Long Term Care Redesign

A Vision of a New System

Wisconsin Association of Homes
and Services for the Aging
204 South Hamilton Street
Madison, WI 53703
(608) 255-7060

January, 1997

Long Term Care Redesign: WAHSA's Vision of a New System

Table of Contents

Page

i **Executive Summary**

iii **Redesign Flow Chart**

1 **Overview and Summary of Proposed WAHSA Models**
- *WAHSA's Long Term Care Redesign Goal*
- *LTC Voucher Program*
- *LTC Managed Care Organization (MCO) Program*
- *Current System Modifications Program*

2 **Common Core Elements of Any New LTC System**
- *Single Point of Entry (SEP)*
- *Comprehensive Assessment*
- 3 *Covered Services*
- 4 *Outcomes/Quality Assurance*
- 5 *System Oversight and Integrity*
- *Enforcement of Divestment, Estate Recovery, and Co-payments*

5 **The LTC Voucher Program**

6 **LTC Managed Care Organization (MCO) Program**

6 **Current System Modifications Program**
- *Comprehensively Assess all LTC Clients: A Call for Data Driven Decision-Making*
- 8 *Eliminate Regulatory Barriers*
- *Other Modifications to the Current System*

9 **Remaining Questions Regarding LTC Redesign**
- *What incentives will MCOs have to participate in the proposed redesigned system?*
- *Who will say "No?"*

10 **Closing Comments**

11 **Glossary of Terms and Acronyms**

13 **Members of WAHSA's 1996-97 Board of Directors**
WAHSA Members of DHFS's LTC Redesign Steering Committees

Long Term Care Redesign: WAHSA's Vision of a New System

Executive Summary

As our population continues to age, government and health care providers will be faced with the need to find a system that brings cost effective health services, including long term care services, to their citizens.

While the State of Wisconsin already has a strong long term care system, changes are necessary because of problems inherent with that system. These problems include limited consumer choice, public dollars not spent in a cost effective way, the inability of some people with significant needs to receive services, the fragmentation of long term care funding, a confusing number of programs with conflicting policies/requirements, inadequate and inconsistent quality assurance mechanisms, and the tendency of government to make long term care policy changes without sufficient supporting research and data analysis.

Given the limitations and disadvantages of the current long term care system, the Wisconsin Association of Homes and Services for the Aging (WAHSA) strongly advocates for a redesigned delivery system which "maximizes an individual's choice of services, providers, and care settings as long as such care is necessary and meets a minimum level of quality standards and is cost-effective." Further, the future delivery 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.

To achieved this desired goal, **WAHSA is proposing three models or programs to initiate changes in the present system. The first and preferred model is one that would provide vouchers to people who qualify for public funding.** The value of the vouchers would be determined according to the care needs of each recipient. They could be utilized by the person (or the person's family or guardian) to directly purchase care and services or to enter into a managed care arrangement with other voucher holders.

The second model is one in which the State of Wisconsin would utilize managed care organizations to purchase long term care services for publicly funded clients. In this model, the State would decide how much it would pay each managed care organization for the care of the clients it serves. The State also would be responsible for quality assurance monitoring of the managed care organizations.

The third model proposes a number of modifications to Wisconsin's current long term care system. These changes would improve an already strong system and would serve as a transition from our present system to one of the two models noted above. This model offers ways to reduce excess institutional capacity, consolidate multiple long term care programs, build better data collection and analysis systems, and more cost-effectively allocate scarce public funds.

All three models contain elements that the Association believes are essential features to any new long term care system. These elements include a *single point of entry.* The organization or entity serving as the single point of entry would determine a person's potential eligibility for public funding, do an assessment of need, gather health maintenance information, and provide information about available services and volunteer programs. While the services of the single point of entry are intended specifically for those in need of public funding, they also would be available to those able to pay for their own care.

The second element of the proposed models is a *comprehensive assessment.* This assessment would include a person's health, socioeconomic, functional, and cognitive status. The assessment also would identify informal support systems available to the client.

The third element of the models is a *fully integrated range of services.* While there are considerable state and federal legal and regulatory roadblocks to achieving a fully integrated health care delivery system for our older adults, the Association believes that integration of primary and acute care, long term care, and supportive services is the best way to provide, finance, and manage the health and long term care needs of our citizens. A system that includes Medicare, Medicaid, state waiver programs, and community-based programs will reduce the incentives for health care providers within the system, or the system itself, to shift costs outside the redesigned program.

The fourth element of the models is *an outcome-based quality assurance program*. This new quality assurance program would define quality of care in terms of outcomes rather than process as in the present system. Outcome measures would focus on health status (such as avoidance of unnecessary hospitalization, contraindicated drug use, range of motion, and increased mobility), quality of life (including timeliness of services, availability of services, and client satisfaction), cost effectiveness (that is, the provision of necessary services in a way that best utilizes scarce financial resources along with the maximum use of informal support systems) and other performance measurements (such as technical competency of the health care provider's staff, staff turnover, and the effectiveness of the provider's internal quality assurance processes).

