

**Principles to Guide Long-Term Care Reform in Wisconsin
Recommendations from the WI Council on LTC Reform
October 2005**

The Comprehensive System Change Committee of the Wisconsin Council on Long Term Care Reform has spent considerable time over the past year discussing how best to move forward on reform of Wisconsin's long-term care system. The committee has reached consensus on a significant number of issues. On other issues, full consensus has not yet been reached. This paper summarizes both sets of issues. It has been reviewed by the Council and was endorsed unanimously by that group on October 14, 2005.

Please note that this paper is limited to advice about the long-term care system serving adults with physical or developmental disabilities and frail elders. It does not attempt to deal with reform of the system for people with mental illness who do not also have LTC needs, nor with the system serving children. It also is not intended to make any comment about SSI Managed Care initiatives.

Areas of consensus

- 1) A reformed LTC system must meet the following goals:
 - a) Choice – give people better choices about the services, supports and providers available to meet their needs
 - b) Access – improve people's access to services
 - c) Quality – improve the overall quality of the long term care system by focusing on achieving people's health and social outcomes
 - d) Cost-effectiveness – create a cost-effective long term care system for the future
- 2) Care planning must be person-centered, one person at a time.
- 3) Care management must encompass the four goals listed above under item 1).
- 4) Consumers must have opportunities for self-directed care.
- 5) Mechanisms such as the Resource Allocation Decision (RAD) method used in Family Care for decision-making about individual care plans should be in place in the new system.
- 6) Mechanisms must be in place for unbiased mediation to help resolve potential disputes between care management organizations and consumers when consumer choice and cost-effectiveness goals appear to be at odds.
- 7) Reform of the LTC system must address strengthening of the LTC workforce. Specifically, mechanisms must be in place to address job satisfaction, wages and benefits, working conditions and retention efforts, all of which have a direct impact on quality and continuity of care.
- 8) Consumers' views must inform the management of care management organizations.
- 9) Organizations managing the new system must be value-driven and those values must be consistent with the four goals listed above.

- 10) Consumers must be active participants in local planning for LTC reform.
- 11) Organizations proposing to manage local systems must collaborate with all stakeholders, including consumers, advocates, counties, and private providers, in developing plans and proposals.
- 12) A major goal of reform should be to improve quality and cost-effectiveness by bringing more care under management.
- 13) A fully reformed system must be funded by the state and federal governments, using pooled and flexible funding mechanisms under principles of managed care, including:
 - a) On a contractual basis
 - b) Through capitated, risk-based mechanisms
 - c) Using adequate, actuarially sound rates.
- 14) Funding for LTC services funded through Medicaid fee-for-service (card), Community Options Program and Medicaid Waiver programs should be integrated.
- 15) The State has ultimate responsibility for contracting with organizations that can and do deliver high quality services and are fiscally sound. To the extent that they have the necessary infrastructure can meet State standards, counties may choose to serve in a variety of roles in the new system, but will not be mandated to serve as care management organizations. Counties will fully participate in decision-making regarding the LTC systems in their geographic areas, but will not have veto authority over the State's decisions.
- 16) As the new system moves away from a statewide, county-mandated LTC system, responsibilities under Chapters 51 and 55 of the statutes must be assumed by the State.
- 17) All LTC populations covered by this paper (frail elderly, adults with physical and/or developmental disabilities) must be served in every area of the state. 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.
- 18) Service areas for care management organizations will in most cases be multi-county, varying in geographic size. Each service area must include sufficient consumers to establish accurate capitation rates and establish manageable risk pools, while maintaining accountability and the ability to deliver individualized service plans. Regionalization is a necessary prerequisite for reform.
- 19) In accordance with the principles listed in items 1 through 18 above, applications for planning or other grants for local LTC reform and state review of those applications should include the following:
 - a) Applicants should be required to explain clearly how care will be coordinated across systems (LTC, acute/primary, mental health, etc.)

