



## Wisconsin Family Impact Seminars

# Long-Term Care Reform: Wisconsin's Experience Compared to Other States

Center for Excellence in Family Studies  
School of Human Ecology  
University of Wisconsin-Madison  
and  
University of Wisconsin Extension

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# Long-Term Care Reform: Wisconsin's Experience Compared to Other States

*First Edition*

## Wisconsin Family Impact Seminars Briefing Report

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School of Human Ecology  
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## Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers. The Seminars are designed to connect research and state policy and bring a family perspective to policymaking. Family Impact Seminars analyze the consequences that an issue, policy, or program may have for families. Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping 20 other states conduct their own seminars through the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension.

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"Long-Term Care Reform: Wisconsin's Experience Compared to Other States" is the 23rd Wisconsin Family Impact Seminar. For information on other Wisconsin Family Impact Seminars topics or on Seminars in other states, please visit our Web site at [www.familyimpactseminars.org](http://www.familyimpactseminars.org).

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## Executive Summary

Long-term care includes a broad range of services needed by people with chronic illness or disabling conditions over a long period of time. In 2004-2005, Wisconsin's Medicaid program spent nearly \$2.2 billion on long-term care, about half on home and community-based programs (48%) and half on institutional care (52%). In 2003, Wisconsin ranked 11<sup>th</sup> highest in the nation for percent of elderly in a nursing home. Often forgotten is that most care for the elderly and disabled is provided free by family members and friends.

Policymakers are anticipating increased demand for long-term care services, because of an increasing elderly population and less time for families to care for the elderly and disabled. Caregivers are experiencing a heavy emotional and physical toll, and often have to make workplace accommodations to meet caregiving demands. Employers are concerned given recent national estimates that lost productivity due to caregiving responsibilities costs them between \$11 and \$29 billion each year. In response, this briefing report features three national experts who review how Wisconsin and other states are reforming long-term care policy.

The first chapter, written by **Wisconsin Family Impact Seminars** staff, reviews why there is so much interest in long-term care and encourages policymakers to consider the important role that families play. Long-term care needs are increasing because of technologies that keep people alive longer and the aging of the baby boomers. Of all the people in human history who have ever lived past the age of 65, half are alive today.

In Wisconsin, the proportion of elderly is growing from 13% of the population in 2000 to an estimated 21% in 2030. The fastest growing age group is those most likely to need long-term care services—the oldest old, those 85 years and older. In fact, in 2002, Wisconsin ranked 8<sup>th</sup> in the nation for percent of people aged 85 or older.

Informal caregivers, primarily family and friends, are the only source of care to 78% of the elderly and disabled who need long-term support. The value of this care, estimated to be three times the amount spent by Medicaid, does not show up in state or federal budget ledgers. Yet, in one study, 50% of elderly people with long-term care needs who lacked a family network lived in a nursing home, compared to 7% who had family caregivers.

Given data like these, some observers have recommended reframing the policy debate to the individuals, mostly family members, who provide most of the care. One central policy question is how we can supplement and strengthen family caregiving. States are supporting family caregiving in many ways, such as respite services, caregiver support programs, tax credits for caregiver expenses, and expansion of family and medical leave. The chapter concludes with criteria that policymakers can use to assess how family friendly long-term care legislation is.

Next, **Mark Meiners**, national director of the Robert Wood Johnson Medicaid/Medicare Integration Program, reports that Wisconsin is widely recognized as a leader for integrating long-term care services. The Wisconsin Partnership Program began in 1996 and operates through four non-profit health plans in selected locations. To improve access and quality, the Partnership Program fully integrates acute and long-term care for clients dually eligible for Medicaid and Medicare. The Partnership Program was able to achieve significant outcomes, even though payments were 5% less than in nonprogram sites. After one year in the Partnership Program, the number of nursing home days decreased 25% for the elderly. The program also decreased hospital use for the elderly and disabled, and prescription drug increases were well below the national average.

Family Care is a Medicaid-only program that was piloted in five Wisconsin counties in 2000. Family Care is administered by county care management organizations. Family Care relies on nurses and social workers to *coordinate* primary and acute care services, rather than to *provide* those services. Family Care has eliminated waiting lists for over three years now. In independent evaluations, members' health outcomes remained good and the cost savings were encouraging. Over the two-year study, Medicaid costs for Family Care members outside Milwaukee were, on average, \$452 less per month than in the comparison group; in Milwaukee, monthly costs were \$55 lower.

The bottom line is that no clear consensus has emerged about how best to integrate long-term care services. The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for the aged and disabled, because it allows full integration of all primary, acute, subacute, and long-term care dollars. Yet Medicare is still a difficult partner, and evaluations of Family Care suggest that significant improvements can be made with partial integration.

**Roy Fredericks** is the Estate Administration Manager of Oregon's nationally known estate recovery program. Oregon's program is based on this premise: if someone uses taxpayer resources for long-term care and if assets remain in their estate upon their death, it is fair that these assets go back to the taxpayers who have been footing the bill. The chapter begins by identifying ways that assets can be transferred between spouses to avoid estate recovery: (a) taking advantage of the penalty for transferring assets; (b) using court orders to transfer assets to the spouse during the Medicaid recipient's lifetime; (c) transferring interest in the home to one's spouse; and (d) transferring assets to annuities that are excluded in determining Medicaid eligibility.

In fiscal year 2003, Oregon recovered \$20 million or 2.2% of Medicaid long-term care expenditures; in contrast Wisconsin's recovered \$17.6 million or 0.8% of Medicaid long-term care expenditures. Oregon is able to recover an estimated \$14 for every dollar invested in the program using a number of best practices. For example, if Wisconsin expanded its definition of estate to include survivorship interests, life estate interests, living trusts, and remainder interests in client-centered annuities, recoveries could increase by an estimated 20% to 25%. Wisconsin could increase its recoveries by an estimated 10% to 15% by pursuing claims against the estate of the surviving spouse for assistance to the spouse who died first. Oregon has also made changes in its probate statutes to make the state a priority creditor, so that the state's interests are paid off before credit cards and other general creditors. In Oregon, the estate recovery unit must be notified of a client's death within 10 working days of the field unit's notification.

Oregon has generated public and political support for its program in several ways. First, any money that is returned to the state goes directly back into human services programs or to help other low income seniors and disabled clients. Second, when heirs want to keep the home, Oregon is willing to take a mortgage and have the family pay back in installments. Third, Oregon's public education program ensures that no client or their family is surprised when the state tries to recover the costs of public assistance. Finally, Oregon's program has highly qualified, well paid staff, who receive training on family-centered practices such as being sensitive to families grieving the loss of their loved one.

In the fourth chapter, **Charles Milligan** and **Ann Volpel** of the Center for Health Program Development and Management discuss two ways that states have entered into public-private partnerships in long-term care: managed care and long-term care insurance. Managed care is fairly common in the delivery of Medicaid acute care services across the nation, with 58% of Medicaid beneficiaries receiving their care this way. In contrast, managed care is rare in the delivery of long-term care services; only 3% of Americans who receive Medicaid long-term care services get them from a managed care organization. One state—Arizona—delivers all of its Medicaid long-term care services through managed care. Six states, including Wisconsin, have managed care programs for certain populations in the state. Of the managed care organizations providing care across the country, 70% are nonprofits and 15% are local government agencies (e.g., counties).

Another public-private venture involves long-term care insurance. Four states (California, Connecticut, Indiana and New York) currently participate in the Long-Term Care Partnership Program. Only 1.3% of the 212,000 people who purchased policies have ever received insurance benefits, and almost 900 people died while receiving benefits. Yet, it is unclear if these facts mean that the Medicaid program saved money. Although many other states are interested in joining the Partnership Program, it cannot be expanded nationwide unless Congress changes the federal estate recovery statutes to relax the asset requirements of individuals who purchase insurance policies. Wisconsin currently has legislation on the books that requires the Department of Health and Family Services to seek federal approval and financing for projects that would allow Wisconsin Medicaid recipients to keep more of their assets if they purchase long-term care insurance.



# A Checklist for Assessing the Impact of Policies on Families


The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

 **This checklist can be used to conduct a family impact analysis of policies and programs.**  
*For the questions that apply to your policy or program, record the impact on family well-being.*

## 1

### Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

## 2

### Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

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**3****Principle 3. Family involvement and interdependence.**

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

**4****Principle 4. Family partnership and empowerment.**

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

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5

**Principle 5. Family diversity.**

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6

**Principle 6. Support of vulnerable families.**

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The Institute has resources for researchers, policymakers, practitioners, and those who work to connect research and policymaking.

- To assist researchers and policy scholars, the Institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the Institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the Institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the Institute provides technical assistance on how to establish your own state's Family Impact Seminars.

This checklist was adapted by the Institute from Ooms, T. (1995), *Taking families seriously as an essential policy tool*. This paper was prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988), *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

The checklist and the papers are available from Director Karen Bogenschneider or Coordinator Heidi Normandin of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 130 Human Ecology, 1300 Linden Drive, Madison, WI, 53706 phone (608)262-5779 FAX (608)262-5335 <http://www.familyimpactseminars.org>





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# A Policymaker's Guide to Long-Term Care in Wisconsin: Public, Private, and Family Perspectives

*by Heidi Normandin and Karen Bogenschneider  
Wisconsin Family Impact Seminars*

*In fiscal year 2005, Wisconsin spent nearly \$2.2 billion on long-term care; about half for home and community-based services (48%) and half for institutional care (52%). Often forgotten is the unpaid care provided by family and friends, valued at three times that of Medicaid expenditures. These informal caregivers are the only source of care to 78% of the elderly and disabled who need long-term services or support. With an increasing elderly population and less time for families to provide caregiving, policymakers are increasingly searching for ways to reform long-term care such as creating public/private partnerships, improving access to home and community-based care, promoting long-term care insurance, and strengthening asset transfer and estate recovery policies. Policymakers are also finding ways to support informal family caregivers through respite services, support programs, and expansion of family and medical leave.*

Long-term care has been called the “sleeping giant” of family policy. As Medicaid has quietly become the nation’s largest payer of long-term care services, state policymakers in particular have become increasingly interested in workable reform strategies. This chapter overviews why there is so much interest in long-term care, defines long-term care and differentiates it from acute care, and explains how much citizens, families, the private sector, and Wisconsin’s government invest in long-term care. The report concludes by examining what public and private actions are being taken to address this important issue, identifying steps that states are taking to promote family involvement in long-term care, and proposing criteria that policymakers could use to assess how family friendly long-term care legislation is.

## **Why are Wisconsin Citizens and Policymakers Interested in Long-Term Care?**

**The number of elderly in Wisconsin is growing.** Long-term care policy involves two major populations: (a) people with mental and physical disabilities and (b) the aged. Long-term care needs are increasing because of technologies that keep people alive longer and the aging of the baby boomers. Of all the people in human history who have ever lived past the age of 65, half are alive today.<sup>1</sup>

The number of elderly in Wisconsin grew by over 51,000 between 1990 and 2000, yet their percent of the population remained about the same (see Figure 1).<sup>2,3</sup> In contrast, predictions about the next 25 years show a steady increase in the proportion of residents who are over 65. By 2020, the number of elderly is

expected to grow to 1.02 million.<sup>4</sup> By 2030, the number is expected to grow to 1.34 million, an estimated 90.2% increase from 2000.<sup>5</sup> As Figure 1 shows, Wisconsin has a slightly higher percent of elderly compared to the nation as a whole.<sup>6,7</sup>

**Figure 1: Number and Percent of Elderly  
(65 years and older)  
1990 to 2030 (estimated)**

Year	Number of Elderly in Wisconsin	Elderly as Percent of Wisconsin Population	Percent of Americans who are Elderly
1990	651,221	13.3%	12.6%
2000	702,553	13.1%	12.4%
2020 (est.)	1,022,359	16.7%	16.3%
2030 (est.)	1,336,384	20.8%	19.6%

In 2002, Wisconsin ranked 8th in the nation for percent of people age 85 or older.<sup>8</sup> The oldest old, those 85 years and older, is the fastest growing age group in Wisconsin and will continue to be until 2010. After 2010 the number will increase more slowly, but it is expected that the oldest old will again comprise the fastest growing age group in 2025 once the baby boomers enter their ranks.<sup>9</sup>

**Many elderly will need long-term care services.** While the majority of elderly do not need long-term care services, the likelihood that they will need services increases with age. In 1999, 15.9% of Americans aged 65 and over received long-term care services of some kind.<sup>10</sup> Of those aged 65 to 69, only 5.7% used long-term care services during the year, compared to 39.8% in the 85-89 age group and 72.1% of those 95 and over.

**Long-term care is costly.** Whether provided to the growing elderly population or people with disabilities, long-term care is a priority for states because Medicaid accounts for nearly half (47%) of the nation's spending on long-term care services.<sup>11</sup> Estimates show that, in 2004, Medicaid paid one third of all long-term care spending on the elderly and 30% of their nursing home costs.<sup>12</sup> For people under 65 with disabilities, Medicaid paid an estimated 60% of their long-term care services and supports in 1998.<sup>13</sup>

According to the Kaiser Commission on Medicaid and the Uninsured, Wisconsin spent 41.8% of its Medicaid dollars on long-term care in fiscal year 2003, exceeding the national average of 31.6%.<sup>14</sup> Long-term care is costly for individuals and families, too. Seniors who do not qualify for Medicaid pay an average of \$70,000 per year for nursing home stays.<sup>15</sup> In 2003, Wisconsin ranked 11th highest in the nation for percent of elderly 65 and over who were in a nursing home—4.9%.<sup>16</sup>

***In 2003,  
Wisconsin ranked  
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nation for percent  
of elderly in a  
nursing home.***

**Family caregivers are less available due to competing demands on their time.**

Most long-term care services are provided in the community, often by family members. Nationally, 75% of people 65 or over who have long-term care needs receive services in the community. The remaining 25% receive care in a nursing home.<sup>17</sup> The vast majority of disabled adults age 18 or over living in the community—about 80%—receive unpaid assistance from family, friends and neighbors.

