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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

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**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

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Tom Moore

WHCA
Wisconsin Health Care Association

October 24, 1997

Joe Leean, Secretary
Department of Health and Family Services
1 West Wilson Street
Madison, WI 53707-7850

Dear Secretary Leean:

WHCA has been an active participant in the long term care redesign initiative. We have been, and continue to be, supportive of DHFS' original goal of developing a comprehensive system that will facilitate "maximization of an individual's choice of services, providers, and care settings as long as such care is necessary, meets a minimum level of quality standards, and is cost effective."

We appreciate the continued opportunity to participate in the redesign effort through membership on the Long Term Care Consolidated Steering Committee. The following identifies our key issues, concerns, and recommendations relative to the substance and direction of the reform effort to date. We request that they be the focus of further discussion by your department and the Steering Committee as the reform initiative proceeds.

System Bias:

No effective managed care system should have an internal bias for or against any particular service or service setting. We acknowledge that the traditional Medicaid system, developed when other long-term care options were not available, primarily paid for institutional care and as a result pushed recipients into more restrictive settings. However, devising a new system that incorporates a bias against institutional or other settings will not resolve existing problems, achieve the objectives of reform, or meet the needs of consumers.

WHCA submits the new system must be designed, implemented and administered in a "site-neutral" fashion with an exclusive focus on providing consumers with services appropriate for their needs, in the most appropriate and cost-effective setting, for the most appropriate duration.

To assure that care management and service delivery systems are properly funded and functioning, they must objectively and judiciously collect and report outcome data that individually measures clinical, functional, fiscal, and satisfaction outcomes.

We seek assurances that the envisioned system will, in fact, be "site-neutral" as described above and that comprehensive performance measures will be in place from the very beginning to assure desired outcomes are being achieved within all components of the new system.

Integration of Acute and Primary Care:

WHCA was more disappointed than surprised at DHFS' recent retraction of its original position on integration and its announcement that integration of acute and primary care will not be required at the "onset" of long term care reform. While there are many key ingredients in the recipe for reform, we continue to believe the capacity to coordinate delivery of acute, primary, and long-term care service is the most critical to system success. Indeed, if integrated financing and service delivery are not built into the new long-term care system, the current problems of fragmentation, confusion, and cost-generating duplication will only be perpetuated in new forms.

Existing fragmentation between Medicare and Medicaid services has led to poor coordination between the acute and long-term care systems, shifts of cost between the programs, and confusion and poor health outcomes for consumers. Combining acute and long-term care within a single managed care environment would result in more rational, efficient, and economical approaches to recognition and responding to an individual's health and social needs, for the same or lower cost as the two current systems combined.

WHCA is encouraged by the fact the Department is promoting pilot and demonstration projects to explore the challenges and potentials of integrated financing and service delivery. However, we believe the Department's initial blueprint for long-term care redesign must necessarily include specific timeframes and provisions for the eventual integration of acute and primary care within the long-term care system. To embark on implementation of a plan for system reform without a commitment and strategy for subsequent integration of acute and primary care would render the resultant system unable to achieve its ultimate purpose of presenting consumers with a seamless and cost-effective service delivery system.

In the backyard of DHFS lies the beautiful Monona Terrace Convention Center that required over 40 years to plan and build. However, unless an adjacent hotel is built, the Convention Center will never realize its full potential, never meet the needs of the consumers it was intended to serve, and will be a continual drain on the taxpayers who must finance its less-than-optimum operational performance. WHCA submits the consequences associated with that unfortunate situation are analogous to what will occur if a plan for a new long-term system is devised ignoring the critical need for coordination of acute, primary, and long-term care service delivery.

Effect of Emergence of Medicare Risk Plans:

WHCA submits that the redesign plan should not be proposed without first assessing the potential effect of the increasing emergence of Medicare Risk Plans within Wisconsin. While currently limited to the PrimeCare plan in Milwaukee, both Blue Cross and Humana have filed applications with the

Office of the Insurance Commissioner (OIC) to operate Medicare managed care plans within the state. Humana's application would apply to southeastern Wisconsin, while Blue Cross' would, if approved, extend state-wide. OIC indicates that approval of each of these applications by the state and HCFA could occur before the end of this year. Indeed, given the recently enacted federal budget's impact on the state's Medicare AAPCC level, it is fair to assume Wisconsin will soon experience a dramatic escalation in the number and coverage of Medicare risk plans. WHCA believes the state-wide presence of these managed care plans adds a new dimension to the scope of long-term care redesign options that must be considered in assessing timeframes, need, and feasibility for integration of acute and primary care.

Accountability of Care Management Organizations:

DHFS recently announced that counties will be given "a right of first selection" to serve as care management organizations within the envisioned managed care system. This will afford a county the potential to separately, but simultaneously: (1) control consumer access, enrollment, and benefit levels in the role of Resource Center gatekeeper; (2) control, as CMO, all of the contracting, arrangement, coordination, and monitoring of service delivery; and (3) provide long-term care services within the delivery system it manages.

An arrangement that would afford any entity an umbrella of control of this magnitude presents obvious conflict of interests issues that have political, operational, and fiscal implications. Unless these issues are resolved, the integrity, accountability, and cost-effectiveness of the system could be compromised.

