overseeing the surveys later directed that in person surveying not resume during the 2019-20 cycle. Through March 16th, the following surveys had been completed:

	NCI-AD			IPS
Program	**Frail Elderly**	**Physical Disability**	**Fee For Service (FFS) Nursing Home**	**Intellectual or Developmental Disability**
Family Care	316	322		107
IRIS	265	270		82
Family Care – Partnership	195	203		43
PACE	48			
FFS Nursing Home			273	
Total	**824**	**795**	**273**	**232**

The total 1,892 NCI-AD surveys represent 84% of that sample goal, but 232 IPS is less than a quarter of the IPS goal. Data quality review and analysis is in progress at the Human Services Research Institute (HSRI) for both surveys, and DHS is working with HSRI and Vital Research to address any follow-up data questions as they arise.

The extent to which this survey data can be used for analysis and reporting varies by survey. NCI-AD data should still allow for most program and target group breakouts, except for PACE, with only slightly greater margins of error than is usually the goal. IPS data will only allow for overall statewide analysis and reporting, and will have a larger margin of error, likely about 7-8% rather than the usual 5% standard. HSRI will allow reporting with a margin of error up to 10% for the 2019-20 pandemic-interrupted survey cycle.

2020-21 Survey Plans

ADvancing States and HSRI will be conducting a pilot of remote surveys for NCI-AD via video conferencing and telephone for 2020-21. No in person surveying will be allowed, and states participating in the pilot will conduct 25-50 surveys per remote mode (video conferencing and telephone). The purpose of this is only to test remote administration of the NCI-AD survey; the data will not be comparable to prior years and is not recommended for use in quality monitoring. Wisconsin plans to conduct 50 pilot surveys via each of the two modes for a total of 100 surveys. This pilot will begin in fall 2020 and conclude by the end of January 2021.

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) and HSRI are allowing states flexibility to determine whether to administer NCI IPS via remote video conferencing, in person surveys, or a combination, depending on the situation in each state. States may start in one mode and switch to the other, or combine both options. With widespread COVID-19 cases in Wisconsin, the current plan is to begin IPS via remote video conferencing in early 2021. It would be possible to amend plans and contracts to conduct in person surveys; however, this would not occur unless and until there is lower COVID-19 case activity. The IPS goal will be 1,015 surveys total, allowing for analysis by program for Family Care, IRIS, and Family Care – Partnership.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Kimberly Schindler and Betsy Genz