The ratio of available caregivers to those needing care is expected to decline by almost two thirds by the year 2050 for many reasons. On average, families are smaller, more apt to have two wage earners, and less likely to live close to relatives. As parents have children later in life and find adult children returning to the nest, they are more likely to be juggling responsibilities for childrearing and elder care.<sup>18</sup> The more problems caregivers report, the greater the chances that family members they are providing care for will be institutionalized.<sup>19</sup> In one study, 50% of elderly people with long-term care needs who lacked a family caregiver lived in a nursing home, compared to 7% who had family caregivers.<sup>20</sup>

**What is Long-Term Care?**

Long-term care includes a broad range of services needed by people with chronic illness or disabling conditions over a long period of time. Long-term care needs are highly correlated with medical conditions such as arthritis, paraplegia, dementia, or chronic mental illness. These services focus on providing assistance with daily activities to minimize, rehabilitate, or compensate for the loss of independence. These services include assistance with a) activities of daily living such as bathing, dressing, and eating and/or b) instrumental activities of daily living such as household chores, meal preparation, cleaning, shopping, money management, and transportation.

One reason that long-term care is such a perplexing policy issue is the range in the type of care that is provided, who provides it, and where it is provided. In regard to the type of care, most long-term care is low-tech, but it may also include high-tech medical interventions such as intravenous drug therapy, ventilator assistance, and wound care. In regard to the caregiver, long-term care may be provided by unpaid family members or friends (informal caregivers) or by specially trained paid professionals and paraprofessionals (formal caregivers).

In regard to where care is provided, long-term care occurs in a range of settings. The most restrictive end of the continuum is nursing home or facility care. Home and community-based care is a catchall for a wide variety of noninstitutional options. Residential care services, such as assisted living facilities and adult foster homes, fall into this category, although there are features of institutional care in these settings. Other settings more clearly classified as home and community-based care include adult day care and care in one's own home. In the home, care is further differentiated between home health care, which includes some level of skilled nursing, and home care, which includes personal care services and homemaking chores.

***The elderly without family caregivers are 7 times more likely to be in a nursing home.***

## **In What Ways Does Long-Term Care Differ from Acute Care?**

One of the most difficult aspects of designing long-term care policy is its inherent differences from the more familiar acute care. Long-term care involves a loss of functional capacity over a period of years; in contrast, acute care is more often a short episodic need for health care. Long-term care requires a series of decisions about the family and institutional supports needed to meet a specific loss of functioning, which is typically followed by another set of decisions as other functions decline. To the contrary, acute care is more apt to require one set of decisions to meet a more well-defined health care need. Long-term care often requires planning for some level of family support, but also identifying and integrating physician, hospital, and sometimes facility care. Acute care often is limited to selecting an excellent physician or hospital.

The dilemma that policymakers face is designing a system without knowing what functions will decline, how long these services will be needed, which medical advances might be developed, and what family supports will be available for the various individuals who will use the long-term care system. Physicians, consumer/patients, family members, and other caregivers are unable to predict whether a patient's particular acute care episode, especially episodes for conditions with lengthy recovery periods, will evolve into a long-term care need. How much functioning will a particular person recovering from a stroke in an acute care setting or receiving rehabilitation in a post-acute setting regain over the course of the treatment? If recovery is faster and more complete, the episode would be considered acute. If recovery is incomplete, the episode would transition to one in which the consumer/patient needs long-term care.<sup>21</sup>

Recently there have been shifts in thinking about long-term care. For example, the disability community is proposing a shift in terms from long-term care to long-term services and supports that allow people to remain in the community. Also instead of talking about quality of care, some people are talking about quality of life at the end of life.<sup>22</sup>

## **How Much does the State of Wisconsin Spend on Long-Term Care?**

***In FY 2005, the Wisconsin Medicaid program spent \$2.2 billion on long-term care services.***

Wisconsin Medicaid dollars pay for long-term care services provided in institutions such as nursing homes, State Centers for the Developmentally Disabled, and Veterans Homes, and in home and community-based settings through programs such as the Community Integration Program (CIP), Family Care, the Partnership Program and the Community Options Program (COP). In 2004-2005, the state Medicaid program spent nearly \$2.2 billion on long-term care services; 48.2% on home and community-based care and 51.8% on institutional care (see Figure 2). The service expenditures presented on the following page do not reflect acute care services that elderly and disabled Medicaid recipients receive, such as hospital care, physician services, and prescription drugs. The Medicaid costs associated with acute care services are reflected elsewhere in the Medicaid budget.

**Figure 2. Wisconsin Medical Assistance (MA) Expenditures for Long-Term Care Services SFY 2004-2005**

	<b>Expenditures</b>	<b>Percent of Grand Total</b>
<b>Community-Based Services</b>		
MA Home and Community-Based Waiver Programs (except COP and COP-W programs)	394,882,422	18.1%
Community Options Program (COP) and Community Options Waiver Program (COP-W)	149,533,736	6.8%
Family Care Capitation Payments	171,047,691	7.8%
Independent Care Program	47,445,872	2.2%
PACE and Partnership Programs	88,786,681	4.1%
MA Card Services for Home Care	<u>200,612,650</u>	<u>9.2%</u>
<b>Total – Community-Based Services</b>	<b>1,052,309,052</b>	<b>48.2%</b>
<b>Institutional Care</b>		
Nursing Homes (other than state facilities)	971,022,000	44.5%
State Veterans Home at King	45,162,000	2.1%
State Centers for the Developmentally Disabled	<u>114,587,000</u>	<u>5.2%</u>
<b>Total – Institutional Care</b>	<b>1,130,771,000</b>	<b>51.8%</b>
<b>Grand Total</b>	<b>2,183,080,052</b>	<b>100.0%</b>

*Source: Wisconsin Legislative Fiscal Bureau (December 2005), based on information from the Wisconsin Department of Health and Family Services.*

### **How Much do Family, Friends, and the Private Sector Spend on Long-Term Care?**

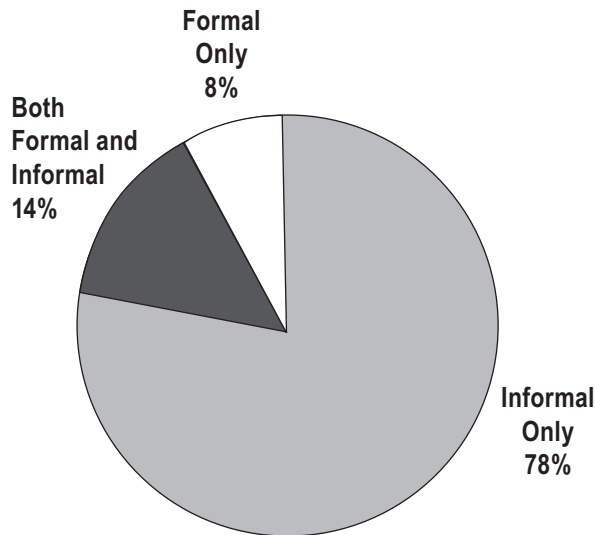
Both the recipients of long-term care services and their families pay for a significant portion of long-term care services. Whereas Medicaid was the largest payer (40%) of total long-term care expenditures in 2003, out-of-pocket spending was the second highest payer category at 25%.<sup>23</sup> Of nursing home expenditures, out of pocket payments (28%) were again second only to Medicaid (46%).

Perhaps more importantly, the vast majority of long-term care for the elderly and disabled is provided free by informal caregivers. An estimated 44.4 million family members and friends provide care to someone 18 or over.<sup>24</sup> Informal caregivers help with activities such as writing checks, cleaning, buying groceries, attending medical appointments, and administering medications. Not surprisingly, the majority of informal caregivers are family members, with a parent (25%), other relative (21%), child (16%), or spouse (15%) providing the care.<sup>25</sup>

The value of this care does not show up in state or federal budget ledgers. The economic value of informal caregiving in 2002 was estimated to be \$256 billion,

or three times the \$82 billion spent by Medicaid.<sup>26</sup> This value may be a result of the heavy reliance on informal caregivers by adults who receive long-term care services at home. The majority of adults (78%) receive only informal care from family or friends (see Figure 3).<sup>27</sup> A much lower percent (8%) receives only formal care.

**Figure 3. Type of Care Received by Adults at Home  
1994-1995**



*Source: Health Policy Institute, Georgetown University. Analysis of data from the 1994 and 1995 National Health Interview Surveys on Disability, Phase II.*

These national statistics mirror what is happening in Wisconsin. According to a 2001-2002 survey conducted by the Wisconsin Department of Health and Human Services, citizens 65 and over rely extensively on family members for care.<sup>28</sup> Of the seniors living alone, 80% said someone checks in on them regularly. Children checked in most frequently (53%), followed by neighbors (24%) and friends (15%). Caregiving *by* the elderly does not stop at old age either. Almost a third (31%) of the elderly respondents said they have at least one kind of caregiver responsibility, including caring for a child with a disability, spouse, or grandchild.

Caregiving can take a heavy emotional and physical toll, with an estimated financial impact of \$12,500 yearly per caregiver to cover expenses such as groceries, medications, and home modifications.<sup>29</sup> Over 6 in 10 (62%) of caregivers report that they have to make workplace accommodations to meet caregiving demands. This lost productivity is estimated to cost employers between \$11 and \$29 billion per year.<sup>30</sup>

**Lost productivity from caregiving demands costs employers \$11 to \$29 billion a year.**

### **What are Citizens Doing to Plan for Future Long-Term Care Expenses?**

In early 2005, the Kaiser Family Foundation conducted a national poll on the public's views on long-term care and nursing homes.<sup>31</sup> Over one-fourth of



Americans (28%) said they are “very” worried that they won’t be able to pay for nursing home and home care services. Over a quarter (26%) say they have given “a lot” of thought to how they will pay for long-term care.

In the Kaiser survey, three in ten (30%) said they would pay for nursing home care with insurance for themselves or family members. Fewer people said they would use personal savings (16%) or government programs such as Medicare or Medicaid (13%). Contrary to the poll results, however, private insurance is estimated to pay only a small share of nursing home expenses (8%), whereas Medicaid finances almost half (46%) of nursing home care.

About one in five (21%) report having a long-term care policy. The 79% without insurance said that the cost was too prohibitive (59%) or they had not thought about insurance (32%). A federal tax credit appears to be an incentive to purchase insurance for some consumers. About half (48%) said they would be more likely to buy a policy if there was a credit; the same number (48%) said they would not.

The vast majority of the survey respondents (84%) have had some experience with nursing homes as a patient, family member of a patient, or visitor. About half (46%) said a family member or close friend has been in a nursing home in the past 3 years. Only about one in ten (12%) said they would choose to receive care in a nursing home if they required full-time care. More (39%) would choose to receive care in a hospital.

## What Could States Do to Reform Long-Term Care?

Last year, the National Governors Association (NGA) released a report on Medicaid and health care reform.<sup>32</sup> Below are selected reform strategies that NGA says states could implement:

- Prevent inappropriate asset transfers. NGA recommends increasing the look-back period from three years to five years (or longer), beginning the penalty period at the time of application, and preventing the sheltering of annuities, trusts, and promissory notes.
- Reverse mortgages. Home equity could be considered a countable asset in offsetting long-term care expenditures. Reverse mortgages and other similar approaches require some form of family contribution to long-term care costs.
- Tax credits and deductions for long-term care insurance. Currently about 28 states, including Wisconsin, provide deductions or tax credits for long-term care insurance.
- Long-term care partnerships. Although their approaches differ, California, Connecticut, Indiana, and New York offer insurance policies which allow individuals to purchase private insurance and still protect some of their assets. Federal law currently prohibits expansion of these partnerships to other states, but 17 states have passed enabling legislation in the event that the prohibition is repealed.

***Currently, 28 states, including Wisconsin, provide deductions or tax credits for long-term care insurance.***

Wisconsin has legislation on the books that requires the Department of Health and Family Services to seek federal approval and financing for a project that would allow Wisconsin Medicaid recipients to keep more of their assets if they purchase long-term care insurance. [See Sections 49.45(31) and 146.91, Wis. Stats.]

- Improving access to home and community-based care. Such care is believed to produce better health outcomes and results in greater efficiencies.
- Improving chronic care management. The chronically ill are a small population in Medicaid that uses a large share of resources.
- Assisting and supporting in-home workers. More than 20 states have passed legislation to increase direct-care workers' wages with state or Medicaid funds.

### **What are States Doing to Promote Family Involvement in Long-Term Care?**

Over a decade ago, the Consortium of Family Organizations recommended reframing the terms of the long-term care to the individuals, mostly family members, who provide the bulk of long-term care. As mentioned earlier, the elderly without family caregivers are over 7 times more likely to be in a nursing home than those with a family network. Given data like these, the key to controlling costs and improving the quality of the care is focusing on the central policy question—how can we support, supplement, and strengthen family caregiving. Responding to this central policy question has become more complicated given recent changes in family life.

Last year the National Governors Association summarized the options states have used to support family caregivers.<sup>33</sup> The six strategies are briefly summarized below.

