

Committee on Comprehensive System Change
Council on Long Term Care Reform
Meeting of September 2, 2005

Minutes

Members present: Gerry Born, Carol Eschner, Jerry Huber (via telephone), Rich Kammerud, George Potaracke, John Sauer and Craig Thompson. Paul Soczynski substituted for Paul Cook.

Members absent: Lynn Breedlove, Paul Cook, Tom Frazier, and Tim Sheehan.

Others present: Judith Frye, Lorraine Barniskis, Diane Waller, Bill Jensen, Kathleen Luedtke, Dane Hayes, Nancy Anderson, Tom Swant, Owen McCusker, Shel Gross, Brian Schoeneck, and Jennifer Gillespie

Chair George Potaracke called the meeting to order at 9:10 AM. Kathleen Luedtke introduced Jennifer Gillespie, who has been contracted to provide staffing for the CSC project.

County roles in a reformed LTC system

Rich Kammerud walked through the revised county roles paper. He noted that the paper was serving several purposes: (1) to prompt counties and others to talk about the specifics of reform and counties' roles; (2) to provide a framework for the CSC committee discussion of the implications of various county options; and (3) to help all stakeholders come to common definitions and understandings about reform options. He noted that many more counties are understanding and becoming interested in pursuing public-private partnerships so that they can participate meaningfully in the new system. Regional meetings have been held in most parts of the state among county representatives. Several examples were given of counties meeting among themselves and with potential private partners to begin to develop specific proposals.

Counties continue to be concerned about what happens to current county mandates under Chapters 51 and 55 if a county cannot or chooses not to be actively involved in the reformed LTC system. It was suggested that the RFI clarify this point. It was also suggested that the statutes be changed to make the State directly responsible for these mandates if and where necessary. It was also noted that considerably more discussion is needed about the possibility of integrating behavioral health and services for children with long-term care needs. There is concern that we will end up with more, rather than less, fragmentation in the human services system. There was discussion about the financial problems that counties are facing because of the new levy freeze law.

Rich Kammerud made and Craig Thompson seconded a motion, subsequently amended to read: The CSC Committee recommends that in reviewing responses to the forthcoming RFI, weight should be given to applicants who demonstrate that they have partnered with any county in the region they propose to serve, or have made good faith efforts to do so. The motion carried.

Residential LTC issues

Tom Swant (DHFS/DDES/BLTS/DD) said that since the ICF-MR Restructuring law took effect on January 1, 2005, 159 people have been relocated from ICFs-MR to community settings under CIP. The number of ICFs-MR and the number of beds in these facilities have declined dramatically over the past several years; there are currently 28 facilities with 1186 beds in operation. Several of these facilities are planning to close or downsize soon, and others are

considering reducing/closing operations. Most of those who have relocated are now in 3 to 4-bed CBRFs; about a dozen are in their own homes/apartments and another dozen are in 1 to 2-bed CBRFs; 25 are in 5 to 8-bed CBRFs. The state relocation team is nearly all in place to assist with relocations.

Daily rates for waiver costs under this program have ranged from \$49 to \$477, with an average of \$177. Judith Frye noted that we will need to work on developing more cost-effective services; budget problems will arise if the average daily rate goes much above \$177. It was noted that work also needs to be done on developing services for people with severe behavioral issues.

Discussion with Mark Moody

Mark Moody, Administrator of the DHFS Division of Health Care Financing, responded to several questions that George Potaracke had provided him.

