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WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

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Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

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TOM MOORE

WISCONSIN LONG TERM CARE SYSTEM REDESIGN: AN ISSUE PAPER

Prepared for the

Wisconsin Health Care Association

June 1997

Prepared by

SubAcute Care of America, Inc.
1333 East Madison Avenue, Suite 206
El Cajon, California 92021
(619) 441-8771

STATEMENT OF PURPOSE

In May, 1997, the Wisconsin Department of Health Services published its preliminary proposal for redesign of the systems that deliver services to the elderly and disabled. Prior to the drafting of legislation, the Department had requested comments from key stakeholders and the public at large.

Although many consumer groups throughout the country have supported the concept of integrated Medicare and Medicaid funding, some Wisconsin consumers have expressed serious concerns about this aspect of the program and about the possibility of managed care organizations involvement in the provision of care.

In view of this opposition to the plan, the Wisconsin Health Care Association has asked SubAcute Care of America, Inc. to assist them in the articulation of their position on the fundamental concepts of the proposed program. The goals of this position paper are:

1. Present an overview of the clinical, social and financial problems of the current Medicare and Medicaid systems as they relate to the provision of services to frail elderly and disabled clients.

2. Explain why integrated Medicare and Medicaid funding is critical to successfully address these problems.

3. Suggest how concerns about the proposed Wisconsin long term care system redesign can successfully be addressed.

"People eligible for both Medicare and Medicaid are being harmed by the incompatibility of the two funding systems. It makes no sense to provide medical care based upon which "funding box" a person fits into instead of what is best for their care. The lack of coordination between Medicare and Medicaid not only wastes money, but inflicts damage on the most vulnerable portion of our society. The current systems have handcuffed the families and doctors of these individuals. That must stop. We can provide better and more cost effective care."

Senator Chuck Grassley, Iowa
Chairman
Senate Special Committee on Aging

SECTION ONE: UNDERSTANDING THE PROBLEM

Over the past fifty years, the nature of illness in Wisconsin and in the nation has shifted from a preponderance of acute illness to a preponderance of chronic conditions. This is due primarily to advanced technologies, which have enabled people to live longer but left them vulnerable to illnesses and disabilities resulting from degenerative conditions. In short, we have extended life but have not in many instances been able to significantly increase the quality of life during those additional years.

It is the Wisconsin Health Care Association's belief that the health care financing and delivery system, at both the national and state levels, has not adapted to these dramatic changes in the basic health care needs of our citizens. The proposed redesign of the Wisconsin long term care system is a significant effort to respond to the shift from acute illness to chronic disability.

Chronic illness represents the highest cost, fastest growing segment of health care. Examples of chronic conditions include Alzheimer's Disease, arthritis, heart disease, stroke, hip fractures, various types of dementia, hypertension and renal disease. No cures have been found for these conditions but it is a common misconception that because a condition cannot be cured, it cannot or should not be treated. In fact, chronic conditions require frequent and continual monitoring to control the symptoms as much as possible and identify other, perhaps more treatable diseases to which the chronically ill are highly vulnerable. The older the person, the greater the number and complexity of chronic problems. As a result, a program of regular assessment and early intervention is critical to maintain the chronically ill and elderly at the highest level of function possible. These types of ongoing, lower tech interventions are generally more effective for the chronically ill than highly aggressive acute medical treatment. While these acute medical services are funded by Medicare, the benefit is time limited and is only available if there has been an acute episode of illness. The ongoing, long term social and medical services which are critical to the elderly and disabled are financed by Medicaid.

The impact of chronic conditions on those who suffer from them is a marked and continual decline in the quality of life unlike those with acute illnesses who can often return to a normal level of function. The chronically ill never attain or regain normal function. Many, if not all of the normal activities of daily living--eating, bathing, dressing, toileting and moving about--become impossible for them. These disabilities require highly flexible, individualized programs of social and supportive services such as personal attendant care, assistive devices, home delivered meals, transportation and counseling, in addition to regular medical assessment. When the problems cannot be managed in the community or when the needed services simply aren't available or affordable, institutional care is usually necessary. These types of long term, social and supportive services are funded by Medicaid for which individuals must meet the state's financial need criteria.

