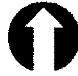
☞ **05hr_SSC-HCR_Misc_pt41b**



☞ Details: Department of Health and Family Services Update and Long Term Care. Hearing held in Madison, Wisconsin on October 17, 2006.

(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)

Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • www.wahsa.org

September 8, 2006

Mr. Fredi Bove, Director
Office of Strategic Finance
Dept. of Health and Family Services
P.O. Box 7850
Madison, WI 53707-7850

Dear Ms. Bove:

I am writing to request information on nursing home relocations and the Medicaid budget.

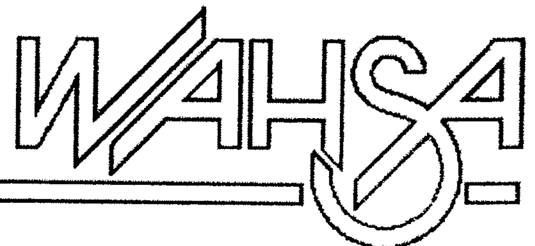
Recently, WAHSA conducted several regional meetings with its nursing facility members to discuss the impact of the Governor's nursing home relocation program and the Family Care program on facilities' census and discharges. Members indicated that these initiatives reportedly have had little, if any, impact on their resident populations or well established discharge patterns. That is, the number of residents being discharged, typically after a rehabilitative or restorative stay, does not appear to being increasing due to the relocation program or Family Care.

To help assess whether a greater number of relocations are occurring under these programs, I request that you provide us with the following information:

1. The number of nursing home residents annually discharged from non-ICF-MR nursing facilities since 1999-2000. Specifically, please provide the number of Medicaid fee-for-service funded nursing home residents who were relocated to the community <u>and</u> then funded under Medicaid (MA, PACE, Partnership, Family Care, and/or waivers). Based on our members' feedback, I suspect some of the relocated residents were <u>eligible</u> for Medicaid but MA's liability was either zero or was limited to the Medicare coinsurance. Our intent is to review the number of nursing home residents annually relocated pre- and post-implementation of the community relocation initiative.

2. Please provide the above data for the Family Care Counties and Non-Family Care (aggregated) Counties.

3. Please provide a summary of the GPR and FED funds that were transferred/allocated from the Medicaid nursing home budget to the relocation budget. Please provide the same information for the ICF-MR relocation initiative.



4. In order for DHFS to sustain the budget savings for the nursing home relocation program, it would appear that relocation savings would need to be continued in subsequent years. Does DHFS intend to continue the relocation program in 2007-09 and, if so, what relocation targets are being considered for fiscal years 2008 and 2009?

5. How many Medicaid nursing home resident days were projected for 2005-06 and 2006-07? How do these projections compare to actual experience for fiscal year 2006 and year-to-date (i.e., projected days used in modeling the 2006-07 nursing home reimbursement formula)?

6. The most recent nursing home bed projections produced by Nachman Sharon suggest that under a mature managed care program with statewide implementation, the number of nursing home beds required to serve the MA population could be reduced by 54% over current capacity. Please provide a county-specific summary of the MA nursing home bed utilization for each of the five Family Care counties since that program became operational.

7. Under s 49.45(6v)(b), WI Stats, DHFS is required to submit to the Joint Committee on Finance a report that provides information on the utilization of nursing facility beds by MA recipients and a detailed projection of the likely balances, expenditures, encumbrances and carry over of currently appropriated amounts for such care and services. Please provide us with this report for 2005-06.

Thank you in advance for providing this information. Should you have any questions or need clarification regarding this request, please do not hesitate to give me a call.

Sincerely,

John Sauer
Executive Director

cc Sec. Helene Nelson
Kevin Hayden
Sinikka Santala

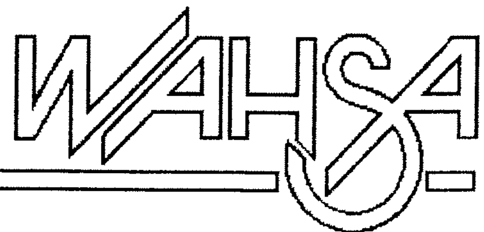
Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • www.wahsa.org

Long Term Care Reform: WAHSA's Blueprint for Change

1. Retain Nursing Facility Medicaid Base Funding
2. Future Role of Nursing Facilities
3. Increase Nursing Facility Capital Rates
4. "Floating Licenses" & Continuing Care Organizations
5. Private Pay Incentives
6. Divestment Loopholes
7. Bed Buyout and Debt Buy-Down
8. Private Partnerships/Facility Closures
9. Allow Non-County LTC Organizations to Manage Dollars
10. Pay for Quality
11. Eliminate CBRF Size Restrictions
12. Pass-Through for Educational Advancement
13. Regionalization and Augmentation of MA Rates (Supplementation)
14. Chapter 50 Revisions
15. Reorganize and Rename BQA
16. Nursing Facility Respite Care and Crisis Intervention
17. Streamline Case Management
18. Integrate Acute/Primary and LTC
19. Liability Insurance Issues
20. Regional Dental Centers
21. Specialized Equipment & Supplies Grants
22. Technology and Service Delivery Innovation
23. Medicaid RCAC Room and Board Funding
24. Funding Coordination

June 2004



A Caring Commitment...Dedicated to Excellence

Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • www.wahsa.org

Long Term Care Reform: WAHSA's Blueprint for Change

This document has been prepared in response to a request by Secretary Helene Nelson, Department of Health and Family Services, for WAHSA's ideas on how to achieve long term care reforms over the next five years. It focuses primarily on ways to implement a more rational nursing facility policy, recognizing the realities of continued facility "rightsizing" and the need for more immediate LTC reform. The proposals summarized in this document are largely excerpts from other WAHSA LTC reform documents previously submitted to DHFS and state legislators. The following summarizes the proposals and does not attempt to furnish the reader with the full implementation details associated with each. Instead, this document is intended to facilitate a meaningful and structured dialogue with DHFS, legislators and other parties on how to achieve substantive LTC reforms.

- **Retain Nursing Facility Medicaid Base Funding:** When a nursing facility is closed or elects to downsize (or "rightsize") the Medicaid dollars appropriated for these nursing facilities are not always retained in the Medicaid budget to fund nursing facility care. For example, the pending closures of Kilbourn Care Center and Highland Health Care Center will result in some loss of Medicaid base funding for nursing facilities. WAHSA proposes that nursing facility "savings" be reinvested in nursing facility payments (see below). To do otherwise simply perpetuates the nursing facility funding crisis. At a time when nursing facilities are suffering from unprecedented losses and operational challenges, Medicaid nursing facility funding can no longer be asked to subsidize other elements of the Medicaid program.

WAHSA also proposes that DHFS be authorized to maintain base-level funding for nursing homes. Under this proposal, for Medicaid budgeting purposes, any positive difference between the current year Medicaid base funding for nursing homes and a reestimated nursing home Medicaid base would be invested in nursing home improvement (e.g., rate increases, private room incentives, buyouts, rightsizing, etc.,--See proposals below.) Section 49.45(6v), Wis. Stats., would need to be revised to retain base level funding for nursing homes.

- **Future Role of Nursing Facilities:** WAHSA urges the DHFS to develop long term care policies that recognize the appropriate role of nursing facilities within the care and service delivery continuum. Persons will continue to utilize nursing homes, and to some extent ICFs-MR, for restorative and rehabilitative services, end-of-life care, chronic health care, dementia care, behavioral interventions, mental health services, respite care, developmental disability services. This means that state policies should not create unnecessary barriers for persons to access the care and service options offered by nursing facilities and ICFs-MR. For example, any preadmission screening or case management requirements should not cause delays or restrict access to necessary care/service options (Note: nearly 80% of all nursing home admissions are from hospitals). Advocacy efforts to expand long term care and service options, long supported by WAHSA and its members, should not utilize anti-nursing facility rhetoric. Instead, the DHFS and the provider community should work together to achieve a healthy, affordable and ethical system.

- **Increase Nursing Facility Capital Rates:** Since nearly two-thirds of all nursing facility residents are on Medicaid, the DHFS should help nursing facilities modernize their physical environments. If Medicaid dollars are not available to help fund this transition from 1960s-designed care settings, it is unreasonable to expect facilities (i.e., private payers) to totally assume this financial burden. WAHSA suggests that the DHFS adopt Medicaid reimbursement policies that would:

    1. Freeze a nursing facility's equalized value at its current level if the facility agrees to convert at least 25% of its licensed beds to private rooms.

2. Increase the maximum equalized value to $99,000 per bed for replacement facilities to establish the necessary incentive for organizations to invest in more efficient and consumer-preferred facilities. WAHSA also requests the DHFS to examine ways to reward those facilities that already have converted to private rooms and/or self-financed replacement or major renovation projects.
3. Allow any facility operating savings generated by physical plant update or replacement projects to be retained by the facility.

