Department of Health Services Legislative Briefing

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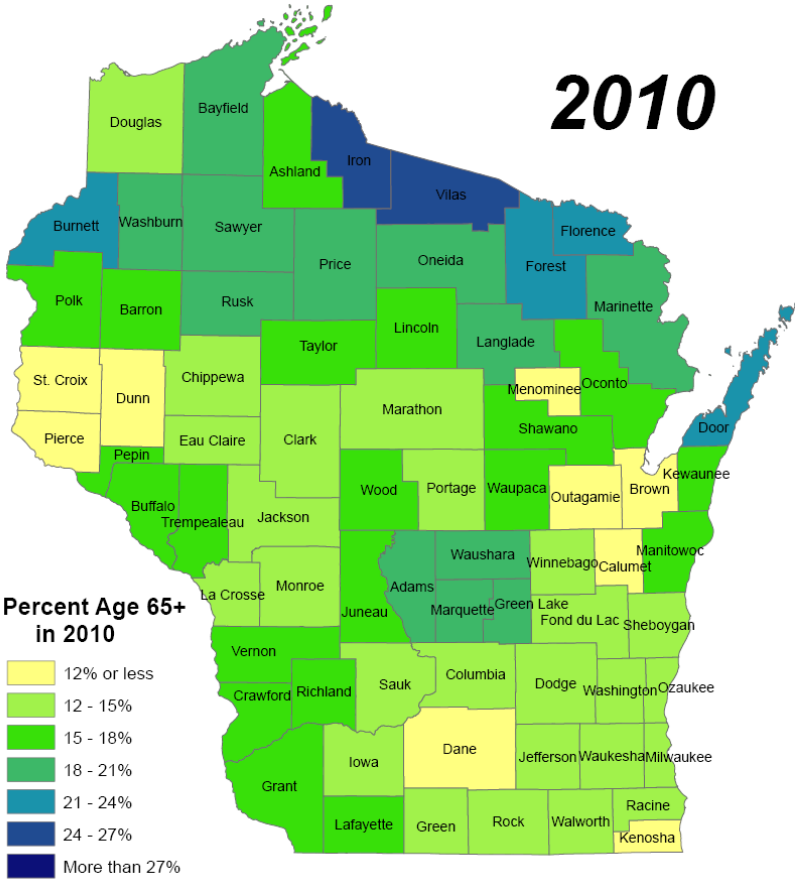
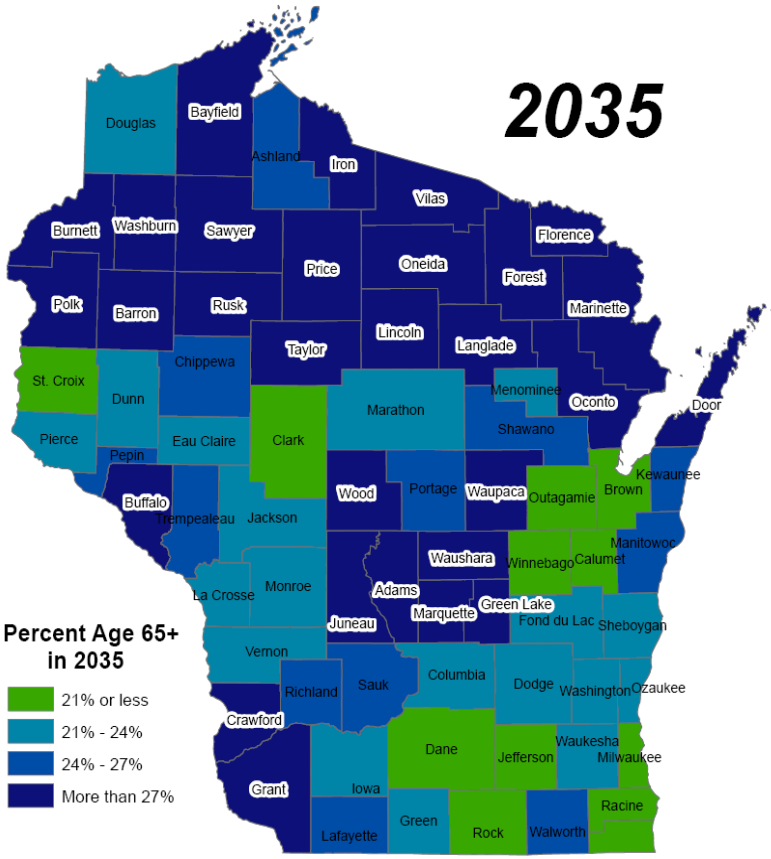
April 2013

