

DHS Family Care Residential Rate-Setting Listening Sessions: WAHSA Recommendations

April 2010

1. Department of Health Services (DHS) should immediately convene a working group to begin the difficult task of creating a methodology to establish uniform residential rate-setting under the Family Care program.
2. The long term provider community objects to any plans by DHS to use the LTC functional screen as the basis for setting acuity levels and payments for assisted living enrollees. This screening tool determines functional *eligibility* for Family Care; it should not be the basis for payment determination because it does not adequately measure the care and service needs of enrollees.
3. Due to their first-hand knowledge of the enrollees, residential providers should be responsible for conducting any resident assessment used to set reimbursement levels;
4. The \$200 “board” monthly maximum allowance established by DHS should reflect only costs related to raw food (e.g., expenses related to food procurement, storage, preparation, delivery and services should be included in care/service rate calculations);
5. Because the amounts allowed by DHS for “room” rates are based on 40% of a county’s average apartment rents, they do not adequately reflect the physical space required to serve assisted living residents or the cost of regulatory compliance (DHS 83, 88, 89). Allowable room rates should be increased to reflect costs associated with space not typically found in the “average apartment,” including dining rooms, therapy space, secured interior and exterior spaces (memory care facilities) storage, and chapels.
6. Each type of assisted living (AFH, CBRF and RCAC) should be provided with a guaranteed “base rate” with additional payments provided to reflect higher resident acuity/behavioral conditions or challenges;
7. Any rate-setting methodology should reflect staffing, wage and benefit costs and allow for annual increases in these expenses;
8. The rate-setting methodology should not assume inadequate Family Care payments will require providers to shift costs to private payers. Family Care payments for assisted living services should generally reflect the cost of providing these services, even if the Family Care program is underfunded or short on cash;
9. MCO case managers should defer to the assisted living staff with respect to resident assessments and care planning. Redundant systems are inefficient and costly. MCO and provider payments should reflect that these primary responsibilities are being shifted to the assisted living staff;
10. The implementation of a standardized uniform rate-setting methodology should be phased-in (three-to-five years) in order to moderate its impact and give providers time to make any changes to their business models.

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