***States are providing the service that family caregivers say they need most: respite and day care.***

- Using state and federal funds to support respite services. States are providing the service that family caregivers say they most need—respite and day care to provide time away from the stresses of caregiving.<sup>34</sup> State program directors believe that expanding caregiver support programs can reduce the strain on Medicaid and other state-funded home and community-based options. Oklahoma, Oregon, and Nebraska are integrating federal, state and local dollars to coordinate respite care for caregivers, regardless of the age of the care recipient. Nebraska provides a subsidy of \$125 per eligible family client per month, which can be banked for up to three months.
- Using state revenue to support family caregivers. California and Pennsylvania use general revenues to provide comprehensive caregiver programs. Wisconsin's Family Caregiver Support Program varies across counties, but each county's program encompasses five components: information about services, assistance in accessing services, individual counseling and training to caregivers, respite care, and supplemental services.

- Maximizing choice for consumers and caregivers. Arkansas, Florida, and New Jersey are piloting a self-directed care model known as *Cash and Counseling*. Medicaid long-term care recipients are paid cash allowances to hire workers (excluding spouses and relatives) and purchase goods and services that meet their needs. North Dakota, which has a shortage of health care workers, provides eligible family members a monthly payment to care for a live-in relative, who would otherwise qualify for nursing home admission.
- Improving the tax treatment of caregiver expenses. At least 26 states offer dependent care tax credits, which reduce the amount of income taxes a family owes for dependent care.
- Expanding family and medical leave. The federal Family and Medical Leave Act guarantees employees of businesses with at least 50 employees 12 weeks of unpaid leave each year to care for a newborn, newly adopted child, or seriously ill family member. States have expanded their laws in several ways; if Wisconsin has such a law, it is included below:
  - ◆ Allowing public and private-sector employees to use their leave to care for an inlaw or grandparent (Washington); Wisconsin law allows taking family leave to care for an inlaw, but not a grandparent (unless the grandparent is raising the child)
  - ◆ Expanding leave provisions to workplaces with fewer than 50 employees (Oregon and Vermont)
  - ◆ Extending the 12 week leave period (California, Connecticut, Louisiana, Oregon, Rhode Island, and Tennessee)
  - ◆ Allowing family medical leave for conditions not covered by the federal law (Maine, Massachusetts, Vermont, and Wisconsin); federal law excludes serious health conditions of less than three days, whereas Wisconsin law will cover serious health and disabling conditions of a shorter duration (e.g., a person who dies after a two-day hospitalization); neither federal or state law covers leave for a caregiver whose child or elder is too sick to go to child or day care, but is not seriously ill
  - ◆ Allowing leave with some wage replacement through disability insurance or sick leave (California, Hawaii, Minnesota, Oklahoma, Washington, and Wisconsin)
  - ◆ Offering paid family leave through the state's disability insurance program (California)
  - ◆ Promoting public/private partnerships and public awareness. Some states are educating employers about the effects of caregiving on their employees' productivity, and other states are raising general awareness of the needs of family caregivers through statewide outreach and marketing efforts.

***Wisconsin law allows taking family leave to care for an inlaw, but not a grandparent.***

## What Criteria can Policymakers Use to Assess how Family-Friendly Long-Term Care Legislation Is?

The Wisconsin Family Impact Seminars encourage policymakers to acknowledge and take into account the crucial role that family caregivers play in providing long-term care. Family-friendly policies would assist families in providing care for the disabled and the elderly without requiring total sacrifice of other personal, family, or occupational pursuits. At the same time, such policies would not absolve individuals of any responsibility to care for and assist family members who have long-term care needs. Legislators can assess laws and legislation for its impact on family well-being by raising and responding to the following family impact questions (the full set of questions starts on page xi of this report).

- Does the policy support and supplement family functioning and provide substitute services only as a last resort?
- Does the policy encourage and reinforce marital, parental, and family commitment and stability?
- Does the policy recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members?
- Does the policy encourage individuals and their close family members to collaborate as partners with programs or professionals in the delivery of services to an individual?
- Does the policy take into account the varying effects on different types of families?
- Does the policy support those in greatest economic and social need, as well as those determined to be most vulnerable to breakdown?

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# A Review of Wisconsin's Strategies for Long-Term Care Reform: Family Care and the Partnership Program

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**W**isconsin is widely recognized as a leader for integrating long-term care services. To improve access and quality, the Wisconsin Partnership Program uses non-profit health plans to fully integrate acute and long-term care for clients dually eligible for Medicaid and Medicare. Family Care is a Medicaid-only program administered by county care management organizations. The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for the aged and disabled, because it allows full integration of all primary, acute, sub acute, and long-term care dollars. Yet Medicare is still a difficult partner, and evaluations of Family Care suggest that significant improvements can be made with partial integration.

Long-term care reform is difficult for many reasons. Perhaps this is because long-term care is not one thing, but many things—things we take for granted when we are young and healthy. For example, long-term care includes things not obviously related to the health care system like family support, transportation, and housing. There is also confusion on what health services are really meant to be for long-term care. Those services that we might think of as directly related to long-term care like nursing home and home health care are not long-term care from Medicare's perspective. But if you are poor and eligible for Medicaid, those same services are indeed major long-term care expenditures that states must help pay for. The key difference is whether these services are skilled-care oriented versus custodial or maintenance services. Medicare only pays for skilled care nursing home and home care, and only for relatively short periods of time where recovery or rehabilitation is likely.

States have been the leaders in the reform of long-term care. The fact that much of long-term care is related to daily living needs rather than health care needs tends to make the approach to care more the concern of individuals and their communities. Perhaps even more important, financing and administration of long-term care under the Medicaid program has been an increasing burden for states. Their desire to find home and community-based alternatives to nursing home care has provided most of the experience with program innovation.

States are hungry for workable models to help deal with their long-term care responsibilities. This interest complements the emerging national recognition of the need to improve the health care delivery system for those with chronic care needs. A commonly accepted premise is that to make progress, we must improve

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services.**

the integration and coordination of acute and long-term care. To do this, state governments along with the Federal Centers for Medicare and Medicaid Services (CMS), health plans, and providers have begun to experiment with new systems of care and financing.

Wisconsin is widely recognized as being among the leaders in creating workable strategies for integrating long-term care services. In this report, Wisconsin's Family Care program and Partnership Program are reviewed in the broader context of the lessons learned from the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program.

### **Why this Interest in Medicare/Medicaid Integration and What can it Accomplish?**

According to one school of thought, form follows finance. That is, in the absence of appropriate financing mechanisms and incentives, long-term care reform will be nearly impossible to accomplish. Several factors have prompted renewed interest in how to best integrate Medicaid and Medicare through managed care: (a) the current Medicaid crisis; (b) the new Medicare prescription drug benefit; and (c) the increased recognition of the high cost and unique care needs of many special needs populations, including those eligible for both these programs who are referred to as dual eligibles.

The Medicare/Medicaid Integration Program, with the support of the Robert Wood Johnson Foundation, has been working with states to help end the fragmentation of financing, case management, and service delivery that currently exists with our two main public financing programs (see: [chpre.gmu.edu](http://chpre.gmu.edu)). Wisconsin, along with Arizona, Florida, Massachusetts, Minnesota, Texas, and New York have made considerable progress in developing integrated care programs with the help of the Centers for Medicare and Medicaid Services. Other states (CA, GA, NJ, MD, and WA) have been working at it and are interested in doing more. The initial focus is on public pay clients, although the ultimate potential of these efforts is to provide an effective and efficient care for all populations in need of or at risk for the full array of acute and long-term care services.

One of the lessons from the Medicare/Medicaid Integration Program is that full integration of Medicare and Medicaid is not easy. However, progress toward the goals of integrated care can be made through coordinating Medicaid managed care benefits with traditional Medicare benefits. This raises the question as to whether there is one best approach. Wisconsin's experience with the Partnership Program and Family Care has helped to clarify and inform what can be accomplished with each.

### **How Do Wisconsin's Partnership Program and Family Care Work?**

The Wisconsin Partnership Program (WPP) began in 1996 and currently operates through four non-profit health plans in selected locations in the State. It is a fully integrated program of acute and long-term care designed to improve access and quality, while achieving cost savings for clients "dually eligible"



for Medicare and Medicaid. It uses special waivers to combine the benefits of each program into one system of care. Doing so helps avoid fragmentation and duplication of services—challenges dual eligibles face in the traditional fee-for-service system. Wisconsin's Partnership Program serves elders and adults with disabilities. Acute and long term support services are coordinated across care settings using an inter-disciplinary team comprised of a physician, nurse practitioner, and social worker or independent living coordinator.

Drawing on the early Wisconsin Partnership experiences and with similar goals, Family Care (FC) began in 2000 in five pilot counties. It is a partially integrated (Medicaid only) program that uses special waivers to serve elders, adults with disabilities, and adults with developmental disabilities. The counties provide a flexible benefit package of long-term care services, along with preventive services coordinated by nurse and social worker care managers. Primary and acute services are coordinated with these services, but offered through traditional fee-for-service arrangements. The county care management organization receives a capitated payment for each enrollee's Medicaid long-term care services, and bears the risk for cost-effective service use.

The motivation behind these programs was a desire to address Wisconsin's significant bias toward providing care in institutions by increasing access to long-term supports in the community. The Wisconsin Partnership Program framework was built off a model of integrated Medicare and Medicaid currently known as PACE (Program of All-Inclusive Care for the Elderly), which is now a permanent option under Medicare. Wisconsin's Partnership Program offers important flexibilities that limit the growth in the number and census of PACE programs. PACE requires the use of staff physicians and frequent attendance at an adult day care. Wisconsin's Partnership Program allows patients to keep their own physician and emphasizes care in the home setting.

Family Care was designed to follow the Partnership Program's lead. However it avoids the difficulty and complexity of integrating Medicare with Medicaid and is administered by counties, which have agreed to operate as the care management organization, rather than non-profit health plans. A special selling point of Family Care is that it set out to eliminate the waiting lists that exist with the home and community-based care waiver programs (e.g., COP and CIP) operating in the counties. Family Care encourages the introduction of a broader array of long-term care services operating through managed care and capitated rate-setting strategies.

Both the Wisconsin Partnership Program and Family Care take a broad view of the long-term care needs of the patient. Importantly, both recognize the interrelationships of acute with long-term care, institutional with community care, and medical with social services. Each of these interrelationships represent trade-offs in the daily struggle of those who are eligible and need Medicare and Medicaid benefits. Learning how to better integrate these components of our health care system has prompted the national interest in the experiences of Wisconsin and the other states that have participated in Robert Wood Johnson's Medicare/Medicaid Integration Program.

***The Partnership Program fully integrates acute and long-term care services for clients dually eligible for Medicare and Medicaid.***

MARK R. MEINERS

## What Challenges Have Evaluators Faced?

As is typical with new program ideas, the devil is in the details. It takes time to sort out the key issues that need to be addressed, figure out how to address them, and then correct the mistakes made in each of these steps as you learn along the way. Generally, this all takes place in a context where some who are tracking the process are not supportive, whereas others are sure the ideas are so good that they want to move further and faster. In both cases, it makes even believers nervous about the learning process.

States often are frustrated by evaluation expectations that require programs to be evaluated too early in the program development process. Because the know-how related to implementing long-term care integration programs is still emerging, the programs may be evaluated before they reach a steady state, from which outcomes can best be measured.

In Wisconsin and other states, the bulk of time and resources early on have been focused on just getting the programs to some level of steady state; typically, little time and energy remain for system improvements to ensure the original program goals are met. Fortunately with both Family Care and the Partnership Program, recent evaluation studies occurred beyond the start up stage. They offer some encouragement that the program goals are being accomplished.

## How Effective has the Wisconsin Partnership Program Been?

In August 2005, program administrators reported outcomes for Wisconsin's Partnership Program (WPP) to the Wisconsin Assembly Committee on Medicaid Reform. Program sites were paid 5% less than comparable groups outside the program, yet were able to achieve the following results:

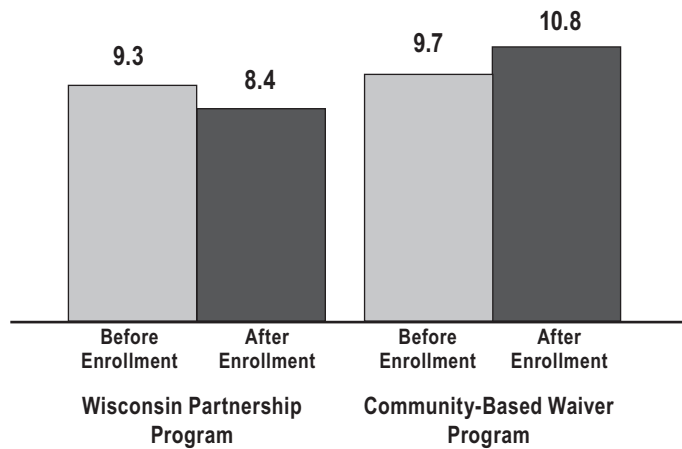
***After one year in the Partnership Program, the number of nursing home days decreased 25% for the elderly.***

- The number of inpatient hospital days decreased 52% for physically disabled members in the first year after enrollment in WPP.
- The number of nursing home days decreased 25% for elderly in the first year after enrollment in WPP. Only about 6% of WPP members are in nursing homes compared to 26% of Medicaid recipients age 65+ across the state.
- By close coordination and monitoring, the WPP has been able to keep prescription drug increases in the range of 9% to 12%, well below the national average of 18% to 21%.
- The vast majority (95%) rated the services excellent or very good. Only 5% of members disenrolled for reasons other than death or relocation.

