LeadingAge™ Wisconsin
Better Services for Better Aging

March 7, 2016

To: Kitty Rhoades, Secretary, Department of Health Services
From: John Sauer, President/CEO, LeadingAge Wisconsin

Subject: LeadingAge Wisconsin Comments on DHS Family Care/IRIS 2.0 Concept Paper

Thank you for the opportunity to comment on the Department of Health Services' (DHS) recently-released Family Care/IRIS 2.0 concept paper. As a provider association representing the full long-term care (LTC) continuum, LeadingAge Wisconsin looks forward to working with DHS as it advances the transformational changes to Family Care and IRIS as authorized by 2015 Wisconsin Act 55, the 2015-17 biennial budget.

During the time DHS was initially considering how to shape the redesign of Family Care and IRIS, LeadingAge Wisconsin submitted extensive comments and recommendations on identified issues (See attached Comments on Family Care and IRIS 2.0, October 19, 2015). This document provided detailed comments on multiple positions and insights on the current Family Care program and our recommendations on how Family Care/ IRIS 2.0 should be operationalized and managed. While each of the points contained in that document remain of great interest to LeadingAge Wisconsin provider members, for purposes of today's time-limited public hearing we have chosen to focus on a few specific issues as discussed below.

Again, recognizing the need for brevity, the following highlights the Association's recommendations on the DHS Family Care/IRIS 2.0 concept paper:

- **Behavioral Health**: As noted above, the DHS concept paper indicates behavioral health will be covered under Family Care/IRIS 2.0. The concept paper sheds little light on what aspects of behavioral health will be included, thereby leaving many questions unanswered. Several counties now operate consortia to assure persons with complex behavioral challenges receive appropriate care and services. In addition, some counties offer Institution for Mental Diseases (IMD) options to address the needs of persons presenting significant mental health and related conditions. Often times, the cost of serving these individuals is partially covered by county budgets. Further, it is at best unclear if and how much needed dementia crisis units will be created and funded.


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**Questions:** How will the new system impact IMDs and county consortia specializing in high-cost clients? Will dementia crisis units be established and, if so, how will they be funded? Who will cover the cost of emergency placements?

- **"Any Willing Provider"/Return to Home/Provider Choice**: Act 55 extends the "any willing provider" protections for a minimum of three years.

  **Position:** Make the "any willing provider" protections permanent.

- **Combined Capitation Rates/All Client Groups:** Currently, the DHS reports the actuarially-determined Family Care managed care organization (MCO) capitation rates as an amalgamated single rate covering all client groups (frail elders, persons with a physical disability and persons with an intellectual disability). Providers serving frail elders often are told by Family Care MCOs that because the DHS capitation rates do not adequately reflect the cost of caring for high-cost clients (primarily persons with intellectual disabilities), MCOs are forced to limit provider rates to avoid an operating loss, an ongoing form of robbing Peter to pay Paul. Further, overall capitation rates are based on costs incurred by the MCO, not the costs incurred by the provider serving the enrollee.

  **Position**: Require the capitation rate-setting methodology for Integrated Health Agencies (IHA), the IHA rates paid to providers, and IHA-incurred expenditures all be reported and tracked by individual client group. Further, the IHA capitation rates should reflect the actual costs incurred by providers to provide care and services, not simply the costs incurred by the IHA. Failure to do so will make it impossible for providers to address the ongoing workforce crisis. ***Assumptions and projections on provider-related costs should be stated explicitly by the actuaries in determining capitation rates.***

- **Medical Loss Ratio:** LeadingAge Wisconsin recommends Family Care/IRIS 2.0 impose an 85:15 Medical Loss Ratio (MLR) requirement for IHAs (the 85:15 standard means an IHA must spend at least 85% of capitation payments for care and services, with the remaining 15% available for administrative purposes). The proposed federal Medicaid managed care rule released in June 2015 would require all Medicaid plans to follow an 85:15 MLR. It is imperative that DHS ensure funds are targeted for hands-on care and services, particularly in light of the well-documented workforce shortage facing the health and long-term care (LTC) provider communities.

  **Position:** DHS should require a Medical Loss Ratio of 85:15. Should the IHA fail to meet the 85:15 MLR, any amounts falling below the 85% standard should be reinvested in provider rates.

- **Enrollee/Provider Appeal Process:** Providers should be able to appeal rates set by the IHA without having to trigger a discharge notice by a residential care provider.

  **Position:** DHS should establish a rate appeal process. Once the IHA sets a provider rate for an enrollee, both the enrollee and the provider should have the right to appeal the rate. The appeal process should compel the IHA to share details on how it arrived at the rate, including copies of assessment and scoring sheets and the rationale for changing any existing rate. Appeals denied by the IHA should be reviewed and acted upon by the DHS.

- **Nursing Homes:** LeadingAge Wisconsin believes there may be some advantage in rolling the nursing home fee-for-services system into Family Care/IRIS 2.0. Under this option, nursing home acuity increases would be funded automatically as a "cost-to-continue" under Family Care/IRIS 2.0. Under the current process, nursing home acuity increases are discussed (inappropriately, we believe) under "rate adjustment" budget discussions and are often viewed as being discretionary (i.e., acuity adjustments for nursing homes were not funded in FY 2016, resulting in a Medicaid nursing home support services reduction of $1.26/resident day). If the nursing home fee-for-service system was rolled into Family Care/IRIS 2.0, it is more likely that acuity adjustments would be viewed as a nondiscretionary item because this adjustment would be necessary to ensure the DHS-determined capitated rates provided to the IHAs are actuarially sound as required under federal law.