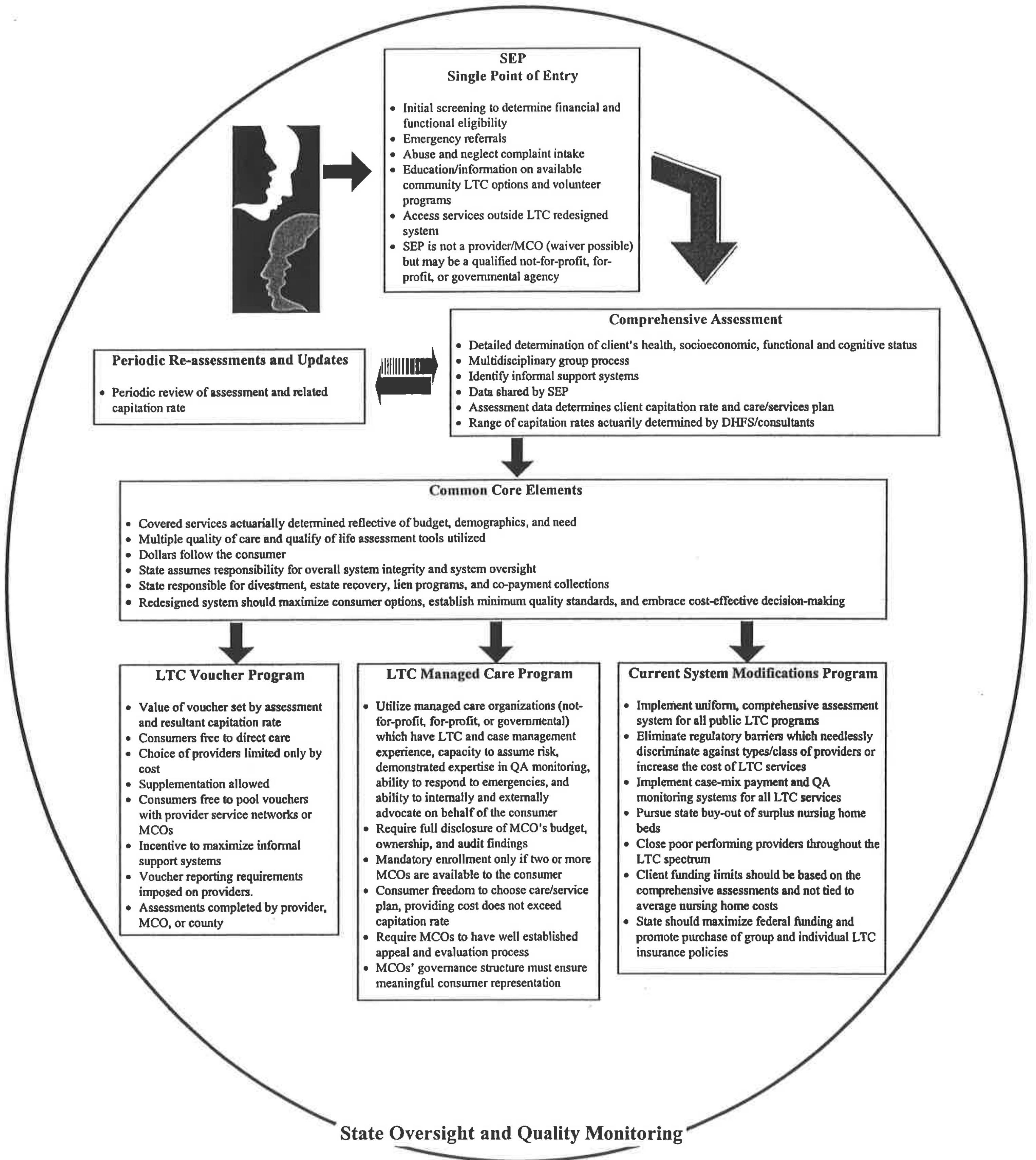
The fifth element of the models is *the availability of a wide range of services*. The Association's plans would not favor one type of service over any other service (for example, nursing homes over home care, or vise versa). Rather, the needs of clients within the system, as determined by the comprehensive assessment, would dictate the type of service provided.

The sixth element of the models includes *procedures to insure the integrity of the new system*. These procedures would include state monitoring of all managed care organizations; a review of the accuracy of client comprehensive assessments; a system for responding to formal complaints of clients, families, and providers; and a prohibition against excess profit-taking.

The final element of the models requires *enforcement of divestment, estate recovery, and co-payments*. Under any redesigned system, the State would retain responsibility for enforcing existing divestment prohibitions, estate recovery, and lien programs.

As the population of the country and the State of Wisconsin continues to age, service demands will outstrip governmental resources available. It is imperative that the State find a way to maximize the use of those resources while insuring proper attention and care to the needs of older and disabled adults. At the same time, we must work towards better coordination of the care and services provided throughout the spectrum of care. To best provide, finance, and manage the health and long term care needs of our aging and disabled populations while best utilizing scarce financial resources, the State must work *now* to integrate acute and primary care, long term care, and supportive services. The models for redesign offered by the Wisconsin Association of Homes and Services for the Aging can move us in that direction.

Redesign Flow Chart



Long Term Care Redesign: WAHSA's Vision of a New System

Overview and Summary of Proposed WAHSA Models

Over the past year, considerable resources have been devoted to creating various options to redesign the current long term care (LTC) delivery "system." Most observers agree the problems inherent in this system include:

- Consumer choices are limited.
- Public dollars are not always spent cost-effectively.
- Persons with the greatest LTC needs may be denied services.
- LTC programs and funds are fragmented and often times have conflicting policies/requirements.
- Quality assurance mechanisms throughout the LTC spectrum are inadequate and inconsistent.
- LTC policy changes are often made without sufficient supporting research and data analyses.

WAHSA's Long Term Care Redesign Goal

Given the limitations and disadvantages of the current long term care system, the Wisconsin Association of Homes and Services for the Aging (WAHSA) strongly advocates for a redesigned delivery system which ***"maximizes an individual's choice of services, providers, and care settings as long as such care is necessary and meets a minimum level of quality standards and is cost-effective."***[1] Further, the future delivery 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.[2]

As a way to begin to address the above cited problems, the Wisconsin Association of Homes and Services for the Aging (WAHSA) has considered three models or programs to initiate changes to the present system. As will be discussed in this paper, each of these models assumes certain common program changes, particularly in the areas of comprehensive assessments, single point of entry, quality assurance mechanisms, and cost-effective allocation of public dollars.

The targeted populations to be served by these models or programs would include elderly and disabled persons.

◆ *LTC Voucher Program*

Under this model, persons who qualify for public LTC funding would be awarded a "voucher" which could be utilized to purchase care and services. The value of the voucher would be determined according to the findings of the person's comprehensive assessment. This assessment would establish a set capitated rate reflective of the individual's LTC needs. The voucher could then be used directly by the person (or his/her family or guardian) to purchase care and services or the person could elect to pool the voucher with other clients under a managed care arrangement.

