LeadingAge™ Wisconsin formerly WAHSA

October 17, 2012

To: Senator Kathleen Vinehout, Co-Chairperson
Representative Samantha Kerkman, Co-Chairperson
Members, Joint Committee on Audit

From: John Sauer, President/CEO, LeadingAge Wisconsin

Subject: Family Care

LeadingAge Wisconsin (formerly known as WAHSA, the Wisconsin Association of Homes and Services for the Aging) is a statewide membership association of not-for-profit organizations principally serving seniors and persons with a disability. Membership is comprised of 188 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 195 nursing facilities (43 of which are county-owned and operated and 7 of which are municipally-owned and operated), 7 facilities for the developmentally disabled (FDD), 98 community-based residential facilities (CBRF), 93 residential care apartment complexes (RCAC), 5 adult family homes (AFH), 104 senior apartment complexes, 18 HUD Section 202/811 apartment complexes for low-income seniors and persons with a disability, and over 300 community service agencies which provide programs ranging from Alzheimer's support, adult and child day care, hospice, home care, and home health to Meals on Wheels. LeadingAge Wisconsin members employ over 38,000 people who provide compassionate care and service to over 48,000 individuals each day.

In 1996, the WAHSA Board of Directors unanimously approved a resolution to seek a redesigned long-term care (LTC) system which "maximizes an individual's choice of services, providers, and care settings as long as such care is necessary, meets a minimum level of quality standards and is cost-effective..... Further, the redesigned system should integrate acute and primary care, long-term care, and supportive services in order to provide, finance, and manage the health and long-term care needs of clients."

204 South Hamilton Street | Madison WI 53703
P 608.255.7060 | F 608.255.7064 | www.LeadingAgeWI.org

As WAHSA did in 1996, LeadingAge Wisconsin continues to support the goals of Family Care: to eliminate waiting lists; promote consumer choice; and offer cost-effective, high quality long-term care and services. Helping to more fully achieve those goals is what we hope to achieve today.

In preparing this testimony, we reviewed our past testimony on the Family Care program and frankly were struck by how many issues of yesterday remain relevant today. For example, review of the November 12, 2009 WAHSA testimony on Family Care before the Assembly Aging and Long-Term Care Committee noted:

- Early reviews of Family Care led to assertions by the Department of Health Services (DHS) that Family Care "saved an average of $452 per person per month in total Medical Assistance expenditures in the four non-Milwaukee (pilot) counties in 2003 and 2004 . . . Because of these savings, Family Care can be expanded within the existing budget and serve people now on waiting lists." In our 2009 testimony, WAHSA asked if it is realistic to expect Family Care to deliver the level of savings originally projected. Reducing the "per member, per month cost" is not the same as producing savings significant to produce lower expenditures for long term services and supports.

- In our 2009 testimony, WAHSA stated the DHS and Family Care managed care organizations (MCO) "have expressed concern over the rising costs attributable to purchasing residential care for Family Care enrollees." That concern, at least for the DHS, apparently remains today, as noted in the first bullet of the DHS LTC Sustainability Plan found on Page 3 of the Department's August 31, 2012 report to the Joint Audit Committee: "Reducing utilization of high cost residential settings." The concerns LeadingAge provider members expressed in 2009 remain a concern today: will the Department's goal of reducing assisted living and nursing home utilization under Family Care be achieved by providing MCOs with capitation rates that are not sufficient to sustain adequate provider reimbursement rates, resulting in staffing freezes or cuts or staff wage and benefits freezes or cuts?

  The reasons for those concerns are illustrated in the following: 70.1% of LeadingAge Wisconsin members responding to a recent survey indicated their Family Care assisted living rates either were frozen or cut in 2012. A similar survey conducted by the Wisconsin LTC Workforce Alliance found that 69% of the respondents had imposed a wage freeze; 34% put hiring freezes into effect; 54% laid-off staff; and 77% reduced benefits or increased employee contributions to health insurance premiums or other benefits. Those reductions certainly can't improve the quality of care being provided to Family Care enrollees.

