The Wisconsin Long-Term Care Coalition

Keep Our Care at Home

April 12, 2016

To: Sen. Alberta Darling and Rep. John Nygren, Co-Chairs, and Members, Joint Committee on Finance
From: Lynn Breedlove and Tom Frazier, Co-Chairs, Wisconsin Long-Term Care Coalition
Subject: Response to April 5, 2016 Legislative Fiscal Bureau Memo to JFC, and Recommended Action on DHS Family Care/IRIS 2.0 Concept Paper

As you know, the LTC Coalition released a 36-page *Stakeholders' Blueprint for Long Term Care Redesign* in late February with extensive suggestions for DHS to incorporate in its Family Care/IRIS 2.0 Concept Paper. When the DHS Concept Paper was released on April 1, we were pleased to see that the Coalition and DHS were in agreement in several important respects. (We list specific areas of agreement at the end of this memo.) But we remain concerned that the 19-page DHS Concept Paper is lacking in specifics in many crucial design elements of the future LTC system for the 60,000+ people who will rely on it.

Consequently, we support the option cited at the end of the April 5 LFB memo:

> ***"The Committee could also defer action on the plan until additional information or clarification is provided."***

In recent discussions LTC Coalition members have had with JFC members, several legislators have expressed concern regarding certain specifics which are not contained in the Concept Paper. While some lack of detail may be expected at this stage, the items we bring to your attention below are those that our members believe are too critical to leave unclear when the committee votes on the Concept Paper. We encourage the Committee to ask DHS for more specifics in all of these areas:

1. Justifying Substantial Disruption and Risk to Participants. Implementing Family Care/IRIS 2.0 will involve the disenrollment of over 60,000 people from the current Family Care and IRIS programs, and re-enrollment in a new program with new IHAs. This will put these people and their 100,000+ workers at significant risk. During the biennial budget session, DHS made the case that this risk and disruption would be justified because the new system will a) improve participant services and experiences in ways which appreciably improve health outcomes and community living outcomes for participants, and b) demonstrably save taxpayer dollars through quantifiable improvements in efficiency and effectiveness (in spite of the fact that the large majority of enrollees are Medicaid and Medicare eligible and Wisconsin will not benefit from Medicare savings). The Concept Paper does not clearly explain or document how either of these things will happen as a result of the proposed changes. DHS has also not explained how the planned phase-in process for the new system will be done to minimize the risk and disruption. A more thorough Plan would spell out the time that will elapse between each region's start-up, how the significant strain on ADRCs during enrollment will be handled, and how enrollees will receive proper notification and education before they have to make decisions.

2. Clarifying the Future of the IRIS Program. During the budget, both legislators and DHS made strong assurances to the 13,000 people in the IRIS program that "the IRIS program in Family Care/IRIS 2.0 will look just like it does now" when it is placed under the IHA umbrella. The Concept Paper does not reflect that.

- In the current IRIS program, DHS has clearly defined a uniform statewide mechanism for calculating individual budgets for each IRIS participant. DHS appears to be proposing that each IHA will be given the leeway to design its own budget-setting methodology for people who choose self-direction. The new system could have as many as 9 different IHAs and as many different ways to determine and implement self-direction budgets. This will inevitably result in inconsistencies across IHAs and "budget-shopping" by participants to see which IHA in their region will offer the highest individual budget; it could also result in a conflict-of-interest in which IHAs could set budgets low in order to increase profits.

-The sequence of the budget allocation and member-centered planning process has been changed significantly and the role of an IHA care management team in the process is unclear. This leaves IRIS participants unclear whether they will actually have real budget and employer authority.

-Aging advocates have raised concerns regarding how both the current and proposed budget mechanisms set budgets for older adults. These concerns have not been addressed.

-DHS has not confirmed that there will continue to be state certification for IRIS Consultant Agencies (ICAs), which provide support for self-direction. Without certification, there is no assurance that the entities that provide self-direction support will be qualified.