Growth in Wisconsin's Aging Population





http://www.dhs.wisconsin.gov/aging/demographics/index.htm

Aging Population Projections

2005	2010	2015	2020	2025	2030	2035
726,280	782,810	900,170	1,060,620	1,234,600	1,402,900	1,485,570

- Between 2010 and 2015 the aging population grows by 117,360 people.
- Approximately 1/3 of these individual will need long term care.
- The number of people is a substantial cost driver.
- Thus, long term care programs must be made more cost-effective and fiscally sustainable.

Overview of Wisconsin's Long-Term Care Programs for Children

Children's Long-Term Supports

- Birth to 3 Program
- Family Supports Program
- Children's Long-Term Supports Home and Community-Based Services Waivers 1915(c) including Autism services
- Katie Beckett Medicaid Eligibility (TEFRA)

Birth to 3 Program

- An early intervention program operated under state and federal law – The Individuals with Disabilities Education Act (IDEA, Part C).
- Administered at the local level by the county agency selected by the County Board – most frequently Human Services.
- Includes approximately 10% of children with long-term support needs, others have developmental delays.
- Eligible children ages birth to 36 months are entitled to services to address developmental needs without waiting.
- Funding: Medicaid; Private Insurance; Part C specific federal and state funds; and County Community Aides.

Family Support Program

- GPR funded Program which provides flexible funding, to a maximum of $3,000/year for each child with a severe disability to address long term care needs and family supports to meet the child's needs.
- Often matched to federal funding through the Medicaid Waivers.
- Approximately 3,500 children receive FSP, however, there are as many children waiting as are currently receiving services.
- Offers information and help in finding services and community resources, and connecting families with other families to strengthen natural supports.
- Service Examples: Specialized Equipment or Supplies; Respite; Architectural Modifications; Specialized Transportation; Specialized Diet/Nutrition; Vehicle Modification; Home Modification; and Parent Training and Education.

Children's Long-Term Supports Waivers – including Autism Services

- Three separate Medicaid Home and Community-Based Services Waivers for each federally defined target group:
  - Developmental disability;
  - Severe emotional disability; and
  - Physical disability.
- The Waivers provide a source of federal financial participation (FFP) funding using a non-federal match of either County Community Aides or GPR. Wait Lists are permitted.
- These services support children living at home or in the community who have substantial limitations in multiple daily activities and provides for a range of services based on the child's assessed needs.

Autism Treatment Services within the Children's Long-Term Supports Waivers

- Young children diagnosed with an Autism Spectrum Disorder (ASD);
- Intensive treatment services using evidence-based behavioral methods to:
  - Reduce the challenging behaviors;
  - Increase social skills; and
  - Increase communication skills.
- May receive for up to three years, after which the child may qualify for ongoing waiver services at a less intensive level.
- The goal of the program is for the child to have fewer needs in the future and to make significant gains towards normal development, including an increase in social, behavioral and communication skills that the child can use at home and in their community.

Katie Beckett Medicaid Eligibility

- Special Medicaid eligibility for children under 19 years of age with long-term disabilities or complex medical needs, living at home with their families.
- Safe and appropriate community care.
- Must meet a Hospital or Institutional Level of Care.
- A Social Security Disability Determination is required in addition to the Level of Care criteria.
- Only the child's income and assets are considered and these must be within the Medicaid guidelines for Institutional Financial Eligibility.
- Medicaid Coverage is provided as Fee-for-Service Medicaid.

