Karen Timberlake
Secretary

State of Wisconsin
Department of Health Services

1 WEST WILSON STREET
MADISON, WI 53703

OPEN MEETING NOTICE

Wisconsin Long Term Care Advisory Council

Tuesday, September 13, 2022
9:30 AM to 2:30 PM

Meeting is available via Zoom:
https://dhswi.zoomgov.com/j/1604096711?pwd=d2xTNkNoT21DZmwrU2NrV1JqT2doUT09

Or via phone:
Phone Number: **1-646-828-7666** *or* **1-669-254-5252**
Webinar ID: 160 409 6711
Passcode: 293444

*Use *6 to mute or unmute your phone Use *9 to raise your hand*

AGENDA

9:30 AM **Meeting Call to Order**

***Carrie Molke**, DHS, Director, Bureau of Aging & Disability Resources*

- Process for meeting
- Introductions
- Review of agenda and approval of minutes

9:40 AM **DMS Department Updates**

***Alicia Boehme**, DHS, Director, Bureau of Quality Oversight*
***Christian Moran**, DHS, Director, Bureau of Programs and Policy*

9:55 AM **DPH Department Updates**

***Carrie Molke**, DHS, Director, Bureau of Aging & Disability Resources*

10:15 AM **Caregiver Survey Results**

***Cindy Piotrowski**, Director, Aging and Disability Resource Center – Portage County*
***Harriet Redman**, Executive Director, WisconSibs*

10:45 AM **Break**

11:00 AM **ARPA HCBS Updates**

***Lisa Olson**, DHS, Medicaid Director*
***Grant Cummings**, DHS, Director, Bureau of Rate Setting*

***Alicia Boehme**, DHS, Director, Bureau of Quality Oversight*
***Carrie Molke**, DHS, Director, Bureau of Aging & Disability Resources*
***Tom Balsley**, DHS, Director - Resource Center Development, Bureau of Aging & Disability Resources*
***Kevin Coughlin**, DHS, Policy Initiatives Advisor – Executive*

11:30 AM **MCO Contract Changes**

Kelly Van Sicklen, DHS, Policy Section Manager, Bureau of Programs and Policy

12:00 PM **Public Comment**

Public comment will be limited to three (3) minutes per person. *Please do not disclose any HIPAA protected information in your comments (e.g., family member names, medical conditions, medical providers, etc.).* Your microphone will be muted after three (3) minutes. If you would like to offer a comment during this period, please raise your hand (option near bottom of screen or *9 if on phone). Use *6 to mute or unmute your phone. Public comment may also be submitted in writing and will be entered into the meeting minutes. Send written public comment to dhsdmsltc@dhs.wisconsin.gov.

12:15 PM **Lunch**

12:45 PM **Fiscal Update**

***Marci Katz**, DHS, Fiscal Oversight*

1:15 PM **State Health Assessment (SHA) and State Health Improvement Plan (SHIP)**

Margarita Northrop, *DHS, State Health Plan Coordinator, Office of Policy and Practice Alignment*

1:45 PM **2021 P4P Results**

***Kaycee Kienast**, DHS, Program & Policy Analyst, Bureau of Programs and Policy*

2:15 PM **Council Business**

***Carrie Molke**, DHS, Director, Bureau of Aging & Disability Resources*

2:30 PM **Adjourn**

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

Please be mindful of scent sensitivities and refrain from wearing heavily scented products such as perfumes, colognes, fragrant lotions, etc.

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability, if you need an interpreter or translator, or if you need this material in

another language or in alternate format, you may request assistance to participate by contacting the Bureau of Programs and Policy at 608 267-7286 or DHSDMSLTC@dhs.wisconsin.gov.

2022 LTCAC Meeting Dates

January 11, 2022
March 8, 2022
May 10, 2022
July 12, 2022
September 13, 2022
November 8, 2022

Meeting Materials can be located here:
https://www.dhs.wisconsin.gov/wltcac/meetings.htm

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Wisconsin Long Term Care Advisory Council (LTCAC)			Attending: Audra Martine, Audrey Nelson, Beth Swedeen, Chris Witt, Cindy Bentley, Dennise Lavrenz, Elsa Diaz Bautista, Janet Zander, Jason Glozier, John Sauer, LaVerne Jaros, Lea Kitz, Michael Bruhn, Shakita LaGrant, Shanna Jensen, Stacy Ellingen
Date: 7/12/2022	Time Started: 9:30 a.m.	Time Ended: 2:52 p.m.	
Location: Virtual Zoom Meeting			Presiding Officer: Curtis Cunningham and Carrie Molke

Minutes

Members absent: Denise Pommer, Stephanie Birmingham, Beth Fields, Kenneth Munson, Darci Knapp

Others present: Curtis Cunningham, Carrie Molke, Brenda Bauer, Grant Cummings, Christian Moran, Alicia Boehme, Tom Balsley, Daniel Perron, Judy Stych, Kathleen Smith, Angela Miller, Kimberly Schindler, Shelly Glenn

Meeting Call to Order, presented by Curtis Cunningham

- Went over meeting processes.
- Approval of May 2022 Meeting Minutes
    - Motion to approve minutes by LaVerne Jaros. Seconded by Stacy Ellingen. Unanimously approved.

Division of Public Health (DPH) Updates, presented by Carrie Molke

1. **Behavioral Health Initiative (BHI) for Deaf, Hard of Hearing and DeafBlind (DHoHDB):** The Office for the Deaf and Hard of Hearing within BADR is leading a behavioral health initiative to improve access, quality and outcomes of behavioral health care for people who are Deaf, hard of hearing and deafblind. Three tracks: Community, Clinicians and ASL Interpreters.

- **Community.**
    - Supporting community education aimed at reducing stigma and increasing knowledge of available resources.
    - Completing a needs assessment of community health and wellness resources, education and support for these populations
    - Completing a feasibility analysis for establishing a DHHDB peer wellness and resiliency specialist/specialty in WI

- **Clinicians.** Training, resources and support for Deaf and hearing clinicians to increase awareness and access to culturally and linguistically appropriate services. Goals:
    - Disseminating training materials to clinicians in WI through a partnership with DSPS who provides licensing for clinicians and other community partners;
    - Developing a process for connecting clinicians specializing in service to these populations with those clinicians who are unfamiliar, in order to support a collaborative approach to treatment
    - Developing pathways for clinicians and providers who are also DHHDB to complete necessary supervision requirements for licensing;
    - Support the development of a specialized network of support for DHHDB clinicians specifically for ongoing supervision and case conferencing.

- **Interpreters.** Training, resources for ASL interpreters focused on working in behavioral healthcare settings

- Partner with interpreter training programs and other community stakeholders to offer facilitated interpreter training.
- Develop a collaboration with established mental health interpreter training programs for Wisconsin interpreters to have a pathway for more specialized mental health training.
- Developing collaborations with internal and external partners to further develop practicum offerings in Wisconsin for interpreters seeking specialized mental health training.
- Developing a case conferencing structure for interpreters in Wisconsin.
- Build and develop a model to offer advanced mental health training topics for interpreters in Wisconsin in partnership with the Board of Evaluation of Interpreters (BEI) that is administered by DHS and within ODHH

- Kicking off the Initiative will a Wellness Day and Interpreter Training on July 23rd (Comfort Suites in Johnson Creek). More information at: Office for the Deaf and Hard of Hearing | Wisconsin Department of Health Services

2. **Coalition to End Social Isolation and Loneliness.**
   - Meeting monthly as a full coalition;
   - LTCAC members are welcome to join if interested;
   - Launched a listserv, so if you'd like to get coalition updates and resources, you can join this as well.
   - Contact Carleigh Olson, BADR, Office for Resource Center Development
     Office: 608-266-3145
     Cell: 608-381-7759
     carleighs.olson@dhs.wisconsin.gov

3. **2024 – 2028 State Dementia Plan Development:** The State Dementia Plan Steering committee, with support from the Department is in the process of developing a new State Dementia Plan, starting with a community engagement process. We are working with partners to identify venues for community conversations. Presentation this afternoon.

4. **APS Redesign Efforts.** Making systems changes necessary to integrate prevention, improve response and implement the state's APS plan.

   - UW - Green Bay is moving forward with the guardianship training project. They are in the process of meeting with stakeholders to get input before they start developing the training. They've met with the follow partners thus far: Ombudsman, APS Supervisors, WI Registrar & Probate Association, Abuse in Later Life group, GWAAR, and BPDD team. They will looking for input at APS roundtable meetings across the State.

   - We are working with NAPSA to implement a state-wide awareness campaign that includes resource sheets for different audiences, PSA videos, social media and potentially billboard materials. We are setting up contracts right now. We hope to be able to work with tribal partners to create resource sheets specific for the population.

   - APS data for 2021 has been published to the DHS website: https://www.dhs.wisconsin.gov/aps/publications.htm

5. **Supporting Volunteer Recruitment, Training and Retention Activities.**
   - Aging Units/ADRCs rely on volunteers for so many of their programs. Delivering meals, doing wellness classes, providing transportation;

- During the COVID 19 Pandemic and a subsequent downturn in the economy the Aging and Disability network has lost so much of it's volunteer base and many older volunteers are still reluctant to return (given the impact of the virus).
- **So, what are we doing?**
    - DHS supported a statewide recruitment campaign
    - Working with United Way- has made their volunteer portal available to ADRCs/Aging Units to advertise their volunteer needs. Just provided a training on this (just last week, I believe)
    - Just hired a volunteer coordinator- who will be helping to organize recruitment, training and retention efforts across the state. Samantha Margelofsky. Comes from Jefferson County where she managed 175 volunteers.

6. **Caregiver Survey- Lynn Gall**
    - The WI Family and Caregiver Support Alliance (for which we are an active member) just completed a statewide survey- focused on WI's working caregivers. survey-full-report.pdf (wisconsincaregiver.org)
    - As expected, the survey showed a number of ways in which caregivers lives and worklives are impacted by caregiving responsibilities, it shows the importance of supportive work environments and new/honed skills of managers and supervisors; and with the employment climate we have right now, shows the need to really understand these needs for the many working caregivers we have in the state- across all sectors.
    - Lynn Gall and other Alliance members will join us in a future LTCAC meeting to share more information.

7. **Elder Nutrition Program.** There is widespread concern throughout the State's aging network about our ability to meet demand for and sustain home-delivered meal services, which includes carryout meals, due to several issues:
    - gas prices/inflation
    - supply chain issues
    - increasing costs of food and supplies
    - losing drivers
    - kitchen capacity
    - budget constraints
    - Some older adults still do not feel comfortable dining in-person so this is putting a strain on HDM and carryout services.

Many of the nutrition programs are preparing for the likelihood that they will need to implement waiting lists. We have been working to provide any support we can in strategies to recruit volunteers and prioritize service to those most in need.

As nutrition programs continued to respond and recover from COIVID-19, congregate dining locations have been slowly reopening. Approximately 35% of WI dining locations had reopened for congregate meal services in the final quarter of 2021. 83% of WI's nutrition programs continued to provide carryout meals throughout 2021.

In CY 2021, Wisconsin's Elder Nutrition Program served 3,029,750 home delivered meals, 561,907 carryout meals, and 210,611 congregate meals to approximately 56,000 older adults.

Division of Medicaid Services (DMS) Updates, presented by Curtis Cunningham

- Thank you to the council for the work on the Geographic Service Region configuration. The RFP was awarded to Inclusa and My Choice Wisconsin in GSR 1 (formerly GSR 7)
- NEMT (non-emergency transportation) RFP awarded to Veyo in lieu of the incumbent MTM. MTM now intends to purchase Veyo.

- ARPA grant program is nearly ready for the application process. Current 25 projects in process.
- Contract changes will be forwarded to the council on July 25th with a deadline for August 19th for feedback. Changes will be sent to MCOs as well. September will be the update to the council.
- The START program address IDD with complex mental health issues. Modeling a program by the University of New Hampshire. It will be discussed with the council. It features a team support approach and reform to crisis intervention.
- WCCEAL Meeting: WCCEAL announced the Heather Bruemmer Award for Excellence in Assisted Living in honor of Heather's dedication and contributions. It was recently awarded to David Zimmerman.
- ***Council Feedback:***
    - Inquired about EVV for SDPC. Curtis indicated that we are looking at a hard launch soon with mounting pressure from CMS. We will be establishing a timeline that allows for technical fixes. There was a recent hearing at the federal level regarding SDPC. DHS has requested and extension for implementation from 1/1/2023 to 1/1/2024. Live-in workers will be exempted. 24-7 home care is still pending.
    - Inquired about the Family Care contract. There are no huge changes. DHS is still briefing internally.
    - The Family Care documents will have highlighted changes.
    - There was discussion regarding the personal care worker workgroup

General ARPA Updates presented by Curtis Cunningham
Current Initiatives and corresponding projects:

- **HCBS Rate Reform**
    - 5% Rate Increase
    - Rate Setting for HCBS Services
    - Fund Tiered Payment Rates for PCS and SHC
- **DCW Reform & Analysis**
    - Staff Stability Survey
    - Certification & Registry
    - Connect to Care
- **Tribal LTC Enhancements**
    - System Development
    - ADRS for Tribes
    - Targeted Initiatives to Enhance Tribal LTC
- **Grants for HCBS Improvements**
- **Independent Living Pilot**
    - Independent Living Pilot
    - Unpaid caregiver assessment, training, and resources
- **ADRC Modernization**
    - Virtual ADRC (Resource Database Client Tracking and Self-Service Portal)
    - Marketing and Outreach Initiative
    - Guardianship Training (Act 97)
- **No-Wrong Door – Supporting Kids Together**
    - Branding/Marketing Initiative
    - Web-based Portal for Family Resources
    - Statewide Agency Partnership
    - Resource Hub
- **Assisted Living Reporting, Member Assessment & Certification**
    - 1-2 Bed AFH Certification Tool
    - HCBS Review System Tool

    - Member Assessment
- **Adult Incident Reporting System**
    - Critical Incident System

- ***Council Feedback:***
    - The Governor's taskforce discussed free training which would be tied to rate, but it is still in progress. Distinction between Supportive Home Care v. Personal Care.
    - To clarify the ADRC relationship with the Tribes, three Tribes partner with the ADRC. There is funding available to begin exploration of ADRS.
    - Tracking HCBS Residential and Non-Residential Heightened Scrutiny. Of the closures, 65% were voluntary.
    - There is not enough progress at this point of the project to determine if the Critical Incident System be a Review Tool or Survey
    - The Virtual ADRC will have an advisory committee to help shape the project. Regional specialists will work with local ADRCs to update the database. Jennifer will speak on it more in detail. This will be a future agenda item.

ADRC Contract, presented by Tom Balsley and Phoebe Hefko

- Presentation of satisfaction ADRC Contract reviewed
- ***Council Feedback:***
    - There was discussion regarding changes in the ADRC 2023 Scope of Services including Long-Term Care Functional Screen for private pay. It was requested that the changes be brought to the LTCAC for review. In June, ADRC comments were obtain via breakout groups.
    - ADRCs are at a critical point with absence of funding. They are facing crisis in County Government. DHS cannot change any funding to ADRCs. The legislature is responsible for determining funding. Change requires that personal stories be shared with policy makers.
    - ARPA funding is not ideal for the ADRC crisis as the funds are temporary.

Public Comment

- Ann Gryphan inquired about the HCBS Grant
- Irma Rappaport spoke regarding Caregivers for Compromise HR3733

Fiscal Update, presented by Grant Cummings

- Presentation of HCBS Fee Schedule
- ***Council Feedback:***
    - Fee schedule will require everyone get paid according to schedule. The minimum rate is set but allows for flexibility in implementation. Could we use "fair and equitable" instead of "minimum"?
    - The timeline for data collection doesn't allow dovetail
    - Still reviewing service definition drafts that may reduce the acuity. Will use the LTCFS as acuity if necessary. There will be more discussion on this
    - Concern expressed about leaving IRIS providers out of this. DHS needs to be proactive. IRIS does not have a minimum fee schedule. Wondering if the fee schedule could be used in IBAs as a guideline. IRIS has usual and customary language and also allows for budget authorizations. The IBA for IRIS is using 2019 data. If there are impacts from the fee schedule, then the IAB would be updated.
    - Concern expressed regarding the market pushing wages beyond our response. MCOs are already increasing their per diem. If the matrix behind the LTCFS was "real" then it would accurate, but the changing cost of labor is happening so quickly. Need provider flexibility to respond to the market.

Assisted Living Date, presented by Dan Perron and Kimberly Schindler

- Presentation on Assisted Living Data
- DHS will be looking for input from stakeholders.
- 1-2 Bed AFH is another project
- Trying to keep e-license in house but will outsource.
- With regard to the data described on page 8 of the presentation, we are looking expand on it. We are looking for trends.
- ***Council Feedback***:
    - DHS is looking at limiting the number of Family Care residents by facility type. Also looking at who can make this determination – administrator vs. RN level
    - We need more data because the prior presentation shows openings equal to the number of requests.
    - It needs to be stressed to providers that this information will not be used for regulatory enforcement but for program and process improvements. The goal is to provide something useful and not "go after" the providers.
    - We are also seeking the right data to use for reimbursements and are trying to make the process as user-friendly as possible. The data is useful outside of this specific project. Need to be strategic regarding the messaging to ensure facilities realize this is not intended for regulatory enforcement.
    - This might be something to try at CBRFs first before moving to smaller facilities.
    - We do not want staff to be overburdened with this, but the funding with ARPA is now, so the timing requires expedience.
    - There have been no detailed discussions between the Rate Band discussions and this project. This is a long term project. As the data from the Rate Bands becomes available, it will be used if relevant. The Rate Band has a much shorter timeline.

