

The Biennial Report of the
Wisconsin Board on Aging and Long Term Care
2006 – 2007



The Wisconsin SHIP
State Health Insurance & Assistance Program



State of Wisconsin
Board on Aging & Long Term Care

Long-Term Care Ombudsman Program

Medigap Helpline

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Introduction

This edition of the Biennial Report of the Board on Aging and Long Term Care gives the reader a sense of the agency's condition and progress over the period of calendar years 2006 – 2007. In the past biennium, the Board on Aging and Long Term Care experienced significant changes both internally and in the manner and scope of the agency's provision of services to the citizens of Wisconsin.

Many of the agency's field staff were moved into home offices as a means to improve advocacy service to the clients they serve by locating the Ombudsman closer to her or his client as well as to realize substantial savings in the agency's budget. The shift to home offices has proven to be a remarkable success by reducing travel time, eliminating internal office distractions and emphasizing the independence of the individual Ombudsman.

The **Long Term Care Ombudsman Program** has made a concerted effort to present an increased presence in Assisted Living Facilities (ALFs). Not only are Regional Ombudsmen spending more time in ALFs, the Board has begun a project using money awarded to the agency as a part of a plea agreement in a criminal proceeding against an Assisted Living provider to fund an effort to place volunteer Ombudsmen into community-based residential facilities (CBRFs).

Recent years have seen a noteworthy increase in the relocation of residents due to facility closures and downsizing. Addressing the needs of these residents has been and continues to be a top priority. The Long Term Care Ombudsman Program has engaged in a project to provide specialized and focused advocacy to residents who are being relocated. A distinct Ombudsman position, using funds collected from facilities as civil money penalties, has been created and used to great benefit of these residents. The Relocation Ombudsman Specialist, in concert with the Regional Ombudsman, provides advocacy for the residents being affected by a closure or downsizing and assures that their voices are heard and their rights and safety are protected.

Privatization of Medicare through private Medicare Advantage Plans has been driving much of the work of the **Medigap Helpline**. Despite efforts by the federal Center for Medicare and Medicaid Services (CMS) to inform the public of the differences between traditional Medicare and the new Advantage plans, the Helpline has been deluged with calls for information and assistance in negotiating the ins and outs of the new form of Medicare.

As well, the Medigap Helpline has been making concentrated efforts to provide outreach to socially and economically isolated Wisconsin consumers. Counselors have been traveling to all corners of the state, holding informational sessions with seniors, answering questions, distributing literature and speaking with insurance industry representatives about the issues and concerns that are coming through loud and clear to the Medigap Helpline phones.

The Board on Aging and Long Term Care website is receiving more traffic than ever before. The demands of an increasingly internet-connected society point up the need for this part of our service to be redesigned to make it more consumer friendly.

Several years ago, the Long Term Care Ombudsman Program initiated a data collection and management system called OmbudsManager which permits remote entry of data in real time by the individual staff member who is doing the work being recorded. This system, created and supported by Synergy Data Systems, also connects directly with the federal Administration on Aging (AoA) data center and allows for direct transmittal of required information to the national database. OmbudsManager is projected to provide a more understandable and readily available body of information for consumers to use when choosing LTC facilities.

At the beginning of the 2007-2008 Legislative session, BOALTC began to push for a statutory change that will permit Ombudsmen to advocate for clients of the state's expanding Family Care Program. A side effect of this change will be the extension of the program's authority to work with Family Care participants who live in Residential Care Apartment Complexes. This extension will, we believe, serve to demonstrate the continuing benefit of the Ombudsman's services to residents in these environments.

Very likely the most significant single event affecting the operations of BOALTC during the course of the recently completed biennium was the retirement of the agency's long-time Executive Director, George F. Potaracke. Mr. Potaracke announced his impending departure early in 2007 and set about providing support for the Board of Directors selection committee that was tasked with finding his replacement. After an Executive Director designee, former Ombudsman Services Supervisor Heather Bruemmer, was announced in September of that year, Mr. Potaracke worked diligently with Ms. Bruemmer to insure that she had an adequate background in the management and administrative processes unique to this agency that would be necessary to guide the agency into the future.

OPERATING BUDGET

July 1, 2005 – June 30, 2007

The agency's administration and program operations are funded by several revenue sources: general purpose revenue (state tax); federal funds through grants from the state Department of Health and Family Services originating from appropriations authorized by the federal Older Americans Act and CMS; program revenue from a segregated fund in the state Office of the Commissioner of Insurance, and funds from private gifting foundations and other sources.