3. Three Regions and No Regional Map. DHS has cited "actuarial studies" as the basis for recommending three regions. Act 55 states that the new regions must have "sufficient population to allow for adequate risk management" and that each region must have "multiple integrated health agencies". Given that the legislature originally specified a minimum of five regions (later vetoed), it seems appropriate that DHS would disclose the results of the actuarial studies and show clearly why a greater number of regions is not feasible. Act 55 indicates that current MCOs will have a pathway to become IHAs. That would be more realistic if Family Care/IRIS 2.0 had more regions. For example, Wisconsin's Badger Care and SSI Managed Care programs each operate with six regions. With only three regions, the risk reserve requirements will be prohibitively high for most, if not all, of the current MCOs. We believe this violates the Committee's intent to create a pathway for Wisconsin-based MCOs to compete in Family Care and IRIS 2.0 and virtually guarantees that everyone currently enrolled in Family Care will lose their current MCO.

4. An Uncertain Future for LTC Provider Agencies. We are concerned that the hundreds of LTC provider agencies across Wisconsin have been put at risk in the planning process, which will also potentially exacerbate the critical direct care workforce shortage in the state. Most of Wisconsin's LTC providers are locally owned small businesses employing tens of thousands of workers statewide. Act 55 states that the current "any willing provider" requirement in Family Care (which protects providers from arbitrary exclusion from an IHA's provider network) will be preserved "for a minimum of 3 years". In the Concept Paper, DHS says that they "will assess the need to extend (this requirement) beyond the initial three-year period", but there is no indication of what the criteria for that review will be, or whether consumers, families, and advocates will have any say in the decision. DHS has not clearly stated what protections will be in place to ensure that every IHA will have provider networks that are adequate to meet the needs of enrollees.

5. Raised Expectations but No Clear Strategy for Behavioral Health Services. DHS has acknowledged that many of the approximately 50% of people currently in Family Care with behavioral health needs are not

getting those needs met. They have also acknowledged that not all of the current MCOs have adequate crisis service capacity. DHS has (laudably) indicated that they intend to improve on that in Family Care/IRIS 2.0, but the Concept Paper doesn't explain how. The reality is that many of the behavioral health services that people need are currently operated by county government. If those services are going to be available in the integrated model via the new IHAs, DHS needs to explain how that will happen.

Having listed the parts of the Concept Paper where we believe that more detail is essential before JFC can make an informed decision, we should also acknowledge our positive reaction to DHS' affirmation that certain important features of the current system will be maintained:

-Aging and Disability Resource Centers (ADRCs) will continue to perform the roles they have now
-Partnership Programs will continue to operate in the counties they are in now (and could expand)
-There will continue to be guidelines regarding maximum profits for IHAs (although there does not appear the be a limit on administrative costs)
-There will continue to be continuous open enrollment year round for Family Care/IRIS 2.0
-There will continue to be a key role for IRIS Consultant Agencies (ICAs)
-There will continue to be an independent, external ombudsman program

There are also a number of ideas in the Concept Paper which (potentially) could result in improvements over the status quo (some of which could be incorporated into the current LTC system), e.g.:

-A set of Guiding Principles which include many values that we support
-Readiness Reviews for the new IHAs (although we'd like to see more of the criteria spelled out)
-Including cultural competency in the Guiding Principles and in Readiness Review criteria for IHAs
-Clarifying DHS' intention for ongoing stakeholder engagement in LTC in the future
-An intensified approach to quality assurance (but there needs to be more quantifiable specifics to ensure that the the quality measures will actually lead to better outcomes for people)

In conclusion, we believe the stakes are so high in approving major changes to the LTC system for the 60,000+ people who rely on it that it is incumbent on the legislature to make a fully informed decision on the DHS Concept Paper. Notwithstanding the fact that there are some parts of the Concept Paper that we support, the Wisconsin Long-Term Care Coalition recommends that the Joint Finance Committee adopt the LFB option cited above and "defer action on the plan" until the crucial missing pieces that we have identified are added and/or clarified. We are committed to working with the Committee and the Administration to resolve the issues still outstanding.