Another recent study compared the WPP to a matched sample of frail and disabled persons in a community-based waiver program.<sup>1</sup> For WPP, hospital admissions for 100 members served for one month (i.e., member months) fell from 9.3 before enrollment to 8.4 after enrollment (see Figure 1). In contrast, for those in the community-based waiver program, hospital admissions per 100 member months rose from 9.7 before enrollment to 10.8 after enrollment.

**Figure 1. Hospital Admissions Declined Among the Frail and Disabled Enrolled in the Wisconsin Partnership Program**

*(Number of hospital admissions for 100 members served for one month)*

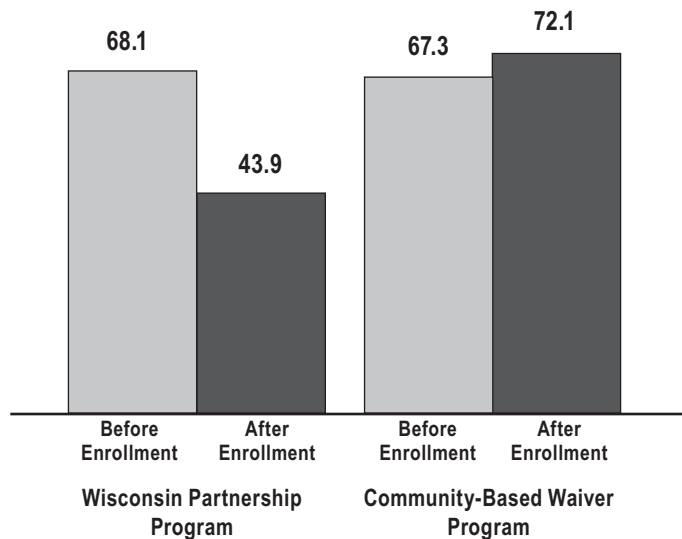


*Note: Based on comparisons of the Wisconsin Partnership Program and a matched sample of frail and disabled persons enrolled in a community-based waiver program (Wiggins, et al., 2005).*

Hospital days per 100 member months showed a similar pattern (see Figure 2). For the Wisconsin Partnership Program (WPP), hospital days per 100 member months fell from 68.1 before enrollment to 43.9 after enrollment. For those in the community-based waiver program, hospital days per 100 member months rose from 67.3 before enrollment to 72.1 after enrollment ( $p < .0001$ ).

**Figure 2. Hospital Days Declined among the Frail and Disabled Enrolled in the Wisconsin Partnership Program**

*(Number of hospital days for 100 members served for one month)*



*Note: Based on comparisons of the Wisconsin Partnership Program and a matched sample of frail and disabled persons enrolled in a community-based waiver program,  $p < .001$ . (Wiggins, et al., 2005).*

***The Partnership Program decreased hospital use for the elderly and disabled.***

These statistically significant results held for both the 65 to 85 and the over 85 age groups. Compared to a community-based waiver program, WPP is an effective intervention for decreasing hospital use for the elderly and disabled populations.

## **How Effective has the Wisconsin Family Care Program Been?**

Family Care has also recently undergone a rigorous independent review conducted by APS Healthcare.<sup>2</sup> The study focused on the fourth (2003) and fifth (2004) years of operation. Evaluators examined Family Care members' health status, health care costs, and long-term care costs compared to similar individuals receiving fee-for-service Medicaid services in the rest of the state.

***Medicaid costs for Family Care members outside Milwaukee were \$452 less per month than for the comparison group.***

The report found that Family Care's Care Management Organizations (CMOs) continued to improve the quality of long-term care services for their members. Waiting list elimination—a key selling point of Family Care—has been achieved for over three years now. Individual health outcomes remain good and the cost savings appear encouraging. Over the two-year study period, Medicaid costs for Family Care members outside Milwaukee were, on average, \$452 less per month than costs for the comparison group. Costs for members in Milwaukee were \$55 lower per month than for the comparison group. The source of these savings was two-fold: (1) a direct effect of a more cost-effective mix of service purchases; and (2) an indirect effect of improving member's health and ability to function independently.

One particularly interesting finding was that Family Care members visit their primary care physician more regularly than the comparison group. This benefit accrued across all counties and target groups. For example, Family Care members outside Milwaukee visited a physician's office 20.6 times on average during the two-year study period, compared to 14.7 visits in the comparison group. This additional attention to primary health care is thought to be related to the work of the Family Care nurse care managers; these nurse care managers may also contribute to reduced institutionalization and less illness burden and functional impairment. More frequent primary care physician visits appeared to provide opportunities to increase prevention and early intervention health care services that, in turn, reduced the need for more acute and costly services.

## **Summary**

Long-term care reform in Wisconsin has the benefit of years of experience with innovative programs. Wisconsin is one of the few states that we can look to for insights on how best to proceed with long-term care integration. The programs are now mature enough to be generating the positive results originally hoped for and this has prompted interest in going statewide. However, the best way to proceed is still a question. Family Care and the Wisconsin Partnership Program each have taken on this challenge quite differently.

Family Care limits its integration efforts to Medicaid-only services that fall under its capitation payments. Family Care relies on nurses and social workers to *coordinate* with primary and acute care services (physician, hospital, prescription drug, dental care, podiatry, vision, and mental health related

services), but does not *provide* those services. The Wisconsin Partnership Program integrates all Medicaid with Medicare benefits through non-profit health plans that blend capitation payments from both these programs. The Partnership Program relies on a broader interdisciplinary team that includes the patient and their physician, along with a nurse practitioner, nurse, social worker, and others as needed.

The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for aged and disabled beneficiaries, because it allows flexible use of all primary, acute, sub acute, and long-term care dollars. This is important to states because it is often the Medicaid-supported care coordination of home- and community-based services that creates savings to Medicare. For example, an evaluation of the PACE program has suggested that savings accrue to Medicare, but Medicaid costs are actually higher in the first year of enrollment than in fee-for-service approaches.<sup>3</sup> States generally feel there needs to be a long-range view in such evaluations. In any case, states would like to share in any Medicare savings or at least protect themselves against Medicaid cost increases that can happen when Medicare's primary and acute care services are not managed well.

Unfortunately, the integration of Medicare with Medicaid is not straightforward. Medicare and Medicaid remain quite different programs. The new Medicare "special needs plan" allows Medicare plans to selectively market to the populations of interest to Wisconsin's Partnership Program and Family Care. Yet, there are still significant programmatic barriers to seamless systems for plans and their members that need to be worked out. Enrollment into Medicare managed care must be voluntary, whereas either mandatory or optional enrollment can be considered for Medicaid. Also, there is no guarantee that the higher Medicare "frailty" payments received by programs like the Wisconsin Partnership Program and PACE will be available when these programs are replicated.

The bottom line is that no clear consensus has emerged about how best to proceed on long-term care integration, especially when best is defined to mean expedient. Because Medicare is still a difficult partner, Wisconsin and other states will look to models like Family Care and the Wisconsin Partnership Program as alternative ways to improve the systems of care to their beneficiaries. The results of the recent Family Care evaluation suggest that significant improvements can be made with partial integration. However, it remains to be determined which approach is more replicable and ultimately best for each of the various vested interests. The good news is that both approaches have demonstrated merit and can inform the next steps for Wisconsin and other states.

***Family Care evaluations suggest that partial integration can improve care and avoid the difficulty of partnering with Medicare.***

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# Oregon's Experience with Asset Transfers and Estate Recovery: Successes and Impediments

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**O**regon's nationally known estate recovery program is based on this premise: if someone uses taxpayer resources for long-term care and if assets remain in their estate upon their death, it is fair that these assets go back to the taxpayers who have been footing the bill. In 2003, Oregon recovered \$20 million or 2.2% of its Medicaid long-term care expenditures; in contrast, Wisconsin recovered \$17.6 million or 0.8% of its Medicaid long-term care expenditures. Oregon recovers about \$14 for every dollar invested in the program using best practices such as expanding the definition of estate, pursuing claims against the estate of the surviving spouse for the spouse who died first, establishing the state as a priority creditor, and promptly notifying estate recovery staff of the client's death.

One of the most controversial policy levers for curbing long-term care costs is estate recovery. States are trying to get a handle on how to control the leakage in asset transfer and estate planning that some people, who otherwise would not qualify, use to become eligible for Medicaid long-term care or waived services. Since 1993, states have been required by federal law to recover, at a minimum, the Medicaid dollars paid to nursing homes. In addition, some states have chosen to recover the cost of Medicaid waived services. However, estate recovery has proven challenging, given the complexity of the issue and a number of political challenges.<sup>1</sup>

This chapter discusses why it is difficult to reform state laws regarding asset transfer and estate recovery, what are some of the most common interspousal transfers used to avoid estate recovery, and how the state of Oregon developed its estate recovery program. Oregon's program was recently cited by the American Bar Association as one of the most effective in the country.<sup>2</sup> The chapter concludes by contrasting some of the best practices that the state of Oregon has put into place with practices currently being used in Wisconsin.

## What is Asset Transfer and Estate Recovery?

Asset transfer is simply the transfer of ownership of assets (i.e., property, cash, stocks, bonds) from one person to another. Of particular interest to policymakers is the federal law that allows unlimited transfer of assets to a spouse, a technique that allows the giving spouse to become eligible for Medicaid. Policymakers are also interested in divestment of assets, whereby assets are transferred for less than fair market value. These and other types of asset transfer transactions are used to "artificially impoverish" the giving spouse and allow him or her to qualify for Medicaid benefits.

***If someone uses taxpayer resources for long-term care, it is fair that assets in their estate go back to the taxpayers.***

A second phase of “artificial impoverishment” is the avoidance of estate recovery to protect inheritances for the children of Medicaid recipients. In response, the federal government requires states to put in place estate recovery programs to recover funds from deceased Medicaid recipients’ estates up to the amount spent by the state for all Medicaid services recoverable under applicable federal/state law. The exact rules about what assets are included and excluded, and when, if, and how this recovery will take place, are generally determined by the states in accord with federal guidelines; not surprisingly, these rules vary significantly from one part of the country to another.

Asset transfer and estate recovery are two sides of the same coin. Assets that are sheltered, transferred, or removed in some way on the front end are not available for recovery upon the death of the Medicaid recipient.<sup>3</sup>

### **Why is Reforming Asset Transfer and Estate Recovery Laws So Difficult?**

Reforming asset transfer and estate recovery laws is difficult for a number of reasons, four of which will be mentioned here. First, some fear that reforms are being driven not by principle, but instead by the large financial stake that states have in the funding of long-term care. For example, for fiscal year 2004, the Kaiser Family Foundation reports that Wisconsin spent almost \$1.9 billion on long-term care services, which was 42% of the total Medicaid expenditures.<sup>4</sup> Second, reform is difficult because the Government Accountability Office and others have concluded that there is little hard data on the extent of asset transfer that is occurring.<sup>5</sup> Third, asset transfer and estate recovery laws are one of those complicated issues in which the devil is in the details. Reforms entail addressing, not only broad statutory changes, but also the minutia of the day-to-day work of Medicaid eligibility workers.

Finally, the issue is politically challenging. Advocates on both sides of the issue see estate recovery as a matter of equity and fairness. Opponents to stricter asset transfer and estate recovery laws cite eligibility rules that already require patients to spend down most of their assets to about \$2,000. Further restrictions, they argue, will primarily hurt the poorest citizens, who are the primary users of Medicaid long-term care services, and the least likely to seek out estate planning advice. Proponents say that if someone uses taxpayer resources for long-term care and if assets remain in their estate upon their death, it is fair that those assets go back to the taxpayers who have been footing the bill. Moreover, proponents contend that the nonpoor are spending down to qualify for Medicaid, which could result in the program becoming so expensive that it may no longer be available for those who need it most.

### **What are some of the Most Common Transfers Between Spouses to Avoid Estate Recovery?**

Many types of transfers between spouses can occur to avoid estate recovery, four of which will be covered here. In several instances, I give examples from the state of Oregon.



***The biggest loophole for Medicaid eligibility for long-term care is the penalty for the transfer of assets.***

- (1) **Penalty or “Look Back” Period.** According to Brian Burwell of Medstat, the biggest loophole in Medicaid eligibility for long-term care is the penalty for the transfer of assets, specifically when the penalty begins. One of the easiest Medicaid planning devices is to transfer half of one’s assets immediately when one enters a nursing home. By the time the remaining half is spent, the penalty period is over and the person can remain in the nursing home and receive Medicaid coverage without a penalty. Hence, this estate planning strategy is aptly known as *half a loaf*. According to Burwell, the real asset limit for Medicaid for long-term care is not \$2,000 for a single individual, but rather half of what you have in countable assets; actually, it is more than half if tax-exempt assets are included.<sup>6</sup>
- (2) **Court Orders.** According to federal law, a Medicaid recipient can transfer an unlimited amount of assets to a spouse, and these assets will be excluded from determining Medicaid eligibility if the transfer is pursuant to a court order. Oregon law allows for these types of court orders for married couples. In Oregon, it is not unusual for a married couple to shelter on the front end up to \$180,000 in assets over and above the family home and automobile.  
  
