



DRW COMMENTS TO:
WI DEPARTMENT OF HEALTH SERVICES' DRAFT MEDICAID MANAGED CARE
QUALITY STRATEGY

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Introduction

Disability Rights Wisconsin (DRW) is the Protection and Advocacy system for people with disabilities in Wisconsin. DRW represents thousands of low-income Wisconsinites every year, including some of Wisconsin's most vulnerable children, seniors, families, victims of crime, and survivors of violence.

We found the Wisconsin Department of Health Services' Medicaid Managed Care Quality Strategy to be broad and unspecific regarding what measures will be put in place and how they will be carried out. The specific data collection methodologies are not listed. Thus, it is difficult to discern what DHS's vision for quality measurement is. The document (p. 9) states that it "meets the federal requirements of 42 C.F.R § 438.204 (2013)." That regulation no longer exists. We assume the correct citation is 42 C.F.R § 438.340 (2016). Assuming that to be the case, the document falls far short of that regulation's mandatory requirements for what needs to be included in Wisconsin's managed care quality strategy. **Our initial recommendation is that DHS withdraw this document and prepare one that complies with the mandates of 42 C.F.R § 438.340 (2016). That revised strategy document should then be released for a new public comment period.**

We offer the following specific comments on how managed care delivery quality may be improved.

Stakeholder Input Must be Incorporated into the Strategy

Absent from this proposal is how stakeholders will be involved in decision-making to ensure quality processes and results. The people receiving these services are in the best position to determine if they are having a quality experience. Their involvement in what should be measured and how it should be measured is critical.

Ombudsman Programs as a Quality Check Resource

Wisconsin's statutes require that DHS contract with an advocate for people aged 18-59 in the managed long-term care system (Wis. Stat. § 46.281(1n)(e)). DHS contracts with DRW to operate this program. The Board on Aging and Long-Term Care, which is the state's long-term care ombudsman, assists managed long-term care enrollees who are over the age of 59. A similar DRW program, the SSI Managed Care External Advocate Program (SSIMCEAP) serves the SSI members enrolled in HMOs. The fact that these ombudsman/advocacy programs exist is testament to the state's desire to ensure enrollees and potential enrollees have help when they encounter challenges in managed care programs. In the process of conducting their individual casework, the ombudsman/advocacy programs identify trends of concern across the state or in a particular managed care organization. They are also tuned into due process issues that enrollees might be experiencing. Through quarterly meetings and other regular contacts, the ombudsman programs traditionally shared these trends or concerns with DHS so that DHS could address them. In this way, DHS was able to problem solve issues in their early stages, before there were severe impacts on many enrollees. In addition, ombudsman programs sometimes alert DHS oversight staff to individual member issues that need intervention by DHS to correct improper

MCO actions. Because the ombudsman/advocacy programs provide a valuable “on-the-ground” quality check, we are surprised to see no mention of them in the entire plan. **We recommend that consultation with the ombudsman /advocacy programs be added throughout the Quality Strategy as an important quality check.**

Strengthening DHS Oversight

DHS has had key management and oversight positions remain open and unfilled for a very long time. This can only result in an easing of what used to be reasonably tight oversight of managed care organization activities. We asked the ombudsman program at DRW for impressions of the oversight provided by DHS staff who are assigned to MCOs. They noted a diminution in the desire to hold MCOs accountable to meet member needs. The ombudsman program observed that oversight staff seem less inclined to intervene on behalf of members. This may be because of the assignment of specific “member care quality specialists” (MCQS) to specific MCOs. While the system allows the MCQS to become familiar with the operation and personnel of the particular MCO, that familiarity has, in some cases, led to the MCQS identifying too closely with the interests of the MCO to which they have been assigned. A better system might be to have a pool of MCQSs who are assigned to member complaints as they come in, regardless of the MCO involved.

