

## Long Term Care Redesign Overview

### I. West Central Wisconsin – Care Management Collaborative

The West Central Wisconsin – Care Management Collaborative (WCW-CMC) is a non-official group of nine counties and 3 private partners that have come together to respond to the Governor's proposal to develop a regional long term care system.

- The nine counties are: Barron, Chippewa, Clark, Dunn, Eau Claire, Pepin, Pierce, Polk and St. Croix.
- The three private partners are: Community Health Partnership (CHP), Group Health Cooperative of Eau Claire (GHC-EC) and The Management Group (TMG).

### II. Framework for Long Term Care Redesign in the Governor's proposal

Wisconsin has a long history of working with the Federal government to seek Medical Assistance Waivers to improve the delivery of long term care services. The Community Options Programs, started in the 1980's, and the Community Integration Programs established a county based system that has creatively used Medicaid funding to help long term care consumers stay in the community as long as possible. These programs evolved to serve frail elders and persons with physical and developmental disabilities. Unfortunately as funding became more limited, waiting lists developed that now total over 10,000 consumers. In the 1990's, Wisconsin sought Waivers for and established two new models of long term care – Family Care and the Wisconsin Partnership Program.

**Family Care** is a model in 5 counties which established a Care Management Organization that entitled services to all three major target groups. In these counties, people on waiting lists and many new applicants were able to receive services, as well as existing consumers. The service package offered includes existing county waiver services and some of the Medicaid card benefits. These include:

- Community services - personal and supportive homecare, day services, rehabilitation services, and work services;
- Residential care services – supported apartments, Adult Family Home, and Community Based Residential Facilities; and
- Institutional care – nursing homes.

**Wisconsin Partnership Program** is a private non-profit community based model in 6 counties. This voluntary program has existed along with county services as a choice for consumers. Partnership serves frail elders and physically disabled persons in a Care Management Organization. Partnership is an integrated service package because it integrates long term care services with acute and primary medical services in one package. It includes existing county waiver services, all of the services under the Medicaid card and all services under the Medicare card. These include:

- Community services - personal and supportive homecare, day services, rehabilitation services, and work services;

- Residential care services – supported apartments, Adult Family Homes, and Community Based Residential Facilities;
- Institutional care – nursing homes; and
- Acute and primary medical care – doctors, hospitals, and prescription drugs.

WCW-CMC and all of the Long Term Care Redesign consortiums in Wisconsin were encouraged by the State to use the experience of these two models in regional planning. The Governor has titled this effort as the expansion of Family Care. Regional planning groups need to offer at least the Family Care benefit package but can plan to offer a more integrated approach like the Partnership model.

### **III. Services in the redesigned system managed by Managed Care Organizations (aka Care Management Organizations)**

A Managed Care Organization will be a legal entity that is:

- Able to receive a capitated (per member per month) payment for all covered services.
- Able to bear the risk for payment for all covered services and has a risk reserve (money set aside) for unexpected higher expenses in any given year.

### **IV. Target groups to be served in WCW-CMC's initial planning efforts.**

- Consumers who are Medicaid eligible and meet a prescribed functional need screen.
- The three major target groups are frail elders and people with physical and developmental disabilities.
- Current planning in Redesign does not address children with disabilities and persons with primary behavioral health disabilities – such as mental illness and substance abuse.

### **V. Redesign Structure components must:**

- Meet the State goals of access, choice, quality and cost-effectiveness for consumers.
- Establish a Care Management Organization (CMO) and a separate Aging and Disability Resource Center (ADRC).
- Assure that there is a “firewall” or a distinct division between governance of the CMO and governance of the ADRC (because the ADRC assigns capitated rates to consumers).
- Have a CMO structure that will:
  - Respond to a competitive request by the State (required by the Federal government) to be selected as the CMO;
  - Be able to receive capitated rates for all eligible consumers;
  - Be able to bear the risk for all covered services;
  - Be able to contract with the range of providers needed to provide all covered services and to offer choice within those services for consumers.
  - Manage the care of consumers within a defined system of care management.
- Have an ADRC that will provide required core services, to include:

- Information and assistance to all people, including consumers, potential consumers, families, caregivers and others;
- Financial and functional eligibility determination for enrollment into the CMO;
- Elderly and disability benefits counseling;
- Long term care options counseling;
- Emergency referrals;
- Outreach and marketing;
- Short term care management;
- Identifying and making appropriate referrals regarding Adult Protective Services (Elder and vulnerable adult investigations and services, Chapter 51- mental health, Chapter 55 – protective services/placements, Chapter 880 – guardianships.); and
- Health promotion, prevention, and early intervention.

## **VI. CMO structure options being considered by the WCW-CMC**

There are three major CMO structures that WCW-CMC is considering. There are also variations within each of these structures to consider. The three major structures are:

- A group of counties and a private licensed HMO(s) create a new risk bearing organization with some form of shared governance.
- A group of counties create a new risk bearing organization with some form of shared governance.
- A private licensed HMO provides the risk bearing.

## ***Dunn County Community Redesign Meeting – June 22, 2006***

### **Participant Questions and Responses\***

1. *How did we get to the three models of structuring? (Group of counties and private licensed HMO(s) create a new risk bearing organization, group of counties create a new risk bearing organization, contract with a private licensed HMO)*

The 3 models seem to fit within the expectations of the State as we understand them to date. The 12 partners in the consortium see these as broad categories/models with many options and details to be discussed and determined in the future.

2. *What information can providers of services lend to the process?*

- Feedback on where we're going.
- Ask questions that keep us on track.
- Begin to think about how, in a managed care system, we can work toward:
  - i. Win-win outcomes for all parties.
  - ii. Avoiding adversarial relationships.
  - iii. Creative ways to change and improve our service delivery systems.
  - iv. Managing for quality and consumer outcomes.
  - v. A wide and deep provider network.
  - vi. Regional ways to improve the delivery system by identifying strengths and gaps and creating seamless services.

3. *Who manages the oversight?*

Quality management and oversight will be developed most likely through a governing board with consumer membership. We must develop a strategy to manage the risk. Other governing issues include determining how core values will be maintained, how quality of services and care will be managed, how profit and loss will be managed, and other issues (identified and yet to be identified).

4. *What is the timeline?*

Current goal is January 1, 2007.

5. *What happens if there is a different governor or change in legislature?*

This project seems to have deep bi-partisan support. It has been on the legislative "agenda" for about 10 years.

6. *Is there really enough money to do this? Can it really happen?*

Redesign is meant to create efficiencies in services through a variety of strategies. Pilot projects have shown success in managing the risk, improving consumer satisfaction and health, and reducing/eliminating waiting lists. There is momentum to make this happen.

7. *How do the developmentally disabled fair in this model?*

It will be different and change can be difficult. Data has been collected that supports moving in this direction with successful outcomes.

8. *How will staff be impacted? How will quality of care be managed? How will wages be determined?*

These are all serious considerations that are being included in the discussions.

\*The responses were primarily provided by Cheryl Huenink, Paul Cook and Tim Sheehan.