Accordingly, WHCA submits that any county which elects to pursue the role of an CMO must demonstrate not only a desire, but a fiscal and professional capacity, to efficiently and effectively perform the CMO's complex care management responsibilities. Such a demonstration entails not only a commitment to observance of strict regulatory and contractual "firewalls" to avoid conflicts of interest in the county's administration of its respective CMO, Resource Center, and service provider functions. It must also embrace the county's express assumption of a legal responsibility for objective measurement, standardized reporting, and accountability for clinical, functional, fiscal, and satisfaction outcomes for the population the CMO serves. In addition, a county must agree to adhere to the same standards of performance and assume the same degree of financial exposure for non-performance that the state would demand of any other entity seeking to serve in this critical role. It is one circumstance for the state to afford counties an inside track in initial competition for the CMO role. It is far another to allow counties to commence and pursue their CMO responsibilities without expressly defined and enforceable expectations of operational efficiency, client outcomes, and fiscal accountability. Such measurable and enforceable performance standards are necessary to achieve the goals of the system reform and to protect the respective interests of the county, state, consumers, providers, and taxpayers.

WHCA submits that whether an organization is proprietary, non-profit, or government-operated does not predict the quality of the service it would provide as an CMO. Yet, much of the debate

surrounding what type of organizations should be allowed to serve as the CMO has focused on fears that certain types of organizations may be administered in a fashion generating a profit that would not be re-invested in the system. As a result of this preoccupation with elimination of profit potential, WHCA submits that too little attention has been given to organizational accountability for cost and outcome performance. Indeed, we believe controlling excessive CMO costs should be of more immediate concern to the Department than limitation or elimination of operational profit. Accordingly, we submit the system must be designed to provide express statutory and contractual protections for the state from CMO operational performance that embrace excessive costs or unacceptable outcomes, as well as undeserved profits.

Projection of Cost and Funding Limitations:

Conspicuously absent in discussions of long-term care reform thus far has been any projection of redesign cost or funding limitations. During the last 20 months of discussion, all participants have essentially been requested to articulate their respective wish lists for an ideal system. To date, no list has been rejected as unreasonable; and the resultant expectations of consumers and providers have been allowed to reach what we perceive as unreasonable and unattainable levels.

WHCA submits that the DHFS and the Consolidated Steering Committee must begin to temper and refine expectations with fiscal reality and demographics. Discussion should embrace the issues of (1) potential cost of reform, (2) potential funding sources and limitations, (3) projected increases in service, demand, and utilization; and (3) funding and service priorities. To that end, WHCA recommends that representatives of the Wisconsin Taxpayers Alliance and Legislative Fiscal Bureau be included in future discussions regarding the system redesign, reform funding, and cost estimates.

* * * *

Obviously, as the reform initiative progresses from the conceptual to the proposal stage, more issues will arise that require resolution. However, the above attempts to capture our major concerns with what is, and is not, apparent in the reform effort's present status.

Sincerely,

Thomas P. Moore
Executive Director

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Report

of the

Residential Options Task Force

to the

Wisconsin Council on Long Term Care Reform

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December 17, 2004

Residential Options Task Force Membership

Tom Rand, Co-chair	Bethany-St. Joseph's Care Center
Stephanie Stein, Co-chair	Milwaukee County Dept. on Aging
Beth Anderson,	Laureate Group
Bill Bender	St. Mary's Care Center, Madison
Rose Boron	Wisconsin Elder Alliance, LLC
Phillip Borreson	Trempealeau County Health Care Center
Jim Canales	Community Care of Portage County
Dick Eschner	Kahler Slater Architects, Milwaukee
Marty Evanson	WI Dept. of Commerce/ Bureau of Housing
Paul Fons	WHEDA
Tom Frazier	Coalition of Wisconsin Aging Groups
Tim Frey	TLC Homes, Inc., Sheboygan
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Glen Grady	Memorial Medical Center, Neilsville
Chris Hess	Chair, Milwaukee Housing Task Force
Steve Jaberg	Cedar Community
Nancy Kosseff	South Madison Coalition
Susan McMurray	AFSCME
Steve Mercaitis	WI Personal Services Association & Lori Knapp, Inc.
Tom Moore	Wisconsin Health Care Association
Jim Olson	Schmitt Woodland Hills
Dan Remick	People First Wisconsin
Maria Rodriguez	Housing Authority city of Milwaukee
Ruth Roschke	Mental Health Advocate
Maureen Ryan	WI Coalition of Independent Living Centers, Madison
Chris Sarbacker	Community Alliance of Providers of Wisconsin
Sue Seegert	Lutheran Homes of Oconomowoc
David Slautterback	Senior advocate
Tim Steller	North Central Health Care, Wausau
Claudia Stine	BOALTC
Debbie Timko	Service Employees International Union, Local 150
Mary Wright	Johnson Bank

INTRODUCTION

The Residential Options Task Force was appointed to advise the Wisconsin Council on Long Term Care Reform on issues relating to a variety of care settings including nursing homes and facilities serving people with developmentally disabilities, the full range of assisted living options, and service supported housing.

The recommendations in this report are the result of brainstorming by informed stakeholders representing a wide spectrum of perspectives on long term care issues. These recommendations are offered to the Council on Long Term Care Reform and the Department of Health and Family Services as ideas to be considered in their efforts to reform and improve Wisconsin's long term care system. These recommendations are not based on extensive research and analysis but instead reflect the knowledge, expertise and viewpoints of Task Force participants. Because of the diversity of the Task Force membership, not all ideas presented here represent a consensus of the group. Where the group felt strongly about but could not agree on a particular recommendation, each viewpoint is described as a sub-point of the recommendation and labeled "Alternative A" or "Alternative B."