<u>Source</u>	<u>Dollars</u>
General Purpose Revenue	1,796,500
Program Revenue (federal)	1,747,100
Program Revenue (OCI)	690,600
Private gifts/grants – other	75,000
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Total	4,309,200

Long Term Care Ombudsman Program

The **Long Term Care Ombudsman Program** is increasingly charged with balancing consumer requests for advocacy and the need to educate and inform the public about the future of long term care and the important role of this agency.

We anticipate that the Legislature will grant authority for the Long Term Care Ombudsman Program to serve older adults in the expanding Family Care program. This expansion of responsibility will extend the scope of the regional ombudsmen's range and they will no longer be known only for their advocacy to residents of nursing homes and community-based residential facilities (CBRF's).

Current Focus

The Wisconsin Long Term Care Ombudsman Program is charged, by statute, to provide advocacy services and outreach to persons age 60 and older who are receiving long term care services in nursing homes, assisted living facilities, or in their own homes and alternate settings when funded by the Community Options Program (COP) or Family Care. Fourteen dedicated and professional Ombudsmen serve consumers in Wisconsin's 72 counties from strategically located regional offices, providing not only individual visits to consumers, but also providing education to facility staff, Family and Resident Councils, and outreach to the community at large. Ombudsmen are involved at local, state and national levels in committee work aimed at influencing public policy impacting Wisconsin's older adults. Contact information for the Ombudsman Program is made readily available to residents of long term care facilities and participants in COP and Family Care. Ombudsmen may be contacted for specific and general concerns by calling the Board on Aging and Long Term Care's toll-free number, 1-800-815-0015, or on the web at <http://longtermcare.state.wi.us> .

Program Highlights

* While efforts in previous years have been mostly focused on issues noted in nursing homes, concerns from those living in assisted living facilities have also increased. Most frequent complaints revolve around issues of not receiving prompt or appropriate care and treatment, quality and quantity of meals, and the provision of adequate and individualized psychosocial programs.

* In an attempt to proactively influence change and advocacy aimed at improving care, the Wisconsin Ombudsman Program plays an active role in the national "Advancing Excellence" campaign, joining with a host of provider, consumer, advocacy and quality improvement entities to effect change in nursing homes.

* Using funds from a Civil Money Penalty Grant (CMP), the Ombudsman Program has been able to temporarily dedicate a position to nursing homes in Wisconsin facing closure or downsizing due to economic reasons, performance, or change in philosophy or focus. This has been a remarkably successful effort, with the Relocation Ombudsman working in tandem with the associated Regional Ombudsman to insure that residents who are relocated receive ongoing services that are respectful of their cultural, familial and personal needs and expectations. An apparent increase in assisted living closures, largely due to economic and regulatory reasons, has also challenged the resources of the Ombudsman Program. The current provisions of the CMP grant limit the Relocation Ombudsman's efforts solely to nursing home activity. This will be a necessary component of strategic planning for the next biennium to insure that consumers have access to and receive the appropriate care and services throughout the continuum of long term care options.

* Though the Board on Aging and Long Term Care has not yet received statutory authority to serve older adults living in residential care apartment complexes (RCAC's) unless they are the recipients of Family Care or other public funding, calls from consumers and providers of these services also are on the increase.

* The Board on Aging and Long Term Care now has a greater capacity to monitor data associated with service provision and outcomes. This translates into opportunities for trend analysis and planning while measuring current quality of service delivery. Such information will also be of tremendous value in determining the appropriateness of staff deployment and how resources may best be used to insure good stewardship of state and federal budget dollars allocated to the program.

Ombudsman Program Activity

Year	Cases	Closed Complaints	Information & Counseling	Presentations
2006	1022	3157	15,497	416
2007	1114	3161	14,356	471
Total	2136	6318	29,853	887

These data show decreases in cases, closed complaints and presentations since the previous biennial report, due primarily to a change in data collection and criteria as directed by the federal Administration on Aging.

Data analysis indicates that the cases and complaints attended to by Ombudsman staff continue to increase in severity, and they often either appear to remain open longer with intensive intervention, or they require referral to the Department of Quality Assurance for regulatory follow up or co-investigation. The increasing number of citations of Immediate Jeopardy, where residents are in danger of actual harm continues to present some of the most intensive challenges for Ombudsman staff.

The following key indicators will be the focus of further data analysis and will direct future program trending and development.