Division of Medicaid Services, Long-Term Care Benefits and Programs

September 8, 2020

Long-Term Care Delivery Regions: Modernization Options

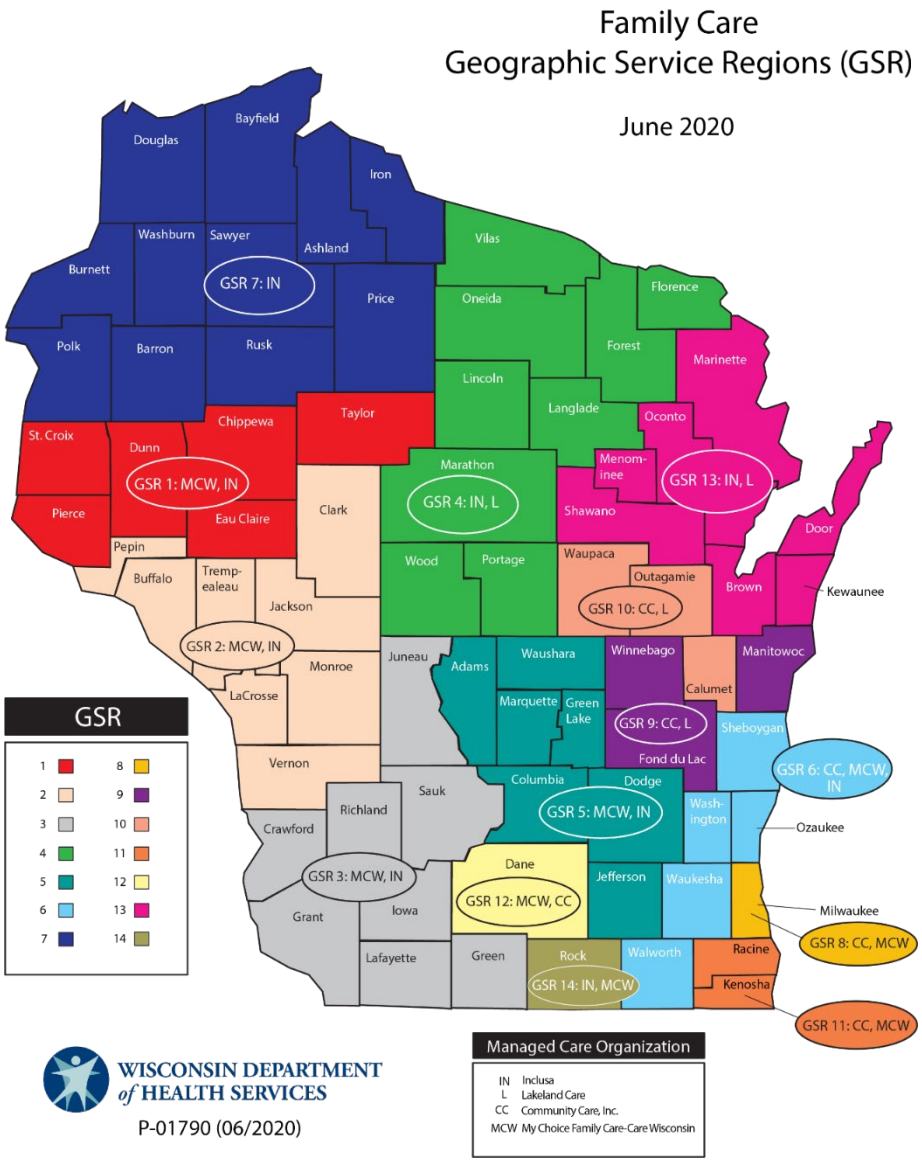
LTCAC Medicaid LTC Charge

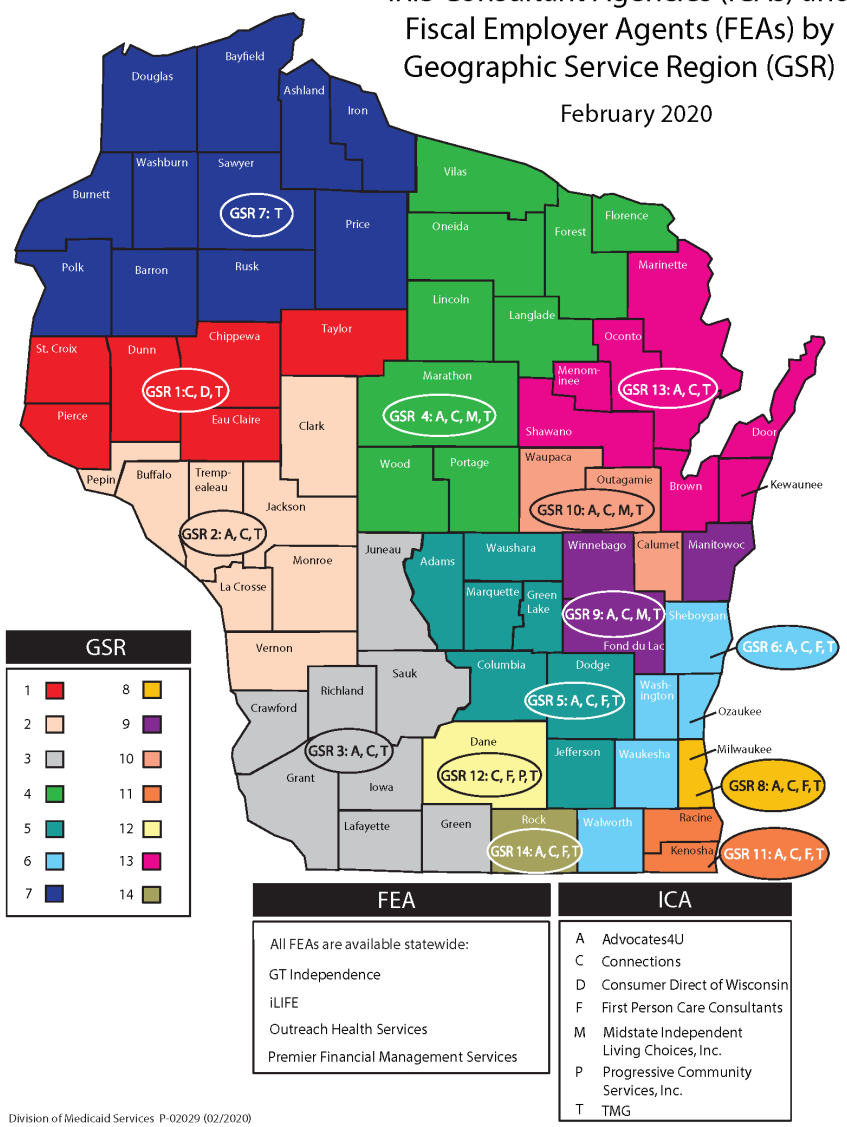
- Provide advice and guidance on the number of Geographic Service Regions (GSRs).
- Provide advice and guidance on the number of Managed Care Organizations (MCOs), IRIS Consultant Agencies (ICAs), and Fiscal Employer Agents (FEAs) in each GSR.

