Comment and Recommendations on Family Care 2.0 Redesign

Background:

The Wisconsin Health Care Association/Wisconsin Center for Assisted Living (WHCA/WiCAL) take pride in being Wisconsin’s most diverse and representative long term care provider association. The WHCA/WiCAL membership consists of over 300 of the state’s skilled nursing and assisted living facilities and embraces all ownership types - proprietary, non-profit, and government-operated facilities. On a daily basis, they individually and collectively provide Wisconsin’s frail/elderly and persons with disabilities access to a spectrum of quality services that span the state’s ever-changing term care continuum.

WHCA/WiCAL was an active participant in the initial design and implementation of the current Family Care system. However, we, like other key stakeholders, have over the past several years voiced increasing concern for the current program’s financial stability and sustainability and its ability to effectively/efficiently coordinate and provide quality care to Family Care enrollees. Accordingly, WHCA/WiCAL welcomes and supports Act 55’s mandate for design and implementation of a new Family Care system and appreciates the opportunity to participate in the reform effort. The following comments and recommendations for change are offered with an intent to assure the new system envisions and embodies significant improvements for those who receive and provide Family Care services and not merely a transition from one flawed model to another.

Prioritizing Workforce Issues:

The critical need to cultivate, nurture and maintain Wisconsin’s long term care workforce should be a primary focal point in the Family Care 2.0 redesign effort. It should also be prioritized in the 2017-19 state budget that will provide funding to support the new system. Unfortunately, most of the current public discussion and debate on Family Care redesign has been misplaced on who may be best suited to coordinate and manage the envisioned integrated delivery system. But, WHCA/WiCAL submits that the most critical to be addressed in redesigning the new system is how to assure sufficient numbers of qualified individuals will be available and willing to provide care to the state’s frail/elderly and disabled citizens.

DHS and all Family stakeholders must make an individual and collective commitment to generate public and legislative recognition that it is the nurses, CNAs, personal care workers and other caregivers, not case managers, who provide the “Care” in Family Care. Indeed, it should be painfully apparent to all that absent adequate numbers of qualified caregivers, no health care delivery system can or will succeed. WHCA/WiCAL accordingly submits that the investment of time and resources that will dictate the success of Family Care 2.0 will not be in establishing how, and by whom care is managed, but rather in where, how, and by whom care and services is actually provided to program enrollees.
To that end, future Family Care 2.0 funding, DHS Capitation Rate Setting Methodologies, and IHA provider payment methodologies must be structured and aligned to facilitate recruitment and retention of a long term care workforce that is of the size and quality necessary to meet existing and projected needs of the state’s frail/elderly and disabled. All funding and rate setting mechanisms must recognize prioritize the need to enable Family Care providers to provide staffing, wage and benefit increases that will allow them to compete with other industries for the dwindling supply of qualified workers.

In 1998, WHCA expressed criticism that DHS’ initial long term care redesign proposal was void of any consideration for the “capacity of the labor supply to provide more extensive services in expanded delivery systems to increasing population of consumers requiring long term care.” The concern we voiced then has since escalated to a crisis of such proportion that it cannot be ignored in the Family Care 2.0 redesign effort.

**Number and Size of Family Care Integrated Health Agency (IHA) Regions:**

WHCA/WiCAL does not object to large regional or state-wide service coverage by the new and competing Integrated Health Agencies (IHAs). However, the size of the regions must be structured to assure all IHA markets embrace a critical mass of enrollees that supports sustainable operational efficiency, predictability and financial stability. Competition between IHA’s should exist, but the number of competing IHA’s should be limited to minimize redundancy in program expenditures to support IHA administrative, overhead and infrastructure costs. By reducing the latter, more program funds can be devoted to supporting enrollee services.

WHCA/WiCAL recognizes and supports the need for competition between IHA in all geographic regions. However, to maximize the ability of provider’s to focus resources on enrollee service and care quality, and to promote administrative efficiency and cost reductions, all IHA’s should be required to employ a standardized contract that provides uniform expectations with respect to the rights and obligations of enrollees and providers within their respective networks.

**Integration of Acute, Primary, and Long Term Care:**

Act 55 mandates that IHA’s provide and enrollees in Family Care 2.0 “receive both long term and acute care services, including Medicare-funded services to the extent allowable by CMS”. WHCA/WiCAL supported the integration of acute, primary, and long term care services in the original design of the Family Care program. Although integration was included in the initial Family Care design draft in 1997, it was removed in DHS’ final blue-print. WHCA/WiCAL has ever since actively promoted system reform to adopt the integrated services concept which we believe essential to better serving consumer needs and achievement of program goals of cost effectiveness. However, we recognize that during the past 19 years the scope, complexity, and cost of the services as well as the concept of integrated managed care have expanded dramatically.