- * The frequency and intensity of complaints about care received.
- * The professional diversity of the staff of the ombudsman program and its leadership.
- * The projected increases in long term care needs and the complexities of those needs, coupled with a greater desire for expanded choice by consumers.
- * The need for BOALTC to continually review the goals of the agency and benchmark status in order to remain responsive to continually changing needs, expectations, funding sources and service options.

Long Term Care Trends in Wisconsin

Past reports had noted an emerging trend among a few providers toward repeated and serious violations of regulations protecting residents' rights and issues related to care and treatment. These concerns remain a focal point for the Ombudsman Program, and are often the topic of prevention-centered educational opportunities offered to the public and the provider community by Ombudsman Program staff.

Other trends, many noted in past reports, continue to take priority in terms of the work of the Long Term Care Ombudsman Program. Involuntary discharges continue at an alarming rate, with residents and families frequently misinformed or not informed in a timely manner of their rights to appeal and advocacy. Some of these discharges point out the confusion among persons applying for public assistance, the lack of direction and support to applicants in order to complete the application process, and the effects of misappropriation of residents' assets by family members that may make an application invalid. Persons with Alzheimer's disease or related dementias are also frequent targets for involuntary discharge due to behavior challenges that facilities are ill-equipped to manage.

The proliferation of assisted living facilities that claim to specialize in dementia-specific care is a growing concern. Providers often charge an inordinate additional cost for providing services that could reasonably be assumed to be part of a typical room and board rate. Families have shown evidence of being charged an increased rate for “services” such as turning on the lights or heat in a resident’s room, or informing a resident when it is time to come to the dining room for a meal. This sort of fiscally motivated practice coupled with a notable lack of scientifically-based specialized services or activities designed to care for residents with these afflictions seems to characterize a number of these “special care” facilities.

Facility closures and performance issues, particularly in northern Wisconsin and in the Milwaukee area, continue to decrease choice for those who have profound needs related to chronic mental health issues or developmental disabilities, and those who require financial support through the Medical Assistance system.

Volunteer Ombudsman Program

The dedicated volunteers in the Volunteer Ombudsman Program (VOP) continue to make an impact on the lives of residents in designated long term care facilities. The presence of an advocate improves and enhances the quality of daily living, care, and treatment.

Volunteers give their time to educate, empower, and extend the services provided by the Long Term Care Ombudsman Program to make a difference in the long term care system.

The volunteers are resident-focused advocates that are screened, trained, and matched to long term care facilities in their community. Volunteers distribute ombudsman program resources during their visit and meet with new admissions to make sure they are aware of the services provided. Volunteers empower residents (and their families) to advocate for themselves, informing them about the rights they have. The VOP is a voice for those who will not or cannot speak for themselves. They are the “eyes and ears” of the Regional Ombudsman in these facilities. The communication and relationship established between the volunteer and the Regional Ombudsman is a critical link to resident care and treatment. Volunteers also communicate with an assigned facility staff member at the end of each visit. This sharing of information, along with visit details will be submitted via a monthly report to the volunteer program managers. Information from the report is documented in the agency data system.

The VOP maintains high quality volunteer advocacy services because of the expertise of Volunteer Coordinators, Regional Ombudsmen, supportive administration and the members of the Board of Directors.

Since 2004, the VOP, annually recognizes and celebrates the accomplishments of a selected Volunteer Ombudsman with the Louise Abrahams Yaffe Volunteer Ombudsman Program Award, named in honor of the programs founder and since retired board member, Louise Abrahams Yaffe. The award recipient selection is made through a formal nomination process and then determined by the Board members of BOALTC.

The prestigious award recipient for 2006 was Jim Haseman, from Rock Co., and the recipient for 2007 was Larry Hammond from Milwaukee Co. Both recipients were honored with their awards at the state Alzheimer's Association conference held in May.

Beginning in 1994, the Volunteer Ombudsman Program initially included Dane, Milwaukee, Monroe and Rock Counties. Early in 2004, an additional VOP coordinator was hired to take over the program in Milwaukee Co. and in the additional counties of Kenosha and Racine. Later in 2004, the expansion continued with the hiring of another VOP coordinator in the central part of the state to establish volunteers in an additional five counties, Marathon, Portage, Shawano, Waupaca, and Wood. By April of 2005 the VOP was operating in eleven counties, serving all the skilled nursing facilities in those areas, and supporting over 120 trained volunteers.