Current Long-Term Care Statistics

- Geographic Service Regions: 14
- Managed Care Organizations: 5 total
  - Family Care: 4
  - Family Care Partnership: 3
  - PACE: 1
- IRIS Consultant Agencies: 7
- IRIS Fiscal Employer Agents: 4

Current Geographic Service Regions





Geographic Service Regions (GSRs)

Constraints and Assumptions

- Reconfiguration and reduction in the number of regions will result in larger regions
- Due to procurement and/or certification processes, agencies can change within each region
- View of state overall – not how individual agencies may be impacted by changes
- Family Care Partnership
- Acute/primary managed care certification

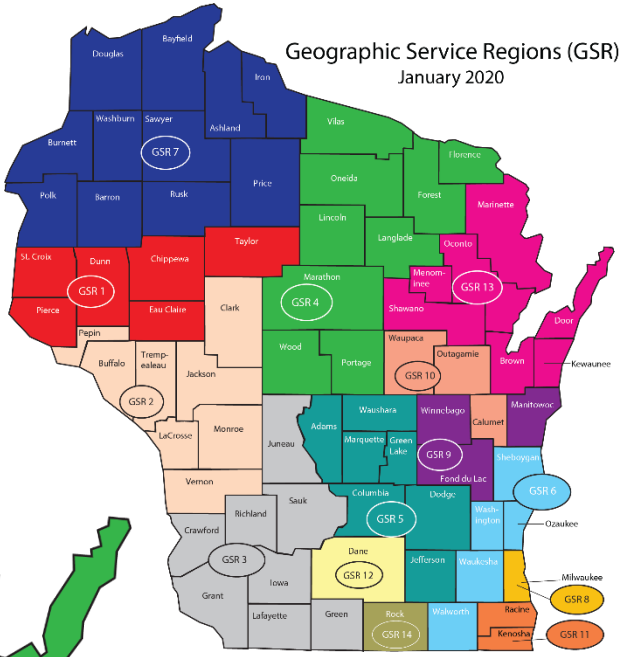
Considerations

- FC procurement considerations:
  - Administrative efficiency
  - Procurement timelines
  - Additional procurement
  - Larger regions
- MCO/ICA & member/participant considerations:
  - Mirror MCO/ICA regions
  - Phasing in a new MCO/ICA
  - Member/participant transitions

Considerations

- Other considerations:
  - Aging and Disability Resource Centers (ADRC)
  - Income Maintenance (IM) Consortia
  - Existing county lines
  - Existing health systems
- Enrollment considerations:
  - Balance of urban and rural areas
  - Population sufficiency to support business and manage services to support member/participant outcomes
  - Consider Milwaukee's population density