What’s more, assets that are transferred from a Medicaid recipient during his/her lifetime are not available to the state on the back end. When the surviving spouse dies, property/asset transfers cannot be used to pay an estate recovery claim for a Medicaid recipient if the decedent did not have an ownership interest at the time of death. However, at least one state, North Dakota, has taken the position that assets traceable to the Medicaid decedent, even if they had no legal interest in the asset at the time of death, may be pursued to satisfy the Medicaid public assistance claim (see Estate of Wirtz, 2000 ND 59, 607 N.W. 2d 882).
- (3) **Home.** According to Burwell, the home is one of the main assets available to states for recovery, because it is not counted in determining Medicaid eligibility and is often still in people’s estate when they die.<sup>7</sup> In Oregon, the Medicaid recipient frequently transfers his or her interest in the home to his or her spouse. Since the transfer occurred during the Medicaid recipient’s lifetime, the equity in the home will not be available to pay an estate recovery claim when the recipient’s spouse dies.
- (4) **Annuities.** Federal law also allows excluding certain types of annuities in determining a Medicaid recipient’s eligibility. Frequently, Medicaid recipients transfer most or all of their assets to their spouse. The spouse can then use these assets to purchase annuities that are not counted in determining Medicaid eligibility. Again, because the transfer of assets occurs during the lifetime of the Medicaid recipient, the annuity cannot be tapped to pay an estate recovery claim when the spouse dies. Oregon has seen cases where \$500,000 of assets or more have been sheltered in this way.

## How Does Oregon's Estate Recovery Program Work?

Oregon is a small state with a population of about 3½ million and annual Medicaid expenditures of about \$2 billion. Oregon has one of the oldest estate recovery programs in the country, starting before Medicaid even existed. In 1949, Oregon enacted legislation authorizing the state to recover the cost of cash assistance provided to the elderly. In 1975, legislation was enacted authorizing the State to recover the cost of Medical Assistance provided to persons 65 or older. In July 1995, Oregon expanded their definition of estate to include joint tenancy, tenancy in common, survivorship, life estate, living trust, or other similar arrangements (e.g., annuity).

In Oregon, we strive to increase estate recoveries, while protecting the personal and property rights of the people we serve. We aggressively seek to return assets transferred incorrectly, and also to preserve assets so that they are available for the current cost of care and the future estate.

## What is the Track Record of the Oregon and Wisconsin Programs?

In Oregon the state makes a priority claim against the property, or any interest therein, belonging to the estate of a deceased Medicaid beneficiary. If there is a surviving spouse, no recovery occurs until the death of the surviving spouse. In response to two state court decisions, Wisconsin does not pursue a Medicaid claim against a surviving spouse's estate. In Oregon, the state does pursue the claim for the deceased Medicaid recipient's public assistance, but limits its claims against the surviving spouse's estate to property or other assets that were received through probate or operation of law at the time of the Medicaid beneficiary's death. We estimate that 10 to 15% of our recoveries involve a claim against the estate of the surviving spouse. The state does not make a claim when there is a surviving child of a beneficiary who is under age 21, blind, or permanently and totally disabled.

According to an American Bar Association study that compared estate recoveries across the nation, Oregon recovered \$20 million in fiscal year 2003, which totaled about 2.2% of Medicaid long-term care expenditures. Wisconsin collected about \$17.6 million from estate recovery efforts, totaling about 0.8% of its Medicaid long-term care expenditures.<sup>8</sup>

***Oregon recovers approximately \$14 for every dollar invested in their estate recovery program.***

Oregon handles nearly 7,700 estate recovery cases each year, despite the fact that 40% of the deceased Medicaid recipients have circumstances where no recovery is possible or exemptions exist that require that we waive or defer recovery from their estate. On average, we collect about \$4,000 for every case that has assets the state can legitimately pursue. Wisconsin attempted recovery from 5,800 estates, with an average recovery of \$3,034. Overall, Oregon recovers approximately \$14 for every dollar invested in the program—a return rate that we are proud of. Also, in Oregon, all Medicaid recoveries that revert to the state are used to sustain programs that serve living, low income senior and disabled Medicaid clients. This provision bolsters legislative support as well as the support for the estate recovery program in the field units that establish eligibility and provide services. Similarly, Wisconsin's estate recoveries are also used to support ongoing Medicaid programs.

## What Best Practices Have Oregon and Wisconsin Put into Place?

One of the reasons that our program has been successful is that we have been doing it for a long time. Over the last 57 years, Oregon has developed a number of best practices. The success of our program is due to how the program is set up, its staffing, training, public education, and administration.

### What Best Practices have both Oregon and Wisconsin Implemented?

Oregon has implemented a number of business practices that alleviate, in part, many of the previously mentioned problems inherent in pursuing estate recovery. Wisconsin already has implemented a number of these best practices including:

- Training on estate recovery in regions around the state.
- Training on estate recovery to new eligibility workers who will be implementing the Medicaid program.
- Using estate recovery staff to review probates filed in counties to ensure a public assistance claim may be submitted where the decedent was a Medicaid recipient.
- Securing statutory authority for the state Medicaid agency to be a priority creditor under state probate law.
- Notification of all probates filed in the state.
- The ability to nominate a personal representative for the client's estate when appropriate.
- Including with all Medicaid applications an estate recovery brochure that clearly and concisely outlines the estate recovery process and provides a toll-free number for interested parties to ask further questions.

### What Other Best Practices has Oregon Implemented?

Below are some of the best practices based on our experience in Oregon that differ from what is currently happening in Wisconsin.

- Since 1995, Oregon has used the “expanded” definition of estate that allows for the recovery of survivorship interests, life estate interests, living trusts, and remainder interests in client-created annuities. Wisconsin does not use this expanded definition. This change is allowable under federal law. This allows the state, and only the state, to recover assets that would otherwise transfer by operation of law and not be probated. Based on my experience in Oregon, changing this definition could increase recovery by an estimated 20% to 25%.
- Oregon pursues the claim against the estate of the surviving spouse for Medicaid assistance provided to the spouse who died first. Wisconsin does not. As mentioned earlier in the report, Wisconsin could expect Medicaid recoveries to increase 10 – 15% if claims could be presented in the estate of the surviving spouse.
- When a beneficiary dies and the heirs want to keep the home, farm, or other real property, Oregon is willing to take a mortgage on that

***Oregon's definition of estate includes survivorship interests, life estate interests, living trusts, and remainder interests in client-created annuities.***

**Oregon will take a mortgage to allow the heirs to buy back the home, farm, or other real property.**

property and have the family pay us back in installments. Technically, the heirs/devisees are able to execute a note and trust deed on the property and make payments to the state over time to pay off any claim to the estate. Wisconsin generally does not encourage this practice, although the state appears to have the authority to do so. In Oregon, we have found that implementing practices that allow keeping the family home in the family, when that is the family's wish, are an important component of eliciting political and public support for our efforts.

- Wisconsin utilizes TEFRA liens (i.e., pre-death liens) on real estate property for those clients entering nursing facilities. I consider this a best practice. However, Oregon has chosen to utilize the claims process exclusively and made changes in its probate statutes so that the state is a priority creditor, thereby ensuring that the public assistance claim will be paid prior to general creditors like charge cards.
- Wisconsin's undue hardship waiver criteria appear to allow for more categories of hardship situations than Oregon's. For example, Wisconsin may waive a claim if the beneficiary or heir of the estate is receiving food stamps, even if the condition may be short-term. Additionally, Wisconsin may waive a claim if the decedent's real property is used as part of the waiver applicant's business and would result in the applicant losing their livelihood; this occurs even if a portion of the business proceeds could, over time, be used to satisfy the state's claim. Oregon's criteria are broader and generally require that the applicant be eligible for public assistance and homelessness *unless* the claim is waived.
- Oregon has a very sophisticated death notification process that allows estate recovery staff to receive notice of the client's death within 10 working days of the field unit's notification. The entire electronic case file for the decedent is transferred to the estate recovery unit. The case file is fully screened and immediate actions are taken to claim (a) client bank account funds (under state banking statutes) and (b) personal incidental funds being managed by providers. Other assets like real property that the client had an interest in are also identified and the representative for the estate is contacted to inform them of the public assistance claim. This proactive screening and recovery process is possible because of the number of staff afforded the estate recovery unit. Wisconsin generally is informed of the client's death when the client's estate is probated or a notice of an affidavit is filed with the state, which may in some instances be months after the client has died.
- Oregon has statutory authority to file a "Request for Notice" with the county clerk asking that the state be informed whenever a piece of real property in which our client has an interest is transferred or encumbered. This notice is not a lien, but it does allow the unit to identify transfers and sales of real property that the field unit may not be aware of that affect ongoing Medicaid eligibility. It has also been helpful in identifying instances of financial exploitation of our clients

before the funds are expended. Wisconsin does not have similar authority.

- The Oregon estate recovery office also has statutory authority to subpoena deceased client bank records and/or other legal documents that may have a bearing on the disposition of client assets when there is evidence of possible Medicaid fraud. The Wisconsin estate recovery program does not have similar authority.

## Staffing

The success of our program is due, first and foremost, to the skills, attitude, and commitment of the employees who implement our program. To deliver such a complex and multifaceted program, our staff of 22 possesses a diverse mix of backgrounds in legal and paralegal education, and experience in such areas as title transfer, Medicaid eligibility, collections, and service delivery. We also utilize the skills of several highly trained attorneys that work for our Department of Justice. Put simply, our staff is highly skilled and well paid. Because of that, there is little staff turn-over and high consistency in how the program is implemented

In Oregon, we have invested in specialized staff who have proven to be cost effective. For example, we recently hired an asset change specialist, whose primary responsibility is to research electronic narratives completed by field units when assets have dropped off during the re-determination of client eligibility. Because of eligibility staff turnover in the field, this position is sometimes able to identify the liquidation of assets that may require the Medicaid recipient to become private pay or allow for a voluntary reimbursement of past assistance to maintain Medicaid eligibility.

## Training

Our success is due, not only to the quality of the staff, but also to the training that we provide. There is no substitute for hands-on training in the field to explain the estate recovery process and also to answer questions. Support of the estate recovery program in the field by case managers and eligibility specialists is critical. They provide the information upon which all subsequent estate recovery activities are based.

We train our estate recovery staff, and we also involve estate recovery staff in the training of local eligibility workers around the state who will be implementing the Medicaid program. This training helps ensure that our local staff understand and have a commitment to the program goals, and helps ensure that clients and their families receive accurate, consistent, and uniform information.

Any training should try to raise sensitivity to the families the program serves such as the stress long-term care decisions can place on families, what ways professionals can work effectively with family members during difficult times, and how to partner with families to reach program goals. Agency procedures should be examined to determine how family friendly they are. For example, in establishing Medicaid eligibility do families have to travel to different sites, fill out countless applications, and file multiple verification forms? Implementing

***Any training should raise sensitivity to the stress long-term care decisions can place on families.***

family-centered agency procedures and staff practices can help ensure that Medicaid eligibility forms are accurately completed, clients are informed of estate recovery, and issues are resolved prior to legal action.

***No Medicaid client or his/her family should be surprised that the state will try to recover the costs of public assistance.***

### **Public Education**

Based on my experience in Oregon, any successful estate recovery program is built on information, information, and information. Also critical is a positive working relationship with all the stakeholders (e.g., field unit staff that establish eligibility and provide services, client advocacy groups, elder law attorneys, health care providers, and, of course, legislators). I also recommend developing a brochure that describes the estate recovery program in a forthright, open manner and provides a toll-free number for further information. No Medicaid client or his/her family should ever be surprised that the state will try to recover the costs of public assistance provided to them.

### **Administration of the Program**

In Oregon, the estate recovery unit must be notified of a client's death within 10 working days from the time the field unit is informed of the death. This timely notification process allows the estate recovery unit to initiate actions that safeguard client assets before they may be used for purposes not in accord with probate law. In recovery efforts, time is of the essence. All newly referred cases are screened for identifiable assets (e.g., bank accounts, real property or stocks) and, depending on the type of asset, an initial letter is generated to the appropriate party informing them of the state's priority claim and its interest in the asset.

Depending on the circumstances, the estate recovery unit may a) negotiate a payment of the public assistance claim, b) nominate a personal representative (a private attorney under contract with the state) to probate the client's estate if the family is unwilling to assume that responsibility, c) refer the case to the state Department of Justice to initiate a legal action, or d) take any other legal action necessary to safeguard our interest.

Perhaps one of the major differences between Oregon's and Wisconsin's estate recovery programs is that Oregon's program has branches throughout the state, but is generally state administered, whereas Wisconsin's program is county administered. Conceivably, this could have some effect on such aspects of the program as the training of staff, public education efforts, and notification procedures, although the state provides each county with a basic model and guidelines.

## **Summary**

Our experience has shown that good estate recovery practices can be sensitive to families as they grieve the loss of their loved ones and still ensure the state does not pay more than its share of long-term care services. Estate recovery will probably never balance a state's budget. However, Oregon's estate recovery program has been successful in working with families and in returning dollars to the state coffers by paying attention to how the program is set up, the quality of its staff, training, public education, and program administration.

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# Public-Private Partnerships in Medicaid Long-Term Care

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**A**lthough managed care is fairly common for Medicaid acute services, using managed care to provide long-term care services is rare. Only 3% of Medicaid long-term care beneficiaries receive care in a managed care setting. Six states, including Wisconsin, have managed care programs for certain populations in the state. Of the managed care organizations providing care across the country, 70% are nonprofits and 15% are local government agencies (e.g., counties). Another public-private venture for states involves long-term care insurance. Four states (California, Connecticut, Indiana and New York) currently participate in the Long-Term Care Partnership Program. Nearly 212,000 people have purchased policies, but only 1.3% have received insurance benefits. The program cannot be expanded nationwide unless Congress changes the federal estate recovery statutes.

Long-term care accounts for approximately one-third of Medicaid spending nationwide. In 2003, nursing home expenditures represented the largest category of Medicaid spending. While the growth of long-term care has slowed in recent years, states are anticipating an increased demand for long-term care services, especially as the population ages.<sup>1</sup>

States increasingly are turning to the private sector for assistance in delivering Medicaid services and in managing the growth of Medicaid expenditures. Several states have reported success in providing Medicaid-funded acute health care benefits through private entities. Building on that success, many states are considering additional partnerships with the private sector to address Medicaid long-term care service delivery.

