Wisconsin Council on Long Term Care
Meeting of July 1, 2008

Approved Minutes

Members present: Pat Anderson, Allen Buechel, Judy Braun, Lynn Breedlove, Heather Bruemmer, Devon Christianson, Paul Cook, Dana Cyra, Carol Eschner, Tom Frazier, Jennifer Ondrejka, Michelle Pike, Todd Romenesko, John Sauer, Tim Sheehan, Stephanie Stein

Members absent: Beth Anderson, Chris Sarbacker

Others present: Lorraine Barniskis, Judith Frye, Donna McDowell, Janice Smith, Sue Schroeder, Carrie Molke, Kristen Felten, Wayne Hagenbuch, Paul Soczynski, Julie Erdmann, Michael Blumenfeld, Katie Mnuk

Meeting call to order. Chair Heather Bruemmer called the meeting to order at 9:30 AM. Members introduced themselves.

Private MCO experience with Family Care Expansion

Paul Cook (Community Health Partnership) provided statistics on new enrollments. Where CHP has been operating for some time (Eau Claire, Chippewa and Dunn Counties), many people are choosing Partnership rather than Family Care. In Pierce, more people are choosing Family Care; people have no experience with Partnership there, and the major physicians' group has not yet signed on as a provider. CHP is expecting an eventual enrollment of about 3000, of whom many will likely choose Partnership. A focus on coordination between the MCO and the ADRC has kept things running smoothly. CHP maintains separate care management teams for Partnership and Family Care. CHP is not subcontracting with county staff. In small counties, county staff were largely absorbed into the ADRC and elsewhere. CHP has directly hired a few county staff, especially in supervisory roles. It has been challenging to find enough RNs for care management teams. It has also been challenging to get information out to consumers; considerable misinformation and rumors are still floating around. More training of ADRC staff is need on Medicare issues, especially drug coverage. CHP is still doing some follow-up on functional screens; ADRCs sometimes are not doing a thorough job on the health side.

Paul Soczynski (Community Care) said that CC does subcontract with several counties for care managers. CC currently has members in Milwaukee, Racine, Kenosha, Sheboygan, Ozaukee and Washington Counties, begins in Waukesha County on 7/1/08, and is scheduled to begin in Walworth County in July 2009. Current enrollment is over 2400 members. CC has incurred substantial financial loses during its rapid expansion period, primarily due to high costs for members with developmental disabilities. The long-range impact of Family Care on CC's financial position is not yet clear. They are working with DHS and other MCOs on capitation rates for each target population. Their greatest challenge is to stabilize operations and finances while continuing to expand. Considerable efforts are underway to bring care more completely under management, including several internal re-structuring efforts, implementation of a review of all care plans within 60 days of enrollment, and preparing to renegotiate all provider contracts that were simply rolled over from counties. A particular focus will be on residential services, where new rate structures will be implemented. Rate methodologies are also being refined for other services, including employment/day services, transportation, and personal care/supportive home care. Planned expansion of integrated models of care is hampered by a shortage of nurse practitioners and the changing health care systems in southeastern Wisconsin. Community Care

has been actively involved in a number of efforts in eastern Wisconsin related to expansion of managed long-term care.

Wayne Hagenbuch, Care Wisconsin First (formerly Elder Care), said that they are working with counties to prepare for transition to Family Care and Partnership. CWF will offer Family Care, beginning between March and November of 2008 in eight of the teal counties (Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waushara, and Waukesha), plus Partnership in three of those counties. They would like to offer Partnership more broadly, but a federal moratorium on expansion of Medicare Special Needs Plans is likely through 2009. Preparation for transition is through group meetings as well as county-specific planning meetings. To facilitate rapid transition, CWF is contracting with all county-contracted providers in transitioning counties. Much of CWF's staff expansion has come from Lutheran Social Services, a partner in the planning consortium for this area. A structured transition plan for contracting with counties for care managers is in place, so that they do not need to handle both Family Care and waiver clients for too long. Care Wisconsin hires nurses directly. Almost all supervisory and management staff who have been added have county experience, especially those with experience with younger people with disabilities. They have tried to focus strongly on continuity for members during the transition period. Having RNs on Family Care care management teams is beneficial. Taking people off waiting lists is very positive for everyone.

