

**Committee on Comprehensive System Change**  
Council on Long Term Care Reform  
**Meeting of January 7, 2005**

**Draft Minutes**

**Members present:** Gerry Born, Lynn Breedlove, Paul Cook, Carol Eschner, Tom Frazier, Jerry Huber, Rich Kammerud, George Potaracke, Craig Thompson

**Members absent:** John Sauer, Tim Sheehan

**Others present:** Tim Steller (for John Sauer), Helene Nelson, Ginny Graves, Chuck Wilhelm, Judith Frye, Lorraine Barniskis, Kathleen Luedtke, Dan Johnson, Tom Moore, Janice Smith, Theresa Sanders, Deb Menacher, David Sievert, Todd Costello, Owen McCusker, Dan Hayes, Joyce Binder, Gail Propsom, Diane Waller

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

**County Government's struggle with LTC Reform**

Craig Thompson, Rich Kammerud and Jerry Huber provided insights about various county actors and processes for developing positions. Craig noted that the WI Counties Association (WCA) speaks for elected officials; all of its board members are elected officials. Positions are almost always adopted by consensus. Rich said that the WI County Human Services Association (WCHSA) is a mix of administrators and elected officials. They work with WCA to coordinate policy positions. Jerry noted that, in general, county board members tend to feel more strongly about having a strong county role in long-term care and to fear the involvement of the private sector.

Other points raised during this discussion:

- LTC is very broad and cuts across many populations and services, only some of which are covered by Family Care.
- To include acute care services, counties need to be co-purchasers with the state for MA services; it is difficult for counties to negotiate independently with HMOs and other big health systems.
- Wisconsin should be proud of its advances in LTC reform, especially Family Care; the question is how to move forward from here.
- County board members tend to be more conservative than administrators, because of their responsibility to local taxpayers; but if administrators make a good case for more spending, they can often get agreement from the board.
- Counties' commitment of resources to LTC has been higher than the state's in recent years.
- If some version of TABOR passes and the state doesn't increase funding for LTC, many counties may want out of LTC altogether.

**Discussion of the issues of county roles and coordination/of LTC with acute and primary care**

Ginny Graves facilitated a discussion around the two issues of county roles in a reformed system and the coordination/integration of primary and acute services with LTC. Following is a summary of that discussion.

Starting points

Agreements:

- LTC reform is essential
- Reform efforts have been stalled in part because of unequal funding and varying perspectives on the problem
- There is a tension between reliance on local funding and consistency of services/good standard of service statewide

DHFS goals	County goals	Advocates' goals
<ul style="list-style-type: none"> <li>• Quality</li> <li>• Access/Entitlement</li> <li>• Choice</li> <li>• Cost-effectiveness</li> <li>• Care management that includes capitation and risk</li> <li>• Individualized and consumer-centered care planning</li> <li>• Management of a comprehensive service package (reduce fragmentation of the system)</li> <li>• Statewideness: move the whole state ahead with consistent services</li> <li>• Maximize federal funding</li> <li>• Retain county funding</li> <li>• No one-size-fits-all model</li> <li>• Stability of funding</li> </ul>	<ul style="list-style-type: none"> <li>• Local control and flexibility</li> <li>• Clarity and fiscal accountability</li> <li>• Clear, statewide eligibility criteria</li> <li>• Relationship between funding and eligibility criteria</li> <li>• Care management (vs. managed care)</li> <li>• Stability of funding</li> </ul>	<ul style="list-style-type: none"> <li>• Individualization of service</li> <li>• Adequate level of service (fear of capitation and risk)</li> <li>• Dependability</li> <li>• Access to decision-makers (public administration of LTC services; distrust of private managed care systems)</li> <li>• Consumer choice</li> <li>• Entitlement</li> <li>• Local control</li> <li>• Stability of funding</li> </ul>

Current county roles and degrees of service integration vary

Program	County roles	Degree of integration
Waivers	<ul style="list-style-type: none"> <li>• Program operator/manager</li> <li>• Fixed state funding</li> <li>• County match funding in some programs</li> <li>• Purchaser of services</li> <li>• Funder</li> </ul>	<ul style="list-style-type: none"> <li>• Limited coordination of LTC with primary and acute</li> <li>• No integration</li> </ul>
Family Care	<ul style="list-style-type: none"> <li>• CMO manages program and assumes risk</li> <li>• Competition</li> <li>• Public/private partnerships (various</li> </ul>	<ul style="list-style-type: none"> <li>• All LTC services integrated (waiver and FFS); coordination with primary and acute</li> </ul>

Program	County roles	Degree of integration
	models) <ul style="list-style-type: none"> <li>• Rate-based increases</li> <li>• Entitlement – must serve all eligibles</li> <li>• Increased local responsibility and accountability</li> </ul>	
Partnership	<ul style="list-style-type: none"> <li>• Approves program operating within county</li> <li>• County cooperation (e.g., determines eligibility)</li> <li>• Private not-for-profit community organization operates program and assumes risk</li> </ul>	<ul style="list-style-type: none"> <li>• Fully integrated, including LTC, acute and primary care</li> <li>• Medicaid (waiver and FFS) and Medicare services</li> </ul>
SSI-Managed Care	County a minimal partner	Varies by county

Questions:

- How much variety in organizational/funding models do we want across the state?
  - How many models can DHFS administer?
  - To what extent can we accommodate local differences?
- How can we avoid silos that hamper local innovation?