  **Position: LeadingAge Wisconsin requests that DHS consider rolling the nursing home fee-for-services system into Family Care/IRIS 2.0, but <u>only if</u> the following conditions were met:**

  - The current RUGs-based rate-setting system is maintained based on the Medicaid nursing home cost reports;
  - The RUGs-based rates are established as the minimum rates an IHA can pay for nursing home care (i.e., these would be the floor rates; IHAs could pay nursing homes higher rates);
  - Existing formula add-ons and adjustments are maintained (e.g., 20% direct care adjustment for facilities with 50 or fewer beds; vent rates; bariatric care);
  - Rates are paid on a timely basis (within 10 days of services) and additional/new prior-authorization requirements are not imposed; and
  - Medicare fee-for-services rates for skilled nursing facilities are in no way impacted by Family Care/IRIS 2.0 changes.

- **Reinvestment of Savings**: During the 2015-17 state budget deliberations, some Family Care/IRIS 2.0 proponents suggested the proposed integration of acute, primary and LTC services could reduce costs by at least $100 million annually. Whatever level of savings generated by the changes made to Family Care and IRIS should be reinvested in the program, specifically to improve wages, benefits and hours related to the provision of care and services for eligible persons. To be direct and without exaggeration, Wisconsin's long term care workforce crisis is the single most important issue facing our long term care system. ***If we fail to further invest in the caregiving workforce, the promise of improving outcomes for frail elders and persons with an intellectual or physical disability will not be realized***.

  **Position:** DHS should commit to reinvesting any savings generated by Family/IRIS 2.0 to improve caregiver wages, benefits and hours.

Thank you for the opportunity to comment on the DHS Family Care/IRIS 2.0 concept paper. LeadingAge Wisconsin members look forward continuing to work with the Department on these important issues.

*LeadingAge Wisconsin, an affiliate of LeadingAge, is a statewide membership association of not-for-profit organizations principally serving seniors and persons with a disability. Membership is comprised of 195 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 185 nursing homes, 6 intermediate care facilities for the intellectually disabled, 182 assisted living facilities, 114 apartment complexes for seniors and over 300 community service agencies which provide programs ranging from Alzheimer's support, adult and child day care, home health, home care and hospice to Meals on Wheels. LeadingAge Wisconsin members employ over 38,000 individuals who provide compassionate care and service to over 48,000 residents/tenants/clients each day.*

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October 19, 2015

To: Kitty Rhoades, Secretary, Department of Health Services
From: John Sauer, President/CEO, LeadingAge Wisconsin

Subject: LeadingAge Wisconsin Comments on Family Care & IRIS 2.0

Thank you for the opportunity to comment on the transformation of Family Care and IRIS to an integrated program covering acute, primary and long-term care and services (now known as Family Care & IRIS 2.0, or "FCI 2.0"). As a provider association representing the full long-term care (LTC) continuum, LeadingAge Wisconsin and its members are well qualified to offer positions and insights on the current Family Care program and recommendations on how Family Care & IRIS 2.0 should be operationalized and managed. I trust you will accept our comments in the positive spirit in which they are offered.

As you recall, LeadingAge Wisconsin has long been a proponent of integrating acute, primary and long-term care under one system.[1] Removing the operating silos within the system should, if done right, enable consumers to access high quality, cost-effective care and services.

The following document reflects our years of experience working under the current Family Care program and notes the successes and failures of the current "system." It is our sincere desire to build effective partnerships between payors (DHS and IHAs) and providers so that persons directly served under FCI 2.0 receive the best possible care and services they need and desire.

*LeadingAge Wisconsin, an affiliate of LeadingAge, is a statewide membership association of not-for-profit organizations principally serving seniors and persons with a disability. Membership is comprised of 195 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 185 nursing homes, 6 intermediate care facilities for the intellectually disabled, 182 assisted living facilities, 114 apartment complexes for seniors and over 300 community service agencies which provide programs ranging from Alzheimer's support, adult and child day care, home health, home care and hospice to Meals on Wheels. LeadingAge Wisconsin members employ over 38,000 individuals who provide compassionate care and service to over 48,000 residents/tenants/clients each day.*

[1] Long Term Care Redesign: A Vision of a New System, WAHSA (now LeadingAge Wisconsin) www.leadingagewi.org/media/29454/WAHSA-LTC-Redesign-.pdf, January 1997


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# LeadingAge Wisconsin Comments and Recommendations on Family Care & IRIS 2.0

**October 19, 2015**

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# LeadingAge Wisconsin
# Comments and Recommendations
# on Family Care & IRIS 2.0

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## Integrated Health Agencies (IHA) and Regional Coverage