The recommendations and more detailed suggested action steps are grouped into nine topics identified by the Task Force as priority goals or themes for moving forward with long term care reform. These include:

1. **FINANCING.** Develop financing and reimbursement strategies capable of supporting an adequate and stable supply of quality residential options for people with long term care needs.
2. **ACCESS.** Ensure that all residential options and services are accessible to people throughout the state.
3. **QUALITY.** Define quality in residential settings and services.
4. **CHOICE.** Make long term care funding available to support individuals in any residential setting, including in-home care.
5. **INNOVATION.** Nurture and develop innovative, cost-effective, quality residential options.
6. **PUBLIC INFORMATION.** Provide accurate public information about residential and other long term care options.
7. **DATA** . Collect and analyze data to inform public policy decisions.
8. **CONSUMER PROTECTION.** Provide consumer protection to all target groups in all settings
9. **SPECIAL NEEDS.** Provide additional residential options for special needs populations.

Broad recommendations in each of the nine topic areas are contained in the body of the report. More detailed action steps to carry out the recommendations are contained in Appendix A. Resolutions requesting specific implementation actions are contained in Appendix B. Guidance provided to other committees of the Wisconsin Council on Long Term Care Reform is contained in Appendices C and D.

BACKGROUND

Residential resources in Wisconsin include a variety of institutional and community based settings where people receive long term care services. Regulated facility types include nursing homes, facilities serving people with developmental disabilities (FDDs), community based residential facilities (CBRFs), residential care apartment complexes (RCACs), and adult family homes. In addition, many people receive long term care services in their private homes or apartments.

Wisconsin is relatively rich in residential resources compared to other states. Wisconsin Ranked 9th among the states in the number of nursing home beds per 1,000 elderly population and 9th in the number of residential care beds per 1,000 elderly in 2001 (*Across the States: Profiles of Long-Term Care 2002*, AARP Public Policy Institute).

A little over half of Wisconsin's long term residential capacity is in institutional settings. Some 43,839 beds or 57% of Wisconsin's regulated care facility capacity as of 2003 was in nursing homes and FDDs, while 32,992 beds or 43% of capacity was in assisted living settings, including CBRFs, RCACs, and adult family homes.

The composition of Wisconsin's long term care system is the result of more than a decade-long trend in which institutional capacity has declined and the number of home and community based care settings has increased. The number of staffed nursing home beds fell 11% (to 42,883) and staffed FDD beds fell 27% (to 2,038) between 1990 and 2000. At the same time, the number of CBRF beds increased by 56% (to 20,968) and licensed adult family home beds increased by 340% (to 2,438). The fastest growing segment of the residential care market is apartment style assisted living. The number of RCAC units grew from 21 when the first facility was established in 1996 to 4,133 units in 2000 and to 5,745 units in 2004.

This change in composition reflects changes in the roles of the long term care residential options. While nursing homes continue to provide a safety net for people with long term care needs, they are increasingly being used for post-hospital rehabilitation and end-of-life care. This is reflected in the increasing acuity of and faster turnover in the nursing home population. The percentage of nursing home residents receiving intense skilled or skilled nursing levels of care grew from 70% in 1990 to 89% in 2000. The number of admissions increased 31% from 1990 to 2000, while the total number of beds and residents declined. Meanwhile, assisted living options have become more widely available and are increasingly selected by consumers with less intense care needs and the resources to exercise choice.

Trends in residential capacity and usage also reflect public preferences and market demand. Statewide surveys in 1986 and 2002 asked older people where they would want to live given different care need scenarios. During that period, the percentage of people choosing the nursing home alternative when faced with a terminal illness increased from 26% to 43%. At the same time, people appear to be much more receptive to assisted

living. The percentage of people saying they would want to go to a nursing home if they became confused or forgetful dropped from 49% in 1986 to 15% in 2002, with 36% choosing assisted living and 36% saying they would want to remain at home. From 24% to 36% respondents to the 2002 survey indicated they would choose assisted living if they needed help with meals, toileting, bathing or daily medical assessment (*Profiles of Older Wisconsin Residents 2002*, Wisconsin Dept. of Health and Family Services).

Nationally, the percentage of Medicaid long term care dollars devoted to home and community based care increased from 14% in 1991 to 30% in 2001 (*Beyond 50 2003: A Report to the Nation on Independent Living and Disability*, AARP Public Policy Institute). Here in Wisconsin, 40% of Medicaid long term care funding went to home and community based settings in FY 2002. The number of people served in Wisconsin's home and community based waiver programs grew from 15,128 in 1992 to 25,197 in 2002. Even so, Wisconsin had 8,735 people on waiting lists for community based waiver services in 2002.

Spending trends notwithstanding, most institutional care today is publicly funded, while most assisted living care is private pay. Almost all of Wisconsin's FDD residents (99%) and 65% of its nursing home residents had their care paid for by Medicaid in 2002. By contrast, publicly funded residents occupied 49% of adult family home, 18% of CBRF and 3% of RCAC capacity.

There are also differences in usage by population group. Nearly two-thirds of elderly Medicaid long term care recipients (63%) lived in institutions in 2002, compared to 19% of younger adults with physical or developmental disabilities.

Nursing home rates in Wisconsin are slightly below the national average, at $92/day for Medicaid recipients (compared to $96/day nationally) and $148/day for private pay compared to $150/day nationally in 2001. Wisconsin's Medicaid and private pay rates ranked 19th and 22nd respectively compared to other states (*Across the States*, AARP). Comparable data is not available on rates for other residential options.

There are many gaps in our understanding of the need for long term care residential options. We know how many facilities there are in the state, how much we spend for care and where our publicly funded long term care consumers live. But there are no widely accepted standards for determining how many "beds" are enough, who is most appropriately served in one residential setting compared to another, and how much the public should spend for care.