- **"Floating Licenses" & Continuing Care Organizations:** WAHSA encourages the DHFS to study options under which nursing facilities could be granted "floating licenses." WAHSA acknowledges the federal regulatory barriers to this proposal. However, federal officials have challenged States to become more innovative and visionary in advancing long term care reforms and we believe that these officials would be receptive to this proposal. As envisioned, facilities could provide SNF, RCAC or CBRF services; if a nursing facility resident no longer needed SNF level of care but would prefer to remain at that facility, the license for that particular resident's room should be allowed to "float" to a CBRF or a RCAC license if the room meets the respective physical plant requirements. The public payment rate for an eligible resident would shift correspondingly from SNF care to the lower MA waiver rate. This option, when appropriate and agreed to by the organization, ultimately could lead to the facility's partial conversion/renovation to CBRF/RCAC licensure. The facility should be allowed to retain overall capital payments for the nursing facility even during the "float periods" (See options below). Because not all nursing facilities will have beds available to "float" and still meet their community's skilled care needs, the long term care organization should be authorized to opt in or out of this program option.

- **Private Pay Incentives:** The States of Oregon and Washington are merely two examples of states with budget problems associated with long term care policies that predominantly rely on a publicly-funded system. Recent cutbacks in those states highlight the fiscal pressures caused by broadly defined, entitlement-based long term care systems. The National Conference of State Legislatures' (NCSL) summary of recent budget battles in Oregon is particularly worth noting. The NCSL indicates that Oregon has intensified its focus on promoting personal

responsibility for long term care and personal planning emphasis (See Attachment I). DHFS should shift its LTC reform discussions to place significantly greater emphasis on attracting greater private investment in and payment for long term care services. DHFS should explore strategies to increase the use of medical/LTC savings accounts, reverse mortgages, Roth-type IRAs for LTC and other ways to promote personal responsibility for LTC. As a matter of policy, it is much more preferable to encourage private payment for LTC than to impose strict estate recovery/anti-divestment requirements (See below). Wisconsin officials should aggressively seek Congressional approval of H.R. 1406 which would create long term care partnerships under which individuals who first exhaust coverage of under a state qualified long term care insurance plan may shelter some or all of their assets while qualifying for Medicaid. This program has been implemented with reported success in California, Connecticut, Indiana, and New York. In addition, more private pay dollars could be brought into nursing homes if Medicaid residents were charged a higher rate for private rooms. Currently, Medicaid residents wishing to reside in a private room are charged the difference between a private pay semi-private room and a private pay private room rate. The administrative rule could be amended to allow facilities to charge Medicaid residents in private rooms an added fee. This fee for a Medicaid private room could be limited to no more than the difference between the Medicaid rate and the private pay rate for a private room. This added fee would be paid for either by the resident or their family/guardian.

- **Divestment Loopholes:** The DHFS should advance statutory language to close widely utilized Medicaid divestment strategies (See State of Minnesota's Medicaid proposal submitted to the Centers for Medicare and Medicaid Services). As a matter of policy, it is imperative that these revisions be passed prior to establishing/broadening entitlement for Medicaid-covered LTC options.

- **Bed Buyout and Debt Buy-Down:** The DHFS should use Medicaid savings to buy-out nursing facility beds and/or to reduce nursing facility operating debt. Under the "Buyout" option, DHFS could pay facilities to close or to significantly reduce their licensed bed capacity. By doing this, DHFS could offer meaningful incentives for certain facilities to create more

private resident rooms, while other facilities could be given an affordable exit strategy (i.e., The DHFS also could purchase 100% of a facility's licensed bed capacity) if the facility determines that it is unlikely to have long term financial viability and its service area does not have a bed shortage. These option were first identified in the DHFS' September 18, 1995 LTC concept paper. A variation of these options would be for DHFS to "Buy-down" a facility's operating debt. By doing so, the DHFS could target those facilities with significant capital debt and no real hope of generating the Medicaid funding needed to make their current mortgages affordable. In exchange for debt buy-down, the facility would agree to reduce its bed capacity. Before these options are implemented, it is strongly recommended that the DHFS complete an analysis of nursing home access, utilization and bed availability by region. The State of Minnesota recently completed such an analysis (See Appendix II).

- **Private Partnerships/Facility Closures:** More nursing facility closures are expected over the next several months. In some cases where the DHFS has determined that quality and financial concerns likely will drive closure of a facility, the Department should consider partnerships with private LTC organizations to take over struggling facilities. When the DHFS determines that closure is imminent, private organizations could be offered the following incentives to help manage the resident relocations and related operational expenses {Note: This proposal is not directed at facilities that, while struggling to overcome Medicaid underfunding, are expected to continue operating.}:

    1. A phase-down agreement to ensure that the troubled facility could be operated safely and without incurring additional losses (WAHSA assumes that private LTC organizations could oversee and close a facility more cost-effectively than placing the facility under state receivership and having DHFS manage the closure).

    2. The private LTC organization would not be responsible for any previously issued state regulatory fines/forfeitures issued to the troubled facility.

    3. The licensed beds from the troubled facility would be transferred to the private LTC organization's nursing facility.

4. The LTC organization would be free to use these additional beds in various ways, including: building a new replacement facility, negotiating a phase-down agreement for its nursing facility, or receiving Medicaid waiver funding for assisted living from DHFS. Under one scenario envisioned by WAHSA, the LTC organization's nursing facility could return the beds to DHFS and, under a phase-down agreement, convert its existing nursing facility's semi-private rooms to private rooms and receive an adequate capital rate to fund this conversion.

- **Allow Non-County LTC Organizations to Manage Dollars:** Private entities offering a menu of continuing care options should be permitted to manage publicly funded LTC dollars as a way to appropriately and cost-effectively transition MA clients from high to lower cost care settings. WAHSA has proposed that the DHFS Life Lease legislation (AB 920) be modified to include this option. In addition to counties being able to manage the relocations and associated dollars, other private entities (e.g., not-for-profit LTC organizations offering an array of facility and community-based options)) should be authorized under AB 920 to manage the relocations. These entities should be provided the option of directly managing the relocation and costs for persons wishing to receive services from the LTC organization but outside the organization's nursing facility. {Consider this scenario: A LTC organization may be able to appropriately care for an Alzheimer's nursing home resident in its CBRF dementia program. The resident and her guardian have a well-established positive relationship with the organization and many of its staff. The guardian does not want the resident to be cared for by any other entity and, while pleased with the quality of care and services provided by the organization's nursing facility, is willing to consider relocation <u>only</u> to the organization's CBRF. Under this proposal, the organization could work with the guardian to secure this alternative placement, a placement that would not have been possible if the relocation receiving care/services from another provider.} WAHSA also envisions that similar options could be developed for ICFs-MR to manage care and services for persons with a developmental disability. Additionally, state policies should not create barriers for the establishment of LTC options within continuing care organizations. For example, there should be no restrictions for COP and waiver funding for adult day care or residential options co-located on the campus which includes a nursing facility.

- **Pay for Quality:** DHFS should work with the provider community to investigate strategies to more directly and effectively link payment to quality. WAHSA suggests that the DHFS explore options that increase payments to facilities with: nursing staffing levels in excess of 3.3 hours/resident day (excluding pool help); low staffing turnover or high retention rates; low or no pool help; a high proportion of private resident rooms; and high performance measures (e.g., lower utilization of restraints compared to the national average, or high level of customer satisfaction). Facilities with higher quality could be surveyed less frequently but at least every 15 months, as required under federal law. WAHSA acknowledges that linking payment to quality in long term care presents a series of analytical and systems challenges. Therefore, the association pledges to work in partnership with the DHFS and the University of Wisconsin to accomplish this important work.

- **Eliminate CBRF Size Restrictions:** The DHFS-imposed restrictions {under ss.46.27 (7)(cm), 46.27 (11)(b)6, and 46.277(4)(d)2)} limiting the size of CBRFs as a condition of receiving COP or Medicaid waiver funding should be eliminated. These size limitations should give way to consumer choice and an appropriate recognition of the economies of scale of larger facilities. While some policymakers may prefer the smaller facilities, many consumers actually prefer the community aspects of somewhat larger facilities and the amenities offered by campus-based LTC organizations. Further, the LTC workforce shortage and elderly demographics will challenge LTC delivery models that do not rely on staff serving multiple clients at a single location.

- **Pass-Through for Educational Advancement:** The Medicaid nursing facility reimbursement formula should fully fund LTC career ladders. For example, Medicaid could pay the tuition fees for CNAs to become LPNs or RNs, for LPNs wishing to pursue their RN degree and for RNs to pursue an advanced practice degree, providing these individuals continue to work in LTC. Under this arrangement, federal Medicaid funds would finance 60% of the tuition costs, and Wisconsin would benefit by addressing the well-documented nursing shortage.

