For Discussion Only

WISCONSIN DEPARTMENT of HEALTH SERVICES

Asset Purchase Briefing

Long Term Care Advisory Council

March 14, 2023

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Overview of Briefing

- General Overview
- Certification Process
- Stakeholder Engagement
- Overview of Stakeholder Feedback
- DHS-MCO Contract Acquisition Amendment

General Overview

What is happening

What is happening?

- There are two separate proposals to purchase MCOs currently contracted to provide Family Care services.
- An acquisition means a company buys the assets of another company or non-profit.
- The purchasing company then owns the assets as part of their larger business.
- Both companies already own entities providing long term care services in Wisconsin.

Humana, Inc

Humana Inc., (Humana) plans to purchase the assets of Inclusa, Inc.

Humana is a DHS-certified MCO for Family Care Partnership and HMO for BadgerCare Plus and Social Security Income (SSI) Medicaid.	Inclusa is a DHS-certified MCO for Family Care.

Molina Health Care

Molina Healthcare, Inc. (Molina) plans to purchase the assets of My Choice Wisconsin.

Molina is a DHS-certified HMO for BadgerCare Plus and SSI Medicaid.	Molina owns TMG. TMG is a DHS-certified IRIS Consultant Agency	My Choice is a DHS-certified MCO for Family Care and Family Care Partnership. It is also an HMO for BadgerCare Plus and SSI Medicaid.

Numbers

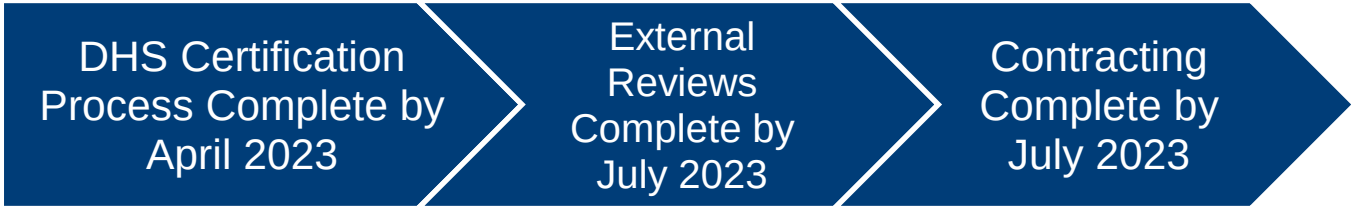
Current Long Term Care Population Distribution by Plan				
My Choice	TMG	Inclusa	iCare	Other Plans
21%	22.2%	20.7%	1.8%	34.3%

Post Asset Purchase Long Term Care Population Distribution by Plan**		
Molina	Humana	Other Plans
43.2%	22.5%	34.3%

* The numbers in these tables are estimated based on past enrollment distribution.

** If entities are purchased

Estimated Timeline for Plans Completing Preliminary Certification by April 2023



- The process may take less time or more time depending on how long the certification and external review processes take
- Timeline may be different for each company
- Other entities are also reviewing the asset purchase agreement
  - State of Wisconsin Office of the Commissioner of Insurance
  - The US Federal Trade Commission and US Department of Justice

Certification Process

What are entities required to provide to the Department of Health Services

MCO Certification Requirements

The purchasing entity must provide attestations and documentation of their transition plans for each of the following components

Administrative Services	Board Approval	Care Management Readiness	Employment	Financial Information
Governance Structure	Marketing and Member Materials	Member Records	Memoranda of Understanding	Organizational Structure and Environment
Policies and Procedures	Provider Contracts	Systems	Timeline	Transfer Agreements

MCO Work Plan

The purchasing entity must provide a 3-year work plan for each of the following components and provide DHS with ongoing reports

- Assuring overall competence (auditing)
- Building a unified culture
- Care management competence
- Care management resources and operations
- Compliance/ Program integrity
- Corrective action plan (if applicable)
- Customer service operations
- Disaster recovery plan
- Employment stability
- Enrollment operations
- Financial stability
- Fiscal operations
- Functional screen department
- Human resources
- Internal and external communications
- Information technology
- Lease agreements
- Marketing and communication
- Member rights
- Memoranda of understanding
- Network systems
- Operational stability
- Policies and procedures unification
- Provider network
- Quality operations

