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Governor

Linda Seemeyer
Secretary

DIVISION OF MEDICAID SERVICES

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State of Wisconsin
Department of Health Services

OPEN MEETING NOTICE

Wisconsin Long Term Care Advisory Council

Tuesday, September 12, 2017
9:30 a.m. – 3:30 p.m.
Clarion Suites -- 2110 Rimrock Rd, Madison, WI 53703 -- (608) 284-1234

AGENDA

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

9:40 AM **Department Updates**
Curtis Cunningham, *DHS – Assistant Administrator of Long Term Care Benefits and Programs*
Carrie Molke, *DHS – Bureau of Aging and Disability Resources*

10:00 AM **CY2018 MCO Contract Review**
Diane Poole, Nate Vercauteren, *DHS – Bureau of Adult Long Term Care Services*

11:00 AM *Break*

11:15 AM **MCO Pay for Performance**
JoAnna Richard, *DHS—Bureau of Adult Long Term Care Services*
Dave Varana, *DHS—Bureau of Long Term Care Financing*

11:45 PM **Comments from the Public**
Heather Bruemmer, *Long Term Care Advisory Council Chair*

12:00 PM ***Lunch (catered)***

12:30 PM **Charges Overview,** 2016-17 LTC Council charges
Curtis Cunningham, *DHS-Assistant Administrator of Long Term Care Benefits and Programs*

1:00 PM **Introduction to and Conversation with DMS Leadership**
Michael Heifetz, *DHS - Director of Medicaid Services*
Casey Himebauch, *DHS – Deputy Director of Medicaid Services*

1:30 PM **Charge Guidance**
Carrie Molke, *DHS- Bureau of Aging and Disability Resources*
-Secretary response regarding Community Development
-Community Development Next Steps

2:00 PM ***Break***

2:15 PM **Charge Next Steps Discussion – Community Development**
Carrie Molke, *DHS – Bureau of Aging and Disability Resources*

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

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

The Long Term Care Advisory Council is advisory to the Department of Health Services.

Contact person: Hannah Cruckson, (608) 267-3660, hannah.cruckson@dhs.wisconsin.gov.

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Proposed 2018 Non-Managed Care Rule Related Contract Changes

No.	Change
1.	Added requirement for MCOs to protect confidential information and enable to Department to impose sanctions for breach of confidentiality.
2.	Added requirement that MCO notify DHS immediately upon receiving notice from a subcontractor providing residential services that an MCO member has been or will be involuntary discharged.
3.	Per CMS request, provided additional detail regarding retrospective adjustment to the acute care component of the capitation rate for dual eligible members in Partnership and PACE.
4.	Per CMS request, provided additional detail regarding retrospective adjustment to the long term care component of the capitation rate for members at the nursing home level of care to reflect the actual target group mix of the MCO's membership.
5.	Added requirement that MCOs require co-employment agencies and fiscal agents to conduct background checks on individuals providing services to self-directing members if the service provider has regular, direct contact with the member.
6.	Added requirement that ADRC contact information be included in marketing materials. Expanded definition of marketing to include providers and agents of MCO.
7.	Clarified language that MCOs must have policies and procedures in place to ensure that information from the functional screen is communicated to IDT staff if the screener is not IDT staff.
8.	Added requirement that MCOs accept enrollment of individuals residing in a nursing home and meeting certain other criteria within 4 weeks of completion of the person's enrollment counseling session with the ADRC. (This requirement was previously contained in an operations memo).
9.	Added requirement that IDT social service coordinator and RN have face-to-face interview in member's residence every 6 months.
10.	Broadened requirement that MCOs immediately notify DHS oversight when there is sexual abuse, physical abuse or neglect by anyone, not just a caregiver.
11.	Clarified that documentation is required in both the comprehensive assessment and MCP for members with complex medication regimes or behavior modifying medications.
12.	Clarified that for Partnership and PACE when the MCO is authorizing Medicare coverable services that it must use and follow Medicare coverage and authorization policies (as opposed to the RAD process).
13.	Added language that the MCP must reflect areas of concerns or risk that IDT staff have identified and discussed with the member but the member has not agreed to as a priority (previously this was optional).
14.	Added language referencing SHC standards and requirement that IDT staff validate providers of self-directed services are qualified.
15.	Added language specifying that the provider has 90 days to submit a claim and that when a claim consists of multiple dates of service the 90 day submission timeframe begins with the last date of service.

No.	Change
16.	Added language specifically requiring MCOs participating in the Partnership program to comply with all federal Medicare requirements.
17.	Added language clarifying that DHS, rather than the MCO, will conduct, compile and distribute satisfaction surveys of MCO members.
18.	Added adult day care services and self-directed personal care services to list of in lieu of services at the non-nursing home level of care.
19.	Added language specifying the minimum amount required for solvency fund, how the required minimum amount is calculated and that it must be established on or before beginning of contract term.
20.	Clarified language regarding retrospective adjustments for HIV/AIDS and vent dependent members.
21.	Added non-compliance resolution process and non-compliance penalties for DHS to implement if MCO has not complied with encounter data requirements.
22.	Added requirement that procedures for retrospective rate reconciliation be included in nursing home provider subcontracts.
23.	Changed and added language to MCO's requirement to pursue recovery of expenses to better align with requirements under BC+/SSI.
24.	Added language regarding pay for performance incentive payments to capitation rate development.
25.	Added language requiring MCOs to describe in their business continuity plans and disaster recovery plans the policies, procedures and steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.