This chapter will review two avenues for public-private partnerships in the delivery and financing of Medicaid long-term care services: a) contracting with private entities for long-term care service delivery, and b) shifting financial responsibility for long-term care services to the private sector through the Long-Term Care Insurance Partnership Program.

## How Common is Managed Care Delivery of Long-Term Care Services?

Over the past 15 years, state Medicaid programs increasingly have implemented managed care programs to provide acute care benefits to their Medicaid enrollees. In 2002, 58% of Medicaid beneficiaries received some portion of their Medicaid benefits through a managed care program.<sup>2</sup> Most Medicaid managed

care programs, however, exclude long-term care benefits and/or populations who use most of the long-term care benefits, such as Medicare/Medicaid dual eligibles. In 2004, less than 3% of the population receiving publicly-funded long-term care services received those services through managed care programs.<sup>3</sup>

### What do Existing Managed Long-Term Care Programs Look Like?

The characteristics of managed long-term care programs vary considerably across the country. Arizona has over 23,000 managed long-term care enrollees in its mandatory statewide program—the only statewide program in the country. Six states operate programs targeted at specific populations within certain counties or groups of counties. Enrollments in these programs range from less than 100 to over 10,000. The third, and most prevalent, model is the Program for All-Inclusive Care for the Elderly (PACE). It operates much like a staff-model HMO and generally serves the patients of a specific provider organization. Close to 8,500 people were served by 40 PACE sites around the country in 2004.<sup>4</sup>

**Most (70%) of the entities in the managed long-term care market are non-profit organizations.**

As shown in Figure 1, most of the entities that have entered the managed long-term care market are non-profit organizations. This group is dominated by provider organizations that manage care through PACE programs. It also includes the four plans in the Wisconsin Partnership Program and those participating in Minnesota’s Medicaid managed long-term care program.<sup>5</sup> Sixteen percent of managed long-term care entities are publicly owned, including the county-based plans in Wisconsin’s Family Care program. Public plans also provide services in many of the rural counties in Arizona. The number of for-profit entities participating in managed long-term care is relatively small. Currently two major commercial health plans lead this group: EverCare and Amerigroup.<sup>6</sup>

**Figure 1. Who Owns Managed Long-Term Care Entities?**

Type of Organization	Number of Entities	Percent
For-profit	9	13%
Not-for-profit	47	70%
Local Government Agency	10	15%
State Government Agency	1	1%

*Data Source: Saucier, P., Burwell, B., and Gerst, K. (2005, April). The Past, Present and Future of Managed Long Term Care. Washington DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.*

Of the existing managed long-term care programs, only two have mandatory enrollment: the Arizona Long Term Care System (ALTCS) and Texas Star Plus. The remaining programs are voluntary.

## Why Partner with Private Health Plans?

The passage of the Medicare Modernization Act in 2003 created an opportunity for expansion of the Medicaid managed long-term care market. The legislation established Medicare Advantage Special Needs Plans as a class of managed care entities that may limit their enrollment to certain populations, such as Medicare/Medicaid dual eligibles, and Medicare beneficiaries residing in nursing facilities. As a result, the private entities that participate in Medicare managed care are poised to better understand the needs of nursing facility residents and enter the market in states that develop Medicaid managed long-term care programs to target the dually eligible population.

Partnering with private entities in the development of a managed long-term care program has several benefits. First, plans that have considerable experience managing commercial health insurance benefits will have well-developed provider networks that likely will include providers who do not typically serve Medicaid populations. Partnering with private plans, therefore, may provide states the opportunity to leverage access to a larger provider network for Medicaid recipients.

Another benefit of partnering with private entities is the ability to avoid problems of cost-shifting. Consider the possible tension created when a dual eligible joins a private Medicare Advantage plan for Medicare-funded services and a different (e.g., county-based) health plan for Medicaid-funded services. There is not always a clear delineation of responsibility between Medicare and Medicaid for certain services [e.g., home health, durable medical equipment (DME), and skilled nursing]. The Medicare plan may make utilization review decisions that shift responsibility for the services to Medicaid. A capitated reimbursement system creates an incentive to shift costs to other entities where feasible. This incentive not only reduces coordination and efficiency, but may also compromise care for the beneficiary, particularly if decisions about which plan is responsible for care are delayed. Privatizing delivery of the Medicaid-funded services allows the beneficiary to enroll in a single plan for both Medicare- and Medicaid-funded services, eliminating the incentive to shift costs to other plans.

***Allowing beneficiaries to enroll in a single plan for Medicaid and Medicare services eliminates the incentive for cost shifting.***

## What are the Possible Disadvantages of Partnering with Private Health Plans?

There are disadvantages to implementing a managed long-term care program that relies on private entities for managing service delivery. When partnering with privately-owned health plans, whether for-profit or not-for-profit, a state should recognize that the operation must remain profitable for plans to stay in the market. With for-profit plans, excess funds become profits to be distributed to shareholders or used to support additional business ventures, often out-of-state. Plans that are not able to generate net operating gains are likely to leave the market. This may cause disruptions in care during enrollees' transitions to other plans. Additionally, the state will need to monitor whether the remaining plans have the capacity to absorb additional enrollment if some plans exit the market.

Partnering with private plans may also negatively impact the existing infrastructure of long-term care service delivery. Private health plans may interrupt long-standing relationships between service providers if they are not all included in the plan's provider network. There is also a risk that traditional safety-net providers, including county-based programs, will lose business if health plans offer enrollees a broader network of service providers.

## What is the Long-Term Care Insurance Partnership Program?

The Long-Term Care Insurance Partnership Program (LTC Insurance Partnership) is a specific type of public-private partnership designed to decrease Medicaid expenditures for long-term care services by increasing the purchase of private long-term care insurance. Individuals who purchase approved long-term care policies, exhaust their benefits, and apply for Medicaid benefits may protect a portion of their assets from being counted during the Medicaid eligibility determination process. Applicants must continue to meet the income eligibility guidelines while receiving Medicaid benefits. The program also protects the insured's assets from later estate recovery by the state Medicaid program. By creating an incentive for individuals to purchase private insurance coverage, states hope to prevent, or at least delay, their reliance on Medicaid to support their long-term care needs.

At present, only four states are authorized to operate LTC Insurance Partnership programs. Congress is considering whether to extend this authority to other states; many states are interested in implementing these programs. The four states that currently operate the program, California, Connecticut, Indiana, and New York, use three different program models.

- **Dollar-for-dollar:** Individuals may protect \$1 of assets for every \$1 of private insurance coverage purchased. In other words, purchasing a \$200,000 policy would allow the individual to protect \$200,000 in assets. California and Connecticut have implemented the dollar-for-dollar model.
- **Total asset protection:** Under this model, all of the individual's assets are protected when a state-defined minimum benefit package is purchased. New York's program offers total asset protection.
- **Hybrid Model:** Indiana has implemented a hybrid of the above two models. Dollar-for-dollar protection is provided for policies under a threshold limit and total asset protection is offered for policies that meet a minimum threshold.

The dollar-for-dollar model allows access to the program for lower-income individuals who may not be able to afford a policy that meets the minimum requirements under the total asset protection model. For this reason, New York is reportedly considering a hybrid model.<sup>7</sup> By way of contrast, Indiana introduced the total asset protection option in 1998 and discovered that it provided a strong incentive to individuals to increase the amount of coverage purchased. Prior to 1998, 29 percent of policies met the minimum threshold to qualify for total asset protection. In the first quarter of 2005, 87 percent of the policies purchased met the threshold.<sup>8</sup>

*By creating an incentive for individuals to purchase private insurance coverage, states hope to prevent or delay their reliance on Medicaid for their long-term care needs.*

## Have the Insurance Partnership Programs Been Successful?

While all four programs have been in place for more than ten years, the data available to evaluate their success are limited. A September 2005 Government Accountability Office (GAO) report indicates that 211,972 policies have been sold and 172,477 remain currently active (see Figure 2).<sup>9</sup>

**Figure 2. Long-Term Care Insurance Partnership Program Experience**

Number of policies ever purchased	211,972
Number of policyholders who have ever received long-term care insurance benefits	2,761 (1.3%)
Number of policyholders who died while receiving benefits	899
Cumulative value of assets protected of policyholders who died while receiving benefits	\$10,869,369†
Number of active policyholders who have exhausted long-term care insurance benefits	251
Have accessed Medicaid	119 (47%)
Have not accessed Medicaid	132 (53%)
Cumulative value of assets protected of policyholders who have exhausted long-term care insurance benefits	\$11,319,409†
Have accessed Medicaid	\$4,162,812†
Have not accessed Medicaid	\$7,156,597†

*Data Source: The above table summarizes data presented in the September 2005 GAO report, "Overview of the Long-Term Care Insurance Partnership Program."*

*† Data from California, Connecticut, and Indiana.*

Only 2,761, or less than 2 percent, of policyholders have accessed long-term care benefits. Of those, 251 have exhausted their benefits. It is interesting to note that of those who have exhausted their benefits, only 47 percent have accessed Medicaid benefits. What happened to the remaining 53 percent? States speculate that they are spending down income or unprotected assets, their health has improved, or their families are providing informal (unpaid) care.<sup>10</sup>

### Who purchases these policies?

- The average age of the purchaser ranges from 58-63 at time of purchase.<sup>11</sup>
- More women than men purchase policies.
- Most purchasers are married and in "excellent" or "good" health.
- Over 90% are purchasing long-term care insurance for the first time.
- A majority of purchasers reported assets greater than \$350,000 at time of purchase.<sup>12</sup>
- The percentage of purchasers with monthly income greater than \$5,000 ranged from 49% (Indiana) to 62% (Connecticut).<sup>13</sup>

***Asset protection does play a large role in encouraging participants to purchase long-term care insurance.***

Most policies are comprehensive, covering both nursing home care and community-based care, and are purchased individually, rather than through groups or organizations.<sup>14</sup>

#### **Are people buying more private insurance?**

A primary goal of the program is to encourage the purchase of long-term care insurance to reduce the dependence on Medicaid as a funder of long-term care services. A key program evaluation question, therefore, is whether the individuals participating in the program would have purchased long-term care insurance without the incentive for asset protection. There is limited survey data from all four states to answer that question. The benefits of asset protection did play a large role in encouraging participants to purchase policies, but it was just one of several considerations.<sup>15</sup>

#### **Does the program save Medicaid money?**

The fact that 899 policyholders died while they were accessing private insurance benefits might suggest the program is resulting in cost savings for Medicaid, but the data are insufficient to make that determination. The main reason is that it is unknown right now whether those individuals would have accessed Medicaid benefits had they not purchased private insurance.<sup>16</sup>

### **What is the Future for These Programs?**

LTC Insurance Partnership programs cannot expand to additional states without a change in federal statutes regarding estate recovery. In 1993, Congress passed legislation that requires states to seek recovery from the estates of individuals age 55 and older who received assistance from Medicaid. Recovery is mandatory for certain services, including nursing facility care, and optional for other services. The only exceptions are those states that had received approval before May 14, 1993 to disregard certain assets when making Medicaid eligibility determinations: Iowa and the four Long-Term Care Insurance Partnership Program states.<sup>17,18</sup>

### **What are Some Questions Policymakers can Ask to Assess Long-Term Care Insurance Legislation?**

The long-term care insurance market is relatively young and experience with the LTC Insurance Partnership programs is limited. As such, policymakers are concerned about a number of key issues, including market regulation, market stability, equity, and reciprocity.

**Market regulation.** Of particular concern is the current regulatory environment for the long-term care insurance market. Are consumer protections adequate?

- Long-term care insurance products are largely regulated by states. The lack of national standards may lead to considerable variation in the level of regulation across states. Officials from states with LTC Insurance Partnership programs, however, argue that the program has increased oversight in these states and improved the quality and regulation of the products offered.<sup>19</sup>

- Policymakers are also concerned about whether inappropriate products will be marketed to vulnerable individuals. For example, products may be sold to individuals who cannot afford to pay the premiums for the life of the policy. The carrier would collect payments and never risk a payout if the policy was cancelled. Another fear is that the coverage will be inadequate to cover the future costs of care—leaving a significant financial burden to the policyholder.

**Market stability.** Some policymakers are concerned about the stability of the market for long-term care insurance. There is a trend of consolidation in the market. One report estimates that nine companies will soon hold more than 90 percent of the market.<sup>20</sup> While this may improve administrative efficiencies and spread the risk across a larger population of policyholders, the insolvency of a single carrier could significantly impact policyholders and the market as a whole.

**Equity.** Another major issue for policymakers is whether the program violates equity standards. Medicaid is designed to assist people who are poor. Additionally, regulations exist to discourage people from transferring assets in order to qualify for Medicaid sooner than they otherwise would. Not everyone can afford to purchase long-term care insurance and in fact, some people are denied coverage. By allowing one group of individuals the opportunity to protect assets, does the program violate equity standards?

**Reciprocity.** Finally, those who purchase policies are concerned about the lack of reciprocity among states with LTC Insurance Partnership programs. While most states would likely support reciprocity, those with large retiree populations may be reluctant to participate for fear of assuming responsibility for long-term care costs for a greater number of individuals whose assets would be protected.<sup>21</sup>

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**Some policymakers are concerned about the stability of the market for long-term care insurance.**

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- <sup>11</sup> Data from Connecticut, Indiana, and New York.
- <sup>12</sup> Data from California, Connecticut, and Indiana.
- <sup>17</sup> Iowa had received approval, along with the four participating Long-Term Care Insurance Partnership states, but has not yet implemented a program.



