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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

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Tom Moore

WHCA
Wisconsin Health Care Association

December 20, 1996

Ms. Joyce Allen
Department of Health & Family Services
Office of Strategic Finance, Room 618
1 West Wilson Street, P.O. Box 7850
Madison, WI 53702

RE: PROPOSAL FOR REDESIGN OF WISCONSIN'S LONG-TERM CARE SYSTEM

Dear Joyce:

In response to DHFS' November 22nd request, WHCA has developed and submits the attached proposal for redesign of Wisconsin's long-term care delivery and payment system.

In developing our proposal, we retained the services of national consultants with extensive healthcare and managed care experience. They, and their experience and credentials, are identified on the attached enclosure.

WHCA believed the consultants' input and guidance was not only desirable but critical to assure the new system's operational design objectively and effectively honored the goals, objectives, and principles which have been the driving force for system reform in Wisconsin. We also felt their extensive expertise and experience in the development and operation of Medicaid/Medicare managed care programs elsewhere in the country would be of particular value in assuring Wisconsin's proposed system design effort recognized the strengths and weaknesses of other public and private sector managed care initiatives which have, to date, been considered or implemented in the field of long term care.

WHCA's staff and managed care committee worked closely with our consultants in developing the attached proposal. Our collective research and preparation for proposal development included a thorough review and discussion of essentially all of the system redesign material that has been previously developed and released by DHFS. That material included the department's internal "think pieces," its "Preliminary Views" papers, and all reports of the "Long Term Care Coordinating Council" and its three key steering committees.

Following that review, we have attempted to craft a proposal that meshes the articulated reform objectives with design features that have been found to be critical success factors in the development and operation of managed care plans. It is structured to provide a model which addresses and coordinates each of the "Key Elements for Redesign Models" which DHFS presented to the

Coordinating Council on November 22. It also attempts to speak to each of the specific questions the department posed within its written presentation of those individual elements.

Time constraints for proposal submission precluded us from submitting a more detailed depiction of the recommendations and options reflected in our model. Accordingly, please contact me or any of the consultants we have utilized if you have any questions or desire additional information regarding the form or substance of our proposal.

WHCA is most appreciative of the opportunity you and the department have afforded us to actively participate in the debate and discussion of long-term care reform over the past year. We especially appreciate the opportunity to present an operational blueprint for a viable means to achieve the objectives of the reform initiative. We look forward to continued participation in the review, discussion, and comparison of all proposals that are advanced and considered as the redesign effort moves forward.

Sincerely,

Thomas P. Moore
Executive Director

jjc

enclosures

CONSULTANTS
WISCONSIN HEALTH CARE ASSOCIATION
PROPOSAL FOR REDESIGN OF WISCONSIN'S LONG-TERM CARE SYSTEM

The following consultants were utilized in the development of WHCA's proposal for redesign of Wisconsin's long term care delivery and payment system:

SANDRA SMITH GOSS, RN, MPA is Vice president of SubAcute Care of America, Inc. Ms. Goss's extensive healthcare and managed care experience includes having developed and administered a fully capitated Medicare/Medicaid risk program for Sutter Health Systems in Sacramento, California, serving as Director of Managed Care for Hillhaven Corporation's Western Region, conducting state and national training programs on managed care for a variety of health care organizations and extensive clinical and administrative expertise in acute rehabilitation, home health, subacute care and skilled nursing. She possesses a unique combination of expertise in healthcare and marketing. She may be contacted at 1333 East Madison Avenue, Suite 206, El Cajon, CA 92021, phone (619) 441-8771.

JILL MENDLEN is President and CEO of SubAcute Care of America, Inc., and Director of Operations for Kennon S. Shea & Associates. Ms. Mendlen has a thorough understanding of operational-approached, managed care strategies, reimbursement issues and strategic direction for integrated post acute and managed care systems. She has experience in operational management of freestanding and hospital-based nursing facilities, including development of contractual relationships with HMO's, PPO's and other third-party payers and development of specialty clinical programs. She has a thorough understanding of the contemporary healthcare environment. She may be contacted 1333 East Madison Avenue, Suite 206, El Cajon, CA 92021, phone (619) 441-8771.