The Residential Options Task Force has reviewed available data but lacked the time and resources to collect new data or conduct rigorous research and analysis. Instead, the Task Force has relied on the experience of its members to address the issues in its charge. Recommendations include ways to address data needs, procedures for identifying the need for and appropriateness of residential settings, and ideas for moving forward based on the knowledge at hand.

RECOMMENDATIONS
Of the Residential Options Task Force

Theme #1: FINANCING

Develop financing and reimbursement strategies capable of supporting an adequate and stable supply of quality residential options for people with long term care needs.

1.1 Consolidate categories of public long term care funding to provide flexibility to meet consumer needs.

1.2 Public funding levels should be predictable and sufficient to encourage providers to develop needed residential services and to ensure the availability of residential services when needed for long term care consumers.

1.3 Research and document the actual cost of providing care in different settings.

1.4 Fund the actual cost of providing consumer access to quality residential service settings.

1.5 Initiate action to improve access to and affordability of liability insurance for all residential service providers.

1.6 Encourage people to prepare for their long term care needs.

1.7 Adjust the amount of long term care funding available to an individual as his or her needs change.

Theme #2: ACCESS

Ensure that residential options and services are available and accessible to people throughout the state.

2.1 All Wisconsin residents should have access to a full array of residential options. Some options may need to be available on a local or county basis and others, on a regional basis.

2.2 A diversity of residential options should reflect and be responsive to the racial and cultural makeup of the service area population.

2.3 Develop data and identify needs for residential resources.

2.4 Take affirmative steps to fill gaps where lack of access to residential options is identified as a problem.

Theme #3: QUALITY

Define quality in residential settings and services.

3.1 DHFS should develop a consistent approach to assessing quality across all residential settings.

3.2 Consumer protection should be one aspect of the approach to quality.

3.3 Include both process and consumer outcome components in the Department's approach to determining quality.

Theme #4: CHOICE

Make long term care funding available to support individuals in any residential setting, including in-home care.

4.1 Consumers should have a choice about where public long term support dollars are spent for their care.

Alternative 4.1 A. Long term care dollars should be available to be used where the consumer wants to use them, considering cost-effectiveness, appropriateness and safety.

Alternative 4.1 B: Long term care dollars should be available to be used where the consumer wants to use them.

4.2 Eligible consumers should have equal access to public funding in all long term care settings.

4.3 Care in all residential settings should be a fully-funded entitlement.

4.4 The appropriateness of using long term care funding in a particular setting should be determined on a case-by-case basis.

Theme # 5: INNOVATION

Nurture and develop innovative, cost-effective, quality residential options.

5.1 Allow providers to get waivers from regulations for proposals that make common sense and do not present harm.

5.2 The agencies responsible for housing and long term care policy and funding should work together to stimulate development of new and innovative residential options.

5.3 Adjust regulations where necessary to permit innovative solutions for long term care.

5.4 Pursue private and government grant opportunities to develop innovation in residential options

Theme #6: PUBLIC INFORMATION

Provide accurate public information about residential and other long term care options.

6.1 Aging and disability resource centers should be made available statewide.

6.2 Provide consumers with accurate information on all residential options and with help in making decisions.

6.3 The state should make information about residential options available on-line and through other means. [Note: The Dept. of Commerce is developing a database to do this for low and moderate income housing.]

Theme #7: DATA

Collect and analyze data to facilitate informed decision-making.

7.1 DHFS should collect and analyze data on need, preferences, availability, location, use, and cost relating to the various residential options.

7.2 DHFS should collect and analyze longitudinal data on the care needs and costs of serving residents in various residential settings using tools such as the long term care functional screen and the MDS.

7.3 Collect and report information in uniform ways, when possible.

7.4 DHFS should use data analysis, together with feedback from information and assistance counselors, care managers and consumers, as a basis for identifying needed changes in system capacity.

Theme #8: CONSUMER PROTECTION

Provide consumer protection to all long term care populations in all settings

8.1 _Alternative A_: The long term care ombudsman should have authority to represent publicly funded elderly people in all residential settings.

Alternative B. People living in all long term care residential settings should have access to a long term care ombudsman or other individual advocate.

8.2 Expand one-to-one advocacy resources for people with disabilities under the age of 60.

8.3 Long term care ombudsman and individual advocacy programs should be funded with general revenues, not through user or provider fees.

Theme #9: SPECIAL NEEDS

Provide additional residential options for special needs populations.

9.1 The Wisconsin Council on Long Term Care Reform should create a task force or committee to identify special care populations and needs and to develop strategies for addressing their needs.

APPENDIX A: ACTION STEPS

The following describes more detailed action steps to implement the recommendations of the Residential Options Task Force.

1. FINANCING

Theme: Develop financing and reimbursement strategies capable of supporting an adequate and stable supply of quality residential options for people with long term care needs.

Recommendations and Action Steps

1.1 Consolidate categories of public funding to provide flexibility to meet consumer needs.

1.2 Public funding levels should be predictable and sufficient to encourage providers to develop needed residential services and to ensure the availability of residential services when needed for long term care consumers.

- 1.2.1 The Governor and Legislature should provide an adequate and stable source of funding for public program recipients in all residential care options.
- 1.2.2 DHFS should report on workable ideas for reimbursement mechanisms by the end of 2005.
- 1.2.3 DHFS should adopt reimbursement mechanisms that ensure that government pays an amount sufficient to cover the cost of meeting facility codes and providing quality services throughout the long term care system without relying on cross-subsidies.
- 1.2.4 Reimbursement should promote and reward quality. Currently, we pay substandard facilities the same as we pay good ones.
- 1.2.5 The State should encourage use of Section 8 Vouchers to pay the rent in residential settings.