◆ *LTC Managed Care Organization (MCO) Program*

Under this program, the Department of Health and Family Services (DHFS) would utilize MCOs to purchase LTC and services for publicly funded clients. The State's primary role under this option would be to establish capitation rates by level of care/service need and to perform quality assurance monitoring. The capitation rates awarded to the MCO would be determined by the comprehensive assessment. This model is the more traditional risk-based approach and incorporates a strong case management emphasis.

◆ *Current System Modifications Program*

WAHSA proposes a number of modifications to the current LTC system. For some, these changes would be the only ones necessary to fundamentally improve an already strong Wisconsin LTC system. Others, however, support these changes as a way to transition from our present system to the redesigned system of the future. This program proposes vehicles to reduce excess institutional capacity, consolidate multiple LTC programs, build better data collection and analysis systems, and more cost-effectively allocate scarce public funds.

---

[1] Source: DHSS Long Term Care Concept Paper, dated September 18, 1995. The WAHSA Board of Directors unanimously endorsed this LTC redesign goal at its January 21, 1996 meeting.

[2] Of the models submitted to DHFS prior to December 16, 1996, The Bureau of Health Care Financing's "All Inclusive Care Model" is the model that best embodies the overall system design as envisioned by WAHSA.

WAHSA recommends that the Department's immediate redesign efforts concentrate on developing the LTC Voucher Program and initiating the program changes contained in the Current Modifications Program. The LTC Managed Care Organization Program could be implemented in response to the Voucher Program, but it would not need to be the dominant vehicle to manage or deliver LTC in the future.

Common Core Elements of Any New LTC System

WAHSA advocates for several elements which we believe must be essential features within any new system. These elements will help ensure that the designed system will meet the Department's and WAHSA's goal to maximize an individual's choice of necessary services, providers, and care settings; establish a minimum level of quality standards; and adhere to cost-effective principles.[3]

➔ *Single Point of Entry (SEP)*

Persons in need of publicly funded LTC services should be able to access the following services through a SEP:

1. Functional and acuity needs assessment to determine potential eligibility for publicly funded LTC services.
2. Financial screening to determine eligibility for publicly funded LTC services.
3. Referrals for emergency services.
4. Information about available LTC service options within the community.
5. Initial intake for abuse and neglect complaints, particularly complaints involving non-supervised settings.
6. Guidance on how to maintain health status in order to prevent the need for LTC.
7. Information on volunteer programs (for participation or access).
8. Access to social and supportive services which are not formally integrated into the redesigned system and remain outside the voucher or MCO approach.

The Department would contract with the SEP entities using a competitive bid process. The SEP entity would be responsible for a defined geographic area, which may or may not correspond to county boundaries. All SEP entities would be required to utilize uniform functional, acuity, and financial assessment screening tools to assure all citizens have equal access to defined services. Individuals would be free to access SEP services provided outside their current community (e.g., when seeking access to LTC services not available in their own community or when moving to live with a family member residing in a different location).

Unless a waiver is granted by the Department, the SEP entity (a not-for-profit, for-profit, or governmental organization) should not be a managed care organization but may be included as a participating provider under contract with the MCO. The SEP would not be responsible for completing a client's comprehensive assessment but would be required to share client screening data with the organization charged with that responsibility. Further, it should be stressed that the SEP screening process typically will not be performed in a traditional office setting. Many elderly and disabled persons in need of LTC services will require the SEP staff to visit with them in the hospital, clinic, nursing facility, senior center, or in their home. The SEP entity will need to be flexible and innovative in performing its screening functions.

These SEP services would be available to individuals who are not eligible or in need of public funding but these individuals would not be required to utilize SEP services as a condition to enter the LTC delivery system.

➔ *Comprehensive Assessment*

The cornerstone of any redesigned LTC system should be a comprehensive client assessment system. This assessment would include data on a client's health, socioeconomic, functional, and cognitive status. The assessment also should identify any informal support systems which may be available to the client. It is recommended that DHFS convene a multidisciplinary group of persons (internal and external to DHFS) with experience in assessing elderly and disabled clients to develop the assessment tool. The challenge will be to develop an assessment tool that captures sufficient client data without becoming unwieldy. Under the redesigned system:

[3] See note 1.

- All entities responsible for completing the comprehensive assessment would be required to utilize the tool developed by DHFS. Entities could gather supplemental information if desired. Depending on the LTC redesign model chosen by the Department, the entity responsible for completing the assessment tool would be the provider, MCO, or county.
- Client information obtained by the SEP would be shared with the entity responsible for completing the comprehensive assessment.
- The assessment and resulting care/services plan would determine which capitation rate is available for each client (the number of captitation rates available will depend on the menu of covered services and levels of care available under the redesigned system).
- Re-assessments would be completed on a scheduled basis (every 90-180 days or when there is a significant change in status/condition).
- DHFS would devote substantial resources to monitoring the accuracy of the client assessments and resultant capitation rates.

➔ *Covered Services*

WAHSA advocates a system which fully addresses the needs of an increasing elderly and disabled population and places greater emphasis on coordinating care and services throughout the spectrum of care. The future delivery system likely will integrate primary and acute care, long term care, and supportive services in order to provide, finance, and manage the health and long term care needs of clients. The traditional roles of diverse provider groups will be challenged, redefined and, in some instance, become blurred as policies begin to promote a "coordinated" versus "episodic" approach to the delivery of care and services to elderly and disabled persons. This new system will require unprecedented cooperation between all parties, including DHFS, counties, advocates, providers, and others, in order to most effectively serve elderly and disabled clients.