In 2006, the VOP encountered challenges including staffing changes and an increased need for recruitment outreach. During that time, current volunteers still needed support. Volunteer coordinators and Regional Ombudsmen stepped up to support the program, making joint facility visits and maintaining documentation during the period of transition. The need for increased and increasingly creative recruitment was shown by a decrease in numbers of volunteers in certain areas of the state. The use of media was increased with more public service announcements in newspapers and on radio. The recruitment efforts were successful and the program continued at full strength.

In early 2007, the VOP expanded services into the Assisted Living arena, enlisting volunteers to make visits in Community Based Residential Facilities (CBRF). This expansion included the hiring of an additional coordinator in a project position. The project is expected to have a time period of 18 months to recruit, screen and place up to 36 CBRF Volunteer Ombudsmen into specified individual facilities in 13 counties: Brown, Dane, Kenosha, Lincoln, Marathon, Marinette, Milwaukee, Oconto, Outagamie, Ozaukee, Sheboygan, Walworth, and Wood. Dane County was

the first to have volunteers in June, 2007. At the end of the biennium there are 26 volunteers serving in the CBRF project. The CBRF volunteers have the same responsibilities, requirements and support as the skilled nursing facility Volunteer Ombudsmen.

The collaborative relationship between the Board on Aging and Long Term Care and advocacy agencies such as AARP Wisconsin, the Coalition of Wisconsin Aging Groups, RSVP Wisconsin, Hospice Care, Inc., and the United Way has been a critical component in the outreach strategies of the VOP. The benefits to the VOP include recruitment mailing, space for training and education, support for recognition events and various media outreach efforts.

The growth and accomplishments of the Volunteer Ombudsman Program has had such positive outcomes for residents, families, and volunteers that we are proposing future expansion into three more counties and their surrounding areas to begin in the next biennium for both skilled nursing facilities and CBRF's.

Medigap Helpline Program

During 2006, the Medigap Helpline counselors answered 9,686 calls, providing assistance to consumers on various concerns as described below. In 2007, there were fewer calls, 8,566, but it was clearly the case that many of these were significantly more complex due to the evolving issues relating to the changes occurring in the design and operation Medicare and its associated private insurance plans (Medicare Advantage Plans). This complexity is reflected in the pattern of each call representing multiple discrete concerns by the caller.

A significant amount of referral traffic between the Medigap Helpline and other information and counseling agencies was again evident. Especially with the start-up of Medicare Part-D, a large number of calls were routed to and from the Coalition of Wisconsin Aging Groups' Part-D Helpline. This two-way traffic included regular contact between the staffs of the two agencies and combined efforts to assure that as many beneficiaries as was possible were served and assisted to obtain the most appropriate plan coverage.

Helpline counselors continued their long-standing relationship with the state's corps of Elderly Benefit Specialists, referring clients to these advocates for local assistance and help in filing appeals, completing necessary forms, and dealing directly with agents and companies.

In addition to the relatively stable volume of calls from consumers concerned about traditional Medicare, 2006 data show more calls relating to the implementation phase of Medicare Part D which ended May 31, 2006. This was the initial enrollment period for the entire country.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to Traditional Medicare</u>	13780	13564
<u>Inquiries relating to Medicare Part-D and related drug coverage</u>	2456	1337

2007 saw an increase in calls about medicare supplement insurance policies because of the availability of Advantage plans and the confusion of Medicare beneficiaries about the different forms of Medicare. Due to new state and federal protections, allowing a beneficiary to go back to their supplement insurance policy during a "trial period" if they found that an advantage plan was not the best plan for them, counselors spent more time informing people of their rights and options.

Also, the new federal Medicare Part D regulations mandated some drastic changes to medicare supplement insurance policies which included removing prescription drug coverage from all supplement policies issued after January 1, 2006. This information was given to each caller to the Helpline who wanted to discuss the impact of Medicare Part D on their current insurance coverage. Once a person enrolled in Medicare Part D, any and all drug coverage that may have been in their individual medicare supplement insurance contract was permanently removed by federal law.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to Medicare Supplement Insurance</u>	10627	15970

2007 saw many more calls concerning Medicare Advantage plans because of the prescription drug component now mandated by federal law to be included with this form of Medicare. Medicare beneficiaries were getting used to the new enrollment periods. Enrollment and flexibility rules changed in 2006, creating many challenges and difficult situations for many people, as the entire system learned to work with the new configuration of Medicare, a short time frame to exchange health plans in the beginning of each year, many plans to chose from, and misunderstandings about the ability to change your mind and go back to what you might have had before. "Growing pains" is a good way to describe what we were going through in 2006 and 2007 in this market.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to Medicare Advantage Plans (Medicare managed care)</u>	8613	13850