- 1 Should a fully integrated (Medicare/Medicaid) managed care system be the immediate goal?
 - The Partnership programs already operate as fully integrated models.
 - It makes good fiscal and management sense to integrate acute, primary and LTC services. All else being equal, it would be a good goal to integrate as much as possible as soon as possible.
 - Governor Doyle is interested in integrating risk for all services. However, integrating funding and risk is not necessary for us to move forward.
 - It does not make sense for Medicaid to invest in reforms that result in savings to Medicare.
- 2 Is it feasible to have several managed systems operating along side each other?
 - Several models are already operating in Milwaukee County
 - If several models are operating in one geographic area, it would make sense to favor the most integrated of them.
 - Having several sis-by-side models serving the same client is not optimal from either the consumer or the fiscal perspective.
 - It would be possible to have multiple “product lines” from which consumers can choose (or assemble services from several of them).
 - Nationally, MA reform is heading toward more flexibility and limited “products.” For example, Senior Care in Wisconsin is customized to the needs of a particular population.
 - All else being equal, choice among CMOs is a good goal. Competition increases consumer responsiveness.
- 3 Is mandatory enrollment for eligible participants a critical feature? Under what conditions?
 - We want to enroll as many people as possible, but enrollment doesn’t necessarily have to be mandatory.
 - One model might be the “all in, opt out” model used in Milwaukee for SSI Managed Care. People are automatically enrolled, but can opt out.
- 4 How could county governments’ role complement a fully integrated system?
 - Counties’ roles are likely to be quite variable. Counties have some strongly developed and crucial skill sets, and weaker skill sets in other areas. They are at varying levels of ability and interest in this area.
 - One role that counties should have is operating Aging and Disability Resource Centers.
 - Counties probably shouldn’t move into managing acute and primary care without private partners.
 - In many places in the state, there are too few people to make assumption of capitated risk feasible. Counties (not necessarily contiguous) should be forming consortia to operate

ADRCs and CMOs. One variation would be for a county to offer a particular service (e.g., care management or claims processing) to others for a fee.

- The issue of county roles is a key issue still to be resolved.

Other discussion included the following points:

- DDES has the lead in DHFS efforts to reform LTC, in collaboration with other divisions. Walls that previously existed between DDES and DHCF have largely disappeared.
- Having many “product lines” can be confusing for consumers and an inefficient use of funding. Evolving to a more integrated model may make some of the smaller, special purpose programs obsolete.
- There currently exist inequities, with an entitlement to Family Care in only 5 of the state’s 72 counties. If we had the resources, it would be good to expand this entitlement to people across the state. However, an entitlement to desired services (as opposed to those that are less desirable) could become too expensive, especially as the population ages.
- Concern was raised that an entitlement to home care could result in a reduction in informal supports from family and friends. This has not been the case in current programs, however. Informal support has actually increased, on average, when formal services are provided.
- We need to be more planful about nursing home downsizing. For-profit homes have a tendency to hang on too long when they have financial difficulties. DHFS has limited tools to assist.
 - The nursing home downsizing fund was used successfully in the past to assist homes to downsize and move resources to other community settings and services. With that fund now gone, we are spending money only on the worst actors instead.
 - The downsizing fund has worked well for a handful of providers, but not at all for others. If it were re-instituted, should there be a revolving fund, with partial pay-back? Should there be a competitive bidding process? Should there be an independent board to evaluate proposals?
 - The Council may want to recommendations for re-establishing this fund, but with some recommendations for overcoming some of the difficulties.

Comments from the public

Shel Gross noted that the county roles paper does not address the issue of what will become of Chapter 51 and 55 systems and services if counties choose not to operate a reformed LTC system. There are many implications that should have further discussion. He invited exchange between the CSC Committee and the Legislative Committee of the Mental Health Council, and will e-mail an invitation to George for the latter committee’s next meeting. Shel also raised a concern about the issue of consumers having choice among CMOs, not just among service providers. He believes that choice among CMOs is important.

Owen McCusker urged the committee to make sure that there is a level playing field. Some very good service networks are not capable of raising venture capital or becoming insurance companies. He also noted that too many “product lines” creates huge administrative burdens for CMOs and providers, who have to deal with many different statutes, rules, and government agencies. He urged administrative simplicity. He also noted that Minnesota exempts counties from requirements for high risk reserves in their managed care programs and suggested that the committee learn more about their requirements. Maybe it would be possible to create a new class

of risk-based organizations to manage LTC services. Finally, he suggested that the state create incentives for counties to form multi-county arrangements.

Nancy Anderson expressed concern about the number of potential health plans available to people, with resulting confusion for both consumers and providers and administrative costs for providers. With the new Medicare managed care plans, as well as drug plans, coming into the state, dually eligible people may be in 3 or 4 different managed care plans. Vendors will be unable to cope with all the complexity of varying financial management and accountability systems. Since we cannot control Medicare, Medicaid LTC reforms need to adapt to Medicare requirements.