The Department has published its "preliminary views" on LTC redesign and apparently has concluded that creating a fully integrated system, one that includes acute care, hospitalization, therapies, and drugs, in addition to traditional LTC services, is not feasible, at least under current constraints. ***WAHSA members strongly believe a fully integrated LTC system must be the ultimate goal of redesign efforts and the DHFS must strive to achieve that goal. However, we also acknowledge there are significant state and federal legal and regulatory roadblocks to achieving a fully integrated LTC system. WAHSA members suggest the DHFS proceed on a parallel track: Pursue incremental redesign efforts while working to overcome any barriers to full integration.***

Approximately two-thirds of all nursing home admissions are from hospitals; at the same time, hospitals annually admit nearly 46,000 patients over the age of 75 due to a chronic condition.[4] Failure to move towards an integrated system will ignore the fact that "individuals with chronic diseases and disabilities move back and forth between physicians, hospitals, nursing homes, and other providers with great frequency over many years, even after a person requires ongoing residential care. Often conditions seen by nursing homes and alternate care programs are simply the final stage of a series of ongoing problems that have been seen by acute care providers for many years. Isolating chronic care to the long term care environment is simply not a reflection of reality and is a major impediment to integration."[5] **Thus, a redesigned system which ultimately does not include Medicare, Medicaid, waiver programs, and other community-based LTC programs will not fully address the problems evident with the current "system" and will create significant incentives to shift costs outside the redesigned program (i.e., managed program costs, not managed care).**

As stated above, WAHSA recognizes that DHFS *initially* is likely to pursue a less ambitious redesign plan. Following an incremental reform pathway will produce needed changes to Wisconsin's LTC system and, therefore, should not be postponed until the regulatory and legal roadblocks to full integration can be removed. The models/programs identified in this paper are offered with this in mind.

As the Department pursues its LTC redesign plan, the following seem clear:

- Current funds allocated for LTC services will be insufficient to pay for the future needs of all persons seeking LTC services. Given the increasing elderly and disabled populations, it is not possible to simply reshuffle the funding streams and introduce more program efficiencies as a way to totally finance the redesigned system, particularly if the goal is to expand the range of covered LTC services and options.

---

[4] "Wisconsin Community Health Profiles", September, 1996 and "Wisconsin Nursing Homes--1994", January, 1996, published by the DHFS, Division of Health, Center for Health Statistics.

[5] "Issue Brief: Barriers to Integration", April, 1993, National Chronic Care Consortium.

- The Department will utilize the redesigned system as a more rational mechanism to ration publicly-funded LTC services.
- Many current county programs which provide a social services safety net must remain for persons with more limited needs (in duration and scope) and for those clients who refuse to accept the care and service options available to them.

This discussion is included under this section of our paper for two reasons. First, the Department will need to perform an actuarial analysis of the cost of including LTC services covered under any future plan. This analysis must consider the increasing population in need of services and the range of services to be offered under its plan. In short, as is true under the current system, the budget will drive final decisions regarding eligibility and covered services.

Second, if the redesigned system does not include acute care services, rehabilitative and restorative care, and intensive skilled nursing services (subacute care), then WAHSA advocates that the menu of services to be rolled into any capitation rate **exclude the first 100 days of skilled nursing care (Medicare benefit).** Carving-out the first 100 days of skilled nursing care would: (1) Save individuals and the State substantial dollars by fully utilizing the federal Medicare benefit; and (2) Recognize that the future role of many nursing homes will be to serve residents with increasingly complex medical or behavioral symptoms and in need of a short term stay in a nursing facility.

In 1995, approximately 62% of all nursing facility admissions were covered by the Medicare program. This compares to Medicare-covered admissions of only 19% in 1985.[6] The Department's redesign plan should not cause the State to unnecessarily shift current responsibility for certain LTC services from the federal Medicare program to the State Medicaid program. Should this happen, the State likely would be forced to make deep funding cuts within current LTC programs. In addition, many of today's nursing home expenditures actually result in programmatic savings because nursing home services are being substituted for more expensive acute care services. Carving-out of the first 100 days of nursing facility care from the capitation rate should continue as long as the redesigned system does not include all health services utilized by long term care consumers.

WAHSA also has concerns about the apparent interest by some to include all social services and supportive services for elderly and disabled persons within the capitation rate. There are certain programs which DHFS may wish to continue outside the capitated system. For example, home-delivered meals may be utilized by an individual only on an infrequent basis. Including meals within the capitated program could result in denying this service to persons who are in need of meal assistance but who do not qualify either functionally or financially for the more comprehensive, capitated LTC benefit. These carve-outs would offer a safety net to many individuals and retain certain necessary services as a county responsibility (other services might include protective services, establishing guardianship, some transportation services, counseling, and intervention). Further, many of these services are funded by the local property tax; it would be extremely difficult, politically and otherwise, to transfer these dollars to the State for purposes of funding the redesigned system.

➔ *Outcomes/Quality Assurance*

As DHFS redesigns the LTC *delivery* system, it also should embark on the task of redesigning the LTC *regulatory* system. The new regulatory system should focus less on process and more on outcome. The Department's own strategic plan voices support for such an initiative.[7]

The redesigned system should extensively utilize multiple data-driven quality indicator measurements to evaluate the care and services financed under the new system. These outcome measurements should focus on quality of care, quality of life, performance measurements and cost-effectiveness[8]. Organizations should be encouraged to develop innovative methods to determine performance and client satisfaction. Measurements should include, but not be limited to:

- Health Status -- e.g., avoidance of unnecessary hospitalizations, emergency room visits, contraindicated drug use, range of motion, increased mobility, MDS quality indicator performance, etc.
- Access & Services Delivery -- e.g., choice of providers, access to specialized services, timeliness of services, following service/care plans, 24-hour availability, etc.

[6] "Health Counts in Wisconsin, Nursing Homes, 1995", DHFS, Division of Health, Center for Health Statistics.

[7] "Aiming High: Health and Family Services", DHFS' Strategic Business Plan, Goals 2 and 4.

[8] The National Academy for State Health Policy has published an excellent briefing paper on this subject. ("Look Before You Leap, Assuring Quality of Care of Managed Care Programs Serving Older Persons and Persons With Disabilities", September, 1996, by Maureen Booth)

- Social Well-Being/Quality of Life -- e.g., client-centered review process specific to each client's care setting and LTC needs and informal support systems.
- Client Participation -- e.g., client's level of satisfaction with the range of services provided and adherence to a well-defined evaluation and grievance procedure.
- Administrative Performance -- e.g., organization's staff competency, turnover, internal QA processes, etc.
- Cost-effectiveness -- e.g., Are necessary services provided in a way that best utilizes scarce financial resources and, relatedly, are informal support systems maximized?

