

**Wisconsin Council on Long Term Care
Meeting of November 3, 2009**

Approved Minutes

Members present: Beth Anderson, Pat Anderson, Judy Braun, Lynn Breedlove, Heather Bruemmer, Paul Cook, Dana Cyra, Tom Frazier, Bob Kellerman, Jennifer Ondrejka, Michelle Pike, Todd Romenesko, Chris Sarbacker, John Sauer, Stephanie Stein

Members absent: Devon Christianson, Carol Eschner

Others present: Lorraine Barniskis, Susan Crowley, Fredi Bove, Janice Smith, Donna McDowell, Sue Schroeder, Michael Blumenfeld, Peter Tropman, Bill Jensen, Dan Hayes, Maureen Ryan, Fred Buhr, Laurie Palchik, Gail Schwersenska, Fil Clissa, Lea Kitz, Paul Soczynski, Wayne Hagenbuch, Tim Garrity, Charles Jones

Chair Heather Bruemmer called the meeting to order at 9:30 AM.

Recommendations to Council from Family Care Quality Committee

In the absence of Carol Eschner, Chair of the Council's Family Care Quality Committee, Heather Bruemmer and Lorraine Barniskis walked through the Committee's recommendations on key areas of focus for oversight of Family Care quality. After some discussion, the voted unanimously, on a motion by Paul Cook, seconded by Chris Sarbacker to forward the following recommendations to Secretary Timberlake, asking her to respond with suggested next steps.

The following recommendations are intended to provide guidance to the Department of Health Services on key areas where DHS should focus its quality oversight of Family Care. The Council believes that the recommendations and findings in the recommended areas should also be used to educate MCO and ADRC governing boards and Regional LTC Advisory Committees about what questions they should be asking in their local oversight roles. The recommendations are made in the context of several considerations:

- Certification requirements establish minimal expectations that an organization must meet before opening for business. In a period of rapid expansion of LTC reform, the committee recognizes that quality expectations will and should increase as the system matures.
- There are many quality requirements and quality assurance processes that govern Family Care, including requirements in the contracts between DHS and MCOs, annual quality reviews conducted by the External Quality Review Organization (MetaStar), and federal requirements that apply both through the federal waivers that enable Family Care and through requirements for external review. Additional federal requirements apply to Family Care Partnership, which covers acute and primary services and is, for many members, funded partially by Medicare. The Council recognizes the value of all these requirements and processes, but believes that there are certain key "bottom line" areas where special attention should be paid.
- The success of LTC reform depends not only on the quality of MCOs, but also on the extent to which Aging and Disability Resource Centers provide good access to the system through counseling, enrollment and other roles for which they are responsible.

The Council recommends that, in addition to assuring that each MCO continues to meet certification requirements, DHS should focus its oversight on the following key expectations:

1. In the first two years of an MCO's provision of Family Care:
 - a. All services needed by members to assure health and safety are in place immediately upon enrollment and in case of a change in circumstances.
 - b. The MCO is making contact with new members within three days.
 - c. Members' care plans are in place within 90 days of enrollment.
 - d. Members' care plans are comprehensive, including identification of personal outcomes important to each member, and plans for supports to assist them in working toward achieving desired outcomes. The Resource Allocation Decision (RAD) protocol is being used appropriately throughout the MCO.
 - e. The MCO has processes in place to develop an organizational culture that embraces the philosophy and key principles behind Family Care at all levels, including member-centeredness, choice, respect, and the encouragement of members to be as self-directing and independent as possible.
 - f. The MCO has teams of care managers with core competencies; there is ongoing training and oversight of care management skills.
 - g. The MCO has systems in place to identify critical transition points for new and continuing members and to assist them in making these transitions. (Examples include transitions for young people from the children's service system, members transitioning from COP and Waiver programs or from the private-pay market, people making major changes in living situation, people being discharged from hospitals, people moving between Family Care and IRIS, and people making end-of-life decisions about where to die.)
 - h. The number and types of grievances and appeals, as well as other appropriate sources of information, are analyzed to determine whether there are patterns that might indicate problems to be addressed.
 - i. Analysis is done of service utilization (types and amounts).
2. As MCOs mature, DHS should continue to focus on areas outlined above, and add the following key expectations:
 - a. Members experience the best physical and mental health possible. (Among others, indicators might include the number of unnecessary hospitalizations, rates of immunization, assessments for risk of falls and prevention measures in place as needed, extent of mental health services provided to members who need them, prevention projects directed at depression, hypertension or other chronic conditions.)
 - b. Members' functional abilities are improving, or at least stable, within expectations for the Family Care target groups (analysis of changes over time in ADLs).
 - c. Members' personal experience (quality of life) outcomes are identified and supported, and success is evident in meeting outcomes. These outcomes include:

- i. Choice – the freedom and authority to choose among cost-effective options about where and with whom one lives the supports and services that one uses, and one’s daily routine
 - ii. Life activities – having relationships with family and friends; being treated fairly and in ways that make one feel respected; engaging in activities that give meaning or significance to life, such as employment or volunteer opportunities; being involved in one’s community to the extent that one desires; having stability in important living conditions; and having a desired amount of privacy.
 - iii. Health and safety – feeling comfortable with one’s level of health; and experiencing a feeling of safety, particularly from abuse or neglect.
- d. Analysis is conducted of the number of members using self-directed supports and the types of services that are being self-directed.
 - e. Analysis is performed on data about disenrollments and the reasons for them.

Issues in Family Care from the MCO perspective

The panel for this item included Paul Cook (Community Health Partnership), Michael Blumenfeld (WI Family Care Association), Tim Garrity (Western Wisconsin Cares), Wayne Hagenbuch (Care Wisconsin), and Paul Soczynski (Community Care).

Paul Soczynski walked through a handout showing that his agency experienced losses in Family Care and profits in Partnership over three years. Major challenges include transitions for care managers transitioning from the waiver system, issues with providers in trying to balance costs and quality, and policy issues related to county versus MCO responsibilities. Federal pressures are impacting Partnership, and the implications of federal health care reform could be major. He recommended that the focus during this time of rapid transition be on bringing care under management and attaining financial solvency. He also said that continued communication and education is needed.

Paul Cook said that the combined loss in 2009 of Family Care and Partnership will be about \$5-6 million, and his organization continues to lose money on Family Care. Significant amounts have been contributed from the Partnership reserves, to the point where the sustainability of Partnership and its HMO license are at stake. One major issue is the residential cost for people with developmental disabilities coming from the waiver programs. CHP is working on rate structures that assure that acuity levels of individuals are matched to the right settings. They are also reducing care manager caseloads and reducing other internal costs. There is no Family Care reserve at this point. There is concern that if we don’t fix capitation issues, the model will become the “managed care” model that many feared. He noted that DHS has worked out risk-sharing agreements with MCOs.

Wayne Hagenbuch noted that Care Wisconsin has contributed about \$9 million to the cost of expansion from its Partnership reserve; more cannot be contributed from this source without jeopardizing their standing with the Office of the Commissioner of Insurance. Their 3-year business plan indicates some light at the end of the tunnel. He noted that it takes time to educate care managers and get care plans into the model of what people need when they need it, and to get negotiated rates controlled. They are working with DHS to figure out ways to fill gaps until these two goals are under better management.

Tim Garrity noted that Western Wisconsin Cares is different from the other MCOs on the panel, in that it is a public Family Care District (La Crosse and seven other counties), and offers Family Care only, with no Partnership in the financial mix. They have on Family Care reserve remaining, and will lose about \$8-9 million this year. Seven of the eight counties in the District are very rural, with little depth in the provider network. They have been very challenged with trying to hire registered nurses. They project a small loss for 2010 and hope to be solvent by the end of 2012.

Other points raised in this discussion included:

- 1) It is a major challenge to realize the required system change from “funding off the shelf” to a more managed funding flow. In some cases, changes are needed in what kinds of providers are available in a given area.
- 2) Concerns exist that some MCOs are providing services in less integrated ways in order to fit costs into available funding.
- 3) All MCOs have contributed greatly and all are approaching issues in a problem-solving mode. DHS is revisiting questions about whether the projected 3-year break-even point is still a reasonable expectation. DHS had hoped to include previous losses in 2010 rates, but were not able to do so; there is still hope that this can occur with 2011 rates.
- 4) John Sauer expressed interest in seeing the 3-year business plans recently submitted to DHS by all MCOs to the extent they can be made public.
- 5) Stephanie Stein said that standardized residential rate-setting would cost Milwaukee money.