Funding and cost-reporting associated with this option should be provided under a separate, cost-based cost center within the nursing home reimbursement formula.

- **Regionalization and Augmentation of MA Rates (Supplementation):** While years of discussions have been held on options to recognize and support regional specialized care/services, to date no state policies have been advanced to formally embrace this concept. Examples of a specialized regional facility would be Trempealeau County Health Care Center and Clark County Health Care Center. To help establish and sustain regional centers, the DHFS should advance, authorize/approve supplementation of Medicaid payments (either by other counties or by the Medicaid program). This could be done by linking Medicaid or county supplemental payments to room and board, non-covered services, or for "bed/service reserve fees." Further, the Medicaid payment system could include an add-on for specialized services in designated care/service facilities.

- **Chapter 50 Revisions:** The DHFS should work to pass 2003 Assembly Bill 842 in the next session of the legislature (or perhaps include this bill in its 2005-07 biennial budget recommendations) and work with provider groups to explore "fit and qualified" provisions. Financially penalizing facilities only serves to further push those facilities towards bankruptcy and does nothing to increase the quality of care and services provided to residents.

- **Reorganize and Rename BQA:** This Bureau should be renamed the Bureau of Quality Improvement-- BQI-- and should be reorganized to better utilize its Provider Regulation & Quality Improvement Section (PRQI). By name ***and*** function, the BQI should adopt a philosophy that the imposition of fines and financial penalties on providers is indicative of failure on the part of the provider ***and*** the regulators. The PRQI staff should advise facilities on how to achieve regulatory compliance and share best practices from other providers.

- **Nursing Facility Respite Care and Crisis Intervention:** The DHFS should encourage nursing facilities to provide short-term respite care for a period not to exceed 13 days. During this time, nursing facilities should be paid by Medicaid to provide respite care

including an evaluation of the client's physical and mental well-being. Respite residents should not be included in the standard nursing facility survey process unless the survey was complaint generated. Similar regulatory polices should be adopted to foster the use of nursing facilities as providers of short-term admissions for crisis intervention services for persons with serious mental health and behavioral challenges. The ICFs-MR also should be viewed by DHFS as available to provide crisis intervention and respite care for persons with a developmental disability.

- **Streamline Case Management:** Family Care enrollees who reside in a nursing facility or assisted living facility are assigned a case manager by the county's care management organization. In some instances, the county case manager performs a redundant service and residents are required to undergo a second battery of assessment questions and procedures. The resident often finds this process both confusing and exhausting. Family Care architects should eliminate redundant assessment and monitoring processes. WAHSA proposes that assessments and case management services for nursing facility residents should be provided by the nursing facility. If the county CMO requests additional assessment and case management services beyond the level typically provided by the nursing facility to non-Family Care residents, the CMO should reimburse the facility for the added costs of these services. Provisions which limit CMO nursing facility reimbursement rates to a facility's Medicaid rate should be amended to require the CMO to establish payments at a level no lower than a facility's Medicaid rate. CMO payments to nursing facilities should be negotiated by the entities and CMO should be authorized to pay facilities for services not included in the Medicaid rate.

- **Integrate Acute/Primary and LTC:** WAHSA urges the DHFS to pursue LTC pilot reforms that integrate acute, primary and long term care. Nursing facilities have proven to offer cost-effective options and reduce both the incidence and cost of hospitalizations (see the Evercare Choice Model at: **www.evercareonline.com/products/choice.html** and also WAHSA's 1997 LTC Visions paper at: **www.wahsa.org/ltc.htm**) Nursing facilities may cost more than home and community-based care, but the research also notes that there are vast differences between these resident-client populations (see CHSRA's October 31, 2003 study).

- **Liability Insurance Issues:** The DHFS and OCI should propose liability caps as a way to lower liability insurance coverage for LTC providers. The cost of liability insurance has skyrocketed in recent years and threatens the future viability of many facility and community-based providers.

- **Regional Dental Centers:** Given the well-documented lack of available dental care for Medicaid clients throughout Wisconsin, the DHFS should authorize the establishment of regional dental centers in or on the campus of LTC organizations. Medicaid could fund a FTE dentist and this practitioner could serve persons from within the organization and the greater community. The LTC organization would be responsible for providing the dental office and related space for the center.

- **Specialized Equipment & Supplies Grants:** As a way to encourage facilities to serve high-cost, specialized populations, the DHFS should offer one-time grants to facilities for the purchase of related equipment or supplies. For example, grants could be used to purchase specialized mattresses, mechanical lifts that accommodate obese residents, or high-cost medical supplies.

- **Technology and Service Delivery Innovation:** The DHFS should review and amend its nursing facility, CBRF and RCAC regulations to allow and promote the use of innovative service and delivery technology. For example, if a regulation requires a physician visit or an RN assessment, when appropriate, this requirement could be met using remote telemedicine technology.

- **Medicaid RCAC Room and Board Funding:** The DHFS should amend its MA waiver to enable funding for room and board in RCACs rather than restricting reimbursement to care/services. This option would help create more affordable RCAC placements by capturing federal Medicaid matching funds.

- **Funding Coordination:** The DHFS should become the lead agency responsible for coordinating the federal and state funding available for seniors, including HUD, food stamps, Medicaid, and drug discounts/cards/purchasing.

WAHSA
June 2004 /11

Attachment I

OREGON

The top issue for long-term care programs and services in Oregon in 2002 and 2003 was lack of funding as the state grappled with major budget deficits. Still, work continued on developing long-range plans for future services for senior citizens and people with disabilities through the efforts of a task force created in 2001.

The Budget

Oregon voters failed to approve a January 2003 ballot measure that proposed a state income-tax increase to eliminate the state's $482 million deficit. The 2002 legislature had directed the termination of a self-directed support services home and community-based waiver program for people with developmental disabilities if the referendum did not pass. The program was created to respond to the settlement of the *Staley vs. Kitzhaber* lawsuit in December 2000, which called for the state to increase funding for community services for people with developmental disabilities through 2007. The number of people receiving support services was to increase by 4,600 during the agreement's six-year period. In August 2002, the Oregon Advocacy Center warned the state that it would return to court if budget cutbacks caused the state to backtrack on the settlement of the lawsuit.

After the referendum failed, however, the legislature rebalanced the budget in a bill signed by the governor on March 4. That bill restored some of the funds cut or planned to be cut by the Department of Human Services (DHS) through the end of fiscal year 2003. The legislature restored $7.4 million of $11.9 million in planned cuts for the *Staley* settlement. DHS had frozen enrollments on February 1, 2003. Department officials said they anticipated being able to keep the program open through the end of the biennium (June 30) by limiting the growth of new enrollments. In early March, they said they were in negotiations with the *Staley* plaintiffs " ... on possible revisions to the agreement due to the budget crisis."

The outlook for long-term care services remained bleak, however, as budget shortfalls for FY 2003-2005 continued to threaten many programs and services. DHS estimated that major reductions in the governor's proposed budget to programs for people with developmental disabilities included " ... eliminating all non-residential services, impacting 5,500 people who were covered by the *Staley* settlement agreement." The proposed budget also eliminated cost of living adjustments for all long-term care providers, reducing provider reimbursement rates for nursing homes and assisted living facilities, and eliminating the Oregon Project Independence Program.

Planning and Reports

The Governor's Task Force on the Future of Services to Seniors and People with Disabilities, which had been created by executive order on June 30, 2001, issued an initial report in September 2002. The task force was

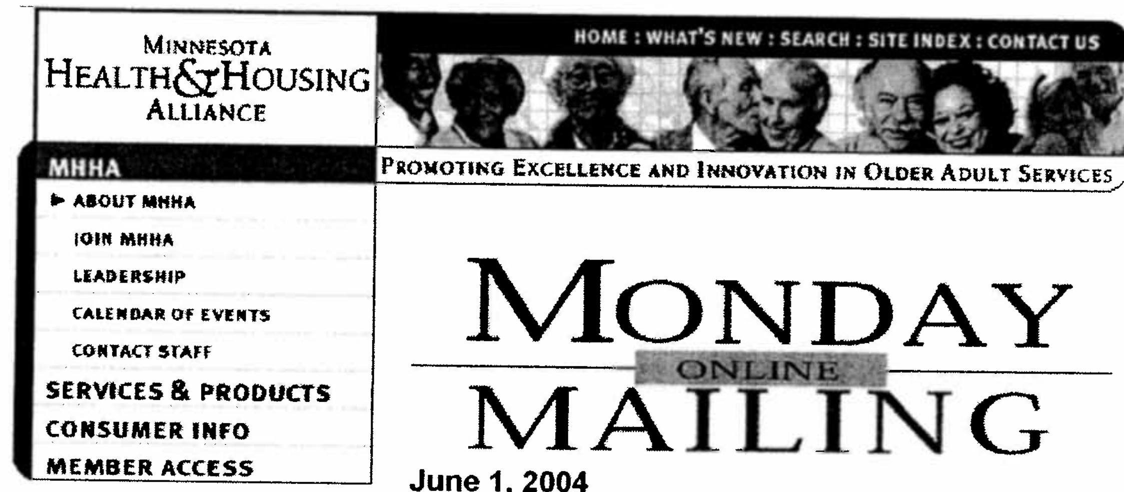
charged with developing a long-range plan on the future of services to senior citizens and people with disabilities and recommending legislative action and levels of funds needed to implement the plan. ***The task force said all Oregonians, regardless of their incomes, needed to begin taking " ... personal responsibility for making healthy behavior choices and for planning and preparing for ... possible long-term care needs." (Emphasis Added)*** The group identified eight overarching recommendations that required attention and implementation within the next year. The following were among the recommendations.