➔System Oversight and Integrity

The Department should assume a vital role in assuring the integrity of the new system. The role of the Department should include setting capitation rates, contract monitoring of all MCOs, reviewing the accuracy of client comprehensive assessments, prohibiting excess profit-taking, and responding to formal complaints voiced by clients, families, and providers. All clients should have a right to appeal care, service, and financing decisions to the Department. It is likely the Board on Aging and Long Term Care also would have an expanded role in this area.

➔ Enforcement of Divestment, Estate Recovery, and Co-payments

Under any redesigned system, the DHFS should retain statutory responsibility for enforcing existing divestment prohibitions and the estate recovery and lien programs -- assuming these laws continue under the new system. This is a governmental responsibility and should not be transferred to providers or MCOs. Under certain circumstances, it also may make sense for co-payment collection duties to become a DHFS responsibility.

The LTC Voucher Program

WAHSA has proposed a LTC Voucher Program as our preferred redesign model because it is the ultimate vehicle for clients to exercise personal choice within a limited-funded system. Under this program, a client's comprehensive assessment would establish a capitation rate which would set the value of his/her voucher. Under this program:

- The dollars would "follow the client."
- Clients would be free to direct their own care and utilize the care/service of their choice.
- Choice of approved providers would only be limited due to cost.
- Clients/families/providers would be free to supplement the voucher payment with other funds.
- The voucher also could be used to purchase case management services. The provider that accepts the voucher could be required to perform case management services.
- Clients could pool their vouchers and purchase care/services as a group using innovative provider service networks or an MCO.
- Incentives would be in place to maximize informal support systems.
- The comprehensive assessment would be completed by the provider, MCO, or county.
- Providers which are paid from this voucher would be required to meet certain reporting and monitoring provisions. Providers especially would be required to adhere to the QA outcome measurements of the new system.

Again, the LTC Voucher Program would operate in accordance with the "Common Core Elements" identified in this paper.

LTC Managed Care Organization (MCO) Program

Based on the DHFS' "preliminary views" on LTC redesign, the Department strongly desires to utilize MCOs as the primary vehicle to deliver LTC in the future. That being the case, WAHSA advocates that all MCOs participating in the State's redesigned LTC program must have:

- Experience in contracting for or directly providing LTC services.
- The capacity to assume financial risk.
- The ability and willingness to provide or contract for the full range of necessary LTC Services. (The MCO would not be required to serve all long term care client groups if the organization does not have the expertise to do so.) The MCO must offer at least two choices of providers within each provider group (e.g., adult day care, nursing home, home health, personal care staff, etc.).
- Demonstrated expertise in QA monitoring and improvement, including a data system in place to evaluate contract performance and client satisfaction.
- The responsibility for case management.
- A governance structure that assures meaningful representation by members of the community, clients and families.
- The ability to respond timely to emergency situations.
- Demonstrated ability to internally and externally advocate on behalf of the client.
- Written protocols for care/service plan development, grievance procedures, appeals, and evaluations.
- An independent audit report provided annually to the DHFS which would include full disclosure of the MCO's revenues and expenditures, changes in ownership and related party transactions.

Again, the LTC Managed Care Organization Program would operate in accordance with the "Common Core Elements" identified in this paper. WAHSA assumes any entity (not-for-profit, for-profit, or governmental) which is able to meet the requirements listed above and adhere to the common core elements could be an MCO under the state program. Enrollment in a LTC MCO would become mandatory ***only*** if there are at least two MCOs within a client's community which offer services to that client group. Otherwise, enrollment would be strictly voluntary. In these instances, the client either could utilize the voucher option or participate in the fee-for-service system (presumably this system would offer fewer service options). Within the MCO program, enrollees generally would be free to choose a care/service plan if the cost of this plan does not exceed the client's capitation rate (determined by the client's individualized comprehensive assessment).

Current System Modifications Program

As the State of Wisconsin transitions to a new LTC system, WAHSA suggests a number of changes could be implemented in the near future to improve the current LTC delivery system. As previously stated, some believe these changes could take the place of the more comprehensive system reforms which rely heavily on the utilization of MCOs and larger networks.

➔ *Comprehensively Assess All LTC Clients: A Call for Data Driven Decision-Making*

In our opinion, the single most important element needed to improve an already good LTC system is the creation of a LTC data system. DHFS should develop a uniform comprehensive assessment and evaluation data system for all LTC clients. Done correctly, this system would provide significant improvements in the way services are currently delivered, financed, and evaluated.

Long term care policy makers presently lack the necessary data to make informed decisions regarding proposed system changes. The paucity of critical data has resulted in a lack of clear, unified policy-making within the Department. We can cite several examples. A DHFS' briefing paper presented to Secretary Joe Leean states that "based on the 1994 nursing home survey, more than 3,000 nursing home residents admitted that year were totally independent in the reported activities of daily living (mobility, transferring, locomotion,

dressing, eating, toileting, and hygiene) at the time of their admission."[9] The clear implication given is that these 3,000 residents were inappropriately admitted to facilities. That may or may not be accurate. That is, the Department has not reported, apparently because the data does not exist, whether these residents were admitted to address behavioral symptoms or a developmental disability (county facilities typically serve residents with complex behavioral symptoms) nor how long their length of stay was. In other words, were these unnecessary admissions? For DHFS to pursue rational LTC policies, it must first implement better data collection and analysis systems.

Of greater concern is the lack of data on the cost effectiveness of services offered throughout the current LTC system. For example, State law requires the Department to submit annually to the Legislature a report of the cost and services in the Medicaid home and community-based waiver programs, CIP II and COP-W. And, annually, this report concludes that these programs are significantly less costly than the cost of serving persons in skilled nursing facilities. However, in recent years some have questioned the accuracy of these reports due to the apparent lack of comparable data among the programs.