Independent Living Update, presented by Curtis Cunningham

- Emily and Phoebe introduced
- Presentation on Independent Living Pilot
- With support, the program helps members delay admission to a facility. There will be initially 5000 individuals participating in the program with services beginning July 1, 2023.
- ***Council Feedback:***
- The 5000 participants will be aware that these services will be for a one-year time frame. All participants will be new in the program. The pilot is for people not already enrolled in services.
- The participants will most likely be elderly and/or with other disabilities.
- The expectations from ADRCs were outlined in the contract. These will be addressed in more detail when ADRCs apply to participate.
- Would like to see the plan serve marginalized and underserved, however it is challenging. Independent Living Center service providers will be a part of this, however ADRC was a natural partner. We are required statutorily to include ADRC. There will be further discussions regarding this.
- Independent housing hasn't been discussed as of yet, but Curtis will take that back for review.
- Committee would like to see rural locations receive a little more assistance with services.
- Continuum of care will be the responsibility of the facility/nursing home.

Dementia State Plan presented by Kathleen Smith and Angela Miller

- Presentation on Dementia State Plan
- ***Council Feedback:***
- DHS will work with health equity to translate information in other languages.
- Thanks to Angela, Carrie, and DHS for the work on this project and incorporating all ideas.

Feedback for a Family Care Community Engagement Incentive presented by Judy Stych

- Presentation on Family Care Community Engagement Incentive
- Goal is for people to feel a part of their facility and help the community understand they are part of the community
- Contract is the ground floor and not the ceiling.
- Purpose of the HCBS is to ensure engagement and inclusion in the community.
- Ensure services aren't underutilized due to capitation.
- ***Council Feedback:***
- Data is subjective as pursuing activities is mainly on an individual basis.
- Discussion about a workgroup for this. NCI surveys and data are being used to quantify and determine the number of support activities.
- Is there a connection to Coalition to end Social Isolation and Loneliness
- Very pleased we're looking at this as an imperative. Before the RAD (resource allocation decision) was changed, there were originally questions on the members preferences and they were all removed. In 2013 it was changed. Changed toward a person's preferences - this bring that back. Will the care team discuss with members their community integration goals? What they want to be involved with in the community? When in a larger place, and two people want to go to an art place, then what about the other two? Could this be folded into how this was set up. As part of the PIP or Quality improvement, there was a withholding - if goals met, then capitation rate was higher.
- One way to improve performance is to provide a financial incentive. Choice at provider level is when it bumps up against HCBS rules (as far as activities if one person wants to go) Intent of HCBS rule is to make sure individuals have those choices. Don't remember incentive/withhold - HMO is 2.5%. Not proposing for MCOs. PIPs are requirement of CMS for MC entities. May be 0.5% in FC for P4P. This is a tool for our contracting and we want to use it to improve the program. People are struggling with this nationally.

Council Business, presented by Carrie Molke

- Next meeting September 13, 2022
- Concerns or new topics for September meeting?
- ***Council Feedback:***
- Growing concern about the number of people in need of LTC or post-acute care that are residing in hospitals. Various solutions being discussed. Need to keep an eye on what those solutions might be. Preventing discharge from hospitals by weeks or months. How people access post-acute and LTC. Council needs to be updated as those issues unfold.
    - Wide variety of individuals in our programs. Also relevant to the discharge issue. Many have co-conditions that complicate placement.
- Need further discussion on rate setting/rate band and marriage of what Dan spoke on. Providers need to be able to pay competitive wages.
- Update on Statewide HCBS Transition Plan
    - CMS visited a number of facilities here in WI recently. The review will be completed by March of 2023. Anything needing correction will be provided to us via corrective action plans. We may need to repost Statewide Transition Plan for feedback.
    - How would you want to facilitate that conversation within the Council construct? Many dynamics in that conversation.
    - Getting data from hospitals regarding precisely who the people are - older, diagnosis, payor source, what makes them so complicated to place? Could have nursing homes talk about their ability to place or not place. Some developments in the LaCrosse and MKE areas - lessons learned. Workforce issues comes into play. Can create a panel with people deep in this issue as

to why these issues exist and how we remedy it. Also member rights - do members want to be there? Is it their choice? Don't want the hospitals to solve on their own.

- Improvements in guardianship issue. Can we get people presumptively enrolled with a plan that could stay with them for 90 days? Can we have MCOs to get them enrolled outside of the hospital.
- Independent Living Pilot - No presumption for LTC services.
- Nurses have been working with hospitals on this issue. Working WI organization - Nurse Leaders. Gundersen, Bellin, number of hospitals looking at this right now. What are the root causes that keep people in the hospital longer than they need to be.
- How do we bring all of the services together to make this person-centered.
- ADRC issue from earlier on a future agenda. Critical nature of funding. Processes that could be streamlined, etc.

Adjourned 2:52pm

Prepared by: Shelly Glenn on 7/29/2022.

These minutes are in draft form. They will be presented for approval by the governmental body on: 9/13/2022

Wisconsin
Family and Caregiver
Support Alliance

Wisconsin's Working Caregivers

STRATEGIES AND RESOURCES FOR EMPLOYERS

Key points to listen for today

- What is WFACSA?
- What we learned about Wisconsin's working caregivers
- How the Aging and Disability Network can help engage more employers
- Why it matters that working caregivers know their options, and how engaging employers impacts your mission.
- How whole communities will benefit.

Wisconsin Family and Caregiver Support Alliance

Extension
University of Wisconsin-Madison

ADRC
Aging & Disability Resource Center of Portage County

wisconsibs
Sisters & Brothers of People with Disabilities

WISCONSIN DEPARTMENT of HEALTH SERVICES

RCAW
Respite Care Association of Wisconsin

GWaar

We knew…

- Employers who are aware of the needs of working caregivers and how to support them can reduce hidden costs (turnover costs, loss of institutional knowledge, loss of productivity) and increase productivity, employee retention, and improve recruitment efforts. *Harvard Business School
- Studies in other states recommend assessing needs of caregivers in the workplace and exploring different policies and resources to support working caregivers. *Massachusetts Business Roundtable; New York Office on Aging and Department of Labor.
- Caregivers seldom use FMLA. *WFCSA study – Feb 2021 (Current survey confirmed at 13%)
- Caregivers also reported that they felt they could continue meeting their work and home responsibilities for longer with just a little more help. *WFCSA study – Feb 2021

We wanted to learn more about how…

1 in 4

working-age adults provide care, balancing home and work

… Wisconsin businesses and families are being affected by family caregiving responsibilities.

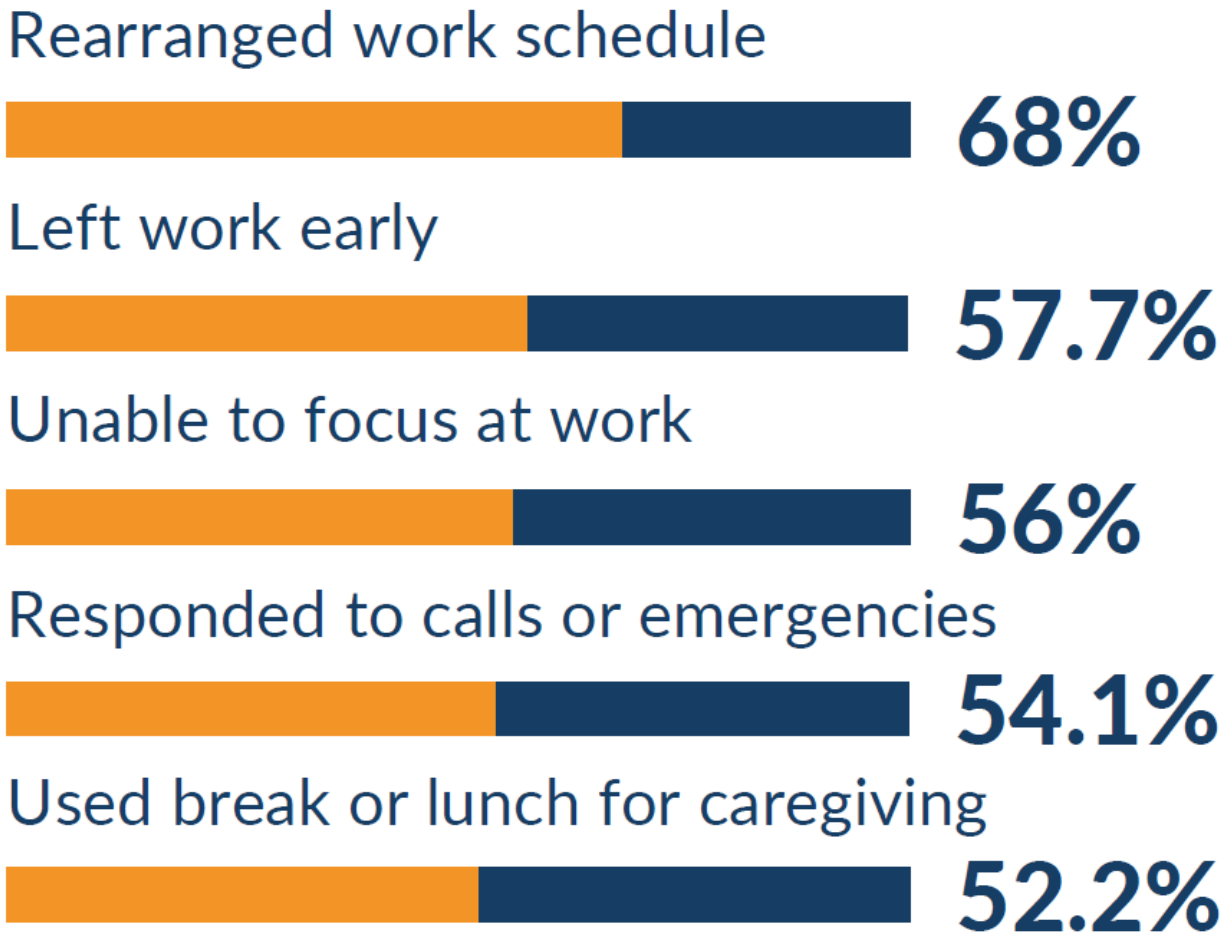
What we did.

1. From June through October 2021, we worked with UW-Madison Division of Extension to create the *Employed Caregiver Survey*.
2. Employed caregiver was defined as “working-age adult providing care or financial assistance to an older family member, an adult child or other loved one with a disability, or a spouse with a long-term illness. This may be in addition to traditional child rearing.”
3. Survey was then completed by 564 individuals, of which 447 (79%) had a family caregiving role.

What we heard

More than **8 in 10** caregivers reported having their work life interrupted

Most common interruptions included



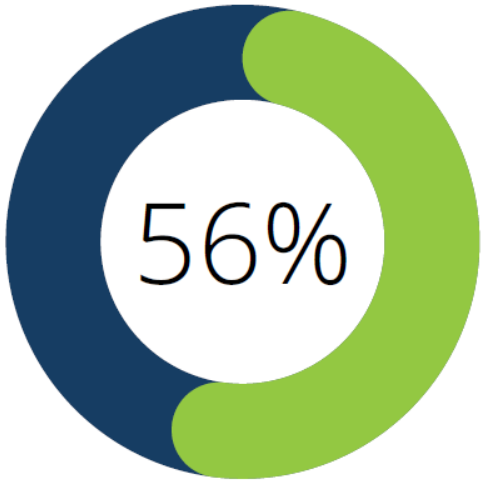
Quotes:

"The just never knowing (is stressful). I am lucky. My boss is FANTASTIC"

"It is used as an excuse by my supervisor to not rely on me, to re-assign work, etc., even though I work many extra hours and am doing significant work."

"Employer promotes work/life balance in words, but not actions."

"[I] always feel like I have to make a choice of which is more important. My [care recipient] or my job."



of caregivers indicated that their current situation is unsustainable

Demographics –

Of all employees, nearly 8 in 10 performed at least one caregiving task in the past 6 months.

- 56% were caring for parents or in-laws
- 18% caring for child with long-term illness or disability
- 14% caring for spouse
- 89% of caregivers were female*
- 64% were above the age of 46
- Most caregivers (46%) have been providing care for 1-5 years, spending up to 7 hours per week.
- A smaller group of caregivers (17%) spent over 40 hours per week on caregiving

Figure 3. Caregiver age

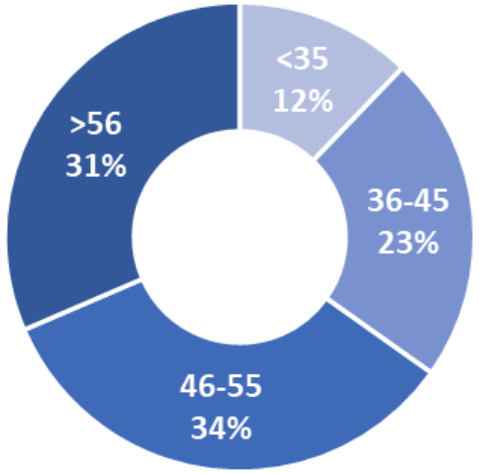
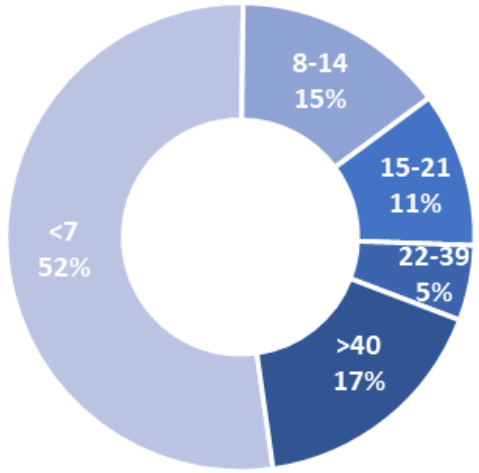
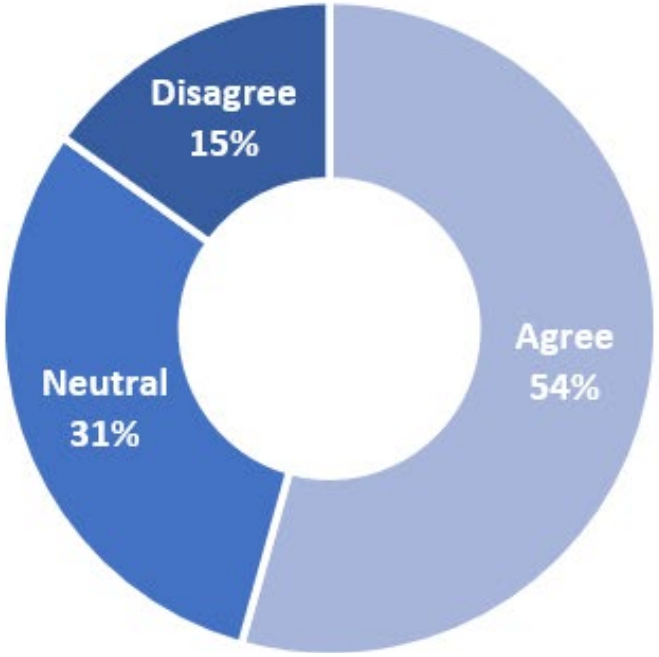


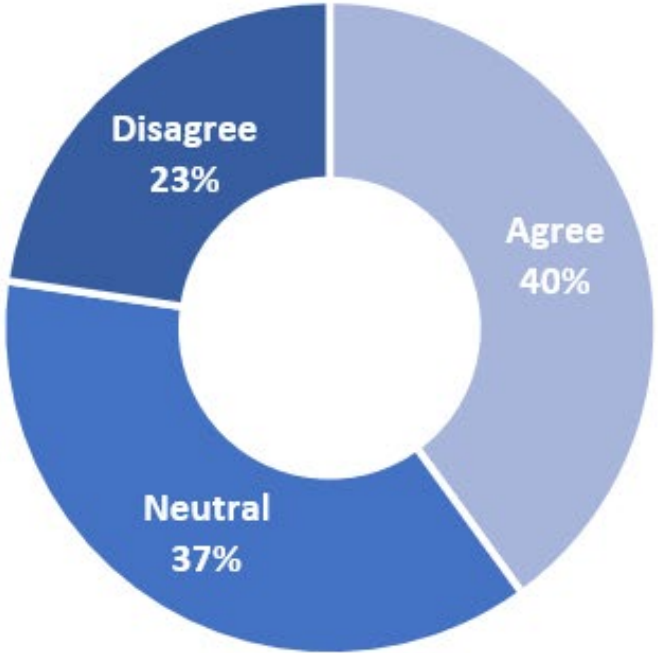
Figure 4. Hours spent caregiving



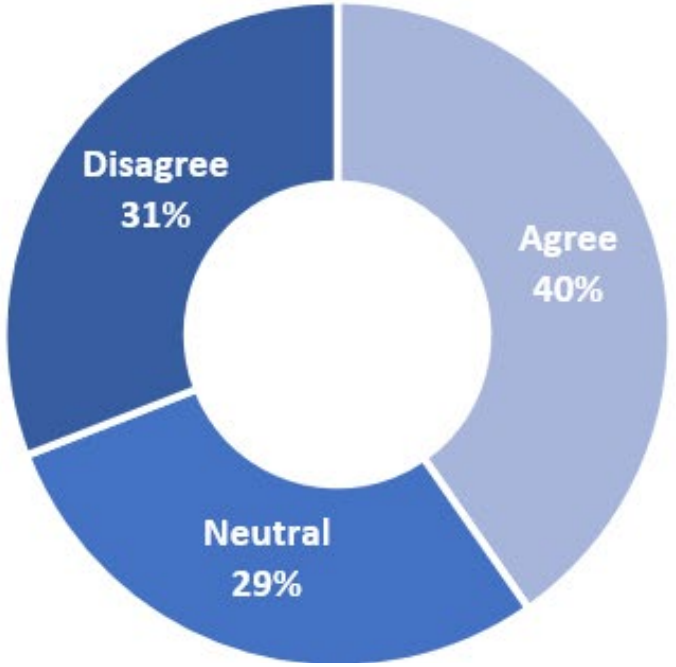
My caregiving responsibilities have increased due to COVID-19



It is more difficult to balance caregiving and my job due to COVID-19



The amount of time to myself has decreased due to COVID-19



Impact of COVID-19 Pandemic

Other findings

3 in 4 caregivers missed work due to caregiving

1 in 4 caregivers - no vacation in over a year.