Option 1a: Family Care MCO-Based Regions



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Ashland 213
Washburn 154
Sawyer 164
Burnett 106
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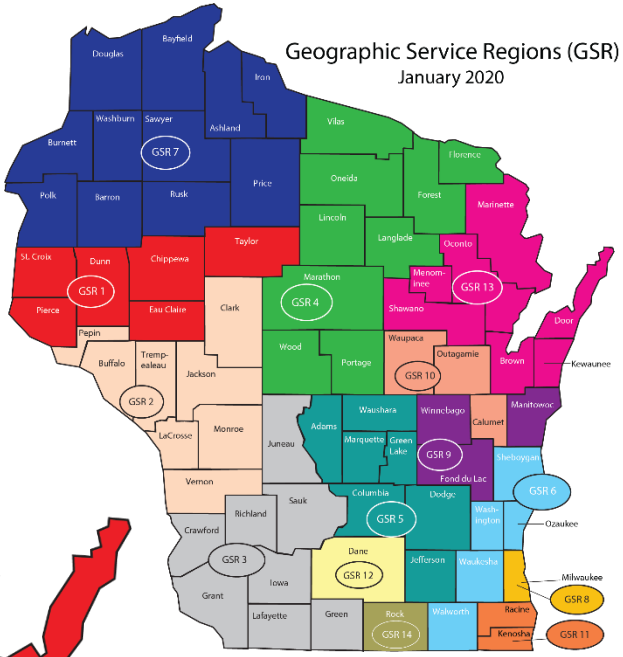
Price 203
Polk 262
Barron 397
Rusk 138
Vilas 153
Florence 35
Oneida 278
Forest 95
Marinette 340
Lincoln 314
Langlade 260
Oconto 309
Taylor 172
Marathon 1,378
Menom-inee 51
GSR 3 8,259
St. Croix 398
Dunn 349
Chippewa 634
GSR 2 9,720
Clark 405
Pierce 228
Eau Claire 1,021
Pepin 67
Shawano 517
Door 244
Wood 995
Portage 817
Waupaca 558
Outagamie 1,249
Brown 2,252
221 Kewaunee
Buffalo 131
Tremp-ealeau 403
Jackson 289
Waushara 270
Winnebago 1,316
Calumet 343
Manitowoc 729
Adams 159
LaCrosse 1,899
Monroe 634
Juneau 318
Marquette 168
Green Lake 197
GSR 4 5,214
Sheboygan 989
Fond du Lac 1,019
Vernon 404
Columbia 457
Dodge 707
GSR 6 5,823
Sauk 666
Richland 369
Wash-ington 963
GSR 5 4,107
Ozaukee 694
Crawford 233
Dane 2,975
GSR 7
Jefferson 980
Waukesha 2,461
Milwaukee 12,327
Iowa 198
Grant 445
Lafayette 129
Green 328
Rock 1,169
Walworth 716
Racine 1,875
Kenosha 1,374
GSR 7 18,551

Combined FC/FCP/PACE enrollment data as of 11/1/19

Option 1b: IRIS ICA-Based Regions



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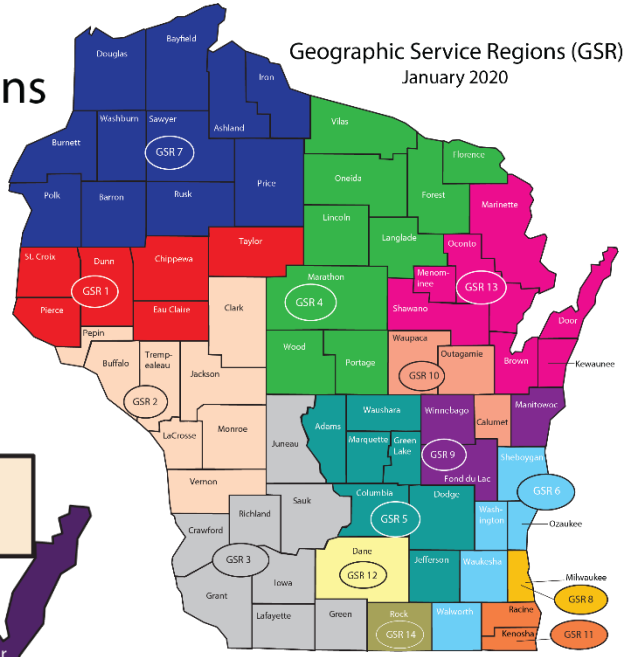
Vilas 28
Florence 11
Oneida 46
Forest 6
Marinette 46
Lincoln 53
Langlade 46
Oconto 40
Taylor 19
St. Croix 236
Dunn 164
Chippewa 248
GSR 2 871
GSR 3
Marathon 303
Menom-inee 7
Pierce 98
Clark 106
GSR 4 2,031
Shawano 65
Eau Claire 333
Door 39
Pepin 53
Waupaca 107
Wood 134
Portage 80
Outagamie 316
Brown 303
Kewaunee 29
Buffalo 60
Tremp-ealeau 49
Jackson 35
Juneau 91
Waushara 89
Winnebago 448
Calumet 114
Manitowoc 231
Adams 30
Monroe 163
LaCrosse 230
Marquette 24
Green Lake 31
GSR 3 2,123
Fond du Lac 108
Sheboygan 265
Vernon 77
Columbia 100
Dodge 181
Sauk 134
Richland 68
Wash-ington 266
Ozaukee 227
Crawford 29
GSR 5 12,528
GSR 6 Dane 1,303
Jefferson 177
Waukesha 728
Milwaukee 8,347
Iowa 64
Grant 111
Lafayette 47
Green 50
Rock 282
Walworth 274
Racine 845
Kenosha 662