MICHAEL H. OWENS, MD, MPH created the contracting strategy and tools for CIGNA's CHMO, PPO, POS Plans, Government Health Care programs and all types of provider relationships (physician, facility, ancillary, etc.). Dr. Owens was Vice President of Government Health Care Programs for CIGNA Health Care of California and was responsible for developing, implementing, and the operational oversight of the Medicare Risk Program for the State of California and the Medi-Cal Program for the State of California inclusive of strategic development; budgeting; clinical program development; marketing; sales; and regulatory compliance (118,000 Medi-Cal lives). Dr. Owens served as the Chief Medical Officer of the Watts Health Foundation, Inc. He was responsible for the qualitative and quantitative features of health services provided by and through the Watts Health Foundation, including the 60,000-member HMO United Health Plan which includes 50,000 Medi-Cal lives. Dr. Owens received his MD and MPH at Yale University School of Medicine and Yale University School of Public Health, respectively.

JOSEPH M. LUBARSKY is a Certified Public Accountant, Partner and National Director, Long-Term Care Services, with BDO Seidman, LLP, Milwaukee. Mr. Lubarsky has over 20 years of experience consulting with long-term care providers. He possesses extensive hands-on experience in all aspects of financial management for long-term care, including budgeting, planning, reimbursement and feasibility. Over the past three years, he has focused on managed care, working with providers and associations relative to contract analyses, pricing issues, and development of cost accounting systems. He may be contacted at 330 East Kilbourn Avenue, Suite 950, Milwaukee, WI 53202, phone (414) 272-5900.

WISCONSIN HEALTH CARE ASSOCIATION

PROPOSAL FOR REDESIGN OF WISCONSIN'S LONG-TERM CARE SYSTEM

Wisconsin Health Care Association

December, 1996

Wisconsin Health Care Association

Proposal for Redesign of Wisconsin's Long-Term Care System

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STATEMENT ONE: STATEMENT OF PURPOSE

The purpose of this paper is to address the key elements of system design which must be considered in developing a managed care approach to Wisconsin's existing Medicaid long term care program. A national analysis of both existing and proposed managed care programs has been conducted to identify those design features which have been found to be critical success factors in both the development and operation of managed care plans.

In evaluating any managed care system, public or private, it is essential to keep in mind the basic tenet of managed care which is that **services are delivered in the most appropriate setting in order to achieve practicable social and clinical outcomes in a cost effective manner.** More specifically, the goals of any managed care program are:

- To eliminate care and services which are not necessary, thus achieving the most practicable possible outcomes for the given disease episode, chronic condition or social situation being addressed.
- To provide continuity of services thereby reducing or eliminating fragmented care furnished by providers whose efforts are not coordinated on behalf of the client.
- To provide services in settings which are the most appropriate to achieve realistic and desirable outcomes.
- To provide incentives for preventative care, early intervention and client education.
- To allow consumer choice (via provider selection) to drive quality issues and ultimately determine which managed care organizations are successful.

It is clear that the goals of managed care are strongly aligned with the goals of the Wisconsin long term care system redesign. Specifically, these goals are to provide coordinated case managed services that: a) are readily accessible; b) appropriate to the individual's needs; c) delivered in as economical and efficient a manner as possible; and, d) offer the beneficiaries the greatest degree of choice and involvement.

SECTION TWO: REVIEW OF KEY ELEMENTS OF REDESIGN MODEL

The purpose of this section is to review the key elements of the proposed redesign with particular emphasis on the strengths and weaknesses of each and to note current approaches being utilized in the design of effective managed care systems.