Pay for Performance (PFP)

PFP strategies can be effective when paired with incentivizing strategies. However, DHS’s Quality Strategy seems to have evolved into the more punitive side of enhancing performance (with its emphasis on “withholds,” “potential sanctions,” and “penalties”) as evidenced by the fact that only PFP is mentioned. Rewarding managed care organizations for investing in innovative strategies to hone in on and address member needs should be incentivized. For example, finding solutions to housing, opening up access to the community, or taking significant steps toward increasing cultural competence and connection through creative program development should be rewarded.

We are also concerned about the limited data upon which PFP will be determined. As stated on page 20 of the Quality Strategy, PFP will be tied to member satisfaction surveys. In order to rely on surveys only, a solid survey process will need to be put in place to obtain valid results. The use of only a PFP element without incentives places a significant burden on well-done surveying in order to prevent erroneous sanctions. It was unclear what safeguards will be put in place to avoid this occurrence.

National Core Indicators

We are pleased that the state has partnered with the Human Services Research Institute (HSRI) to participate in National Core Indicators (NCI) to collect quality data and compare it to other states. This is a well-regarded, reliable system that has collected valuable data across the country for many years. Implementing this program in Wisconsin has been quite an undertaking; we are eager for the results and commend DHS for this initiative.

Regional Long-Term Care Advisory Committees

In creating Family Care, Wisconsin statutes added a requirement that DHS develop Regional Long-Term Care Advisory Committees (RLTCACs) (Wis. Stat. § 46.2825). This was in part to remedy the fact that when a county rolled over to managed care, opportunities for people who receive services had no avenue to positively influence the provision of services or the policies that impacted them on a local level. Though improvements could certainly be made to the statute, the beauty of it is that it provides the only way to really examine how things are going in one's area, both positively and negatively, and it provides a path to make recommendations for improvements. It encourages a cooperative exchange between MCOs and the people affected by local access to services. In addition, the RLTCACs would be particularly useful in identifying, and gathering information about specific workforce inadequacies in their regions.

Yet these committees were never implemented. There has been a confounding resistance to doing so. In 2010 and 2011 ineffectual efforts to collect local comments were made, but the processes and results were quite disconnected from the requirements of the statute. No actual implementation that adheres to the statute has ever taken place. This would be a prime opportunity to understand the quality and sufficiency of services in an area, and RLTCACs would provide recommendations for improvement. This would be done through data sharing (types of services supported, disenrollment data, etc.) required of MCOs and ADRCs and through local understanding of gaps in services.

We recommend that DHS take immediate steps to implement the RLTCAC statute as a demonstration of commitment to the value of quality assurance. We have included the statutory language in the appendix to clearly illustrate its forward-thinking goals. We encourage serious consideration of how RLTCAC might be implemented across the state.

Monitoring of Trends Over Time

There do not appear to be systems in place to monitor the impacts of managed care change implementation or changes in policy or practice. Here are a few examples.

Workforce capacity: It is widely understood that Wisconsin, like many other states, is facing a significant workforce shortage. As provider rates are driven sharply down, while “scope of services” included in contracts with providers have increased (in other words providers are expected to do more with less), it is impossible to divorce the obvious impact managed care must have on the workforce. Financial challenges faced by providers further exacerbate the reduction of resources they have available to attract quality staff. Nothing is mentioned in the Quality Strategy about how DHS has or will track these very serious issues. To DHS's credit, an ongoing discussion is occurring with stakeholders to find solutions, but those solutions never seem to address the pay/contract issues faced by providers. Though discussions are happening, it appears that no data collection on provider impact has occurred over time, hampering the ability to make decisions based on data analysis. In order to truly understand whether quality service is being provided at an appropriate cost, DHS needs to gather the data necessary to establish whether the rates MCOs are paying providers are, in fact, adequate to ensure that the

consumers desired outcomes are being met. If DHS determines that the MCO provider rates are inadequate it then needs to determine if the capitated rate it pays the MCOs is adequate. Significant data collection is needed.

