

**Committee on Comprehensive System Change**  
Council on Long Term Care Reform  
**Meeting of August 5, 2005**

**Minutes**

**Members present:** Gerry Born, Paul Cook, Carol Eschner, Tom Frazier, George Potaracke, John Sauer, Tim Sheehan, and Craig Thompson. Theresa Sanders and Tim Steller substituted for Jerry Huber and Rich Kammerud.

**Members absent:** Lynn Breedlove, Jerry Huber, and Rich Kammerud

**Others present:** Chuck Wilhelm, Judith Frye, Lorraine Barniskis, Diane Waller, Bill Jensen, Michael Blumenfeld, Nancy Crawford, Karen McKim, Kathleen Luedtke, Charles Jones, Monica Deignan, Ken Eimers, Wayne Hagenbuch, Steve Landkamer, Deb Menacher, Dan Johnson, Cheryl Lofton, Nancy Leipzig, Dane Hayes, Tim Cook, Nancy Anderson, and Helene Nelson

Chair George Potaracke called the meeting to order at 9:00 AM.

**Quality assurance and improvement efforts**

Judith Frye provided an overview of quality monitoring in long-term care. The BQA survey process is the primary quality assurance process for nursing homes; MetaStar is conducting quality improvement projects. DHFS has discussed changing nursing home reimbursement to pay for quality outcomes, but this is difficult to do if based on BQA survey results. In COP and the HCB Waivers, ongoing annual monitoring includes consumer outcome interviews, reviews of operational processes, case reviews, and complaint and grievance processes. In addition to these, Family Care CMOs and Partnership programs are required to conduct annual quality improvement projects. Partnership has also conducted consumer satisfaction surveys. Work is progressing on a pay for performance contract for Family Care for 2006.

Karen McKim and Nancy Crawford provided handouts and presented information about quality management in Family Care and Partnership (see handout). Karen noted that to assess quality, consistent information is needed over time. Current state-level results monitoring includes the Family Care Dashboard (statistical information providing overviews and potential indicators of problem areas), the External Quality Review conducted by MetaStar, and the Independent Assessment conducted by APS Healthcare, Inc. The federal HCB waiver quality assurances have to do with process, not results. To meaningfully monitor results in these programs, Wisconsin will need to develop its own systems. Quality management in HCB services is not as developed as systems for acute and primary care, or for nursing home care.

DHFS is working on new ways to get direct feedback from consumers about the extent to which their desired outcomes are being achieved. The process that has been used previously will not be continued. It was too expensive, and covered too small a sample of people. A new tool developed by CMS was tested in Wisconsin, and found unsatisfactory.

The Quality Close to Home project, now about halfway through its three-year funding period, is reviewing current quality management practices and developing recommendations for sustainable improvements in the quality management systems for HCB Waiver programs. A consultant (TMG and APS team) has been hired to assist with this effort. A local advisory panel of about 45 people is advising.

Assistance is requested from the LTCR Council with identifying exactly what DHFS and the Council itself should be monitoring. What are the desired outcomes/results? What are appropriate benchmarks and outcome indicators? What quality expectations should be in the CSC RFP that eventually goes out? What expectations should be in new contracts with LTC managed care entities? Policy design needs to be explicit about exactly what we want to achieve, then quality monitoring systems need to be designed to monitor whether we are meeting those expectations.

### **Discussion on principles for reform; unresolved issues**

The committee discussed several as yet unresolved issues in this ongoing discussion. There was agreement that all eligible people, in all geographic areas, should be served and all the needs of each consumer should be addressed. There was less agreement about whether each CMO should be required to serve all eligible populations. It was noted that assurances are needed that any private entity serving as a CMO not be able to cease operation without adequate transition to another entity and that its assets from the program not be transferred to another part of the corporation. On the question of the potential roles of Local Long Term Care Councils, it was suggested that they should focus on consumer issues, such as complaints and grievances. There need to be clear lines of communication and accountability; these councils need to report to somebody.

### **Discussion with Secretary Nelson**

DHFS Secretary Helene Nelson said that the RFI will be out within the next six months. In keeping with promises made to CMS in the CSC grant proposal and the state's MA budget problems, the goal will be to get more integration and more care under management as soon as possible. DHFS will work with the Governor's Office and the Department of Administration to prepare the RFI. The RFI likely will be a rather open-ended invitation for public and private organizations to respond to questions about their capacity to manage care. She said that she would like to see both Family Care and Partnership models available, to provide more choice for consumers. As long as the federal government operates Medicare, a fully integrated model is not necessarily best for everyone, especially if it is mandated. Statewideness and equity for consumers across the state are goals. Aging and Disability Resource Centers, operated by one or more counties, must be the entry point for service.

There was a request that the RFI make it clear what will happen with current statutory requirements (e.g. Chapters 51 and 55) for a county if the county cannot or chooses not to assume risk for a CMO. There was also a request that there be meetings and/or a think piece prior to release of the RFI, so that organizations can be better prepared to respond.

There was also significant discussion about the impact of the recently enacted biennial budget bill and subsequent vetoes on the nursing home industry.

### **Medicare Modernization Act**

Steve Landkamer walked through a PowerPoint presentation (see handout) on the new Medicare Part D (drug benefit) and its implications people dually eligible for Medicaid and Medicare. Several sources of help are available to help people choose among plans, including county aging benefit specialists, the Medigap hotline, the Wisconsin Coalition for Advocacy, and CWAG's elder law center.

Paul Cook discussed Special Needs Plans created in the Medicare Modernization Act (MMA). Several types of these managed care plans were created to serve Medicare enrollees with special

needs; there is overlap in the definitions for these plan categories. States have no role in deciding whether or how these plans operate, even when they serve people who are dually eligible for Medicare and Medicaid. Over 100 of these plans have been approved by CMS, operating in 22 states and territories. Some sponsors offer multiple plans. Community Health Partnership is planning to offer one of these plans, which may include people not eligible for Medicaid.

### **Comments from the public**

Nancy Anderson noted that providers are being encouraged to make sure that all dually eligible people that they serve get the letter from Medicare informing them of the requirement to enroll in a Part D plan and to direct them to a source of help in understanding their options. She also 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.

### **Updates from DHFS**

Judith said that Jackie Rueden, currently the Director of Northern WI Center, has been appointed to serve as the overall manager for the four regional teams providing technical assistance in the Community Integration Initiative. Most other members of these teams have been hired or assigned from within DHFS. Chuck Wilhelm alerted the committee that CMS is reviewing states' HCB Waiver programs, with an eye toward assuring that policy and application of policy are consistent across waivers and across counties. They have reviewed programs in Pennsylvania and Ohio and have told Wisconsin that they expect inconsistencies to be resolved by the next time that our various waivers are up for renewal. Most of Wisconsin's waivers are up for renewal in 2007.

### **Committee business**

- The minutes of the meeting of July 7, 2005 were approved unanimously without change.
- George noted that he and Carol Eschner will meet to discuss appointment of a Council committee on quality, and the possibility of state or regional meetings to educate people about, and get broader input on the upcoming RFI and longer range LTC reform.
- Next meeting confirmed for September 2, 2005. Suggested items for future agendas (cumulative list):
  - Invite Mark Moody to discuss LTC reform with the committee
  - Continued discussion of long-range reform models and criteria for local planning grants under the CSC project.
  - Continued discussion of county roles in a reformed system (revised version of paper by Kammerud and others)
  - Independent assessment of Family Care from APS Healthcare, including cost-effectiveness information (September)
  - 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

**Meeting adjourned** at approximately 3:15 PM.