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## Glossary

### **1115 Waiver**

A Section of the Social Security Act that gives the Secretary of the U.S. Department of Health and Human Services the authority to approve experimental, pilot, or demonstration projects likely to promote the objectives of the Medicaid statute. States have used Section 1115 waivers in Medicaid a number of ways, including changing eligibility requirements or the scope of services provided. Section 1115 waivers must be cost neutral over the course of the demonstration, typically five years.

### **1915(b) Waiver (“Freedom of Choice” Waiver)**

The Section of the federal Social Security Act that allows states to waive the requirement that its Medicaid recipients must be able to select any willing and qualified provider of a service funded by its Medicaid program. Rather, this waiver allows a state to deliver a package of some or all of the state’s Medicaid services through a managed care organization’s limited network of providers. It also allows the managed care program to share any savings that result from managed care with its enrollees by offering additional services that are not available to Medicaid recipients not participating in the managed care program.

### **1915(c) Waiver (“Home and Community-Based Services” Waiver)**

The Section of the federal Social Security Act that allows a state to provide home and community-based services to Medicaid recipients as an alternative to nursing facility care. These waivers allow the state to target services to persons otherwise eligible for specific kinds of nursing facilities (e.g., nursing homes), to use the higher financial eligibility income limits available for institutional services, and to limit the amount, duration and scope of services a recipient receives to those identified in an individualized service plan.

### **1915(b) and 1915(c) “Combination” Waiver**

Combining these two types of waivers allows states to deliver home and community-based services through a managed care model. These combination waivers allow a state to use managed care organizations to deliver a defined set of its available Home and Community-Based Waiver services and Medicaid services that are usually available only through the Medicaid card. (See Family Care.)

### **Activities of Daily Living (ADL)**

An index or scale that measures a patient’s degree of independence in bathing, dressing, using the toilet, eating, and moving from one place to another. People who need assistance with Activities of Daily Living are said to have long-term care needs.

### **Acute Care**

Care for illness or injury that has developed rapidly, has pronounced symptoms and is finite in length. The goal of acute care is to cure disease and restore the

person to an improved level of functioning. In-patient hospital care is acute care, as are doctor's visits, surgery, and X-rays.

### **Aging and Disability Resource Centers**

Currently available in twelve counties in Wisconsin, these centers are designed to be a single entry point where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their communities. Resource centers also help individuals access publicly funded long-term care. Services are provided through telephone interviews or in-home visits. The State plans to expand the availability of aging and disability resource centers to all counties.

### **Asset Transfer**

The act of transferring ownership of assets (i.e., a home, cash, stocks, or bonds) to a family member or other person.

### **Assisted Living**

A broad range of residential care services that include assistance with activities of daily living and instrumental activities of daily living, but does not include nursing services such as administration of medication. Assisted living facilities generally stress independence and provide services that are less intensive than those found in nursing homes.

### **Care Management Organizations (CMO)**

The managed care organizations that manage and deliver the Family Care benefit, which is available in counties where Family Care is available (Fond du Lac, La Crosse, Portage, Milwaukee and Richland Counties). CMOs either provide long-term care services using CMO staff or by purchasing the service from other providers. Each CMO receives a flat monthly payment for each enrolled member, who may be living at home, in a group living situation, or in a nursing facility.

### **Centers for Medicare and Medicaid Services (CMS)**

The federal government agency within the Department of Health and Human Services that administers the Medicare program and works in partnership with states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

### **Clawback**

Money that the federal government recaptures from state Medicaid agencies that is associated with the federal government's coverage of dual eligibles (Medicaid and Medicare) under the Medicare prescription drug program. To recapture these savings, the federal government reduces states' Medicaid matching rate.

### **Community Integration Program (CIP)**

A Medicaid 1915(c) Home and Community-Based Waiver received from the federal government in 1983 that allows Wisconsin to use Medical Assistance (MA) funds to serve Medicaid-eligible persons with developmental disabilities who are eligible for services in a nursing facility serving people with developmental disabilities. Each county receives funds for a certain number

of CIP eligible persons; the funds come from both the State's general purpose revenue and federal Medical Assistance funds.

### **Community Options Program (COP)**

A state-funded, county-administered home care program that began in 1981 for Wisconsin residents with long-term care needs (i.e., frail elders and persons with serious disabilities) to reduce their use of institutions and nursing homes by providing home and community-based long-term care services and supports. This is not an entitlement program; counties serve only the number of people that funds allow. The main funding source for COP is the State's general purpose revenue. Covered services include an assessment and care plan and may include, depending on the income of the participant and the availability of COP funds in the county, home modification, home health care, personal care, and other services and care.

### **Community Options Program – Waiver (COP-W)**

A Medicaid 1915(c) Home and Community-Based Waiver received from the federal government in 1987 that allows Wisconsin to use Medical Assistance (MA) funds to serve Medicaid-eligible elders and persons with physical disabilities who are eligible for nursing home care. Similar to the Community Options Program, each county receives funds for a certain number of COP-W eligible persons, but the funds come from both the State's general purpose revenue and federal Medical Assistance funds.

### **Dual Eligible**

A person who is eligible for both Medicare and Medicaid.

### **Estate Recovery**

Under the Omnibus Budget Reconciliation Act of 1993, states are required to recover the cost of nursing facility and other long-term care services from the estates of certain Medicaid beneficiaries. For example, a state may place a lien on the home of a Medicaid beneficiary, then collect on it when the house is sold or changes ownership. The exact rules about what assets are included and excluded, and when and how this recovery will take place, are determined by the states and vary significantly from one part of the country to another.

### **Family Care**

A program that began in 2000 that uses Section 1915(b)/(c) Combination Waiver authority to use managed care to provide both traditional fee-for-service long-term care services (such as home health, personal care, and institutional services) and home and community-based waiver services (such as supportive home care services, adult day health services, and respite care). Family Care serves the elderly, adults with physical disabilities, and adults with developmental disabilities in five counties (Fond du Lac, La Crosse, Portage, Milwaukee and Richland). The Family Care benefit is managed by a Care Management Organization (CMO).

Unlike the Partnership Program, acute care is not a Family Care benefit, although Family Care care managers coordinate the primary and acute care services Family Care participants receive. Information about long-term care

options and access to enrollment in Family Care is processed through Aging and Disability Resource Centers.

### **Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA)**

A Section 1115 waiver that can be used in Medicaid or the SCHIP program. States can use this waiver to modify the Medicaid benefits package or require cost sharing amounts for optional eligibility groups. States can also use federal Medicaid dollars to enable eligible individuals to purchase private health insurance coverage. The goal is to use program savings to increase the numbers of insured individuals by expanding coverage to individuals not previously covered by Medicaid or SCHIP. These waivers must be cost-neutral to the federal government.

### **Home and Community-Based Services (HCBS)**

Services provided to older adults and people with disabilities that help them remain independent in a home or community-based setting (as an alternative to institutionalization).

### **Home Care**

Personal care provided in the home setting that consists of assistance with personal hygiene, dressing, feeding or other activities of daily living.

### **Home Health Care**

Care provided in the home setting that may include intermittent or part-time nursing services, home health aide services, case management, and medical supplies and equipment. Services must be medically necessary and ordered by a physician. Home health care is sometimes defined to include non-medical *home care* (see definition above).

### **ICF/MR**

Intermediate care facilities for people with mental retardation

### **Informal Caregiver**

An unpaid family member, friend, neighbor, or volunteer who assists a person who has long-term care needs with activities of daily living or instrumental activities of daily living. Care can be provided in the home, an assisted living facility, or a nursing home.

### **Instrumental Activities of Daily Living**

An index or scale that measures a person's degree of independence in aspects of cognitive and social functioning, including shopping, cooking, doing housework, managing money, and using the telephone. People who need assistance with Instrumental Activities of Daily Living are said to have long-term care needs.

### **Long-Term Care**

A set of health care, personal care, and social services required by persons who have lost, or never acquired, some degree of functional capacity (i.e., the chronically ill, aged, or disabled) and provided in an institution or home on a long-term basis. The term is commonly used more narrowly to refer to long-

term institutional care such as that provided in nursing homes, homes for the developmentally disabled, and hospitals for persons with mental illness.

### **Long-Term Care Insurance**

Insurance policies that individuals may buy to pay for long-term care services (such as nursing home and home care), since Medicare and Medigap policies do not cover long-term care services. Policies vary in terms of what they will cover. Coverage may be denied based on health status or age.

### **Medicaid**

A joint federal-state governmental health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets broad guidelines for the program. A state is then given latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population. The program is authorized under Title XIX of the Social Security Act.

### **Medicare**

The national health insurance program provided primarily to older adults (65 and older) and some disabled people who are eligible for Social Security benefits. Medicare has three parts: Part A, which is hospital insurance; Part B, which covers the costs of physicians and other providers; and Part C (Medicare + Choice), which expands the availability of managed care or other insurance arrangements for Medicare recipients. Part C gives beneficiaries a choice of enrolling in a coordinated care plan (HMO, PPO, or PSO), private fee-for-service plan, or medical savings account as an alternative to the traditional Medicare fee-for-service system.

### **Medicare Part D Drug Benefit**

A Medicare prescription drug benefit that was signed into law in December 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The coverage includes most FDA-approved drugs and biologicals, using the Medicaid coverage decisions definitions. There are a few exceptions. Part D includes other items that aren't normally considered covered such as smoking cessation agents; vaccines and insulin; and insulin-related supplies such as syringes, needles, alcohol swabs and gauze, but not lancets and test strips. The full benefit went into effect in January 2006.

### **Nursing Home**

Includes a wide range of institutions that provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems that range from minimal to serious. Nursing homes can be free-standing institutions or components of other institutions that provide nursing care. Nursing homes include skilled nursing facilities and extended care facilities, but not boarding homes.

**Olmstead Decision**

A 1999 Supreme Court decision in the case of *Olmstead v. L.C.* whereby the Court found that unnecessary institutionalization of individuals with disabilities is unconstitutional under the Americans with Disabilities Act. State Medicaid programs were affected if they provide both institutional and home and community-based long-term care services; they must have a plan that ensures individuals with disabilities receive services in the most integrated setting appropriate to their needs.

**Partnership for Long-Term Care**

A public/private alliance between state governments and insurance companies to create long-term care insurance programs. Beginning in 1988, the Robert Wood Johnson Foundation awarded grants to the four existing states (California, Connecticut, Indiana, and New York) to implement the initiative which currently combines private long-term care insurance with special Medicaid eligibility standards.

**Program for All-Inclusive Care for the Elderly (PACE)**

A managed care program that provides both acute health and long-term care services to the elderly who are eligible for nursing home care. Similar to the Wisconsin Partnership Program, it is a voluntary program available to people who are eligible for both Medicaid and Medicare. Unlike the Wisconsin Partnership Program, PACE beneficiaries must attend a day health center on a regular basis to receive services and their primary physician must be a member of the PACE organization. Currently, the only PACE site in Wisconsin is in Milwaukee.

**Wisconsin Partnership Program (WPP)**

A long-term care program that operates under both a Medicaid 1115 demonstration waiver and a Medicare Section 222 waiver and serves two populations: elders and adults with physical disabilities. The program, which began in 1996, operates in six counties by four non-profit organizations. Similar to Family Care, it is a managed care program that provides long-term care services in a variety of settings. Unlike Family Care, it also provides primary and acute-care services and is funded by both Medicaid and Medicare.

**Respite Care**

Temporary care given to a person needing long-term care services so that the usual caregiver (usually a family member) can rest.

**Supplemental Security Income (SSI) Program**

A federal government income support program that began in 1972 for the aged, blind, and people with disabilities. Wisconsin currently gives an additional state cash benefit to SSI recipients under Ch. 49.77 and 49.775, Wis. Stats.

**SeniorCare**

The program approved under the Section 1115 Medicaid Pharmacy Plus waiver to provide prescription drug benefits to Wisconsin seniors (aged 65 and older) with incomes at or below 200% of the federal poverty level. SeniorCare is

administered on a fee-for-service basis and involves pharmacies that participate in the Wisconsin Medicaid program (about 98% of all pharmacies in the state). Enrollees in the program pay an enrollment fee, copayments for drugs, and may have an annual deductible.

### **Skilled Nursing Facility**

A nursing care facility participating in the Medicaid and Medicare programs that meets specified requirements for services, staffing, and safety.

#### **Sources:**

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Elderweb Web site glossary: <http://www.elderweb.com/glossary/?Do=glossary>

North Carolina Family Impact Seminar. (2005, June). *Medicaid Cost Containment Strategies in North Carolina and Other States (briefing report)*. Retrieved July 29, 2005 from <http://www.pubpol.duke.edu/centers/child/fisindex.html>.

