2011-2013
Long Term Care Sustainability

Family Care Administrative and Program Efficiencies

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Family Care Administrative and Program Efficiencies
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Implement strategies to streamline program and administrative processes in Family Care to better align operations with current and future needs, to improve management, and to reduce program costs.

Main Message Points:

- As of January 2012, ten managed care organizations (MCOs) provide LTC benefits through Family Care, PACE and Partnership. Of these, six are Family Care MCOs, three are Family Care/Partnership MCOs, and one serves people enrolled in Partnership/PACE.
- Most areas of the state are served by one MCO; however enrollees in Milwaukee County have a choice of two MCOs, along with PACE and Partnership.
- The current care management model of an interdisciplinary team within Family Care is intended to ensure that people's individual needs are assessed from multiple perspectives including social work and nursing services. However, there are concerns that the model as specifically defined in contract requirements and as implemented may result in duplication of efforts or more care management than needed by some people.

Proposed Modifications

1. **Streamline and Improve Care Management.** Assure that care management is tailored to the needs of each individual, using a strength-based assessment process that identifies and utilizes natural supports when addressing member outcomes when planning for services and supports.
   - Use a strengths-based assessment process, including building upon natural supports in a person's life to assure that publically-funded supports strengthen rather than supplant unpaid supports and that the service authorization process leads to cost savings while maintaining strong quality outcomes.
   - Modify contractual and procedural requirements to reduce administrative overhead and eliminate care management paperwork.
   - Permit MCOs to develop protocols that account for acuity, level of care and natural supports in order to provide the right amount of care management that is unique to each person's assessed needs.
   - Retain access to registered nurses (RNs) for all members, but allow MCOs to not routinely assign RNs or to provide that the nurse be the primary point of contact for some members, such as medically complex frail elders.
   - Promote a strength-based assessment process by MCOs to:
     - Focus on the skills people have;
     - Identify natural supports; and
     - Account for these strengths when developing the formal care plan.
   - Reduce administrative paperwork and processes, including:
     - Streamlined notice of action and appeals process;

- Reduced and automated paperwork and documentation to eliminate duplication;
- Simplification of the RAD;
- Reduced submissions to DHS to only federally required documentation;
- Evaluation of the impact that the Annual Quality Reviews (AQR) or other reviews in contributing to duplicative or unnecessary work on behalf of the MCOs; and
- Increased use of IT systems in place of paperwork and processes.

- Minimize contractual barriers in Partnership that currently limit the role of Nurse Practitioners as an extension of the Primary Care Physician and ensure that the roles of the Nurse Practitioner and the Nurse are not duplicative.

2. **Streamline Care Management in Residential and Institutional Settings.** Develop standards and strategies for interdisciplinary team oversight to reduce duplication and enhance care management when a member is in a residential care setting, including:
   - Reduce the frequency of oversight in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance;
   - Reduce the number of different teams involved with oversight of members within a single facility; and
   - Increase collaboration with facility staff.

3. **Strengthen Oversight of Service Authorization.** Strengthen MCO authority to institute "checks and balances" to ensure that care plans reflect cost-effective choices.
   - Provide flexibility to establish written protocols to guide interdisciplinary teams (IDTs) in determining acceptable services/products, subject to DHS approval and require that written guidelines do not in any way modify the range of services authorized in the waiver.
   - Revise member informing materials to emphasize that any products/services paid for with public funds must be related to the long term care outcome for the member.
   - Communicate and stress the importance of input from all members of the care planning team to ensure that the care plan reflects cost-effective choices.
   - Allow MCOs to implement a secondary review for high-cost products and services.

4. **Administrative Initiatives.**
   - Streamline reporting requirements and required paperwork to ensure that member outcomes are identified and supported and that member health and safety is ensured.
   - Review current reporting requirements, eliminate unnecessary paperwork, and determine what is necessary to meet DHS requirements for health and safety as well as any requirements established in the waiver or by CMS.

5. **Appeals.** Streamline and simplify the appeals process to ensure timely decision-making for consumers and MCOs**.**

6. **Business Plan Requirements and Administrative Oversight.** Streamline Business Plan requirements to reduce unnecessary administrative burden on MCOs and DHS.

7. **Member Handbooks and Provider Network Directories.** Minimize administrative burden and costs associated with providing written copies of Member Handbooks and Provider Directories except when requested.

8. **Provider Contracts/Relations.** Require that MCOs:
   - Share proposed contractual changes at least 30 days in advance of implementation, facilitate disclosure of specific changes proposed in provider contracts, and work collaboratively with providers to maintain networks during negotiations;
   - Make timely payments to providers; and
   - Explore opportunities across MCOs to standardize protocols, claims processing and data reporting for providers to the extent possible.

9. **Streamline and Improve the Consistency of Claims Processing and Other IT Functions.** Explore opportunities to leverage IT systems and contracts to improve the uniformity and consistency of data collection, to enhance program

management and program integrity, and to reduce costs.

10. **Increase Competition in MCO Service Areas.** Foster competition within Family Care by allowing existing MCOs organized through Long Term Care Districts to compete in additional counties and service areas, subject to the approval of their Board.

11. **Future Expansion Counties.** Work with persons in legacy waiver programs in advance of the transition to managed LTC programs and IRIS through strength-based care management and the RAD to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

12. **Best Practices and Self-Directed Supports.** Incorporate MCO best practices and enhanced use of self-directed supports in future Family Care MCO procurements.

Effect of this change:

- Reduce administrative burden and administrative costs.
- Improve the efficiency and cost-effectiveness of MCO operations.
- Increase quality and ensure more cost-effective support of people's outcomes.
- Streamline and improve care management practices at the MCO level.
- Eliminate duplication and streamline administrative processes.