1.3 Research and document the actual cost of providing care in different settings.

1.4 Fund the actual cost of providing consumer access to quality residential service settings.

- 1.4.1 DHFS should publish the projected cost of, the Governor should request, and the Wisconsin Legislature should appropriate sufficient funding to ensure access to quality long term care for Wisconsin residents. The State

must invest in its long term care programs. More State dollars need to go into the long term care system. Budget neutrality is not possible.

1.4.2 The Wisconsin Council on Long Term Care Reform and DHFS should collaborate on a resolution to Wisconsin's congressional delegation requesting that a fair share of federal dollars be returned to the State, with special attention to funding for long term care. Any increases in federal funding should be used as a supplement to, and not a substitute for, state investment in long term care services.

1.4.3 Improve the environment of nursing homes by retaining and reinvesting Medicaid dollars saved from nursing home facility closures and downsizing and making these dollars available to nursing home providers for higher direct care payments and for capital investment (e.g., for renovation, replacement, private room conversion, etc.).

1.5 Initiate action to improve access to and affordability of liability insurance for all residential service providers.

1.6 Encourage people to prepare for their long term care needs.

1.6.1 DHFS should work with the Office of the Insurance Commissioner to ensure that long term care insurance options are affordable and available to assist with the cost of care in all residential options.

1.6.2 DHFS should collaborate with other state agencies to develop and promote strategies that encourage people to prepare for long term care needs. Such strategies could include savings plans, reverse mortgages, tax credits and other mechanisms to increase the individual's financial potential for meeting his or her long term care needs.

1.6.3 Strengthen restrictions to limit divestment of resources for the purpose of establishing MA eligibility.

1.6.4 Re-examine issues relating to Medicaid supplementation. Families and others should be allowed to contribute toward the cost of care.

1.7 Adjust the amount of long term care funding available to an individual as his or her needs change.

2. ACCESS

Theme: Ensure that residential options and services are available and accessible to people throughout the state.

Recommendations and Action Steps

2.1 All Wisconsin residents should have access to a full array of residential options. Some options may need to be available on a local or county basis and others, on a regional basis.

2.1.1 DHFS should identify areas in Wisconsin that have limited or inadequate residential options and support services and work with federal and state housing finance agencies and providers to prioritize the availability of housing financing to the under-served areas.

2.2 A diversity of residential options should reflect and be responsive to the racial and cultural makeup of the service area population.

2.3 Develop data and identify needs for residential resources.

2.4 Take affirmative steps to fill gaps where lack of access to residential options is identified as a problem.

2.4.1 Work with providers, developers and lenders to stimulate more affordable long term care options.

2.4.2 DHFS should work with WHEDA, WHEFA, Dept. of Commerce and other lenders to improve access to funding for development and operations for providers of long term residential settings. Strategies should include:

a) Providing access to capital for nursing homes to convert to other forms of housing, "rightsize", renovate or replace.
b) Incentives for investing in long term care residential settings
c) Improving outreach and education on available financing resources to prospective developers and providers.
d) Supporting and promoting the coordination of funding resources for facility development and operation. It is often necessary to use multiple financing sources to support an affordable residential setting, and conflicting requirements and timelines can make this difficult to achieve.

2.4.3 DHFS should help providers transition from obsolete or unneeded facilities to new models of facilities and services.

2.4.4 DHFS should promote the development of the resources necessary to support residential options such as, but not limited to, an adequate and well-trained workforce, transportation services and other related services.

3. QUALITY

Theme: Define quality in residential settings and services.

Recommendations and Action Steps

3.1 DHFS should develop a consistent approach to assessing quality across all residential settings.

- 3.1.1 Expectations for quality should be consistent in all settings and apply statewide. The regulations may be different, but the measures of quality and outcomes should be the same.
- 3.1.2 Start by using currently available measures as a proxy for quality and refine over time.
- 3.1.3 Look to existing initiatives and models, including Family Care tools and innovative approaches to residential care (such as Wellspring, Eden, and Pioneer), as a source of ideas.
- 3.1.4 Consider having a vendor such as the Center for Health Systems Research and Analysis at UW-Madison (CHSRA) develop the quality standards for all settings.
- 3.1.5 Developing quality measures should be an ongoing process. Ensure that standards/indicators can be updated as ideas and best practices change. Ongoing review of appropriate quality indicators is necessary.
- 3.1.6 Involve stakeholder groups in the development and implementation of quality initiatives, quality standards, and quality education. Stakeholder involvement should include consumers, organizations representing older people and people with disabilities, trade and professional associations, home care professionals and non-professional caregivers.
- 3.1.7 Encourage trade and professional associations and their members to generate quality initiatives.

3.2 Consumer protection should be one aspect of the approach to quality.

- 3.2.1 Recognize regulatory compliance as an important, if not sufficient, aspect of quality in residential settings.
- 3.2.2 Regulatory staff should be actively engaged in providing technical assistance to promote compliance and best practices in all regulated care settings.
- 3.2.3 Licensing regulations should be consistently interpreted and applied by regulatory staff in all areas of the State.

3.3 Include both process and consumer outcome components in the Department's approach to determining quality.

3.3.1 The approach to quality should be responsive to individual needs and preferences and should include Family Care outcomes or something similar.

3.3.2 Find an appropriate mix of quality measures, rather than simply adding on outcome and quality of life measures to what we have now.