Overview of Wisconsin's Long-Term Care Programs for Adults

Aging and Disability Resource Centers (ADRCs);

Adult Protective Services;

Aging Programs under the Older Americans Act;

Medicaid Home and Community-Based Services Waivers in non-Family Care parts of Wisconsin:

- Community Options Program (COP)
  - For Frail Elders and People with Physical Disabilities
- Community Integration Program (CIP)
  - For People with Developmental Disabilities

Overview of Wisconsin's Long-Term Care Programs for Adults

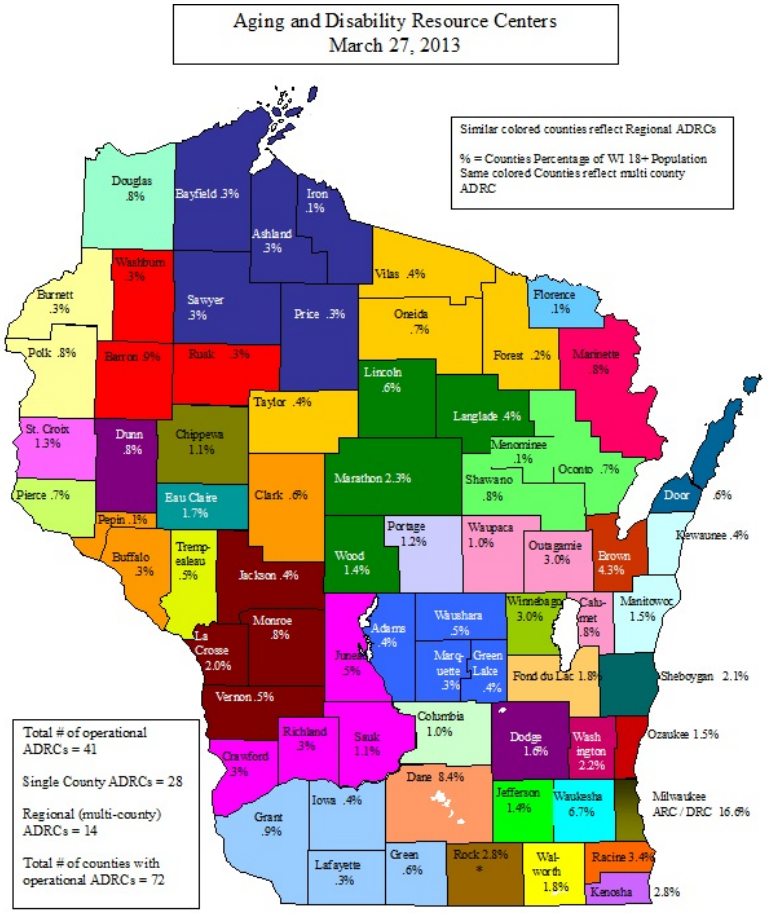
Long-Term Care Redesign

- Family Care
- IRIS
- PACE
- Partnership

Nursing Homes

- Financial Management (Division of Long Term Care)
- Quality Management (Division of Quality Assurance)

Aging and Disability Resource Centers (ADRCs) - Locations



Aging and Disability Resources Centers (ADRCs): Services

- Outreach & Marketing
- Prevention Activities
- Information & Assistance
- Long-Term Care Options Counseling
- Elderly & Disability Benefit Counseling
- Link to various community supports
- Emergency Referral
- Functional Eligibility
- Financial Eligibility
- Adult Protective Services/Elder Abuse Prevention

Adult Protective Services

- County boards are required to identify an agency as the "adults-at-risk" agency for the county.
- Wisconsin Statues Chapter 46 (elder adults at risk), Chapter 54 (guardianships) and Chapter 55 (adults-at-risk and adult protective services) define adult protective systems in Wisconsin.
- Chapter 55 requires the "adults-at-risk" agency to complete a report form on its response to each reported case of suspected abuse, financial exploitation, neglect, or self-neglect.
- This report information is collected by the Department of Health Services using a web-based application called: Wisconsin Incident Tracking Systems (WITS).