Changes in policy: In 2013, a significant change was made to the tool used by managed care organizations to make decisions about services that will be included in a member's person-centered plan. This tool is called a RAD (Resource Allocation Decision), and it walks a care team through a short series of questions that define the problem, consider options, and finally helps the team determine the best support that will serve the intended goal. The original RAD focused on "personal experience outcomes," which focused on what the member's goals were, and the RAD questions were very member centered, allowing the member to express preferences and dialog about options. The revised RAD is focused on "long term care outcomes," which can be identified by the member OR the care team staff, and must meet "clinical or functional needs." Member preference has been removed from the tool. This change in focus from person-centered to MCO-centered decision making must have had a significant impact on the development of care plans. As far as we could see, no data tracking was done. We asked the ombudsman program at DRW if they saw a change at the time of the change to the RAD and if they see an ongoing impact. They were able to anecdotally report that they saw a shift away from supports for community integration toward a narrowing emphasis that focused on ensuring health and safety. Without data tracked by DHS, it is impossible to objectively evaluate changes like these.

Changes in practice/protocol: In the beginning of 2017, DHS implemented a change to the target group determination in its Long-Term Care Functional Screen (LTCFS). This change not only automated the process to improve consistency (the stated goal of the project), but also changed the actual determination factors. This primarily affected individuals with intellectual and developmental disabilities, and it caused a significant increase in the number of people finding themselves ineligible for the full benefit package. At the time of implementation and for months afterward, DRW requested the impact numbers many times. It finally took a FOIA request to obtain them. It was hard to know if DHS was tracking the impact before and during the implementation of this significant change, or if the FOIA request caused officials to pull the data. Tracking numbers before and during implementation of new projects would allow DHS, ombudsmen, advocates, providers, and others to respond in a way that minimizes negative impacts.

Appeals and grievances: It would be helpful to know what types of appeals and grievances are taking place, along with the results. 42 C.F.R. § 438.416 mandates states to require PIHPs to "maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy." We see no reference to using data derived from this monitoring in the plan, though this was to be effective 7/5/16.

Use of Stakeholder Input

DHS has access to numerous avenues to obtain stakeholder input. Regarding policy development, DHS tends to use its' relationship with these individuals and groups as a reporting function, rather than an opportunity to receive meaningful feedback. Though DHS has continuing communication with community advocates, it seems averse to involving them while developing policies or making changes. Stakeholders can provide valuable ideas and suggestions to the development of policies and programs that will increase quality and will often avoid unnecessary problems or hardship on members. Here are a few examples.

Changes to the Long-Term Care Functional Screen: As noted above, the LTCFS was changed at the beginning of 2017. As far as DRW can discern, changes to the LTCFS (automation of target group determination) were made without input from anyone outside of DHS. The reported purpose was to create consistency in how screeners entered information. The actual outcome was a substantive change in target group determination factors. Because the changes were made in a vacuum, no one had an opportunity to avoid the negative impact on many enrollees and potential enrollees.

Annual changes and updates to the MCO contract: Wisconsin uses a “generic” contract; all MCOs abide by the same contract. It is updated at least annually to reflect changes in federal or state requirements or changes in program policy set by DHS. In one notable instance, DHS worked closely with DRW to rewrite language to better protect vulnerable adults receiving services. After a tragic event that resulted in a member death, DRW investigated the situation and wrote recommendations to DHS that increased in-person contact requirements. DHS was open to the recommendations; the language change to the contract has resulted in improved oversight for well-defined vulnerable or high-risk adults. This situation was a demonstration of a collaborative effort that resulted in an improved product. This was, unfortunately, the exception to the rule. DHS makes sometimes small and sometimes significant changes to the contract, all without any stakeholder involvement during contract development and editing. We asked the ombudsman program at DRW if they are given an opportunity to provide feedback and we were told that they are not. At the very least, the external Ombudsman programs (DRW's and BOALTC's as well as DRW's SSIMCEAP) should be consulted on changes to the contract as those changes are being considered and developed, not after they have been finalized. Such a dialogue occurs between DHS and the MCOs as annual contract revisions are developed. There is no reason LTC consumers (through their advocates) as the beneficiaries of these contracts, should not be involved in contract change discussions from the time they are initiated. If DHS oversight is easing, as is mentioned above, we are concerned that critical language in the MCO contract might not only lose its strength, but some of it might actually be removed altogether. This should not be done without consultation with at least some stakeholders, such as the ombudsman programs.