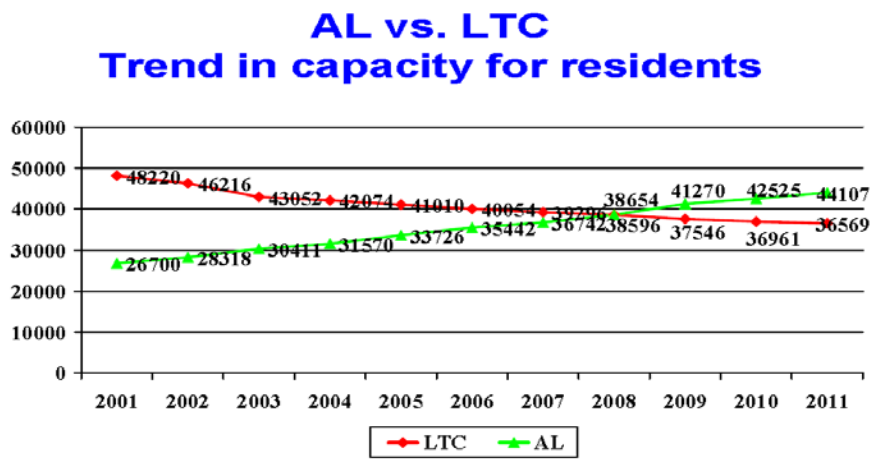
- In 2009, WAHSA asked: "If a MCO seeks to reduce assisted living reimbursement rates, is it possible that some providers may opt out of the Family Care program?" The question certainly is relevant today, as illustrated by one of the responses to the recent LeadingAge Wisconsin Family Care survey: "We cannot take Family Care because the rate is so low that it does not allow us to staff to our minimums."

Questions LeadingAge Wisconsin/WAHSA posed to this joint committee at a July 14, 2010 public hearing on the need for a Family Care audit also are worthy of further discussion today:

- Will insufficient funding to assisted living providers drive these Family Care providers from the program and, possibly, out of business?
- Can efficiencies to the program be gained by eliminating areas of service duplication?
- Is enrollee choice being trumped by Family Care cost containment strategies?
- Is Family Care, a program which helps *manage* LTC costs but does not help *finance* those costs, fiscally sustainable in the face of the Baby Boomer demographic?

LeadingAge Wisconsin applauds much of the DHS' efforts to improve Family Care efficiencies that are reflected in its LTC Sustainability plan. Our read of the DHS plan is that the Department agrees it is far better to focus efforts on maintaining Family Care enrollees in their own homes, and to do this cost-effectively, than attempting to balance the burgeoning Family Care fiscal pressures by forcing cuts or rate freezes on the provider community. LeadingAge Wisconsin also supports DHS' efforts to explore how technology and more efficient care management assignments could contribute to program savings.

Committee members also should be aware of the decade-long movement to shift much of the long term care population from nursing homes to assisted facilities. As noted by the DHS-produced chart below, nursing home bed capacity has decreased by nearly 12,000 beds since 2001, while at the same time the number of assisted living units has increased by over 17,000 units. As such, it should not surprise anyone that the acuity (care and service needs) of persons residing in assisted living facilities has increased dramatically as these facilities are serving persons who ten years ago would have resided in a nursing home. This trend has also driven the cost of assisted living higher and Family Care certainly is not immune from these cost pressures.



While the above points offer a somewhat global perspective on the Family Care program, the remainder of my testimony will touch upon changes to the Family Care program which LeadingAge Wisconsin members believe will improve the program both from an operational and a quality standpoint. Those recommended changes include the following:

- **The LTC functional screen needs to be modified and the results from those screens should be shared with provider serving each individual.** This is not a new recommendation from LeadingAge Wisconsin members or virtually all Family Care providers. According to the DHS, "Wisconsin's LTC FS was developed to provide an automated and objective way to determine the long-term care needs of elders and people with physical or intellectual/developmental disabilities and their functional eligibility for publicly funded program assistance" for programs such as Family Care. The current LTC functional screen is inadequate because it fails to capture the frequency, intensity and complexity of an enrollee's service needs and of the services being provided. It also fails to adequately address the needs of Family Care enrollees with behavioral challenges.

  The LTC functional screen's inadequacy as an assessment tool is one thing; of equal concern is its use by some MCOs to set acuity levels and payments for Family Care assisted living services. It was never intended to be used to set provider rates and it certainly should not be used as the sole source to set rates because it does not adequately measure the care and service needs of Family Care enrollees.

  Finally, under current practice, MOCs do not routinely share the results of the LTC functional screen with the providers who are providing care to the Family Care enrollees. To optimize resident care, those screen results should be shared.

- **Providers should have a formal appeals process to contest rate cuts.** One of the major provider objections to the current operation of Family Care is the "take it or leave it" negotiating stance of many MCOs. Rate freezes or cuts are frequently dictated, not negotiated. For example, some MCOs have imposed provider rate reductions in mid-contract year simply by giving facilities a 30-day notice. Some providers have the ability to "leave it" and the Family Care program has lost a number of quality providers because of one-sided negotiations. But for those providers who either need to participate in the Family Care program to survive or whose mission directs them to program participation, the "leave it" option isn't available. A provider coalition has offered the attached proposal to permit Family Care providers to appeal MCO provider rate payments. It would enable providers to review pertinent information which is not shared currently by MCOs, such as MCO payment methodologies, the LTC functional screen scores for enrollees, and explanations for the changes which in the MCO's perspective warranted new rates. An administrative appeal would be available to providers seeking to contest non-negotiated rate decreases. The Department may have indirectly signaled its support for this appeals proposal: In its August 2012 response to questions the federal Centers for Medicare and Medicaid Services (CMS) raised with the DHS' Virtual PACE proposal, the Department acknowledged it was reviewing a provider request for a Department-level provider payment review or appeal mechanism and would "consider incorporating some of these components into ICO ("Integrated Care Organization" under Virtual PACE) contracts."