A central question during the 2015-2017 State Budget debate was whether IHAs should be required to provide statewide coverage or be allowed to operate regionally. LeadingAge Wisconsin supports the position advanced by the Legislature calling for regional coverage, as well as the apparent acknowledgement that the high number (11) of Geographic Service Regions (GSRs) presently designated under the Family Care program is neither efficient nor cost-effective. From the providers' perspective, a plethora of FCI 2.0 regions means substantial time and resources will be devoted to designating and establishing regions, including ensuring each region has sufficient potential enrollee populations, conducting actuarial projections and feasibility studies, ensuring provider availability, and monitoring program performance within each region. On the other hand, the establishment of a single, statewide region would likely disqualify several existing high-performing Wisconsin HMOs from participating in FCI 2.0. The Association defers to the judgment of the actuarial firms and consultants to suggest the appropriate number of regions within the state. ***However, that decision needs to take into account regional population, fiscal and eligibility data, and other factors that ensure at least two IHAs could operate effectively within each region.***

That leads us to comment on the number of IHAs that should be granted approval to operate within each FCI 2.0 region. It has been the experience of LeadingAge Wisconsin providers that while multiple MCOs within a region enhances consumer choice, an oversupply of MCOs has resulted in an unnecessary drain of resources as state officials and providers address numerous and often duplicative operational issues. ***The Association, therefore, strongly supports DHS designation of at least two IHAs within each region.*** While we assert two is the minimum number of IHAs that should operate within each FCI 2.0 region, we are uncertain as to what number of IHAs within each region would be determined an "oversupply." What we are certain of is an oversupply of IHAs would mean more funding would be allocated for administrative expenses, diverting dollars that could otherwise be spent on care and services. Such an oversupply also would require providers to "negotiate" multiple, separate and varying IHA contracts, work with multiple care management teams within and among the IHAs, and spend hours addressing non-direct care issues related to prior authorizations, medical reviews and documentation. ***These activities consume scarce provider time and dollars. More than two IHAs could be designated in the more heavily populated regions of the State; however, we again defer to the actuaries to determine how many IHAs should serve each region.***

## Medicare and FCI 2.0 Integration

**Maintain Medicare Payments:** As noted in our introductory comments, LeadingAge Wisconsin has long supported systems that integrate acute, primary and long-term care (e.g., PACE, Partnership). At present, the federal government has established several roadblocks which make it extremely difficult to fully integrate Medicare and Medicaid on a large scale (statewide) basis.[2] However, 2015 Wisconsin Act 55 directs DHS to include in its FCI 2.0 waiver request permission to integrate its Medicaid managed care program by providing acute and primary, as well as LTC services, and to include Medicare-funded services "to the extent allowable by the federal department of health and human services." At present, we are uncertain how DHS intends to follow this statutory directive with respect to Medicare, primarily because we do not know what would be "allowable" to the Department of Health and Human Services (HHS). Assuming the federal government is unlikely to allow DHS to seamlessly integrate Medicaid and Medicare for FCI 2.0 enrollees, LeadingAge Wisconsin urges the Department to avoid any operational changes that could curtail or otherwise limit Medicare payments to skilled nursing facilities. As you know, Medicare payments are critically important in maintaining the financial viability of most nursing homes, especially those specializing in the provision of short-stay rehabilitative care and services.[3] Denial or disruption of these Medicare payments would seriously threaten the continued operation of many facilities. ***The Association recommends that DHS efforts to integrate Medicaid and Medicare benefits be done in a manner that effectively coordinates care but does not jeopardize existing Medicare provider payments.*** For example, providers obviously would oppose any program changes that would result in care for FCI 2.0 nursing home residents being paid at the Medicaid rate for Medicare covered services, or receiving less than the Medicare RUGs rate for Medicare covered days.

**Medically Necessary Services:** If providers are obligated by law or regulation to provide care/services to an enrollee (e.g., rehab therapy) the IHA should be prohibited from denying associated provider payments.

**Passive Enrollment:** In addition, we are aware of other States' experiences with integrating care and services for dual eligibles (i.e., persons eligible for both Medicaid and Medicare). In some States, dual eligibles are "passively enrolled" in a Medicare Advantage plan operated by the same entity that also operates the Medicaid IHA/HMO. It is argued that the IHA/Medicare Advantage plan is better able to coordinate acute,

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[2] Even on a more limited basis, DHS gave up on pushing for federal approval to integrate care for nursing home residents. The proposed DHS Virtual PACE pilot program was terminated before it began. See December 19, 2013 letter from DHS Secretary Kitty Rhoades to then CMS Director of the Office on Medicare-Medicaid Coordination, Melanie Bella, www.leadingagewi.org/files/dhscms.pdf

[3] MedPac Report to the Congress, Medicare Payment Policy, http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf, Chapter 8, March 2015

primary and long-term care without facing the fiscal disincentives often found under the currently fragmented systems. As noted by CMS officials, however, simultaneous enrollment in Medicaid and Medicare, including a Medicare Part D plan, presents an exceedingly complex occurrence for the dual eligible population.[4] Reportedly, many

Medicare beneficiaries subject to passive enrollment have been confused about their available provider network, benefit coverage and personal fiscal obligations. ***For that reason, at this time LeadingAge Wisconsin recommends against implementing passive enrollment of dual eligibles in Medicare Advantage plans as a condition of FCI 2.0 participation.***

## FCI 2.0 Integrated Benefits and Covered Services

Under the 2015-2017 State Budget, it is anticipated that FCI 2.0 will include the current LTC services plus, if federal approval is secured, any primary and acute health services mandated under federal Medicaid law, such as physicians' services, inpatient hospital services, and skilled nursing home services, that the Department chooses to offer as a benefit under the Family Care program.[5] {NOTE: Family Care currently covers skilled nursing home services; about 10% of nursing home residents have their care covered by Family Care. LeadingAge Wisconsin assumes the Medicaid fee-for-service system will be maintained.} We further understand DHS intends to include behavioral health and mental health services to the list of FCI 2.0 covered benefits.

