

SUMMARY OF QUESTIONS FROM WALA FAMILY CARE SEMINARS

(Includes questions asked at the Community Care, CCCW and NorthernBridges seminars, as well as pre-seminar questions submitted for the WWC seminar)

1. Family Care background
 - a. How are MCOs formed?
 - b. Why were decisions made to roll out expansion the way it is being rolled out?
 - c. How do I get included in the MCO provider network?
 - d. How can I find out what MCO covers what county?
 - e. What is the difference between Medicaid and Family Care?

2. Rates
 - a. What is your rate setting methodology, and what changes do you envision in it?
 - i. Room and Board
 - ii. Care and Supervision
 - b. Adequacy of rates for high needs/high costs people
 - c. Treatment of leasing costs in the room & board rate
 - d. Pros and cons of flat rates vs. cost based rates vs. “point system” acuity-based rates
 - e. How do acuity-based rate setting systems work? Is the LTC-FS an appropriate tool for this purpose?
 - f. How is transparency of rate setting achieved?
 - g. There are situations where Family Care sets different room & board rates for residents in the same facility. This is untenable from the perspective of the provider.
 - h. How can providers be expected to maintain high quality services and homelike environment with rate restrictions?
 - i. How can providers pay living wages to workers with rate restrictions? How will restricted rates affect the ability to attract and retain high quality employees?
 - j. When calculating room and board rates, what county FMR is used as the rate setting base—the county of responsibility or the county of residency?
 - k. Counties within a MCO may have as much as \$100 difference between their FMR’s. If I operate two homes one mile apart but in different counties will I be receiving different amounts for room and board?
 - l. What size unit is used for room and board calculations—efficiency, 1 bed, 2 bed, 3 bed or 4 bed?
 - m. What is the model developed to set the ancillary rate? Without that tool it is impossible for providers to anticipate the income for our services for supporting members. How can we plan and budget without this information? How do I know if I’m being fairly compensated for my services?

3. Claims

- a. Questions about turnaround time for claims payment
- b. Questions about turnaround time for prior authorization
- c. Issues concerning electronic claims processing

4. Referrals

- a. Who determines what providers to contract with and use? What are the criteria?
- b. How does the referral process for assisted living work?
- c. How does the referral process for supportive home care work?
- d. I've had the experience of getting referrals from a MCO, and only afterwards finding out that the rate the MCO is offering is inadequate to cover costs associated with the resident.

5. Care management

- a. What is the role of the social worker within the MCO? What authority does the social worker have?
- b. What are expectations for how the social worker/IDT works with provider?
- c. What can a provider do if they are unhappy with a member's/resident's care plan?
- d. How is member's condition monitored to make sure they don't deteriorate in a new setting? What is in place to ensure that a member's needs are being met?
- e. Why aren't member-centered plans routinely given to the provider?
- f. Possibility of AL provider participation on IDTs
- g. Possibility of sharing outcomes and goals

6. Audits

- a. What are audit requirements, and how can they be made workable and affordable for providers?

7. Insurance

- a. What are insurance requirements for providers?
- b. Are there affordable approaches for providing health insurance for employees?

8. Communications

- a. What can I do if I'm unhappy with the MCO?
- b. Who can I go to if the care manager doesn't return calls?
- c. My contract requires me to train my staff about your organization, but I have never received any formal training about your organization? How about training on the functional screen? Member-centered plans? RAD, IRIS, outcomes, IDTs, risk, integrated assessments. Help us to be more effective by teaching us how this system was intended to work. State offices tell me it is the MCO's responsibility to provide this training.

9. Family Care financial viability

- a. How great are MCO reserves, and how much are MCO's "in the red"?
- b. What happens if an MCO goes out of business?
- c. What are the obligations of providers if the MCO goes out of business? Some contracts state that they are required to keep serving members.
- d. What does the MCO budget look like (percent of expenditures for administration, care management, services, reserves and solvency fund.)?

10. DHS role

- a. What is the nature of the DHS contract with MCOs? How does the contracting process work? What is the oversight?
- b. Why are there so many differences among how MCOs operate? This makes it difficult for providers who work with several MCOs.
- c. How does DHS determine capitation rates for MCOs?
- d. Family Care is expected to save money. What is the theory behind that expectation?
- e. How realistic is it to believe that everyone who is financially and functionally eligible can be served? Won't increasing the number served reduce the amount of funding available to serve those already in the program?

11. Future vision

- a. What can we expect from Family Care in the next 3-5 years, including the future for assisted living rate
 - i. View from DHS
 - ii. View from the MCO