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Complex Patient Pilot Program
(Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 263, #2]

CURRENT LAW

Under federal law, hospital emergency rooms must provide care to stabilize any patient, without regard to ability to pay or type of insurance coverage. For other types of hospital services, admission criteria may vary by hospital type. However, admission criteria are used to verify the medical necessity of any hospitalization. Medical necessity as defined by the Centers for Medicare and Medicaid Services (CMS) means the patient has a condition requiring treatment that can only be safely provided in a hospital setting.

Once a person no longer needs hospital services, that patient is discharged from the hospital. As a condition of participation in the federal Medicare program, hospitals must have in effect a discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers or support persons in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions.

Beyond general requirements relating to discharge planning, there are additional requirements for patients in need of post-acute care services. Specifically, for those patients discharged home and referred for home health agency (HHA) services, or for those patients transferred to a nursing home (skilled nursing facility or SNF) for post-hospital extended care services, or transferred to an inpatient rehabilitation facility (IRF) or a long-term care hospital (LTCH) for specialized hospital services, the following requirements apply:

(1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs

that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

(3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

DISCUSSION POINTS

1. According to Leading Age Wisconsin and the Wisconsin Health Care Association/Wisconsin Center for Assisted Living (WHCA/WiCAL) Wisconsin nursing homes admitted almost 36,000 patients from hospital settings in 2022. Further, data from the Department of Health Services indicate that nearly 92% of all nursing home admissions are directly from hospitals.

2. Despite the large volume of nursing home admissions from hospital settings, the Wisconsin Hospital Association estimates that, at any one time, 350 to 400 people are waiting to be discharged from a hospital to a post-acute care setting, such as a nursing home. However, these patients are difficult to place due to their greater than average needs.

3. AB 43/SB 70 would provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Under the proposed pilot, DHS would be required to provide payments to partnership groups designated as participating sites for care provided during the course of the pilot program under this program. All provisions relating to the pilot would be repealed effective July 1, 2025.

4. Under the bill, DHS would be required to form an advisory group to assist with development and implementation of a complex patient pilot program. Further, the DHS Secretary or designee, would be required to chair the advisory group, and members of the advisory group would be required to have clinical, financial, or administrative expertise in government programs, acute care, or post-acute care. The Department would be required to use its request-for-proposal procedure to select partnership groups that would be designated as participating sites for the complex patient pilot program.

5. The advisory group would be required to develop a request for proposal for the complex patient pilot program that includes eligibility requirements. Further, the complex patient pilot advisory group would be required to: (a) determine and recommend to DHS an amount of the funding budgeted for the complex patient pilot program to be reserved for reconciliation to ensure that participants in the pilot program are held harmless from unanticipated financial loss; (b) develop a methodology to evaluate the complex patient pilot program, including a recommendation on whether DHS should contract with an independent organization to evaluate the complex patient pilot program; and (c) make recommendations to the DHS Secretary regarding which partnership groups should receive designation as a participating site for the complex patient pilot program.

6. As it pertains to application requirements, the bill specifies that only partnerships of at least one hospital and at least one post-acute facility would be eligible to submit proposals. Further, the bill would require that each partnership group that applies to DHS to be designated as a site for the complex patient pilot program address all of the following issues: (1) the number of beds that would be set aside in the post-acute facility; (2) the goals of the partnership during the pilot program and after the pilot program; (3) the types of complex patients for whom care would be provided; (4) the per diem rate requested to adequately compensate the hospital or hospitals and the post-acute facility or facilities; (5) a post-acute bed reserve rate; and (6) anticipated impediments to successful implementation and how the applicant partnership group intends to overcome the anticipated impediments. In addition, each partnership group would be required to address its expertise to successfully implement the proposal, including a discussion of at least all of the following issues: (a) experience of the partners working together; (b) plan for staffing the unit; (c) ability to electronically exchange health information; (d) clinical expertise; (e) hospital and post-acute facility survey history over the past three years; (f) acute care partner readmissions history over the past three years; (g) discharge planning and patient intake resources; and (h) stability of finances to support the proposal, including matching funds that could be dedicated to the pilot program. While no applicant would be required to provide matching funds or a contribution, the advisory group and DHS may take into consideration the availability of matching funds or a contribution in evaluating an application.