- **Duplication of services must be addressed.** The first suggested area to address is the role of the care manager. The complaints from providers about care managers often include: multiple care management teams are assigned to single nursing homes consuming precious facility staff time, a practice that is both costly and inefficient, care managers often don't collaborate with facility staff, they don't know the residents/enrollees, they are difficult to contact, and they are more interested in process management than managing care. Clearly, the role of the care manager must be better defined. But the major objection is duplicative assessments being conducted by facility staff, as mandated by federal and state statute, as well as MCO care managers. Assessments for new enrollees are understandable since neither the facility nor the MCO truly "knows" the new enrollee. But it makes no clinical nor fiscal sense for both the facility and the MCO to conduct reassessments, which the facility is mandated by law to conduct, especially since it is the facility staff, who work and "live with" the enrollee every day, who truly know the enrollee, not the MCO care manager who may not know the enrollee at all. Never mind the fact that many times, the enrollees object to the dual assessments. How costly is this process and are the outcomes worth those costs? If continued MCO involvement in enrollee reassessments is deemed warranted, at the very least those reassessments should be a facility-MCO collaboration. Our hope is that the DHS LTC Sustainability plan will thoroughly

address and correct this concern; we are optimistic that changes will be implemented.

There are other areas where duplication of efforts makes no sense: a LeadingAge Wisconsin member told us of a MCO representative who visited his HR department to conduct an audit to ensure the facility was doing staff criminal background checks, checks which are both mandated by state law and are monitored as part of the nursing home and assisted living survey process. Where specific licensure and certification requirements apply to facilities, MCO involvement in those same mandated activities should be the exception, not the rule.

- **Better warning mechanisms should be in place to alert providers and advocates about the financial distress facing individual MCOs so that needed changes to the managed care system and networks can be better anticipated.** We hope that the transition of Southwest Family Care Alliance (SWFCA) to the counties formerly served by Community Health Partnership (CHP) works for both SWFCA and for its new clients. But the question is, how do we avert another CHP? And is there another CHP on the horizon?

- **Any "scope of services" requirement of assisted living providers should be mutually agreed upon by providers, MCOs and the DHS.** The DHS had previously drafted a proposed "scope of services" document which squeezed virtually any conceivable optional service into the assisted living daily rate. Although the Department never adopted the "scope of services" draft proposal, some MCOs have adopted it. Those requirements should not be implemented unilaterally.

- **The DHS should better explain how capitation rates account for "outliers" whose care and service costs greatly exceed typical client costs.** Once again, how do we avoid another CHP? And if the capitation rates for "outliers" do not truly capture those atypical costs, revise the methodology.

Thank you for the opportunity to testify on the Family Care program and offer some recommended changes which we believe, if adopted, would significantly improve the program not only for providers, but for the MCOs, the state and, most importantly, the Family Care enrollees themselves.

LeadingAge™ Wisconsin
Better Services for Better Aging

204 South Hamilton Street | Madison WI 53703
P 608.255.7060 | F 608.255.7064 | www.LeadingAgeWI.org

FAMILY CARE

APPEAL of MCO Provider Payment Rates

1. Within 10 days of receipt of a notice of a change in a provider's MCO contract payment rate for a family care enrollee, a provider may request, and the MCO shall provide, provide, any or all of the following:

   a. A copy of the MCO payment methodology that was utilized in calculating the resident's rate;
   b. A copy of the MCO assessment of resident need that was applied in the rate calculation;
   c. The MCO rate worksheet which reflecting the rate calculation specific rate calculation;
   d. An explanation of any change to the MCO payment methodology and/or the MCO's assessment of the resident's needs that was the basis for the rate change reflected in the MCO notice.

2. An MCO must respond to request filed under subparagraph 1) above within 10 days of receipt of the request.

3. The provider has a right to contest and file administrative appeal challenging a proposed MCO on the basis of any of the following:
   a. That the MCO failed to properly apply its payment methodology in calculation of the provider's payment rate for a specific enrollee
   b. That the MCO's rate calculations were inaccurate;
   c. That the MCO assessment of a resident needs was materially inaccurate or incomplete.

4. A provider appeal of an MCO rate determination, must be filed within 10 days of receipt of the information the MCO provided under subparagraph 2 above. The appeal must be in writing and
   a. identify the general basis for the appeal under subparagraph 1) above, and
   b. identify the specific errors or omissions on which the appeal is founded.