1 in 5 caregivers used time off without pay.

Strategies

1. Find out how many employees are caregivers. UW-Extension offers a survey that is FREE to any employer.

2. Explain what resources are available to employees.

3. Ask employers to consider what could work for them - benefits or programs they could offer employees. (Flex time, lunch and learn, EAP, connecting employees to community resources such as the local ADRC)

4. Train HR and supervisors to understand caregiver needs and resources.

5. Use the worksheet in our survey report to set goals and get buy-in from others in your organization. Find at WisconsinCaregiver.org

Questions?

Proposed DHS-MCO Contract Changes, January 2023 Amendment

Stakeholder Feedback

Language for two other changes, including Pay for Performance language, will be forthcoming.

Number	Reason for Proposed Change	Language of Proposed Change	MCO / LTCAC Comments
1.	The Administrative Code, DHS 101, has been updated to include definitions for "functionally equivalent" and "telehealth." Permanent Telehealth Coverage Policy and Billing Guidelines (wi.gov)	Article I, Definitions 57. Functionally Equivalent: a service provided via telehealth must meet both of the following criteria: a) The quality, effectiveness, and delivery mode of the service provided must be clinically appropriate to be delivered via telehealth. b) The service must be of sufficient quality as to be the same level of service as an in- person visit. Transmission of voices, images, data, or video must be clear and understandable. ~~57.~~ 58. Gift: … ~~58.~~ 59. Group A… ~~59.~~ 60. Group B… … ~~136.~~ 137. Telehealth: The use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a certified provider and a recipient that consists solely of an email, text, or fax transmission. ~~136.~~ ~~137.~~ 138. Third Party Administrator or TPA	**From Survivor's Coalition, BPDD, GWAAR** • Participant should agree the service is functionally equivalent Functional equivalence is determined by the MCO. The member determines whether the member would like to receive the functionally equivalent service in person or via telehealth. • Participant should actively choose telehealth option The member can choose in-person options at any time; it is a member right. This recommendation will be forwarded to DHS staff who manage the member handbook. • Participant should be able to switch to in-person at any time The member can choose in-person options at any time; it is a member right. This recommendation will be forwarded to DHS staff who manage the member handbook. • Repeat language from Section K, (1) c within the "functionally equivalent" definition to

		~~137.~~ ~~138.~~ 139. Urgent Care … **Current DHS-MCO Contract Provisions Related to Telehealth** Article V, Care Management K. Service Authorization 1. Service Authorization Policies and Procedures e. Remote Waiver Services and Interactive Telehealth i. Remote Waiver Services Remote waiver services means waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Other than telephonic care management contacts discussed in Article V., remote waiver services does not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail. The IDT cannot require the use of remote services to authorize the service. For services in Addendum VI.A, the IDT must first determine the service is necessary to support an outcome by using the RAD or other Department approved alternative	acknowledge the service cannot be functionally equivalent without adequate equipment. Internet connection and technology access can fluctuate for many reasons, impacting Telehealth delivery. DHS respectfully declines this suggestion for additional language. Proper equipment and connectivity is adequately addressed in sub c. **From BOALTC** • Add language from the Permanent Telehealth Coverage Policy and Billing Guidelines (wi.gov) Member Consent Guidelines for Telehealth section. Suggestion from BOALTC: K. Service Authorization; 1. Service Authorization Policies and Procedures; e. Remote Waiver Services and Interactive Telehealth b) On at least an annual basis, obtain informed consent from the member to receive the service remotely, including a statement member was informed and understands their right to decline services provided via telehealth. Thank you; we are not incorporating this suggestion at this time. Because we already require MCOs to obtain members' informed consent for telehealth, and the language suggested is for providers, we will leave the

			and then determine whether it can be authorized remotely. To authorize a waiver service for remote delivery, the IDT must: a) Determine that the service is functionally equivalent to in-person service. ~~can be delivered remotely with functional equivalence to face to face as the in-person service. Functional equivalence exists when a there is no reduction in quality, safety, or effectiveness of the in-person service because it is delivered by using audiovisual telecommunication technology.~~ b) Obtain informed consent from the member to receive the service remotely. c) Determine that the member has the proper equipment and connectivity to participate in the service remotely. The MCO is not required to provide the proper equipment and connectivity to enable the member to access the service remotely. If the IDT determines that the service cannot be authorized remotely based on the above, the IDT must authorize the service in	contract language as-is for now. The DHS-MCO contract already requires that the MCO obtain the member's informed consent to authorize the service remotely. Article V.K.1.e.i.(b): "Obtain informed consent from the member to receive the service remotely." The member can choose in-person options at any time; it is a member right. This recommendation will be forwarded to DHS staff who manage the member handbook. **From DRW** • Will a medical professional using remote connection feel free to require an in-person visit if they see something of concern, or is it possible they will hesitate due to lack of authorization from the MCO? The provider is likely making the request and will use their judgment to determine whether in-person or telehealth is most appropriate.

		person. A member may grieve the IDT decision. … ii. State Plan services via interactive telehealth Interactive telehealth means telehealth delivered using multimedia communication technology that permits 2-way, real-time, interactive communications between a certified provider of Medical Assistance at a distant site and the Medical Assistance recipient or the recipient's provider.	
2.	MCOs requested clarification on what "identity means." DHS edited some of the Equity and Inclusion language for clarity and removed references to "identity" because DHS does not currently have a department-wide definition for the term "identity."	Table of Contents VIII. Provider Network H. Equity ~~+~~and Inclusion IX. Marketing and Member Materials E. Accessible Formats~~,~~ ~~and~~ Languages, and Cultur~~eal +~~ and ~~Identity~~ Respect~~fulness~~ Article VIII. Provider Network H. Equity ~~+~~ and Inclusion	**From BPDD** Re: "E. Accessible Formats, Languages, Cultural Respect" – Can the use of plain language/easy read materials be included? Existing contract language added last year addresses this. Article IX.E.2 2. Materials Easily Understood and Accessible All materials produced and/or used by the MCO must: a. Use easily understood language and format. b. Use a font size no smaller than 12 point.

		1. Equity and~~+~~ Inclusion ~~and Values~~ The MCO shall encourage and foster ~~E~~equity ~~+~~ and ~~I~~inclusion… 2. Cultural ~~+ Identity~~ Preference and Choice Article IX, Marketing and Member Materials D. Provider Network Directory and Information 5. The provider directory shall include providers that are under contract with the MCO, including physicians, hospitals, pharmacies, behavioral health providers, and long-term care providers. The directory will include the following information for providers under contract with the MCO: g. The provider's cultural~~, identity,~~ and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed training in an ~~Equity + Inclusions framework~~ equity and inclusion framework, such as ~~Cultural Competence, Cultural Humility, or other~~ cultural competence, cultural humility, or other types of equity and inclusion trainings[.]" E. Accessible Formats~~, and~~ Languages, and Cultural ~~+~~ and ~~Identity~~ Respect~~fulness~~	c. Be available in alternative formats and through the provision of auxiliary aids and services upon request and at no cost. d. Include conspicuously visible taglines and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll free and TTY/TDY telephone number of the MCO's member/customer service unit. **From Inclusa** There is a reference to identity at the bottom of this section under E3. Thank you. Implementing change: Article IX, Marketing and Member Materials E. Accessible Formats~~, and~~ Languages, and Cultural ~~+~~ and ~~Identity~~ Respect~~fulness~~ 3. Culture~~al + and Identity~~ Respect Materials for marketing/outreach and for health-promotion or wellness information produced by the MCO must be appropriate for its target population and reflect respect to the diverse cultures ~~and identities~~ served.

		3. Culture~~al + and Identity~~ Respect Materials for marketing/outreach and for health-promotion or wellness information produced by the MCO must be appropriate for its target population and reflect respect to the diverse cultures and identities served. If the MCO uses material produced by other entities, the MCO must review these materials for appropriateness to its target population and for respectfulness to the diverse cultures and identities served. Article X, Member Rights and Responsibilities I. Provision of Interpreters For related information, refer to Article IX.E., Accessible Formats ~~and~~ Languages, and Cultural ~~+ and Identity~~ Respect~~fulness~~.	If the MCO uses material produced by other entities, the MCO must review these materials for appropriateness to its target population and for respectfulness to the diverse cultures ~~and identities~~ served.
3.	DHS edited existing contract language to clarify that not all sanctions are required to be reported to CMS. The current language is too broad and should be tightened in order to comply with federal regulations. Fed reg 42 CFR § 438.724 requires that CMS be notified for any of the sanctions listed in 42 CFR § 438.700	**Article XVI, Contractual Relationship** **E. Sanctions for Violation, Breach or Non-Performance** *2. Sanctions* d. Notice of Sanctions ii. Notice to CMS 1099075 The Department must notify CMS no later than thirty (30) calendar days after ~~the imposition~~ imposing or lifting ~~of any~~ those sanction~~s described in~~ listed in ~~Article XVI.E.2, items~~ XVI.E.2.i-viii. The notice shall include the name of the MCO, the kind of sanction and the reason for the	**From BPDD** • Add failure to provide other Medicaid-funded HCBS services as a reportable offense • Require the number of authorized hours compared to the number of service hours delivered as a metric as part of its assessment as to whether services have been provided. • Make clear the consequences an MCO would face when the MCO fails to meet LTC performance standards This contract change does not change the bases for imposing sanctions in XVI.E.2. This only establishes

		Department's decision to impose or lift the sanction.	which sanctions are reportable to CMS. If BPDD has other concerns, please provide contract language or areas of the contract to be modified.
4.	DHS added Institute for Mental Disease reporting language and suggests the reporting be made biannual rather than annual.	Article XIV, Reports and Data C. Reports: Regular Interval 4. *Biannual IMD Report* The MCO shall track all IMD stays and submit a Biannual IMD Report that includes all IMD stays within the applicable reporting period (January 1 through June 30, or July 1 through December 31). The Biannual IMD Report is due forty-five (45) calendar days after the reporting period or, if the forty-fifth day falls on a holiday or weekend, the following business day. The MCO shall complete the report using an excel spreadsheet that the Department will e-mail to each MCO. The report spreadsheet shall be returned, password-protected, via encrypted e-mail to DHS at DHSIMDRI@dhs.wisconsin.gov. 5. *Quarterly Report* 6. *Quarterly Employment Data Report*	**From BPDD** Does this reporting also include people with I/DD placed in ITP beds at the state DD Centers? No. ITP admissions are not counted for IMD reporting. **From DRW, iCARE** In this context does biannual mean every 6 months or every 2 years? Semiannual or biannual? Every 6 months. Implementing change: Article XIV, Reports and Data C. Reports: Regular Interval 4. *Semiannual IMD Report* The MCO shall track all IMD stays and submit a Semiannual IMD Report that includes all IMD stays within the applicable reporting period (January 1 through June 30, or July 1 through December 31). The Biannual IMD Report is due forty-five (45) calendar days after the reporting period or, if the forty-fifth day falls on a holiday or weekend, the following business day. The MCO shall complete the report using an excel spreadsheet that the

			Department will e-mail to each MCO. The report spreadsheet shall be returned, password-protected, via encrypted e-mail to DHS at DHSIMDRI@dhs.wisconsin.gov. 5. *Quarterly Report* 6. *Quarterly Employment Data Report* From GWAAR We recommend reporting include both length of stay information, as well as location of the IMD. DHS agrees. In addition to tracking the frequency of stays, we ask many questions including the length of stay. This has helped identify trends in IMD use and supported better interventions and policy recommendations.
5.	The Board for People with Developmental Disabilities (BPDD) recommended including specific language that MCO staff and providers receive training in mandated reporting and requirements under Wis. Stat. 46.90 (4) and 55.043 (1m)	J. Member Safety and Risk 1. Policies and Procedures Regarding Member Safety and Risk … g. Training and guidance for IDT staff that at every in-person contact, the IDT staff are required to check and document in the chart that each member with a Behavioral Support Plan (BSP) and/or Restrictive Measure have an effective, up to date BSP and/or Restrictive Measure in place and that residential	**From DRW** Does this training automatically make all of these individual staff members at the MCO and at providers mandatory reporters? Who would be included as mandatory reporters? Direct staff and IDT's, their supervisors, member rights, member rights supervisors? MCOs should work with their legal team regarding mandatory reporting required by these two statutes.

		provider staff are trained and following the BSP and/or Restrictive Measure appropriately. h. Training in mandated reporting and requirements of Wis. Stat. §§ 46.90 (4) and 55.043 (1m)	
6.	BPDD recommended adding in Article VIII D. Provider Agreement-pgs. 128-130 specific language that providers agreements require implementation of written policies and training processes, including training in mandated reporting and requirements under Wis. Stat. 46.90 (4) and 55.043 (1m). Provider Agreement Language-The contract requires they identify, respond, document and report member incidents. Consider adding additional language or a separate requirement to include the following: 1. Written abuse, neglect, and financial exploitation reporting policies. 2. Written abuse, neglect, and financial exploitation investigation policies. 3. Training for new and current staff on abuse, neglect, and financial exploitation. 4. Training on mandated reporting under Wis. Stat. 46.90 (4) and 55.043 (1m)	Article VIII. Provider Network D. Provider Agreement Language 11. Member Incidents The MCO shall require its providers to identify, respond to, document, and report member incidents as required in Article V.J.5. Identifying and Responding to Member Incidents. 12. Abuse, Neglect, Exploitation and Mistreatment The MCO shall require its providers to implement a. Written reporting policies on abuse, neglect, and financial exploitation; b. Written investigation policies on abuse, neglect, and financial exploitation; c. Training for new and current staff on abuse, neglect, and financial exploitation; d. Training on mandated reporting under Wis. Stat. §§ 46.90 (4) and 55.043 (1m)	**From DRW** How will this be enforced? What if a policy isn't followed? What are the consequences? This is a new provider requirement for MCOs to implement. The MCO is responsible for putting it into their provider contract as a requirement, and the MCO would have to ensure the provider is meeting the provider's contract requirements.
7.	DHS amended Article XVIII.N. to remove a COVID-19 justification for a risk corridor and added information about	**Article XVIII. N. Risk Corridor – Family Care and Partnership Programs**	**From GWAAR**

	"related party" and information to the medical loss ration section to align with the DHS HMO contract.	The Department will utilize a risk corridor mechanism ~~to mitigate the significant uncertainty outside of MCO control related to the ongoing COVID-19 pandemic~~. The risk corridor will address variances in costs for all benefit services other than care management. The risk corridor will not address variances in administrative costs.
		
		2. Settlement Methodology
		
		The following methodology will be used to determine risk corridor settlement results:
		a. The numerator for calculating the HMO's actual Risk Corridor Loss Ratio for the rate year will equal total claim costs for benefit services based on HMO financial data reporting.
		b. The denominator for calculating the HMO's actual Risk Corridor Loss Ratio for the rate year will equal all capitation revenue including maternity kick payments, gross of pay for performance withholds, net of hospital access payments, and all retrospective adjustments attributed to the rate year.
		c. The numerator from 2.a will be divided by the denominator in 2.b to calculate the actual Risk Corridor Loss Ratio.
		d. The actual Risk Corridor Loss Ratio will be subtracted from the Capitation Rate Target Risk Corridor Loss Ratio calculated in 2.c. to determine the Risk Corridor Loss Ratio gain or loss.
		e. The Department will recoup the Department's share of the HMO's gains and pay out the Department's share of the
			• Factor in authorized, but undelivered, services as a trigger to require investment of gains or a risk corridor calculation that does not hold an MCO harmless for failure to deliver services authorized in a care plan.
			
			From GWAAR, Survivor's Coalition, BPDD
			
			• Limit administrative costs to 5% cap.
			
			MCOs are independent entities that may spend however much their budgets can afford on administrative expenses. The risk corridor limits how much an MCO can shift the benefits portion of the capitation rate to cover administrative expenses.
			
			• Limit MCO margins to include implementation of profit caps set at 2%.
			  ○ (From Survivor's Coalition / BPDD only) The margin should include investment in technology and other services or devices that help participants self-direct their care, including:
			  ▪ a caregiver registry that allows participants to search, evaluate, and schedule available caregivers;
			  ▪ a provider network registry that tracks available providers and whether providers are accepting new patients/clients in real time; and
			  ▪ connection to technology assessments to assist

		HMO's losses as a percentage of the HMO's capitation revenue, according to the following schedule: Gain / HMO Share / Department Share <= 2.0% / 100% / 0% >2.0% to 6.0% / 50% / 50% > 6.0% / 0% / 100% f. The Department will compare the MCO's encountered medical benefit service costs to the MCO financials to determine reasonableness of the encounter data. g. The Department may adjust the risk corridor numerator calculation if, upon review of encounters, financials, or other information associated with such payments, that the HMO's benefit services reimbursements are not at market-based levels and do not incent efficient and high quality care. h. Related party expenses reported in the numerator will be capped at 100% of the fee-for-service reimbursement rate for services provided unless the MCO can demonstrate the expenses do not exceed the costs that would be incurred if these services were provided by an entity that is not related. 1. Related party is defined as any type of arrangement with an entity that is associated with the MCO through any form of common, privately-held ownership, control, or investment. ~~h.~~ i. An interim risk corridor settlement based on 4 months of claims runout will be completed no earlier than 6 months after the rate year has ended.	participants with understanding which options may be useful to them in meeting care plan goals. ○ The contract should require profits in excess of two percent to be invested in several areas: ▪ Building provider network capacity, including building capacity for services where there are authorized hours in care plans that are not delivered, geographically under or underserved areas, and increasing provider choice and density to lower time and distance to providers for participants. (Wider provider networks that improve access and choice for participants may create administrative costs that could be incorporated into capitated rates.) ▪ Improving targeted outcomes that lead to greater independence for participants including community integrated employment, community supported living, use of remote support technology, increased access to non-driver transportation options, and social/recreational opportunities.