7. The bill would specify that no later than 90 days after the effective date of the bill, the advisory group must complete development of the request for proposal for partnership groups to be designated as participating sites in the complex patient pilot program and provide its recommendations to the DHS Secretary. Subsequently, no later than 150 days after the bill's effective date, the advisory group must review all applications submitted in response to the request for proposal and select up to four partnership groups to recommend to the DHS Secretary for designation as participating sites for the complex patient pilot program.

8. The complex patient pilot would serve two main purposes. The first would be to ensure the successful transfer of these difficult to place individuals from hospital settings to more appropriate post-acute care settings. Leading Age Wisconsin and WHCA/WiCAL indicate that this would alleviate pressure on the hospital system and instead utilize excess bed capacity at Wisconsin nursing homes, in situations where discharge to a nursing home is appropriate. Further, WHA indicates that patient well-being and hospital financial issues could be served by ensuring that people are receiving care in the most appropriate setting, since hospital reimbursement for continuing to house these individuals varies greatly, depending on the individual's insurance status once they no longer require hospital care.

9. The second purpose would be to learn more about these difficult to place individuals and to identify systemic barriers to appropriate placement for these individuals, as well as future individuals with similar characteristics. Specifically, Leading Age Wisconsin and WHCA/WiCAL, indicate that the complex patient pilot program would be able to draw from the experiences of hospitals and post-acute facilities that have initiated collaborative efforts designed to better serve hard to care for patients. For example, Froedtert Hospital and Luther Manor in Southeastern Wisconsin have a collaborative history of working to address the needs of complex patients, and a hospital system and group of long-term care providers in the La Crosse area have more recently initiated similar efforts. Participants have expressed challenges related to the types of patients they are able to admit, regulatory hurdles, securing a sustainable funding source, and ensuring ongoing access to specialty care providers (such as physicians, behavioral health practitioners, and wound care certified staff). The associations indicate that complex patient pilot would be a broader and more systematic way to better identify these barriers and create solutions that could be replicated in other areas of the state.

10. Targeting that purpose, funding in the bill would be available to fund a study of the pilot. Further, the bill would specify that between six and 18 months after the effective date of the bill, the partnership groups designated by DHS as participating sites in the complex patient pilot program must implement the pilot program and meet quarterly with both DHS and the advisory group or any independent organization hired by DHS for the purpose of evaluating the pilot program to discuss experiences relating to the pilot program. No later than June 30, 2025, the advisory group or any independent organization hired by DHS for evaluating the complex patient pilot program must complete and submit to the DHS Secretary an evaluation of the complex patient pilot program, including a written report and recommendations.

11. In light of industry support and in an effort to ensure that patients are receiving the right care, at the right time, in the right place, for both psychosocial and financial reasons, the Committee could provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. [Alternative 1]

12. The funding in the bill does not correspond to any cost estimates provided by the Administration. Rather, it is one-time funding that would be available to support the pilot program's costs until the funding is fully expended or the end of the 2023-25 biennium, whichever comes first. Consequently, the Committee could support the pilot at a lower level of funding. For example, the

Committee could provide $5,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program. If the Committee chooses this option, DHS would likely reduce the scope of the pilot project, for example by selecting fewer partnership groups and participating sites, than if Alternative 1 were selected. [Alternative 2]

13. Finally, the Committee may determine that there is no need for the state to take action on this issue, since hospitals are currently incurring the costs of caring for these patients, and hospital rates, paid by insurers, private individuals, Medicare, and Medicaid, should reflect the costs of caring for all patients, including patients who may be harder to discharge for a variety of reasons. Further, the Committee may determine that, due to the complexity of the issue, the matter should be addressed in separate legislation. [Alternative 3]

ALTERNATIVES

1. Provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Incorporate the statutory provisions of AB 43/SB 70 relating to this item in the bill.

ALT 1	**Change to Base**
GPR	$15,000,000

2. Provide $5,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Incorporate the statutory provisions of AB 43/SB 70 into the bill.

ALT 2	**Change to Base**
GPR	$5,000,000

3. Take no action.

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