In 1995, approximately 100 million Americans were afflicted with chronic conditions. In the next 25 years, the size of the chronically ill population will increase by about 35 million.

While we often think of chronic illness primarily as a problem of the elderly, persons of every age are afflicted. Of those living in the community, the majority, 64%, are under age 65. Of those living in institutions, however, the reverse is true, with greater than 90% over age 65. But the elderly, whether they are living in the community or in institutions, are far more likely to suffer from multiple chronic conditions. About 69% of those over 65 have multiple conditions while only 46% of those under 65 have more than one condition.

An important subset of the chronically ill are those who qualify for both Medicare and Medicaid, called the *dually eligible*, of which there were six million in 1995. This group experiences many more health problems than those eligible only for Medicare and they are far more likely to have multiple, chronic conditions. For example, over one-third of dual eligibles have limitations in activities of daily living compared to only 10% of non-dual eligibles. Two and one-half as many suffer hip fractures and twice as many have strokes. Effective medical management of these complex, often interrelated, multiple conditions requires an emphasis on early intervention and rigorous monitoring so that problems can be identified and dealt with before they escalate and require hospitalization. Just as important, a variety of social services and supports are necessary to help offset functional disabilities.

County and state health workers and providers who work with the elderly and disabled, as well as consumers themselves, have long been frustrated, confused and confounded by the conflicts and inconsistencies between Medicare and Medicaid policy and financing.

Care for dual eligibles is seriously fragmented. Each type of service has different eligibility criteria and is financed differently. In addition, there are wide variations in such features as the services themselves, who can provide them and for how long. It can be extremely difficult and time consuming for people to access services from two or three different systems with different rules, case managers, telephone numbers, identification cards, etc. In reality, those with chronic care needs simply do not fit into the separate acute and long term care financing and delivery boxes we have created in the current Medicare and Medicaid programs.

QUALITY OF CARE ISSUES

Health care consumer groups and providers have long recognized that the current divided system with totally separate Medicaid and Medicare funding has made the provision of coordinated, effective, quality medical and social supportive care to the chronically ill almost impossible.

Fragmented Clinical System - Currently each clinic, hospital, nursing home, home care agency and other provider conducts its own independent case management operation. There is poor communication between the physicians responsible for the management of acute and long term medical services and the hospitals, clinics, nursing homes and home care agencies where care is provided. As a result, some services may be unnecessarily duplicated and other, extremely important needs may go unrecognized and unmet.

For example, an elderly diabetic hospitalized for a seriously infected foot ulcer resulting in a bone infection was discharged from the acute hospital with instructions to take medication, monitor her diabetes closely and stay off her feet for two weeks. The physician and hospital discharge planner trusted the family to help her, as they had agreed to do. A home health agency followed up with weekly visits by an RN to check on the foot lesion. The only information she had on the patient was the acute hospital discharge summary and admission history and physical, which the home health agency didn't receive until several visits had been made. Whenever she made scheduled visits, the patient was lying down with her feet elevated as ordered.

What none of the health care providers knew was that the patient's family was not helping out at home and were frequent drug abusers and left their children in the care of the elderly woman. She was spending many hours cooking and picking up after the children and was extremely worried about their well-being. She was too tired and too stressed to take her meds properly and bed rest was impossible. She did not want to cause trouble for herself or her family so she was careful to keep up appearances for the home health nurse. The Medicaid case worker was aware of the problem, as was the community clinic nurse, who had initially spotted the foot ulcer, but they didn't know about the order for bed rest and medication and they were no longer seeing her.

Four weeks after her first discharge, the wound had failed to heal and was, in fact, worse. She was readmitted to the hospital where her foot was amputated as the result of a severe bone infection.

A fragmented health care system with separate funding streams caused this woman's most critical needs to fall through the cracks and resulted in a serious medical condition which permanently altered her functional ability.

Medicare covered the hospital and home care costs and Medicaid paid the deductibles, but Medicaid did not provide for ongoing supportive home services such as a chore worker to help with personal care for several hours a day and communicate with the home health nurse. In addition, the completely divided Medicare and Medicaid systems discouraged any communication among the community based Medicaid providers and the acute care based Medicare providers. The social problems were undetected and the result was a life threatening medical condition. Communication between a supportive care worker and home health nurse would have lead to early intervention

such as temporary placement in a nursing home were she could have received the rest and medication monitoring she needed.