4. CHOICE

Theme: Make adequate long term care funding available to support individuals in any residential setting.

Recommendations and Action Steps

4.1 Consumers should have a choice about where public long term support dollars are spent for their care.

[Note: Task Force members disagreed on whether access to funding should be limited by considerations relating to cost-effectiveness, appropriateness and safety.]

Alternative 4.1 A. Long term care dollars should be available to be used where the consumer wants to use them, considering cost-effectiveness, appropriateness and safety.

Alternative 4.1 B: Long term care dollars should be available to be used where the consumer wants to use them.

4.1.1A State funded long term care programs should establish mechanisms to ensure that consumer choice of residential setting is explored and honored to the extent feasible, considering cost and safety.

or

4.1.1B State funded long term care programs should establish mechanisms to ensure that consumer choice of residential setting is explored and honored.

4.1.2 Adopt policies that enable public long term care program participants to have a private room in all residential care settings and that reimburse providers accordingly. Current MA policy is to pay only for a semi-private room under most conditions in nursing homes.

4.1.3 State funded long term care programs should establish policies and procedures to reassess the suitability of placements and services to achieve desired outcomes.

4.2 Eligible consumers should have equal access to public funding in all long term care settings.

4.3 Care in all residential settings should be a fully funded entitlement.

4.4 The appropriateness of using long term care funding in a particular setting should be determined on a case-by-case basis.

4.5.1 DHFS should develop protocols for determining when admission to and discharge from each type of residential setting is appropriate.

a) People with similar care needs may appropriately be served in different settings provided that the setting can meet their care needs.
b) The appropriateness of a care setting depends on a combination of factors including, but not limited to, its ability to meet the person's care needs, quality, safety, cost-effectiveness, and the person's informed choice, regardless of pay source.

5. INNOVATION

Theme: Nurture and develop innovative, cost-effective, quality residential options.

Recommendations and Action Steps

5.1 Allow providers to get waivers from regulations for proposals that make common sense and do not present harm.

5.1.1 DHFS should use its authority to approve waivers or variances to administrative rule requirements where necessary to permit provision of innovative models of residential care, provided that resident health, safety, welfare and rights are not compromised.
5.1.2 DHFS should create an appeal process for applicants whose request for a waiver or variance from residential care regulations has been denied. [See Appendix A: Resolutions.]
5.1.3 Create the statutory authority and develop procedures to permit development of innovative residential options that may be inconsistent with the uniform licensure code. [See Appendix A: Resolutions]

5.2 The agencies responsible for housing and long term care policy and funding should work together to stimulate development of new innovative residential options.

5.2.1 As a general principle, DHFS should encourage innovation in residential care.

5.2.2 DHFS should support pilots and models to test new types of residential settings, especially campus-based alternatives.

5.2.3 The Governor and legislature should provide funding to support creative, cost-effective alternatives and to encourage innovation.

5.2.4 Allow for flexibility in funding programs so that resources can be used in demonstration projects and other innovative settings.

5.2.5 Promote the expansion of cooperative housing and other ownership models.

a. Identify current funding sources and encourage access to this funding.
b. Take advantage of federal programs that provide assistance with down payments and closing costs to encourage growth of co-ops.
c. Find a way to bring services into housing co-operatives to permit "aging in place."

5.3 Adjust regulations where necessary to permit innovative solutions for long term care.

5.3.1 Once desirable models have been identified, then DHFS should examine its regulations to see if additional flexibility is needed. Don't start by providing regulatory flexibility.

5.3.2 Remove regulatory barriers which prevent the efficient and effective use of staff and/or physical facilities, so long as quality of care is not compromised. For example:

a. Permit caregivers from home health agencies, adult day care facilities or other regulated service providers located in the same building as independent living apartments to provide services to apartment residents in their living units without the apartments having to be licensed or regulated.
b. Permit sharing of staff among nursing homes, assisted living and other residential options located in a campus setting.
c. Allow a nursing home and assisted living or independent apartments to share the same common areas.
d. There should be no restriction on the doors that can be used to enter the day care building.

5.3.3 DHFS should allow more flexibility in residential care settings, subject to appropriate accountability and with consideration for the impact on quality and regulation.

a. Allow multi-purpose facilities
b. Allow/encourage assisted living facilities to define and tailor their services to specific target populations
c. Allow facilities to be more consumer directed.
d. Allow facilities to use their staff to provide care services in the community.
e. Allow some flexibility in the levels of care that can be provided in nursing homes, CBRFs, RCACs and AFHs.
f. Allow a variety of arrangements for providing services, including partnerships and coordination of services from multiple providers.

5.3.4 DHFS should promote expanded availability of unlicensed, service supported housing consistent with regulatory requirements.

a. Permit owners of unlicensed housing to provide services to tenants if the owner is licensed or certified to provide those services.
b. DHFS should re-examine the threshold for determining when a service or service supported housing should be required to be licensed, registered or certified.

5.4 Pursue private and government grant opportunities to develop innovation in residential options.

6. PUBLIC INFORMATION

Theme: Provide accurate public information about residential and other long term care options.

Recommendations and Action Steps

6.1 Aging and disability resource centers should be made available statewide.

6.1.1 DHFS should provide clear expectations, informational materials and resources, and financial support to assist resource centers in carrying out their responsibilities.

6.2 Provide consumers with accurate information on all residential options and with help in making decisions.

6.2.1 Resource centers and other county-level information and assistance programs for older people and people with disabilities should provide consumers and their families with objective information and assistance so that they are better able to make informed choices about long term care options.

