The Wisconsin Long-Term Care Coalition

Keep Our Care at Home

Talking Points for DHS Public Hearings on Long-term Care: Principles that must be the foundation of Wisconsin's future Long Term Care system

Keep what works well in our current system

a. Family Care has successfully supported people with complex needs in their own homes and community, and has reduced institutional placements. The new system must continue to operate in this way to ensure everyone is able to live in the community.
b. Provide services on a regional basis. Consumers benefit when services reflect the unique needs of the communities in which they live.
c. Maintain a strong self-direction option using the principles of IRIS.
d. Create a clear pathway for our existing Managed Care Organizations (MCOs) to become Integrated Health Agencies (IHAs).
e. Continue Wisconsin's nationally recognized Aging and Disability Resource Center (ADRC) model.
f. Don't let profits drive the new system. Our current system caps administrative costs at 5% and profits at 2%. These caps should not be lifted.
g. Maintain emphasis on facility and institutional downsizing.

Same services at the same levels

h. Current and future long term care participants should have access to all of the services that are available now.
i. Types and levels of service must be based on a comprehensive assessment of the individual's needs and goals.
j. Services should not be reduced, modified, or terminated without a documented change in the individual's needs or circumstances that can be independently reviewed and challenged by the individual with the assistance of an Ombudsman.

Ensure there is no financial incentive to place people in institutions

k. Include both non-institutional and institutional services in the capitation rate.
l. Measure and report placements into and transition out of nursing homes, state Developmental Disability centers and ICF-ID, and mental health institutions.
m. Incentivize transition from institutions back into the community and de-incentivize institutional placements.
n. Ensure high cost individuals have the right to live and be served in the community.

Ensure robust provider networks in all areas and allow participants to keep existing consumer-provider relationships

o. No matter where someone lives in the state, they should have access to the services they need and have a choice of providers.

p. Establish time and distance standards to ensure all needs can be met quickly and locally, and quality measures to assess adequacy of the provider network.
q. Specify remedies to build provider options in areas with inadequate capacity and articulate when IHAs are required to pay for out-of-network providers.
r. Protect existing consumer- provider relationships, and ensure continuity and coordination of care.
s. Predictability in rate-setting. Capitation rates must be sufficient to address participants' needs and maintain a quality provider network.

Pay-for-Performance and quality of life outcomes

t. Use performance-based payments and/or penalties to hold health plans and providers accountable. Health plans should be rewarded for activities such as placement rates for competitive employment, providing services in the community, and consumer satisfaction.
u. Support innovative options that empower individual participants to make decisions and are cost effective (assistive technologies, self-directed supports and care, creative agency scheduling practices, etc.)
v. Emphasize and reward health plans for integrated employment outcomes. Provide supports that enable integrated employment, such as personal assistance services, supported employment and peer support services.
w. Measure key experiences and quality of life indicators for participants (National Core Indicators, Council on Quality and Leadership, Program Operations Manual System).
x. Use person-level encounter data to ensure that all individuals receive quality care.

Self-Direction

y. Anyone eligible for long-term care should be able to self-direct their services.
z. People who self-direct must have full budget and employer authority. This means that people should be able to spend their budget how they want and hire the people they want.
aa. Provide ongoing support for people engaging in self-direction.

Person-centered Planning

bb. Person-centered planning must be holistic. This means allowing individuals to make decisions about their medical and non-medical services and supports, and includes services provided by both the IHA and those available in the community.
cc. The person drives the process and the care plan reflects the person's goals.
dd. The care team must include professionals and non-professionals, including individuals chosen by the participant.
ee. People must be given the ability to make decisions about their own lives, and allowed the dignity of risk.

Participant Protections

ff. A strong grievance and appeals process must be in place.
gg. Participants must know and be able to exercise their rights.
hh. A third party ombudsman program with a clear ratio of staff to beneficiaries must be available.