Formation of regional LTC advisory committees

Donna McDowell distributed a map approximating results of the previous Council discussion on how to divide up the state into regions for LTC advisory committees. The populations of the proposed regions are roughly similar. The regional lines mostly align with the boundaries of MCOs; as possible, there would be two or more MCOs in each region. She also distributed discussion questions. Discussion points included the following:

1. *What are the major subjects that the regional advisory committees should address? Committees are advisory to whom? What is uniquely the role of the advisory committees compared to the ADRC Boards, the state LTC Council, or the state's quality oversight role?*
    - The committees should be assessing uniformity in implementing key values of reform (choice, quality, access, etc.) Their audiences include MCOs and ADRCs.
    - The committees advise DHS, the state LTC Council, MCOs, ADRCs and local officials. They should look at the general status of managed LTC and other services for older people and people with disabilities and access to them through ADRCs. Their uniqueness comes from the breadth of their mission. The questions should be broad ones such as whether the system is increasing choice, improving access and cost-effectiveness.
    - There should be a continuing dialogue between committees and MCOs regarding improvements needed as found by the committees. Others felt that this was an unrealistic goal.
    - Committees should be given "dashboard" information about MCO quality.
    - Lots of education should be provided to committee members in their first year. Terms should be relatively long so people can get knowledgeable and be effective.
    - Committees need to look at the whole aging, disability and LTC systems – with all their components.
2. *How often should the regional committees meet? What is a reasonable travel distance? Who will pay the travel expenses?*

    - Committees should meet at least quarterly; they could agree to meet more frequently.
    - Use technology to reduce face-to-face meetings and thus travel costs.
    - Possible sources for travel costs: DHS, ADRCs.
3. *Are the boundaries as proposed acceptable? Is the population of each area comparable enough? Are there two MCOs in each area? Should there be?*
    - Dane and Rock Counties could be added to the orange region on the map to make populations more equal and reduce the number of regions.
    - Some counties are not yet aligned with an MCO. Boundaries will be adjusted as makes sense.
4. *When should the regional advisory committees be organized and begin meeting in each area? How should this timing relate to the development of ADRCs and MCOs?*
    - There was broad agreement that establishing the committees too soon would set them up for failure. A regional LTC advisory committee should be established one year after all ADRC boards in the region have been established. That would mean that the southeastern regional committee would start in September 2009.

Comments from the public

There were no public comments.

Funding issues for small ADRCs

Donna McDowell noted that the current cost model for ADRC funding doesn't provide enough money for a small single-county ADRC. The formula thus provides an incentive to create regional ADRCs. There have been questions about whether this approach is truly cost-effective. There was a question about whether the formula should be based on the population in poverty versus the general population, and whether it should factor in the percentage of the population aged 65 and older. Tim Sheehan noted that the formula for Independent Living Center funding provides for base funding plus add-ons for special needs such as higher travel costs in rural areas.

Linda Symons discussed the formation of the ADRC of Southwestern Wisconsin, operated by an eight-county consortium. The ADRC is divided into two regions (north and south). Each region has a regional board and director, who oversee four satellite agencies, one in each county. The ADRC's mission, vision, resources and core administrative functions are shared. There are many built-in feedback loops, so counties don't "go solo." There are minimum staffing requirements for each satellite office. Richland County's ADRC originally had sufficient funding, but is losing money to the region and having a hard time financially. The ADRC is operated under an inter-county contract model, which may result in too many layers of administration in the long term. Creation of the regional model was a huge transformation, requiring inter-county cooperation at an unprecedented level. The ADRC Workgroup laid a solid foundation in developing a model with a system of support.

Available funds from the ADRC cost model are not sufficient to support minimum requirements to operate the ADRC and give good customer service. There is concern that the cost model is based on what the state has, not the true costs of operation. Static or declining funding levels may mean cuts in prevention programs. There are many benefits to a regional model, including the ease with which family members and others in the region can have access to information and services. Linda suggested that the next step should be to allow financial eligibility determinations across county lines.