Proposed 2018 Managed Care Rule Related Contract Changes

No.	Reason for Change	Change
1.	Compliance with 42 CFR §§438.10(g) and 438.102	The MCO is not required to provide counseling or referral service if the MCO objects to the service on moral or religious grounds. If the MCO elects not to provide, reimburse for, or provide coverage of, counseling or referral service because of an objection on moral or religious grounds, it must inform members (1) of the excluded-service policy at least 30 days prior to the policy's effective date and (2) how they can obtain information from the Department about how to access the excluded service.
2.	Compliance with 42 CFR §438.608(d)(2)	A subcontractor must (1) Report an overpayment to the MCO when identified; (2) Return the overpayment to the MCO within 60 calendar days of the date on which the overpayment was identified; and (3) Notify the MCO in writing of the reason for the overpayment.
3.	Compliance with 42 CFR §438.110	MCOs must create and staff a Member Advisory Committee to advise the MCO on its policies and operations. The committee must have a reasonably representative sample of members from the target populations or community individuals representing those members and meet at least once per year.
4.	Compliance with 42 CFR §438.332	An MCO must inform the Department during annual certification whether it has been accredited by a private independent accrediting entity.
5.	Compliance with 42 CFR §438.330	MCO must document in its Quality Management program the member's long term care and personal experience outcomes to ensure the setting in which the member resides supports integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community.
6.	Compliance with 42 CFR §§438.3(h) and 438.230	Expands the scope of who has access to the subcontractor's premises from the State to CMS, HHS Inspector General, the Comptroller general or their designees; provides that access and audit rights last 10 years from the date of the contract or 10 years from the date of completion of any audit or for as long as records are retained. Clarifies that access includes premises, physical facilities, equipment, records, documents, books, contracts, computers and other electronic systems. Clarifies that if the State, CMS or the HHS inspector general determines that there is a reasonable possibility of fraud that they can exercise access and audit rights at any time.
7.	Compliance with 42 CFR §438.608(a)(1)(iii)	The MCO must establish a Regulatory Compliance Committee on the MCO's governing board and at the senior management level charged with

No.	Reason for Change	Change
		overseeing the organization's compliance program and its compliance with the requirements under the contract.
8.	Compliance with 42 CFR §438.608(a)(7)	Added “waste” to fraud and abuse that must be reported to the Department.
9.	Compliance with 42 CFR §438.606	Data, documentation and information must be certified by MCO management concurrent with its submission.
10.	Compliance with 42 CFR §438.608	MCOs’ arrangements or procedures are required to include: rights of employees and contractors regarding False Claims Act and rights of employees as whistleblowers; prompt reporting of overpayments to DHS; method to verify services have been delivered by network providers; implementation of internal monitoring and auditing of compliance risks.
11.	Compliance with 42 CFR §438.608	Encounter data must include provider overpayments. Quarterly reports must include overpayments recovered as well as overpayments identified but not recovered. MCOs are required to submit a monthly report of any capitation payments or other payments in excess of amounts specified in the contract within 60 calendar days of identification.
12.	Compliance with 42 CFR §§438.3(h), 438.3(u) and 438.416.	Records and documents must be retained for at least 10 years (was 5 years) and expanded what records and documents must be retained.
13.	Compliance with 42 CFR §438.102	MCO may not prohibit or otherwise restrict a provider who is acting within the lawful scope of practice from advising or advocating on behalf of a member. An MCO could be subject to sanctions by the Department for violation of this prohibition.
14.	Compliance with 42 CFR §438.3	Expanded bases of discrimination in enrollment and disenrollment to include: age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job-related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, use of a legal substance outside of work hours.
15.	Compliance with 42 CFR §438.210	Expanded definition of medically necessary services to better reflect non-State plan services that are covered under waiver.

No.	Reason for Change	Change
16.	Compliance with 42 CFR §438.602(c)	MCOs are required to provide written disclosures of information on ownership and control; adds reference to federal citation and link to specific form MCO must complete and submit to the Department.
17.	Compliance with 42 CFR §438.602(d)	MCOs are required to check federal databases for list of excluded individuals and entities monthly – expanded to include the Social Security Administration's Death Master File, National Plan and Provider Enumeration System, and System for Award Management.
18.	Compliance with 42 CFR §438.10	Added numerous requirements to MCO written and electronic materials to ensure accessibility for individuals with various disabilities and limited English proficiency. Added definitions for auxiliary aids and services, limited English proficient, and readily accessible.
19.	Compliance with §438.608(c)	MCOs must disclose to the Department any relationship with an excluded individual or entity within ten days of discovery of the individual or entity's excluded status; adds specific information that must be reported.
20.	Compliance with 21st Century Cures Act, 42 CFR §§438.602 and 438.206	Providers who provide State Plan services must be enrolled with the Department.
21.	Compliance with §438.3(t)	For a dual eligible Family Care member, the MCO shall pay any deductible, coinsurance or copayment amount for a Medicare service that Medicaid would pay for fee-for service recipients, if the service is also a Medicaid State Plan service in the Family Care benefit package.
22.	Compliance with 42 CFR §§438.8, 438.74, 438(b)(9)	MCOs must calculate and report a Medical Loss Ratio (MLR) each year. Provides MLR reporting requirements and required content of MLR report.
23.	Compliance with 42 CFR §438.3(l)	Replaced "health professional" with "network provider" in contract.