Because DHS has significant experience in contracting with Medicaid HMOs, the Association generally assumes integrating most acute and primary care into FCI 2.0 can be accomplished, albeit not overnight. However, members are anxious to learn more about the Department's intent regarding high-acuity, high-needs populations. ***We seek additional information on the following:***

- **Behavioral and Mental Health:** Several counties now operate consortia to assure persons with complex behavioral challenges receive appropriate care and services. In addition, some counties offer IMD options to address the needs of persons presenting significant mental health and related conditions.[6] Often times the cost of serving these individuals is partially covered by county budgets.

[4] The Dual Eligible Demonstration Projects: The Passive Enrollment Challenge, Community Catalyst, www.communitycatalyst.org/doc-store/publications/Pass_enrollment_briefFINAL.pdf, January 2013

[5] Long-Term Care Changes (DHS -- Medical Assistance -- Long-Term Care), Legislative Fiscal Bureau, http://legis.wisconsin.gov/lfb/publications/budget/2015-17%20Budget/Documents/Budget%20Papers/356.pdf, May 27, 2015

[6] 27.11 Institutions for Mental Disease (IMDs), DHS Medicaid Eligibly Handbook, www.emhandbooks.wisconsin.gov/meh-ebd/policy_files/27/meh_27.11_institutions_for_mental_disease_(imds).htm, July 30, 2015

How will FCI 2.0 address the needs of and pay for persons with behavioral and mental health challenges? Does DHS know the cost of serving these individuals and will these costs be fully reflected in capitation/rate calculations?

- **Dementia Crisis Units:** Over the past two years, LeadingAge Wisconsin has joined DHS and others to help improve (redesign) our State's dementia care system. Significant progress has been made in the areas of community awareness, education and training, and introduction of new programs enjoyed by persons with dementia. One area that has yet to be addressed is the designation of specialized facilities (dementia crisis units) to serve persons in need of intensive dementia-related care and for whom stabilization in a less intensive environment is no longer a viable option.[7] How will FCI 2.0 lead to the development, designation and funding of needed dementia crisis units?

- **LTC Functional Screen:** The Long-Term Care Functional Screen (LTCFS) is used to determine a person's functional eligibility for Family Care; it is a general assessment tool that is now being used in part to determine MCO capitation rates which in turn may determine rates paid to providers. Our Association has been particularly vocal about the limitations of the LTCFS as an assessment tool that is used to determine payments.[8] For example, diagnoses included in the LTCFS are not fully weighted for severity and do not indicate the degree to which clinical interventions or assistance (intensity) may be required. With FCI 2.0 implementation requiring an integrated program, it is even more imperative to utilize a data collection system that more fully reflects an individual's need for acute, primary and LTC services. Failure to do so will continue the system's failure to fully recognize enrollees' conditions and challenges and set adequate provider payments. What form or tool will be used by DHS to establish IHA capitation rates? Will the LTCFS be greatly revised and expanded to capture the needs of enrollees? Will providers be allowed to complete the form/tool to give DHS and the IHAs a more complete summary of a resident's needs? {NOTE: As one would expect, the day-to-day provider typically knows far more about a resident's needs than a care manager who might visit with the person every 90-180 days.}

- **Exceptionally High-Cost Clients:** It is widely known that exceptionally high-cost enrollees can threaten the financial viability of a MCO or HMO. Over four years ago, the Legislative Audit Bureau noted, "Because the Family Care managed care funding model depends on the ability of MCOs to offset expenditures for higher-cost participants with unspent capitation payments for participants with less-expensive care needs, MCOs contend that substantial increases in the number of participants with higher-cost needs have resulted in

[7] LeadingAge Wisconsin Testimony Regarding Dementia Redesign and Services www.leadingagewi.org/media/29147/Speakers-ALZ-TS-Sauer.pdf, October 6, 2015

[8] Concerns About the use of the Functional Screen as a Tool for AL Reimbursement, Jim Williams, www.leadingagewi.org/media/29443/WAHSA-Analysis-of-the-Functional-Screen-JW-CC.pdf, March 22, 2010

capitation amounts that are insufficient."[9] This concern remains today and the alarm is amplified when one contemplates the impact adding acute and primary care responsibilities under FCI 2.0 will have on ability of the IHAs to manage care *and* costs effectively. So the question remains, will DHS allow a carve-out provision to enable high-cost enrollees to be served outside of a capitated system, thereby preventing the need for IHAs to reduce provider payments (the practice of robbing Peter to pay Paul is often present in today's Family Care program)? LeadingAge Wisconsin suggests that high-cost enrollees be identified and managed separately using targeted resources and approaches similar to a process suggested by Dr. Atul Gawande in his work on *Hot Spots*.[10]