6.2.2 Providers and consumers should be informed of the limitations on the nature, scope and cost of services that are covered for publicly funded consumers.

6.2.3 Get information out so that it is available to people when they need it. Often people make decisions in a crisis situation.

a) Publicize the availability of resource centers and other information and assistance services through public service announcements, churches, etc.
b) Make information available in the places where consumers are.
c) Take information to the people who make or influence decisions – families, physicians, etc.

6.2.4 DHFS should educate the public on how to make choices when selecting a long term care setting.

6.2.5 Educate consumers on how to recognize and assess quality in a residential setting.

6.2.6 DHFS should provide training for people who advise consumers on long term care about residential options and about the philosophy and practice of consumer driven services. Training should be provided to hospital discharge planners, doctors, information and assistance counselors, financial planners, the court system, care managers and others.

6.3 The state should make information about residential options available on-line and through other means.

6.3.1 Provide the public with access to information about facility and service provider quality.

a) Information provided needs to be accurate and current.
b) Start by providing information on the "least common denominators" across facility types.
c) Information provided should not be limited to regulatory compliance.
d) For assisted living, give information on whether the facility has no major violations and is qualified for an abbreviated survey.
e) Consider creating a seven-point rating system.

6.3.2 Provide advocates to help people navigate the long term care system and get their care needs met on a one-to-one, problem solving basis.

7. DATA

Theme: Collect and analyze data to facilitate informed decision-making.

Recommendations and Action Steps

7.1 DHFS should collect and analyze data on need, preferences, availability, location, use, and cost relating to the various residential options.

7.1.1 Develop data and identify needs for residential resources.

7.1.2 Analyze longitudinal data on the care needs, consumer preferences and costs of serving residents in various residential settings using tools such as the long term care functional screen and the MDS.

7.1.3 Research and document the actual cost of providing care in different settings.

7.1.4 Mandate counties to hold public hearings once or twice a year to let citizens identify unmet needs and to report annually to the State and to the Council on Long Term Care Reform.

7.2 Collect and report information in uniform ways, when possible.

7.2.1 DHFS should develop measures of care need which are consistent across all long term care settings and to which reimbursement can be related.

7.2.2 The State needs to define what it considers to be "affordable" for consumers of its long term care programs.

a. Analyze what public sector long term care programs and their consumers can afford to pay for housing and services and what can be provided at that cost.
b. Consider what is affordable from the perspectives of the consumer, the State, and the residential care provider.
c. Recognize that costs will differ by facility type and for different regions of the State.
d. Consider definitions of affordability used by HUD and other public agency programs.
e. Recognize that middle income people also need to have access to affordable long term care.

7.2.3 Develop measures of residential facility quality so that we are not "pushed" to using a system like that CMS uses for nursing home information in its Nursing Home Compare.

7.3 DHFS should use data analysis, together with feedback from information and assistance counselors, care managers and consumers, as a basis for identifying needed changes in system capacity.

7.3.1 DHFS should measure the need for long term residential care and determine whether adequate resources are available, considering regional distribution as well as overall capacity.

7.3.2 Resource Centers and the Council on Long Term Care Reform should inform county and state level policy makers about need for long term care residential options and make recommendations to the Secretary of DHFS.

7.3.3 DHFS should prepare an annual report to the legislature on the amount of private funds which support Medicaid through cross-subsidies.

7.3.4 DHFS should examine the impact of regulation on the cost of providing services and identify requirements that unnecessarily increase cost and could be waived or eliminated without jeopardizing health, safety, welfare or quality of life.

7.3.5 Consider the approach used by Community Care of Portage County as a possible model for identifying need for residential options.

8. CONSUMER PROTECTION

Theme: Provide consumer protection to all long term care populations in all settings.

Recommendations and Action Steps

8.1 *Alternative 8.1 A*: The long term care ombudsman should have authority to represent publicly funded elderly people in all residential settings.

or

Alternative 8.1 B. People living in all long term care residential settings should have access to a long term care ombudsman or other individual advocate.

8.2 Expand one-to-one advocacy resources for people with disabilities under the age of 60.

Alternative 8.2.1 A. Individual *and* independent advocacy should be available for people with disabilities in any residential setting.

or

Alternative 8.2.1 B. Individual advocacy should be available for people with disabilities in any residential setting.

8.3 Long term care ombudsman and individual advocacy programs should be general revenue funded and not funded through user or provider fees.

9. SPECIAL NEEDS

Theme: Provide additional residential options for special needs populations.

Recommendations and Action Steps

9.1 The Wisconsin Council on Long Term Care Reform should create a task force or committee to identify special care populations and needs and to develop strategies for addressing their needs.

[Note: See resolution in Appendix B and recommendations to the Committee on Special Needs in Appendix D.]]

APPENDIX B

Resolutions Adopted by the Residential Options Task Force

RESOLUTION

Regarding Review of Denials of Requests to Waive or Vary Administrative Rule Requirements for Long Term Residential Care Settings

As adopted by the Council on Long Term Care Reform, 10-8-04

Whereas the Residential Options Task Force seeks to encourage creativity and innovation as ways to improve quality, expand options, and control costs in long term residential care; and

Whereas innovative models of residential care may not meet all administrative rule requirements that apply; and

Whereas a strict interpretation of the administrative rules may present a barrier to approval of facilities or programs which incorporate innovative designs or models of care; and

Whereas the Department of Health and Family Services has broad authority to waive or vary its administrative rules; therefore be it

Resolved, That the Residential Options Task Force requests the Wisconsin Council on Long Term Care Reform to recommend the following to the Secretary of the Wisconsin Department of Health and Family Services:

1. That DHFS create an appeal process for applicants whose request for a waiver or variance from residential care regulations has been denied.