1. Eligibility

In order to avoid over medicalization of service delivery to individuals with chronic conditions, it is essential that eligibility for the proposed system be based on functional status rather than medical diagnosis. In addition, unless it is the intent of the State of Wisconsin to shift the Medicaid program from a means tested to an entitlement program, the potential client's financial status should play a key role in eligibility determination as well.

If program eligibility is restricted to only those individuals who meet the functional requirements for NF institutionalization (as they are defined today), services will not be available for frail clients who are identified as being at risk for institutionalization but who do not yet meet the current NF criteria. Aggressive screening and early intervention programs can prevent or postpone inpatient placement. The experiences of national demonstration projects such as the social health maintenance organizations (SHMO's) and the prepaid all inclusive care for the elderly program (PACE) point to the effectiveness of this approach in avoiding unnecessary institutionalization.

The most effective system would extend eligibility to those whose functional level is slightly higher than that required for NF eligibility. This provides the program contractor with an incentive to deliver community based services with the goal of preventing unnecessary institutionalization.

The scope of eligibility for any system consistent with Wisconsin's historical commitment to long term care should include all individuals who meet the criteria for long term care services regardless of age, medical diagnosis or living arrangement. The target populations would be:

1. Persons over 65 years of age
2. Pediatric clients (under 17)
3. MR/DD and disabled adults (18 to 65)

In the interest of practicality, the three populations should be phased in over time. The eligibility screening tool should be based, as previously stated, on the client's functional status.

The system should provide the opportunity for privately funded individuals to purchase, on a fee-for-service basis, the services of the Single Entry Point (SEP, see definition below). This would provide them with an overview of the long term care services potentially available to them. In essence, this is an information and referral service, offering the state three potential benefits:

a) Additional income to help offset costs associated with overall program administration;

b) Perception as a positive public service in helping seniors to identify what services are available within their community and offering them potential assistance in accessing the services of their choice; and

c) Delaying institutionalization for seniors who are able to make better and more appropriate use of community based support services as they become aware of the various options available to them.

2. Single Entry Point - (SEP)

The single entry point concept is efficient and promotes continuity of service delivery. The SEP organization should ideally be an entity which has experience in service delivery to the designated population. The services provided by the SEP should include:

- Determination of financial eligibility
- Determination of functional eligibility
- Assessment to determine level of care
- Beneficiary education relative to available services
- Consumer advocacy

One of the basic principles of managed care is that the entity at financial risk, not the SEP, determines the target outcomes. In this way, the managed care organization can assure the best possible outcomes by utilizing the most appropriate setting for the provision of care and/or services to their enrollees. One of the major problems with the traditional fee-for-service system is that providers, who are not at risk financially, are able to determine what care is provided without providing accountability that their increases in care expenditures generate proportionately better outcomes. Conversely, placing the determination of services and outcomes solely in the hands of any organization or individual outside the MCO creates another version of the old problem because service determinations are made by an entity which is not connected to the

revenue stream. For this reason, **the SEP should not engage in outcome determination, care planning or case management.**

Another basic principle of managed care is that no service can be provided which does not have an identifiable revenue stream. It is therefore critical that the funding source for the SEP program be clearly identified; separate and distinct from the funding earmarked for care and services.

To facilitate effective client education and informed choice in the selection of managed care plans, the SEP should consider the use of video taped presentations to explain the various options available. This solves the problems associated with illiteracy or poor reading skills often encountered when utilizing only written educational materials.

Adult Protective Services is not within the scope of any managed care organization and should remain as a government function. Certainly, all reporting requirements will apply to the MCO's and their contracted providers.

3. Geography

The noteworthy geographic feature in Wisconsin is the marked division of the state into distinct urban and rural areas. Extending a managed care program to rural areas is always problematic. The major rural issues are: a) an insufficient number of covered lives which makes capitation impractical; b) a lack of providers who are willing or able to deliver services; c) absence of adequate transportation systems to transport clients to service sites; and, d) the distances which must be traveled between clients by providers who deliver services in the home.