## Provider Participation and "Return to Home" Assurances

Under s. 46.284(2)(c), the DHS requires any MCO to contract for the provision of services under the Family Care benefit with any provider "*that agrees to accept the reimbursement rate that the care management organization pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the care management organization requires of other providers with which it contracts to provide the same service."* The Legislature adopted this "any willing provider/resident freedom of choice/return to home" provision as part of 2007 Wisconsin Act 20, the 2007-09 state budget. The provision is intended to prohibit a MCO from arbitrarily denying a provider from being part of the managed care provider network if the provider adheres to the criteria outlined in the statute. More importantly, the provision seeks to expand consumer choice by ensuring that the provider of their choice has every opportunity to be a part of a given MCO provider network. Federal law contains a similar "return to home" provision, which was adopted in response to a number of instances where managed care organizations in other states refused to return a hospitalized nursing home/assisted living resident to their "home" nursing home/assisted living facility because it was not part of the HMO's provider network.

The 2015-2017 State Budget sunsets the "return to home" protections after three years. ***LeadingAge Wisconsin urges DHS to include in its 2017-19 budget request a recommendation to repeal the scheduled sunset of this provision and make the "return to home" protections permanent.*** It is one thing to tell an older adult they must change where they pick up their medications; it is an entirely different matter to tell her she can no longer reside in an assisted living facility, receive rehabilitation services at the associated skilled care facility on campus, or receive personal care services from the attendant who has cared for her for years.

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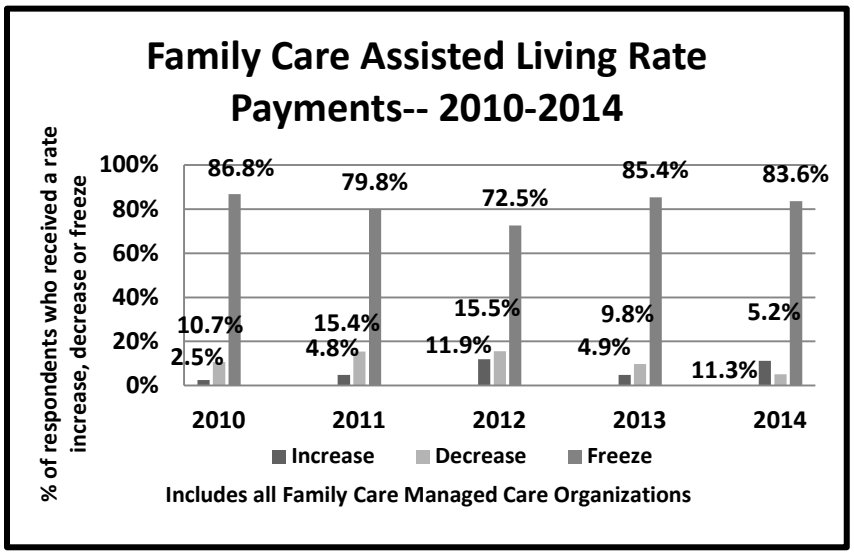
[9] An Evaluation: Family Care, Department of Health Services, Legislative Audit Bureau, http://legis.wisconsin.gov/lab/reports/11-5full.pdf, April 2011,, Page 32.

[10] The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?, Atul Gawande www.newyorker.com/magazine/2011/01/24/the-hot-spotters, January 24, 2011

# FCI 2.0 Capitation Rate Issues

**Rates Should Reflect Provider Costs:** Almost since Family Care's inception, LeadingAge Wisconsin has raised concerns regarding the method by which MCO capitation rates are established. Our primary issue is the information and data provided by DHS to its actuaries are incomplete and generally rely on past program expenditures to establish MCO capitation rates. These expenditures reflect the expenses incurred *by the MCO* to purchase care and services for enrollee; the actuaries are not given estimates of the actual cost of providing care and services. Because most MCOs have not given provider rate increases for a number of years (particularly to assisted living providers), the MCO expense data results in capitation rates that are disconnected from the actual cost incurred by providers serving Family Care enrollees.

Earlier this year, a survey of provider members from four associations (LeadingAge Wisconsin, Wisconsin Health Care Association, Wisconsin Assisted Living Association, and Residential Services Association of Wisconsin) found that during the 2010-2014 period, 95.3% of the 297 respondents received either freezes (84%) or cuts (11.3%) in their Family Care rates at a time that Family Care service expenditures climbed 3.4% and now exceed $1 billion.[11]




Further, despite repeated efforts by providers to obtain information in a straightforward manner, DHS has been reluctant to provide information on the assumptions used by actuaries to project Family Care cost increases. Although some general statements have been made about a projected rise in enrollee acuity based largely on functional screen data, historically little information has been provided on projected direct care costs

[11] Family Care Funding and Access, Provider Associations, www.leadingagewi.org/media/22380/FC-FA-April-20-2015.pdf, March 2015

related to staffing, wages and benefits, transportation, fuel and utilities, or other operating expenses incurred by the provider community. ***Assumptions and projections on provider-related costs should be stated explicitly by the actuaries in determining capitation rates.***