No.	Reason for Change	Change
24.	Compliance with §438.14	Revised definition of Indian and Indian Health Care Provider; included provision that Indian members in Partnership cannot be disenrolled for choosing a non-network Indian health provider as primary care provider; added provision that MCO must authorize Indian member's request to obtain services from non-network Indian health care provider; added new network requirement to include Indian providers or allow to go out of region/State if none or too few Indian health care providers in region.
25.	Compliance with 42 CFR §438.10(h)	MCOs must update their provider directories within 30 days from receiving updated information. Provider directories must be on the MCO website in machine readable file and format. Expanded information about providers that must be included in the directory (i.e. specialty, linguistic capabilities, accessibility).
26.	Compliance with §438.214	MCOs must implement written policies with supporting procedures for provider selection and retention and provide those written policies and procedures to the Department upon request.
27.	Compliance with 42 CFR §438.6(e)	For a member in the PACE or Partnership program age 21 through 64, an MCO may provide inpatient services in an IMD hospital or IMD nursing home for a stay of no more than 15 days during the period of the monthly capitation payment in lieu of hospital services, provided that certain conditions are met. No capitation is payable to a Family Care, Partnership or PACE MCO for the days of any month in which a member age 21-64 is in an IMD, unless a stay of no more than 15 days is covered by the MCO for a Partnership or PACE member as an in lieu of service.

LTC Council Charges

July 2016 – December 2017

Council Charge Stages

We have been moving through each 2016-2017 charge based on the following steps:

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

During the period of July 2016 to December 2017, Secretary Seemeyer is charging the Long Term Care Advisory Council (LTCAC) with the following:

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

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

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

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

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

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

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

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

Workforce

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

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

Secretary Response

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

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

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

Workforce Charge Stages

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

Sep '16	**Overview of the State's Labor Force**	**Dennis Winters**	2 Topic Presentation in Depth
Sep '16	**Workforce Discussion Workgroups**	**Council**	3 Workgroups Discussion
Nov '16	**Workforce Draft Summary**	**Curtis Cunningham**	4 Draft Summary
Jan '17	**Final Workforce Summary**	**Curtis Cunningham**	5 Final Summary
Mar '17	**Secretary guidance regarding Workforce**	**Curtis Cunningham**	6 Secretary Response
May '17	**MCO Provider Networks and Workforce presentations**	**CommunityLink, Care Wisconsin**	8 Next Steps
May '17	**DHS Caregiver Career Program Civil Money Penalty Grant**	**Kevin Coughlin**	8 Next Steps
Jul '17	**LTC Workforce and Employment**	**Becky Kikkert**	8 Next Steps
Jul '17	**Next Steps Regarding LTC Workforce**	**Curtis Cunningham**	8 Next Steps

Quality

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

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

Secretary Response

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

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

Quality Charge Stages

May '17	**NCI Data**	**Angela Witt**	0 Updates
Jul '17	**NCI Custom Questions**	**Angela Witt**	0 Updates
Sep '16	**Quality Scorecard**	**Angela Witt**	0 Updates
Sep '16	**Quality Strategy**	**Curtis Cunningham**	1 Topic intro
Nov '16	**Presentation: National Core Indicators**	**Mary Lou Bourne**	2 Topic Presentation in Depth
Nov '16	**Quality Discussion Workgroups**	**Kevin Coughlin**	3 Workgroups Discussion
Jan '17	**Quality Summary**	**Curtis Cunningham**	4 Draft Summary
Mar '17	**Final Quality Summary**	**Curtis Cunningham**	5 Final Summary
May '17	**Secretary response regarding Quality**	**Curtis Cunningham**	6 Secretary Response

Communication

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

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

Secretary Response

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

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

Communication Charge Stages

Nov '16	**Communications Introduction**	**Curtis Cunningham**	1 Topic intro
Jan '17	**Communications Discussion Introduction**	**Karen Kopetskie**	2 Topic Presentation in Depth
Jan '17	**Communications Discussion Workgroups**	**Kevin Coughlin**	3 Workgroups Discussion
Mar '17	**Draft Communications Summary**	**Curtis Cunningham**	4 Draft Summary
May '17	**Final Communications Summary**	**Curtis Cunningham**	5 Final Summary
Jul '17	**Secretary response regarding Communication**	**Curtis Cunningham**	6 Secretary Response

Community Development

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

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

Community Development Charge Stages

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