- Developing measures to determine whether services in various settings achieve outcomes, promote quality of life and are cost-effective.
- Encouraging personal responsibility by educating Oregonians about the need to engage in healthy lifestyles and planning for future long-term needs.
- Providing information and education on long-term care needs, services and planning, including conducting a public action campaign and expanding education of consumers and families about various long-term care options.
- Increasing system capacity by developing the long-term care work force and providing family caregiver supports.
- Maintaining a safety net for those who cannot afford to pay for their care.

Source: http://www.ncsl.org/programs/health/forum/ltc/ltcor.htm

2004

Attachment II



June 1, 2004

DHS Releases Rebalancing Long-Term Care Report

Progress Has Been Made But Legislators Told Additional Work is Needed

Last Thursday, the Department of Human Services released a report to the Minnesota Legislature titled "Status of Long-Term Care in Minnesota 2003." The report contains information previously gathered for two separate reports: (1) The bed distribution study for nursing facilities; and (2) The gaps analysis for home and community-based services. The report includes demographic trends, estimates of the need for long-term care, and the status of home and community-based services across the state. The following is a summary of the key findings included in the report. To access the complete study, go to Hot Topics on the MHHA Web site.

Demographic Trends & Need for Long-Term Care

- **The highest growth rate is occurring within Minnesota's population over 85. This group is expected to grow 25 percent in the next 10 years.**
- **Demographic changes will also reduce the number of family members and workers available to provide care at the very time when the need for long-term care will be at an all-time high.**
- **While age-specific disability rates have declined by 1 percent or more per year for the past several decades, the number of elderly needing long-term care will continue to rise due to the large increases in the overall numbers of elderly.**
- **The most recent National Long-Term Care Survey completed by the National Center for Health Statistics found that 15.6 percent of the 65+ population needs community-based long-term care while 4.2 percent need skilled services.**

Informal Home & Community-Based Services

- **Since 1988, the percent of care provided informally by family members dropped from 97 percent to 91 percent in 2001. During the same time period, the proportion of older Minnesotans that purchased services increased 16 percent.**

- **Additional help is secured through volunteer-based programs to supplement what is provided informally through family or through purchased services. It is estimated that there are now between 500 and 700 volunteer based programs (such as Red Cross, Block Nurse or church affiliated programs) operating in communities throughout Minnesota.**

- **In 2003, nearly 240,000 Minnesotans over age 60 were served by programs provided through the Area Agencies on Aging using federal Older Americans Act funds i.e. senior nutrition, transportation, chore, or respite services.**

Gaps Analysis

- **93 percent of counties reported that there were more home and community care options in their county in 2003 than in 2001 (the first year the Gaps Analysis was conducted). 60 percent of counties described their supply of H&CBS as "adequate."**

- **Transportation services remain the biggest gap despite a decrease in the percentage of counties reporting it as a critical service gap from 66 percent in 2001 to 42 percent in 2003.**

Community Service/Service Development Grants

- **Since 2001, about $8.6 million in grant funds have been awarded to nearly 200 projects in 46 counties.**

- **The projects have expanded services to nearly 20,000 older persons in Minnesota.**

Publicly Funded Home & Community-Based Services

- **In the past three years, the number of persons 65+ served through the EW, AC and MA home care programs has increased 25 percent from 23,000 to nearly 30,000 Minnesotans.**

- **The expenditures for H&CBS have increased 50 percent—from $130 million to nearly $200 million during the same period.**

- **The state's February 2004 forecast for elderly long-term care estimates that H&CBS will increase from 19,000 persons served monthly in 2000 to 27,000 in 2007. At the same time, demand for nursing home care will continue to decline from 25,000 persons served monthly in 2000 to 22,000 in 2007.**

Impact of 2003 Legislative Changes to Alternative Care Program

The 2003 Legislature enacted major policy changes in the AC program including tightening eligibility criteria, expanding monthly fees, and imposing state recovery provisions (liens), in an effort to reduce program expenditures. As a result, the number of clients on the AC program dropped from 7,100 in June 2003 to 5,900 in December 2003. About 10 percent have moved to a nursing home.

Senior Housing

There are an estimated 80,000 units of senior housing in Minnesota and 9,500 board and care/adult foster care units. About 50 percent of the 80,000 units are considered assisted living.

In 2001, 50 counties identified affordable senior housing as the biggest gap followed by adult foster care, assisted living and market rate rental. In 2003, 27 counties reported subsidized or affordable housing developments, 17 reported creation of adult foster care, and 16 reported development of assisted living.

Assisted Living

- There are now 907 assisted living residences registered in Minnesota, comprised of 40,086 units serving an estimated 35,000 seniors.

- The number of residences doubled (426 to 907) between 1997 and 2004 and the number of available units tripled (13,000 to 40,086).

- By comparison, there are 432 nursing facilities with 39,530 beds. This marks the first time that Minnesota has had more assisted living residences and units than nursing homes and nursing home beds.

- The number of EW and AC clients receiving "congregate residential care" (assisted living) has grown from 4,285 clients in 2000 to 7,403 in 2003 – a 73 percent increase.

Nursing Homes

- The number of nursing home beds peaked in 1987 at 48,307 beds and as of Sept. 30, 2003, the number of beds had decreased to 39,530 -- an 18 percent reduction.

- The number of beds per 1000 for the 65+ age group dropped from 83.9 in 1993 to 65.7 in 2002. During the same period the beds per 1,000 for the 85+ age group dropped from 643.2 to 431.4 (which is below the national average). In 1998 Minnesota had the fifth highest ratios in the country, by 2002 the state had dropped to the 10th highest.

- In 1984, the utilization rate was 8.4 percent. By 2002 it declined to 5.5 percent -- a 52 percent drop.

Publicly Funded Nursing Home Care

- The average daily cost of a nursing home in Minnesota is now $136.14 or $49,691 annually.

- Expenditures for nursing home care in the MA program were nearly $1 billion in 2003 or 20 percent of the total MA budget.

- MA expenditures for nursing home care grew from $900 million in 2001 to $973 million in 2003 despite serving 3,246 fewer seniors.

Projections

- The state must address whether it has an adequate supply of nursing home beds for the foreseeable future or if additional beds will be needed; therefore, DHS made projections based upon both historic changes in the number of beds and utilization of nursing home services.

- The projections based on nursing home utilization are likely to be a better barometer of future demand than changes in the number of beds.

- In previous analyses of bed need (1999 and 2001), the three-year trend line showed the steepest decline in the number of beds needed. The three-year trend line based on utilization is the first time that it suggests an eventual increase in bed need.

- Given the volatility of the three-year trend line, DHS recommends watching this and seeing if the trend persists.

- At this time no strategies to encourage further bed closures are being actively pursued by DHS.

Long-Term Care Benchmarks

- **Benchmark #1: Percent of public long-term care dollars spent on institutional vs. community care for persons 65+**
- **Benchmark #2: Percent of nursing home residents 65+ that are case mix A**
- **Benchmark #3: Percent of EW/AC recipients that are case mix B-K**
- **Benchmark #4: Ratio of nursing home beds per 1000 persons 65+**
- **Benchmark #5: Percent of EW/AC recipients in assisted living that are case mix B-K**

Progress on 2001 Long-Term Care Reforms

This analysis makes it clear that much progress has been made on the long-term care reform set in motion in 2001.

The five long-term care benchmarks all indicate that the measures are changing in the direction called for in the 2001 reform.

Key systems changes are being made that will support continued reform.

A number of future challenges exist including:

- **Developing consumer-and family-directed services;**
- **Managing chronic care;**
- **Expanding community capacity and infrastructure;**
- **Addressing technology needs and labor shortages;**
- **Addressing challenges in assisted living; and**
- **Reforming long-term care financing.**

The report acknowledges that since the reform efforts of 2001, the state has seen major budget deficits that have had an impact on the rate of progress toward achieving the state's "rebalancing" goals. It goes on to say, "It is unclear whether the rate of progress on reform efforts to date is adequate to prepare us for the upcoming challenges that the state will face as the baby boom generation begins to grow old and need long-term care." The report suggests "we may need to take bolder steps in the next two years in order to move forward more quickly as the retirement of the boomer generation draws closer."