HMO Certification Requirements

The purchasing entity must submit a readiness assessment for each of the following components

- Operations
- Member and Provider Impact
- Provider Network
- Rate Setting
- Utilization Management
- Change Management
- Enrollment
- Quality
- Policies and Procedures
- Credentialing
- HMO Health Plan Integration
- Systems
- Materials (member/provider/internal)
- Appeals & Grievances

Stakeholder Engagement

Ways DHS has actively engaged stakeholders

Advocates and Stakeholder Engagement

- Active engagement with stakeholders to communicate and gather feedback
- Open-door policy for meeting request regarding the asset acquisition

Examples of communication and engagement:

- Long Term Care Advisory Council
- IRIS Advisory Council
- Long Term Care Advocates meeting
- Standing and other meetings with advocacy organizations
  - Standing DMS meeting
  - Survival Coalition
  - BPDD
  - DRW
- Two public forums
- Website established to post Q and As and certification information
- Disability Service Provider Network Conference

DHS Website

Stay connected by going to the DHS website at: www.dhs.wisconsin.gov/Medicaid/mco-purchase.htm.

Forum Overview

- Dates & Times
  - Wednesday, December 14 from 9:00 AM – 11:00 AM
  - Thursday, December 15 from 6:00 PM – 8:00 PM
- Agenda
  - 30-minute DHS presentation
  - ~3-minute time allotment per individual
- Types of feedback
  - Verbal
  - By 1/10/2023, preferred
  - Email: dhsltccomments@dhs.wisconsin.gov
  - US Mail:

    Acquisitions
    DHS/DMS/BPP
    1 West Wilson, Room 518
    Madison, WI 53701-0309

Forum Numbers

Forum Date	# Registered	# Attended	# Presented	Duration
Wednesday, December 14	585	492	27	2.6 hours
Thursday, December 15	271	159	20	2.3 hours
Total	856	615	47	4.9 hours

**some people attended both Wednesday and Thursday forums*

Overview of Stakeholder Feedback

Concerns and suggestions

DMS Scope

- Contracting
- Oversight
- Certification

National/For Profit Concerns

Stakeholder Concern	Action Plan
Profit as primary motivation • Mission of profit over people • Establish in and then exit from market • Profit levels will increase	✓ Contract change to increase termination sanctions ✓ Contract change to increase notice requirements ✓ Contract change to require presence in Wisconsin ✓ Current contract limits regarding profit
Power over others • Impact on competition • DHS ability to monitor • Market power (current locally grown providers and MCOs)	✓ Contract change to prohibit restricting provider right to contract with others ✓ Current strong contract and oversight of program and fiscal
Loss of local • Medicaid and Wisconsin taxpayer money leaving the state • For profit use of revenue; not infusing back into Wisconsin • Consumer representation on boards • Willingness to partner with Wisconsin associations and others	✓ Contract change to require presence in Wisconsin ✓ Current contract limits regarding profit ✓ Current contract requirement for board representation ✓ Current fiscal reconciliation and payback ✓ Molina and Humana currently communicating with various advocates and associations
Conflict of interest related to multiple lines of business	✓ Contract changes to clarify expectations and increase firewalls ✓ Effective oversight
History in others states	✓ Strong contract and oversight ✓ DMS reviewed HMO experience in LTC programs

Service Concerns

Stakeholder Concern	Action Plan
Impact on member choice	✓ Provider network requirements and continuity
Continuity of services	✓ Provider network requirements and continuity
Denial of services • Unwillingness to compromise • Increase in red-tape/grievances/appeals	✓ Current contract outlines the resource allocation decision and method and appeal and grievance processes ✓ Contract oversight and monitoring
Quality decline • Experience of poor quality services from Humana and Molina	✓ Current contract and monitoring: Annual quality review, quality plans, internal audits ✓ No current evidence
Responsiveness to member needs	✓ Monitored through annual quality review and oversight
High caseloads	✓ No change to contract requirements ✓ Currently monitored ✓ Publicly posted caseloads on ADRC scorecard
Decrease in positive member outcomes • Community integration and employment levels	✓ Monitored through the annual quality review and oversight ✓ Pay for performance initiatives