		~~i.~~ j. The Department may elect to pay or recoup only a portion for the interim risk corridor settlement. ~~j.~~ k. The final risk corridor settlement based on 16 months of claims runout will be completed no earlier than 18 months after the rate year has ended. Article XVII. H. Medical Loss Ration (MLR) 2. MLR Reporting Requirements a. Each MCO expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided. b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.	▪ (From BPDD / Survivor's Coalition only) Pilot projects that test innovative service system delivery methods, and support for families with members who are family care participants. DHS currently has a risk corridor in place that limits MCO profit on the benefit portion of the capitation rate to 4%, with 50% of profit between 2% and 6% being returned to DHS and 100% of the profit over 6% being returned to DHS. We believe this incentivizes MCOs to reinvest funding into the provider community in innovative ways to meet member needs. **From Survivor's Coalition, BPDD** • Specific considerations for determining margin assumptions should be built into **capitation rates**. ○ As part of the data collected to evaluate capitation rates, ▪ Determine the number of authorized hours versus the number of actual service hours provided to assess paid provider capacity. This data could be used to justify additional funding or reinvestment to develop specific service capacity and expand provider networks. ▪ Collect the number of unpaid hours assigned to "natural supports" in

		f. Related party expenses will be capped at 100% of the fee-for-service reimbursement rate for services provided unless the MCO can demonstrate the expenses do not exceed the costs that would be incurred if these services were provided by an entity that is not related. ~~1. Related party is defined as any type of arrangement with an entity that is associated with the MCO through any form of common, privately-held ownership, control, or investment.~~ ~~f.~~ g. The MCO will use the Credibility Adjustment Worksheet to enter the number of member months and calculate the required adjustment established by CMS. ~~g.~~ h. The MCO will aggregate data for all Medicaid eligibility groups covered under the contract with the Department for the long-term care programs. ~~h.~~ i. The MCO's MLR report must include the following:	care plans and assign a risk factor based on ages of caregiver and care needs of the participant. In the event current natural supports are unable or unwilling to provide the same level of support, these participants are at risk of acute crisis. This data could incentivize strategic future planning conversations and exploration of community supported living options and employment goals before family caregivers can no longer provide care. ○ Capitation rates should factor outcome indicators and goals incentivizing community integrated outcomes into performance-based bonus payments to MCOs. Bonus payments should include factors such as robustness of care plan goals, progress made on participant care plan goals, overall increases in community integrated employment, community supported living, and ability of participants to hire and retain quality care workers. ○ Capitation rates should assume the paid caregiving crisis is a long-term problem and build in rate band progressions and pay scale increases into the contract that reward workers with specialized skills and worker retention so MCOs can sustainably increase worker wages for Direct

			Support Providers/Personal Care, especially rewarding providers serving geographically underserved areas and high acuity populations. o DHS should build assumptions into the capitation rates that evolve away from congregate residential and employment service models to implement the spirit of the HCBS settings rule and participants' preferences. The rate can build in provider transformation funding—with expectations of community integrated outcomes—with a transition to payment based on outcome (for example, number of hours a participant worked, number of residents successfully supported in community supported living, etc.). o Capitation rates should include an estimate of the number of children in CLTS with significant care needs transferring to the adult system and bridge funding for services to be consistent between the children's and adult system. This will ensure young adults with the same care needs will not experience extreme rate cuts in the amount providers are compensated due to an arbitrary factor such as a change in age. o Capitation rates should include an estimate to cover the cost of care needs for people transitioning out of

			state DD Centers or other institutional settings. **From BPDD / Survivor's Coalition** • Factor in authorized but undelivered services as a trigger to require investment of gains or at least result in a risk corridor calculation that does not hold an MCO harmless for failure to deliver services authorized in a care plan. **From People First Wisconsin** • Rates for service should be consistent from CLTS to adult long-term care. Wages should be competitive and increase to address rising costs of living CMS requires states to set capitation rates that are expected to cover the expected costs under the contract. MCOs are contractually required to provide the services members need which will include costs associated with the items identified below. Existing Risk Corridor contract language Article XVIII Payment to the Managed Care Organization N. Risk Corridor – Family Care and Partnership Programs The Department will utilize a risk corridor mechanism to mitigate the significant uncertainty outside of MCO control related to the ongoing COVID-19 pandemic. The

			risk corridor will address variances in costs for all benefit services other than care management. The risk corridor will not address variances in administrative costs. 1. Capitation Rate Target Risk Corridor Loss Ratio a. The target Risk Corridor Loss Ratio percentage will be developed by dividing the benefit service component of the rate, excluding care coordination, by the entire capitation rate, gross of pay for performance withhold. b. The care coordination costs to be excluded from the numerator and the capitation rate used as the denominator in a. will be calculated specific to the actual target group mix, level of care mix, GSR, dual eligibility status for Partnership, and pricing assumptions for each MCO. 2. Settlement Methodology The following methodology will be used to determine risk corridor settlement results: a. The numerator for calculating the MCO's actual Risk Corridor Loss Ratio for the rate year will equal total encounter costs for benefit services other than care coordination. b. The denominator for calculating the MCO's actual Risk Corridor Loss Ratio for the rate year will equal all capitation revenue, including all

retrospective adjustments attributed to the rate year.
c. The numerator from 2.a. will be divided by the denominator in 2.b. to calculate the actual Risk Corridor Loss Ratio.
d. The actual Risk Corridor Loss Ratio will be subtracted from the Capitation Rate Target Risk Corridor Loss Ratio calculated in 2.c. to determine the Risk Corridor Loss Ratio gain or loss.
e. The Department will recoup the Department's share of the MCO's gains and pay out the Department's share of the MCO's losses as a percentage of the MCO's capitation revenue, according to the following schedule:

Gain	MCO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%

Loss	MCO Share	Department Share
<= 2.0%	100%	0%
>2.0% to 6.0%	50%	50%
> 6.0%	0%	100%

f. The Department will compare the MCO's encountered medical benefit service costs to the MCO financials to determine reasonableness of the encounter data.
g. The Department may adjust the risk corridor numerator calculation if, upon review of encounters, financials, or other information associated with such payments, that the MCO's benefit

			services reimbursements are not at market-based levels and do not incent efficient and high quality care. h. An interim risk corridor settlement will be completed no earlier than 4 months after the rate year has ended. i. The Department may elect to pay or recoup only a portion for the interim risk corridor settlement. j. The final risk corridor settlement will be completed no earlier than 9 months after the rate year has ended.
8.	DHS added APS to list of authorities in this section: "Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances." DHS added "Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury" because such serious incidents need to be more frequently and timely reported DHS also added a requirement for MCOs to notify DHS if the MCOs hear of an event in the news involving DHS, the MCO, an MCO member, or the Family Care program. This has been a quasi-expectation in the past but was not proposed for the contract until now.	Article: V.P MCO Duty to Immediately Report Certain Member Incidents 1. *The MCO is required to report immediately to its DHS Member Care Quality Specialist any of the following:* a. Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances: i. The member is under guardianship/protective placement; ii. The member has been identified as a vulnerable/high risk member as defined under Article I.137; iii. The MCO has reason to believe that the member's health or safety is at risk; iv. The member is a potential threat to the community or self;	**From BPDD** Re: "Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances"-- BPDD would still request a change to the immediate reportable to include any physical or sexual abuse even if it does not result in injury or accident. This is not incorporated because the type of incident being described is not an immediate reportable and is instead reportable in IMS reporting. This reporting type is certainly included in the AIRS (Adult Incident Reporting System) that we are working on via ARPA project. AIRS will have more timely reporting of all incident types.

		v. The member has a significant medical condition that would deteriorate without medications/care; vi. The member lives in a residential facility; or vii. The area is experiencing potentially life-threatening weather conditions. b. Upon learning a member has died under any of the following circumstances: i. Death involving unexplained, unusual, or suspicious circumstances; ii. Death involving apparent abuse or neglect; iii. Apparent homicide; iv. Apparent suicide; v. Apparent poisoning; vi. Apparent accident, whether the resulting injury is or is not the primary cause of death; or vii. When a physician refuses to sign the death certificate. c. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances i. When unexplained, unusual, or suspicious circumstances exist; ii. When physical abuse, sexual abuse, or neglect exist; iii. When the member has been poisoned; or iv. When law enforcement, Adult Protective Services (APS) or a court of law have investigated and/or are involved;	MCOs determine whether an event meets immediate reportable criteria. DHS is confident that most sexual/physical abuse is reported as an IR. **From DRW** Re: Reporting news events Does this mean that every single time a FC member is in the news, regardless of the context, the MCO must report it to DHS within 24 hours? Does DHS have an expectation that MCOs will constantly scan the news daily to find mentions of members in every conceivable newsworthy event that garners media attention? The statement regarding IRIs is confusing, also. Is that mentioned as a separate point? Or is all of #2 really about IRIs and not about any news mention? Just a perplexing item. No, DHS does not expect MCOs to constantly scan the news daily. The new contract language states "of being made aware of a news story". So, the requirement would be when an MCO is just learning there is such a news story. if a news item meets the IR criteria, then the MCO needs to do both the IR process and send the news item within 24 hours. From Community Care

		d. Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook. e. Upon learning that an Emergency Restrictive Measure, as defined in Wis. Stat. § 46.90(1)(i), was used on a member regardless of injury: 2. The MCO is required to notify the ~~Oversight Team~~ contract coordinator and MCQS within 24 hours of being made aware of a news story involving an MCO member, the Family Care Program, the MCO, or ~~DHS~~ the Department, by email when a member(s) or an MCO is involved or mentioned in a newsworthy event and/or received media attention. A submission of an Immediately Reported Incident is only required if it also meets a circumstance in a-~~f~~ e above. 3. In addition to the immediate reporting requirements provided by Article V.O.1., MCOs shall also comply with all other reporting requirements in this contract, including, but not limited to, the reporting requirements provided at https://www.dhs.wisconsin.gov/familycare/mcos/report-reqs.pdf	What is the definition of "immediately" in this requirement? "Immediately" is currently undefined. DHS has an upcoming project (within the next contract cycle) that should eliminate most if not all references of "immediately" currently in the DHS-MCO contract. "Immediately" in this part of the contract has been in the contract for over 5 years. Practice around immediately reporting incidents is not changing. MCOs should continue to report as they currently are. Also, re: "the MCO is required to notify the contract coordinator within 24 hours of being made aware of a news story involving…" In #2 – you refer to Family Care. Does this mean on Family Care or does it apply to Partnership as well.? Change incorporated: 2. The MCO is required to notify the ~~Oversight Team~~ contract coordinator and MCQS within 24 hours of being made aware of a news story or social media story involving an MCO member, the Family Care Program, the Family Partnership Program, the MCO, or ~~DHS~~ the Department, by email when a member(s) or an MCO is involved or mentioned in a newsworthy event and/or received media attention. A submission of an Immediately Reported Incident is only required if it also meets a circumstance in a-~~f~~ e above. From MCW

			2: Will this requirement encompass both news coverage and social media coverage that involves a MCO member, the Family Care Program, the MCO or the Department? Change incorporated: 2. The MCO is required to notify the ~~Oversight Team~~ contract coordinator within 24 hours of being made aware of a news story or social media story involving an MCO member, the Family Care Program, the Family Care Partnership program, the MCO, or ~~DHS~~ the Department, by email when a member(s) or an MCO is involved or mentioned in a newsworthy event and/or received media attention. A submission of an Immediately Reported Incident is only required if it also meets a circumstance in a-~~f~~ e above. c. iv. Below- with regard to APS investigations/involvement, would this include anytime a member is under a protective placement order as APS is involved? No. The incident would first have to meet c: "Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances" and then also meet iv. Example: a member received an injury and APS is investigating or involved as it may be physical abuse.
9.	DHS added prevalent non-English languages based on geographic service region to the contract to better address	Article IX, Marketing and Member Materials E. Accessible Formats,~~ and~~ Languages, and Culture~~al + and Identity~~ Respect~~fulness~~	**From BPDD** • Write all major materials critical to understanding the Family Care program and

	federal regulation 42 CFR 438.10 and assist MCOs with accessible language compliance.	1. Accessible Language a. All written materials for potential members must include taglines in the prevalent non-English languages in the State, as well as conspicuously visible font, explaining the availability of written translations or oral translation to understand the information, the toll free number of the resource center providing choice counseling, and the toll free and TTY/TDY telephone number of the MCO's member/customer service unit. ~~DHS~~ The Department shall determine the prevalent non-English languages in each MCO service area. b. Material directed at a specific member shall be in the language understood by the individual or oral interpretation shall be provided to the individual free of charge. c. Written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices shall include taglines and be available in prevalent non-English languages in the MCO's service area. d. Non-English Prevalent Languages by Geographic Service Region (GSR) See XIX.B. for list of Geographic Service Regions. **GSR** — Languages (other than English) **1** — Chinese, Hmong, Spanish, Somali **2** — Hmong, Laotian, Spanish **3** — Chinese, Spanish	services, care planning and other program processes, complaint processes, and participant rights in plain language/easy read and tested with a representative sample of program participants and their supporters. Thank you for this suggestion. Existing contract language added last year addresses this. Article IX.E.2 2. Materials Easily Understood and Accessible All materials produced and/or used by the MCO must: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services upon request and at no cost. d. Include conspicuously visible taglines and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll free and TTY/TDY telephone number of the MCO's member/customer service unit. **From DRW** • Require that MCOs ensure that material be in the language understood by legal guardians, so they can effectively participate in service planning It is best practice for MCOs to provide information in a way understood by an authorized representative. However, there is not a current state or federal

		4 Hmong, Laotian, Spanish **5** Spanish **6** Chinese, Hmong, Spanish ~~**7** Chinese, Somali, Spanish~~ ~~**8**~~ **7** Arabic, Hmong, Spanish ~~**9**~~ **8** Hmong, Spanish ~~**10**~~ **9** Chinese, Hmong, Spanish ~~**11**~~ **10** Chinese, Serbo-Croatian, Spanish ~~**12**~~ **11** Chinese, Hmong, Spanish ~~**13**~~ **12** Chinese, Hmong, Spanish ~~**14**~~ **13** Spanish	requirement that MCOs have information regarding an authorized representative's preferred language. **From Community Care** Please submit this as a question to DHS whether they plan to post the FCP Dual Eligible NOA letter in other languages as they have for FC and PACE. DHS is working to translate the FCP Dual Eligible NOA in other languages. Updated chart for 1/1/2023 d. Non-English Prevalent Languages by Geographic Service Region (GSR) See XIX.B. for list of Geographic Service Regions. **GSR** Languages (other than English) **1** Chinese, Hmong, Spanish, Somali **2** Hmong, Laotian, Spanish **3** Chinese, Spanish **4** Hmong, Laotian, Spanish **5** Spanish **6** Chinese, Hmong, Spanish ~~**7** Chinese, Somali, Spanish~~ *

			8 Arabic, Hmong, Spanish **9** Hmong, Spanish **10** Chinese, Hmong, Spanish **11** Chinese, Serbo-Croatian, Spanish **12** Chinese, Hmong, Spanish **13** Chinese, Hmong, Spanish **14** Spanish * As of 1/1/2023, GSR 7 is eliminated and the region is combined with region 1.
10.	DHS deleted the Business Associate Agreement requirement because MCOs are trading partners, not business associates. DHS corrected the DHS contacts in this section.	Article XIII.A.1(c) Unauthorized Use, Disclosure, or Loss If the MCO becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this contract, or if any confidential information is lost or cannot be accounted for, the MCO shall notify the Department's ~~the~~Privacy Officer and the contract coordinator ~~in the Department's Office of Legal Counsel~~ within one day of the MCO becoming aware of such use, disclosure, or loss. The notice shall include, to the best of the MCO's understanding, the persons affected, their identities, and the confidential information that was disclosed. ~~Article XIII.P~~ ~~Business Associate Agreement~~	**From BPDD** As Trading Partners, do MCOs have the same expectation of keeping protected health information subject to HIPPA secure? MCOs are still bound by HIPAA. See Articles A.1 Article XIII. A. Member Records The MCO shall have a system for maintaining member records and for monitoring compliance with their policies and procedures. 1. Confidentiality of Records and HIPAA Requirements The MCO shall implement specific procedures to assure the security and confidentiality of health and medical records and of other personal information about members, in accordance with Wis. Stats.