Aging Programs

- Information and Assistance to help older adults and their families connect with the services they need.
- Benefit Specialist Program to help older persons coordinate private insurance, pension, or government benefits.
- Caring for People with Alzheimer's Disease, the Family Caregiver Support Program, responds to the stress and service needs of families.
- Elder Abuse Information how to report abuse and prevent abuse, and local resources for help.
- Elderly Nutrition Program for Information on meals for older adults provided at home and in a group setting at congregate meal sites.
- Family Caregiver Support Program meets the needs of the spouse or relatives who care for older people.

Community Options Program

- Counties operate the program, which is GPR Funded, can be matched to FFP under the Medicaid Waivers.
- Wait lists are permitted.
- Helps people who need long-term care stay in their own homes and communities.
- Purpose is to provide cost-effective alternatives to institutions and nursing homes.
- Provides funding and assistance in locating services for the elderly and people with serious long-term disabilities regardless of age or type of disability.
- Income guidelines are used to determine if COP will pay for part or all of the cost of services determined necessary by the assessment.

COP Service Examples

- Home modification
- Respite care
- Adaptive equipment
- Financial counseling
- Care management
- Communication Aids
- Supportive Home Care
- Residential Services
- Housekeeping/Chores

Community Integration Program

- Counties operate the program, which is GPR Funded, can be matched to FFP under the Medicaid Waivers.
- Wait lists are permitted.
- Helps people with developmental disabilities to stay out of institutions, or to relocate from state centers and nursing homes back to the community.
- Area Quality Specialists are assigned to specific county waiver agencies and/or tribes to provide technical assistance and quality assurance.

CIP Service Examples

- Home modification
- Respite care
- Adaptive equipment
- Financial counseling
- Care management
- Communication Aids
- Supportive Home Care
- Residential Services
- Employment Services
- Housekeeping/Chores

Purpose of Reforming Long-Term Care

- A primary goal of long-term care redesign is to support member outcomes while making sure public money is used in the most efficient way possible.
- Leverage innovation and market competition to support people in their own homes and/or with family.
- Achieve 15% savings, over time, as a result of care management.
- Purchase services cost-effectively.
- Improve transparency, equity, objectivity, and alignment of provider rates with both costs and acuity of their members.
- Family Care payments reflect a member's functional needs and acuity so that providers serving people with similar needs are paid similar rates.

Lowering the Cost Curve

Changes in capitation rates show that:

- As of March 2012, the average capitation revenue decreased by 0.3% on a per member per month (PMPM) basis, relative to the first three months of 2011.
- The average PMPM cost has declined in each of the past two years, from $2,997 in 2010, to $2,897 in 2011 and $2,887, to date, in 2012.

Family Care

- Managed Care under a 1915(b) and 1915 (c) Federal Medicaid Authority.
- Managed Care Organizations are paid a capitated rate on a per member per month basis to provide for the long-term care needs of eligible individuals.
- Strives to foster independence and quality of life while recognizing the need for interdependence and support.

Family Care Goals

- CHOICE – better choices about the services and supports available to meet their needs.
- ACCESS – Improve people's access to services.
- QUALITY – Improve the overall quality by focusing on achieving people's outcomes.
- COST-EFFECTIVENESS – Create a cost-effective long-term care system for the future.

IRIS

- Federal (CMS) requirement as a choice to Family Care for long-term care services.
- Available wherever Family Care is offered.
- Operated under a Federal Medicaid 1915(c) authority.
- IRIS Self-Directed Personal Care 1915(j) authority (began October, 2009).
- Participants must manage services within an Individual Budget.
- Managed by DHS through Contracted Agencies:
  - IRIS Consultant Agency; and
  - IRIS Financial Services Agency.