DHS Updates

- 1) Feedback on proposed charge to the Council for 2010. Council members suggested:
 - a) Be more specific about the connection between rates and quality
 - b) Include the issue of financial stability of MCOs
 - c) IRIS already has a very active advisory group that wants to be on the committee on self-directed supports across the system; the LTC Council should take only a minor role in this area.
 - d) Include the issue of preparedness of counties that are not yet in Family Care.
 - e) Add something about the adequacy of capitation rates, and give the Council a role in financial oversight of the system.
- 2) IRIS update: The number of enrollments to date is 1,122; of these, 42% are people with developmental disabilities, 33% are people with physical disabilities, and the remainder are elders.
- 3) Two vendors, Vestica and WPS, met qualifications for a third party administrator for Family Care claims payment. DHS hopes to have contracts in place by January 1, 2010.
- 4) About ten organizations responded to the RFI related to business systems for Family Care. Analysis is underway, with a target to finish by late November.
- 5) Changes have been made in the definition of pre-vocational services, consistent with the recommendations from the Employment and Managed LTC Task Force and CMS guidelines (see handout). Lots of misinformation about these changes has been floating around; Council members are urged to help correct the misunderstandings. It was noted that Disability Rights Wisconsin, the Board for People with Developmental Disabilities, and People First had all formally supported the DHS position on this issue.
- 6) Changes are about to be formally implemented through emergency administrative rules in the certification process for personal care agencies (see handout). The changes will allow agencies previously subcontracting with counties to get certification directly from DHS if a county stops being a certified provider.

Recognition of Tom Frazier on the occasion of his retirement

Heather Bruemmer presented a plaque to Tom Frazier expressing the Council's appreciation of his contributions over the years. Cake was served, Lynn Breedlove made additional comments, and Paul Cook contributed a song. Tom thanked the Council and said that despite challenges, we can still make good policy and good policy can be good politics.

Comments from the public

Fred Buhr, volunteer data entry clerk for the McFarland Senior Outreach Program, provided written and oral comments expressing concern about privacy issues related to electronic health records of elderly meal program participants.

Leah Kitts, ARC of Winnebago County, expressed concern the current process for Family Care claims, and said that the process under the new third party claims processors should include methods for prompt resolution of disputes. She noted that ARC had opposed Family Care in Winnebago County, primarily because it is under-funded and has the potential for reducing choice for consumers.

Rate setting for residential services

Charles Jones, DHS, discussed MCO support of room and board costs in residential settings. The level of support has to be cost-effective, has to be substituting for something more expensive and/or restrictive, and has to be documented on a case by case basis. Workgroups have been working to standardize the methodology for calculating the room and board portion of residential rates and the calculation of a member's ability to pay, and to systematize the method for documenting cost-effectiveness. Draft recommendations will go out for stakeholder comment very soon, and plans are to implement them some time in 2010. One goal of standardization is consistency across MCOs in how much a person will be charged for room and board.

Guardianship issues

Donna McDowell and Charles Jones discussed the issue of guardianship costs, working from a handout emailed prior to the meeting, and invited comments. Members had several comments, including that we need more volunteer guardians but that they need more support from the state level. Funding needs to be restored for CWAG's Guardianship Support Center.

Development of the Wisconsin Institute for Healthy Aging

Gail Schwersenska and Donna McDowell provided several handouts and talked about the development of a private, non-profit Institute for Health Aging. The vision is to provide a bridge between researchers and community organizations that could implement evidence-based prevention programs, including training in other states. On a motion by Bob Kellerman, seconded by Chris Sarbacker, the Council unanimously supported sending a letter of support for this project as part of the NIH grant application project. (This was later done.)

Council business

Approval of 9/1/09 meeting minutes. The minutes were unanimously approved, on a motion by Paul Cook, seconded by Bob Kellerman.

2010 meeting dates. The Council agreed to continue meeting on first Tuesdays of alternate months. 2010 meeting dates will be: January 5, March 2, May 4, July 6, September 7, and November 2.

Announcements There were no announcements.

Future agenda items. The following item was suggested for a future Council meeting:

- Information and possible Council position on legislation likely to be introduced regarding physician-ordered life-saving treatment

Meeting adjourned at 3:10 PM.