Accordingly, WHCA/WiCAL deems it imperative that DHS’ new blue-print for reform clearly delineate the specific acute, primary and long term care services the IHA’s will be responsible for managing within the capitation rates under which they operate. This includes precisely defining program expectations for the
integration of mental health and behavioral services which was originally scheduled to be implementation and administration by existing MCOS’s in January 2016.

The integration of acute and primary care services will also entail a broad expansion of the types of providers and services that will be within the new IHA provider networks. The Family Care redesign effort should identify all provider types that will be permitted to participate in the new managed care system; the scope of services they will be expected to provide; and how, and under what circumstances, the individual and collective cost of those services will be projected and rolled into the capitation rates paid to the IHA’s.

It is also important that, the DHS Family Care 2.0 plan specifically identity any long term care, acute, and primary care services and outliers that will not be included or reimbursed under the new system, and how such services will be provided and reimbursed if required to meet enrollee needs.

**Coordination of Medicare-Funded Services:**

Act 55 calls for IHA’s coordination of acute, primary, and long term care services, “including Medicare-funded services to the extent allowable by CMS.” The latter mandate will presumably result in DHS seeking written clarification from CMS on the extent to which federal law will permit IHA’s to engage in case-management of Medicare services for program enrollees.

It is impossible for WHCA/WiCAL or other stakeholders to anticipate the precise position CMS will take on this issue. But there can be no doubt that the response DHS receives will have a profound impact the design and direction of Family Care 2.0; the authority of IHA’s to define the nature and scope of services enrollees receive; and providers’ future Medicaid and Medicare payments. Accordingly, WHCA/WiCAL requests that DHS timely provide all stakeholders with a copy of any written requests submitted to CMS or other agencies /authorities on the issue and any and all responses to those submissions. When the latter occurs, stakeholders should be given the opportunity to provide additional comment and recommendations as respects Family Care 2.0 design, funding and IHA rights and obligations with respect to management of Medicare funded services.

**Definition of “Medical Necessity”:**

As the expressed above, Family Care 2.0 redesign anticipates Family Care 2.0 will dictate some degree of IHA case management responsibility for coordinating Medicare-funded services for enrollees. Irrespective of the extent of that responsibility, it essential all DHS/IHA/Provider contracts uniformly recognize that the Medicare definition of what constitutes “medically necessary nursing and therapy services” was expanded as a result of a January 24, 2013 court settlement in Jimmo vs. Sebelius.

Prior to the settlement Medicare coverage for those services was determined on the basis whether the recipient “will improve.” As a result the Jimmo case, which successfully challenged the improvement standard, services are now coverable by Medicare if the services are necessary to maintain the individuals condition, or prevent or slow their decline.”
Rates and Rate Setting for Residential Care Facilities:

Currently, DHS’ contracts with Family Care MCO’s do not require the MCO’s to disclose the payment methodologies they utilize to reimburse residential care facilities or other network providers. While the practices of the current MCO’s vary somewhat, none of the current MCO provider contracts presently afford providers the right to review the MCO rate calculations to assure that proposed rates represent an accurate assessment of resident needs and proper application the MCO’s rate-setting methodology. Rarely are residential care providers are given the opportunity to review the MCO’s underlying calculations. They have never been permitted to contest the MCO’s proposed rate as inaccurate or insufficient to meet the fundamental needs of a resident.

WHCA/WiCAL submits that under Family Care 2.0, all IHA’s should be required to disclose the payment methodologies that apply to the various provider types within their respective provider networks. DHS contracts with the IHA’s should retain the current contract requirements limiting the circumstances under which residential care providers Family Care rates may be changed. Once a rate is established between an IHA and a residential provider, it may only be changed 1) by their mutual consent; 2) when there has been a change in resident condition; or 3) after it has remained in effect for 12 months. To provide transparency, stability, and integrity to the Family Care 2.0 rate setting processes, providers should be afforded the right to review IHA rate calculations to assure proposed rates represent an accurate assessment of enrollee needs and proper application of the IHA’s payment methodology. To the extent material errors or inaccuracies exist, a provider should be allowed to contest the rate. To that end, WHCA/WiCAL recommends Family Care 2.0 include an IHA contract provision or legislation that would embrace the following or similar expectations:

1. Within 10 days of receipt of a notice of a change in a provider’s IHA contract payment rate for a family care enrollee, a provider may request, and the IHA shall provide, provide, any or all of the following:
   a. A copy of the IHA payment methodology that was utilized in calculating the resident’s rate;
   b. A copy of the IHA assessment of resident need that was applied in the rate calculation;
   c. The IHA rate worksheet which reflecting the rate calculation specific rate calculation;
   d. An explanation of any change to the IHA payment methodology and/or the IHA’s assessment of the resident’s needs that was the basis for the rate change reflected in the IHA notice.