Development of Tribal-specific services: It is unclear in the plan what is meant by “tribal consultation.” It seems to be mentioned only in passing without specifics about quality monitoring with or for the Tribes. Have the Tribes been able to provide meaningful input

into the quality assurance of managed care for their members? If so, what has been or will be put in place to monitor quality? Will those quality assurances be more than punitive sanctions on Tribes as they work to implement long-term care programs that integrate their members with managed care organizations? Is DHS providing adequate information and support to the Tribes, while respecting the sovereignty of the Nations, so they can successfully implement complicated Medicaid programs and maintain culturally relevant services to their members?

Culturally and racially diverse stakeholders: In a few places, the plan suggests implementation of “culturally and linguistically appropriate services,” but it is unclear how the quality of those services will be measured. It is further unclear how stakeholder input will be sought by various populations to implement quality programs.

Mental health stakeholders: While mental health is addressed throughout the document regarding acute care, it is not clearly addressed for long-term care. There is a brief mention about “providing increased support for behavioral health” on pages 33 and 34. The Quality Strategy should indicate how DHS intends to ensure that LTC enrollees receive appropriate and adequate mental health treatment and support. There has been a disconnect between Family Care and the coordination with county mental health support systems and other providers. DRW has worked with DHS for many years to address this issue and DHS has taken some steps to improve the managed care response. Mental health advocates should continue to be involved with decision making on these issues. DHS should be closely tracking whether enrollees are adequately accessing mental health services. There is no articulated methodology to do so in the Quality Strategy.

APPENDIX

Regional Long-Term Care Advisory Committees: Wis Stat. § 46.2825

46.2825 Regional long-term care advisory committees.

(1) CREATION. The governing board of each resource center operating in a region established by the department under s. 46.281 (1n) (d) 1. shall appoint the number of its members that is specified by the department under s. 46.281 (1n) (d) 2. to a regional long-term care advisory committee. At least 50 percent of the persons a resource center board appoints to a regional long-term care advisory committee shall be older persons or persons with a physical or developmental disability or their family members, guardians, or other advocates.

(2) DUTIES. A regional long-term care advisory committee shall do all of the following:

(a) Evaluate the performance of care management organizations and entities that operate a program described under s. 46.2805 (1) (a) or (b) in the committee's region with respect to responsiveness to recipients of their services, fostering choices for recipients, and other issues affecting recipients; and make recommendations based on the evaluation to the department and to the care management organizations and entities, as appropriate.

(b) Evaluate the performance of resource centers operating in the committee's region and, as appropriate, make recommendations, concerning their performance to the department and the resource centers.

(c) Monitor grievances and appeals made to care management organizations or entities that operate a program described under s. 46.2805 (1) (a) or (b) within the committee's region.

(d) Review utilization of long-term care services in the committee's region.

(e) Monitor enrollments and disenrollments in care management organizations that provide services in the committee's region.

(f) Using information gathered under s. 46.283 (6) (b) 2. by governing boards of resources centers operating in the committee's region and other available information, identify any gaps in the availability of services, living arrangements, and community resources needed by older persons and persons with physical or developmental disabilities, and develop strategies to build capacity to provide those services, living arrangements, and community resources in the committee's region.

(g) Perform long-range planning on long-term care policy for individuals belonging to the client groups served by the resource center.

(h) Annually report to the department regarding significant achievements and problems relating to the provision of long-term care services in the committee's region.

(i) Review and assess the self-directed services option, as defined in s. 46.2899 (1).

History: 2007 a. 20 ss. 968, 970, 977; 2015 a. 55.