**Combined Capitation Rates for All Client Groups:** Currently, DHS reports the actuarially-determined MCO capitation rates as an amalgamated single rate covering all client groups (frail elders, persons with a physical disability and persons with an intellectual disability).[12] According to the December 2014 PricewaterhouseCoopers report on Family Care, expenditures related to care and services for persons with intellectual disabilities average approximately $1,000 per member per month more than monthly reported expenditures for frail elders or persons with a physical disability. In fact, persons with an intellectual disability represented 42% of all clients served by Family Care in 2013 and 51% of the program's total (MCO) expenditures that year. By contrast, frail elders represented only 27% of the program's total clients and 23% of total MCO expenditures.[13]

Providers serving frail elders often are told by Family Care MCOs that because the DHS capitation rates do not adequately reflect the cost of caring for high-cost clients (including persons with intellectual disabilities), MCOs are forced to limit provider rates to avoid an operating loss (see previous comments on exceptionally high-cost clients). Again, an ongoing form of robbing Peter to pay Paul. As DHS transitions to FCI 2.0, ***LeadingAge Wisconsin requests that the capitation rate-setting methodology, final IHA rates, and incurred expenditures all be reported and tracked by individual client group.*** Doing so would create greater transparency as to how capitation rates are established and in determining the adequacy of the rates for each client group.

LeadingAge Wisconsin is hopeful that the recently released CMS 2016 Medicaid Managed Care Rate Development Guide will provide the impetus for States to be more transparent in setting MCO/IHA capitation rates. Specific CMS guidelines related to the establishment of capitation rates include:

> **Projected Benefit Costs and Trends**[14]
>
> A. The rate certification and supporting documentation must describe the development of the projected benefit costs included in the capitation rates, including:

[12] 2015 Family Care Capitation Rates, DHS, www.dhs.wisconsin.gov/familycare/mcos/capitationrates.htm

[13] Calendar Year 2015 Family Care Capitation Rates, PricewaterhouseCoopers https://www.dhs.wisconsin.gov/files/fc2015capitationrates.pdf, December 2014

[14] Draft 2016 Medicaid Managed Care Rate Development Guide, http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf, CMS, June 2015

i. A description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.

ii. Any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last certification must be described.

B. The rate certification and supporting documentation must include a section on projected benefit cost trends (i.e., an estimate the projected change in benefit costs from the historical base data period(s) to the rating period of the rate certification).

i. This section must include:

(a) Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions. The descriptions of data and assumptions should include citations whenever possible.

(b) The methodologies used to develop projected benefit trends.

In addition, with respect to establishment of separate capitation rates for each client group, one could argue the Medicaid Managed Care proposed rule released June 1, 2015 (CMS-2390-P – Medicaid and Children's Health Insurance Program [CHIP] Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability) would place greater pressure on DHS to follow our recommendations. According to the COMMENTS section of the CMS proposed rule:

> Payments from any rate cell must not be expected to cross-subsidize or be cross-subsidized by payments for any other rate cell. In accordance with the existing rule in §438.6(c)(2)(i), we propose that all payments under risk contracts be actuarially sound and that the rate for each rate cell be developed and assessed according to generally accepted actuarial principles and practices. *See* 67 FR 40989, 40998. We now propose to make this a more explicit standard in the regulation text in paragraph (b)(3) to eliminate any potential ambiguity on this point and to be consistent with our goal to make the rate-setting and rate approval process more transparent. [15]

**Medical Loss Ratio:** LeadingAge Wisconsin recommends FCI 2.0 impose an 85:15 Medical Loss Ratio (MLR) requirement for IHAs (the 85:15 standard means a managed care organization must spend at least 85% of capitation payments for care and services, with the remaining 15% available for administrative purposes). The proposed Medicaid managed care rule released in June 2015 would require all Medicaid plans to follow an 85:15 MLR. According to CMS:

> As of 2015, Medicaid and CHIP are the only health benefit coverage programs to not utilize a minimum MLR for managed care plans….We believe that 85 percent is the appropriate minimum threshold and is the industry standard for MA and large employers

[15] Federal Register, Vol. 80, No. 104, Proposed Rules, www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf, June 1, 2015, Page 31120

in the private health insurance market. ***We believe that considering the MLR as part of the rate setting process would be an effective mechanism to ensure that program dollars are being spent on health care services, covered benefits, and quality improvement efforts rather than on potentially unnecessary administrative activities.***[16] (Emphasis added)

It is imperative that DHS ensure FCI 2.0 funds are targeted for hands-on care and services, particularly in light of the well-documented workforce shortage facing the health and LTC services provider communities. Through the second quarter of 2015, the Family Care MCOs averaged approximately an 82:18 MLR.[17] It should be noted we have appropriately categorized the MCOs' care management expenses as being administrative in nature. The Association recommends should an IHA fail to meet the 85:15 MLR, any amounts falling below the 85% standard be reinvested in rates paid to providers.