IRIS enrollment data as of 12/1/19

Option 2: DPH-Based Regions

Combined Long-Term Care Enrollment Data



GSR 1
10,480

GSR 2
6,329

GSR 3
13,034

GSR 4
12,261

GSR 5
31,759

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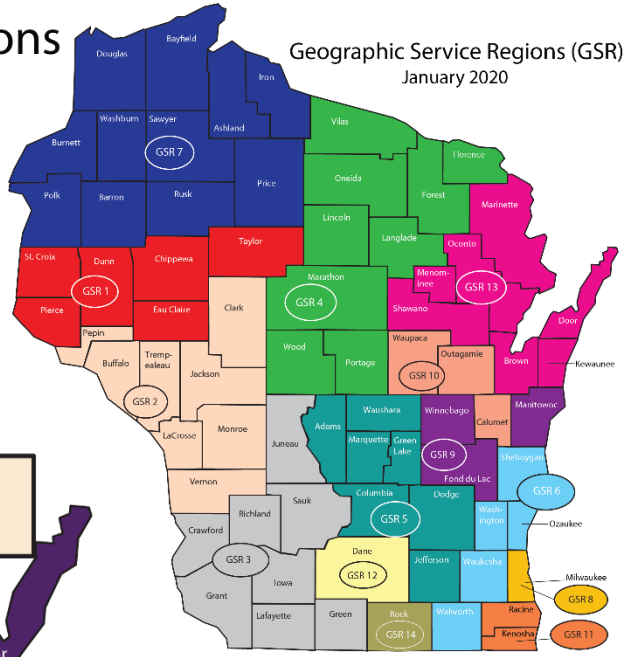
Bayfield 227
Ashland 303
Iron 86
Vilas 181
Florence 46
Burnett 140
Washburn 228
Sawyer 242
Price 248
Oneida 324
Forest 101
Marinette 386
Polk 393
Barron 653
Rusk 195
Lincoln 367
Taylor 191
Langlade 306
St. Croix 634
Chippewa 882
Menom-inee 58
Oconto 349
Marathon 1,681
Pierce 326
Dunn 513
Eau Claire 1,354
Clark 511
Shawano 582
Door 283
Pepin 120
Wood 1,129
Portage 897
Waupaca 665
Outagamie 1,565
Brown 2,555
Kewaunee 250
Buffalo 191
Tremp-ealeau 452
Jackson 324
Waushara 359
Winnebago 1,764
Calumet 457
Manitowoc 960
La Crosse 2,129
Monroe 797
Juneau 409
Adams 189
Marquette 192
Green Lake 228
Fond du Lac 1,127
Sheboygan 1,254
Vernon 481
Columbia 557
Sauk 800
Richland 437
Dodge 888
Wash-ington 1,229
Ozaukee 921
Crawford 262
Iowa 262
Dane 4,278
Jefferson 1,157
Waukesha 3,189
Milwaukee 20,674
Grant 556
Lafayette 176
Green 378
Rock 1,431
Walworth 990
Racine 2,720
Kenosha 2,036

