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Greater Wisconsin
Agency on Aging Resources, Inc.

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October 10, 2018

Curtis J. Cunningham, Assistant Administrator
Long Term Care Benefits and Programs
Family Care Waiver Renewal Comments
DHS/DMS/BAPP – Room 518
PO Box 309
Madison, WI 53701-0309

Re: Family Care Waiver Ideas

Thank you for the opportunity to submit our ideas regarding the future direction of the Wisconsin Family Care and Family Care Partnership long-term care programs as the DHS prepares its application to the CMS for renewal of the Family Care waivers. We appreciation your consideration of our ideas and look forward to working with you throughout the renewal process.

The Greater Wisconsin Agency on Aging Resources (GWAAR) and the Wisconsin Aging Advocacy Network (WAAN) offer several recommendations to improve the Family Care waiver and address growing concerns regarding the shortage of direct care workers, expand and enhance provider capacity, promote greater independence and community integration, and strengthen and protect participant rights.

To help stabilize the direct care workforce and ensure participants home and community-based service needs can be met, we recommend the following:

- Include a tiered rate structure to provide enhanced wages for workers serving individuals or populations with higher health care and support needs.
- Include a tiered rate structure to provide enhanced wages for workers in areas with provider shortages.
- Establish a Medicaid rate to reimburse personal care workers for transportation costs (mileage, bus fare, etc.) associated with commuting between client homes.
- Include inflationary rate increases for providers, including targeted funds for lifting the wages and/or improving the benefits of direct care workers.

To further identify and address existing service gaps and expand provider capacity, we offer the following recommendations:

- Hire an external contractor to conduct an ongoing statewide independent assessment of the current Family Care provider network capacity, calculate projections of needed capacity, and make recommendations that can inform actuaries and lead to more accurate capitated rate setting.

- Include mechanisms for both Family Care providers and participants to report and document services that were not received, delivered incompletely/partially, late, provided by substitute staff or were completed by family members or informal supports because paid/authorized providers were unable/unavailable.

- Include minimum time and distance standards and other network adequacy standards within the Family Care waiver and MCO contract as metrics to assess whether the networks of their contracted plans are adequate. Require collection of data elements that demonstrate geographic access, provider-client ratios, and timely access to care can be met for all services offered, or that a plan to increase provider capacity is being implemented.

To further promote greater independence and community integration, we recommend:

- Require care plans to include the transportation services necessary to support community integration and *all* care plan goals to achieve a self-reported high quality of life for Family Care participants.

- Unbundle transportation services from residential care provider reimbursement to establish improved tracking of participant transportation needs, utilization/access to transportation services, and costs associated with meeting transportation needs to ensure Family Care participants remain connected with their communities and able to achieve established care plan goals.

Lastly, to strengthen and protect participant rights, we share the following recommendations:

- The Family Care waiver should guarantee participants that their services will not be reduced, changed, or ended without a documented change in their needs that can be independently reviewed and challenged.

- The Family Care waiver should mandate and fund an Ombudsman to Family Care participant ratio of 1:2500.

- Reinstate retroactive eligibility for Family Care benefits back to application date. Retroactive coverage is available for those receiving care in institutions for up to 3 months prior to the date of application, but for those receiving care in the community retroactive eligibility is not even available back to the date of their application. This

presents significant barriers for those individuals for whom the application process takes longer than 30 days, yet they have no funds to purchase needed services. Delays in completing the application process can occur for a variety of reasons (both applicant and systems issues), those wishing to receive their care in the community should not be penalized. This is a significant equity issue.

Thank you for your consideration of our ideas.

Sincerely,

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