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

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The Case for a Fully Integrated System:

"Given the limitations and disadvantages of the current long term care system, the Wisconsin Association of Homes and Services for the Aging (WAHSA) strongly advocates for a redesigned delivery system which '*maximizes an individual's choice of services, providers, and care settings as long as such care is necessary and meets a minimum level of quality standards and is cost-effective.*' **Further, the future delivery system should integrate acute and primary care, long term care, and supportive services in order to provide, finance, and manage the health and long term care needs of clients**." (Emphasis added)

Long Term Care Redesign: WAHSA's Vision of a New System, 1996, www.wahsa.org/ltc.htm

"For many in the field of publicly financed care, myself included, **integrated care for the dual eligibles represents the single most important opportunity for reforming the current U.S. healthcare system. It is tantamount to a Holy Grail that has been pursued literally for decades.** The first efforts to integrate care for dual eligibles began in the early 1980s with efforts like the On Lok/Program of All Inclusive Care for the Elderly (PACE) program and social HMOs, and eventually the state-based Medicare-Medicaid integration waivers in Massachusetts, Minnesota, and Wisconsin." (Emphasis added)

Melanie Bella, Senior Vice President at the Center for Health Care Strategies, U.S. Senate Special Committee on Aging testimony, 3/09/2009, http://aging.senate.gov/events/hr205mb.pdf

"**The 9 million Medicare-Medicaid enrollees accounted for approximately $120 billion in combined Medicaid Federal and State spending in 2007 – almost twice as much as Medicaid spent on all 29 million children it covered in that year.** While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 26 States, more than half of such spending in 4 States (Connecticut, New Hampshire, North Dakota and Wisconsin) and not less than a quarter of total spending in any State." (Emphasis added)

Melanie Bella, Director of the CMS Medicare-Medicaid Coordination Office, U.S. House Committee on Energy and Commerce, Subcommittee on Health, testimony, 6/21/11, http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/062111%20Dual%20Eligibles/Bella.pdf

WAHSA---Soon to be known as: LeadingAge™ Wisconsin

Discussion Points on Virtual PACE Exploration:

- DHS should articulate a Vision: How is Virtual PACE different than Partnership? PACE? Is there a preferred model in mind that looks different than the Partnership or PACE models that exist on a relatively small scale today?

- Will the Virtual PACE program rely on large insurance companies or managed care entities to operationalize the Virtual PACE program, or will start-up entities be sought to offer integrated care? For example, is there a place in the pilot experimentation phase for CCRCs/LTC/housing providers, hospital and physician networks and HCBS providers to form a PACE partnership?

- Will DHS offer "backroom support" for newly formed entities under which DHS (subcontractors) handles the routine administrative duties, while the provider entities are held responsible for the actual management of care/services and outcomes?

- Will the Virtual PACE pilot participants (providers or managed care entities) be offered any assistance to build the necessary infrastructure or are these costs to be "fronted" or assumed by the participants? (Electronic health records across settings, claims processing, state and federal reporting and tracking, reserve requirements, stop-loss insurance protections, negotiated add-ons for high cost clients, defined gain-sharing or deficit controls).

- Will DHS support a model that requires certain dual eligibles to join the Virtual PACE pilot? If all members residing at a CCRC or a defined "neighborhood" are enrolled, there is a better opportunity to cost-effectively direct and manage resources.

- Would DHS support directing all Family Care MCOs to offer a fully integrated care and service benefit package by the year 20__? This could be accomplished either directly by the MCO or via contract.

- Is DHS interested in pursuing integration on a smaller scale during the pilot phase? For example, could providers be incentivized to address specific conditions or diagnoses and receive enhanced payments for better outcomes and reduced overall Medicare/Medicaid costs? This may not fall under a capitated payment system. Consider: reduced hospitalizations; reduced cost in serving "outlier" residents and patients; avoidance of acquired conditions/infections.

- Would DHS support funding shared nurse practitioners on site (LTC/HCBS) and supporting transitions between hospitals and post-acute settings?

- Could the pilot waive the Medicare 3-day hospitalization requirement, provide incentive payments to the hospital and post-acute provider, and reward providers for avoiding unnecessary rehospitalizations or ER visits?

- Will DHS embrace separate capitation rates and financial and programmatic reporting for different clients groups? Will Virtual PACE entities be required to serve older adults *and* persons under the age of 65 with a disability?

- DHS should modify the LTC functional screen to better reflect the cost of clients with behavioral issues and complex or increasing medical conditions. This is especially needed once the system is fully integrated.