FC/FCP/PACE enrollment data as of 11/1/19
IRIS enrollment data as of 12/1/19

Option 2b: DPH-Based Regions

Milwaukee Separate

Combined Long-Term Care Enrollment Data

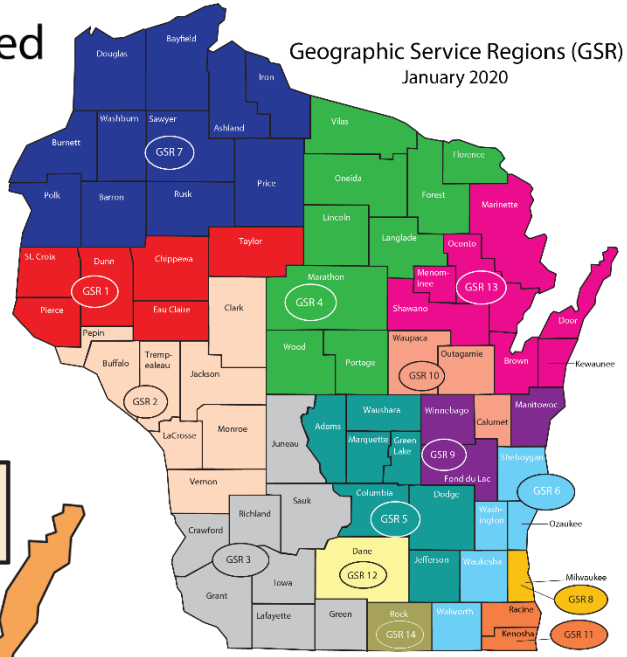


Douglas 638
Bayfield 227
Ashland 303
Iron 86
Vilas 181
Florence 46
Burnett 140
Washburn 228
Sawyer 242
GSR 2 6,329
Price 248
Oneida 324
Forest 101
Marinette 386
Polk 393
Barron 653
Rusk 195
Lincoln 367
Taylor 191
Langlade 306
GSR 3 13,034
GSR 1 10,480
St. Croix 634
Chippewa 882
Menom-inee 58
Oconto 349
Marathon 1,681
Pierce 326
Dunn 513
Eau Claire 1,354
Clark 511
Shawano 582
Door 283
Pepin 120
Wood 1,129
Portage 897
Waupaca 665
Outagamie 1,565
Brown 2,555
Kewaunee 250
Buffalo 191
Tremp-ealeau 452
Jackson 324
Waushara 359
Winnebago 1,764
Calumet 457
Manitowoc 960
La Crosse 2,129
Monroe 797
Juneau 409
Adams 189
Marquette 192
Green Lake 228
Fond du Lac 1,127
Sheboygan 1,254
Vernon 481
Columbia 557
Sauk 800
Richland 437
Dodge 888
Wash-ington 1,229
Ozaukee 921
Crawford 262
GSR 4 12,261
Jefferson 1,157
Waukesha 3,189
GSR 6 Milwaukee 20,674
Iowa 262
Dane 4,278
Grant 556
Lafayette 176
Green 378
Rock 1,431
Walworth 990
Racine 2,720
Kenosha 2,036
GSR 5 11,085

FC/FCP/PACE enrollment data as of 11/1/19
IRIS enrollment data as of 12/1/19

Option 3: BadgerCare Plus-Based Regions

Combined Long-Term Care Enrollment Data



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7,056

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Iron 86
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Washburn 228
Sawyer 242

GSR 2
11,661

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Florence 46
Oneida 324
Forest 101
Marinette 386
Price 248
Polk 393
Barron 653
Rusk 195
Lincoln 367
Taylor 191
Langlade 306
Menom-inee 58
Oconto 349
Shawano 582

GSR 3
12,904

St. Croix 634
Dunn 513
Chippewa 882
Pierce 326
Eau Claire 1,354
Clark 511
Marathon 1,681
Pepin 120
Door 283
Wood 1,129
Portage 897
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Outagamie 1,565
Brown 2,555
Kewaunee 250
Buffalo 191
Tremp-ealeau 452
Jackson 324

GSR 4
11,473

Waushara 359
Winnebago 1,764
Calumet 457
Manitowoc 960
La Crosse 2,129
Monroe 797
Juneau 409
Adams 189
Marquette 192
Green Lake 228
Fond du Lac 1,127
Sheboygan 1,254
Vernon 481
Columbia 557
Sauk 800
Richland 437
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Dodge 888
Wash-ington 1,229
Ozaukee 921
Iowa 262
Dane 4,278
Jefferson 1,157
Waukesha 3,189
Grant 556
Lafayette 176
Green 378
Rock 1,431
Walworth 990
Racine 2,720
Kenosha 2,036