Financing Aging Services

A Framework for America

Report of the AAHSA Financing Cabinet to the AAHSA House of Delegates
April 1, 2006
Presented by Tom Slemmer

Overview of Financing Cabinet

- Charge
- Composition
- Approach:
  - Principles
  - Research and analysis
- Key issues and options
- Recommendations
- Next steps

Finance Cabinet Members

Keith Perry-CHAIR	Al Loewenberg
Erwin Bodo	Todd Murch
David Gehm	Brian Schoeneck
Dan Holdhusen	Tim Steller
John Kaduce	Jodi Wasserstein
Jim Leich	Susan McDonough
Jo-Ann Costantino	Robert Olsen
Dan Heim	Dana Petrowsky
David Houle	Tom Slemmer
Brian Kaser	Doug Struyk
Dan Lindh	Scott Wynn

The Charge

In June 2004, the Cabinet convened with this charge for the next 2 years:

1. ...to provide a recommendation to the Board, after appropriate study regarding AAHSA's position with respect to a model for financing LTC
2. ... to provide guidance to AAHSA staff on more immediate issues

What principles should guide a new Financing system?

Brainstorming

Ideal Characteristics:

- "promotes and supports informal care-givers"
- "provides equitable benefits"; "promotes consumer choice"
- "promotes quality"; "promotes consumer-defined quality"
- "promotes access to technology and its integration into the continuum of care"
- "integrates medical & social model"
- "promotes/rewards innovation, efficiency, & competition"
- "provides a safety net for those without resources"
- "promotes financial responsibility—personal & for nation"
- "stable operating environment for providers"

Approach

- Reworked, reviewed initial list as deliberations proceeded
- Considered results from 2004 House of Delegates Survey of Principles and Values
- Boiled down to three core principles...

Core Principles

A new financing system should include:

1. Consumer choice
2. Financial responsibility
3. Equitable availability

Note that these sometimes compete

Core Principles

A new financing system should include:

1. Consumer choice: *Promote consumer choice in quality and service*
2. Financial responsibility: *Promote personal financial responsibility and stewardship of provider and public resources*
3. Equitable availability: *Promote equitable availability of its benefits*

Research & Analysis

Review of American system:

- Extensive literature review-considered "right" and "left" proposals,
  - pros & cons;
  - detailed review of selected state analyses and proposals (e.g., Hawaii, and Minnesota);
  - considered AHCA "LIFE" proposal (encourage private LTC insurance & federalize Medicaid)
- Expert testimony,
  - Drs. William Scanlon, Judith Feder, and Robert Friedland;
  - Met Life Insurance representative;
  - Lisa Alexich (the Lewin computer model);
  - selected Congressional staff

Research & Analysis

Review of International systems:

- Literature review
- Expert testimony:
  - Mary Jo Gibson (overview of international systems from AARP research);
  - World Bank;
  - CEO of large non profit system from Germany;
  - representatives from provider & insurance systems in Netherlands;
  - obtained preview results of computer simulation—financial effect of "German-like" system in US

The Challenge

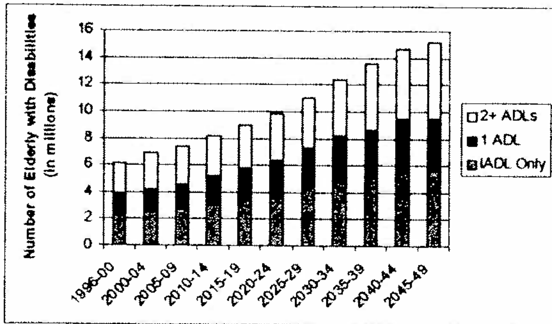
- People who need LTC will double by mid century
- Welfare model not working
- Medicaid is absolutely unsustainable
- Where will the resources come from ?

The Challenge

People who need LTC will double

- There is a large and growing number of people who need LTC: 10 million today (4 million under age 65)
- Demand projected to more than double by mid century

Projected Number of Elderly with Disabilities More than Doubles



Decline in disability rates has less effect than growth in numbers of elderly

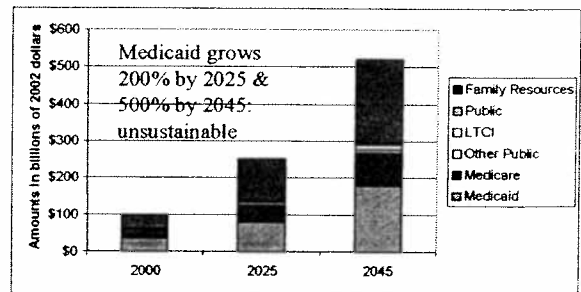
The Challenge

- Welfare model not working
  - Current financing relies on a "welfare model" with Medicaid already overburdened; families & friends provide extensive help—burden can be overwhelming;
  - Research shows critical unmet needs (lack of needed aid in eating & toileting) among those in the community
  - Individuals must be impoverished before eligible (e.g., rules to protect community spouse when other is in NF still require spend down to income no more than 150% poverty level & assets under $100,000; states not required to protect community spouse for HCBS Medicaid eligibility; divorce an unattractive alternative)

The Challenge

- Medicaid is absolutely unsustainable!
- The increasing burden on Medicaid is unsustainable—but the need for financing from other than personal/family savings increases dramatically over the next several decades

Expenditures by Source of Financing

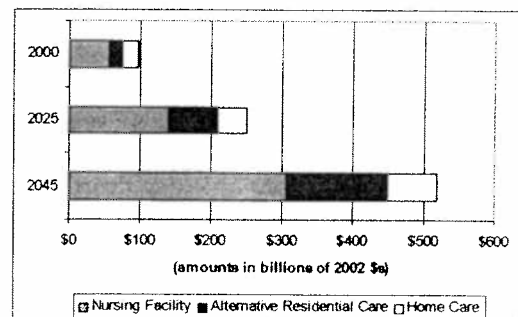


very sophisticated forcast: Lewin Model

The Challenge

- Where will the resources come from?
- More $$ will have to be spent in the future on LTC (due to sheer growth in need). Where will it come from?

Projected Expenditures: policy changes to divert more people to less expensive alternatives can marginally change picture –demographics & increasing labor costs overwhelm policy changes



We should move from a welfare model to an insurance model..experts all agree.

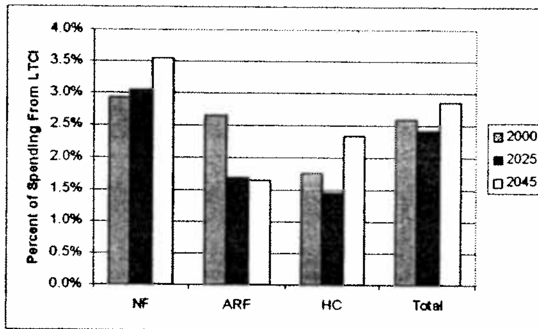
Why?

- LTC is an "insurable event"
- The risk for using LTC increases with age, but 40% of those needing LTC are under age 65
- Risk is relatively predicable in the aggregate, but not on an individual basis. For those turning 65 today: 31% will not use LTC; 17% will use less than 1 year; 20% need care for more than 5 years.
- Costs for those with lengthy and/or extensive needs are catastrophic

What kind of insurance? Public or Private ?

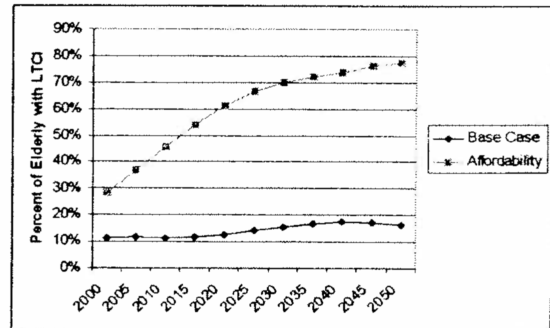
- Experts also agree that some mix of public & private insurance is optimal—what kind of mix is the issue
- After reviewing the evidence, the FC concluded that while private LTC insurance should remain an important component of a national strategy, a system that better insures more universal coverage (a larger risk pool; fewer falling through the cracks) is essential.
- Key analysis: the best computer model available shows that even with "best estimate" of growing LTCI purchase, the impact on Medicaid is minor.
  - Most experts agree tax incentives to purchase LTCI are costly & have a small effect on inducing new purchases. Even if draconian Medicaid policies induced more LTCI purchase, high cost relative to incomes and benefits, underwriting rules, and young people's distrust substantially limits purchase
  - **It takes near universal coverage with cheaper, better policies to substantially reduce Medicaid costs in the future.**

Projected Role of LTCI in Financing LTC: Lewin Model "best estimates"

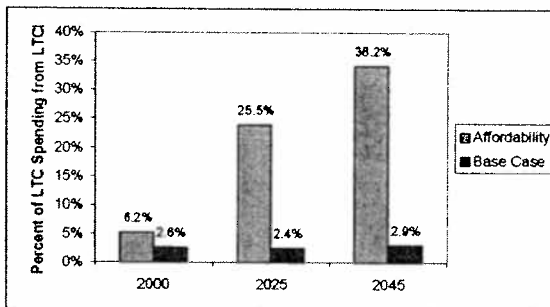


Why aren't we buying: too expensive given perceived risk; cost more than double what it could be; many can't meet underwriting standards; younger people who could buy cheaper worry about obsolescence & lack trust in insurance companies

What if everyone who could could "afford" private LTCI (<4% of elders' income; <2% income of others' income) actually bought it?