2007 saw an increase of counseling calls inquiring about Medical Assistance because of the new low income subsidy (LIS) assistance available to make the Medicare prescription drug program affordable Medicaid beneficiaries.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to Medicaid / Medical Assistance</u>	1555	4778

In 2007, employer group insurance plans were beginning to view Medicare Part D as a way to reduce their cost by eliminating the prescription medication coverage for retirees. Employers requested guidance on the mandatory notices they were required to give to let their group members know whether or not the prescription coverage in the group policies met federal criteria. The Helpline staff was asked to speak to several employers who did not understand the federal requirements, the impact on their employees and retirees on Medicare, nor the ongoing responsibility it would represent for them.

Also in 2007, the Medigap Helpline was instrumental in saving the insurance for approximately 77 families. The employer was encouraging the retirees to drop their individual medicare supplement insurance policies, failing to realize that a beneficiary cannot enroll in a Medicare health plan at any time of the year, only during a specific period of time. Two families contacted the Helpline for assistance because they had received a letter that led them to believe that their health insurance was ending June 30, 2007. One beneficiary was very ill, had just come home from the hospital and was worried that she would now have no insurance. The family knew that no other insurer would accept the retiree because of her health conditions. The Helpline worked with the family and the employer and, with the assistance and intervention of an insurance agent assigned to the retirees who was dedicated to helping them keep their insurance, the counselor was able to help resolve this issue.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to Employer Group / Retiree Group insurance plans</u>	2705	3393

The Helpline has seen an increase in long term care insurance counseling calls as there are more and more people beginning to think about how they plan to pay for long term care. Understanding the continuum of care from the least restrictive to the most restrictive and what the options are for providing this care is changing the way the Medigap Helpline addresses this issue. Staff now discuss Family care and Medical Assistance along with private long term care insurance as a routine matter of course in counseling.

Our primary responsibility with respect to long term care insurance counseling is helping individuals to identify for themselves whether this product is suitable for their needs, and if it fits within their budget. We also help people to understand the limited role of the insurance, provisions of the contract relating to policyholder's rights and protections and how it is only a part of the long range planning that they need to be doing.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to private long term care insurance</u>	662	812

The Wisconsin Health Insurance Risk Sharing Plan (HIRSP) underwent some drastic changes as a result of the federal government implementing the Medicare prescription drug program. The most significant concern that the Helpline encountered in working with HIRSP beneficiaries covered by Part-D drug plans as well as HIRSP was the policy of the HIRSP Authority to not cover pharmaceuticals if the drug was not listed in a particular Part-D plan's formulary. Before this time, HIRSP maintained its own formulary and would cover the drugs listed in that document regardless of any other plan. With the transition to Part-D as a primary drug insurance, and the fact that not all drugs are covered in all Part-D formularies, a drug formerly covered by HIRSP may or may not be covered under the Part-D plan chosen by the beneficiary. If the drug is not covered, HIRSP does not reimburse for prescription.

The Board on Aging and Long Term Care pointed out to the HIRSP Authority that it was inequitable and a hardship for beneficiaries. We also pointed out that this policy unfairly discriminates against the individuals based upon a actions of the Part-D plan which the policyholder has no control over.

	<u>2006</u>	<u>2007</u>
<u>Inquiries relating to HIRSP issues</u>	1115	1051

Medicare Advantage Plans

Medicare Advantage Plans are "private" Medicare replacement plans established under Part C of the Medicare Program. Private insurance companies submit proposed plans which are reviewed and, if approved by the Centers for Medicare & Medicaid Services (CMS), these plans can be sold to beneficiaries to provide coverage for Medicare approved services. The plan premiums are paid by CMS to cover the services that would have been otherwise covered under Original Medicare. Beneficiaries who choose to enroll into one of these plans may pay an additional low premium or no premium at all. Beneficiaries still pay the Part B premium to Medicare. Beneficiaries pay co-payments for services received and covered under their plan.

Co-pays vary from plan to plan and maximum out-of-pocket limits may also differ. The terms and coverages of Medicare Advantage plans can change each year as determined by the issuing insurance company.