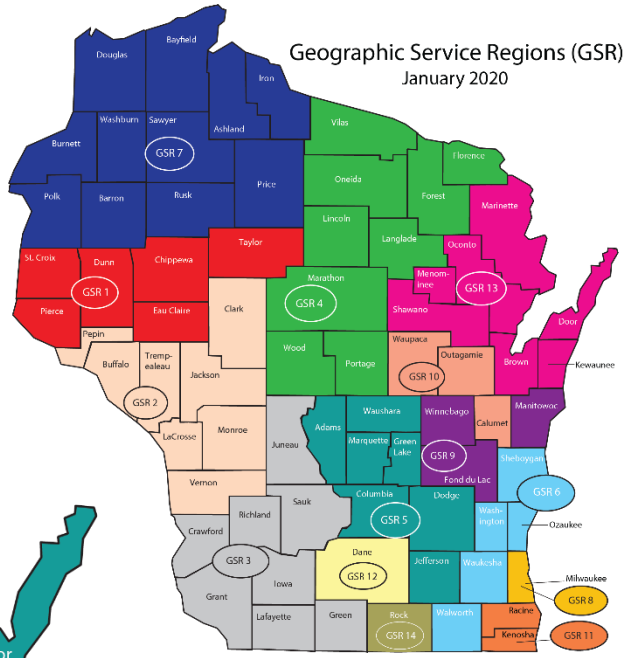
GSR 5
10,095

GSR 6
Milwaukee
20,674

FC/FCP/PACE enrollment data as of 11/1/19
IRIS enrollment data as of 12/1/19

Option 4: Contiguous Regions-Based

Combined Long-Term Care Enrollment Data



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Price 248
Polk 393
Barron 653
Rusk 195
St. Croix 634
Dunn 513
Chippewa 882
Taylor 191
Pierce 326
Eau Claire 1,354
Clark 511
Pepin 120
Buffalo 191
Tremp-ealeau 452
Jackson 324
La Crosse 2,129
Monroe 797
Vernon 481

GSR 2
12,559

Juneau 409
Adams 189
Waushara 359
Marquette 192
Green Lake 228
Columbia 557
Sauk 800
Richland 437
Crawford 262
Dodge 888
Iowa 262
Dane 4,278
Grant 556
Lafayette 176
Green 378
Rock 1,431

GSR 3
16,033

Vilas 181
Florence 46
Oneida 324
Forest 101
Marinette 386
Lincoln 367
Langlade 306
Menom-inee 58
Oconto 349
Marathon 1,681
Shawano 582
Wood 1,129
Portage 897
Waupaca 665
Outagamie 1,565
Brown 2,555
Door 283
Kewaunee 250
Winnebago 1,764
Calumet 457
Manitowoc 960
Fond du Lac 1,127
Sheboygan 1,254
Wash-ington 1,229
Ozaukee 921
Jefferson 1,157
Waukesha 3,189
Milwaukee 20,674

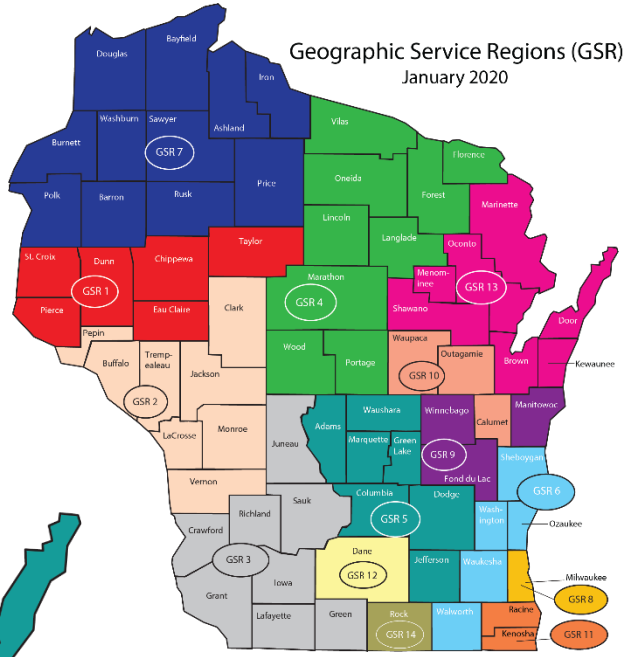
GSR 4
33,013

Walworth 990
Racine 2,720
Kenosha 2,036

FC/FCP/PACE enrollment data as of 11/1/19
IRIS enrollment data as of 12/1/19

Option 4b: Contiguous Regions-Based

Milwaukee Separate
Combined Long-Term Care Enrollment Data



GSR 1
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Ashland 303
Burnett 140
Washburn 228
Sawyer 242
Price 248
Polk 393
Barron 653
Rusk 195
St. Croix 634
Dunn 513
Chippewa 882
Taylor 191
Pierce 326
Pepin 120
Eau Claire 1,354
Clark 511
Buffalo 191
Tremp-ealeau 452
Jackson 324
La Crosse 2,129
Monroe 797
Vernon 481

GSR 3
16,033

Vilas 181
Florence 46
Oneida 324
Forest 101
Marinette 386
Lincoln 367
Langlade 306
Oconto 349
Menom-inee 58
Marathon 1,681
Shawano 582
Door 283
Wood 1,129
Portage 897
Waupaca 665
Outagamie 1,565
Brown 2,555
Kewaunee 250