Unless these issues are addressed in the system's design, both in terms of adequate funding and realistic expectations for covered and deliverable services, it will be impossible for MCO's of any type, public or private, to succeed in Wisconsin's rural settings. As a result, provider-sponsored networks and/or a state or county MCO may be the most likely delivery systems to assume risk in rural areas. This is the approach utilized by the Arizona Long Term Care System and one which is under consideration by other states faced with similar problems in introducing managed care programs into rural areas. The caveat here is that these are new structures that lack experience in managing risk, designing and operating comprehensive information systems and performing effective case management. This would leave them vulnerable to financial and clinical failure. Therefore, phasing the program in over a period of time is highly recommended to allow the MCO to gain operating experience in the rural area.

Typically states have found it effective to initiate managed long term care programs in urban areas first and then expand into rural regions. MCO's that successfully manage care in the urban setting would likely then be more comfortable and have the experience and the expertise to take on the rural marketplace. In addition, by

expanding their geographic coverage, they increase covered lives thereby further spreading the risks associated with capitation.

4. Enrollment

Enrollment must be mandatory and the state must obtain a Federal 1915 Freedom of Choice Waiver for this to occur. Without this element, the benefits of a managed care system will not be realized. MCO's will need significant enrollment because if this is not achieved there will be too few covered lives to spread risk and insufficient purchasing power to obtain the necessary efficiencies and cost reductions required for the program to succeed.

To provide a smooth transition to the new system, new beneficiaries could be required to select a managed care option, while existing beneficiaries could have the choice between the traditional system or the new one for two years, after which time they must choose a managed care option.

If a newly enrolled beneficiary (for whom the mandatory enrollment requirement applies) fails to select a plan within a predetermined time period, they should be automatically defaulted into a managed care plan.

Once the beneficiary has been assessed by the SEP, their level of care determined and plan selected, the SEP should submit the beneficiary's name to the MCO. Organizations which have been effective in the management of high risk populations are quick to contact the new enrollee, conduct their own assessment of risk and begin the case management process. For example, Pacificare's Secure Horizons' Medicare risk plan has developed its own risk assessment tool, as has Sutter Health Systems, an Integrated Delivery System in Northern California which is at risk for a large number of Medicare lives. Such tools, adapted to the chronic, long term care population, would be important components in the Wisconsin system.

5. Covered Services

Since all covered services must have an identified revenue stream, the new plan should cover all services currently funded under various state and county programs. The capitation rate would result from a pooling of all current funding sources. Additional services could be added to the plan on a fee-for-service or co-pay basis through a purchasing cooperative formed by the various plans in conjunction with the state. A more detailed review of capitation payment mechanisms is found in Section 14.

The ideal system would integrate Medicare and Medicaid funding. This would provide for true continuity of care and allow at-risk organizations to manage services across the full continuum. Research shows that the majority of savings derived from Medicaid

managed care programs is the result of a reduction in acute hospital utilization. Therefore, there is an obvious need to combine Medicare and Medicaid funding. Physician co-pays and payments could be folded into the capitation payment. Integrated funding is problematic at present, as HCFA has stated that no integrated funding waivers will be granted in the foreseeable future. It is advisable to continue to monitor HCFA's position on this issue and strive for dual funding at the earliest possible opportunity.

Anecdotal experience from some PACE sites indicates that the payment of informal care givers can present serious problems related to skill levels, commitment and reliability of the care givers. As a result of these liability issues, the MCO should have the ability to authorize or deny payment for informal care as part of a beneficiary's specific plan of care.

6. Linkages

The key linkage mechanism for successful managed care organizations is a well organized, informed and empowered case management system. It is the case managers, using information systems, who have the "big picture" in the management of each case. Communication between various providers, regardless of the payor source, is facilitated by the case manager who follows the client throughout the continuum of care. For example, managed care organizations at risk for Medicare services often take an active role in monitoring non-Medicare services which are delivered to their enrollees. This enables them to keep informed as to the client's needs, to facilitate continuity of care whenever possible and to monitor the co-payments for which they are at risk.