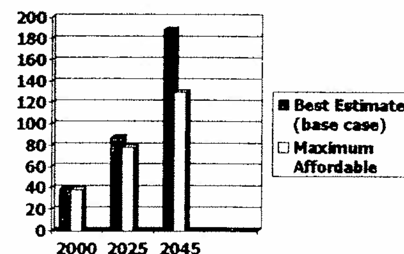


Assuming that everyone who possibly could afford private LTC insurance purchases the kinds of policies purchased today (e.g., many with limited inflation protection)



Conclusion: to get a substantial effect on Medicaid, need to have nearly universal purchase of less costly & better policies

If everyone who can "afford" private LTCI buys it, Medicaid costs still triple by 2045, but without that dramatic increase in proportion of the population covered, Medicaid costs increase 5-fold. [$Billions spent on Medicaid in 2005 dollars]



We need nearly universal coverage with better insurance: How do we get there?

- Tax strategies to encourage private LTC insurance purchase are costly and have limited effect, most researchers conclude
- Recently passed legislation to tighten asset transfer rules projected to have very small effect according to federal analysts:
  - Projected Medicaid NF costs for next 5 years = $328.9B
  - Savings from changing the penalty date = $ 1.4B
  - Savings from increasing look-back period = < $ 0.1B
- Even if draconian Medicaid policies lead to more purchase of private LTC insurance, unlikely to get anywhere close to near universal coverage with that strategy
  - How draconian? Research suggests would need to eliminate safety net completely to make private insurance at current costs & benefits a wise financial choice for most of the income distribution; substantially cutting the quality of Medicaid-financed NF care could also work, say researchers

FC's conclusion: we need to get as close to a mandate as politically feasible and this means a public insurance system for the foundation

If we need nearly everyone insured, why not mandate *private* long term care insurance?

- Competing private plans have high overhead costs, small risk pools, need for investor returns, hence higher premiums
- Hard to mandate a product that can't sell itself in the market
- Could (more likely) mandate public insurance; could also do auto-enrollment with voluntary opt-out option to get near universal participation, but
  - can't auto-enroll people in private plans with very different cost/benefits (unethical)
  - And if one tried to solve that problem by requiring all private plans to have an identical "basic plan" for auto-enrollees, what's the point of competition?
- Medicare D is experiment in competing private plans—FC concerned about consumer confusion

What kind of insurance?

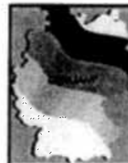
- Universal (or nearly so) public insurance as the foundation. Next question: Health care insurance or a disability model?
- LTC is more suited to a disability insurance model
  - Cash vs. payment for services
- Why?
  - because LTC services and supports are more about maintaining well being in the face of disability;
  - consumers can better judge what's best in LTC compared to greater need for professional judgment in medical matters

Conclusion of Cabinet

- We should move to an insurance model;
- A voluntary system based on private insurance won't work;
- A disability model with cash benefits best fits LTC
- Are there any models out there?

European models provide helpful design ideas

- US age wave is 10-15 years behind Japan and Europe
- New (and revised) systems there provide lessons
- Scandinavian models rely more on state owned & run systems, unlikely to be applicable in US
- But England, Europe, and Japan have all adopted public/private systems for LTC financing; central to all is near universal coverage
- The FC found elements of the German system particularly appealing



The German system

- 10 years ago they had a similar financing system as US (heavily dependent on equivalent to Medicaid) with similar problems—pressure from "states" for (conservative) federal government to fix

The German system

- Goals met with new system by 2005:
  - Shifted burden from states & counties
  - "Medicaid" costs cut in half
  - Dignity & self reliance increased with 20% fully off "Medicaid" (more will come off over time)
  - Expanded consumer choice & home & community-based services
  - Costs did not explode
- FC proposal adapts some features from the German system but changes others to suit American system and experience, particularly lessons learned from Cash & Counseling experiments

Cash and Counseling Demo

- Experiment in AR, NJ, FL since 1998; enrolled 6000 Medicaid persons; randomly assigned to regular personal care through agency or **cash to hire own workers, do home modifications, or whatever needed**
- Consumers *love* the program—lives improved:
- Fewer unmet needs; large increases in satisfaction with care
- Fraud/abuse was rare
- Quality of care same or better [than conventional services]
- Informal caregivers' well-being improved; workers satisfied, not exploited; workers received wages the same or higher than agency workers
- Personal care hours increased; NF admissions & costs reduced

Systems that worked to make cash payments work better:

- People could choose to get cash directly or have cash deposited with Fiscal Intermediary who paid bills; but people had to take a test to prove they could manage (e.g., worker's taxes)—almost all chose FI
- Counselors worked out budgets with clients and helped put together plan

The Financing Cabinet Recommends a LTC Financing System with the following key elements.....

- An insurance model, not a welfare model
- Financed by premiums, not from general revenues
  - For most people, a "flat" rate, e.g. $30/month
  - For low income people , rate tied somewhat to income level
- Universal inclusion—everyone pays, everyone covered
  - Optimally a totally universal mandatory system; "near universal" may be achieved with voluntary "opt out" system

Recommendations (con't)

- Benefits:
  - **<u>Based on assessed level of ADL needs</u>** (e.g., 2-6 levels of need; higher benefit for greater need)
  - **<u>Cash is at least one of the options</u>**
    - Example: $50/day for 2 ADL needs; $100/day for 4+ADLs
    - Cash could be the only option (maximum flexibility) or, as in German model, get choice of in-home specified services, nursing home, or cash—with $$ value of cash less (restrains expenditure growth but less appealing to wider constituency); other approaches possible; key is cash should be an option
  - **<u>Beneficiaries must have access to enhanced consumer protections and help making choices</u>**

Recommendations (con't)

- Administration:
  - Investment of premiums and claims processing by a federally-chartered, quasi-governmental entity (not like Social Security)
  - Disability assessment is a federal system with appeals process

The CLASS Act

- A bill introduced by Senators De Wine (R., OH) and Kennedy (D., MA) in Dec.
- Roughly 75% consistent with FC's key elements; originated with younger disabled issues
- The FC believes that the CLASS Act "is an excellent start" and proposes that AAHSA generally support it while working closely with Congressional staff to move refinements more towards ideal
- Serendipity; A platform for discussions

Next Steps-2006

- April:
  - Presentation at HOD; listen to reaction & issues raised
  - Interim Discussion Paper to Board (revised version of previous presentation to Board), with Issues raised by HOD reported
- May:
  - Discussion with Board on April paper & HOD issues
  - Comments sought from additional, selected experts
- June:
  - Final proposal ("White Paper") submitted for Board decision
  - Input from State Execs on roll-out
- July:
  - Board decision
- November:
  - General session at the Annual Meeting

Wisconsin Long Term Care Functional Screen Analysis: Final Report for Wisconsin Department of Health and Family Services
October 31, 2003

Sara Karon, Ph.D, and Jim Robinson, Ph.D
Center for Health Systems Research and Analysis
University of Wisconsin – Madison

The following are excerpts from this report:

- Nursing home admissions were consistently found to exhibit higher functional impairment levels than new enrollees in managed care programs. (page 1)

- Nursing home entrants were older than those entering other programs. (page 37)

- The greatest levels of ADL (activities of daily Living) impairment were found among NH entrants, 39% of whom were impaired in 5 or 6 ADLs. (page 38)

- For most ADLs, more entrants to nursing homes need constant assistance than is true of entrants to community-based LTC programs. (page 40)

- Individuals entering nursing homes appear to be more severely impaired than those entering Family Care (or the Partnership Program) across all five measures (with one exception for PP-CHP relative to SNF/ISN classification). However, we know that individuals entering nursing facilities are older with more diagnostic conditions than those entering Family Care. (page 46)

