WISCONSIN DEPARTMENT of HEALTH SERVICES

Minimum Fee Schedule: Frequently Asked Questions

Providers should work directly with the Managed Care Organizations (MCO) if there are questions or concerns regarding the minimum fee schedule by contacting the email boxes listed below.

- Community Care- MinimumFeeSchedules@communitycareinc.org
- Inclusa and iCare - WIMarketMFS@humana.com
- Lakeland - networkrelationssupport@lakelandcareinc.com
- My Choice - hcbsminimumfeeschedule@molinahealthcare.com

Questions for the Department of Health Services (DHS) related to the Minimum Fee Schedule should be sent to: DHSMinimumFee@dhs.wisconsin.gov.

Information on the Minimum Fee Schedule, including the current minimum fee rates, recorded webinars and additional resources is located at: https://www.forwardhealth.wi.gov/WIPortal/cms/page/managedcare/HCBSMinimumFee

Quick links to questions

FAQs

1. What if my current rate is above the minimum rate?

   Providers will only receive an increase based on the minimum fee schedule if their current rate is below the minimum rates for their provider type and for the needs of the members they are serving. For providers currently paid above the minimum rate, MCOs continue to be contractually required to meet members' care needs and that includes paying rates above the minimum when necessary.

2. Where can I get a definition of "room and board"?

   The Family Care contract includes the contractual requirements for room and board. The Family Care contract is found here: https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2024-contract-amend.pdf.

3. Do the minimum rates include room and board?

   No, the minimum rates are only for care and supervision.

4. Right now, care and supervision are bundled with room and board for a single residential rate from MCOs. Will these now be separated?

   The minimum fee schedule does not require MCOs to separate care and supervision from room and board. MCOs can still pay a single residential rate. MCOs may also choose to unbundle room and board from care and supervision.

5. How does a residential provider calculate the full amount they will receive from an MCO under the minimum fee schedule?

   The minimum rates are only for care and supervision. MCOs are required to calculate every member's room and board obligation, collect this obligation, and give it to the residential facility on behalf of the member. Room and board is not a Medicaid-coverable expense and MCOs are not required to supplement room and board payments.

   In these cases, the provider's total funding from the MCO would be at least the total of the minimum rate plus the member's room and board obligation. DHS will be enforcing the minimum fee schedule by monitoring that MCOs are paying at least that amount.

6. Is room and board still going to be based on U.S. Department of Housing and Urban Development (HUD) Fair Market Rent (FMR)?

   There is no change to the room and board requirements in the Family Care and Family Care Partnership programs.

7. How will this impact the IRIS (Include, Respect, I Self-Direct) program?

   The Minimum Fee Schedule does not apply to IRIS. IRIS participants negotiate their own rates within their budget.

8. Sometimes what is reflected on the adult Long-Term Care Functional Screen (LTCFS) is not how a person functions once they have moved in to a facility. How can this be addressed?

   MCOs continue to be contractually required to meet members' care needs and that includes paying rates above the minimum when necessary. Providers can negotiate with MCOs, as they do today, if they believe a member has additional needs requiring higher payment than what is provided under the member's tier designation. Further, providers can work with their contracted MCO if there are questions about a functional screen for a member.

9. Where can I find information about the LTCFS?

   Information about the LTCFS can be found at https://www.dhs.wisconsin.gov/functionalscreen/index.htm.

10. Is the LTCFS being revamped to add in behavioral challenges?

    The minimum fee schedule tiers and rates were developed with the information currently available in the LTCFS. There have been no changes to the criteria for when screeners select behaviors on the LTCFS.

11. When are functional screens completed for members?

    At a minimum, all members receive a LTCFS annually. This is consistent with current and existing contractual requirements.

12. Who completes the LTCFS to determine a member's tier?

    The LTCFS is completed by MCO staff, who are trained and certified by DHS. The LTCFS system then automatically calculates the tier.

13. Where are diabetic care needs fitting into the tiers? Insulin administration and continuous glucose monitoring, for example?

    Diabetic care needs are not a component of the tiers.

14. How do we request the information from an individual's LTCFS?

    Providers will see the individual's tier assignment on their authorization from the MCO. Providers can also request a report that shows the residential tier directly from their contracted MCO without a release of information. To request the full LTCFS, the member or their legal decision maker would need to consent and agree to sign a release of information.

15. Have MCOs already sent out amended contracts?

    MCOs have started to send out contract amendments, and each MCO is working toward a target date of December 31 for full MFS implementation. If providers have not received an amended contract, please contact the MCO using the MFS-specific contact information included at the top of this document.

16. Will we be given more responsibilities as providers in the new contracts?

    The minimum fee schedule should not change the responsibilities under the contract.

17. Corporate 1-2 bed Adult Family Homes (AFH) follow the tiered schedule. What about owner-occupied 1-2 bed AFHs?

    The minimum payment rates for owner-occupied 1-2 bed AFHs are to be no less than the equivalent of the 15-minute MCO-directed supportive home care (SHC) minimum payment rate ($6.38 per 15 minutes), multiplied by the 15-minute units of time needed to provide care and active supervision to the member as specified in their plan of care.

