

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

Minutes

Members present: Gerry Born, Lynn Breedlove, Paul Cook, Carol Eschner, Tom Frazier, Rich Kammerud, George Potaracke, John Sauer, Tim Sheehan and Craig Thompson

Members absent: Jerry Huber

Others present: Judith Frye, Lorraine Barniskis, Chuck Wilhelm, Jennifer Gillespie, Kathleen Luedtke, Sue Schroeder, Charles Jones, Dave Lund, Mark Stein, and Bill Jensen

Chair George Potaracke called the meeting to order at 9:10 a.m.

Updates from DHFS

Chuck Wilhelm updated the committee on the Community Relocation Initiative. As of November 29th, 183 people have expressed interest in relocating; 129 care plans have been approved and another 25 are pending cost estimates. Thirteen people have withdrawn their request and 16 people are on a waiting list pending availability of adequate funding. At least 64 people (40 elderly and 24 physically disabled) have actually relocated; additional Family Care and Partnership members have relocated. Forty-eight counties have submitted requests to date. In response to questions from committee members, more detailed information will be provided by DHFS staff.

The ICF-MR Restructuring Initiative continues to run ahead of projections. The original estimate was that 500 people would relocate over the biennium. Given that 228 relocations have occurred to date, it is now anticipated that 650-700 relocations will occur over the biennium. Most relocations continue to be to 3-4 bed adult family homes and to 5-8 bed CBRFs.

Judith Frye announced that Sue Schroeder will be returning to DHFS soon to work full-time on a variety of nursing home issues and restructuring initiatives, including working with the CSC Committee on access issues. Kathleen Luedtke will have the internal DHFS/DDES lead on access issues.

Report on WCHSA Fall Conference

Rich Kammerud reported that Jerry Huber will be the new president of WCHSA beginning in January 2006. Rich was part of a panel at the December 1st fall conference, along with Mark Moody, Chuck Wilhelm, Ginny Graves and Paul Cook, on LTC and Medicaid Reform Initiatives in Wisconsin. Rich described the evolving development of positions on county roles in a reformed system and talked about the strengths of counties in this regard. Chuck provided updates on the Community Relocation Initiative and the ICF-MR Restructuring Initiative, and suggested that attendees watch the web casts available from several of the forums held on the LTC Reform RFI/RFP. Paul Cook said that Ginny Graves did a good job describing the La Crosse and Dane County projects and reported that this presentation was eye-opening to many in the audience who had been unaware of the level of information and analysis necessary for this kind of project. Paul talked about the strengths that the private sector could bring to reform efforts and about the value of integrating LTC with primary and acute care. Chuck clarified that the level

of service/funding integration ranged from Family Care as the “floor” to Partnership as the “ceiling.”

Presentations from this panel will be posted on WCHSA’s web site at <http://www.wchsa.org/>.

Current information on nursing facilities and residents in Wisconsin

Jennifer Gillespie described four maps that had been distributed prior to the meeting. These included nursing home (NH) beds per 1000 population age 65+ and age 85+, each by county and by Health Service Area. A new table was distributed at the meeting showing, by county, both NH beds per 1000 age 65+ and age 85+, along with the percent of the age 65-84 and age 85+ populations eligible for Medicaid.

Dave Lund highlighted several findings from the “Health Counts” summary of the annual NH Survey, which had been distributed prior to the meeting. He noted that there have been dramatic changes over the past decade, with the number of NH beds down from about 50,000 to about 40,000. The number of residents declined from about 43,000 in 1995 to about 35,000 in 2004. During the same time period, admissions increased sharply – from about 39,000 to over 54,000. There are far fewer long-term stays, and many more short-term rehabilitative stays. Looking both at new admissions and all residents, levels of care (acuity) have been creeping up. Primary disabling diagnoses of residents have also changed.

Dave distributed 3 additional maps, showing NH residents over age 85 and under age 65 by county, and the total number of people receiving NH and selected, publicly-funded community services (COP, CIP and Family Care). (These will be sent electronically to the committee.) He noted that nursing facilities are facing new challenges and issues as they take in people under age 65 with significant behavioral issues along with their frail elderly residents. George requested similar information on primary disabling diagnoses of people in community-based programs; this was promised by DHFS.

Nursing home industry perspectives on current and future roles and issues

John Sauer noted that WAHSA has two distinct groups of members: (1) non-profit providers, most of whom operate campus-style, with independent housing, assisted living and nursing facilities, and (2) county nursing homes. He presented an updated version of a presentation that he and Tom Moore gave to the Council’s Residential Options Task Force on January 16, 2004. (This will be sent electronically to members.)