Beneficiaries who enroll into a Medicare Advantage plan will receive all of their healthcare coverage from this private plan, not from Original Medicare. Therefore they will be subject to that plan's limits. If the plan is a Managed Care plan (HMO) or a Preferred Provider Organization (PPO), there will be a network of providers from which to choose. If the beneficiary decides to use providers outside of the network, he or she may either pay a higher co-pay or be responsible for the full cost of care. Beneficiaries may opt to enroll into a Private Fee For Service (PFFS) plan which allows freedom to choose to use any doctor, clinic, hospital or other provider. The plan will pay for services rendered if, and only if, the doctor, clinic, hospital or other provider agrees to accept the terms and conditions of reimbursement of the particular Medicare Advantage Plan. So it is preferable for beneficiaries to first ask their healthcare providers if they are willing to accept the Medicare Advantage plan they are interested in prior to enrolling.

In 2006, the State of Wisconsin had 9 separate insurance companies providing Medicare Advantage Plans. In the majority of companies, there were 2 to 4 different plan offerings in the counties/areas they served. Each offering had a different co-pay structure with different "caps" or maximum out of pocket limits, and they may or may not have included Part D drug coverage. By the end of 2007, Wisconsin had 16 Medicare Advantage insurers, each offering 2 or more different plans.

The beginning of 2006 also brought an added component to Medicare Advantage Plans. Medicare's prescription Part D drug plan was launched. Many of the Medicare Advantage plans then began including a prescription drug component to their coverage. The Part D portion met the guidelines set forth by CMS, complete with the gap, or "doughnut hole" in coverage. The co-pays paid for the prescriptions are not included in any Plan maximum out-of-pocket limits for services. In many cases, the beneficiary was limited to the Part D plan that was offered with that company if they needed Part D coverage. Only by enrolling into a PFFS plan without Part D was a beneficiary allowed to select a different Part D plan that may better cover their prescription needs.

In 2006, CMS instituted a "lock-in" provision. Beneficiaries no longer had unlimited timeframes with which to enroll, disenroll, or switch their Medicare Advantage plan. Lock-in imposes specific time frames in which to make a change.

The Annual Election Period (AEP) is from November 15th thru December 31st of each year with the enrollee's selection becoming effective on January 1st of the new year. The Open Enrollment Period (OEP) is from January 1st thru March 31st where the beneficiary can make a change to a substantially similar plan. Outside of these timeframes, the beneficiary will be locked into their plan for the remainder of the year unless they would happen to qualify for one of the few Special Enrollment periods (SEP).

There have been coverage issues with beneficiaries due to a time delay in the communications between Medicare and the Private Plans. Some Advantage plans have denied changes requested by a beneficiary because the plan did not understand the effect of the different SEPs that are allowed. In this situation, the Medigap counselor must assist the beneficiary by explaining the SEP to the company and often times, submitting complaints to CMS for intervention. These can be very time-consuming and especially frustrating for the beneficiary who doesn't realize who actually is providing their coverage.

There has been confusion due to the media advertising of the enrollment time frames. Often a person with a traditional medicare supplement will also want to make a change in their coverage, mistakenly believing that they, too, have this "enrollment" period, when in actuality, they can make a switch at any time to a different supplement if they would pass the health underwriting of the policy they wish to purchase.

With the expansion of Family Care in the state, there have been other issues and concerns arising affecting beneficiaries enrolled a Medicare Advantage plans. With Family Care beneficiaries who are also in a Medicare Advantage plan, there have been conflicts of coverage with health care providers who accept family care but may or may not accept the Medicare Advantage plan. Educating Family Care organizations on the different coverage types a beneficiary may have and the potential conflicts that may arise has been an important role for the Medigap Program counselors.

A new twist has been showing up more and more when working with caller's concerns with the cost of services in a Medicare Advantage Plan. Providers are allowed to decide for themselves whether or not they will accept the plan a patient may have. Providers who accept PFFS plans where there is no defined network may charge their patient more than the co-pay designated by the plan if the provider does what is termed "balance billing". This allows the provider to charge the beneficiary up to 15% over the stated reimbursement rate for services. This now requires beneficiaries to also ask providers if they accept the reimbursement rate as payment in full.

If the beneficiary fails to ask, they run the risk of paying more out of pocket than the plan's co-pay structure has indicated.

Medigap counselors continue to work with beneficiaries who are confused over the type of coverage they have enrolled in. Counselors assist beneficiaries in their disenrollment efforts with SEP provisions. Counselors are frequently required to refer complaints relating to marketing practices of agents attempting to enroll beneficiaries into the Medicare Advantage plans. CMS has instituted mandatory training for all agents who sell Medicare Advantage plans.