Donna McDowell distributed emailed notes from Todd Romenesko, who was unable to attend the meeting. The ADRC serving Calumet, Outagamie and Waupaca Counties (COW) operates under a "consolidated services model." The state contracts with Calumet County for the ADRC serving all three counties. Calumet then enters into a purchased service contract with the other two counties to meet contract requirements. There are branch offices in each county. Todd feels that this arrangement works well, partly because of the long history of collaborative services among the participating counties. There are cost savings in a number of areas, including IT, administration, trainings, marketing, outreach, public education, prevention and others. There are some disadvantages, including the need to develop consistency of philosophy and services across several offices that may not have come into the enterprise with similar ways of doing business.

Dana Cyra suggested that in addition to state funding, ADRCs need to look at what counties and local communities can contribute. Portage County has a history of a very high level of aging services, for example, which they should be expected to maintain. There is considerable county levy in ADRC and aging services, which discourages the formation of a multi-county ADRC with other counties. The ADRC also gets considerable services from the county infrastructure at no cost to the ADRC. If a regional model is wanted in their area, it would probably work best if other counties contracted with Portage to provide services.

Paul Cook moved that the Council recommend to DHS that ADRC funding levels be sufficient to allow ADRCs to carry out all functions and by a formula that takes into account population differences across counties (i.e., a base level of funding with add-ons for special needs). Carol Eschner seconded the motion, which was approved unanimously.

Pre-admission referral options

Carrie Molke led a discussion on pre-admission referral options, using handouts that had been emailed to members before the meeting. After considerable discussion, an informal poll of members found the most support for options two and five as presented in the issue paper.

Background on CLA closing

Judith Frye provided information on the history behind the closure of Community Living Alliance's health plan (Partnership program). She emphasized that CLA's other services are still operating. CLA had ten years of experience, but was always small, serving only adults with physical disabilities in Dane County. They got some differential rates to help keep them financially solvent. When rates were changed, CLA decided to use surplus funds to build a building. They tied up all cash, so were unable to meet cash reserve requirements of the Office of the Insurance Commissioner (OCI). CLA re-financed its mortgage with the state. They also volunteered to operate SSI Managed Care. Because of pent up demand for primary care, costs were always above revenues. CLA lost money and gave up the SSI Managed Care contract. By the fall of 2007, they were in a precarious financial position.

Many committed people provided care management at CLA, but they did not have close-knit interdisciplinary teams. Instead, various units of the organization tended to act independently; for example, the Personal Care Unit made independent decisions about the number of PC hours to be provided to members, rather than the Partnership care managers. They strongly expected members to self-direct and did not provide care management support when needed or wanted. There was also not enough focus on provider network development. In the 4th quarter of 2007, hospitalizations spiked, with resulting high costs compounded by the fact that post-hospital care largely occurred in step-down facilities because not enough in-home supports were available. This so badly compromised their already precarious financial condition that the OCI decided to

require the surrender of their HMO license. Within two months (a time frame required by OCI regulations), all members and almost all care management staff were transitioned to Care Wisconsin. Care Wisconsin and state staff worked very hard to make this a smooth transition for consumers.

Council business

Report from the Family Care Quality Committee. Carol Eschner reported that the committee held its first meeting in June. It was a good meeting, with considerable information provided and good participation by committee members.

Approval of 5/6/08 meeting minutes. The minutes were unanimously approved, on a motion by Devon Christianson, seconded by Paul Cook.

Announcements. Heather Bruemmer reminded members who do not have an organization behind them to cover personal mileage, that the state can provide assistance.

Future agenda items. In addition to those noted above, members suggested that the following items be included in future agendas:

1. Biennial budget issues
2. Standardization of information and processes used by ADRCs in options counseling, and education of Human Service care managers doing this function during the transition.
3. Status of the IRIS waiver

Meeting adjourned at 3:30 PM.