		~~Due to the MCO using and/or disclosing protected health information subject to HIPAA, the MCO shall review and execute a Business Associate Agreement (BAA) F-00759 with the Department as a mandatory and critical exhibit to the Contract. A BAA must be executed before the MCO performs any work of any kind for DHS as a result of this Contract.~~	Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. 431, Subpart F; 42 C.F.R. 438; 45 C.F.R. 160; 45 C.F.R. 162; and 45 C.F.R. 164 and any other confidentiality law to the extent applicable. There are a handful of other contract provision requirements related to HIPAA. Definition of Trading Partner Agreement, 45 CFR s. 160.103 *Trading partner agreement* means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.) Sample Trading Partner Agreement from Forward Health Does the Department's Privacy Officer have specific legal response duties or powers in the event of a data security breach that are equivalent to the Office of Legal Counsel? The privacy officer is an attorney who is a member of OLC.
11.	DHS edited the section on network adequacy standard waiver exceptions to ensure that when DHS finds waiver appropriate, MCOs can receive that waiver. DHS added	**Article VIII.I.5** 5. Assuring Network Adequacy	Thank you for feedback on network adequacy standards. We have forwarded it to the workgroup

	clearer language about how DHS will evaluate whether waiver should apply.	a. The MCO shall demonstrate that its provider network complies with the state developed network adequacy standards ~~(time and distance and non-time and distance)~~ as specified in the MCO Provider Adequacy Policy: https://www.dhs.wisconsin.gov/publications/p02542.pdf . b. ~~DHS~~ The Department may grant an exception to these standards if the MCO requests an exception and provides all of the following to the Department: ~~a. Conclusive evidence that there is an insufficient number of providers for a service in a given county;~~ ~~b. An explanation of the factors beyond the MCO's control contributing to the inadequate supply; and~~ ~~c. The MCO's strategy to provide a similar service to support member outcomes or other alternatives.~~ • ~~The geographic location of providers and members, distance, and travel time for members~~ i. ~~The number of and availability of provider types in the service area~~ The number of and availability of providers in the particular specialty who are practicing in the service area ii. The ~~HMO's~~ MCO's ability to contract with available providers	reviewing and updating the network adequacy standards. • Network Adequacy Standard waiver criteria should account for the following: 1. (Survivor's Coalition, BPDD) Geographic location of providers and members, and member time/distance should be a considered factor when considering whether to grant a waiver. Location, distance, and travel time are being removed during this cycle because DHS does not currently have a method to monitor these standards. 2. (Survivor's Coalition, BPDD, People First Wisconsin) Criteria to accurately gauge the number of providers accepting new Medicaid or Family Care participants, not just the number of providers; Thank you for this feedback. DHS declines to add "who are accepting Medicaid patients or Family Care participants" as part of the waiver for network adequacy standards. 3. (Survivor's Coalition, BPDD, GWAAR) When assessing impact to members in each area, factor the content of members' care plan goals and outcomes, and any natural supports identified in the care plan in the

		iii. The impact to members in the proposed ~~county and the surrounding areas~~ service area iv. The MCO plan for how the ~~HMO~~ MCO will serve its members despite network adequacy deficiencies c. The Department will require the MCO to submit documentation to address the factors listed above. If the Department grants an exception, the Department will monitor member access to affected provider type(s). Further, if the Department grants an exception, the MCO will be required to provide updates on its efforts to meet network adequacy requirements every 90 days or upon the Department's request.	proposed service area when considering what a lack of provider capacity means to members Thank you for this feedback. DHS will continue to work with MCOs to ensure adequate networks for all members and oversee access to providers. 4. (Survivor's Coalition, BPDD, People First Wisconsin, GWAAR) Under the required MCO plan for how it will serve members if a network adequacy standard waiver is granted, require MCOs reinvest administrative funds and profits to grow network capacity, and use innovative strategies (including technology) to increase service delivery capacity. DHS currently has a risk corridor in place that limits MCO profit on the benefit portion of the capitation rate to 4%, with 50% of profit between 2% and 6% being returned to DHS and 100% of the profit over 6% being returned to DHS. We believe this incentivizes MCOs to reinvest funding into the provider community in innovative ways to meet member needs. 5. (Survivor's Coalition, BPDD) If a provider inadequacy waiver is granted, impose a temporary stop on the

			addition of new members until provider capacity is sufficient to serve existing members. DHS will take appropriate action for MCOs not meeting network adequacy standards, which may include an enrollment freeze. **From DRW** How will this work? How will DHS enforce the plan to serve members despite network inadequacies? Whose responsibility is it to find out-of-network providers? Thank you for this feedback. DHS will continue to work with MCOs to ensure adequate networks for all members and oversee access to providers.
12.	CMS required DHS to update the HMO contract to include mandatory reasons for terminating providers. DHS OIG recommended that the same additions be made to the MCO contract. While monitoring for the reasons listed in the provider termination language is primarily DHS's responsibility, if an MCO finds that one of the reasons applies to its provider, the MCO may need to terminate the provider and inform DHS as explained in the contract. Resources August 2016 CMS provider termination booklet: https://www.cms.gov/files/document/mpe-booklet082616pdf	**DHS-MCO Contract Provisions involving terminations of providers** **Article VIII, Provider Network** D. Provider Agreement Language 5. Term and Termination a. The provider agreement specifies the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the MCO's ability to terminate and suspend the provider agreement ~~based on quality deficiencies~~	**From iCare** With respect to iv. Required termination for "Failure to Submit Timely and Accurate Information. . . .", Please clarify the scope of this requirement. Does it only pertain to instances where DHS has advised the HMO that the provider has failed to submit information to DHS? Please confirm it does not require that HMOs terminate providers for immaterial oversights or reasonable delays in the provider submitting requested information The intent behind this termination reason is to terminate providers who fail to provide information or provide inaccurate information at enrollment. Currently, the MCO is responsible for enrolling waiver

	42 CFR § 455.416 Termination or denial of enrollment https://www.law.cornell.edu/cfr/text/42/455.416 42 CFR § 455.2 Definitions section that applies to 455.416 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455 Proposed rule in 2011 establishing provider terminations: https://www.federalregister.gov/documents/2010/09/23/2010-23579/medicare-medicaid-and-childrens-health-insurance-programs-additional-screening-requirements List from Medicaid Provider Enrollment Compendium (MPEC) starting on p. 82	and a process for the provider to appeal ~~appealing~~ the termination or suspension decision. b. The MCO will ensure that provider agreements reflect all current MCO contract and provider agreement requirements. - c. The Department is responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Art. VIII.D.5.d and f. The Department will inform the MCO when a provider is terminated from the Wisconsin Medicaid program for cause and the MCO must terminate that provider from its network. d. The MCO must terminate a provider for cause in all the following circumstances: i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e.	providers. Therefore, the MCO has discretion to determine whether a provider has failed to provide accurate or timely information. The MCO would only be terminating the provider from the MCO's network. If the provider is a Medicaid enrolled provider, the Department would primarily be responsible for making this determination. Updated language **DHS-MCO Contract Provisions involving terminations of providers** **Article VIII, Provider Network** D. Provider Agreement Language 5. Term and Termination a. The provider agreement specifies the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the MCO's ability to terminate and suspend the provider agreement ~~based on quality deficiencies~~ and a process for the provider to appeal ~~appealing~~ the termination or suspension decision. b. The MCO will ensure that provider agreements reflect all current MCO contract and provider agreement requirements.

			ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a). iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department's request. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e. iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider fails to submit timely and accurate information. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e. v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless	c. The Department is primarily responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Art. VIII.D.5.e and h. The Department will inform the MCO when a provider is terminated from the Wisconsin Medicaid program for cause and the MCO must terminate that provider from its network. d. The MCO is primarily responsible for monitoring and terminating waiver services providers for the reasons listed below in Art. VIII.D.5.e and h. e. The MCO must terminate a provider for cause in all the following circumstances: i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.f.

		the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.e. vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program. e. The MCO must terminate a provider due to a reason in Article VIII.D.5.d.i and iii. through v., unless the MCO obtains approval from the Department to not terminate the provider. This process is not available for an MCO when a provider must be terminated due to a reason in Article VIII.D.5.d.ii and vi. The MCO must contact its contract coordinator to request permission to not terminate the provider. The contractor coordinator shall alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived. f. As required in Article VIII.J.1.a.i., the MCO is required to notify the Department at DHSDMSLTC@dhs.wisconsin.gov within seven (7) calendar days when any notice is given by the MCO to a provider, or any notice given to the MCO from a provider, of a provider agreement termination, a pending provider agreement termination, or a pending	ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a). iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department's request. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.f. iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider fails to submit timely and accurate information. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.f.

		modification in provider agreement terms that have potential to limit member access or compromise the MCO's ability to provide necessary rights. g. The MCO may terminate a provider for cause in all the following circumstances: i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished unless otherwise authorized by telehealth rules, or when the equipment necessary for testing is not present where the testing is said to have occurred. ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension. iii. Improper Prescribing Practices. The MCO determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 C.F.R. § 455.2, or represents a threat to the health and safety of members. iv. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.	v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless the MCO receives permission from the Department to not terminate the provider as identified in VIII.D.5.f. vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program. f. The MCO must terminate a provider due to a reason in Article VIII.D.5.e.i and iii. through v., unless the MCO obtains approval from the Department to not terminate the provider. This process is not available for an MCO when a provider must be terminated due to a reason in Article VIII.D.5.e.ii and vi. The MCO must contact its contract coordinator to request permission to not terminate the provider. The contractor coordinator shall alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived. g. As required in Article VIII.J.1.a.i., the MCO is required to notify the Department at DHSDMSLTC@dhs.wisconsin.gov within seven (7) calendar days when any notice is given by the MCO to a provider, or any notice given to the MCO from a provider, of a provider

		v. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration. vi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs. vii. Provider Conduct. The provider or any owner, managing employee, or medical director of the provider is excluded from the Medicare or Medicaid programs. ~~b.~~ h. Residential rates … J. Change in Providers 1. Required Notifications a. Notice to Department The MCO is required to notify the Department at DHSDMSLTC@dhs.wisconsin.gov within seven (7) calendar days when: i. Any notice is given by the MCO to a provider, or any notice given to the MCO from a provider, of a provider agreement termination, a	agreement termination, a pending provider agreement termination, or a pending modification in provider agreement terms that have potential to limit member access or compromise the MCO's ability to provide necessary rights. h. The MCO may terminate a provider for cause in all the following circumstances: i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished unless otherwise authorized by telehealth rules, or when the equipment necessary for testing is not present where the testing is said to have occurred. ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension. iii. Improper Prescribing Practices. The MCO determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 C.F.R. §

		pending provider agreement termination, or a pending modification in provider agreement terms that have potential to limit member access or compromise the MCO's ability to provide necessary rights. ii. A community residential care provider reports to the MCO that an MCO member has or will be involuntarily discharged b. Notice i. The MCO must make a good faith effort to give written notice of termination of a contracted provider, by the later of 30 calendar days prior to the effective date of the termination or fifteen (15) calendar days after receipt or issuance of the termination notice, to each member who received his/her primary care from, or was seen on a regular basis by, the terminated provider.	455.2, or represents a threat to the health and safety of members. iv. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits. v. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration. vi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs. vii. Provider Conduct. The provider or any owner, managing employee, or medical director of the provider is excluded from the Medicare or Medicaid programs. ~~b.~~ i. Residential rates …

13.	DHS changed a contract reference incorrectly added to the 2022 contract.	Article VIII, Provider Network N. Standards for MCO Staff 5. Caregiver Background Checks g. Certification and Contracting with 1-2 Bed AFH's i. MCO must adhere to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes: https://www.dhs.wisconsin.gov/publications/p0/p00638.pdf ii. Placing MCOs are required to notify a 1-2 bed certifying agency of all new placements in a 1-2 bed AFH. iii. Placing MCOs are required to notify the certifying agency of any incidents, identified in Article V.H.2~~.i.~~, that occur in a 1-2 bed AFH within 24 hours. iv. Certifying MCOs are required to inform all placing agencies ~~(agencies can be MCOs, IRIS or Counties)~~ of any incidents that may jeopardize the health and safety of residents residing in a 1- 2 bed AFH they certify within 24 hours. v. Certifying MCOs are required to investigate and follow up when incidents, identified in Article V.H.2~~.i.~~, take place in the homes they certify. vi. Certifying and placing MCOs are responsible for assuring that 1- 2 bed AFHs are notifying both the placing agencies and certifying agency of all incidents, identified in Article V.H.2~~.i~~,. vii. Certifying MCOs are responsible for tracking all incidents, identified in Article V.H.2~~.i.~~, and the incident outcomes that take place in the homes they certify. viii.. Certifying MCOs are required to submit their training plans and policies to ~~DHS~~ the Department on how the MCO	**From BPDD** While this is a simple change due to incorrect contract reference, BPDD is still concerned that the current certification manual has not been updated to reflect the changes in the setting rule. We also provided extensive comments related to this manual. DHS is currently updating the certification manual.

		ensures their staff have the knowledge and capability to certify and contract with 1-2 bed AHFs. ix. Certifying MCOs must inform contracting agencies immediately if the certification will be revoked or the certifying MCO plans to let the certification lapse without renewal	
Other Feedback			
14.	**From Survivor's Coalition** Mergers / acquisitions • Molina acquiring MyChoice • Humana acquiring Inclusa Recommending that Family Care contract be more comprehensively revised to better orient the deliverables of the contract around participant outcomes and reinvesting of a portion of MCO earnings into developing capacity within the long-term care system. From GWAAR With the introduction of multi-state, large-scale, for-profit health care agencies into Wisconsin's Medicaid Managed long-term care system, it is necessary for the state's MCO contracts to not allow profits to be prioritized over quality and meeting participant goals and outcomes. Capitation rates must ensure MCO solvency, while requiring MCO reinvestments to build the capacity of the long-term care provider network. As the number of MCOs is reduced, participants will face increasingly limited options/choices. Wisconsin's long-term care system has benefitted from		Thank you for your feedback. DHS will continue to provide oversight for all MCOs. DHS will add this issue as a topic for discussion at a LTCAC meeting.

	locally developed and value based MCOs. The state system is rapidly evolving away from our home-grown system; efforts must be in place to ensure choice, quality, and our non-medical model of care aren't lost for good. Contract requirements must not be reduced to entice the few players we have left from leaving, but instead must remain focused on individual outcomes that lead to more independence and community integration. Please write a contract that is participant centered--and reward MCOs for meeting participant outcomes. Pay for performance gives incentives to provide better services. I'm worried that if a for-profit provider takes over, it will compromise the care I need to live independently. Currently, I live in my own apartment with supports. I am with a small, home-grown provider that helps me build skills--and do things for myself.Little things like...knowing that spinach shrinks when you cook it, cleaning the bathroom from top to bottom etc. are things I can practice when my caregivers aren't there. And if I have questions, I can text them. If I still can't complete the task, we can do it at our next appointment. If a big for-profit insurance company bought out my home-grown MCO, I might lose skills. And have a more limited life than when I started receiving cares. The company would have bigger profits, and I would have a smaller life. From People First Wisconsin **Concern:** There will be less choice of MCOs and no options to change to a different MCO, if a participant is unhappy		

	with services. As smaller providers go out of business or are absorbed into bigger companies, there will also be less choice of providers. A self-advocate who uses Family Care, shared how she changed from a provider who did things for her to one who taught her how to do things such as cook and clean her apartment. She is happier and becoming more independent. We worry that participants will lose their options to change providers. This could lead to lower standards for providers because they will be the only "show in town" and participants will be put into a "take it or leave it" position. Some of our members and their families have expressed fear of losing a service if they speak up about a concern or advocate for improvements, because they don't want to lose what they have, as other options are limited already. This makes participants more vulnerable to abuse and neglect. **Request:** Please write a contract that is participant-centered and rewards MCOs for meeting participant outcomes. Pay for performance to give the incentive to provide better services.		
15.	**From Survivor's Coalition, People First Wisconsin, GWAAR** Eliminate the contractual provision in Family Care that allows Managed Care Organizations to **bundle transportation with residential services**. Transportation needs are independent from residential services and should be recognized as such.		Thank you for this feedback. It is in the administrative code that residential providers provide transportation. DHS 89.13(31) *Supportive services: meals, housekeeping in tenants' apartments, laundry service and arranging access to medical ser**[1]**vices. In this subparagraph, "access" means arranging for*

			*medi**[1]**cal services and transportation to medical services.* DHS 83.38(1)(k) **(k)** *Transportation.* The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents
16.	**From BOALTC** Contract expects all IDT staff to understand various components of the SDS program OR to have access to MCO staff with expertise. Without an appropriate basic knowledge or tool to inform, IDT may lack the awareness of when to contact an expert. Lack of knowledge may have contributed to negative SDS experiences in 2022. DHS Self-Directed Supports in FC, FC Partnership and Pace: A Best Practice Manual for IDT, is a tool which provides basic knowledge for IDT, however it is not mentioned or referred to in contract. • Request adding language in Article VI. Self- Directed Supports referring to DHS document P-00539 (10-2017) Self-Directed Supports in FC, FC Partnership and Pace: A Best Practice Manual for IDT https://www.dhs.wisconsin.gov/publications/p0/p00593.pdf	**Draft 1 from BOALTC** VI. Self-Directed Supports B. MCO Requirements 4. Ensure that all IDT staff understand SDS … 5. Ensure that all IDT staff understand how to create a budget… 6. Ensure that all IDT staff understand how to monitor	Thank you for this feedback. We will be reviewing this document for updates. It will not be included in the 2023 contract, but could be included in future contracts after it is updated. MCOs are required to submit their training plans to DHS for approval. It is a requirement that IDT staff are trained on SDS. MCOs have created SDS brochures and information to assist the IDT staff in explaining SDS to members. Self-Directed Supports in Family Care, Family Care Partnership, and PACE (wisconsin.gov)

	Addition of document and link to Addendum VIII. Materials Cited in this Contract & Other Related Communications		
17.	**From BOALTC** Request update to Family Care Member Handbook Template to reflect contract language, which correctly identifies the MCO as the entity to assist with completion of Application for Reduction of Cost Share Member Handbook Template for Family Care, P-00649 www.dhs.wisconsin.gov/library/p-00649.htm **Family Care Member Handbook Template** P-00649, pg. 29 Cost Share Reduction – language *incorrectly directs* member to Family Care ombudsman programs. *Incorrect template verbiage:* "If you need help completing the application, you can obtain assistance, free of charge, from an ombudsman. Contact information for the Family Care ombudsman programs is on page 50." Contract language – pg. 33 D. Medicaid Deductibles or Cost Share 2. Cost Share or Patient Liability c. ii. 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** .		Thank you for the feedback. This has been shared with staff who update the member handbook.