In April, 1995, two researchers from the University of Wisconsin issued a report which reviewed community-based long term care initiatives with an emphasis on Wisconsin's Community Options Program (COP). Dr. Mark A. Sager, MD, and Dr. Greg Arling, Ph.D., reviewed the national research on community-based long term care programs (CBLTC) and concluded:

> "In essence, CBLTC was assumed to be more cost-effective than nursing home care, i.e., it could provide similar or better care at a lower cost. From a budgetary standpoint, CBLTC programs presumably could be implemented without additional public expenditures and, in fact, they might even result in cost savings. Unfortunately, after nearly two decades of experimentation, various approaches to CBLTC demonstrations failed to reduce nursing home or other health service use; they added to public LTC expenditures rather than reducing them; and they had only minimal effects on the health, functional status, or well-being of older persons participating in the programs"[10]

The report goes on to make the following observations specific to Wisconsin's COP:

> "The limited data that are available from COP suggest that COP clients may have fewer care requirements (lower level of care and less likely to be terminally ill) than nursing home residents. Yet, it is the more dependent and medically unstable individual who is at greatest risk of nursing home admission. The State has reported lower average costs for COP/COP-W clients when compared to nursing home users. Yet, these **comparisons may not be valid because the they fail to adequately adjust for potential differences in care needs between the two populations. Unfortunately, information is not available with which to make accurate cost comparisons between community and institutional settings (emphasis added).**"[11]

Although some questioned the findings of this report, eighteen months later, the Department's own Office of Strategic Finance, Strategic Planning & Evaluation Section, also released a report which concluded that nursing home residents:

> "tend to show more adverse conditions, functionally or mentally, than their community waiver counterparts. Relatively more nursing home residents are at a higher level of skilled nursing care need, have many more functional impairments in activities of daily living such as bathing, dressing, eating, toileting, and transferring between surfaces, and show signs of memory loss or cognitive problems. They are also more likely to exhibit problem behaviors, show signs of mental distress, and have problems with incontinence."[12]

And finally, Joshua M. Wiener of the Urban Institute recently published research sponsored by The Commonwealth Fund in which he notes:

> "The most persistent hope of long term care reformers has been that the expansion of home care and nonmedicalized residential settings could reduce overall long term care spending, and states such as Washington, Wisconsin, and Oregon have been active in reorganizing their long term care delivery systems. However, a large, rigorous research literature suggests that expanding traditional home care is more likely to

[9] "Long Term Care Concept Paper" dated September 18, 1995, submitted to DHFS Secretary Leean by Chuck Wilhelm, Linda Belton, Gerry Born, and John Chapin.

[10] "Review of Community Based Long Term Care with Emphasis on Wisconsin's Community Options Program", April, 1995, Dr. Mark A. Sager, MD, and Dr. Greg Arling, Ph.D., University of Wisconsin, Departments of Medicine and Preventive Medicine, Geriatrics Section, and Center for Health Systems Research and Analysis.

[11] See note 10.

[12] "Profile of Long Term Care Clients, Medicaid Nursing Home Residents and Medicaid Home and Community-Based Waiver Program for Elderly and Persons with Physical Disabilities", October, 1996, Tun-Mei Chang, DHFS, OSF, Strategic Planning & Evaluation Section.

increase rather than decrease total long term care expenditures, in part because home care for nursing-level persons without extensive family supports is expensive. Acknowledging these problems, Oregon has developed an alternative strategy of expanding nonmedical residential alternatives, such as assisted living and adult foster care. As of yet, no systematic, rigorous cost study has been performed."[13]

We offer these extensive remarks on the need for data and cost-effective decision-making because we are under no illusion that the State of Wisconsin will pursue LTC reform measures other than those that control the rate of increase in overall Medicaid and LTC program expenditures. **However, absent reliable program, assessment, and fiscal data, DHFS will not have the necessary tools to meet this desired outcome.** One should not construe our references to the above studies as an attempt by nursing homes to "circle the wagons." In fact, WAHSA favors a system in which nursing home residents who can be served more cost-effectively in alternative settings be given that opportunity.

What we are suggesting is that all LTC programs be carefully scrutinized for cost effectiveness and customer satisfaction and that no assumptions be accepted until the data necessary to confirm these assumptions is collected and properly analyzed. A uniform comprehensive assessment system which sets capitation rates for all LTC clients (a system in which the dollars follow the consumer) would create, we believe, many more options compared to today's choices.

➔ *Eliminate Regulatory Barriers*

DHFS should undertake an extensive review of its LTC regulations and eliminate those which unnecessarily favor one provider group over another.

Under a redesigned system in which clients have greater care and service options, and capitation payments are determined according to comprehensive assessments, many regulations would become obsolete. For example, WAHSA questions the future need for: limiting COP funding for CBRFs; restricting the use of Medicaid waiver funds for facility-based adult day care programs; much of HFS 83 and Chapter 150 (as it relates to the cost per bed limitation which forces many facilities to continue to utilize semi-private rooms); and restricting the use of single task employees and unlicensed staff in certain limited supervised settings. Further, DHFS should encourage the development of accreditation programs throughout the LTC spectrum as a way to foster innovative QA monitoring programs.

➔ *Other Modifications to the Current System*

WAHSA also supports the following changes to the current long term care system:

- Reimbursement for all LTC services should reflect the acuity/service needs of clients. Payments under COP and nursing homes should reflect resource allocation principles, adjusted for case-mix.
- DHFS should pursue the option identified in its September 18, 1995 LTC concept paper which suggests the buy-out of surplus nursing home beds.[14]
- DHFS should increase efforts to close poor performing providers throughout the LTC spectrum.
- DHFS should implement quality assurance monitoring systems throughout the LTC spectrum, including both residential and nonresidential settings.
- Funding limits imposed on clients should reflect maximum expenditure levels based on a comprehensive assessment, not on the average cost of nursing home care. Assessments and care plans should be updated regularly and evaluated. DHFS should utilize progressive recipient cost-sharing provisions to maximize the availability and cost-effectiveness of publicly funded services.
- DHFS should act to maximize third party payments and allowable federal financial participation for all programs (e.g., ITP funds, client and resident share, and Medicare billings).
- The State of Wisconsin should actively promote the purchase of group and individual long term care insurance policies through taxation and policy modifications.
- The measure of success in evaluating Wisconsin's LTC system should not be based on the type of care and service providers utilized under this system. Instead, the system's success should be determined on whether it "maximizes an individual's choice of services, providers, and care settings as long as such care is necessary and meets a minimum level of quality standards and is cost-effective."[15]

---

[13] Can Medicaid Long-Term Care Expenditures for the Elderly be Reduced?", June, 1996, Joshua M. Wiener, Urban Institute.