As previously stated, the case management function in any managed care system must be performed by the MCO because it bears the financial risk, authorizes all services and is highly motivated to provide cost effective services in the most appropriate setting to produce desirable outcomes. It is an economic reality that bad outcomes of any kind (clinical, financial or social) result in increased expenditures for the MCO as well as a loss of enrollees who move to other plans when they are unhappy with the services provided.

The key to a good case management system is an information system which includes all the clinical, utilization, outcome and financial data needed to make effective decisions on behalf of the client. Data that must be captured and tracked in an information system includes, but is not limited to:

- client level of care
- functional status
- outcome measures
- service encounters

- social supports
- intensity of care directives
- required co-payments
- primary care physician
- utilization data (pharmacy, lab, diagnostics, etc.)
- in-patient days in acute and NF
- cost of service utilized in each care setting

7. Case Management

Placing the case management/care management function with an entity other than the at-risk organization makes it virtually impossible for that organization to manage its risk and control their medical loss ratio sufficiently to stay in business. It is unlikely that any private MCO, for profit or nonprofit, would agree to participate in such a program. This would leave only government agencies that might be willing to participate, but even their financial viability would be tenuous.

Case management in a successful managed care operation is achieved with the use of well trained, committed, highly ethical staff who have access to an information system that includes all the pertinent financial, clinical, and social data necessary to develop effective care plans for their enrollees. Ongoing communication with the client, the family, the physician and other care providers is essential.

Experienced managed care organizations have found that the educational background of case managers is less critical to their success than their personal characteristics, clinical experience and the quality of the training they receive from their organization.

The most effective case managers have proven to be RN's who have experience with the client populations being served (either frail elders, chronically impaired children or adults). In addition, they need to have a high level of commitment to serving their clients, the ability to handle multiple deadlines and priorities and an above average ability to establish rapport with a wide range of clients and providers.

Proper training and education of case managers is critical to the effectiveness of the program. The redesign of the Wisconsin system might include a statewide case management training program. To be effective, the case management function should be based on a case management policy and procedure manual or handbook which clearly defines all aspects of the Medicaid long term care plan, SEP assessment forms, covered benefits and all forms and policies necessary for successful, efficient case management to occur.

Examples of forms and policies which should be included in the program include:

- A tool for assessing clients for degree of risk for institutionalization
- An ongoing mechanism for identifying clients who need early intervention in order to avoid institutionalization
- A system for authorizing needed services
- A mechanism for communicating care goals with physicians and other providers
- A skills/experience/competencies check list for case managers
- A method for monitoring client visits to various physicians and resultant co-pays for which the MCO is responsible.
- A mechanism for monitoring services provided in home and community based settings.

8. Managed Care Organizations

Managed care organizations participating in the program should be required to meet the criteria set for at-risk organizations currently operating in the state. The most critical attributes for an effective managed care organization are:

- The financial and clinical ability to render the services for which they are at risk
- Experience with balancing the management of risk with the delivery of services, customer satisfaction and desirable outcomes
- Familiarity with the population to be served
- An established, efficient case management system
- A comprehensive information system with the ability to fold in the data necessary to effectively manage the population to be served
- Clearly defined quality assurance and member grievance policies.

Ideally, the MCO's in the long term care initiative should remain under the jurisdiction of the state agency which regulates all other managed care entities in Wisconsin. A

separate reporting relationship would create duplication and inefficiencies in MCO oversight.

A requirement for experience in areas such as the promotion of consumer participation and choice, a history of operation in the specific communities served and coordination of medical and social services may eliminate many experienced managed care organizations. As a result, many of the at-risk contractors may be newly-formed, provider-sponsored networks or local initiatives. Their lack of experience in risk management, case management and data systems may make joint venturing and alliances with existing managed care organizations a viable option.