18.	**From People First Wisconsin** **Concern:** We worry about the greater use of institutions and other congregate settings. Some of our members cannot find caregivers and are going without care or their family members (sometimes elderly parents) are providing it. It increases the chances of illness and injury that could lead to a hospital and rehabilitation stay. Once institutionalized, it is difficult to get back home and some participants feel that MCOs are not always doing everything they can to get them back home as soon as possible. We really don't know how many people with disabilities are going without care or whose family members are struggling to provide it, but we are hearing of more people in these situations than ever before. **Request:** Please track information about authorized hours of care not used and use the data collected to develop strategies to address the caregiver crisis and to get people out of institutions. Rates for direct care workers need to be more competitive to create a career path so there is less turn over and more consistent care.		Thank you for the feedback. Thank you for the feedback. MCOs are responsible for tracking over and underutilization and for taking the necessary steps to address any issues. The MCOs have established a workforce shortage workgroup along with a handful of residential providers to brainstorm on strategies to address the caregiver crisis. Also, over the last several years, the MCOs have passed increases to providers through the direct care workforce funding, ARPA funding and the state directed rate increase.
19.	**From GWAAR** Section V. Care management E. Providing, arranging, coordination, and monitoring services section (see FC-FCP 2022 Contract) – This area of the contract should indicate that MCO staff must run Medicare Plan Finders for enrollees and help them with enrollments into Medicare Part D plans. Enrollment must be maintained year after year by running a new Plan Finder for Medicare eligible members during Medicare's Open Enrollment Period in the		DHS declines to make this change and believes the existing contract language is sufficient.

	fall between October 15-December 7th of each year. To prevent members from losing eligibility for critical public benefits, Family Care case managers must be required to provide the necessary help to ensure that MCO participants remain on and get assistance with renewals for Wisconsin's Home Energy Assistance Program (WHEAP), housing subsidies (Section 8), and Supplemental Security Income (SSI). Additionally, to avoid a dual-eligible (Medicare/Medicaid) participant from unknowingly receiving services from out-of-network providers and then being strapped with large, unpayable bills for uncovered services, Family Care Partnership case managers must counsel participants about how networks work and help participants understand who their in-network providers are and the financial consequences of seeking out-of-network care. Case managers inform members about using in network providers. Information about network providers is also included in member handbooks.		Case managers inform members about using in network providers. Information about network providers is also included in member handbooks.

WISCONSIN DEPARTMENT of HEALTH SERVICES

DHS-MCO Contract Amendment 2023: DHS Responses to Stakeholder Feedback

Kelly Van Sicklen

DHS, DMS, BPP, Managed Care Policy Section

Discussion

- New DHS-MCO Contract changes based on stakeholder feedback

- DHS responses to stakeholder feedback

Edit Equity and Inclusion references

Inclusa Feedback:

- Missed removing several references to “identity”

DHS Response:

- Removing these additional references to “identity”

#2 on attached chart

Clarify IMD Reporting

Feedback from iCare:

- Question on definition of “biannual”

DHS Response:

- Changing from “biannual IMD report” to “Semiannual IMD report”

#4 on attached chart

Clarify Reportable Incidents

New language for 2023 based on several suggestions and questions from stakeholders:

- Clarify that MCOs report to DHS contract coordinator AND managed care quality specialist
- Clarify that MCOs must also report these incidents for Partnership
- Add “or social media story” to reporting requirement

#8 on attached chart

Add Non-English Prevalent Languages

DHS received several questions and suggestions related to the proposal to add prevalent non-English languages to the contract.

We will include an updated Non-English prevalent languages chart reflecting elimination of GSR 7

9 on attached chart

Clarify Provider Termination Language

iCare Feedback: please confirm this does not require termination for reasonably delay or immaterial oversight

DHS Response: Adding language to clarify that the MCO is primarily responsible for monitoring and terminating waiver service providers

#12 on attached chart

Add Definition of "Functionally Equivalent"

Feedback from Survivor Coalition, BPDD, GWAAR:

- Participant should actively choose telehealth, be able to switch to in-person at any time, and agree the service is functionally equivalent

BOALTC Feedback:

- Add language requiring annual member consent for telehealth

DHS Response:

- Functional equivalence is determined by the MCO. Members can choose in-person options at any time.

#1 on attached chart

Clarify Sanctions Reported to CMS

BPDD Feedback:

- Add failure to provide other Medicaid-funded HCBS services as a reportable offense
- Revise metric for determining whether services have been provided
- Clarify consequences of MCO failure to meet LTC performance standards

DHS Response:

- Original contract change does not change bases for imposing sanctions

#3 on attached chart

Add Required Provider Training on Mandated Reporting

Feedback rom DRW:

- Questions on whether the training makes all of the attendees mandatory reporters

DHS Response:

- MCOs should work with their legal teams regarding mandatory reporting requirements

#5 on attached chart

Risk Corridor Changes

DHS received several suggestions and questions on the proposed change to:

- Remove a COVID-19 justification for a risk corridor, and
- Add information about “related party” and information to the Medical Loss Ratio section to align requirements

#7 on attached chart

Remove Business Associate Agreement

BPDD Feedback: As Trading Partners, do MCOs have the same expectations for keeping health information protected?

DHS Response:

- MCOs are still bound by HIPAA

#10 on attached chart

Clarify Roles in Network Adequacy Waivers

DHS received several questions and suggestions related to network adequacy

We forwarded the suggestions to the workgroup reviewing and updating the network adequacy standards

#11 on attached chart

Additional Feedback

Responses to all feedback received can be found on the attached chart

Family Care
MCO Financial Statement Summaries
YTD for Period Ending December 31, 2021 Audited

	Inclusa	LCI	MCW	CCI	Total
Revenues					
Capitation	614,124,037	300,961,115	612,299,741	505,903,243	2,033,288,136
Interest Income- Operating Acct	188,568	0	15,078	0	203,646
Other Retro Adjustments, DHS	13,071,403	11,426,620	4,246,029	5,744,684	34,488,736
Other Income	48,094	74,639	127,003	0	249,736
Total Service Revenue	627,432,102	312,462,374	616,687,851	511,647,927	2,068,230,254
Expenses					
Member Service Expenses	568,427,097	293,612,688	579,779,522	465,127,350	1,906,946,657
Cost Share	(15,657,044)	(9,157,990)	(20,067,247)	(16,204,225)	(61,086,506)
Room & Board	(47,925,558)	(26,829,714)	(53,352,070)	(46,232,477)	(174,339,819)
Other Third Party	(3,347)	(103,564)	0	0	(106,911)
Net Member Services Expenses	504,841,148	257,521,420	506,360,205	402,690,648	1,671,413,421
Net Care Management Expenses	80,771,517	37,557,471	65,729,210	49,695,248	233,753,446
Administrative Expenses	25,052,753	9,592,396	20,122,008	10,633,915	65,401,072
Total Operating Expenses, CY	610,665,418	304,671,287	592,211,423	463,019,811	1,970,567,939
Income (Loss) from Operations, CY	**16,766,684**	**7,791,087**	**24,476,428**	**48,628,116**	**97,662,315**
Other (Revenue)/Expense, Ordinary					
Total Other (Revenue)/Expense	(7,416,658)	(1,596,519)	(12,186,665)	3,925,871	(17,273,971)
Net Income/ (Loss)	**24,183,342**	**9,387,606**	**36,663,093**	**44,702,245**	**114,936,286**
Member Months by FC Target Group					
Developmentally Disabled (DD)	49.8%	48.7%	40.7%	44.5%	45.6%
Physically Disabled (PD)	16.9%	15.1%	17.9%	20.5%	17.8%
Frail Elder (FE)	33.3%	36.2%	41.4%	35.0%	36.6%
Total Member Months	185,813	90,487	189,241	146,113	611,654
Key Ratios (as % of Revenue)					
Member Service Expense, Net	80.4%	82.4%	82.1%	78.7%	80.8%
Care Management Service Expense	12.9%	12.0%	10.7%	9.7%	11.3%
Total Member Service Expense	**93.3%**	**94.4%**	**92.8%**	**88.4%**	**92.1%**
Administrative Expense	4.0%	3.1%	3.3%	2.1%	3.2%
Total Operating Expense	97.3%	97.5%	96.1%	90.5%	95.3%
Income (Loss) from Operations, CY	**2.7%**	**2.5%**	**3.9%**	**9.5%**	**4.7%**
Net Income/(Loss)	3.9%	3.0%	5.9%	8.7%	5.6%

Family Care
MCO Financial Statement Summaries
YTD for Period Ending December 31, 2021 Audited

	Inclusa	LCI	MCW	CCI	Total
Summary PMPM Presentation					
Revenues					
Capitation	3,305.06	3,326.02	3,235.55	3,462.41	3,324.25
Interest Income- Operating Acct	1.01	0.00	0.08	0.00	0.33
Other Retro Adjustments, DHS	70.35	126.28	22.44	39.32	56.39
Other Income	0.26	0.82	0.67	0.00	0.41
Total Revenues	3,376.68	3,453.12	3,258.74	3,501.73	3,381.38
Expenses					
Total Member Service Expenses	3,059.14	3,244.81	3,063.71	3,183.34	3,117.69
Cost Share	(84.26)	(101.21)	(106.04)	(110.90)	(99.87)
Room & Board	(257.92)	(296.50)	(281.93)	(316.42)	(285.03)
Other Third Party	(0.02)	(1.14)	0.00	0.00	(0.17)
Net Member Service Expenses	2,716.94	2,845.96	2,675.74	2,756.02	2,732.62
Net Care Management Expenses	434.69	415.06	347.33	340.12	382.17
Administrative Expenses	134.83	106.01	106.33	72.78	106.92
Total Operating Expenses, CY	3,286.46	3,367.03	3,129.40	3,168.92	3,221.71
Income (Loss) from Operations, CY	**90.22**	**86.09**	**129.34**	**332.81**	**159.67**
Other (Revenue)/Expense, Ordinary					
Total Other (Revenue)/Expense	(39.91)	(17.64)	(64.40)	26.87	(28.24)
Net Income/(Loss)	**130.13**	**103.73**	**193.74**	**305.94**	**187.91**
Member Months by FC Target Group					
Developmentally Disabled (DD)	49.8%	48.7%	40.7%	44.5%	45.6%
Physically Disabled (PD)	16.9%	15.1%	17.9%	20.5%	17.8%
Frail Elder (FE)	33.3%	36.2%	41.4%	35.0%	36.6%
Total Member Months	185,813	90,487	189,241	146,113	611,654

Family Care
MCO Financial Statement Summaries
YTD for Period Ending December 31, 2021 Audited

	Inclusa	LCI	MCW	CCI	Total
Solvency Protection					
Working Capital					
Current Assets	134,402,113	60,218,925	167,792,060	135,434,341	497,847,439
Current Liabilities	58,376,352	31,843,799	75,776,961	64,167,346	230,164,458
Working Capital (Curr Assets- Curr Liab)	76,025,761	28,375,126	92,015,099	71,266,995	267,682,981
Working Capital Requirement	17,763,078	9,354,321	18,559,462	14,554,878	60,231,739
Excess/(shortage)	58,262,683	19,020,805	73,455,637	56,712,117	207,451,242
Restricted Reserve					
Current Restricted Reserve	6,945,948	4,126,203	7,206,864	5,869,928	24,148,943
Restricted Reserve Requirement	6,921,026	4,118,107	7,186,487	5,851,626	24,077,246
Excess/(shortage)	24,922	8,096	20,377	18,302	71,697
Solvency Fund					
Current Solvency Fund	3,757,642	1,924,460	3,913,231	2,894,000	12,489,333
Solvency Fund Requirement	3,693,253	1,924,460	3,913,231	2,893,460	12,424,404
Excess/(shortage)	64,389	0	0	540	64,929
*Restricted Equity - Solvency Protection	28,377,357	15,396,888	29,659,180	23,299,964	96,733,389
Other Equity	76,978,756	21,409,190	98,123,098	95,889,782	292,400,826
**Total Equity	105,356,113	36,806,078	127,782,278	119,189,746	389,134,215

*Restricted Equity-Solvency Protection is the calculated sum of the Working Capital, Restricted Reserve, and Solvency Fund requ

**Total Equity includes restricted and unrestricted equity, and availability of equity for investment in or support of current year ope

The DHS presentation of financial results is a subset of the full financial statement reports from the MCOs and reviewed for reasonableness. The MCO financial reporting is on a generally accepted accounting principals (GAAP) basis. Financial reporting is technical in nature and no party should use, or make assumptions about, the results without a thorough understanding of the program and health care industry financial reporting.

Family Care Partnership/PACE
MCO Financial Statement Summaries
YTD for Period Ending December 31, 2021 Audited

	MCW- HP	CCHP - FCP	CCHP - PACE	iCare	Total
Revenues					
Capitation-MA	71,054,259	39,692,497	22,232,239	63,958,971	196,937,966
Capitation- MC	38,194,781	17,068,927	17,968,992	22,794,634	96,027,334
Interest Income-Operating Acct	65,625	-	-	318,658	384,283
Other Retro Adjustments, DHS	(218,125)	862,409	-	(4,593,696)	(3,949,412)
Total Revenues	**109,096,540**	**57,623,833**	**40,201,231**	**82,478,567**	**289,400,171**
Expenses					
Total Acute & Primary Services	32,100,013	15,955,322	10,243,187	31,154,728	89,453,250
Total LTC-Family Care Expenses	67,742,532	35,304,038	26,825,250	38,088,261	167,960,081
Cost Share	(2,377,224)	(892,994)	(603,968)	(527,308)	(4,401,494)
Room & Board	(6,079,914)	(2,816,128)	(1,118,451)	(1,448,635)	(11,463,128)
Other Third Party	-	-	(181,550)	-	(181,550)
Net Member Services Expenses	91,385,407	47,550,238	35,164,468	67,267,046	241,367,159
Net Care Management Expenses	10,839,189	4,863,977	5,429,846	7,408,466	28,541,478
Administrative Expenses	6,762,157	2,984,387	2,128,061	3,721,800	15,596,405
Total Operating Expenses	108,986,753	55,398,602	42,722,375	78,397,312	285,505,042
Income (Loss) from Operations, CY	**109,787**	**2,225,231**	**(2,521,144)**	**4,081,255**	**3,895,129**
Other (Revenue)/Expense, Operating					
Total Other (Revenue)/Expense	(4,089,384)	(1,834,579)	(1,787,623)	(2,023,279)	(9,734,865)
Net Income/ (Loss)	**4,199,171**	**4,059,810**	**(733,521)**	**6,104,534**	**13,629,994**
Member Months by FC Target Group					
Developmentally Disabled (DD)	21.3%	36.4%	9.8%	27.6%	24.4%
Physically Disabled (PD)	27.0%	33.3%	8.1%	42.9%	30.7%
Frail Elder (FE)	51.7%	30.3%	82.1%	29.5%	44.9%
Total Member Months	**20,531**	**8,722**	**6,211**	**15,747**	**51,211**
Key Ratios (as % of Revenue)					
Member Service Expense, Net	83.8%	82.5%	87.5%	81.6%	83.4%
Care Management Service Expense	9.9%	8.4%	13.5%	9.0%	9.9%
Total Member Service Expense	93.7%	90.9%	101.0%	90.6%	93.3%
Administrative Expense	6.2%	5.2%	5.3%	4.5%	5.4%
Total Operating Expense	99.9%	96.1%	106.3%	95.1%	98.7%
Income (Loss) from Operations, CY	**0.1%**	**3.9%**	**-6.3%**	**4.9%**	**1.3%**
Net Income/ (Loss)	**3.8%**	**7.0%**	**-1.8%**	**7.4%**	**4.7%**

Family Care Partnership/PACE
MCO Financial Statement Summaries
YTD for Period Ending December 31, 2021 Audited

	MCW- HP	CCHP - FCP	CCHP - PACE	iCare	Total
Summary PMPM Presentation					
Revenues					
Capitation-MA	3,460.89	4,550.85	3,579.49	4,061.69	3,845.65
Capitation- MC	1,860.38	1,957.00	2,893.09	1,447.56	1,875.15
Interest Income-Operating Acct	3.20	-	-	20.24	7.50
Other Retro Adjustments, DHS	(10.62)	98.88	-	(291.72)	(77.12)
Other Income	-	-	-	-	-
Total Revenues	5,313.85	6,606.73	6,472.58	5,237.77	5,651.18
Expenses					
Total Acute & Primary Services	1,563.52	1,829.32	1,649.20	1,978.47	1,746.77
Total LTC-Family Care Expenses	3,299.58	4,047.70	4,318.99	2,418.78	3,279.80
Cost Share	(115.79)	(102.38)	(97.24)	(33.49)	(85.95)
Room & Board	(296.14)	(322.88)	(180.08)	(91.99)	(223.84)
Other Third Party	-	-	(29.23)	-	(3.55)
Net Member Services Expenses	4,451.17	5,451.76	5,661.64	4,271.77	4,713.23
Net Care Management Expenses	527.95	557.67	874.23	470.47	557.34
Administrative Expenses	329.37	342.17	342.63	236.35	304.55
Total Operating Expenses, CY	5,308.49	6,351.60	6,878.50	4,978.59	5,575.12
Income (Loss) from Operations, CY	**5.36**	**255.13**	**(405.92)**	**259.18**	**76.06**
Other (Revenue)/Expense, Ordinary					
Total Other (Revenue)/Expense	(199.18)	(210.34)	(287.82)	(128.49)	(190.09)
Net Income/ (Loss)	**204.54**	**465.47**	**(118.10)**	**387.67**	**266.15**
Member Months by FC Target Group					
Developmentally Disabled (DD)	21.3%	36.4%	9.8%	27.6%	24.4%
Physically Disabled (PD)	27.0%	33.3%	8.1%	42.9%	30.7%
Frail Elder (FE)	51.7%	30.3%	82.1%	29.5%	44.9%
Total Member Months	**20,531**	**8,722**	**6,211**	**15,747**	**51,211**
*Equity	68,129,860	18,981,524		103,185,682	190,297,066

* Total Equity may include restricted and unrestricted equity, and availability of equity for investment in or support of current year operations should not be assumed.