Provider Concerns

Stakeholder Concern	Action Plan
MCO contract rates too low for providers	✓ Outside scope of asset acquisition ✓ Rate setting process/minimum rates
Cuts to service provider rates	✓ Outside scope of asset acquisition ✓ Rate setting process/minimum rates
Ability to negotiate rates with Humana and Molina	✓ Rate setting process/minimum rates
Poor current treatment of providers by Humana and Molina	✓ Monitored through annual quality review and oversight ✓ No current evidence
Direction of services shifting away from established/current providers	✓ Network adequacy currently monitored ✓ MCOs generally looking to add to networks

Other System Concerns

Stakeholder Concerns	Action Plan
Health care companies' ability to be successful in LTC space	✓ Certification process requires entities to provide evidence
Health Equity	✓ Ongoing priority of DHS
Reduction in number of MCOs over years and possibility of continued trend	✓ Outside scope of asset acquisition ✓ Topic for further discussion
Current system not serving people adequately	✓ Outside scope of asset acquisition ✓ Topic for further discussion
Facility closures and movement of members	✓ Outside scope of asset acquisition ✓ Topic for further discussion
Families as unpaid caregivers	✓ Outside scope ✓ Topic for further discussion
Access to dental care and mental health treatment	✓ START Evaluation and next steps
DD Centers	✓ Outside scope

Suggestions Not Directly Related

Suggestion	Suggestion
Compensate unpaid supports	Consider travel time when considering whether to grant a provide network inadequacy waiver
Long Term Care Functional Screen changes	Require detailed provider capacity plans when an MCO is granted a provider inadequacy waiver
Get rid of MCOs and DHS run Family Care	Account for providers accepting Medicaid clients within provider network adequacy
Impose salary limitations on organizations	Research Illinois's HCBS
Capitation rates and other rate setting suggestions	Create Benefit Specialist positions in SHIP exclusively for Family Care and IRIS
Reduce case load sizes	Make member appeals process simpler & quicker
Provide contracts to members	Increase frequency of contractor reviews
Stronger ombudsmen contracts	End the Public Health Emergency
Pay differentials for workers with specialized skills and/or who provide care in underserved areas	Examine private equity ownership and controlling interest of providers
Bridge funding for members aging into Family Care from children's system	Create financial incentives for claims payment timing and adjudication quality

Suggestions Already Covered

Suggestion	How Covered
Performance bonuses	P4P 2023
DHS ability to terminate contract if member health or welfare in jeopardy	In contract
Create benchmarks for performance requirements	MetaStar, scorecard, annual certification, P4P, PIPs, report cards
Require COLAs to be built into provider contracts	Happens through rate band schedule
Require MCO RNs to check in with providers	In contract
Require monthly reporting on utilization, claims submissions, claim denials, appeals filed, etc.	In contract
Create strategic plan for loss of natural supports	In contract
Ensure plain language is required	In contract
People with lived experience on boards in meaningful ways	In contract
Prohibit MCO discrimination based on health status, life situation or anticipated future health needs	In contract
Provide contracts to members	On DHS website
More rigorous enforcement of fail to earn back pay for performance	Entity does not earn back money

Suggestions Already Covered

Suggestion	How Covered
Require a 3-year phased transition with “Transition Group” of current MCO managers providing oversight and member advocacy	Already require 3-year transition plan in certification process
Increase DHS transparency around certification process	Certification information on website
Measure proportion of provider’s revenues from private pay vs. Family Care	Part of current ARPA project
Require proof of service delivery	We currently track through encounter data. EVV will help as well.
Require Humana and Molina to provide plan for how they will address care worker shortage as a part of certification	Currently part of certification requirements
Require process to maintain access to services if an MCO stops serving a geographic region	In contract
Require MCOs to meet with provider council quarterly	Currently in contract to meet annually; on list for contract change next contract year
Determine number of authorized service hours and compare with actual service hours to assess provider capacity	Currently part of encounter project. DHS will have access to this information

