TO: Fredi Bove, Deputy Administrator
Division of Long Term Care

FROM: Community Alliance of Providers of Wisconsin (CAPOW)
Rehabilitation for Wisconsin (RFW)
Residential Services Association (RSA)
Wisconsin Assisted Living Association (WALA)
Wisconsin Association of Homes and Services for
the Aging (WAHSA)
Wisconsin Center for Assisted Living (WiCAL)
Wisconsin Health Care Association (WHCA)

RE: Recommendations: Residential Rate Setting Project

DATE: May 7, 2010

During the Residential Rate Setting "listening sessions" on April 16th and 23rd, members of our respective organizations advanced numerous recommendations deemed essential for the development and implementation of a uniform Family Care rate setting methodology for community-based residential programs.

We want to underscore that the vast majority of the recommendations presented individually have the collective support of all of our organizations. To eliminate any question as to the scope and substance of what we have proposed, we have summarized the key elements below. We believe that what we propose below represent ingredients necessary for the successful development of a fair and rational reimbursement system that will be responsive to the needs of those who receive and provide services under Family Care.

Proper Funding and Payment of Costs: The Legislature, DHS and MCO's must accept the that Family Care funding levels, MCO capitation rates and provider payments cannot be crafted with the express or implied expectation private payers can and will pay higher rates to subsidize the program's failure to cover legitimate cost of serving Family Care Enrollees. Budget funding must be secured, and MCO capitation and provider rates must be established on the basis of what it costs to provide care. Continued shoehorning of rates to fit unrealistic funding levels and expectations of budget neutrality is not acceptable and results in payments bearing no relationship to cost of care.

Stakeholder Steering Committee: While we appreciated the April "listening sessions," the forums did allow for discussion between DHS, MCO, provider, and consumer representatives. Achieving a productive partnership and the open

lines of communication DHS has expressed it supports, dictates that members of the provider community be at the table with DHS and MCO representatives to engage in continuing dialogue on the design and development of a rational assisted living reimbursement system. To that end we propose that DHS immediately convene a steering committee of stakeholder representatives to commence and choreograph that undertaking.

Measuring Resident Acuity: The Functional Screen was never intended or designed to serve as a means to assess acuity and serve as a payment tool. It establishes functional eligibility for Family Care benefits. It should not be allowed to be the foundation for rate determinations as it does not adequately capture or measure the care and service needs of enrollees.

The functional screen must accordingly be substantially modified or a separate tool designed which will accurately capture the elements that identify the variables necessary to provide care to an individual.

Recognition of Cost of Care: To date, there has been little or no effort by DHS or the MCOs to solicit cost of care provided in long term care settings. DHS and MCOs in collaboration with provider organizations must secure cost information that can be tied to acuity of individuals in those settings. Costs identified from a representative sample can then be extrapolated. The current practice of shoehorning rates to fit funds available is not acceptable and results in payments bearing no relationship to cost of care. The solicitation of cost data must include existing wage and benefit levels of care givers.

Room and Board: Because the amounts allowed by DHS for “room” rates are based on 40% of a county’s average apartment rents, they fail to reflect the physical environment required to serve assisted living residents or the cost of regulatory compliance (DHS 83, 88, 89). Allowable room rates must be increased to recognize costs associated with physical space not typically found in the “average apartment” but inherent and essential to serving residents in the assisted living environment. Such space would include dining rooms, therapy space, secured interior and exterior spaces (memory care facilities) storage, and chapels.

The $200 “board” monthly maximum allowance established by DHS should reflect only costs related to raw food. Facility expenses embraced by procurement, storage, preparation, delivery, and services should be recognized and reimbursed in care/service rate calculations.

Recognition of Care Giver Wages/Benefit Costs: The standardized rate methodology must be structured so as to permit recruitment and retention of a long term care workforce that is of the size and quality necessary to meet enrollee needs. The rate setting methodology must recognize staffing, wage and benefit costs and allow for annual increases in these expenses.

“Base Rates”: The uniform payment methodology should be structured to provide each type of residential service provider with a guaranteed “base rate” that will be augmented with additional payments reflecting adjustments for higher resident acuity/behavioral conditions or challenges.

MCO Care Management Teams: MCO case managers should defer to assisted living staff with respect to resident assessment and care planning. The redundancy in the current system attributable to the number, dispersion and activities of MCO care management teams is inefficient, costly and disruptive to resident care.

Moreover, Family Care should not be allowed MCO’s to characterize and report the administrative cost of their care management teams as resident service costs. It is our understanding that MCO management team costs add another 14-18% to the 5% administrative costs MCO’s are currently reporting. This siphoning of funding intended for hands-on resident care is unacceptable. DHS/MCO/provider community should devise a system, not unlike the current nursing home system, where resident acuity information submitted by the provider via the MDS triggers the applicable payment rate.

Phase-In of Standardized Rate Methodology: The implementation of a standardized/uniform residential rate setting methodology should be phased-in over a period of 3-5 years. The phase-in would temper the impact and afford providers time to implement required changes in their business models.

Transparency in the Current System: DHS’ commitment to partnership and open communication in development of the new system must be matched with an enhanced sense of DHS/MCO communication and transparency in the administration of the current rate setting system. To better understand where we need to go, it is essential that providers are afforded the opportunity to access and assess the mechanics of the current system. To that end we request that DHS instruct all MCO’s that they share how functional screen and/or other resident assessment information has been utilized and applied in determining individual rates.

Elimination of Unnecessary MCO Contract Expectations: DHS must not allow MCO’s to impose costly, duplicitous and unproductive contractual requirements on providers beyond expectations currently mandated under state and federal licensure and certification laws. Any contractual expectations in excess of provider statutory, regulatory and professional standards must be consistent throughout the MCO community. Any diminished capacity of DHS/MCO’s to reimburse resident care costs cannot be allowed to manifest itself in the imposition of regulatory/contractual demands for providers to provide services the MCO or program is not prepared or able to reimburse.

Further, a standardized grievance process should be developed and mandated for inclusion in all MCO/provider contracts. The process would afford providers the opportunity to contest 1) payment rates that are not established or paid in conformity with the standardized rate setting methodology and 2) other MCO action that is inconsistent with the MCO's statutory, regulatory, or contractual responsibilities to the provider.

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We request that within the next 2 weeks we meet to discuss the Department reaction to each of the above recommendations and the specifics of how it will proceed with incorporating our proposals into the development of Family Care's uniform residential service rate setting methodology.