In another instance, a patient was put on a blood pressure medication by a physician who saw him in the acute hospital (a Medicare service). Then, in the community clinic, he saw another physician who ordered a blood pressure medication, unaware of what had already been ordered. The patient and his family didn't understand what the meds were for and he dutifully took both. In a few weeks, he developed dizziness and experienced a fractured hip as the result of a fall. The problems resulted from the lack of communication between the physician treating the patient in the Medicare system and the provider in the Medicaid system. With separate funding streams and separate eligibility criteria, each was incentivized to act independently of the other.

Poor Clinical Incentives - Under the current fee-for-service payment schedule, Medicare pays physicians more if they treat seniors in the hospital or clinic instead of the nursing home. Medicare pays physicians and other health care professionals nothing for working with families and community services to keep the disabled in their own homes and out of institutions. In addition, Medicare managed care plans are paid more for seniors in nursing homes and those payments are reduced substantially when the individual is discharged to the community. Since those who manage acute care services are not at risk for long term care costs, this payment arrangement sets up an incentive to institutionalize rather than work to prevent unnecessary nursing home placements.

Since physicians and other community providers are not incentivized to provide aggressive monitoring of chronic conditions, the clients must wait until the situation is acutely serious so they can receive appropriate services. This is certainly not a quality minded approach to care.

Cost Shifting Between Providers and Programs - Hospitals have incentives to admit seniors frequently to obtain Medicare payment, but to discharge them quickly to maximize their Medicare DRG payment. Nursing homes have incentives to send people to the hospital for short stays rather than provide the extra care they require if they can generate a new Medicare benefit and/or payment period. Health plans have no incentive to keep seniors in their own home especially if they require skilled care, as they are responsible for payment of these services under the Medicare benefit. If a Medicare risk health plan admits a senior to a nursing home they do not have to pay for the cost or provision of custodial long term care. Thus, they have an incentive to reduce the provision of skilled nursing services and define the care a patient requires as custodial whenever possible. Cost shifting between fee-for-service Medicare and Medicaid and managed Medicare plans is a common occurrence.

Duplicative Administration - Providers are required to duplicate paperwork and send one bill to Medicare and another to Medicaid for the same service. Dually eligible seniors receive a flurry of confusing paperwork from Medicare, even though Medicaid is

paying for their Medicare co-insurance and deductibles. This is a cause of great stress for frail individuals who don't understand that they are not financially responsible for the hundreds or sometimes thousands of dollars they see on the acute hospital statement.

Lack of Accountability - Responsibility for care outcomes is passed from one provider to another which leads to further confusion between both providers and consumers. With multiple payor sources dealing with multiple but interrelated problems, it is impossible for a single provider to understand the client's medical, functional and social situation well enough to develop an effective, service integrated plan of care across various settings and payment systems.

It is clear that lack of coordination between Medicare and Medicaid services in the current system is resulting in care delivery which is primarily driven by the funding mechanism rather than by what most effectively meets the client's needs in a particular circumstance.

FINANCIAL CONSEQUENCES OF CHRONIC ILLNESS

The High Cost of Chronic Illness - The economic consequences of chronic disease are significant. In 1995 nearly 70% of national expenditures for personal health care was for direct medical costs for persons with chronic conditions. Chronic illness costs the country approximately $660 billion per year--$425 billion in direct medical expenses and the remainder in lost productivity. For example, in 1987 (the most recent data available) annual per capita costs for those with only acute care conditions were $817 while per capita costs for those with a single chronic condition was $1,829. Those with more than one chronic condition incurred average costs of $4,672 annually. This differential can be attributed to the proportion of health care services consumed by this population. For example, approximately 69% of all hospital admissions and 80% of hospital days were attributed to the chronically ill who had average lengths of stay of 7.8 days, compared to 4.3 days for those with only acute conditions.

Increased Growth of Chronically Ill - The health care costs of the chronically ill, dually eligibles will grow exponentially in the years to come, given current demographic trends. The elderly, particularly those age 85 and older, who have the greatest health care needs, are the fastest growing segment of the population and also the most prone to multiple, chronic conditions.

