

**Committee on Comprehensive System Change**  
Council on Long Term Care Reform  
**Meeting of February 4, 2005**

**Minutes**

**Members present:** Lynn Breedlove, Paul Cook, Carol Eschner, Jerry Huber, Rich Kammerud, George Potaracke, John Sauer and Craig Thompson

**Members absent:** Gerry Born, Tom Frazier and Tim Sheehan

**Others present:** Ginny Graves, Chuck Wilhelm, Judith Frye, Lorraine Barniskis, Kathleen Luedtke, Dan Johnson, David Sievert, Joyce Binder, Diane Waller, Elizabeth Childers, Bill Jensen

Chair George Potaracke called the meeting to order at 9:05 AM.

**Update on Comprehensive System Change grant project**

Kathleen Luedtke said that in addition to herself as project manager, four additional staff have been hired to work on the project, including Elizabeth Childers, who will also provide support for the LTC Reform Council and its committees. Twenty to thirty additional people throughout DHFS will assist with grant activities. The CSC Committee will provide guidance to the project.

Kathleen provided a handout outlining activities that DHFS can start on now, including:

- Increasing consumer access to information, including an internet source for information. Donna McDowell will lead this effort.
- Alzheimer's disease early detection. Dr. Mark Sager and colleagues at the Alzheimer's Institute will conduct research in this area.
- Training on local strategic planning for local LTC governing bodies. UW Extension will assist with this effort.

Judith Frye described DHFS preliminary thinking on the process for soliciting proposals for local planning grants for reform. The CSC Committee will set policy direction for these grants and advise on the process. Subject to CSC advice, DHFS suggests sending out a solicitation broadly, asking for a concept paper. Grants of about \$100,000 would be awarded for development of a full, specific proposal for a local planning process. The best of the proposals would receive about \$250,000 for the detailed planning phase. The initial solicitation could go out late spring or summer of this year if the CSC Committee has set enough policy direction.

## **Models and platforms for LTC reform**

Ginny Graves facilitated this discussion. Notes from flip charts:

### LTC Reform Goals

- Choice
- Access
- Integration
- Cost effectiveness (how and when measured?)
- Quality
- Multi-county
- Public/private partnership

### LTC Reform Platforms

#### Program/Funding

- MA card services
- Home & Community-Based Waivers
- Family Care
- WI Partnership Programs
- SSI Managed Care

#### Administrative/Management

- Family Care District
- County-Based Purchasing
- Organized Health Care Delivery System
- Medicare Advantage Waiver Part D
- Other

### LTC Reform Model Questions

- Target population(s) and numbers served
- Financing mechanisms and risk
- Scope of services
- Required federal waivers/other authorizations needed
- Administrative infrastructure
- Timeframe for reform
- Platforms

### LTC Reform Public/Private Partnerships

- Local Providers
  - Health Care
  - LTC
- Managed Care Organizations
- Federally Qualified Health Centers
- WI Partnership Programs
- Not-for-profit service organizations
- Family Care County

→→ Continuum of LTC & Health Care Services →→

<ul style="list-style-type: none"> <li>• No LTC</li> <li>• No care management</li> <li>• Fragmented care</li> </ul>	<ul style="list-style-type: none"> <li>• LTC services</li> <li>• Care mgmt of LTC</li> <li>• Limited to no coordination with health care</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC</li> <li>• Coordination with health care</li> <li>• Care mgmt for LTC</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC &amp; MA-funded health care</li> <li>• Care mgmt for LTC &amp; MA covered health care</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC, Medicaid &amp; Medicare services</li> <li>• Comprehensive care management</li> </ul>
<ul style="list-style-type: none"> <li>• Medicaid Card</li> <li>• FFS</li> </ul>	<ul style="list-style-type: none"> <li>• HCBW</li> <li>• Nursing homes</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC/coordination with health care</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC &amp; MA card services</li> </ul>	<ul style="list-style-type: none"> <li>• Managed LTC, MA card &amp; Medicare services</li> </ul>
Private pay		Family Care (entitlement, county-based, county-wide, NH diversion)	I-Care II	Partnership
Self-directed care				

→→ Degrees of Care Management & Integration →→

Discussion points raised:

- Need to get more private money into the system and influence how private pay individuals make decisions
- Prevention needs to be part of management (and it is hard to fund publicly)
- Need mechanisms for earlier intervention – e.g., Family care could expand to better include intermediate level clients
- Need to understand better the tangible differences for consumers between coordination and integration of acute and primary services
- Need to push the acute/primary system to treat and manage chronic illness and disability better; more holistic approach
- Service areas of health care systems, LTC systems, counties, HMOs, etc. are all different – it will be a challenge to integrate on a regional basis
  - Statewide system may or may not be county based
- Differences among potential partners in experience base
  - HMOs don't have experience with LTC
  - Counties don't have experience with management of acute/primary services
  - Partnership programs have both
- There are huge administrative issues to resolve when forming partnerships, especially integration of IT systems
- Counties need to define their role(s) in public-private partnerships. Counties are good at care management, but not so good at managing risk
- Minnesota multi-county purchasing consortia have experience in seeking out and working with private sector partners. Counties started by managing acute/primary care and are expanding to LTC.
- SSI-Managed Care programs say they need to manage HCB LTC in order to stabilize health care needs
- Keep focus on statewideness as an eventual goal, so that people have similar choices throughout the state
- For significant integration of acute/primary and LTC for dual-eligible elderly, need to involve Medicare, which pays biggest share of acute/primary; may be difficult to convince enough elders to join a managed care plan and give up broader range of Medicare provider choices
- For many younger people with disabilities, most of acute/primary costs are covered by Medicaid; with at least two managed care choices available, could make enrollment mandatory. Medicare is not a significant funding source for people with developmental disabilities.
- Going statewide with managed care models(s) implies lifting the current statutory responsibility of counties for being the safety net for some populations
- Need to bring OCI into the discussion. Try to pursue (statutorily, if necessary) special insurance licenses or requirements (e.g. connection with county) for models that manage LTC services on a risk basis.
- Commercial LTC insurance could be integrated with publicly funded system (e.g. federal Partnership program in 4 states, Congress being asked to expand to other states)
- Need to flesh out how self-directed care fits into any model

## Discussion of models for potential development:

1. Transitional, short-term model
  - Simplified MA waiver programs
  - Expand availability of one-stop assistance for information and assistance, and benefit counseling (Resource Centers)
  - Intensified institutional diversion and relocation component (including funding)
2. Expand the models already piloted
  - Resource Centers
  - Family Care or other managed care model for LTC – single or multi-county (entitlement?)
  - Screening tools/gate
  - Partnership or other integrated model widely available
3. “Primary provider” model
  - Counties continue to manage HCB waiver programs
  - Counties manage MA card services, with no risk
4. “Family Care Plus” or “Partnership Light”
  - Integrate Medicaid acute/primary, but not Medicare
5. Seamless statewide system
  - Statewide requirements and expectations
  - Commercial LTC and public payer
  - May or may not be county-based
  - Lift current statutory county responsibility
  - State criteria and standards in statewide solicitation for funding
  - Shared administrative functions
  - Risk-based
  - Recognize regional basis – purchasing role
  - Degree of integration/coordination/care management?
  - Relationship of community-based and institutional services?

## **Comments from the public**

There were no comments from visitors.

## **Issues from WAHSA’s legislative agenda**

John Sauer provided two handouts describing the legislative agenda of the WI Association of Homes and Services for the Aging. He highlighted the following:

- Medicaid funding:
  - Retaining base funding for nursing homes;
  - Development of policies on the future role of nursing homes;
  - Rightsizing, including continuation of negotiated downsizing agreements;
  - Increasing capital rates to allow modernization of facilities;

- Assistance for conversion to private rooms;
- Nursing home rate increases of 5%, to be funded partially by an increase in the bed tax.
- Regulatory reform:
  - Move from a punitive system to one based on quality improvement;
  - Support for legislation to prevent citation of the same violation twice (once under state regulation and once under federal);
  - Avoid over-regulation of assisted living.
- Liability reform; set caps to make liability insurance more affordable and accessible.
- Maintain the property tax exemption for non-profit providers of senior housing.
- Pursue LTC pilot reforms that integrate acute, primary and long-term care.
- Foster honest discussion on LTC options and costs
  - Modify Life Lease legislation to allow private entities to manage funds;
  - Pursue changes that will get away from the need to demonstrate that “but for” home and community-based programs, clients would enter a nursing home.
  - Enhance the LTC functional screen and pilot its use (starting in Family Care counties) to set level of care for nursing home admission. Eventually, use the functional screen as the basis for acuity-based nursing home rates. MetaStar will lead this effort.

#### **Committee business**

- The minutes of the meeting of January 7, 2004 were approved unanimously.
- Suggestions for future agenda items included:
  - Continuation of discussion of long-range reform models.
  - Continuation of discussion of criteria for local planning grants under the CSC project.
  - Priorities for data collection and analysis.

**Meeting adjourned** at approximately 2:15 PM.