Major points of this presentation included the following:

- Both NH associations support the position of the BOALTC White Paper of 2003 that NH care should be re-focused toward rehabilitation and sub-acute care in all but specified circumstances such as dementia, brain injury and terminal illness. John also noted that residents with long term chronic illnesses or behavioral symptoms may also require ongoing nursing home care.
- Both NH associations support the DHFS LTC reform goal to develop a comprehensive LTC system that 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. The associations also support the expansion of Aging and Disability Resource Centers.
- Nursing facilities have changed dramatically over the past 10 to 15 years. Today:
 - Shorter lengths of stay
 - Residents have medically complex needs
 - NHs are more focused on restorative/rehab, dementia, respite and specialty care

- For longer term stays, private rooms and innovative designs are the trend
- The business model of non-profit campus organizations is changing. Whereas the nursing facility used to be the basis of the business, now assisted living is subsidizing NH care. The NH is used for rehab/restorative care and its residents are often younger than those in independent living units.
- County homes are struggling, under pressure to reduce reliance on property tax levy subsidies, at the same time as state subsidies are disappearing as IGT funds are withdrawn. Any future rate increases will have to come from GPR funding.
- Almost all nursing homes have substantial Medicaid losses. Private pay residents subsidize Medicaid by over \$1500 per month.
- Many NHs have closed or downsized over the past several years, often due to financial pressures.
- Lack of sufficient funding is one reason for high turnover of staff, which hurts quality.
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John noted that since his January 2004 presentation to the Residential Options Task Force, the following actions have been taken: the Governor vetoed a 1.4% nursing home annual rate increase; a surprise announcement was made that DHFS is seeking to close 25% of Wisconsin's nursing home beds; the "100-day provision" was vetoed which would have directed the Department to focus the relocation program on persons residing in a facility for at least 100 days (this 100-day provision was a recommendation of the DHFS Long Term Care Reform Council); DHFS attempted to: implement a "Texas-style" flat-rate payment system for direct care; DHFS attempted to require nursing homes to complete the 18-page long term care functional screen for every resident; a proposal was advanced but rejected to increase the monthly nursing home bed tax by \$50 and use half of the revenue increase to fund non-nursing home expenses; and the DHFS suspended the highly effective nursing home downsizing incentive program. He suggested that it was time to undertake meaningful initiatives to help nursing homes improve the quality of care and services offered to their residents.

He urged the Committee, and the DHFS, to move forward and made the following recommendations:

1. Increase Medicaid rates for nursing facilities and funding the pending acuity-based payment system with new dollars, not through a reallocation of base funding levels.
2. Reinvest nursing home relocation "savings" in nursing homes.
3. Create meaningful incentives for facility replacement, renovation and remodeling to create better residential living and care environments.
4. Work with the provider community on "pay-for-performance" standards.
5. Rename and refocus the Bureau of Quality Assurance to the Bureau of Quality Improvement, and seek authorization to implement a State quality improvement and oversight system independent from the federal Center for Medicare and Medicaid Services.

John also urged the CSC to advance significant recommendations to DHFS on the following “Big Picture” questions:

- How should we facilitate the future role of nursing homes in Wisconsin?
- Should there be regional facilities?
- How should we reward quality?
- How can we pay adequate wages/benefits under managed care (or now)?
- Is there a concern about non-nursing homes serving high-acuity clients?
- How do we pay for LTC?

Further updates from DHFS and reports from Committee members on RFI/RFP

Judith reported that all the RFI/RFP forums have been completed and there was good turnout everywhere. She said that Secretary Nelson had had a good discussion about the RFI/RFP with Rep. Gielow’s Medicaid Reform Committee recently, and handed out the presentation used there. The Q and A document has been completed and is on the web site at <http://dhfs.wisconsin.gov/LTCare/rfi/> (copies were distributed at the meeting). LTC expenditure data by county is available at the same site.

Lynn Breedlove reported on a number of concerns that have been raised by disability and aging advocates and some counties, including:

- The RFI seems neutral on county involvement. The principles developed by the CSC Committee recommended a requirement or strong preference for county involvement.
- The RFI is silent on whether people with mental illness are included. Many counties are considering including them. The possible elimination of county responsibilities under Chapters 51 and 55 is of great concern to advocates.
- The RFI doesn’t seem to favor the Family Care model, despite the recent favorable independent assessment of that program.
- There is no mention in the RFI of a possible future entitlement, or even funding to reduce waiting lists.
- Despite the lack of preference expressed by the RFI toward a model that fully integrates LTC with primary and acute care, there is concern that that is the intent.
- Several other CSC-developed principles were not included in the RFI, including those related to self-directed options, workforce expectations, and consumer input into planning and CMO management.