- b) Applicants must demonstrate how they will address both the health care and LTC needs of consumers through a broad network of high quality providers.
- c) Applicants must describe their vision of the role of nursing homes, including appropriate nursing home utilization.
- d) Whether a private sector applicant is for-profit or not-for-profit is not necessarily of concern, but requiring transparency regarding finances is essential.
- e) In reviewing proposals, the State should give preference 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.
- f) As single counties, or as a consortium, possible county roles in the reformed system include:
 - i) County serves as Aging and Disability Resource Center (ADRC) and Care Management Organization (CMO) and maintains full responsibility for services under Chapters 51 and 55 of the statutes.
 - ii) County serves as ADRC and as CMO for LTC services and seeks a public or private partner to manage acute and primary services. The county maintains full responsibility for services under Chapters 51 and 55 of the statutes.
 - iii) County serves as the ADRC. The State selects the CMO. The county may provide case management or other services under a sub-capitated arrangement with the CMO. County and State negotiate the ADRC responsibilities, specifically for emergency crisis response, APS and Elder Abuse protective programs related to on-going services.
 - iv) County does not serve as either the ADRC or the CMO, but retains limited responsibility for some services under Chapters 51 and/or 55 (e.g. Elder Abuse and Neglect investigations).
 - v) County does not serve as either the ADRC or the CMO and retains no responsibilities under Chapters 51 and 55 of the statutes.

Issues on which full committee consensus has not yet been reached

1) If and when enrollment should be mandatory for eligible individuals

There was general agreement that:

- When the new system is available, Community Options Program related home and community-based waiver services should be available only through the new system (with an orderly transition to accommodate conversion).
- Enrollment should not be mandatory within a service area until care management organizations have demonstrated adequate consumer choice and quality.
- If enrollment is mandated, good consumer safeguards must be in place.

- During any period of voluntary enrollment, incentives for enrollment should be provided.
- The issue of mandatory vs. voluntary enrollment is intertwined with several other issues, including:
 - The degree to which LTC and acute/primary health care funding and management are integrated;
 - Whether the new LTC benefit is an entitlement; and
 - Whether there are multiple CMOs available to consumers within a geographic area.

Points of discussion included the following:

- Retaining MA card services as an alternative for people eligible for the new system will impede the goal of getting services under management.
- Mandatory enrollment prevents creaming of "easy" clients or opt-out by hard to care for and costly enrollees.
- If there is only one CMO available in an area, consumers may not have sufficient choice of providers and care managers.
- Enrollment should be mandatory for those who receive HCBW services.
- Enrollment should be mandatory for those who are being newly admitted to a nursing home.
- For models that integrate Medicare, enrollment must be voluntary.
- The federal government currently requires that enrollment in Medicaid managed care be voluntary unless there is a choice of at least two CMOs available to consumers.

2) How quickly LTC funding and management should be integrated with acute and primary care

There was general agreement that one intent of reform should be to achieve, as soon as possible, a system that fully integrates acute, primary and LTC services in a manner that results in the right service at the right time at the right cost for consumers. As we make progress toward that goal, mechanisms must be in place that will assure coordination of all these services. The services currently contained in the Family Care benefit package (LTC services funded through Medicaid fee-for-service (card), Community Options Program and Medicaid Waiver programs) should be the minimum scope of services under management. A broader benefit package should be encouraged. As many health and LTC services as possible should be brought under management.

However, a minority of the committee felt that the benefit package should immediately include the full range of acute, primary and LTC services.

Points of discussion in this debate included the following:

- Many individuals have strong relationships with physicians or other health care providers that might not be in a CMO's network. This would discourage voluntary enrollment.
- Models that integrate Medicare will not work for those who are not eligible for Medicare (including most people with developmental disabilities).
- If full integration is required immediately, few if any counties are in a position to act as CMOs unless they can immediately find private partners. Counties are the most experienced entities in managing home and community-based services.
- Full integration adds value in the following ways:
 - Better control and leverage over acute and primary care by organizations that thoroughly understand LTC
 - Allows more flexibility in use of funds
 - More holistic for individuals; balances are achieved through the care planning process among consumer needs, funding and risk
 - Creates change in priorities (e.g., CMO works hard to prevent hospitalization)
 - Having nurse practitioners on care teams is very helpful to managing physical health concerns

3) Whether multiple care management organizations should be available within a geographic area

Points of discussion included the following:

- There may not be a sufficient number of organizations available in all parts of the state, especially in rural areas, to allow multiple CMOs of high quality. Two or more CMOs would be possible only where there is a sufficient number of eligible people to manage risk within each CMO.
- Fewer CMOs could result in a simplified system for consumers, providers, and the State.
- Competition and choice among CMOs will better serve the consumer. Where possible (i.e., where there are sufficient eligible people to spread risk among two or more CMOs), we should not award a winner-take-all CMO contract.
- The federal government currently requires that enrollment in Medicaid managed care be voluntary unless there is a choice of at least two CMOs available to consumers. If enrollment is voluntary, Medicaid fee-for-service (card) services must be maintained; this is arguably the part of the current system most in need of stronger local management.