Medical Assistance

Medical Assistance (MA) is also known as Medicaid or Title XIX. MA is an entitlement program that has strict income and asset limits. Enrollees must meet both income and asset limits to both become eligible for, and remain covered by the MA program. Medigap staff work with callers to the Helpline who are "dual eligible." This means that the person is enrolled in both Medicare and Medical Assistance coverage, with MA acting as the enrollee's secondary payer.

There are a variety of Medical Assistance programs a caller could be enrolled in or eligible to apply for. Medigap Staff discuss Medical Assistance coverage known as "MA Subprograms" or "Medicaid Waiver" programs. While these subprograms allow a person enrolled in Medicare to have higher income or assets, they may not provide a full MA benefit because the caller's income or assets are too high. A person who is eligible for a subprogram may receive assistance with payment of Medicare premiums, and in some instances, Medicare co-payments and deductibles.

An additional benefit for Medical Assistance enrollees, regardless of which MA program they are in, is that the enrollment into an MA program automatically makes that person eligible for the full 100% Low Income Subsidy (LIS) or Extra Help for their Medicare Part D prescription coverage. This will save the MA recipient potentially thousands of dollars in out-of-pocket prescription drug costs if they take many medications or have very expensive drug costs. The "True Out of Pocket" cost (TrOOP) for Part D for 2008 is approximately \$4,050, but can vary by plan. The LIS will substantially reduce, or even eliminate, this TrOOP.

Significant enrollment problems for Medical Assistance recipients have been an on-going problem since the inception of Part D in January, 2006. There is a minimum three month delayed enrollment into the LIS benefit for a new MA enrollee. This has caused severe negative consequences. People with lower income and assets often do not have the resources to pay for their medications out of their own pocket.

New MA enrollees have gone without needed medications, and have had to tax already limited community resources to try and cover their medical needs for this three month period.

This issue will not be resolved until the Center for Medicare and Medicaid Services (CMS) change the timeline for beneficiary updates from once a month to either daily or weekly updates. The lag time in enrollment and disenrollment for Medicare Advantage plans, original federal Medicare, and Part D is a nationwide issue that has negatively impacted all Medicare and Medical Assistance enrollees.

Marketing to dual eligible Medicare beneficiaries to convince them to enroll in a Medicare Advantage plan has also been an on-going concern of Medigap staff. There are potential out-of-pocket costs a Medical Assistance enrollee will incur if they chose a private Medicare Advantage Plan rather than enrolling in the original federal Medicare A and B program. For example, there may be an additional premium for the advantage plan that the state of Wisconsin will not pay. The state will pay only the Medicare Part B monthly premium for an MA covered state resident, not the advantage plan additional premium that, in Wisconsin, can cost from \$5.60 to \$150.90 per month.

If a dual eligible person enrolls in a Medicare Advantage plan and the out-of-pocket co-payments are higher than the 20% co-payment under Medicare Part B, there is no guarantee that the amount due above the 20% will be covered by the state. Federal rules are clear. Each state can choose whether or not it will cover all the out-of-pocket costs of an Advantage Plan. Medigap staff have received calls from dual eligible state residents who are being balance-billed for their Advantage Plan co-payments that exceed the 20% Part B co-payment.

Medical Assistance beneficiaries are our most vulnerable population, being both the lowest income and often times the sickest, including many nursing home residents. Advocacy needs to take place to make sure that this population does not have gaps in valuable coverage, and that there is access to needed medical care and prescription drug coverage. The Board on Aging and Long Term Care is taking up this challenge.

Agency Counsel : Systemic Advocacy

During the course of this biennium, the Counsel to the Board on Aging and Long Term Care engaged in significant systemic advocacy intended to further the interests of the aging and disabled client groups we serve. These efforts of the Counsel were concentrated in the Legislative, Regulatory, and agency internal policy areas.

As a designated Legislative Liaison for the agency, the Counsel represented the positions of the agency before committees and in direct conversations with legislators on several important proposals. The agency expressed its support for measures including the efforts to rewrite the statutes relating to identification and prevention of elder abuse (2005 AB 539), adult protective services and placement (2005 AB 785), and guardianship (2005 SB 391); to substantially strengthen the standards for licensure of Nursing Home Administrators (2005 AB 32); to extend whistleblower protection laws affecting caregivers (2007 AB 224); to provide funding to permit more voluntary relocations from nursing homes to community living arrangements (2006 SB 312); and to establish clear standards for facilities claiming to provide specialized care for dementia (2007 SB 283).