These problems suggest that health care cost containment demands three critical steps:

1. Policy makers must establish comprehensive national and state policy agendas that consider the interrelationships between all public and private sector programs serving the chronically ill, with special regard for Medicare and Medicaid recipients.

Rules governing these programs should be streamlined and made uniform, with elimination of conflicting financial incentives.

2. Federal and state governments must undertake Medicare and Medicaid reform together instead of considering these programs as totally separate budgets and delivery systems.

3. Policy makers must develop administrative and financial policies that recognize the need for greater attention to a care strategy that prevents, delays or minimizes the progression of disability over the long term and, thus, reduces the accumulation of costs over time. This need can only be met if Medicare and Medicaid services are integrated.

In summary, the health care system has failed to respond to the need for integration of primary, acute and long term care services in a way that:

1. Simplifies access to consumers;

2. Offers providers the flexibility to provide whatever combination of services are most appropriate at a given time for a specific individual to produce an achievable positive outcome;

3. Recognizes the potential to improve quality and reduce costs through an integrated delivery system approach; and,

4. Takes a long-run view of systems reform and cost containment.

SECTION TWO: WISCONSIN'S RESPONSE TO THE PROBLEM

In response to these pressing issues, the Wisconsin Department of Health and Family Services is redesigning the current service systems for the elderly and disabled. The following is a summary of the key elements of the proposed system:

- Aging and disability resource centers that provide one stop shopping for information on the services available, how to access them and enrollment in the care management organization of their choice;

- Integration of Medicare and Medicaid funding into a single pool of funds that can be used to develop an individual plan of care to fit the individual client's needs;

- Two benefit levels--comprehensive support and intermediate support--based on the client's functional capacity;

- Inclusion of all services in the continuum; and,

- Public or private care management organizations that will bear risk for services in return for a capitated payment per-member-per-month. Involvement of consumers and their families on governing or advisory boards of local agencies and in development of targeted outcomes to be measured.

SECTION THREE: HOW THE PROPOSED WISCONSIN PROGRAM REDESIGN ADDRESSES THE PROBLEMS IDENTIFIED IN THE CURRENT SYSTEM

The Wisconsin long term care redesign proposal has been developed to eliminate or at least alleviate the major problems outlined in Section One of this paper. Although there are several key aspects of the plan which would help to accomplish this end, the concept of integrated Medicare and Medicaid funding is the most important feature of the program.

Quality of Care Issues

Integration of Medicare and Medicaid funding results in one single payor source for all services. As a result, the following goals are achieved:

- Provider and health plan clinical incentives can be aligned since they are all reimbursed from a single pool of funds. In this system, the providers are not working in isolated funding streams, each trying to treat or not treat based on the funding mechanism rather than on the client's true needs. Integrated funding makes it possible for the provider to focus exclusively on delivering the right services for the client in the best setting for the most appropriate duration.

- True continuity of care is possible since the care management function can move across the continuum as a result of the single funding stream. It eliminates the fragmentation of care which is inevitable when each provider is funded separately. For example, some clients require a preponderance of Medicare services while others need a preponderance of Medicaid funded services. In the current system, neither would have their needs fully met. With the flexibility possible under integrated funding, the provider and health plan case manager can identify which services are more appropriate for the client and then use a single pool of funds to meet those needs without the restraints resulting from the limitations of two separate systems.

- Easier access to the system is assured under integrated funding since it eliminates the myriad of eligibility and paperwork requirements, necessary phone calls and

other frustrations clients face as they attempt to move through a maze of services, all with separate sets of rules.

- In the current system, requirements regarding patient assessments, care planning, data collection and record keeping are separately defined by clinics, hospitals, nursing homes and community based service settings, resulting in high costs and care fragmentation. This separate program administration results in a major duplication of effort and greatly increases the difficulty of communication among care providers. With a single funding stream one administrative entity will link the continuum of services and simplify documentation requirements by utilizing a system-wide approach to data collection, processing and dissemination.

- Accountability for the quality of services provided to clients can be achieved when all funding sources are combined into a single program. This is critical in achieving not only quality of care but an effective consumer grievance program as well.

