



September 5, 2003

Via Email

To: Rep Kitty Rhoades

Subject: Long Term Care Reform

As you requested, I am forwarding to you my comments on ways to improve Wisconsin's long-term care (LTC) system. WAHSA members have been very active in advancing proposals to create a better, more affordable and rational system. To date, unfortunately, these ideas have not been given serious consideration.

I'll try to keep this response relatively short, but would very much like to speak with you to provide more details on these suggestions.

I suggest the following:

1. **Private Capital Required:** The state should explore ways to make the purchase of private long-term care insurance more attractive. Instead of focusing our attention on Medicaid eligibility criteria, I suggest that we shift our focus to creating incentives for persons to pay for their own long-term care without relying on Medicaid. For instance, why couldn't tax incentives be used to help people buy long-term care insurance? Under such a scenario, individuals who pay for 2 or 3 years of LTC coverage and use up that coverage could after that time be allowed to enter the Medicaid program without having to surrender their assets/home under an estate recovery program. I know that some states

piloted this idea some time ago, but am uncertain why the experiments weren't continued. While Family Care may offer a solution, the recently released evaluation of the demonstration project by The Lewin Group and the State Auditor's response raise serious questions about the program's cost and affordability. Can the state pay for a statewide expansion of this comprehensive program at a time when the number of persons over age 65 is increasing and will continue to increase at an unprecedented rate?

2. **Close Divestment Loopholes:** Continue to investigate ways to plug the MA divestment loopholes at both the state and federal levels. Discussions of this topic have begun recently with the DHFS Division of Health Care Financing. Also, review eligibility guidelines to verify that those receiving MA benefits are in fact entitled to those benefits. A meeting with county income maintenance workers I'm sure would be enlightening for legislators. These folks have stories to tell about how some otherwise ineligible persons aggressively "work" the system (buying excluded assets or purchasing annuities) in order to achieve eligibility. In addition, the Joint Legislative Audit Committee has directed the Legislative Audit Bureau to audit the State's eligibility determination processes for the Medicaid, BadgerCare and SeniorCare programs, a request made by State Senator Mary Lazich.
3. **Explore Cost-Sharing and Supplementation Options:** Review cost-sharing options. Is it possible for persons with higher incomes to supplement the cost of services provided to a MA recipient? Could non-MA eligible persons pay privately for the "room and board" of relatives who are MA eligible and have Medicaid pay for the service component of their care/services? Could the cost of caring for a resident of one county but placed in a county home located in another county be supplemented/subsidized by the county of origin? Doing so would help create regional care facilities especially for hard-to-place persons with complex behavioral and medical conditions.
4. **Stop Costly Punishment and Pursue Quality Improvement:** Eliminate the nursing home "double jeopardy" situation where a nursing home receives both a federal civil

monetary penalty (fine) and a state forfeiture (fine) for the same deficient practice. This would require a statutory change to Chapter 50, Wis. Stats. Hitting homes with double penalties for the same deficiency does not lead to improved quality of care but does add to the cost of care. We suggest that federal nursing home rules be followed and enforced and that state statutes/rules be imposed only where the federal rules are lacking. It is costly to operate under dual systems, especially when doing so does not enhance quality. (Representative Pettis has requested and received a LRB draft of such a bill, which WAHSA and WHCA currently are reviewing). For further discussion on regulatory reform see: <http://www.wahsa.org/03issue02.pdf>

5. Allow nursing homes more of an opportunity to change with the times. I suggest:
 - A. Nursing homes be allowed to have "floating licenses" under which these homes could provide SNF, RCAC or CBRF services. If a nursing home resident no longer needs SNF level of care but would prefer to remain at that facility, the license for the particular resident's room should be allowed to "float" to a CBRF or a RCAC license. The public payment rate for an eligible resident would shift correspondingly from SNF care to the lower MA waiver rate.
 - B. The State create meaningful incentives for older facilities to modernize or "rightsized." If there is a belief that Wisconsin has too many nursing home beds and the goal is to reduce capacity, the way to produce positive change is NOT by continuing the state's current destructive policy of "downsizing by starvation." Currently, some capacity reduction has come as a result of neglecting the nursing home infrastructure and financially bleeding facilities to closure. Not surprisingly, quality of care suffers and communities often are forced to launch a desperate plea to save their community nursing home. The state could offer real financial incentives for facilities to decrease their number of licensed beds, to convert their beds to assisted living, to establish private rooms or, if appropriate, to close. The downsizing mechanisms currently allowed by the DHFS are a good start, but they

do not help facilities whose existing debt or capital costs can't be met if revenues are lost (e.g., revenue loss occurs when a home converts double occupancy rooms to private rooms, resulting in fewer dollars to pay fixed capital costs). One option worth exploring would be for Medicaid to freeze a facility's existing capital payment so that a rate reduction would not be triggered when rooms are converted to single occupancy private rooms. {Note: On August 21, 2003, DHFS announced its intent to include this option in the 2003-04 Medicaid nursing home state plan amendment which will be submitted to the Centers for Medicare and Medicaid Services prior to 10/1/03.}