- After case mix adjustment, individuals entering nursing homes have significantly (in a statistical sense) more ADLs impaired than those entering Family Care. IADL (Independent-ADL) impairments are moderately higher. The fraction of NH entrants with cognitive impairment or classified as ISN/SNF is comparable to that for Family Care. (page 50)

- Nursing home entrants exhibit significantly (again, in a statistical sense) higher impairments in dressing than is the case for Family Care enrollees. Although not highlighted (i.e., not significant at the 5% level), review of the p-values shows moderately greater impairment in mobility and toileting among nursing home entrants than Family Care enrollees. (page 51)

- Nursing home admissions consistently report higher functional impairment levels than new enrollees to other programs, with 3.6 of 6 ADLs (versus 2.9 for all programs), 3.7 of 6 IADLs (versus 3.3), and 2.6 of 3 critical IADLs (versus 2.3). While CIP1 reported 4.3 IADLs, the number of enrollees in the study for this program is only 6. We also note that functional impairment levels varied significantly by Family Care county (e.g., from 2.13 ADLs to 3.11 ADLs). (page 62-63)

The report stresses the importance of exploring and documenting the differences between nursing home and other long term care populations. The authors note that this level of empirical analysis "can provide better understanding of the reasons underlying differences in program populations, and can lead to methods of adjusting for differences to create more meaningful comparisons across populations. ***Such understanding is important to the development of fair and equitable reimbursement policies and quality assurance programs, especially when policies related to community-based LTC programs are based on comparisons to institutional services."*** (Emphasis added) (page 69)

Note: This ~~two page~~ summary was prepared by WAHSA. The complete CHSRA report can be obtained from the WAHSA office (608.255.7060.)

April 2004

THE HOME CARE RESEARCH INITIATIVE

POLICY BRIEF

FALL 2001

More for Less in Long-Term Home Care Services: Titrating Payment to Risk, Value and Effectiveness

This brief describes a new budgeting approach for allocating home care services for frail elderly people developed by William Weissert, a grantee of the Home Care Research Initiative (HCRI). The services discussed are personal care, nursing and other services delivered in the home to chronically ill, frail, elderly individuals who are likely to receive many more unskilled than skilled services and are not typically in need of rehabilitative, restorative or other post-acute care.

Proposal

- Home care payment policy should be reformed. It should be designed to align incentives for appropriate resource allocation among home care clients with efficiency and outcome goals.
- Patient care budgets should be titrated to an individual home care client's risks of adverse outcome, the effectiveness of home care in mitigating each adverse outcome risk, and the value of avoiding those outcomes.
- Most care should be provided where it will do the most good and less where it is ineffective and potentially wasteful.

The aim of this new budgeting approach is to produce better and more effective care at lower overall costs despite potentially increasing the total number of clients served.

The Problem

Three decades of randomized controlled and comparison group studies have shown that when access to home care is expanded by offering free Medicare or Medicaid-subsidized services, most clients who then seek home care are in fact at quite low risk of entering a nursing home.[1,2] This can be clearly seen from the results of control groups that did not receive the expanded home care. Among these groups, at most a quarter of clients entered nursing homes, demonstrating that three-quarters of patients—who were just like those who received home care—stayed out of nursing homes without it.[3]

1 Weissert, W.G., Cready, C and Pawelak, J. (1988). "The past and future of home and community based long-term care." *Milbank Quarterly*, 66(2): 309-388.

2 Weissert, W.G. and Hedrick, S.C. (1994). "Lessons learned from research on the effects of community based long-term care." *JAGS*, 42: 348-353.

3 Hedrick, S.C. Rothman, M.L., Chapko, M., Ehreth, J.L., Diehr, P., Inui, T.S., Connis, R.t., Grover, P.L., and Kelly, J. R. (1993). "Summary and discussion of methods and results of the adult day health care evaluation." *Medical Care*, 31: SS94-SS103.

The problem, according to Weisssert, is client selection, or targeting, and another, well-known principle of health care provision—complementarity. That is, when ambulatory services are offered as a substitute for institutional care, some clients do indeed use it as a substitute for institutional care. However, others–who would not have used institutional care–now ask for the ambulatory service, in this case, home care. Thus, total users of health care, both institutional and noninstitutional, increase and costs rise.[4,5]

The tendency to serve clients at low risk of entering a nursing home means that if the care is designed (and budgeted) principally to keep patients out of such institutions, many clients who use home care will not benefit from it. Patients at low risk of nursing home entry may have other needs that home care might serve, but only if their low risk of nursing home entry is acknowledged so home care can focus on other needs and budget accordingly.

Three-quarters of home care clients will not enter a nursing home whether they get home care or not. Nevertheless, according to Weissert, many factors promote denial of this fact.

- The federal government requires states to attest that all their clients are at high risk of entering a nursing home. Indeed the law says that Medicaid may not pay for them unless "but for home care" they would enter a nursing home.

- Congress fails to change the law to recognize that for most patients, home care is better suited to serving needs other than nursing home prevention, because perpetuating this myth is one way of keeping the total number of those eligible for home care under some control.

- Likewise, some state officials want home care not for its intrinsic value, but because they have been promised that it will save them money by reducing demand for nursing home beds.

- Patients like home care, and they themselves often believe it is helping them stay out of a nursing home. Furthermore, to the extent that any savings are generated, analysis shows that much of it goes to the patients and their families rather than to Medicaid or other government funding sources.[6]

Why It Matters

Since public policy is rational only if viewed from the multitude of perspectives of all who participate in it, there is some temptation to say "so what?" Who cares if home care does not achieve policy goals so long as some people keep coming to it? Weissert points out, though, that the stakes are high for several reasons:

- First and foremost, home care has the potential to produce more benefits, but does not do so. This may be because it operates under false assumptions about its purpose for a given set of clients. If the first step toward solving a problem is recognizing its existence, it seems to follow that it is just as important to recognize the right problem rather than the wrong one. For patients at low risk of nursing home entry, working to keep them out of nursing homes means that resources are being directed at a problem that does not really exist. The opportunity cost may be failure to work on problems that do exist and could be solved or at least mitigated.

4 Weissert, W.G., Cready, C and Pawelak, J. (1988). "The past and future of home and community based long-term care." *Milbank Quarterly,* 66(2): 309-388.

5 Weissert, W.G. and Hedrick, S.C. (1994). "Lessons learned from research on the effects of community based long-term care." *JAGS,* 42: 348-353.

6 Kemper, P. (1988). "The evaluation of the national long-term care channeling demonstration: 10. Overview of the findings." *Health Services Research,* 23: 161-174.

• A second consequence of poor management of home care's resource allocation is that it substantially adds to total program costs – an important concern considering that millions of individuals go entirely without Medicaid coverage while states fret over the rising share of their budgets which are consumed by Medicaid in general and Medicaid long-term care costs in particular. If patients could be served more efficiently, Medicaid funds saved could be spent on others, or on other services demanding broader coverage—from mental health and substance abuse prevention and treatment services to contraceptive services, dental care and prescription drugs.

• A third consequence is that great efforts are made—often unsuccessfully—to screen applicants to find those at high risk of nursing home use. Could it be better perhaps to skip the screening and meet the other needs of home care clients? The following approach essentially answers that question with a "yes."

Proposed Reform

Weissert suggests that what is needed is *an alternative payment system for home care intended to better allocate resources so that waste is minimized and outcome benefits are maximized.* An additional consequence may be that a larger total number of home care clients can be served without additional expenditures over current levels of aggregate home care spending.

Rather than serve everyone as if they all faced the same expensive threats of nursing home or hospital entry, Weissert proposes that home care be adjusted to actual risks faced. He calls it titrating, as when an intravenous drug is adjusted to a patient's disease severity, age and bodyweight. According to Weissert, the amount of home care should be titrated to the risks the home care client faces – more care for those at high risk, less for those at low risk. Furthermore, he proposes to adjust the amount of care so that it also reflects the value of the outcomes to be achieved. The amount would be further adjusted by how effective home care is in achieving each outcome.

The result is a payment formula for home care that emphasizes Effectiveness, Risk, and Value, or ERV. For example: An elderly woman at high risk of hospitalization and loss of one of her ADLs would receive a high budget for home care under our formula because hospitalization is an expensive adverse outcome and therefore highly valued. If home care is effective in preventing hospitalization and loss of physical function, then this individual would be likely to receive a high home care budget: high E (effectiveness of home care in mitigating the risks she faces), high R (if she is at high risk), and high V (because hospitalization is an expensive adverse outcome and likewise, preventing loss of physical function might be highly valued, an issue which is explored more fully below).

Conversely: An individual at low risk of hospitalization, low risk of nursing home use, low risk of death, low risk of functional decline, and low risk of loss of life satisfaction would receive a low home care budget since her risk, R, is low even if effectiveness of home care in mitigating those risks, E, is high and the risks are highly valued, V. That is, payment is based upon the product of ERV (effectiveness, risks and value).