9. Service Delivery Model

Managed care systems deliver services either directly via their own employees or by contracting with community providers utilizing a variety of payment mechanisms. The case manager, via communication with the client and the various providers involved, and following the client's individual plan of care, links the various services together, authorizing each before it is delivered. This process is used routinely by MCO's regardless of their organizational structure.

In the fee-for-service system, each provider controls the delivery of services in their specific area. The result is fragmented and sometimes duplicative or unnecessary care. In addition, there is no ability to integrate funding so that services are often of a restrictive or limited nature. In a capitated, case managed system, the MCO has a strong incentive to coordinate care and provide the most effective service at the most appropriate level. For example, in a fee-for-service system, a client may be under the care of three different physicians, each a specialist in their own area and each prescribing an antihypertensive medication for the client. The client complains of dizziness and is treated with yet another medication. The results are: 1) Poor coordination of medical care; 2) Greater chance for the client to experience negative outcomes; and, 3) Greater expense since each physician's visit is reimbursed by Medicare. If the individual were enrolled in the proposed managed care system, the case manager would be aware of the multiple physician visits since the MCO would be at risk for the required co-pay and would be tracking physician encounters. In this way, the polypharmacy issue would be identified and resolved resulting in the delivery of higher quality, cost effective care even though the Medicare and Medicaid funding streams were not integrated.

MCO's must be required to accept all eligible enrollees who select their individual plans. This eliminates "creaming" or gaming the system by accepting only the healthier members.

No effective managed care system should have a bias for or against any particular care setting. The traditional fee-for-service system pays primarily for institutional care and

has therefore pushed clients into more restrictive settings. Creating an equally strong bias against institutional care does not solve this problem, it merely shifts the direction of the bias. The best approach is to create a "site neutral" system which emphasizes providing the right care in the most appropriate and cost- effective setting.

10. Outcome Measurement

Volumes have been written on the appropriate outcome measurements for health service delivery systems in general and for managed care systems in particular. What is certain in all the dialogue is:

- Outcome measurement is an evolving concept in healthcare and the "ideal" system has yet to be developed.
- MCO's and integrated delivery systems of all types are developing outcome systems but most are in rather early stages.
- Collection of outcome data is extremely labor intensive and must be undertaken judiciously in order to be effective.
- Before data on a particular subject is collected, the managing entity must answer some hard questions including:

    1. Is there evidence to support a relationship between what is measured and its effect on the outcome?
    2. What is the value of the outcome to the fiscal goals? To the service delivery goals? To the mission?
    3. Is the organization reasonably able to collect the data?
    4. Is there a standardized tool and approach for data collection available so that information obtained is statistically relevant, objective and is judged against consistent factors?

It is a common mistake in organizations new to outcome measurement to rush forward with a long list of desirable measures without answering the above questions and setting reasonable priorities for choosing what to measure.

The following matrix is helpful in establishing priorities for outcome measures:

Priority Setting Matrix For Choosing Subjects In An Outcome Measurement Program

Outcome Category	Relationship of Subject Measured to Achievement of Desired Outcome	Value of Subject Measured to Mission of Program	Value of Subject Measured to Fiscal Goals of Program	Ease of Data Collection
Clinical Outcomes 1. 2. 3. 4.				
Functional Outcomes 1. 2. 3. 4.				
Fiscal Outcomes 1. 2. 3. 4.				
Satisfaction Outcomes 1. 2. 3. 4.				

1. Decide on an outcome category for each subject being considered for study.
2. List each subject under the appropriate category.
3. Rank each subject from 1 (low) to 3 (high) relative to the above items.
4. Total the scores.
5. Set priorities based on highest.

Source: Patrice L. Spath, ART, BA Forest Grove, OR

Using this matrix, a set of perhaps no more than 10 or 12 major outcome measures can be developed for the new long term care program, with more added periodically as the MCO's ability to collect and track data increases. Critical outcome measures could possibly include:

- Member satisfaction with the plan after the first quarter of enrollment, then after one year. This would include a uniform client self-report of health and functional status and a satisfaction survey given to all enrollees on a predetermined schedule.
- Number of grievances per month, per plan.
- Reduction, by a threshold percentage, in Medicaid dollars expended per enrollee per month at end of first quarter, then after one year.