Considered Suggestions

Suggestions	Considered
Do not allow a company to own and run both Family Care and IRIS programs	✓ No legal ability to deny
Deny certification	✓ No ability to deny if certification criteria is met
Require entities to go through procurement process, not just certification	✓ Lack of precedence for waiting until procurement process
Require Humana and Molina to continue using WPS to process claims	✓ Private business decision
Require entities to provide the number of enrollee grievances submitted for the previous three years in every state they operate in.	✓ Will not give accurate picture of LTC service grievances
Require Humana and Molina to provide annual quality measures reported for Medicaid services and all other lines of business for the last three years, from every state they operate in.	✓ Current ability to check nationally reported measures
Five year moratorium on referring members to providers owned by Human and Molina	✓ Concerns about member rights to services and other unintended consequences

Considered Suggestions

Suggestion	How Covered
Require Humana and Molina to provide extensive information relating to their performance in the state they are applying in and every other state in which they operate. This includes: • utilization rates for various types of services • utilization rates by age, race, ethnicity • any enforcement actions taken against the applicant during the previous five years, including corrective action plans, financial sanctions and non-financial sanctions	✓ Utilization rates captured in monthly in encounters but not by age, race and ethnicity ✓ Enforcement actions captured in annual business plans and throughout the year for current programs ✓ Connection with OCI about ongoing status of current programs ✓ Contract requires entities to report corrective actions from State and Federal regulatory agencies

Suggestions for Future

Suggestion	Future Action
Prevent MCO who withdraws from Family Care from re-applying for a Family Care contract for at least two contract cycles	Will explore this suggestion ahead of 2025 procurement process
Examine Molina and Humana's performance related to their contracts	Will occur as a part of contract oversight
Revise grievance procedure to make more accessible to members and providers	Process identified in federal rule. Able to explore educational materials

DHS-MCO Contract Acquisition Amendment

Draft changes under consideration

DHS Authority

Wis. Stat. § 46.284

- Contract with entity that meets certification standards

DHS-MCO Contract

- Written consent from DHS required to assign contract

National/for-profit entity directing LTC services

Require MCOs to maintain at least fifty percent (50%) of their staff in Wisconsin

Entity guiding member to most profitable line of business

Adding contract language to require a data firewall for MCOs that are also involved in IRIS to address concern of moving members from capitated managed care to IRIS

Entity guiding member to most profitable line of business

Clarify MCO expectations about member enrollment choices

Prohibit MCOs from influencing member enrollment and disenrollment choices

Unexpected MCO termination

Update MCO requirement to give 6 months' notice rather than 90 days' notice to terminate the DHS-MCO contract

Establish that an MCO that terminates the contract before the end of the rate year is not eligible to earn back the P4P withhold

Unexpected MCO termination

Require MCO to be responsible for transition costs when withdrawing from a region

Controlling provider choice

Prohibit MCOs from prohibiting or discouraging providers from contracting with another MCO

Discussion

WISCONSIN DEPARTMENT of HEALTH SERVICES

Protecting and promoting the health and safety of the people of Wisconsin.

Definitions & Acronyms

- Managed Care Organization (MCO)
  Manages long term care and other services for members of Wisconsin Family Care, Family Care Partnership and Program of All-Inclusive Care of the Elderly (PACE)
- Health Maintenance Organization (HMO)
  Manages health insurance plans for individuals in the BadgerCare Plus and Social Security Income (SSI) Medicaid programs
- IRIS (Include, Respect, I Self-Direct)
  Wisconsin's self-directed program for adults with disabilities and people who are older and need assistance
- Department of Health Services (DHS)