Expenditure Trends

- At $32 million GPR, in FY 13, the cost to remove the Family Care enrollment cap was lower than early estimates.
  - Fewer people enrolled from the wait list.
  - PMPM cost is 25% lower for new members.
- Direct care costs comprise 94% of MCO expenditures.
- Over the past decade, long term care spending as a share of total Medicaid spending has declined from 53% to 43%.

Federal (CMS) Role in Rate Setting

- Establishes the general regulatory framework and specifically requires a risk-based payment method.
- Has a policy 'checklist' to guide states, available at: http://www.dhs.wisconsin.gov/managedltc/grantees/webcasts/033006.htm
- Approves the capitated rates submitted by the state.
- Contributes to funding the rate.

DHS Role in Rate Setting

- Must calculate an "actuarially sound rate":
  - A reasonable projection of the **average** PMPM cost to provide the Family Care benefit to the target population.
- Works with CMS:
  - Demonstrates compliance with CMS rate checklist.
- Works with MCOs:
  - Obtains data, shares information, presents analysis, and reviews contract language.
- Contracts with an independent actuarial firm to calculate rates:
  - PricewaterhouseCoopers is the current actuarial firm.

DHS Rate Setting Process

- Uses encounter data from MCOs - detailed, person-specific service and cost information.
- Uses some functional status criteria from individual assessments in the long term care functional screen.
- A statistical model correlates these data to calculate average cost and is adjusted for member acuity.
- The statistical model identifies:
  - A minimum amount each MCO will get for every member;
  - Certain functional characteristics strongly related to costs above the minimum, and
  - The level of additional cost associated with specific functional member characteristics.

DHS Rate Setting Process

- Higher PMPM rates are paid to MCOs with higher need members.
- Rates are trended forward to the contract year which accounts for projected inflationary and utilization changes.
- Actuarial analysis is available on the DHS website:

http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/CapitationRates.htm

Managed Care Organization's (MCOs) Role

- MCOs work with members to develop an individual care plan that meets long-term care outcomes. The right care, in the right amount, and in the right setting.
- Cost-effective means using the least costly option that is efficient and effective to support a member's outcomes.
- Develop business plans to estimate the cost of providing member care.
- Supply reliable, timely encounter data after providing services to members.
- Work with service providers to:
  - Plan and authorize services, person-by-person;
  - Negotiate contracts; and
  - Set rates.
- Identify and implement appropriate efficiencies.

Managed Care Organization's (MCOs) Role

- The PMPM rate paid by DHS may not be used as an upper limit on the cost of services each person receives.
- Relationship to risk:
  - Revenues may exceed costs, generating a surplus over time. The industry average is 2%.
  - Costs may exceed revenues in a given year.
- Managed care risk = unpredicted service cost:
  - Capitation revenue is based on historical costs;
  - MCO contracts with providers establish the rates for payment; and
  - Member service needs may differ from historical average.
- DHS shares this risk with the MCO in early or expansion years.

Cost Effectiveness & Fiscal Sustainability

Implement cost-effective and fiscally sustainable strategies to:

- Delay entry into the publicly funded long term care system;
- Strengthen Self-Directed Supports;
- Assure a continuum of services;
- Assure the right service, in the right amount based on a person's long-term support needs;
- Support integrated community employment;
- Prevent nursing home and hospital stays with medication management and other effective strategies;
- Ensure utilization of informal supports whenever possible;
- Ensure consistency between programs; and
- Promote effective interventions and diversion practices related to nursing homes and assisted living facilities.