The DHS presentation of financial results is a subset of the full financial statement reports from the MCOs and reviewed for reasonableness. The MCO financial reporting is on a generally accepted accounting principals (GAAP) basis. Financial reporting is technical in nature and no party should use, or make assumptions about, the results without a thorough understanding of the program and health care industry financial reporting.

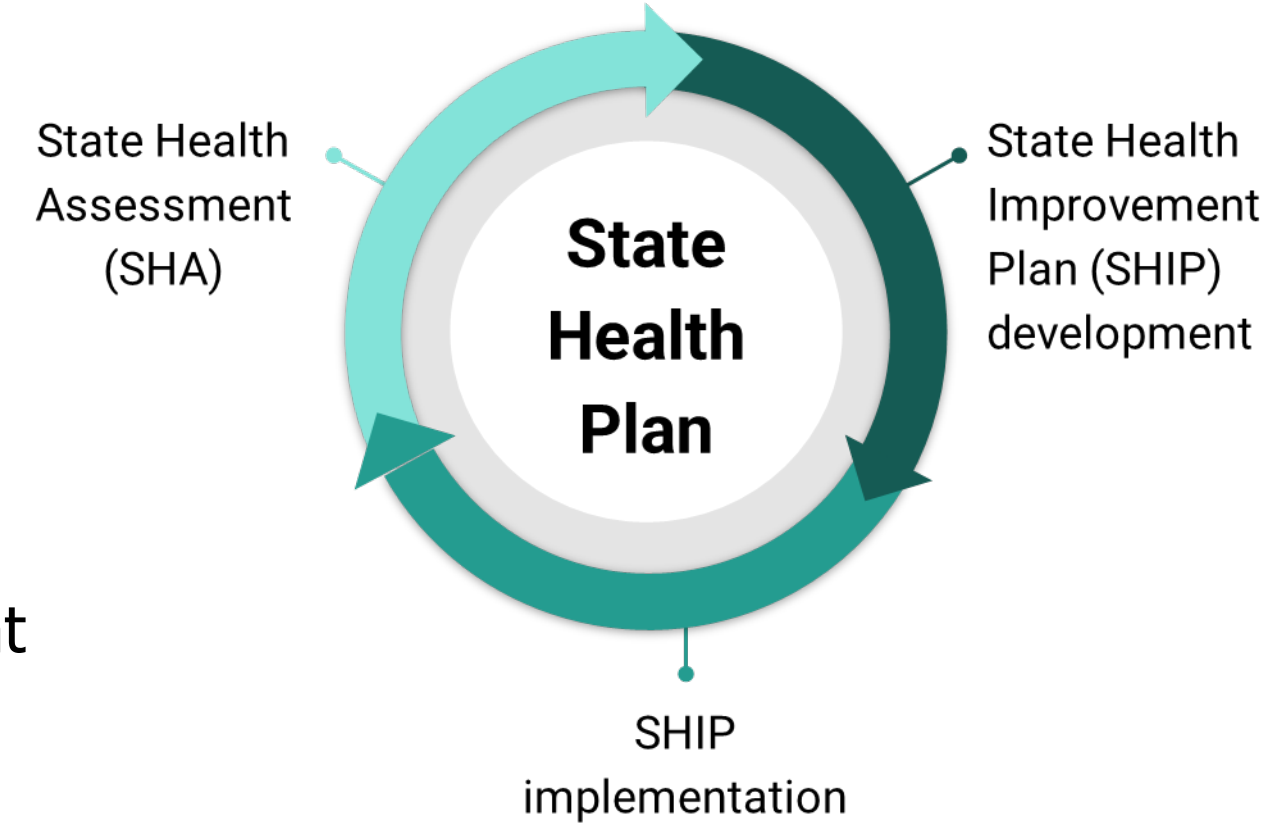
State Health Improvement Plan (SHIP) Development Update

Long Term Care Advisory Council
September 13, 2022

WISCONSIN DEPARTMENT of HEALTH SERVICES

Wisconsin State Health Plan

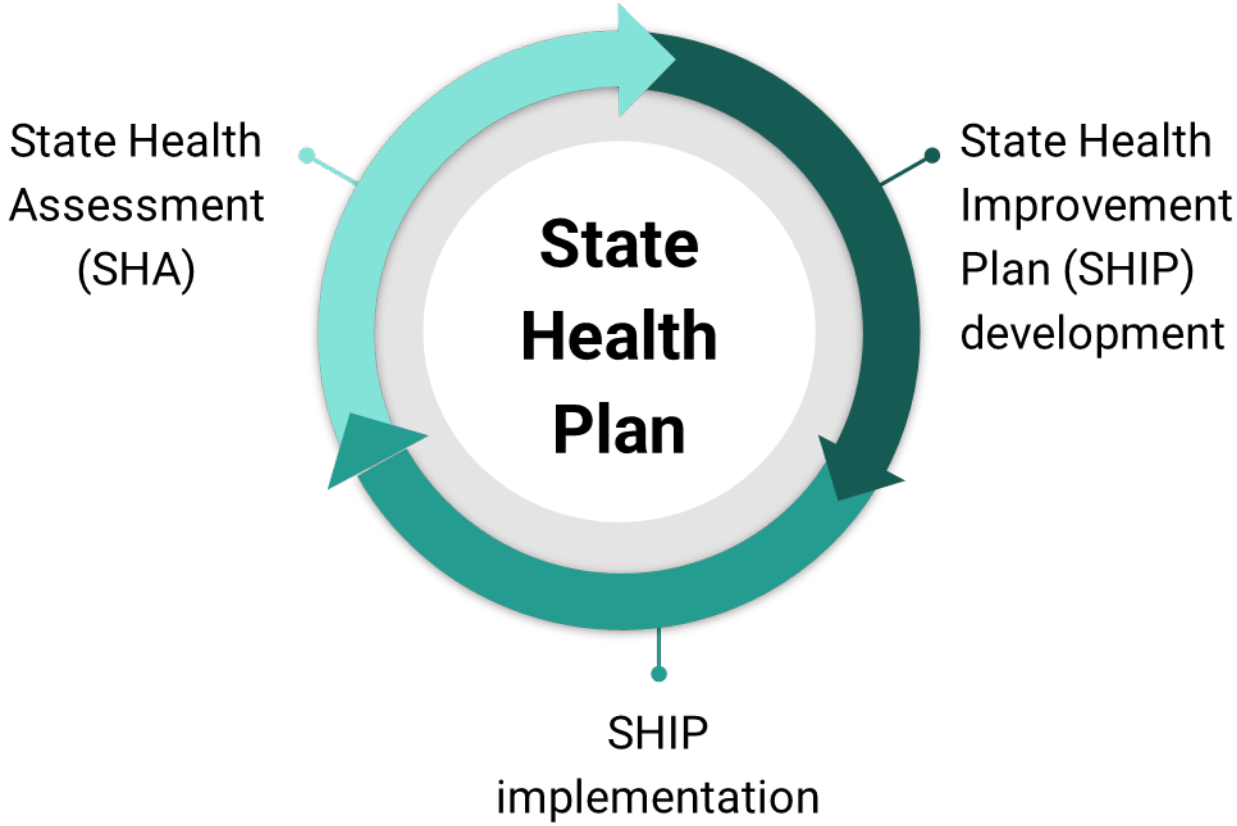
- Statutory mandate
- 5-year cycle
- Public health agenda and roadmap
- Series of iterative and overlapping processes
  - State Health Assessment (SHA)
  - State Health Improvement Plan (SHIP) development
  - SHIP implementation



State Health Assessment

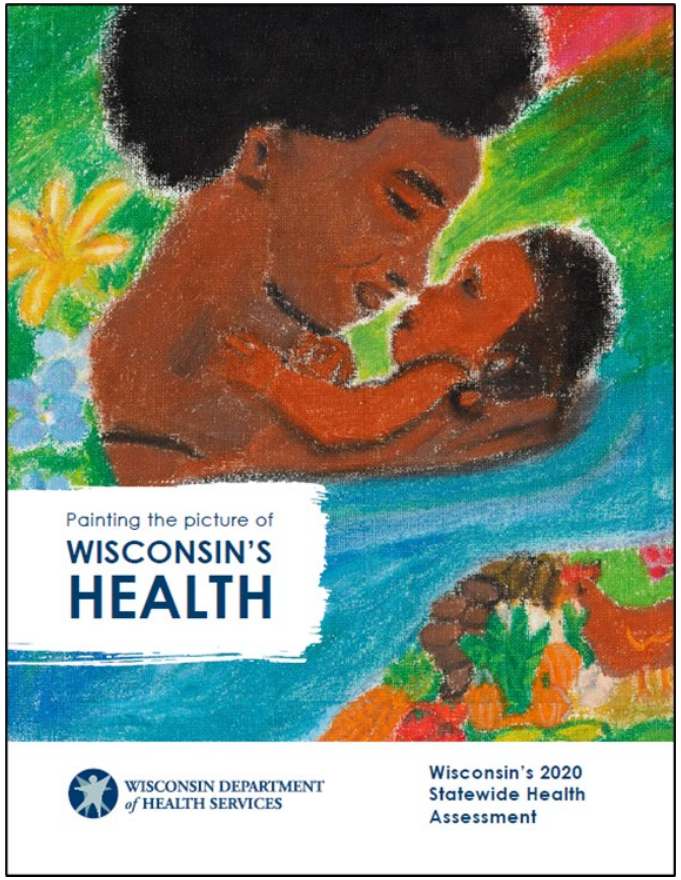
- Comprehensive overview of all health in state
- Serves as a base for the state health improvement plan (SHIP)

- For the 2020 Assessment:
  - 70+ community conversations
  - 100s of quantitative data points reviewed



2020 State Health Assessment Outcomes

- Qualitative Themes
  - Increasing social and community connections
  - Access to reliable transportation
  - Access to affordable housing
  - Access to jobs and other opportunities
  - Decreasing institutional biases
  - Access to quality and culturally informed healthcare
  - Access to community-based resources
- Increased focus on upstream factors



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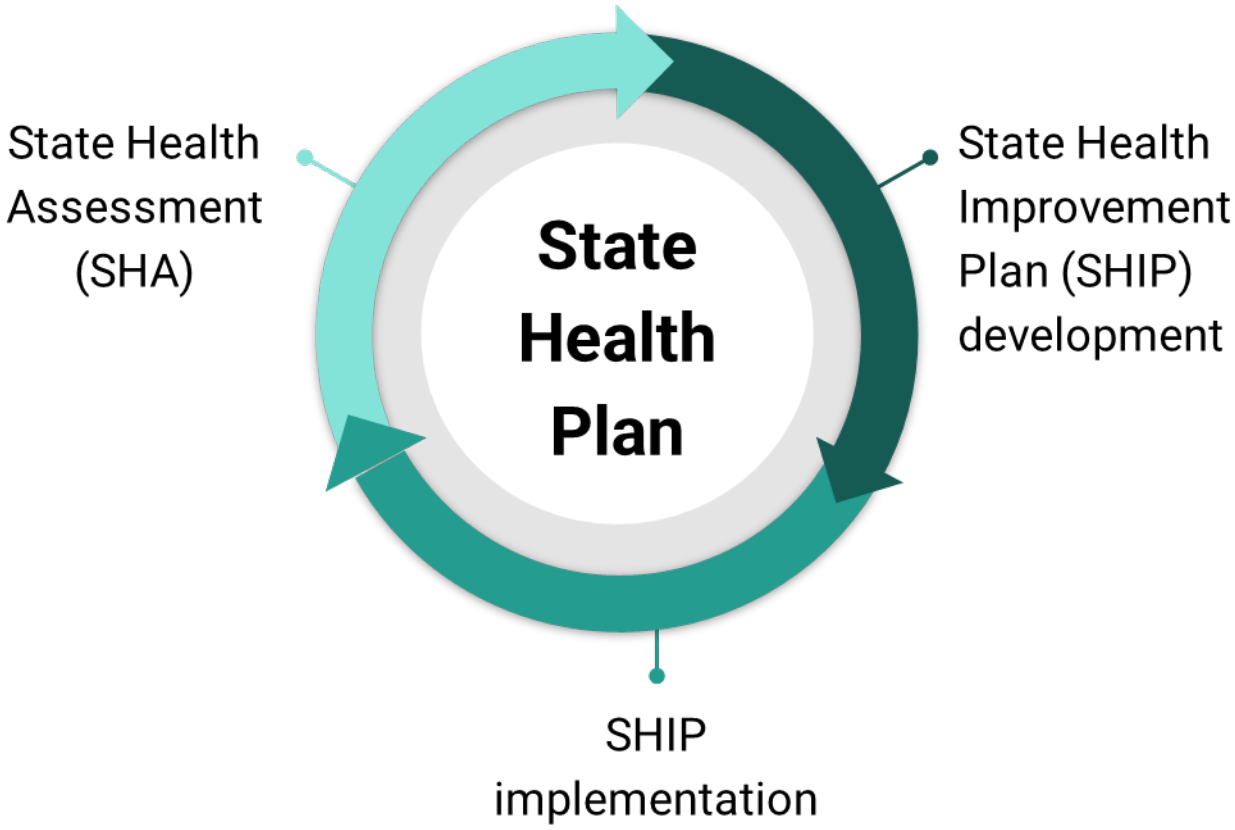
2023-2027 SHIP Development

Guiding principles:

- Center equity, stories and community voices in process and outcomes
- Move upstream to prioritize policy, systems and environment change



SHIP Collaborative Prioritization Process Phases

- Generative: Initial community-based partner conversations
- Alignment: Community of Practice meetings with Tribal and Local Public Health partners, conversations within DHS, and other state agencies, councils, health care partners, and more
- Accountability: Additional community-based partners conversations to ensure fidelity

2023-2027 State Health Improvement Plan Timeline and Process

1

March – April

Collaborative prioritization with community-based organizations

2

May – August

Engagement with institutional and systematic partners

Tribal partners

Local health departments

DPH Staff

3

September

Finalize framework and narrative

4

November

2023-2027 SHIP is finalized

SHIP Prioritization Process Themes

- Human-centered basic needs (social determinants of health)
  - Housing
  - Economic well-being
  - Child care
- Building and shifting power
- Physical and psychological safety
- Mental health
- Institutional bias and equity
- Social and community connection
- Comprehensive, accessible, culturally inclusive community-based resources
- Comprehensive, accessible, and culturally inclusive healthcare
- Sustainable community-driven funding
- Upstream change (policy and systems)

VISION: All people and communities in Wisconsin have the opportunities and supports they need to reach their full potential

Foundational shifts

- Institutional and systemic fairness (addressing the "-isms", including structural racism)
- Representation and access to decision-making (shifting and sharing power)
- Community-centered resources and services (includes funding and community input)

Priority areas

Social and community conditions
- Economic well-being
- Supportive systems of dependent care
- Healthy housing

Physical, mental, and systemic safety (including trauma, violence, systemic oppression)

Person and community centered health care (including dental and other care)

Social connectedness and belonging (including civic engagement)

Mental and emotional health and well-being (including treatment and care, substance use)

Our Approach to Upstream Work

- Shifting public narratives and building unity: expanding the understanding of what creates health
- Equitable policy and decision making: partnerships for policy, systems and environment change and building a shared agenda
- Organizing people and resources: building community capacity for change and equitable resource allocation

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Next Steps

Finalize SHIP Framework

- Review framework and share any “red flags”
- Anticipated report publication: November 2022

Implementation

- Partner to align priorities and action as we move toward implementing this new SHIP

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Reflection

- How does this SHIP framework and its priorities resonate with you?
  - Do you have any questions?
  - Does anything particularly stand out as relevant to your work and priorities and the work of the council?
  - How can we support your work in spaces where alignment and shared goals exists?
- Are there any programs or strategies you think we should especially look at when we start to build out the SHIP implementation plan?

Contact

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2021 MCO Pay for Performance Results

July 14, 2022

Kaycee Kienast
Programs and Policy Analyst - Advanced
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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	2022
Satisfaction Survey	Satisfaction Survey	Satisfaction Survey	Satisfaction Survey	Satisfaction Survey
	Competitive Integrated Employment	*CIE P4P suspended due to COVID-19	Competitive Integrated Employment	Competitive Integrated Employment
	Assisted Living Communities	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 supports and services you receive meet your needs?