The Board on Aging and Long Term Care expressed its opposition to measures which we believe would have harmed or infringed upon the rights of the residents of the state's long term care facilities in some way, including 2005 AB 207 which would have limited the ability of a person to direct significant elements of her or his future medical care unless a specific declaration of intent accompanied a durable power of attorney for health care document.

On the regulatory front, the Board on Aging and Long Term Care actively worked with the staff of DHFS in their efforts to draft revisions to regulations governing the operation of community-based residential facilities (HFS 83); those governing the operation of nursing homes (HFS 132); and the document that regulates the operation of corporate guardians (HFS 85). BOALTC input was also solicited by and given to the Office of the Commissioner of Insurance on their efforts to revise Insurance regulations in INS 3 which relate to the regulation of Medicare Supplemental insurance policies and the new long term care partnership insurance. The input of the agency counsel and other agency staff took the form of direct participation in workgroup deliberations and drafting efforts and in comments to the particular department following completion of the drafts.

The agency Counsel continued the ongoing process of revising, updating and creating new internal policies for the Board on Aging and Long Term Care to reflect the intent of the management of the agency to deliver the highest quality advocacy for our clients in an environment that respects the needs of our staff.

BOALTC Governing Board

The Wisconsin Board on Aging and Long Term Care is a citizen board. Its members are appointed by the Governor, with the advice and consent of the State Senate, to serve five-year terms. The terms are staggered to assure continuity and the Board annually elects one of its own as chairperson. On 31 Dec 2007, the following individuals comprised the Board on Aging and Long Term Care.

Patricia Finder-Stone	DePere
Rose Boron	Mosinee
Dale Taylor	Eau Claire
Eva Arnold	Beloit
Tanya Meyer	Gleason
Terry Lynch	Racine
Barb Thoni	Madison

Members who left the Board during the Biennium:

Eugene Lehrmann	Madison
Margaret Tollaksen	West Allis

BOALTC Agency Staff

The Board appoints an executive director as the chief executive and administrative officer for the agency. The executive director appoints and supervises the agency staff. The Executive Director and the Agency Counsel work in the Madison office. On 31 Dec 2007, the following individuals comprised the administration and staff of the Board on Aging and Long Term Care.

Executive Director	George F. Potaracke
Executive Director Designate	Heather Bruemmer
Counsel to the Board	William P. Donaldson

Long Term Care Ombudsman Program

<u>Ombudsman Services Supervisor</u>	Vacant
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Regional Ombudsmen

Robb Jirschele	Eau Claire
Martha Sanville	Eau Claire
Julie Button	Green Bay
Amy Panosh	Green Bay
Dennis Granzen	Madison
Matt Rohloff	Madison
Patti Noble	Milwaukee
Joan Schmitz	Milwaukee
Rachel Selking	Milwaukee
Paul Sokolowski	Milwaukee
Christy Daley	Phillips
Vickie Bergquist	Saukville
Joan Cantlon	Stevens Point
Carol Kriemelmeyer	Stevens Point

Relocation Ombudsman Specialist

Tom LaDuke	Kenosha
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Ombudsman Program Advocacy Specialist

Vickie Valdez	Madison
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Volunteer Ombudsman Program Director

Kellie Miller	Madison
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Volunteer Ombudsman Program Coordinators

Duane Mireles	Milwaukee
Suzanne Ankenbrandt	Stevens Point

Volunteer Ombudsman Assisted Living Project Program Coordinator

Emily Wirkus

Madison

Medigap Helpline:

Counselors

Donna Bryant

Madison

Vicki Buchholz

Madison

Vickie Baker

Madison

Steve Shapiro

Madison

Intake Specialist

Diana Santos

Madison

Support Staff

David Cauffman; *Office Manager*

Madison

Karen Schrader; *Clerical Assistant*

Madison

Vi Quang; *I.T. Specialist*

Madison

Agency Staff who left BOALTC during the Biennium

Vicky Elliott *Regional Ombudsman*

Madison

Laura Gillis *Ombudsman Program Advocacy Specialist*

Madison

Mark Eisenmann *Medigap Counselor*

Madison

Karen Bryant *Medigap LTE*

Madison

Tammy Stewart *Volunteer Ombudsman Program Coordinator*

Milwaukee