2. An IHA must respond to request filed under paragraph 1 above within 10 days of receipt of the request.

3. The provider has a right to contest and file administrative appeal challenging a proposed IHA on the basis of any of the following:
   a. That the IHA failed to properly apply its payment methodology in calculation of the provider’s payment rate for a specific enrollee;
   b. That the IHA rate calculations were inaccurate;
   c. That the IHA assessment of a resident’s needs was materially inaccurate or incomplete.
IHA Capitation Rates:

In the calculation of MCO service capitation rates, DHS’ current methodology for projection of long term care service costs utilizes historical encounter data (past payments to Family Care providers) and functional screen information. The exclusive use of historical “encounter data” to project future program costs perpetuates under funding of the cost of services enrollees receive. So too, the functional screen was never intended or designed to serve as a means to assess acuity or serve as a payment tool.

Family Care 2.0 funding levels, IHA capitation rates and provider rates must be established on the basis of what it costs to provide care to enrollees. Continued shoehorning of IHA capitation and provider rates to fit inaccurate projections of enrollee service costs perpetuates inadequate program funding and a payment system that will not support the level or quality of care enrollees require.

The current functional screen should not be allowed to be the foundation for rate determinations as it does not adequately capture or measure the care and service needs of enrollees. During the design and development of Family Care 2.0, the functional screen must be substantially modified or a separate tool designed which will accurately capture the elements that identify the variables necessary to provide care to an individual.

WHCA also recommends that separate capitation rates must be established for each Family Care enrollee group served by an IHA. This would anticipate establishing separate capitation rates for 1) frail elderly; 2) persons with intellectual disabilities; and 3) individuals with physical disabilities.

IHA Provider Contracts:

Each of the 8 current Family Care MCO’s have been permitted to develop and utilize their own provider contracts which afford varied and often conflicting interpretations of state, federal, and DHS requirements with respect to provider rights and responsibilities. Compliance with the extensive and varied policies, reporting requirements, and unique expectations of the MCOs impose an unreasonable and costly administrative burden on providers.

WHCA/WiCAL recommends that Family Care 2.0, DHS should expressly require all IHAs to utilize a standardized provider contract. Contractual expectations of providers within the standardized agreement should not exceed recognized professional standards, state licensure requirements, or those imposed under federal certification/waiver requirements.

Any Willing Provider Protections:

One of the founding principles of the current system that must remain a cornerstone for the new model is the need to maximize consumer access and choice in service delivery. With the movement to an integrated system, it is even more essential that enrollees and their families are assured the transition will not immediately or eventually dilute their current right to choice of services, providers, and care settings. To that end, WHCA/WiCAL recommends that the Family Care 2.0 provide permanent recognition of existing “Any Willing Provider” provisions.
Timeliness of Claims Processing and Payment:

DHS contracts with IHA’s must provide that provider claims are to processed and paid within 10 days of receipt. IHA noncompliance must result in the imposition of financial penalties which shall be paid to the provider.

Appeal of IHA Service Denials:

Family Care 2.0 providers and enrollees should each be afforded opportunity to contest IHA rates and service denials.

Focus of IHA Case Management Activities:

HAs case management should be structured and monitored to assure they supplement and complement, not duplicate, nursing home and assisted living resident assessment, care planning, and case management efforts. IHA case managers should respect and defer to the expertise of nursing home and assisted living staff in understanding and effectively managing the needs of their residents. The redundancy in the current system attributable to the number, utilization, and activity of MCO care management staff is inefficient, costly, and disruptive. Reduction of administrated expenditures for duplicative and unproductive IHA case management costs will increase program funds available for support of enrollee services.

Alignment of Family Care and State Fiscal Year:

WHCA/WiCAL submits that the complexities of administration of Family Care 2.0 might be reduced and simplified if IHA program operations and provider contracts are aligned with the state fiscal year rather than the calendar year.