## IHA Relationships with the Provider Community

As the State transitions to FCI 2.0, there are a number of Payor (IHA) – Provider issues that should be given further attention and guidance. Resolution of the following issues will keep the focus on delivering high quality care and services to the program's enrollees:

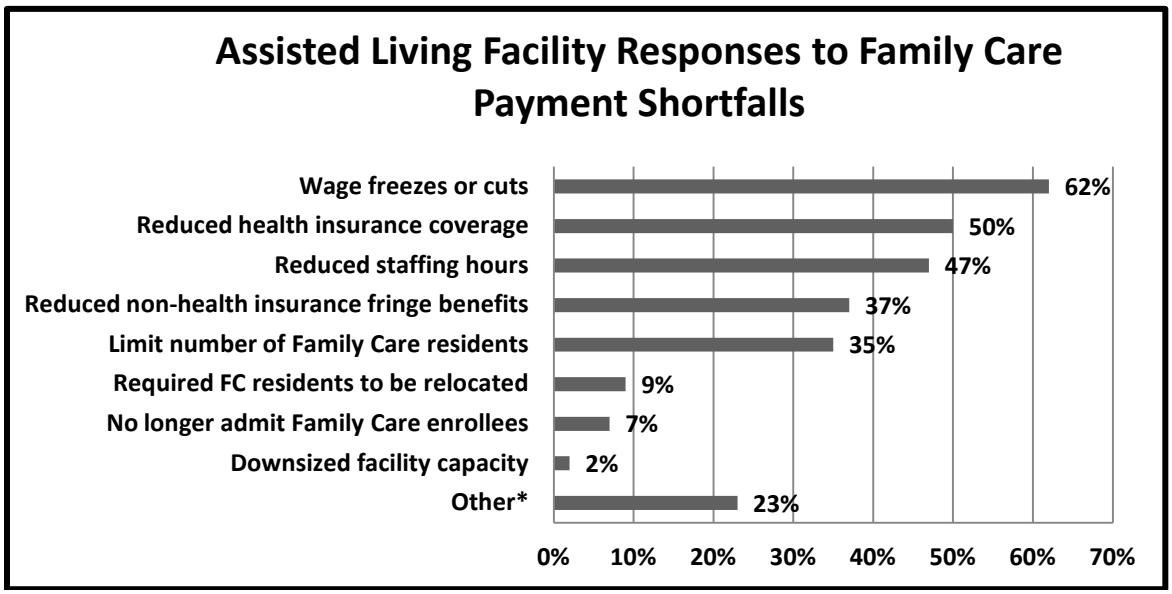
**Provider Reimbursement Rates:** It should come as no surprise that our assisted living providers' #1 issue with the current MCOs is payment. As noted above, the provider associations jointly conducted a survey of their respective memberships in March 2015 and found over 95% of the respondents received a rate cut or freeze every year since 2010. According to the survey findings, the impact of the MCOs' failure to provide adequate rates has resulted in the following:

- Over 70% of the survey respondents indicated insufficient Family Care funding forced them to take actions which were in the best interests of neither their staff nor their Family Care enrollees: 63% of those forced to address Family Care funding shortfalls stated they imposed staff wage freezes or cuts; 50% reduced staff health insurance coverage; 47% reduced staff hours; 35% limited the number of Family Care enrollees they would serve; and 7% no longer admit Family Care enrollees to their facility. Access as well as quality care are threatened by insufficient Family Care funding.[18]

[16] Federal Register, Vol. 80, No. 104, Proposed Rules, www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf, June 1, 2015, Page 31107

[17] Family Care Financial Summaries, DHS, www.dhs.wisconsin.gov/publications/p0/p00599-2q-15.pdf

[18] Family Care Funding and Access, Provider Associations, www.leadingagewi.org/media/22380/FC-FA-April-20-2015.pdf, March 2015




- The correlation between insufficient Family Care funding and an inability to compete for needed staff became readily apparent with the findings of another survey of provider members, this one on workforce availability. That survey found that on average, the 103 assisted living provider respondents had a facility staff vacancy rate of just over 7% (7.14%): a 4% vacancy rate for registered nurses (RN), a 7% vacancy rate for licensed practical nurses (LPN), and a 9% vacancy rate for resident care/certified nurse aides (CNA), the primary caregivers in assisted living facilities. There always has been a correlation between staffing and quality; unfortunately, when staffing is insufficient, quality almost invariably suffers.

Taking into account our recommendations under the above section, FCI 2.0 Capitation Rate Calculation Issues, **IHAs should be required to increase the average provider rate(s) commensurate with the cost-to-continue and inflationary adjustments reflected in the IHA capitation rates set by DHS and the actuaries.**

**Full Disclosure Requirement:** Under FCI 2.0, **the IHAs should be required to publicly disclose their provider rate-setting methodology, including any "scoring system"** based on an enrollee's comprehensive assessment so that the entire rate-setting process is fully transparent. Too often, the current MCOs have been unwilling to share their provider rate-setting methodology or the assessment tool that drives payment determinations.