[14] See note 1.

[15] See note 1.

Remaining Questions Regarding LTC Redesign

It clearly will be a challenge to design a new LTC system in which greater care and service delivery options are made available to an increasing elderly and disabled population. This is particularly so given the stated intent to slow the rate of increase in LTC expenditures. In addition to this challenge, the Department should begin to address the following public policy questions:

? *What incentives will MCOs have to participate in the proposed redesigned system?*

Managed care staff have noted that expanding managed care to include elderly and disabled Medicaid recipients will require the Department to answer a number of serious questions. MCOs typically are able to manage their budgets by taking on risks associated with enrollees with varying health care needs. That is, of those enrolled in a managed care program, some are known to be high users of services, while many others will have more limited, and less costly, projected needs. In essence, this is the business of insurance, the ability to spread risk over a large enrollment base. For example, Health Maintenance Organizations (HMOs) which offer Medicare managed care coverage are thriving in many areas of the country because of these very reasons. The captitation rate paid to these HMOs is sufficiently high to warrant risk-taking on behalf of the HMO, and perhaps more importantly, the HMO has the ability to attract a sufficient number of relatively low cost "healthy" enrollees to offset the cost of other enrollees.

MCOs serving the Medicaid elderly and disabled population, however, will likely have very few "low cost/low users" of services. Almost by definition, this population tends to have long term chronic conditions. Therefore, it is unlikely that the new redesigned system will be viewed by many potential MCOs as a wise business venture, unless the capitation rates are adequate. This is particularly so if the new system does not also include acute care, MD visits, therapies, drugs, and other health care services which will afford MCOs greater opportunities to effectively manage care and costs.

Therefore, DHFS should answer the following:

- ➢ Why will large MCOs be interested in participating in the redesigned system?
- ➢ What entities does the State envision as serving as MCOs and what incentives is the State prepared to offer for their participation?
- ➢ How will DHFS ensure that MCO business decisions are in the best interests of the Medicaid program and its recipients?
- ➢ Will the new system allocate sufficient dollars for care versus administration and oversight?
- ➢ How will DHFS provide and fund incentives to MCOs to cover preventive care/services?

? *Who will say "No?"*

Managing care for elderly and disabled persons will require some very difficult and, perhaps, unpopular decisions as organizations attempt to implement care and service plans within a limited funded system. The Department's LTC Steering Committees have spent little time on this issue and WAHSA encourages DHFS to address this matter more openly. Specifically, DHFS needs to directly confront the following related questions:

- ➢ If a client desires a more service-rich plan than can be financed by the capitation rate (even under a pooled system), will the State or the MCO have the responsibility to inform the client that their service demands are greater than the public funds they are eligible for and, therefore, cannot be fully met?
- ➢ If the organization determines that the client has health and LTC needs that can be best met within a congregate care facility, but the client desires to receive care in his/her own home, will the client be denied services or offered a service plan that does not adequately address needs identified by the comprehensive assessment?
- ➢ How will the new system deal with noncompliant clients? For example, the care and services plan requires the client to report changes in health status to the organization or to take certain medications but the client refuses to do so.[16] The client's refusal to comply with the care and service plan can lead to utilization of more costly health and/or LTC services. How will the new system address these situations?[17]

---

[16] The redesign plan submitted to DHFS by the Partnership Program states the "Members participate in the planning and management of their care by contributing to service plan development and implementation, maintaining working relationships with the team and network providers, reporting health care concerns in an appropriate manner, participating in quality assurances processes, and engaging in healthy choices and lifestyles." How will a redesigned system deal with clients who refuse to participate?

[17] Under the Medicaid HMO program for AFDC recipients, habitually noncompliant clients may by disenrolled from the HMO only upon the approval of DHFS. These clients then receive their health care under the traditional fee-for-services system.

- Research has shown that home and community-based care can be less costly compared to facility care if significant unpaid informal support systems are available. How will the new system maximize the use of informal support systems? Will options for clients with no informal support system be more limited than for other clients? If so, how will this be determined?

Although a redesigned LTC system offers enormous opportunities to improve the current delivery system, it will not be able to avoid these questions. Organizations most assuredly will be reluctant to participate in a managed care system in which they are required to assume significant financial risks and yet are given limited authority to effectively manage these risks. In short, DHFS should articulate "who will say 'no' under the redesigned system?"

Closing Comments

WAHSA advocates for a redesigned system which fully addresses the needs of an increasing elderly and disabled population, and places a greater emphasis on coordinating care and services throughout the spectrum of care. **The future delivery 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.**[18] WAHSA believes that although there presently are considerable potential state and federal legal and regulatory roadblocks to achieving a fully integrated LTC system, the Department's redesign efforts should proceed and not wait until the roadblocks to full integration can be cleared. At this time, the Department should concentrate on developing the LTC Voucher Program and initiating the program changes contained in the Current Modifications Program. The LTC Managed Care Organization Program could be implemented in response to the Voucher Program, but it would not need to be the dominant vehicle to manage or deliver LTC in the future.

Wisconsin's COP is being replicated by several states, our LTC facilities are among the best in the country, and the State has avoided LTC funding crises which have fiscally paralyzed other states' LTC programs.[19] Finally, in redesigning the current LTC system, the Department would do well to remember Wisconsin already is light years ahead of many states in the delivery of quality care and services to elderly and disabled persons.

Approved by the WAHSA Board of Directors on January 23, 1997

Wisconsin Association of Homes and Services for the Aging (WAHSA)
204 South Hamilton Street
Madison, WI 53703
ph: 608.255.7060
FAX: 608.255.7064

[18] See note 2.

[19] See note 13. Joshua Wiener notes: "The hard reality is that the current method of Medicaid long term care financing is actually a pretty economical system. Payment rates are much lower than Medicare and the private sector. ...the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system it is difficult to obtain large savings."

