

**Department of Health Services, Division of Long Term Care
Residential Rate Setting Listening Forums
Summary Notes from April 16 & 23, 2010**

Member Characteristics

1. People with developmental disabilities have uniquely different needs than other target groups.
2. Vulnerable people need 24/7 supervision.
3. Care costs associated with medications, wound care, and oxygen are missing from Long Term Care Functional Screen (LTCFS) tool.
4. Need to know person's history.
5. People with dual diagnosis of DD/ MH have unique cost needs, not captured in LTCFS.
6. LTCFS doesn't adequately capture outliers.
7. LTCFS doesn't adequately capture transportation needs.
8. Need to factor in environmental and positive behavior supports.
9. Factor in technological and engineering approaches that can be used to support residents.
10. Community inclusion requires staff resources.
11. Guardians need to be involved.
12. Guardian's wishes and responsibilities need to be respected in process.
13. Rate tool needs to incorporate quality of life costs, not just basic care needs.
14. Reassess for change in condition to be used to update reimbursement.
15. Tool needs to distinguish target groups (e.g. not moving DD to FE target group at age 60).
16. Acuity can change rapidly and can result in immediate need to vary services, can't await reassessment for increase in reimbursement.
17. Method can't result in aligning likeness of characteristics to drive living arrangements.
18. Question the validity of LTCFS as a rate setting tool.
19. Question the accuracy of assessment tool done by MCO; the nursing home assessment tool, the MDS, is done by the nursing home provider.
20. As quality increases, acuity or perceived acuity can decrease; not easy to capture the impact of quality or level of staffing on reduction in behaviors.
21. Assessment is only a snap shot based on the services currently in place.
22. Recommend not using the LTCFS.

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Provider Characteristics

23. Development and capacity to expand needs to be factored into rates.
24. Finding property and land for housing is time consuming and difficult.
25. Impact on providers if MCO fails (insolvent).
26. Allow for volume pricing and other good business practices. Don't remove MCO's incentive to manage business.
27. Wages and benefits need to be adequate.
28. Consider caregiver wages and benefits in relation to staff turnover.
29. More favorable wages reduce staff turnover.
30. Recognize providers with quality outcomes.
31. DD providers rely solely on public funding.
32. Providers need predictability - base cost method would help this.
33. Flat or average rate methods do not adequately capture unique characteristics of providers.
34. Rate should be cost based.
35. Punishing providers for being tax exempt is wrong - tax status was created as an incentive.
36. Unfair to have rates based on acuity and then reconciled for audit findings.
37. Why should providers have audits completed when MCOs set the rates?
38. Once method is developed, model the impact on implementation ahead of time.
39. Regulatory requirements add to staff costs.
40. Regulatory training requirements – the College of Direct Support training curriculum is a more cost effective training model than the DQA mandated training.
41. Allow for timely rate adjustments to reflect new regulatory training requirements.
42. When looking at other states rate setting methods, consider the related regulatory requirements and the effect on cost.
43. Need to create consistency across MCOs in the service package being purchased.
44. MCOs function as a monopsony, i.e., the single buyer in the market, in the case of residential services for individuals with DD, because there are no private pay clients or clients with other funding sources.
45. Providers have cost/ rate information.
46. Rates should be based on minimum 24/7 supervision.
47. Other states have rate setting tools- such as Arizona. Note the regulations these states have and the facility sizes.

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Implementation Issues

48. Increase transparency of current methods.
49. Need to harness expertise in this room.
50. Request steering committee composed of stakeholders to develop methodology
51. Recommend convening workgroup to address issues and establish rate method.
52. Need to research costs based methods.
53. Providers need a mechanism to appeal rates.
54. Look at what MCOs are currently doing with acuity rate methods, lots of time and money went into this work and see some value in it.
55. MCOs have been implementing various rate methods, DHS now looking to develop something different, request moratorium on any moves until final method developed.
56. Legal issues- protective placements, licensing and regulations, Family Care Statutes all impact process for living arrangements and need to be incorporated into implementation.
57. Develop regional resources – specialty settings.
58. Dane County has a rate setting tool based on the LTCFS, works well for Elderly, with the exception of behaviors.
59. Recommend providers complete the assessment tool.
60. All should be consulted and in agreement on assessment findings.
61. Phase in new method including recovery of cost from current rates.
62. Need reconciliation process for reviewing assessment findings- process for appeal and dispute resolution.
63. Check with national experts.
64. Hold harmless, cap the adjustment to a specified range like in MA rate changes (e.g., will be less than 5% over a period of time).
65. Providers need to know the rates they will be paid in advance of implementation. Recommend 90-day continuation of current rates. Providers caught in limbo while MCOs decide what to pay the provider.
66. Providers need time to adjust business model to any new method.
67. DHS needs to clearly communicate the expectations.
68. Expectations need to align to funding (can't ask providers to do more than the rate allows).

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Quality

69. Member choice - people's desires on where and with who to live must be respected.
70. Decisions need to be based on outcomes, not cost.
71. Decision-making on living arrangements need to include all people in decision -- the member, caregivers, and others in the person's support system.
72. Need to accommodate people with different needs living together. Not align all like people in one setting .
73. Caregiver wages need to be factored in, little or no increase = 30% turnover in 90 days.
74. Uniformity across MCOs in implementation.
75. Safety essential.
76. Consistency across MCOs in quality standards, should be based on provider regulations.
77. Accreditation status should be factored into rate method.
78. Question the quality of certified AFH, lack qualifications and oversight of DQA regulated providers.
79. Allow people to purchase amenities beyond the required care.

Regional

80. Housing costs vary across state.
81. Labor cost, food, wages and benefits necessary to compete for workers varies.
82. Regulatory interpretation varies across regional DQA offices .

Other

83. Review redundancies of care management.
84. Revise paperwork requirements between MCO and providers to reduce/eliminate inefficiencies.
85. MCO RN and Provider RN are duplicative.
86. DHS needs to look at MCO administrative inefficiencies.
87. Need to resolve bed hold issues – occupancy cost driven per person unit rate.
88. MCOs eliminated respite for AFH providers.
89. Reassess fiscal assumptions in MCO funding model, MCOs not able to save the projected ~ \$400/ PMPM. MCOs reducing cost through rate reductions with providers.
90. Regulatory requirements- rewrite of 83 (CBRF rules) have provider cost implications (e.g. travel and training).

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Room and Board Issues

91. HUD method doesn't reflect cost of housing, staffing space, congregate space, property tax, profit/ non-profit status, utilities.
92. Physical accessibility costs increase housing costs.
93. WHEDA and Family Care have contradictory rules & responsibilities.