**Provider Rate Protections:** The Association requests continuation of and extension to all providers the DHS-MCO contract requirement protecting providers from being subjected to rate cuts imposed by the MCO after rate "negotiations" have been completed between the MCO and the provider. Current contract provisions state:

> Residential rates shall be for a period of not less than one year, unless there is mutual agreement upon a shorter term. Residential services subcontracts or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rates may be changed:
>
> i. Anytime, through mutual agreement of the MCO and provider.
> ii. When a member's change in condition warrants a change in the acuity-based rate setting model.
> iii. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:
>
> a) The MCO must provide a sixty-day written notice to the provider prior to implementation of the new rate.
> b) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.
> c) Rates which are reduced using sub iii are protected from additional decreases during the subsequent twelve (12) month period.[19]

**Enrollee/Provider Appeal Process:** Once the IHA sets a provider rate for an enrollee, **either the enrollee and/or the provider should have the right to appeal the rate.** The appeal process should compel the IHA to share details on how it arrived at the rate, including copies of assessment and scoring sheets and the rationale for changing any existing rate. Appeals denied by the IHA should be reviewed and acted upon by DHS. A suggested appeal process was advanced earlier by the provider associations for consideration by DHS.[20]

**Timely Payments and Care:** LeadingAge Wisconsin is aware of several instances in which health care insurance companies have been found out of compliance with CMS managed care regulations related to prior authorizations and failure to timely pay claims ("recognize covered services"). We recommend that IHAs be required to pay provider claims timely (e.g., within 10 days of claims submission). Any prior authorization requirements imposed by the IHAs should recognize the responsibilities of the provider to provide care and services deemed necessary per clinical assessments and standards and/or required by statute or code. For example, nursing facilities are required by federal law to provide medically necessary therapies and interventions and failure to do so would place a facility in regulatory jeopardy.

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[19] DHS Division of Long Term Care and MCOs, January 1, 2015 – December 31, 2015, Article VIII, Provider Network, 5,b., www.dhs.wisconsin.gov/familycare/mcos/cy2015mcocontract.pdf, Page 111

[20] Issue: Family Care Provider Payment Rate Transparency, LeadingAge Wisconsin and others, www.leadingagewi.org/files/ipfamcare.pdf, March 2013

**IHA-Imposed Requirements and Requests:** LeadingAge Wisconsin requests that the DHS-IHA contract require the IHAs to acknowledge and respect the providers' rights regarding HIPAA and quality assurance safeguards and protections. Further, unless otherwise agreed to by the providers, IHAs should be prohibited from imposing provider reporting requirements or standards that are redundant or conflict with existing DHS Division of Quality Assurance or other statutory or administrative rule requirements.

**Care Management and Subcontracting:** Facility-based providers continue to voice concerns over the redundancy of the MCOs' care management function. While providers understand the need for MCOs to monitor the quality of care and services provided to its enrollees, the current care management process often is inefficient, redundant and costly to both the MCO and the facility. Current law and processes require facilities to fully assess the needs of their residents and implement an individualized plan of care designed to meet those needs. Given these responsibilities, the facility clearly knows more about their residents on a day-to-day basis than MCO employees who might visit with the resident every 90 to 180 days. The Association recommends the IHAs be authorized to subcontract with facilities for care management responsibilities. This subcontract logically could include updating resident assessments/functional screens (see above comments). Allowing the facility to complete the assessments/functional screens required under FCI 2.0 would ensure the resident's needs are more completely and accurately recorded.

**IHA Uniform Contracts:** Under the current Family Care program, each MCO has developed its own unique provider contract. In some areas of the State, providers need to wade through up to four MCO contracts at considerable time and expense. LeadingAge Wisconsin requests the IHAs be required to use a standard uniform contract with supplemental IHA-added provisions clearly delineated.

**Retrospective Provider Audits:** IHAs should not require assisted living providers, particularly adult family homes, to submit detailed audits as part of the rate-setting or reconciliation process. The Association supports continuation of the DHS-MCO language stating:

> In accordance with Wis. Stats. §46.284(2)(d), MCOs are prohibited from including in a contract for residential services, prevocational services, or supported employment services a provision that requires a provider to return to the MCO any funding that exceeds the cost of those services.[21]

**IHA Indemnification**: Providers should not be required to indemnify the IHA or otherwise assume risks appropriately held by the IHA. Providers are subcontractors and should not be asked to take-on the operating and program responsibilities of an insurance company.

[21] DHS Division of Long Term Care and MCOs, January 1, 2015 – December 31, 2015, www.dhs.wisconsin.gov/familycare/mcos/cy2015mcocontract.pdf, Page 115

**Nursing Home Rates:** LeadingAge Wisconsin requests that current provisions requiring MCOs to reimburse nursing homes at a level no lower than the Medicaid fee-for-service rate for persons enrolled in Family Care be continued under FCI 2.0. IHAs also should be required to mirror all other nursing home formula adjustments/add-ons and special rates (e.g., ventilator and bariatric rates) authorized for residents served under the remaining Medicaid fee-for-service system.

## Reinvestment of Savings

During the 2015-2017 State budget deliberations, some advocates supporting the transformation of Family Care and IRIS to FCI 2.0 suggested the proposed integration of acute, primary and LTC services could reduce costs by at least $100 million annually. LeadingAge Wisconsin recommends that any savings that might result under FCI 2.0 be reinvested in the program specifically to improve wages, benefits and hours related to the provision of care and services for eligible persons. If we fail to further invest in the caregiving workforce, the promise of improving outcomes for frail elders and persons with an intellectual or physical disability will not be realized.

LeadingAge Wisconsin members and staff pledge to work with DHS and other stakeholders on the ongoing redesign of the Wisconsin health and LTC services delivery system. Should you have any questions or comments related to this document, please do not hesitate to contact John Sauer, President/CEO, LeadingAge Wisconsin, at 608.255.7060 or jsauer@LeadingAgeWI.org.

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