- Thresholds for expenditures on home and community based services per member per month which would be at or below the cost of institutional care.

- Clinical outcomes could include measurements that are currently being used by MCO's, PACE programs, and SHMO's. These include: incidents of polypharmacy; incidents of falls; and, development of other conditions such as skin lesions and incontinence.

- Functional outcomes which would include a Functional Independence Measure (FIM) score following each episode of care, whether institutional or community-based.

- Utilization of preventative services as evidenced by number of routine diagnostic tests, e.g., mammograms, prostate exams, etc., or screens ordered per member per year and community health education activities conducted by the MCO.

- Average length of time spent with each potential enrollee by the SEP counselor.

- Member perception of the value and accuracy of plan information provided by the SEP.

- Average length of time between a request for an appointment with the SEP to eligibility determination and assessment.

- MCO satisfaction with the information provided to them by the SEP.

Outcomes to be monitored must be measurable with accessible, empirical data including surveys of customer perception of service. Unclear outcomes which cannot be objectively measured will only result in a waste of staff time and effort, increased frustration and ultimately failure. Examples of immeasurable outcomes include those with phrases such as "increased," "decreased," "evidence of," and other terms that are not sufficiently concrete to be measurable.

11. Choice and Participation

This is one of the most difficult issues to deal with in any type of health and social service delivery system and is particularly problematic in a managed care approach. Unquestionably, any managed care system limits consumer choice to some extent. That is, in part, how care is "managed." Ironically, however, it is consumer choices of plans which is the key to the quality of services provided and, in fact, the success or failure of any managed care organization. Still, consumers want as broad a choice of providers and services in a managed care plan as they once had in a fee-for-service system. In response to this demand for choice, many managed care plans have developed "point of service" (POS) products which allow consumers to go to providers outside the plan or to see specialists without a primary care physician referral. In return for this increased choice, consumers pay slightly higher premiums and co-pays. The principles of a POS product could be applied to Wisconsin's long term care redesign, as well.

It is important to keep in mind that the United States, which has given providers free choice in determining what and how services are delivered, has created one of the most costly, but not always most effective, health care systems in the world. A new system, giving free choice to the consumer, would be equally inadvisable because it is human nature for clients who are not paying for services to want as rich a service package as possible. In addition, clients are not always the best judge of which services will produce the best outcomes for them. For example, many frail elders refuse the notion of physical or occupational therapy since it can be both painful and time consuming. Yet this is the very service which helps to maintain functional status and subsequently, quality of life. Other clients may resent having a "stranger" (i.e., a chore worker or care giver) in the home, yet this service may prevent or delay institutionalization. These examples point to the fact that strong preferences and emotional attitudes can color consumers' service choices.

In an effective managed care system, the consumer has input and participation in the plan of care and services delivered, but does not direct or control their delivery.

Effective enrollee education regarding service and care options, as well as ongoing communication among the client, the MCO case management team and the providers giving care, serve to assure consumer involvement.

Beyond this, consumer satisfaction surveys, a user friendly grievance process and the openness of the case manager to the needs and concerns of the client, work together to empower enrollees.

Certainly participants in any program must have free choice in selecting a managed care plan. This is only curtailed in areas where there is only one organization

contracted for the provision of services. In order to avoid this situation and to give beneficiaries as much choice as possible, the new system should be designed to encourage and motivate managed care organizations to contract with the program.

12. Quality Assurance

Unquestionably there is a need for a clearly defined quality assurance program for any managed care system. There are two components of an effective quality assurance plan--internal and external quality assurance activity.