Long-Term Care Efficiency & Sustainability

Change in Policy: Explore options to address cost drivers and ensure the cost-effectiveness and fiscal sustainability of long term care programs, including:

▪ Increase Administrative Efficiencies / Savings	▪ Increase Program Integrity	▪ Nursing Home Intervention/Diversion
▪ Flexibility / Light Touch	▪ Residential Services	▪ Strengthen Self-Directed Supports and IRIS
▪ ADRCs Outreach, Early Intervention and Prevention Activities	▪ Youth in Transition	▪ Continue Community Relocation Efforts
▪ Level Playing Field between Long Term Support Options	▪ Employment	▪ Crisis Intervention and Stabilization

Nursing Home Improvement Efforts

- Licensed Bed Assessment
- Nursing Home Quality – Falls Prevention Project
- Nursing Home Modernization

Licensed Bed Assessment

- Provider assessment on nursing home beds since 1991-92 in Wisconsin.
- 2003 Wisconsin Act 33 created the current Licensed Bed Assessment program, under which nursing homes and ICFs-ID pay a monthly amount per licensed bed.
- The assessment applies to all licensed beds, regardless of whether the bed is occupied by a resident whose stay if funded via Medicare, Medicaid, or private pay, or is unoccupied.
  - Nursing Homes operated by the Department of Veterans Affairs are exempt from paying the bed assessment.
- For skilled nursing facilities, the Licensed Bed Assessment is $170 per month.
- The rate for ICF-ID beds is calculated by formula, and is currently $910 per month.
- Revenues generated from the nursing home bed assessment are deposited in the Medicaid Trust Fund, and draw federal match.
- Revenues received were approximately $72.3M in SFY 11-12.

Nursing Home Quality – Falls Prevention Project

- Sponsored by Secretary-Elect Rhoades.
- Department initiative with cross-divisional leadership from: Divisions of Long Term Care, Quality Assurance, and Public Health.
- In collaboration with LeadingAge WI and WI Health Care Association.
- In collaboration with Center for Health Systems Research & Analysis (CHSRA) utilizing Civil Money Penalties (CMP) funds.
- Collaborate with MetaStar for training.

Nursing Home Quality – Falls Prevention Project: Objectives and Goals

Goal – decrease falls; decrease citations; decrease cost to system; and improve quality of life.

- Identify leaders within the provider community with expertise in fall prevention.
- Study what's working and share demonstrated practices with those needing improvement.
- Study the effectiveness of this mentoring model.
- Publish successful models.
- Increase effective falls prevention across the provider communities.

Nursing Home Modernization

The goals of the Modernization Property Incentive are to:

- Support the use of resident-centered facility design concepts to update and improve nursing home facilities; and
- To do so in a manner which will not increase overall costs to the Medicaid program.

- Beginning in calendar year 2013, facilities may request a special Modernization Property Incentive rate adjustment to support construction projects related to renovation or replacement of existing buildings.
- Successful applications will:
  - Include design features that emphasize resident quality of life as well as demonstrating cost neutrality or cost savings to the Medicaid program;
  - Be prospective: requests will not be considered for projects already underway or previously completed; and
  - Involve the return of licensed beds to the state.

Nursing Home Modernization, continued

Design Criteria

- Various design elements will be considered.
- Successful applications will feature design elements that are aligned to a resident-centered, home-like facility.
- Facilities have flexibility to incorporate resident-centered design elements to fit their approach to skilled nursing care, project budget, and property footprint.

Cost Neutrality

- Applicants must demonstrate cost savings to the Medicaid program that will, at a minimum, equal the Modernization Property Incentive payment. Loss of revenue from Bed Assessment payments is included in the cost neutrality projection.
- The time frame over which cost neutrality will be achieved is specified in the application, and will vary from project to project.

Nursing Home Modernization, Options

Four Options

	Nursing Home Downsizing	Replacement Facility	Small Replacement/ Renovation – 60 beds	Small Replacement/ Renovation – 50 beds
Return Bed Licenses to State	15% Min. Census Reduction	Yes	Yes	Yes
Include Resident-Centered Design Elements	Yes	Yes	Yes	Yes
Cost Neutrality Requirement	Yes	Yes	Yes	Yes
Rate add-on	No	No	$5/MA Patient Day	$10/MA Patient Day
Base Rate Impacts	Frozen during Project	Property URC Increased to $135,000 after completion	Property URC Increased to $135,000 after completion	Property URC Increased to $135,000 after completion