2. That DHFS create a Waiver and Variance Review Committee comprised of senior department staff to review appeals, determine whether the request is consistent with the intent of Department policy, and work with legal or other experts to determine whether the waiver or variance should be granted.

RESOLUTION

Regarding Authority for DHFS to Exempt Demonstration Projects from Statutory Requirements for Care Facilities under Chapter 50

As adopted by the Council on Long Term Care Reform, 10-8-04

Whereas the Residential Options Task Force seeks to encourage creativity and innovation as ways to improve quality, expand options, and control costs in long term residential care; and

Whereas innovative models of residential care may not meet the definitions and requirements for regulated care facilities contained in Chapter 50 of the Wisconsin Statutes, therefore be it

Resolved, That the Residential Options Task Force requests the Wisconsin Council on Long Term Care Reform to recommend the following to the Secretary of the Wisconsin Department of Health and Family Services:

1) That DHFS seek legislation to amend the statutes to authorize DHFS to approve demonstration projects for the purpose of creating new and innovative residential care options and to exempt these demonstrations from the provisions of Chapter 50, provided they do not jeopardize the health, safety, welfare, rights or quality of life of any person;

2) That DHFS establish performance standards that demonstration projects will be required to meet;

3) That requests for demonstration projects be submitted to the Department in writing and include a description of its innovative nature; identification of the provisions requested to be waived; an analysis of how the requestor will maintain the health, safety, welfare and rights of residents living in the demonstration project; and a description of how the performance criteria will be met;

4) That DHFS create an independent advisory committee to recommend performance criteria for the demonstration projects and to review and advise the Department on requests for demonstration designation. The committee should be composed of at least seven people appointed by the Secretary of DHFS, less than 50% of whom shall represent industry interests. The chairperson of the committee should be a neutral mediator/facilitator; and

5) That DHFS include in its 2005-07 budget submission a request for $10,000 annually to support travel and other advisory committee expenses.

RESOLUTION

Regarding Creation of a Committee on Special Needs

Whereas the Wisconsin Council on Long Term Care Reform recognized the need for improved understanding of the demand for care of special populations, such as those with significant behavioral challenges, in its charge to the Residential Options Task Force; and

Whereas the Residential Options Task Force believes there is a significant need to improve long term residential options for people with behavioral challenges and/or complex medical needs; and

Whereas the Residential Options Task Force has identified a number of potential special needs populations, including people with behavior issues related to dementia or other organic brain damage, older people with non-dementia related psychiatric disorders, younger people with severe developmental disabilities, medically fragile children, people on ventilators, people who are dually diagnosed with developmental disabilities and mental health needs, and people with serious mental illness who have exhausted other community options; and

Whereas the Residential Options Task Force has identified a number of general strategies for addressing the needs of special populations but lacks sufficient time, data or expertise to develop detailed recommendations appropriate for the various sub-populations; therefore be it

Resolved, That the Residential Options Task Force recommends that the Wisconsin Council on Long Term Care Reform:

1. Establish a Committee on Special Needs, in consultation with the Co-chairs of the Residential Options Task Force; and

2. Convey the recommendations contained in Appendix D of the *Report of the Residential Options Task Force* to the Committee on Special Needs for its consideration.

APPENDIX C

Recommendations for the Committee on Direct Care Workforce
from the
Residential Options Task Force
9-17-04

1. The Residential Options Task Force supports development of a quality caregiver initiative that involves DHFS working in collaboration with the technical colleges and other agencies.

2. Wisconsin needs education and training programs that are specifically designed for people who work in long term care. Wisconsin's technical college and other training programs are primarily intended for CNAs, LPNs and RNs who work in acute care settings and are oriented to a medical model of care. Training for staff who work in residential care settings is also needed.

3. Strategies are needed to promote a sense of value for the work that caregivers provide in long term care settings.

4. Workforce solutions should also address the lack of access to geriatricians and geriatric psychiatrists. Wisconsin's medical system is inadequately prepared to deal with long term care needs.

APPENDIX D

Recommendations for the Committee on Special Needs
from the
Residential Options Task Force
11-19-04

1. Ensure that the functional screen is sensitive to special care needs. Use the screen to identify special needs populations and to help identify appropriate settings.
2. Mandate that DHFS develop a state/local plan to meet identified needs for improving service to special populations and monitor progress toward implementation.
3. DHFS should develop quality standards for specialty care facilities and services. These might involve certification as opposed to regulatory standards.
4. DHFS should identify and promote best practices, where available, for serving special needs populations.
5. DHFS should ensure that people with special care needs have a choice of residential providers by working with counties and service provider organizations to encourage development of a variety of settings designed to fill identified gaps in residential options for people with special care needs, including:

    a. Creative, non-traditional settings to expand options for people to live in environments that provide support while being less costly and less confining than traditional regulated settings
    b. Regional special care services and settings
    c. Special care units within a larger care setting, to benefit from economies of scale
    d. Small facilities for children and non-elderly adults who are medically fragile or need very intensive care, where cost-effective

6. Resources should be provided to help special needs populations succeed in a variety of long term care environments, including:

    a. Support for both families and facility staff
    b. Crisis intervention
    c. Assistance with the transition back to a more "normal" residential environment
    d. Training for families in how to care for their family member with special needs.

7. Provide highly skilled and experienced case managers for people with special needs.
8. The State should provide reimbursement incentives to existing and potential new providers for serving special care populations.
9. Re-examine how regional facilities should be funded.