Glossary of Terms and Acronyms

ADL -- Activities of Daily Living -- tasks essential to maintain basic hygiene and manage self-care, typically including eating, walking, dressing, bathing, and using the bathroom.

Capitation -- A method of payment for services in which providers are paid a pre-determined, fixed amount of money per enrolled member per time period, in return for providing contractually agreed upon services to a specifically defined population.

CBLTC – Community Based Long Term Care

CIP – Community Integration Program, a Medicaid-waiver program – CIP-IA is for persons relocated or diverted from DD centers; CIP-IB is for developmentally disabled persons relocated or diverted from nursing homes; CIP II is for elderly and physically disabled persons diverted or relocated from nursing homes to appropriate community settings with the assistance of home and community based care and with continuity of care. Care in the community is financed by MA through a home and community based service waiver.

Co-payment -- A contractual provision whereby the member is required to pay a specific charge for a specific service, usually at the time the service is rendered. Usually applies to physician office visits, prescriptions, emergency, or hospital services.

COP/COP-W – Community Options Program -- The long term care community options program screens persons who are at risk of entering a nursing home or state Center for the Developmentally Disabled to determine whether they can be served by noninstitutional, community-based services. The program provides for both assessment of persons to determine if community-based services are appropriate and funding for eligible, low-income persons to obtain those services necessary to remain at home or in the community. COP is funded solely by state general purpose revenues; the COP waiver program utilizes state/federal Medicaid funding.

DHFS -- Department of Health and Family Services

Divestment – In reference to eligibility for Medicaid, the disposal of resources at less than fair market value in order to qualify for benefits.

Health Maintenance Organization (HMO) -- A term applying to an organization or set of related entities organized for the purpose of providing service benefits to an enrolled population, for a predetermined fixed periodic amount to be paid by the purchaser (e.g., government, employer, individual).

LTC – Long Term Care

Managed Care -- A broad term describing health and long term care coverage in which providers agree to negotiate payment levels for defined populations. Providers also typically agree to more aggressive utilization and quality assurance review than in traditional fee-for-service arrangements.

Managed Care Organization (MCO) -- A broadly used term to describe any entity that utilizes managed care techniques for health care delivery. Can involve anything from a loose association of providers on a discounted fee-for-service arrangement to a highly-integrated provider organization utilizing a global capitated budget.

Medicaid/Medical Assistance/MA -- A welfare program, adopted in 1965, to provide health insurance to eligible disabled and low-income people, administered by the federal government and participating states. The program's costs are shared by the federal government and state governments and paid for by general tax revenue.

Medicare -- A federal entitlement program that covers the costs of hospitalization, medical care and some related services for eligible persons over age 65. Medicare has two parts: Part A covers inpatient costs including limited skilled nursing care, while Part B covers outpatient costs. Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in an outpatient setting.

Minimum Data Set (MDS) – The MDS for nursing facility residents is a comprehensive resident assessment instrument that measures functional status, mental health status, and behavioral status. Under federal regulation, assessments are conducted at the time of admission into a nursing facility, upon return from a 72-hour hospital admission, whenever there is a significant change in status, quarterly, and annually.

Quality Assurance -- A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies.

Spousal Impoverishment Law – Refers to S.49.455, Wisconsin Statutes, which is designed to prevent the impoverishment of the noninstitutionalized spouse of an institutionalized MA recipient by reserving part of the couple's income and resources for the support of the spouse who is not institutionalized.

Subacute Care -- A level of care for patients not requiring the intensity of services of a hospital, but that require some ancillary, nursing and support services beyond typical skilled nursing care.

WAHSA -- Wisconsin Association of Homes and Services for the Aging -- WAHSA is a not-for-profit trade association representing not for-profit and governmental homes, housing projects and services for the aging. Currently this association represents 187 member corporations that own a total of 194 nursing homes, 22 ICF/MR facilities, 56 community based residential facilities, 91 independent living facilities, and more than 300 community service programs.

Members of WAHSA's 1996-97 Board of Directors

Fran Anderson
Countryside Home
Jefferson

Michael Basch
Sheboygan Retirement Home
Sheboygan

Mike Berry
St. Anne's Home for the Elderly
Milwaukee

Jennifer Bieno
Divine Savior Nursing Home
Portage

Kyran Clark
Marquardt Village
Watertown

James Ertz
Hillview Health Care Center
La Crosse

Sheila Gibbs
Grace Lutheran Foundation
Eau Claire

Rodney Gilles
Heritage of Elmwood Nursing Home
Elmwood

Kurt Graves
St. Francis Home, Inc.
Superior

Steven Jaberg
Cedar Lake Health Care Center
West Bend

Mary Ann Kehoe
Good Shepherd Services, Ltd.
Seymour

David Keller
Luther Manor Health Care Center
Milwaukee

Daniel Krejci
Juliette Manor
Berlin

James Lehmkuhl
Milwaukee

Charlene Lowe (President)
Park View Health Center
Winnebago

Fred Schlosser
Knapp Haven Nursing Home
Chetek

Steve Seybold
Homme Home for the Aging
Wittenberg

Mary Lou Stuenzi
Bethany Lutheran Homes
La Crosse

Anne Whalen
Attic Angel Nursing Home
Madison

Phyllis Williams
Lakeland Nursing Home
Elkhorn

David Yochum (President-Elect)
Fairhaven Corporation
Whitewater

Michael Zimmerman
Marian Catholic Center
Milwaukee

WAHSA Members of DHFS's LTC Redesign Steering Committees

Fran Anderson
Countryside Home
Jefferson

Mike Berry
St. Anne's Home for the Elderly
Milwaukee

Phil Borreson
Trempealeau Co. Health Care Center
Whitehall

Dale Hagen
Portage County Health Care Center
Stevens Point

Tom Rand
Bethany-St. Joseph Health Center
La Crosse

David Rothman
Outagamie County Health Center
Appleton

Terry Scieszinski
Rock County Health Care Center
Janesville

Tim Steller
North Central Health Care Facilities
Wausau