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

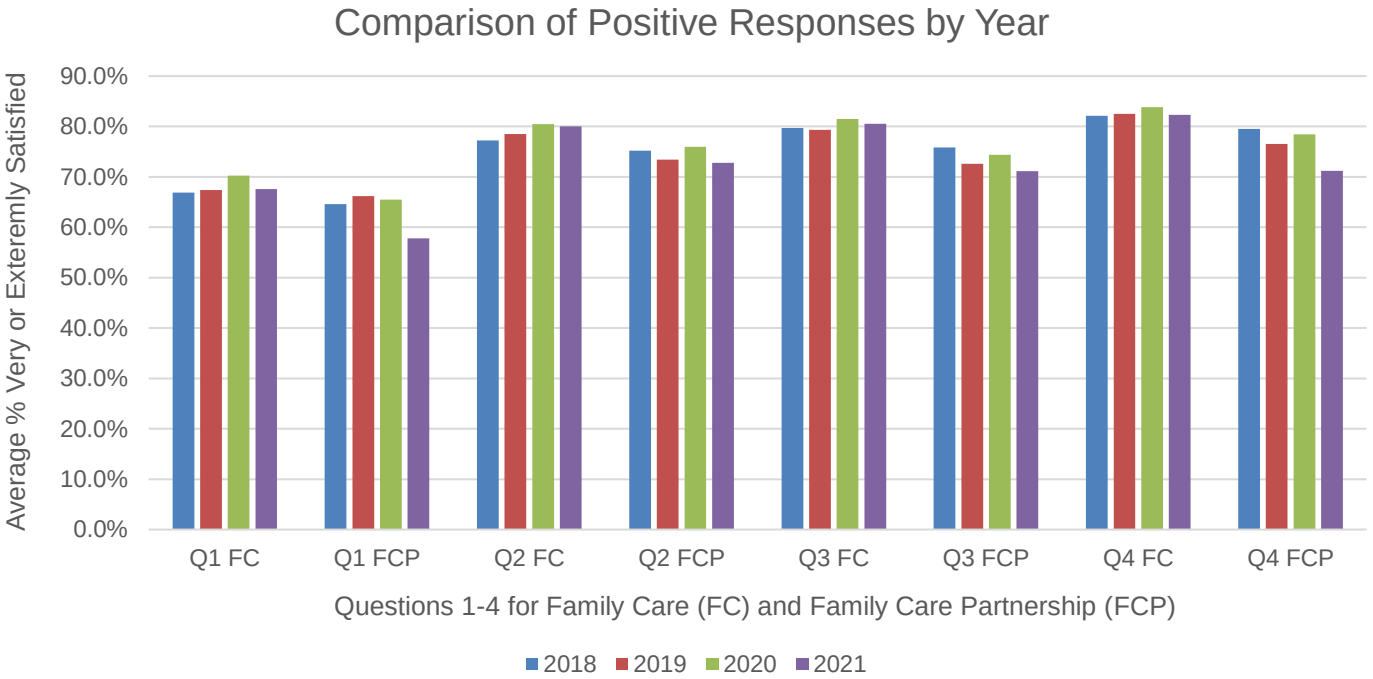
Satisfaction Survey: 2021 Results

MCO	**Withhold (up to 0.25%)*** "Very" or "Extremely" Satisfied	**Incentive (up to 0.20%)**** Only "Extremely" Satisfied
Inclusa (Family Care)	**3/4 (.1875%)**	**3/4 (0%)**
Community Care, Inc. (Family Care)	**2/4 (.125%)**	**0/4 (0%)**
Lakeland Care, Inc. (Family Care)	**0/4 (0%)**	**0/4 (0%)**
My Choice Wisconsin (Family Care)	**0/4 (0%)**	**0/4 (0%)**
iCare (Partnership)	**3/4 (.1875%)**	**3/4 (0%)**
My Choice Wisconsin (Partnership)	**0/4 (0%)**	**1/4 (0%)**
Community Care, Inc. (Partnership)	**0/4 (0%)**	**0/4 (0%)**

*0.0625% withhold earned for each survey question that met the minimum performance standard up to a total of 0.25%.

**Minimum performance standards for all survey questions must be met to earn the incentive.

Satisfaction Survey
2018-2021 Comparison



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

- Meets the following three criteria for an abbreviated Division of Quality Assurance (DQA) survey as of 12/31/2021:
  1. No enforcement action in the last three years
  2. No substantiated complaints with deficiencies issued in the last 3 years
  3. Licensed/certified by DQA for at least three years

Assisted Living Communities
Overview

Incentive 2 Category

Members in an ALC that:

- Meet the incentive 1 criteria

+

- 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 2021.

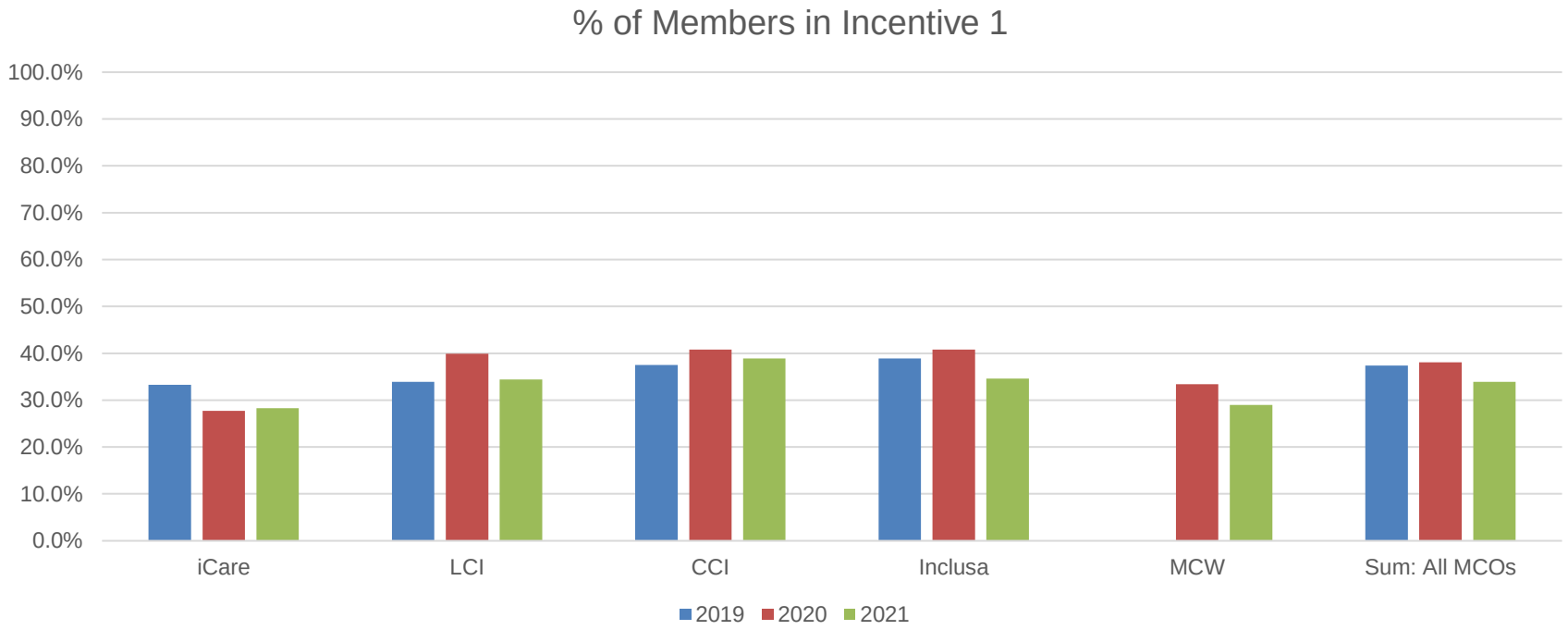
Assisted Living Communities
2021 Results

	iCare	LCI	CCI	Inclusa	MCW	All
# Members in **Incentive 1** Category (HCBS and DQA abbrev. survey)	45 **(28.3%)**	927 **(34.4%)**	1782 **(38.9%)**	1651 **(34.6%)**	1612 **(29.0%)**	6017 **(33.9%)**
# Members in **Incentive 2** Category (HCBS, DQA abbrev. survey, WCCEAL, and falls measure met)	8 **(5.0%)**	217 **(8.1%)**	355 **(7.7%)**	442 **(9.3%)**	331 **(5.9%)**	1353 **(7.6%)**
# Members in **Neither** Category	106 **(66.7%)**	1548 **(57.5%)**	2447 **(53.4%)**	2675 **(56.1%)**	3621 **(65.1%)**	10397 **(58.5%)**
# Total Members in ALCs (MCO data submissions as of 12/31/2021)	159 **(100%)**	2692 **(100%)**	4584 **(100%)**	4768 **(100%)**	5564 **(100%)**	17767 **(100%)**

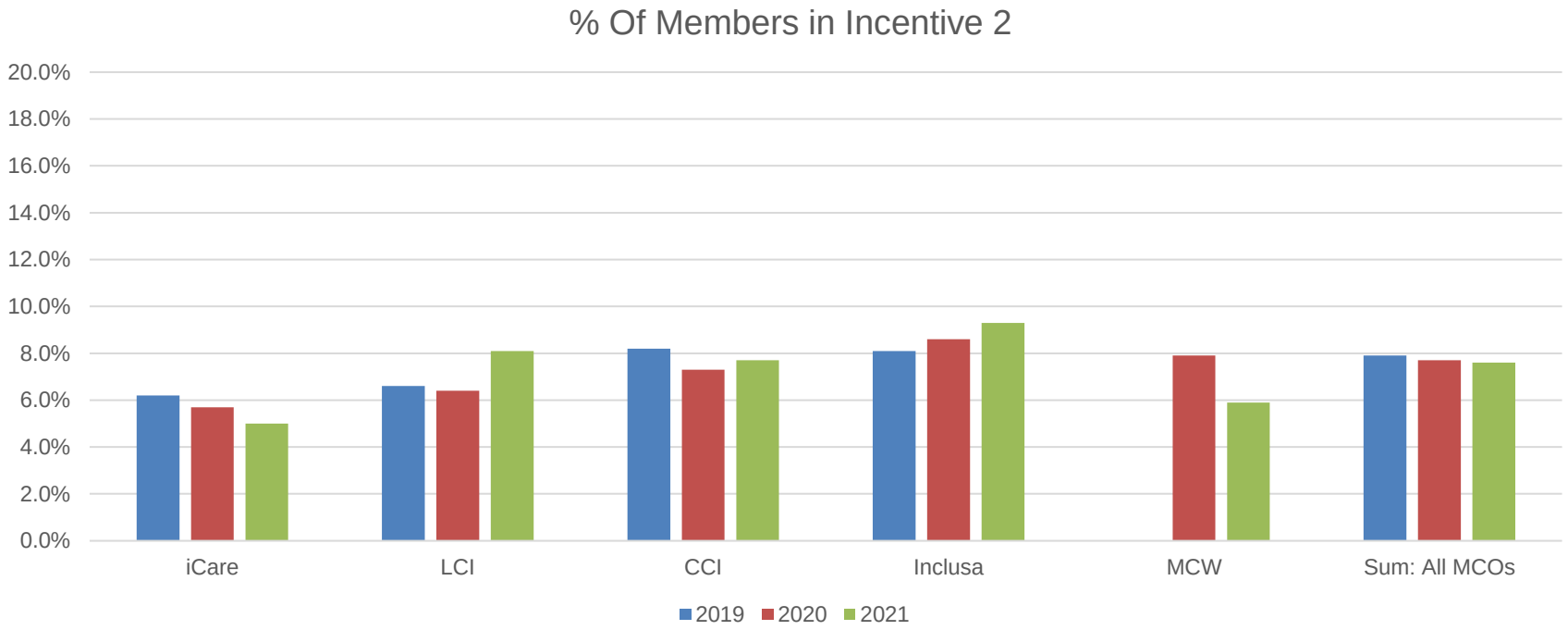
Assisted Living Communities
2021 Results

	iCare	LCI	CCI	Inclusa	MCW	All MCOs
Incentive 1 Earnings	$7,478.81	$154,063.49	$296,160.88	$274,389.23	$267,907.60	$1M
Incentive 2 Earnings	$5,912.79	$160,384.33	$262,379.90	$326,681.45	$244,641.54	$1M
Total Earnings	$13,391.60	$314,447.82	$558,540.77	$601,070.68	$512,549.13	$2M

ALC P4P Incentive 1: 2019-2021 Comparison



ALC P4P Incentive 2: 2019-2021 Comparison



ALC P4P Effectiveness: WCCEAL

- WCCEAL ALCs experienced a decline in 4th quarter 2021 but have rebounded back in 1st quarter 2022
- In Q4 2021 there were 460 WCCEAL ALCs, up from 409, Q4 2018 (12.5% increase)
- Gold membership benefit began Q3 2019 and continues to increase. Gold members exemplify a high level of engagement with WCCEAL. As of Q4 2021 there were 190 Gold Member ALCs up from 129 in Q4 2020 (47% increase)

Competitive Integrated Employment (CIE): 2019-2020 Overview

2019:

- MCOs submitted a comprehensive, unified five-year plan to advance CIE.
- MCOs submitted documentation of CIE conversations with 90% of its members ages 18-45 to gather level of employment interest
- MCOs submitted documentation of follow-up employment activities intended to support members in maintaining employment, identifying employment interests and opportunities, or successfully gaining employment

2020:

- P4P was suspended due to the effect of COVID-19 on rate of unemployment
- MCO employment leads continued to meet with DHS on a bi-monthly basis to problem solve issues related to employment during COVID-19.

Competitive Integrated Employment 2021 Overview

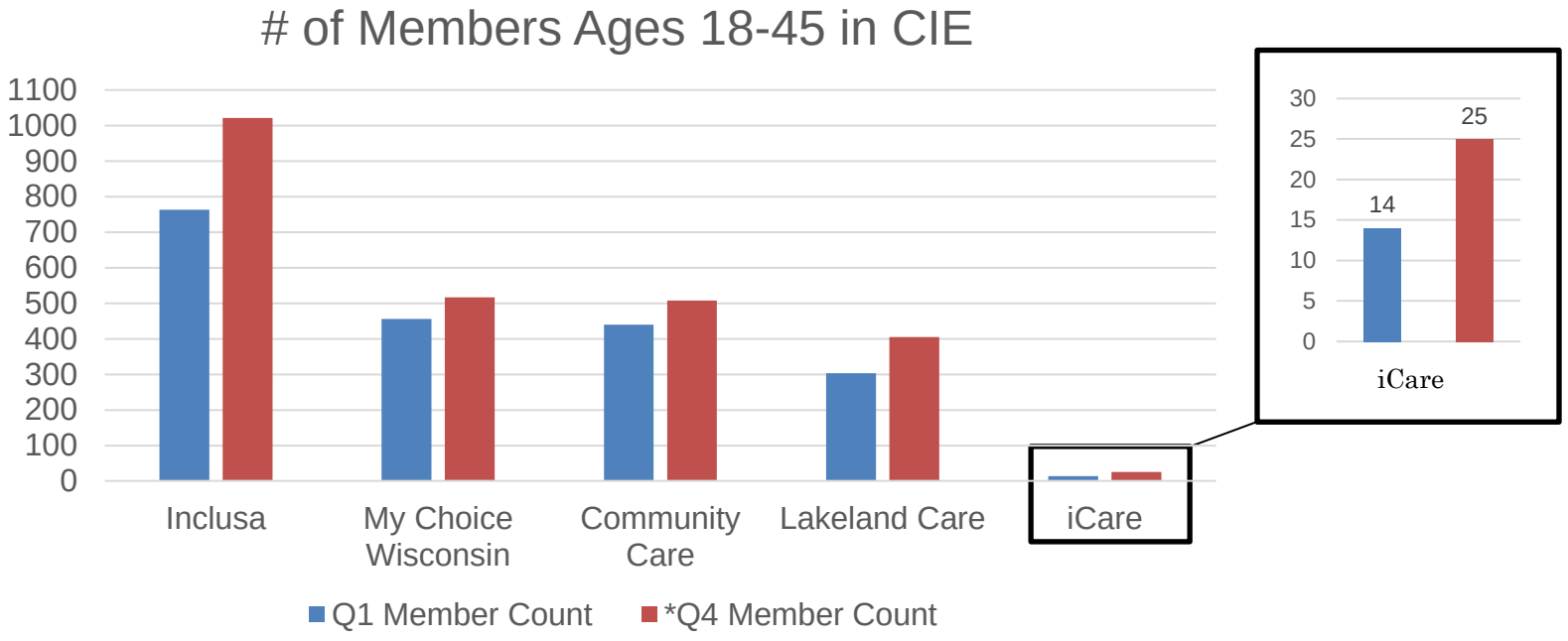
Withhold and incentive criteria is based on maintaining or increasing the number of members ages 18-45 employed in CIE. Percent increase is compared between Quarter 1 of 2021 to Quarter 4 of 2021 based on MCO IES data submission.

0.25% Withhold
Maintain **90-100%** of the number of members in CIE age 18-45
Or 0.125% Withhold
Maintain **80-89.9%** of the number of members in CIE aged 18-45

0.10% Incentive
Make a **4% increase** in the number of members in CIE aged 18-45
Or 0.05% Incentive
Make a **2-3.9%** increase in the number of members in CIE aged 18-45

CIE:2021 Results

All MCOs increased the number of members employed in CIE between Q1 and Q4 by more than 4% and earned the .10% incentive



CIE:2021 Results

	Q1 Results (Baseline)	Q4 Results			Required Q4 Member Counts per MCO for each Withhold and Incentive Threshold				
IES Submitter	Member Count	Member Count	Average Hours per Week	Average Hourly Wage	Q4 Member Count for .125% Withhold	Q4 Member Count for .25% Withhold	Q4 Member Count for .05% Incentive	Q4 Member Count for .10% Incentive	% Increase Q1 to Q4
Community Care	440	508	16.97	$10.64	352	396	449	458	15.45%
iCare	14	25	18.46	$10.74	11	13	14	15	78.57%
Inclusa	763	1021	15.43	$10.28	610	687	778	794	33.81%
Lakeland Care	303	405	16.21	$10.14	242	273	309	315	33.66%
My Choice Wisconsin	456	517	15.91	$10.49	365	410	465	474	13.38%