Update on CSC grant project and updates from DHFS

Judith Frye had the following updates:

- Initial contact with counties indicates that many people are ready to relocate from nursing homes under the recently enacted Nursing Home Relocation Initiative. There will be a formal process in place by next week. DHFS will review proposed care plans. Seven regional forums will be held to facilitate discussions among stakeholders about how best to do outreach to identify people wanting to relocate. A tracking system will be in place to assure savings without denying relocation to people whose community care costs would be high. A number of relocations have already been done since July 1st, by the Partnership Program in Milwaukee. DHFS will be able to offer some start-up funding to counties for this initiative.
- A survey of home care providers is nearly ready to be conducted, inviting suggestions on how to achieve the savings required under the recently enacted state budget.
- Work is nearly complete on adaptations to the functional screen to enable it to be used to do prior authorization for personal care – at least for people in waiver programs.
- Considerable progress is being made on using MDS information to establish nursing home level of care.
- The new Council for Children with Long-Term Support Needs has been formed and is meeting next Friday. Liz Hecht will chair this council.
- The independent assessment of Family Care conducted by APS Healthcare will be finished soon. Highlights will be presented at the October CSC Committee meeting.
- Considerable work is being devoted to planning for assisting with the effects of Hurricane Katrina and for the likely influx of refugees from the storm.

Kathleen Luedtke distributed 4 handouts with information about the CSC grant project. She walked through the highlights of the latest workplan and a summary of progress to date. As indicated on the budget handouts, there was considerable underspending in the first year of the grant, which ends September 30. The underspending is almost all related to not having distributed local planning funds as originally planned, and delays in contracting for staffing. All of the underspent funds will be carried over into the 2nd year. All handouts will be forwarded electronically to members.

Principles for LTC reform

A quorum was not present for further discussion of remaining issues in the “principles paper,” but the members present agreed to the following:

- Enrollment in the new system should be mandatory, with good consumer safeguards in place. (It was noted that the “all in, opt out” system used by SSI Managed Care

will not work for LTC, since waiver services will not be available except through managed care.)

- The goal should be to move incrementally toward a system that fully integrates acute, primary and LTC services. As we make progress toward that goal, mechanisms must be in place that will assure coordination of all these services.
- All LTC populations must be served. However, these populations could be served by separate organizations, provided care was coordinated to serve consumers with multiple needs that cross systems. These organizations could form a new entity to jointly assume risk, or one organization could accept risk and sub-capitate part to one or more other organizations. At a minimum, agreements among these organizations must be in place to assure that consumers are effectively and efficiently served.
- Regionalization is a necessary prerequisite for reform. A minimum number of enrollees is necessary to manage risk. Fewer CMOs will mean a simplified system for consumers, providers, and the state.
- The services currently contained in the Family Care benefit package should be the minimum scope of services under management.

Absent members will be polled to determine whether there is consensus on these issues. Information about the issues where there is consensus among CSC members – and where there is not – will be conveyed to Secretary Nelson and to the full Council by early October.

Committee business

- At the request of John Sauer, the minutes of the meeting of August 5, 2005 were amended to reflect significant discussion with Secretary Nelson about the impact of the budget bill and subsequent vetoes on the nursing home industry. With this change, the minutes were approved unanimously.
- George noted that Carol Eschner will be exploring with Secretary Nelson the possibility of the Council's involvement in statewide and/or regional meetings to educate people about and get broader input on the upcoming RFI and longer range LTC reform.
- Next meeting scheduled for October 7, 2005. Suggested items for future agendas (cumulative list):
 - Independent assessment of Family Care from APS Healthcare, including cost-effectiveness information (October)
 - Discussion on using MA mechanisms to manage downsizing of nursing homes. (John Sauer has been invited to put together some thoughts on this for discussion at the October meeting.)
 - Additional discussion on how Medicaid LTC reform will interface with Medicare managed care, including how to avoid Medicaid investments in reform resulting only in savings to Medicare.
 - Update on ICF-MR Restructuring Initiative
 - Update on the CSC project.
 - Update on the Community Relocation Initiative and other budget implementation issues
 - County panel on nursing home relocation experience (or include on agenda of full Council instead)

- Consider asking EverCare to present their model.
- Discussion on how SSI-managed care, CCS benefit, and LTC reform fit together
- It was noted that the Assembly Committee on Medicaid Reform plans to rewrite the Medicaid laws, including reform of LTC. It was suggested that Committee Chair Rep. Curt Gielow be invited to brief the Council about current plans. Carol Eschner will discuss with Secretary Nelson the appropriateness of such an invitation and how best to proceed.

Meeting adjourned at approximately 3:15 PM.