WAHSA Recommendations:
Medicaid/Family Care Cost Savings,
Program Efficiencies and Reform Measures

{Note: The following was developed by WAHSA members and staff in response to DHS' request to indentify suggestions on how to reduce Medicaid expenses through program reforms, efficiencies or cost-cutting measures. The ideas noted below are intended to stimulate further conversations between WAHSA and the DHS leadership on strategies to reduce or control cost increases; obviously, many of these items will require further review, discussion and development.}

Family Care /Managed Care Reforms & Improvements

(Systemic Changes)

1. Promote integration of acute, primary and long term care through an expanded PACE, Partnership or provider-based risk sharing model under which the State assumes shared responsibility with the managed care (provider) entity.

2. Study preferred providers being able to contract directly with Medicaid. Provide "bundled payments" to a single provider to manage facility-based care (Pursue "Virtual PACE" program via a provider alliance with DHS serving as the administrator).

3. Give all Family Care MCOs two years to convert their programs to a fully integrated acute, primary and long term care managed program.

4. Rebid the Family Care contracts and encourage consolidation or merger of the existing nine MCOs.

5. Consider targeted/focused managed program for high-cost clients currently served in Family Care (Transfer out of program & utilize a bidding process).

Family Care /Managed Care Reforms & Improvements (continued)

(Administrative Changes)

6. Require that MCO clients residing in SNFs and ALs be "case managed" by the facility staff, not the MCO; case reviews could be done via teleconference on an as-need basis, perhaps quarterly. Consider allocating Family Care payments directly to providers for long-term placements.

7. Prohibit MCOs from imposing additional and more stringent requirements on providers beyond the requirements of current law (e.g., abuse reporting, background checks).

8. Review the proposed "scope of services" document to ensure the Family Care assisted living base benefit is not more generous than offered to private pay residents.

9. Review MCO case management in assisted living facilities by tracking the number of physician visits and acute care hospitalizations.

10. Discourage MCOs from routinely imposing additional/redundant requirements on NH and AL facilities after a "bad" survey; let the regulatory system drive the corrective action.

11. Eliminate the monthly Prior Authorization requirements for long term clients in adult family homes.

12. Allow the ADRCs to assist (develop recommended care options) for persons with incomes and assets above the Medicaid eligibility limits as a way of discouraging divestment practices.

13. Develop consistent guidelines on qualifying for assisted living, homecare and nursing home services under the Family Care benefit.

14. Modify LTC functional screen to better reflect the costs of clients with behavioral issues and complex or increasing medical conditions.

Medicaid-Related Rules and Payments

15. Establish reasonable upper limits for "non-institutional" services (e.g., ≠ $1,000/day).

16. Create incentive payments to SNFs (and other providers) that achieve better resident outcomes (decrease pressure ulcers, falls, hospitalizations..) and save acute/primary care dollars.

17. Require all individuals seeking Medicaid eligibility to complete an advance directive document and make this a condition of continued Medicaid eligibility

18. Authorize nursing homes to utilize a drug formulary to encourage cost-effective use of generic medications.

19. Directly reimburse physicians and nurse practitioners for visits in the resident's home, including their nursing home and assisted living residences.

20. Develop true and positive Pay-for-Performance system.

21. Promote the use of technology via pilot programs—telemedicine; drug administration and dispensing; health monitoring, etc.,

22. Reinstate Level-of-Care reviews to relocate inappropriately placed SNF residents to lower cost settings.

23. Allow blended licenses within a same building-- SNF, AL, ADC-- and eliminate "punitive or prescriptive" regulations requiring separate entrances, program space and staff. Oppose the pending CMS Medicaid waiver rule that would stop MA payments to memory care CBRFs and other settings.

24. Extend risk-based contracts to SNFs and other providers.

25. Pursue direct contracting with AL or other providers for community services (case management, personal care, etc.,).

26. Promote ICFs-MR "independence" within campus-based settings.

Medicaid-Related Rules and Payments (continued)

27. Contract for "supportive/assisted living and services," versus the current approach which requires contracting by location (CBRF, RCAC, ADC, etc.,) with regulations specific to the level of care and services provided, to not the setting (e.g., Seattle program).

28. Create specialized RCACs for residents with behavioral challenges similar to that provided by Trempealeau County.

29. Divestment: ensure that the rules are applied uniformly to Family Care and other Medicaid eligible clients.

30. Establish a unified licensure system for Medicaid; one assessment system; and one payment system.

31. Review current transportation policies that allow individuals to be reimbursed for physician appointments and treatments.

32. Extend risk-based contracts to SNFs and other providers.

33. Allow non-hospital specialized facilities (e.g., county homes) to accept short-term admissions for emergency services for persons with behavior challenges (Allow SNF settings to serve these individuals, rather than relying on hospital emergency rooms).

34. Educate income maintenance workers of the fiscal ramifications of convincing residents to drop their Medicare supplemental insurance.

35. Standardize the income maintenance process on (re: 1st day of the month eligibility and retroactive eligibility).

Division of Quality Assurance/Provider Regulations

36. Eliminate all nursing home HFS 132 regulations not addressed in the federal code and follow a single regulatory standard for all nursing facilities.

37. Ask CHSRA or other entity to conduct polypharmacy reviews and share this information with medical providers to eliminate unnecessary and contraindicated medications.

38. The number of DQA surveyors for the annual health survey should be based on size of facility *and* the facility's survey history.

39. Allow CBRFs to be located within the same building regardless of floor location (first floor limitation).

40. Implement the following DQA administrative efficiencies:
    - Require DQA to hire surveyors with actual LTC experience.
    - Complaint surveys should be limited to one surveyor with the investigation specifically focusing on the issue at hand ("in and out").
    - DQA should not request SNF staffing reports unless there's a staffing concern.
    - LSC engineers should only survey facilities with more than one licensure annually.
    - Direct DQA to conduct a greater number of verification visits via a desk review rather than on-site.
    - Require that the SODs & POCs be distributed and submitted electronically.
    - Create a formal channel for DHS and Providers to jointly challenge CMS regulatory interpretations of federal statutes or codes (e.g., abuse reporting or sprinkler interpretations).

41. Reform the survey process by making it a more collaborative process, including providers (hospitals, SNFs, and others) in the process (federal waiver).

42. Promote better coordination of care between hospitals and LTC providers using common and accepted standards of best practice.

Division of Quality Assurance/Provider Regulations (continued)

43. If SNF resident no longer requires SNF services, allow the SNF the ability to pursue more aggressive discharge plans without imposition of cumbersome regulations.

44. Require DQA to report to DHS Secretary Smith on the costs incurred by DQA and the nursing homes related to complaint investigations, and facility staffing hours required for "investigations" of "allegations of poor customer service or missing socks."

45. Provide that Wisconsin will not automatically adopt changes in NFPA without verifying the cost-effectiveness and reasonableness of the proposed changes. Require DQA LSC engineers to provide a copy or reference to the specific regulations being cited prior to issuance of any deficiency.

46. Require DHS & CMS to complete a Provider Economic Analysis Statement whenever new regulations are proposed.

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The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and persons with a disability. Membership is comprised of 188 religious, fraternal, private and governmental organizations which own, operate and/or sponsor a total of 505 nursing homes, assisted living facilities and senior apartment complexes, employing over 38,000 individuals who provide compassionate care and services to over 48,000 people each day.