Tim Sheehan said that he had heard similar questions and concerns from the Independent Living community. He had particularly heard concerns about the difficulty of consumers being involved at a regional level, and fears about major system changes affecting quality.

Tim said that mental health advocates have concerns about the potential implications of two scenarios: (1) a county CMO integrates their mental health system with a LTC CMO or (2) a county opts out of LTC and the State takes over Chapter 51 responsibilities. He also noted that all CMOs need to be prepared to serve the mental health needs of their LTC consumers. Gerry Born noted that inclusion of non-LTC mental health is unlikely unless/until acute services are included in the benefit.

Craig Thompson noted that there is lots of interest among counties. At the same time, there is considerable concern about the potential implications of shifting Chapter 51 and 55 responsibilities from counties to the State. Much more work is needed on how that would play out. There is county confusion about what it would mean for a county to operate a managed care

program, and even more confusion about what it would mean to counties and consumers if the county decides not to participate.

Paul Cook reported that most of the questions he had heard related to nuts and bolts about the format of submissions. He noted that regional discussions have been somewhat difficult, but that there is a great willingness to continue those discussions.

Gerry Born said that the WI Council on Developmental Disabilities is more receptive to managed care opportunities than in the past. Many people seem to think that they need to have every detail decided now, not understanding that this is just an RFP for funding to plan and decide those details. Entitlement is a big issue; the state is asking organizations to build substantial infrastructure without any indications that more people can be served.

George said he had been surprised at how little some people knew about any of this reform effort, including some in the aging network and some mental health advocates. He agreed that RFI/RFP review efforts must include attention to assuring that consumers' voices are heard in local planning efforts.

Lynn suggested that DHFS could send a follow-up communication to clarify that if an organization wants to include people with mental illness, there are specific parameters that must be met (including the principles developed by the Blue Ribbon Commission). He also suggested that DHFS should require that private organizations discuss their proposals with counties in the proposed service area.

Judith emphasized that the RFI simply asks who wants to work with DHFS to plan for reform. She noted that the original guiding principles for LTC reform were attached to the RFI/RFP, and that these are broader than those adopted recently by the Council. In response to a question, she said that state legislation will be needed to implement further reform. At a minimum, we will need to remove the current restriction that Family Care serve not more than 29% of the eligible population. There are a number of smaller corrections that should also be made, based on the experience of the pilot phase. Statutory changes would also be needed to allow COP/CIP funds to be given to private CMOs rather than counties. Secretary Nelson is anxious to move forward under existing federal authority for Family Care and Partnership. Integration of more acute and primary care services could be added to Family Care over time. DHFS has been, and will continue to meet with the Mental Health Council and other mental health advocates to better understand and respond to their concerns. Work needs to be undertaken on what steps are possible and necessary to move toward the goal of entitlement.

Kathleen Luedtke noted that the CSC grant project does include efforts to enhance consumer involvement in planning and managing LTC. A contract has just been signed with UW-Extension for a half-time person to assist with local planning efforts. DHFS will monitor these efforts. The Council's State and Local Stakeholder Participation Committee will also have a strong oversight role.

Craig re-emphasized that the committee should discuss further the implications of potential changes in Chapters 51 and 55, particularly what happens if a county decides not to take up LTC reform. It was agreed that this should be on the February agenda. George noted that Secretary Nelson has indicated that she wants to discuss next steps with the committee, after responses to the RFI/RFP are in. If her schedule can be accommodated, we will try for the February meeting.

Comments from the public

Bill Jensen said that iCare has been talking with several groups of counties about possible partnerships, and noted that he has also heard concerns from counties about the short turn-around time for the RFI/RFP.

Discussion on future role and size of the nursing home industry

Judith Frye reminded the committee that internal work on NH reform has been divided into several areas: (1) acuity based rates (DHCF lead); (2) quality based rates (DDES lead; hope to work with MetaStar advisory groups); and (3) access issues (DDES lead, with CSC Committee and LTC Reform Council as advisors). Committee discussion on questions that it should address included the following points:

- We need to develop consensus on a vision of the role of nursing homes and appropriate distribution of beds for publicly-funded consumers, and a plan for how to get there.
- There is consensus that we will need an array of congregate living options in the future.
- More education on innovative models of NHs and other facilities is requested.
- To some, it seems incongruous to hear expressed concerns about access to Medicaid NH beds at the same time as the administration has an explicit goal of reducing capacity by 25%.
- Some view the Community Relocation Initiative as asking NHs to be the funding source for LTC Reform.
- Two current models exist and will be needed: (1) for short-term, sub-acute stays, and (2) household designs for longer-term residents
- Acuity is increasing in assisted living.
- Incentives are needed for NHs to make their facilities more homelike and more private. The capital allowance under current MA policy is \$72,000 per bed, but the actual replacement cost is at least \$100,000 per bed.
- Discontinuing downsizing funding for financially stable NHs is inconsistent with a goal of a planful approach to system downsizing.
- We need a projection of the overall need for LTC and the subset of this need that can/should be met in NHs. Further, we need some analysis of where those NH beds should be to match projected need.
- The State should use its purchasing power to affect the desired size and distribution of the NH industry. The State should also be prepared to pay for what it wants, for all kinds of LTC, including NHs.
- An acuity-based payment system will begin to change provider behavior and roles. Other ideas that should be discussed include:
 - Licensure issues, including the possibility of a license that floats between NH and CBRF as a resident's acuity level changes
 - Pay for performance reimbursement systems
 - The continuing need to serve people with behavioral needs, likely through regional facilities
- We should develop principles to guide services in congregate settings that would let people stay in place, rather than making them move as their needs change.
- Along with a plan for what we do want, we should develop an analysis of what will happen without a planful approach and sufficient funding to meet LTC needs.

Update on self-directed supports project

Charles Jones reported that in February 2005, about 2,000 Family Care members (of a total of 9,200) were participating in some form of self-directed supports. However, the percentage of members doing so has stayed stagnant for the last few years. A workgroup from Family Care CMOs is looking at ways to improve this.

About 91% of self-directing members direct their personal care and/or supportive home care services; another 5% self-direct respite services; 4% direct other services. Some creative ways that consumers have re-directed funds include paying co-workers for transportation and/or job coaching, buying a health club membership in lieu of formal physical therapy, using bank debit cards to purchase meals in lieu of congregate/home-delivered meal programs.

A study will be out soon on the reasons for slow development of self-directed supports in Family Care. Among the challenges that seem to have contributed are (1) CMOs initially faced major challenges just figuring out how to operate managed care; (2) self-direction actually takes more case management time than tradition case management; and (3) some counties had difficulty finding agencies that would offer an a la carte array of services from which a consumer could choose. The study will likely recommend a variety of training initiatives for consumers, care managers and providers.

DHFS will do focused site visits with CMOs soon on this issue. A cross-unit team in DDES, with other stakeholders, is looking at options for making standards for self-directed supports more uniform across all waiver programs. Figuring out how to measure quality in self-directed supports is part of a broader effort to define and measure quality in all programs. A web site is being developed to disseminate information on self-directed supports, including Family Care CMO policies.

Interface between Medicaid LTC reform and Medicare reform

Paul Cook updated the committee on Medicare Special Need Plans. There has been tremendous growth in plans: 275 nationally as of October, 2005, compared to 123 at the end of August. Several plans are offered in Wisconsin, including all the Partnership programs (in the nursing home certifiable category) and 2 plans (both in the dual eligible category) offered by United Healthcare. Paul recommended that the committee schedule future discussions on how the relationship between counties and SNPs will work when people are enrolled in both a SNP and COP/CIP. There is the potential for cost-shifting to Medicaid card services and/or waivers from SNPs.

Committee business

- George announced that he has communicated with Secretary Nelson and that she expects the CSC committee to provide advice during the review process for the RFI/RFP. He hopes that she will attend the committee's February meeting.
- Kathleen Luedtke announced that Lorraine Barniskis will continue to staff the Council and the CSC committee during 2006.
- On a motion by Paul Cook, seconded by Carol Eschner, the minutes of the November 4, 2005 meeting were approved unanimously.

Future agenda items

- Next meeting scheduled for February 10, 2006. Suggested items for future agendas (cumulative list):
 - Update on ADA plan implementation
 - Discussion on future role and structure of nursing facility industry. Get a picture of the current industry, recent trends. More information about new models of nursing facilities being developed. Discussion of additional data and analysis. Discussion of proposed work plan.
 - Update from Secretary Nelson on responses to RFI/RFP and discussion on next steps
 - Update on MA home care cost controls
 - Further discussion on implications of shifting Chapter 51 and 55 responsibilities from counties to the state.
 - 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 and cost-shifting from SNPs to Medicaid. Related interface issues from provider perspectives (address concerns expressed by WPSA). Relationships between SNPs and counties for people receiving services from both.
 - Updates from Rep. Curt Gielow on plans and activities of Assembly Medicaid Reform Committee (CSC and/or Council)
 - Overviews of various risk-based payment systems and trends toward individually based rates
 - Updates on ICF-MR Restructuring Initiative, Community Relocation Initiative and the CSC project.
 - County panel on nursing home relocation experience (or include on agenda of full Council instead)
 - Consider asking EverCare to present their model.

Meeting adjourned at approximately 2:30 PM.