- C. Allow SNF to manage dollars with incentives to lower the cost of care. The DHFS has been quick to convert nursing home beds to community slots as a way to create a long-term care funding stream to the counties. In most instances, this conversion has worked well and has kept long term care dollars "in the system." We suggest that nursing homes be incentivized to manage care and costs by offering homes the opportunity to directly manage long term care slots. Under this option, an organization would be reimbursed a per diem rate to care for a resident in their skilled nursing home with a diagnosis requiring ongoing SNF care (i.e., not a short-term admission). If this organization developed a care/service plan that enabled the resident to be relocated to the organization's assisted living/independent/housing/adult day care setting, the organization would be able to retain the Medicaid per diem rate to pay for the new care/service plan. The Medicaid per diem could be reduced by 5% in order for the State to achieve overall cost savings. In turn, the organization would be able to effectively manage the resident's care and service needs and would be assured of a funding stream to finance their non-nursing home options.

Formal Long-Term Care Redesign Proposals

In addition to the comments offered above, WAHSA already has devoted considerable time and resources to long-term care redesign discussions. In 1997, the association authored *Long-Term*

Care Redesign: WAHSA's Vision of a New System (see: <http://www.wahsa.org/ltc.htm>), which outlined three different models for long term care reform. One model called for the creation of **long-term care vouchers**, which we believe could create more cost-effective and innovative delivery systems. **This is our preferred model.** Individuals would be afforded maximum choice in care/service options, organizations could package care/service plans for clients, and pooling of vouchers would enable risk to be shared. All of this could be accomplished without creating enormous and costly bureaucracies. The second model would rely on managed care organizations to effectively provide case management services. The third model would implement more incremental changes to the current system and includes several of the ideas referenced above. Common elements of each model are summarized by the flow chart: <http://www.wahsa.org/ltcflow.htm>

Commentary

Every day, WAHSA member organizations manage the long-term needs of thousands of individuals. Most do so on campuses, which include a nursing home with either a CBRF, a RCAC and/or an independent living facility. Those members have become experts in “managed care” and know how to stretch the dollars available. To those who suggest that persons living on member campuses “cost too much” and that the State’s focus should be more on “community-based” care than “institutional” care, I offer these two observations: First, our campuses ARE community-based. They serve the community, are in and are part of the community and their residents and employees are from the community. Second, many residents of our campuses do not rely on the government (Medicaid) to pay their bills. These private pay retirees include former business leaders, educators, public servants, tradespersons and others who have planned for their retirement needs. These individuals spent a lifetime paying their bills and managing their financial affairs. To hear some state agency staff imply that these individuals, who have chosen to live at a retirement community and accept the fact they ultimately may need nursing home care, are not aware of the long-term care service options that are available or have exercised poor financial judgment, is condescending and a blatant insult to their intelligence. These individuals and their families have evaluated their options and determined that the level of care, services, support, activities, socialization and security offered by a retirement community is

what they desire and are willing to pay for. Perhaps the State can learn from these private payors how to purchase cost-effective, high quality long-term care services, and not the other way around.

Finally, please allow me to add my two cents on the recent attacks of county nursing homes as being too costly and a burden on state and local taxpayers. Many county homes provide the true long term care safety net for those individuals with complex behavioral and medical challenges. Without these facilities, many counties would be forced to rely on the State mental health institutes or mental health hospitals, at a far greater cost to the local taxpayer. I ask that you and your colleagues challenge those that testify before legislative committees on the need to close county facilities by asking these persons who will care for these residents in the absence of county homes. As you recall, the Legislative Audit Bureau noted that “the best available data suggest that county-owned facilities do provide care to residents who present more behavioral challenges, in addition to their other needs, than residents of privately owned facilities do. We found that 41.9 percent of residents in county-owned facilities were reported to exhibit challenging behaviors, compared to 27.1 percent of residents in privately owned facilities.” (LAB Report 00-01, January 2000) The LAB report can be accessed at: <http://www.legis.state.wi.us/lab/reports/00-1tear.htm>

In closing, I deeply appreciate your interest in long term care financing and reform. WAHSA members and staff pledge to work with the Legislature and the Administration to create a more comprehensive, high-quality, cost-effective long term care delivery system. I look forward to continuing our discussions on this important topic.

cc Mr. Kevin Moore, Legislative Assistant
to Rep. Kitty Rhoades
WAHSA Board of Directors

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