The key requirements of the MCO internal quality assurance function are:

- It must meet the requirements of the state agency regulating managed care organizations.
- It must emphasize the outcome measures which have been determined to be critical to the organization's success.
- It must be ongoing and include all areas of MCO operation.
- It must have a heavy customer satisfaction element.
- It must be supported and encouraged by top management in the organization and include employees at all levels.
- It must have a clear feedback loop by which findings are identified, plans of action developed and implemented, and follow-up completed to assure continuous quality improvement.
- It must be in writing, available to all employees.
- It must be an integral part of the MCO's culture.

The requirements of external quality assurance for an MCO are:

- It must be conducted by a third party accrediting body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the National Commission on Quality Assurance (NCQA).
- It must be consistent throughout all at-risk entities and providers in the system.
- Like the internal system, it must address the areas most relevant to the effectiveness of the organization.

The federal standards of Medicare risk organizations are quite stringent and could form the basis of a sound quality assurance program for the state's program contractors. In addition, JCAHO and the National Chronic Care Consortium have each developed standards and measurement tools to gauge the quality and effectiveness of integrated delivery systems. These could also provide valuable guidelines for both internal as well as external quality assurance functions for MCO's.

13. Transitioning to the New System

Most states that have moved their Medicaid programs into a managed care format have done so in phases and found this to be successful. A logical transition plan would include a phase-in by eligibility, enrollment status and geography.

Eligibility Phase-In:

The program could begin by covering those over 65 then move to pediatric eligibles and finally to MR/DD adults.

Enrollment Status Phase-In:

To ease the transition to the new system, currently eligible beneficiaries could have a two year "grace period" during which they could choose a managed care plan or the traditional system. After that time, enrollment in a managed care plan would be mandatory. Enrollment for new enrollees would take place immediately.

Geographic Phase-In:

Most programs of similar scope are initiated in urban areas where there are more covered lives, available providers and fewer access issues. They are rolled out into rural areas in a second phase.

14. Payment and Capitation

The purpose of capitation rates is to transform the state from a payor to a buyer of health care services. Risk is shifted from the state to the program contractors accepting the capitation rates. Capitation rates should motivate the program contractors to provide quality care in the most appropriate setting at the lowest cost.

It makes total sense to capitate primary, acute and post hospitalization services to the elderly. It is being accomplished in the traditional Medicare arena with the proliferation of Medicare risk contracts. Even relative to nursing home eligibles in the community,

the Medicare average adjusted per capita cost can and is frailty adjusted (PACE program and Minnesota Long Term Care Pilot).

Relative to Medicaid covered services to the elderly, it also makes sense to use a capitated approach. One method would actuarially establish a per member, per month rate based upon current utilization, encounter and cost data for both institutional care and home and community-based services. For example, current encounter data may indicate that for nursing home eligibles, 80% of long term care spending is for institutional care and 20% is for home and community-based services. The initial capitation rate may be set based upon that blend but if the relative proportion changes over time, the capitation blend will change. It is imperative that cost effectiveness tests be applied to non-institutional services and compared to the cost of institutionalization on an individual and aggregate basis, and that program contractors provide detailed encounter data and costs by unit of service.

Under any option, the lack of experience by all parties in Medicaid managed care for long-term care, and the lack of accurate cost and encounter data, makes it imperative that the state partner with the MCO's; sharing risk and reward. Cost savings would be shared with the state while, at the same time, if expenditures exceed capitation payments, the state will provide funding for some portion of the excess expenditures. Over time, the at-risk contractors would become fully at-risk as more accurate encounter and cost data becomes available.

Finally, it is important to understand that, as it pertains to long term care, savings from managed care and capitation approaches will primarily be generated from strict controls on eligibility and service utilization rather than on the price paid for care. For example, a research study by Laguna Research Associates estimated that service costs for the elderly in the Arizona Long Term Care System (which utilizes a capitated approach) were 18% less than they would be in a traditional Medicaid program. However, savings per unit of service delivered, (price savings) were only about 2% lower. Savings were derived almost entirely from providing services to 16% fewer people.