In this way, care is titrated to risks and value of those risks, and home care programs have an important incentive to achieve high effectiveness since payment rises with effectiveness of home care in mitigating risks.

Calculating the effectiveness, risk, and value of home care To calculate a well-titrated budget for home care patients, good information is needed about each component of the calculation. Initially, setting the value portion of these budgets must be relatively arbitrary. Similarly, good effectiveness data are not yet available. Estimating the risks, on the other hand, is more straightforward. One simply statistically profiles the factors that are associated with each of the adverse outcomes for which we plan to budget. (That is, from a home care-eligible population's experience, those who had the adverse outcome are statistically compared with those who did not, to see how much each difference between the two groups increases the probability of the adverse outcome occurring.) However, problems remain.

For which outcomes do we calculate the risk?

The outcomes in this study included only death, hospitalization, nursing home admission, and decline in physical function. Ideally, all risks for all types of outcomes likely to be suffered by home care patients would be included in the calculation: Loss of personal control, loss of privacy, etc.. Positive outcomes could also be included, such as reduced anxiety, freedom from worry, reduced caregiver burden and reduced caregiver stress, and any other outcome for which home care might be effective. But coming up with risk estimates requires data, and data to measure these more subtle outcomes are simply not available because they have not been collected.

Major risk factors for home care outcomes

- Prior hospitalization
- Age
- Dependencies
- Living alone
- Nonwhite race
- Lack of living spouse

So, for the study reported here, the range of outcomes used was quite limited. To illustrate the approach (and perhaps encourage collection of better outcome data), just four outcomes were used, although more would have been preferred. The risk estimation regression analysis findings, which use five years of panel data from the Arizona Long-Term Care System (ALTCS), are available elsewhere.[7]

What do we know about the effectiveness of home care services?

As with outcome data, effectiveness data for home care are hard to come by. The literature was scoured for studies that measured the ability of home care services to achieve specific outcomes (of various types) and used those results. When there was a distribution of effectiveness available, higher estimates were typically chosen in favor of lower ones, because of the belief that if home care were better budgeted and managed, it would be more effective.[8,9] The author preferred to err high in estimating budgets.

How valuable are home care services?

Finally, the biggest challenge was estimating the value of the outcomes achieved by home care services. For hospitalization and nursing home use, the costs of outcomes are relatively easy to estimate from national cost statistics. But how should a value be set on things like loss of function in one activity of daily living? Here Weissert relied on estimates of the value of a quality adjusted life year, or QALY. He synthesized estimates from many U.S. and international studies, sorting by standard ways of valuing QALYs (human

7 Chernew, M.E., Weissert, W.G., and Hirth, R.A. (2001). "Heterogeneity of risk in a managed home health care population." *Medical Care*. Accepted for publication.

8 Miller, E.A. and Weissert, W.G., "Incidence of four adverse outcomes in the elderly population: Implications for long-term care policy and research." Submitted to *Research on Aging*, Spring 2000.

9 Miller, E.A. and Weissert, W.G. (Sept. 2000) "Predicting elderly people's risk for nursing home placement, hospitalization, functional impairment and mortality: A comparative review and analysis." *Medical Care Research and Review*. 57(3): 259-297.

capital versus occupational and nonoccupational risk assumption payments). A detailed presentation of the method of valuation is published elsewhere.[10] More work is clearly needed on this topic, but his method provides a starting point that is intended as an illustration of the approach, rather than as a hard estimate.

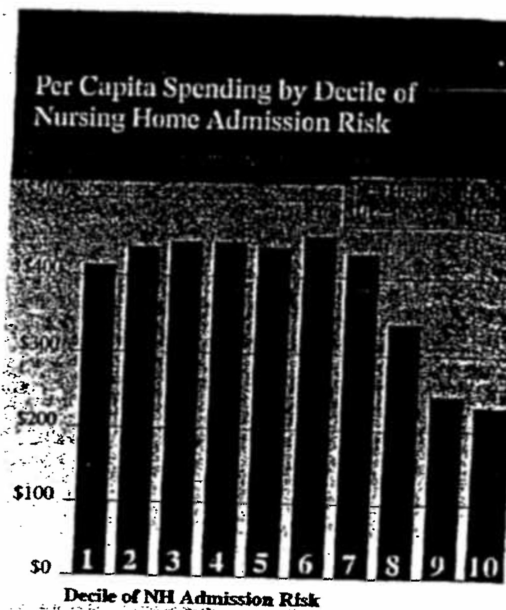
Taken together, these valuations allowed the production of a risk profile for the four risks for each patient in the ALTCS sample, which had over 50,000 assessments of more than 25,000 patients. We estimated each patient's risk of each of four adverse outcomes, set an estimate of home care's effectiveness in avoiding the outcome, and placed a value on each outcome. Then the budgets for each risk were summed across all the patient's risks and a budget for each patient was obtained.

Does current spending match patients' risks?

Using the proposed method, Weissert compared actual spending in the ALTCS program with each patient's calculated risks (see figure 1). Little systematic relationship was found between how much care the patient used and how much risk they faced, illustrating exactly what Weissert thinks is wrong with home care and why a new approach is so badly needed. Because effectiveness, risk and value are not taken into account in setting home care budgets, the amount spent on a given patient bears little relationship to how much value can be recouped for that patient by home care. The sickest patients—those at greatest risk—may be getting too little care, while low risk patients may be getting too much. The estimates showed that low-risk patients may get twice as much care as their risks would suggest they should get, while high risk patients got perhaps half as much as their risks would suggest.[11]

How would the budget work?

Case managers would be given three pieces of information on each patient: Assessment results; a risk profile for each of several outcomes; and a budget for each risk, summed to produce a total monthly budget for each patient. The risk profile would give case managers a clear set of goals for patients: Mitigating high-risk outcomes. The budgets would be targets only, with discretion to spend more or less on a given patient, but variations from the targets would require explanation and in some cases, authorization. Training for case managers would be an important component of the program, and would focus on the kinds of home care that have proven effective for each outcome, and the extent to which home care is effective for a given risk. In the short run this method would produce two major benefits: reallocation of



10 Hirth, R.A., Chernew, M.E., Miller, E., Fendrick, A.M., and Weissert, W.G. (2000). "Willingness to pay for a Quality-adjusted Life Year: In search of a standard." *Medical Decision Making*, 20, 332-342.

11 Weissert, W.G., Chernew, M., and Hirth, R. (2001) "Beyond managed long-term care: Paying for home care based upon risks of adverse outcomes." *Health Affairs*, 20(3):172-180.

Table 1: Illustrative ERV Budget for a Patient Facing Several Risks

Characteristics	Outcome	Monthly Risk	Monthly Target Budget
[illegible]	[illegible]	[illegible]	$119
[illegible]	[illegible]	[illegible]	$90
[illegible]	[illegible]	[illegible]	$100
[illegible]	[illegible]	[illegible]	$1,537
	Total		$1,846

resources from low-risk to high-risk patients, and more focus on specific risks for specific patients. In the longer term, the method should produce better outcomes and no increase in total spending.

Conclusions

If home care monthly budgets were adjusted for the patient's risk, effectiveness and value, case managers would know what risks were paramount for a patient, and which patients were at highest risks. Moreover, much of the pressure currently placed on screening would be relaxed because individuals who are wrongly judged to need home care would not automatically become expensive mistakes—as they do now. Instead, their home care could be kept at low cost to suit their low risk. As the program gains experience with individual patients or patients' health status changes, budgets could be adjusted appropriately.

The consequence should be that more patients are served, more effectively and more efficiently, with a substantially improved ability to correct and make adjustments in response to unavoidable patient selection errors. Care would be guided by the patient's risk profile, and allocations among patients would be more equitable in the true sense of the word: Allocations would reflect risk. Home care could be like other venues in the health care system—where we routinely expect dosage of care to be determined not by the myth of meeting some threshold, but by calculated estimation of risk and the potential to benefit, so that the care is worth the cost.

THIS POLICY BRIEF WAS PREPARED BY
WILLIAM WEISSERT, PH.D.
SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

THE HOME CARE RESEARCH INITIATIVE:
A PROGRAM OF THE ROBERT WOOD JOHNSON FOUNDATION
www.vnsny.org/hcri

The Home Care Research Initiative, a program of The Robert Wood Johnson Foundation, was established to support research and analysis that will improve the knowledge base underlying home care policy and practice. It is based at the Center for Home Care Policy and Research at the Visiting Nurse Service of NY.

CENTER FOR HOME CARE POLICY AND RESEARCH
VISITING NURSE SERVICE OF NEW YORK
107 EAST 70TH STREET NEW YORK, NEW YORK 10021
PH. 212.794.6300 FAX 212.794.6610

The views expressed by the authors of this policy brief are not necessarily the views of the Home Care Research Initiative or The Robert Wood Johnson Foundation.