Several Rocks, Several Hard Places

- LTC reform cannot be financed and organized for 72 individual counties; vs. LTC funding in a reformed system goes directly through each county
- Integration of care appears to be financially and programmatically successful; vs. Health care systems (providers and MCOs) and county-based systems don't necessarily match
- Additional funding is needed to proceed; vs. There is a big Medicaid shortfall and general fiscal constraints.
- Current statutes (especially Chapter 51) give responsibility to counties for some groups; vs. Under competitive system, there is the potential for contract between DHFS and private organizations that bypass the county
- Lack of political will to do move forward; Legislature operates on a 2-year cycle and has a hard time looking forward to the demographics of the future
- Integration of services is not a priority with legislators
- Mistrust of motives, methods of the acute care system; fear that acute care (medical model) will take over and LTC/other needs of consumers will not be adequately addressed.

### Alternative managed care models

(Working with local strengths)

#### Dane County

- Broadening of reform from a Partnership platform
- Community Living Alliance negotiating with MH Center of Dane County to partner on integrating MH services with LTC, acute and primary – and to broaden to a larger population through SSI Managed Care
- County at the table
- MH “net out” – significant planning time and money, data analysis
- Risk-adjusted rates
- Quality
- May expand to DD services as populations are added in future

#### La Crosse County

- Broadening of reform from a Family Care platform
- Goal to get all MA services under care management
- County role: manage all LTC services and all MH/SA services
- County negotiating with local acute/primary providers to expand integration of services through SSI Managed Care public/private partnership
- Want DHFS and County to be co-purchasers of FFS Medicaid
- May eventually expand to region beyond county boundaries

### Possible pathways for moving forward

- Expand Partnership (or a similar more integrated model) to all counties as an option for consumers
- Expand Family Care to counties that want to pursue it (regionalization from existing programs and/or new single-county programs)
- Public/private partnerships (e.g., between Community Health Partnership and Dunn and Eau Claire Counties; between Kenosha County and CCO)
- Develop core principles, values, parameters for SSI Managed Care and models of LTC reform that use it as a building block
- Multi-county purchasing consortia for acute and primary care, like Minnesota model
- Explore Federally Qualified Health Centers as other possible partners for counties

### **Comments from Secretary Nelson**

Secretary Nelson said that the Department plans to schedule, within the next four to five weeks, a policy discussion around nursing home issues. She suggested that willing members of the CSC Committee, additional key representatives of the nursing home industry and senior DHFS staff compose the group. Members will be polled for availability for several possible dates.

She noted that with the downsizing of state government, the number of LTC reform models needs to be kept manageable. The Department is interested in getting to more flexible and integrated models of LTC, with *at least* all LTC services included (e.g., Family Care) and *at least* better coordination (if not integration) of acute and primary care. Waiver simplification must be viewed as an incremental step toward that goal.

### **Comments from the public**

There were no comments from visitors.

### **Committee business**

- The minutes of the meeting of December 10, 2004 were approved unanimously.
- Kathleen Luedtke updated the Committee on progress of the CSC grant project. Most recent effort has been focused on logistics, especially staffing. A more comprehensive update will be provided at the next Committee meeting.
- Suggestions for future agenda items included:
  - Updates from joint discussions that are beginning to be held by Partnership programs and Family Care CMOs
  - Follow up discussions on county roles and related issues
  - Bringing key legislators into the discussion – with this committee or with the full Council
- Carol Eschner noted that work is underway to form a committee to bring consumer input into the reform process. She requested nominees from CSC members.

### **Waiver simplification**

Chuck Wilhelm distributed an amended DHFS proposal on waiver simplification, along with a motion adopted by WCHSA's Executive Board. After some discussion, the Committee voted to re-affirm, with minor amendments, its original positions on integration of (1) CIP IA and IB and (2) COP-W and CIP II. The vote was 8 yes and 1 abstention. The Committee also maintained its original position that COP Regular be folded into these two new programs on a vote of 5 yes and 4 abstentions.

### **Consumer brochure on ADA Title II rights**

Paul Cook and Gail Propsom presented a rough draft of a consumer brochure developed by the New Freedom Initiative Committee. The brochure is designed to inform consumers about their rights under the Americans with Disabilities Act, Title II. Paul Cook, Rich Kammerud and Tim Sheehan were appointed as a sub-group to further develop the brochure and bring it back to the Committee. Gail Propsom will assist.

### **ICF/MR Restructuring**

Chuck Wilhelm provided a handout on the ICF/MR Restructuring Initiative. The Committee agreed to provide oversight on the implementation of this initiative, which began on January 1, 2005. This item will be on the agenda again within the next six months.

**Meeting adjourned** at approximately 3:00 PM.