    Active supervision is defined as intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Active supervision is generally used during periods of noncompliance or behavioral outbursts that cause risk to the health and safety of the member or others and require the caregiver to take action needed to re-direct the member to stop unwanted behaviors and return to baseline behaviors. Verbal cues and companionship are not considered active supervision. For the purposes of enforcement, DHS considers that the equivalent 15-minute units of care and active supervision provided to more than one member at a time should be divided by the number of members present.

18. What about members with exceptional needs requiring 1 to 1 staffing or more?

    The highest tier for the minimum fee schedule is tier 3. MCOs are required to negotiate rates necessary to meet a member's care needs.

19. How does the continuation of the 5% ARPA HCBS increase intersect with the minimum fee schedule?

    Providers whose current contracted rates (inclusive of the 2021 state-directed increase and/or the 2022 ARPA increase) are below the minimum will have new contracted rates at the minimum. Providers whose current contracted rates (inclusive of the 2021 state-directed increase and/or the 2022 ARPA increase) are above the minimum will at least continue with the current rates and should not have their rate reduced below the minimum. If a provider is above the minimum only because of the June 2021 4.24% state-directed increase and/or the January 2022 5% ARPA increase, MCOs cannot reduce the provider's

rate because both of those rate increases are contractually required state-directed payments. MCOs will still be required to identify the state-directed unit rate increases in MCO contracts with providers as separate line items.

20. Can MCOs assign multiple rates for different members with the same MCO?

    Yes.

21. Will SHC rates reflect the same minimum fees when provided in Adult Day Services, Adult Day Care and/or Respite?

    No. Adult day Services, Adult Day Care and Respite are not part of the minimum fee schedule.

22. Are there different rates for 3-4 bed owner-occupied adult family homes?

    All 3-4 bed AFHs, including owner occupied, will follow the 3- tier system.

23. What is considered an offensive behavior?

    Offensive or violent behaviors are defined based on LTCFS instructions as behaviors that cause, or can reasonably be expected to cause, discomfort or distress to others or threaten to cause emotional or physical harm to others.

24. As an owner-occupied AFH, how should we charge for care, if they leave for day-programming? Or how do we use 15-minute increments to measure the vast variety of care. Like laundry, or cleaning, shopping?

    The MCO and the provider will need to contract for an average amount of care and direct supervision.

25. If a member's needs change and they qualify for a lower tier does the MCO need to be paid back?

    When a member's needs change such that they qualify for a lower tier, the MCO must make any change to the provider's payment rate effective 30 days after the screen date of the tier change. MCOs have 60 days to make this change. The payment rate in effect prior to the change in the member's needs was accurate and the MCO should not be requiring providers to pay back higher rates that were in effect prior to the member's change in needs were documented in the LTCFS.

26. Will DHS be collecting data on the number of participants falling into tiers 1, 2, and 3?

    DHS is collecting information on the number of members in each tier to monitor the minimum fee schedule.

27. In the MCO contract MCOs could not change the member's rate for the first yearfor at least 12 months. Will this still be a requirement?

    Specific to the minimum fee schedule, MCOs may change the rate if the member changes minimum fee schedule tier. The contract has been amended to reflect this update. Prior and current MCO contract requirements allow MCOs to change the rate when the member's change in conditions warrants a change in the acuity-based rate setting model. Otherwise, the first year/12-month requirement still applies. The contract has been amended to reflect this update.

28. What is the opt-out option?

    Self-directed supportive home care workers can choose not to receive the minimum SDS SHC rate of $4.08 per 15 minutes. If they chose not to receive the minimum SDS SHC rate, they must complete the opt out form.

29. How were staff wages considered when rates developed?

    The rates were developed with a $15.75 per hour direct care wage rate, plus funding for benefits and retirement contributions.

30. What is the definition of active supervision?

    Intervention by an in-person caregiver needed to maintain the health and safety of the member or others. Generally used during periods of noncompliance or behavioral outbursts that:

    - Cause risk to the health and safety of the member or others
    - Require the caregiver to take action to re-direct the member to stop unwanted behaviors and return to baseline behaviors
    - Verbal cues and companionship are not considered active supervision.

31. Supportive care S5126 is a per diem. What is the minimum fee for S5126?

    The minimum payment rates for supportive home care per diem rates are to be no less than the equivalent of the 15-minute MCO-directed SHC minimum payment rate ($6.38), multiplied by the 15-minute units of time needed to provide care and direct active supervision to the member as specified in their plan of care.

    DHS will consider that the equivalent 15-minute units of care and direct active supervision provided to more than one member at a time should be divided by the number of members present.

32. DHS has it so a member is fully aware of how their SDS budget is utilized and requires their approval for wage and code usage when becoming an employer through SDS. Can DHS give insight as to why the opt-out form does not require member approval via signature?

    The minimum fee schedule applies to self-directed supportive home care services. The worker, not the member, decides if they want to decline the minimum fee schedule rate.