U.S. Department of Health and Human Services' Web site: <http://aspe.hhs.gov/daltcp/diction.shtml#L>

Wisconsin Department of Health and Family Services' Web site: [www.dhfs.state.wi.us](http://www.dhfs.state.wi.us)





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# Selected Resources on Long-Term Care Issues

## Wisconsin Legislative Service Agencies

### **Charlie Morgan, Program Supervisor**

Wisconsin Legislative Fiscal Bureau  
1 E Main Street, Suite 301  
Madison WI 53703  
(608) 266-3847  
Fax: (608) 267-6873  
charlie.morgan@legis.state.wi.us

*Interests:* State health and family services programs, insurance, state budgeting, the legislative and budgeting process

### **Mary Offerdahl, Staff Attorney**

Wisconsin Legislative Council  
1 East Main Street, Room 401  
PO Box 2536  
Madison WI 53701-2536  
(608) 266-1304  
Fax: (608) 266-3830  
mary.offerdahl@legis.state.wi.us  
<http://www.legis.state.wi.us/lc>

*Interests:* Assembly Committee on Aging and Long-Term Care

### **Laura Rose, Deputy Director**

Wisconsin Legislative Council  
1 East Main Street, Room 401  
PO Box 2536  
Madison WI 53701-2536  
(608) 266-1304  
laura.rose@legis.state.wi.us

*Interests:* Health, family and medical leave and insurance

### **Richard Sweet, Senior Staff Attorney**

Wisconsin Legislative Council  
1 East Main Street, Room 401  
PO Box 2536  
Madison WI 53701-2536  
(608) 266-1304  
richard.sweet@legis.state.wi.us

*Interests:* Administrative rules and health-related legislation, long-term care insurance

## State Agencies

### **Kathleen Emmerton, Section Chief**

Estate Recovery Section  
Wisconsin Department of Health and Family Services  
PO Box 309  
Madison WI 53701-0309  
(608) 261-7831  
emmerkm@dhfs.state.wi.us

*Interest:* Estate recovery

### **Judith Frye, Associate Administrator for Long-Term Support**

Division of Disability and Elder Services  
Wisconsin Department of Health and Family Services  
PO Box 7851  
Madison WI 53707-7851  
(608) 266-5156  
fryeje@dhfs.state.wi.us

*Interests:* Long-term care, long-term support for elders, adults with physical or mental disabilities, children with disabilities, employment and other forms of community integration for people with disabilities, institutional care for people with developmental disabilities

### **James Johnston, Executive Policy and Budget Manager**

State Budget Office  
Wisconsin Department of Administration  
101 E Wilson Street, 10th Floor  
Madison WI 53707-7864  
(608) 266-3420  
james.johnston@wisconsin.gov  
<http://doa.wi.gov/>

*Interests:* Health care reform; health care programs at the Department of Health and Family Services (e.g., Medicaid, High Risk Insurance Pool, BadgerCare, SeniorCare), Office of the Commissioner of Insurance, Board on Aging and Long-term Care

### **Mark Moody, Administrator**

Division of Health Care Financing  
Wisconsin Department of Health and Family Services  
PO Box 309  
Madison WI 53701-0309  
(608) 266-8922  
moodymb@dhfs.state.wi.us

*Interests:* Medicaid, managed health care, health information, Medical Assistance, BadgerCare, SeniorCare, international health care

**Sinikka Santala, Administrator**

Division of Disability and Elder Services  
Wisconsin Department of Health and Family Services  
PO Box 7851  
Madison WI 53707-7851  
(608) 266-0554  
santass@dhfs.state.wi.us

*Interests:* Long-term care, regulation and licensing, people with disabilities, mental health and substance abuse issues, elder services

**LeAnna Ware, Director**

Bureau of Civil Rights  
Equal Rights Division  
Department of Workforce Development  
PO Box 8928  
Madison WI 53708  
Phone (608) 266-1997  
E-mail: leanna.ware@dwd.state.wi.us

*Interest:* Wisconsin's Family and Medical Leave Act

**University of Wisconsin-Madison**

**Dr. Michael Fleming, Professor**

University of Wisconsin-Madison Medical School  
Department of Family Medicine  
777 S. Mills Street, Room 3817  
Madison WI 53715  
(608) 263-9953  
FAX: (608) 263-7919  
mike.fleming@fammed.wisc.edu

*Interests:* Family medicine

**Donna Friedsam, Researcher and Associate Director**

University of Wisconsin Population Health Institute  
Department of Population Health Sciences  
760 WARF Office Building  
610 Walnut Street  
Madison WI 53726  
(608) 263-4881  
dafriedsam@wisc.edu  
<http://www.pophealth.wisc.edu/uwphi>

*Interests:* Medicaid, health care financing, insurance coverage, access to health care, health care reform, health policy, special populations

**Karen Goebel, Professor and Extension Specialist**

Professor, Department of Consumer Sciences, UW-Madison  
Family Consumer Economics Specialist, UW Extension  
1300 Linden Drive  
Madison WI 53706  
(608) 262-0080  
kpgoebel@wisc.edu

*Interests:* Family estate planning, elder care, scams and frauds

**Roberta Riportella, Associate Professor and Extension Specialist**

Associate Professor, Department of Consumer Sciences, UW-Madison  
Health Policy Specialist, UW Extension  
Human Ecology, Room 370 B  
1300 Linden Dr  
Madison WI 53706  
(608) 263-7088  
rriporte@wisc.edu  
<http://www.uwex.edu/ces/flp/specialists/riportel.html>

*Interests:* Barriers to accessing care for under-served populations, Medicare

**Barbara L. Wolfe, Professor**

University of Wisconsin-Madison  
Department of Population Health Sciences  
La Follette School of Public Affairs  
Department of Economics  
7432 Social Science Building  
1180 Observatory Drive  
Madison WI 53706  
(608) 262-0662  
bwolfe@wisc.edu

*Interests:* Health insurance coverage, public coverage, income inequality and health, welfare reform

## **National Organizations and Associations**

**AcademyHealth and  
Changes in Health Care Financing and Organization**

W. David Helms, President  
1801 K Street NW, Suite 701-L  
Washington DC 20006  
(202) 292-6700  
<http://www.academyhealth.org>  
<http://www.hcfo.net>

*Conference Proceedings:*

“Long-Term Care Financing: Private Sector Solutions and International Comparisons” presented at June 2004 annual research meeting. Available online at: <http://www.academyhealth.org/2004/monday.htm#ltc> (scroll down to 4:00 p.m. to 5:30 p.m. concurrent session).

*Issue Briefs:*

“Long-Term Care: Collaborating for Solutions” (2003). Available online at: <http://www.academyhealth.org/publications/ltc-solutions.pdf>.

**Centers for Medicare and Medicaid Services**

U.S. Department of Health and Human Services  
<http://cms.hhs.gov/>

**Commonwealth Fund**

Karen Davis, President  
1 East 75th St  
New York NY 10021  
(212) 606-3800  
[www.cmwf.org](http://www.cmwf.org)

*Reports:*

“Improving the Quality of Long-Term Care with Better Information” (September 2005). Available online at: [http://www.cmwf.org/publications/publications\\_show.htm?doc\\_id=317291](http://www.cmwf.org/publications/publications_show.htm?doc_id=317291).

**Georgetown University Long-Term Care Financing Project**

Health Policy Institute  
2233 Wisconsin Ave NW, Suite 525  
Washington DC 20007  
(202) 687-0880  
<http://ltc.georgetown.edu>

*Issue Briefs:*

“Who Needs Long-Term Care? (May 2003). Available online at: <http://www.ltc.georgetown.edu/pdfs/whois.pdf>.

“Long-Term Care: Support for Family Caregivers” (March 2004). Available online at: <http://www.ltc.georgetown.edu/pdfs/caregivers.pdf>.

“Medicaid and an Aging Population” (July 2004). Available online at: <http://www.ltc.georgetown.edu/pdfs/merlis.pdf>.

**Government Accounting Office**

441 G St, NW  
Washington DC 20548  
(202) 512-3000  
<http://www.gao.gov/index.html>

*Report:*

“Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage” (September 2005). Available online at: <http://www.gao.gov/new.items/d05968.pdf>.

*Testimony:*

“Long-Term Care: Growing Demand and Cost of Services are Straining Federal and State Budgets” (April 2005). Available online at: <http://www.gao.gov/new.items/d05564t.pdf>.

**Kaiser Family Foundation**

The Kaiser Commission on Medicaid and the Uninsured

Diane Rowland, Executive Director

1330 G Street, NW

Washington DC 20005

(202) 347-5270

<http://www.kff.org>

<http://www.statehealthfacts.org> - State Health Facts

<http://www.kaisernetwork.org> - Webcasts on Health-Related Hearings and Meetings

*Reports:*

For a comprehensive listing of long-term care-related reports, visit [www.kff.org/medicaid/longtermcare.cfm](http://www.kff.org/medicaid/longtermcare.cfm).

“The Public’s Views on Long-Term Care” (May/June 2005). Available online at: [http://www.kff.org/healthpollreport/june\\_2005/index.cfm](http://www.kff.org/healthpollreport/june_2005/index.cfm).

“Long-Term Care: Understanding Medicaid’s Role for the Elderly and Disabled” (November 2005). Available online at: <http://www.kff.org/medicaid/7428.cfm>.

*Issue Brief:*

“Asset Transfer and Nursing Home Use” (November 2005). Available online at: <http://www.kff.org/medicaid/7436.cfm>.

*Webcasts:*

“Caring for the Elderly: Is there an Answer to Rising Health Costs?” (September 2005). Available online at: [http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1517](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1517).

“Cash and Counseling: Part of the Long-Term Care Answer?” (July 2005). Available online at: [http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1486](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1486).

“Creating a Comprehensive National Long-Term Care Policy” (April 2005). Available online at: [http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1404](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1404).

### **National Academy for State Health Policy**

Alan Weil, Executive Director  
50 Monument Square, Suite 502  
Portland ME 04101  
(207) 874-6524  
www.nashp.org

#### *Reports:*

“State Perspectives on Medicaid Long-Term Care: Report from July 2003 Forum.” Available online at: [http://www.nashp.org/Files/LTC\\_16\\_final.pdf](http://www.nashp.org/Files/LTC_16_final.pdf).

### **National Conference of State Legislatures**

7700 East First Place  
Denver CO 80230  
(303) 364-7700  
www.ncsl.org

#### *Audioconference:*

“Family Caregivers: The Backbone of Long-Term Care” (July 2004). Available online at: <http://www.ncsl.org/programs/health/webcast2-jul2004.htm/>

### **National Governors Association**

Hall of the States  
444 N Capitol St  
Washington DC 20001  
(202) 624-5300  
www.nga.org

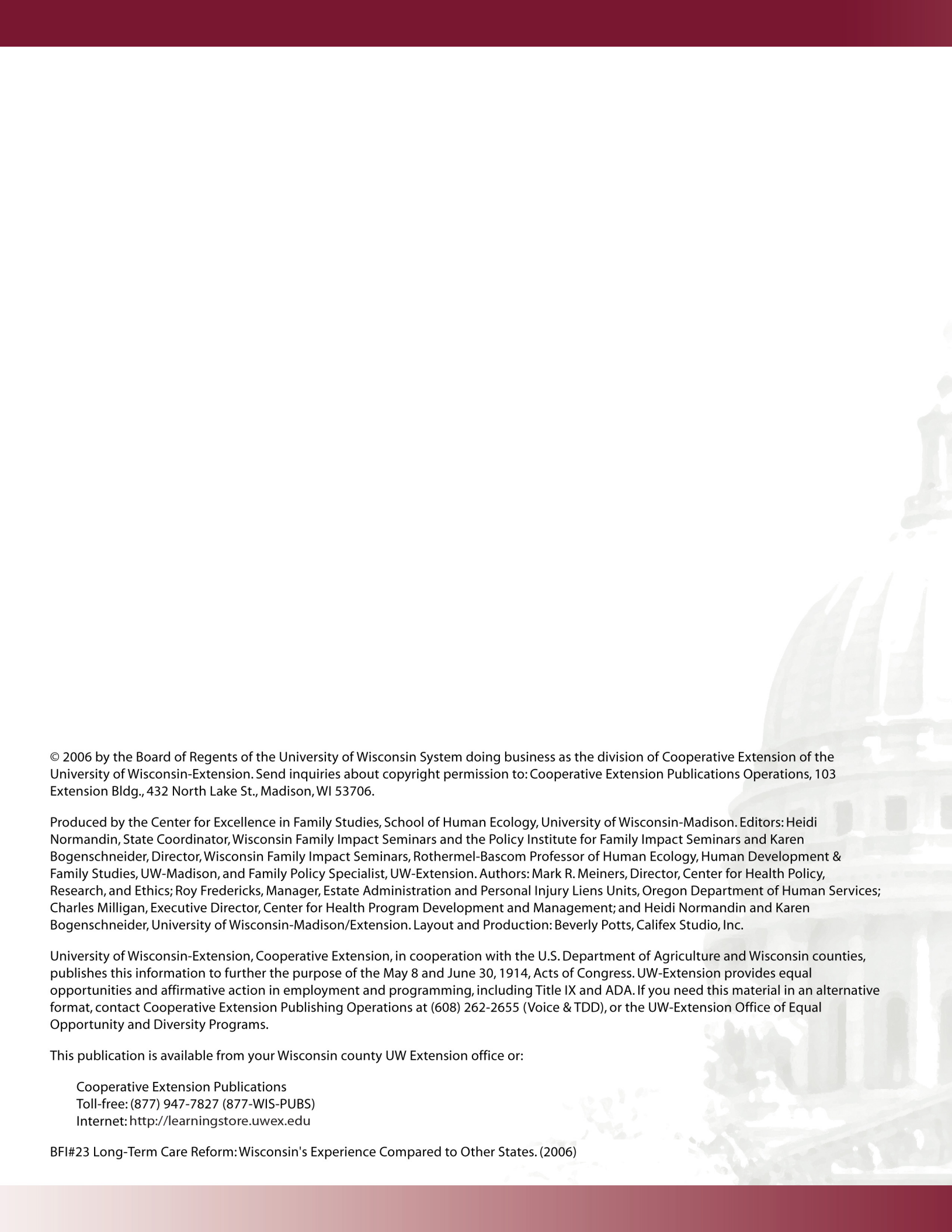
#### *Issue Brief:*

“State Support for Family Caregivers and Paid Home-Care Workers” (June 2004). Available online at <http://preview.nga.org/Files/pdf/0406AgingCaregivers.pdf>.









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