GSR 2
12,559

Waushara 359
Winnebago 1,764
Calumet 457
Manitowoc 960
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Juneau 409
Marquette 192
Green Lake 228
Fond du Lac 1,127
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Columbia 557
Sauk 800
Richland 437
Dodge 888
Wash-ington 1,229
Ozaukee 921
Crawford 262
Dane 4,278
Jefferson 1,157
Waukesha 3,189
Iowa 262
Grant 556
Lafayette 176
Green 378
Rock 1,431
Walworth 990
Racine 2,720
Kenosha 2,036

GSR 5
Milwaukee
20,674

GSR 4
12,339

FC/FCP/PACE enrollment data as of 11/1/19
IRIS enrollment data as of 12/1/19

Number of Managed Care Organizations (MCOs), IRIS Consultant Agencies (ICAs), and Fiscal Employer Agents (FEAs) in each Region

Current Process for MCOs

- Wis. Stat. § 46.284(2)(bm) requires DHS to procure Family Care and Family Care Partnership services through a competitive request for proposals process.
- DHS determines the number of awards per region.

Current Process for ICAs and FEAs

- DHS uses an open certification process for ICAs and FEAs.
- Willing and qualified providers may submit an application in accordance with the expectations set forth in the Certification Criteria documents.
- Currently, no limitations as to the number of ICAs or FEAs that may work within a specific region.

Current Number of MCOs, ICAs and FEAs per Region

- Family Care MCOs:
  - 1 region has one MCO
  - 12 regions have two MCOs
  - 1 region has 3 MCOs
- ICAs:
  - 1 region has 1 ICA
  - 4 regions have 3 ICAs
  - 9 regions have 4 ICA
- All 4 FEAs are currently statewide

Option 1: Defined number of agencies statewide

- Specify defined number of agencies statewide per region
  - For example, each region has 2 MCOs, 2 ICAs and 1 FCP MCO.
- Considerations:
  - Not based on fiscal/enrollment sufficiency
  - Would require CMS-approved IRIS waiver amendment to limit choice of provider.
  - DHS currently has discretion to the number of MCO contracts awarded.

Option 2: Defined number of agencies per region

- Specify defined number of agencies per region based on fiscal/enrollment sufficiency.
  - For example, regions with less than 10,000 people have 2 MCOs/ICAs; regions with 10,000-20,000 have 3 MCOs/ICAs; regions with 20,000+ have 4 MCOs/ICAs
- Considerations:
  - Dependent on defined number could increase or decrease procurements/certifications.
  - May require CMS-approved IRIS waiver amendment to limit choice of provider.
  - DHS currently has discretion to the number of MCO contracts awarded.

Option 3: Statewide

- Retain procurement/certification process but all awarded agencies serve the entire state (no regions)
- Considerations:
  - Some current agencies may not be able to serve the entire state.
  - If agencies no longer serve members/participants, it could be very disruptive to transition to other agencies.

Option 4: Statewide with GSR Assignment

- Statewide procurement to select agencies with secondary evaluation to assign agencies to specific regions.
- Considerations:
  - Relieves some procurement administrative burden.
  - Would require CMS-approved IRIS waiver amendment regarding choice of provider.
  - More detailed analysis of current RFP process would be required.
  - Secondary evaluation would be a new process and may create additional opportunities for protest.

Option 5: Open Procurement

- No minimum/maximum number of MCOs/ICAs per regions – allow all agencies that pass procurement evaluation/certification into marketplace.
- Considerations:
  - More detailed analysis of current RFP process would be required.
  - Some regions may not be able to absorb a large numbers of agencies
  - Family Care evaluation could be provided on pass/fail vs. rating system – any agency that meets the minimum evaluation points would be awarded.

Option 6: Open Certification

- No procurement and no minimum/maximum number of MCOs or ICAs per region– allow all agencies that pass certification process.
- Considerations:
  - Some regions may not be able to absorb a large numbers of agencies.
  - Would require statutory change to remove FC procurement requirement. More detailed analysis of current RFP process would be required. If statutory change approved, would relieve procurement administrative burden.
  - Current process for IRIS.
  - Could significantly impact members/participants and other partners if the agencies could not remain financially viable.

Other LTC Delivery Regions Modernization Considerations

Other Considerations

- Do modernization options need to be the same across both Family Care and IRIS?
- Should IRIS move from the certification model to a procurement model for new ICAs/FEAs?
- Should FC move from the procurement model to a certification model?
- Should ICA and FEA services be combined and provided by ICAs?
- Should there be only one FEA to serve the entire state?

Discussion