Financial Issues

The High Cost of Chronic Illness - The key to reducing the costs of chronic illness is to move from an acute care to a chronic care orientation in the delivery of both medical and social support services. By reducing the fragmentation of care and the conflicting incentives for providers and health plans, an integrated funding system allows for the shift to a chronic care focus. It eliminates the current emphasis on high tech care, institutionalization and medical intervention by allowing case managers to determine what is best for the client, apart from how services are financed.

Cost Shifting Between Providers and Programs - Medicare policy and reimbursement drive clinical decisions that in turn affect Medicaid utilization and expenditures. For example, Medicare pays for a large portion of hospital and physicians' care but decisions made by hospitals and physicians in response to Medicare payment incentives can affect Medicaid costs since Medicaid covers all Medicare co-pays and deductibles. Conversely, Medicaid-reimbursed providers have an incentive to shift costs to the Medicare side which results in unnecessary hospital admissions and an overall "medicalization" of care. Integrated funding eliminates the incentives for cost shifting and thereby controls the costs of high end medical care as well as unnecessary long term institutionalization.

Increased Growth of the Chronically Ill Population - Integrated funding helps to position Wisconsin for the coming exponential growth in chronic care needs by providing a mechanism to control the unnecessary costs inherent in the current system. It allows health plans and providers to focus on a care strategy that prevents, delays or minimizes the progression of disability over the long term and therefore reduces the accumulation of costs over time.

SECTION FOUR: SPECIFIC RESPONSES TO CONCERNS EXPRESSED BY COUNTY GOVERNMENTS AND CONSUMERS

As previously stated, a coalition of Wisconsin consumers and county governments has expressed serious concerns about the proposed system redesign particularly in regard to integrated Medicare and Medicaid funding and the involvement of managed care organizations in the provision of care.

The following points address these concerns:

1. Some concern has been expressed that integrated funding would result in a shift from social and supportive services, funded by Medicaid under the current system, to aggressive medical treatment currently covered by Medicare. The basis for this concern is that the higher cost services would result in a drain of the Medicaid portion of the integrated pool. The experiences of the PACE (Program of All Inclusive Care of the Elderly) indicates that just the reverse is true in integrated funding. In the current system, there is more funding for Medicare services than for Medicaid. As a result, patients are frequently moved up the acuity chain to receive services for a condition or problem that could be addressed at less intense levels or that actually requires social rather than medical interventions. Since there is little or no funding currently for these lower acuity social services, they are not often offered to consumers. Integrated funding gives the health plans and providers access to the Medicare pool for use in the best interest of the client. As a result, the social and supportive services are usually emphasized in an integrated funding model.

2. The flexibility of service provision and alignment of provider incentives which result from integrated funding do more to promote true consumer centered care than any other changes that could be made in the current system.

3. Integrated funding is considered by many health policy analysts, consumer groups and service agencies to be the key to achieving better care for the chronically disabled and elderly. Among those who have recognized the value of integrated funding include: The National Chronic Care Consortium; The National PACE Association; Minnesota Senior Health Options; The New England States Consortium; and, the State of Texas. The American Association of Retired Persons has developed a policy statement which supports the concept in principle, provided a number of provisions for consumer involvement, benefit protection and quality assurance are met.

4. The ability of a health plan to misuse integrated funding can easily be regulated. For example, California's Knox-Keene Act, which regulates HMO's, stipulates that health plans cannot take more than 25% of the premium dollar for administrative services.

5. Whether an organization is for-profit or not-for-profit does not predict the quality of the service it provides. Every day, millions of Americans place their lives in the hands of for-profit companies in the food, airline, pharmaceutical and countless other industries. The quality of their products is regulated by a plethora of rules and regulations as well as by the ability of consumers to simply stop using their products. The same is true for health plans.

6. Currently there is a strong consumer movement designed to force unethical health plans to make better client-centered care decisions. Those who don't will be put out of business. The media is eager to carry stories of health plan abuse, and, in addition, a number of states have recently enacted or are considering legislation which protects consumers from health plan abuses. These factors indicate that consumers have fast, direct control over the policies of managed care organizations. In fact, it suggests that they may have more direct control over managed care organizations than they have over county governmental agencies.

7. Managed Care Organizations delivering care under the proposed system will be subject to regulators' oversight by the State of Wisconsin and will be accountable for client outcomes. Further, third party monitoring is available from organizations such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA).