

# **MANAGED LONG-TERM CARE AND THE FUTURE OF THE AGING NETWORK**

## **WISCONSIN FAMILY CARE**

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# OVERVIEW

- **Brief Background on the Wisconsin Family Care**
- **Major LTC Reform Proposals Regarding Wisconsin Family Care**
- **Issues, Challenges, and Opportunities**

# WISCONSIN'S LONG TERM CARE

- Total state LTC expenditure in 2012, \$2.64 billion (43% of overall Medicaid expenditures)
- Medicaid FFS residential stay in a nursing home,  
OR,
- Medicaid HCBS waiver services
  - County-operated “legacy waiver” programs
  - Managed LTC programs - Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE)
  - Self-directed long-term care - IRIS (Include, Respect, I Self-Direct)

# FAMILY CARE AND LTC IN WISCONSIN

- **Family Care**
  - A managed, Medicaid-only, long-term care program
  - **Structure**
    - Aging and Disability Resource Center (ADRC)
    - Managed care organizations (MCO), CMU, CM teams

# FAMILY CARE AND LTC IN WISCONSIN

	<b>BEFORE Family Care</b>	<b>AFTER Family Care</b>
<b>Waitlist</b>	<b>10,800 (1999)</b>	<b>0</b>
<b>Cost</b>	<b>50% higher than national average spending per Medicaid beneficiary</b>	<b>Less than FFS (average monthly costs \$452 lower per person in Family Care than FFS)</b>
<b>Nursing Home</b>	<b>Over 80%</b>	<b>32% in 2011</b>
<b>Hospitalization</b>	<b>-</b>	<b>Reduced</b>
<b>Satisfaction</b>	<b>-</b>	<b>Remain high</b>

# 2006-2010 STATEWIDE EXPANSION

- Senate Bill 653 in 2006 passed to expand Family Care
- Expanded from 5 to 53 counties
- Expenditures from \$248.4 million to \$936.4 million

Table 7

DHS Expenditures by Funding Source<sup>1</sup>  
(in millions)

	FY 2005-06		FY 2009-10	
	Amount	Percentage	Amount	Percentage
Federal Revenue	\$138.8	55.9%	\$645.0	68.9%
General Purpose Revenue	109.5	44.1	249.1	26.6
Program Revenue <sup>2</sup>	0.1	<0.1	42.3	4.5
<b>Total</b>	<b>\$248.4</b>	<b>100.0%</b>	<b>\$936.4</b>	<b>100.0%</b>

# 2015 LTC REFORM PROPOSAL

## ■ February

- February 3, Governor's 2015 - 2017 State Biennial Budget released including major changes to LTC
- Massive communication efforts by advocates including Wisconsin Long-Term Care Coalition

## ■ March

- Public hearings (3/18-3/26)

## ■ April

- Legislative Joint Finance Committee holding their own sessions
- Legislative Fiscal Bureau putting out budget papers

## ■ May

- Executive sessions
- Full Legislature approved on 5/27

## ■ July

- Governor signed into law (Act 55)

# 2015 LTC REFORM PROPOSAL (CONT)

## ■ September 2015

- 8 public hearings hosted by DHS
- Wisconsin Long-Term Care Coalition start working on the “Blueprint” document

## ■ February 2016

- Wisconsin LTC Coalition Blueprint released (2/15/16)

## ■ March 2016

- Concept Paper released by DHS (3/2/16)
- 2 public hearings (3/7/16)
- Wisconsin LTC Coalition’s response to the Concept Plan

## ■ Between now and future

- April 1, 2016 - DHS Submit concept paper to Legislature
- Upon Legislative Approval, draft waiver request
- Release waiver for public comment
- Submit waiver to federal government



<b>Original Family Care / ADRC / IRIS</b>	<b>Governor's Biennial Budget Proposal</b>	<b>ACT 55</b>	<b>DHS Concept Paper</b>
<b>FC: Medicaid and LTC services only</b>	<b>Integrate all – Medicare, Medicaid; acute, primary, behavioral, and LTC</b>	<b>Same as the governor's budget</b>	<b>Same as the governor's budget except – Medicare can be kept separate</b>
<b>FC: 13 regions, 7 MCOs</b>	<b>Statewide, insurance companies</b>	<b>Integrated health agencies (IHA) to run FC</b>	<b>3 regions; 3 IHAs per region</b>
<b>FC: competitive bid process /regulation</b>	<b>No competitive bidding process; DHS determines the insurance company to provide</b>	<b>Same as the governor's budget</b>	<b>DHS will use competitive RFP process</b>
<b>FC: limited to 2% surplus, 5% admin cost</b>	<b>No cap</b>	<b>No cap</b>	<b>No cap</b>
<b>ADRC</b>	<b>Eliminate</b>	<b>Keep</b>	<b>Keep</b>
<b>IRIS</b>	<b>Eliminate</b>	<b>Keep</b>	<b>Under FC - no self direction on acute/ primary, behavioral SVC</b>
<b>PACE/Partnership</b>	<b>Stay as they are</b>	<b>Stay as they are</b>	<b>Stay as they are</b>

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FC: limited to 2% surplus, 5% admin cost	No cap	No	Originally JFC proposed - 5 regions; 2 IHAs per region; provide pathways for MCOs to become IHAs - This was VETOED by the Governor
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# BIG QUESTIONS

- Integrated model of care - primary, acute, behavioral, and long-term care
  - Medicare FFS or Medicare Advantage, Opt-in or Opt-Out?
  - Can IHA manage all these services equally well?
  - What does “person-centered” mean?

# BIG QUESTIONS

- **Integrated Health Agency (IHA) and Regions**
  - New concept, no idea on how IHA should be regulated
  - IN - Private insurance companies
  - &
  - OUT - public/nonprofit MCOs
  - “Quality standards without enforcement”
  - No caps on profits or administrative cost
  
- **And many other issues**
  - IRIS
  - Engaging stakeholders

# ADVOCATES' PERSPECTIVES

- Recognize fundamental issues with the proposed new model
  - Where is the evidence that integrated M/M model saves money?
  - Can you still save money if many opt-out to keep their Medicare FFS?
  - If cost saving is major concern, why no cap on admin/surplus reserve?
  - More importantly, why fix something that is not broken, but rather working well?

# ADVOCATES' PERSPECTIVES CONT

- If we were to enhance the current model, let's make this right
  - Blueprint has specific questions, issues, and suggestions regarding developing the new model
  - Take additional time to design this right
  - Work with
    - JFC to address questions and concerns
    - US senators and representatives from WI
    - ADRC to get words out to consumers and families (current FC and IRIS care managers are prohibited to talk about these changes to their consumers)

# ADVOCATES' PERSPECTIVES ON GAINS SO FAR

- Revitalized advocacy community
- Motivated to think about ways to improve the current system
  - E.g., How can you coordinate care better?
- More attention / education on aging issues and public programs
  - Public
  - Legislators
- Recognize assets
  - History of strong collaboration between aging and disability community
  - Existing structure - ADRC, elderly benefit specialists
  - Re-activated advocacy groups



**THANK YOU.  
ANY QUESTIONS?**

# ADDITIONAL INFORMAITON

# WI LTC COALITION

## ■ WI LTC Coalition

- Formed in Feb 2015
- Over 65 individuals from over 40 aging and disability advocates and organizations
- Organized grassroots campaigns, meetings, active advocacy with JFC members, DHS, public, etc
- Drafted and issued Blueprint documents in Feb 2016
- 3 meeting (only selected individuals) with DHS since Jan 2016

# GOVERNOR'S 2015 - 2017 STATE BIENNIAL BUDGET PROPOSAL

- 1. Administration of Family Care program**
  1. Statewide instead of by geographic region
  2. No more oversight by the Legislative Joint Finance Committee over contracts
  3. No competitive procurement process, DHS determines who meets the criteria
  4. To be licensed and regulated by the Office of Commissioner on Insurance
  5. Preference given to entities providing health services
  
- 2. Integrate primary and acute health care services with long-term care benefits**
  
- 3. Eliminate**
  1. IRIS
  2. ADRC and replace with private entities
  3. Legacy Waiver COP Program

# 2015 WISCONSIN ACT 55

- 1. Family Care will be statewide**
  1. By January 2017 or a later date to be determined by DHS
  2. JFC wrote 5 regions (not statewide) but vetoed by the Governor
- 2. DHS will ask CMS to change the Family Care Waiver to:**
  1. Combine LTC, primary/acute health care, and behavioral health services in Family Care, and
  2. Be administered by at least two Integrated Health Agencies (IHAs) in each region.
  3. IHAs will be required to coordinate health care and behavioral health as well as LTC services.
- 3. The new Medicaid Waiver will include self-direction within the IHAs, as part of the “new” Family Care.**
  1. IRIS will no longer operate as a separate program.

# DHS CONCEPT PAPER TO THE JOINT COMMITTEE ON FINANCE: FAMILY CARE /IRIS 2.0

- 1.** DHS will contract with integrated health agencies (IHAs).
  - 1.** Wisconsin will have three Family Care/IRIS 2.0 regions and three IHAs will serve each region.
  - 2.** DHS will select IHAs through a competitive Request for Proposal (RFP) process.
- 2.** Dual-eligibles have the right to choose to obtain their Medicare benefits through fee-for service Medicare or through a managed Medicare program.
- 3.** There will be continuous open enrollment in Family Care/IRIS 2.0.

# DHS CONCEPT PAPER TO THE JOINT COMMITTEE ON FINANCE: FAMILY CARE /IRIS 2.0

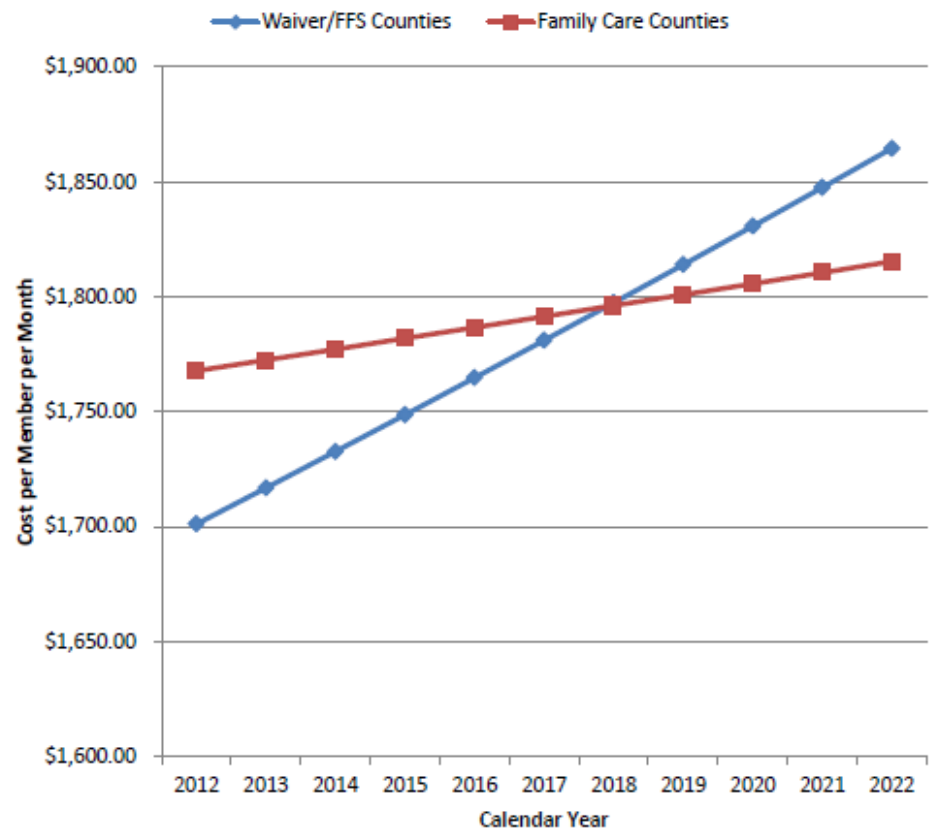
- 1.** Aging and Disability Resource Centers (ADRCs) will continue to provide unbiased enrollment counseling to assist individuals in making a choice of which IHA to select.
- 2.** Self Direct LTC Services
  - 1.** Members will decide whether to fully self-direct, fully managed, or have a blend of care management and self-direction.
  - 2.** No self-direct of primary, acute or behavioral services

# 2005 EVALUATION OF FAMILY CARE

## ■ APS Healthcare Report (2005)

- Eliminating waitlists (in 12 months)
- Decreasing length of hospital stays
- Higher ratings on consumer satisfaction compared to comparison sites
- Overall cost effective

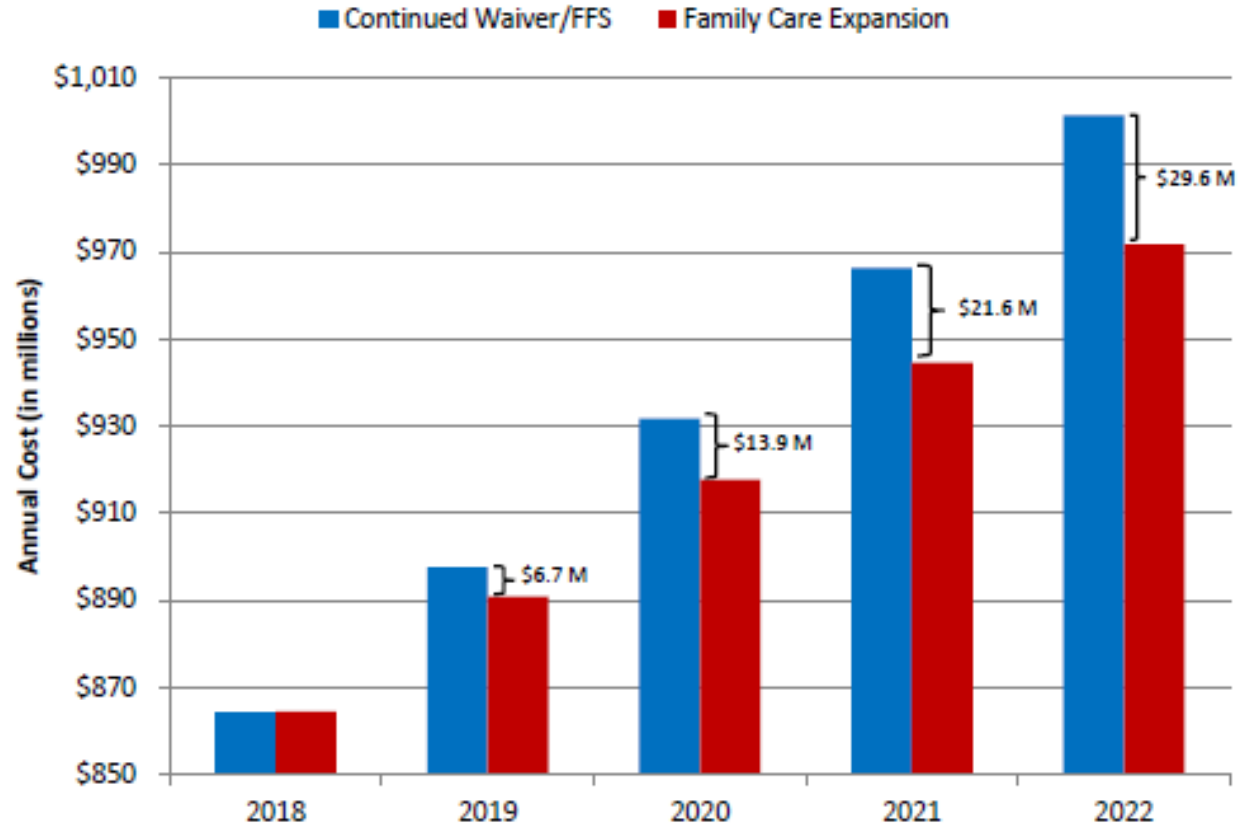
Chart 5: Projected Cost for Elderly, Blind and Disabled Members: 15 Waiver/FFS Counties and Family Care Counties





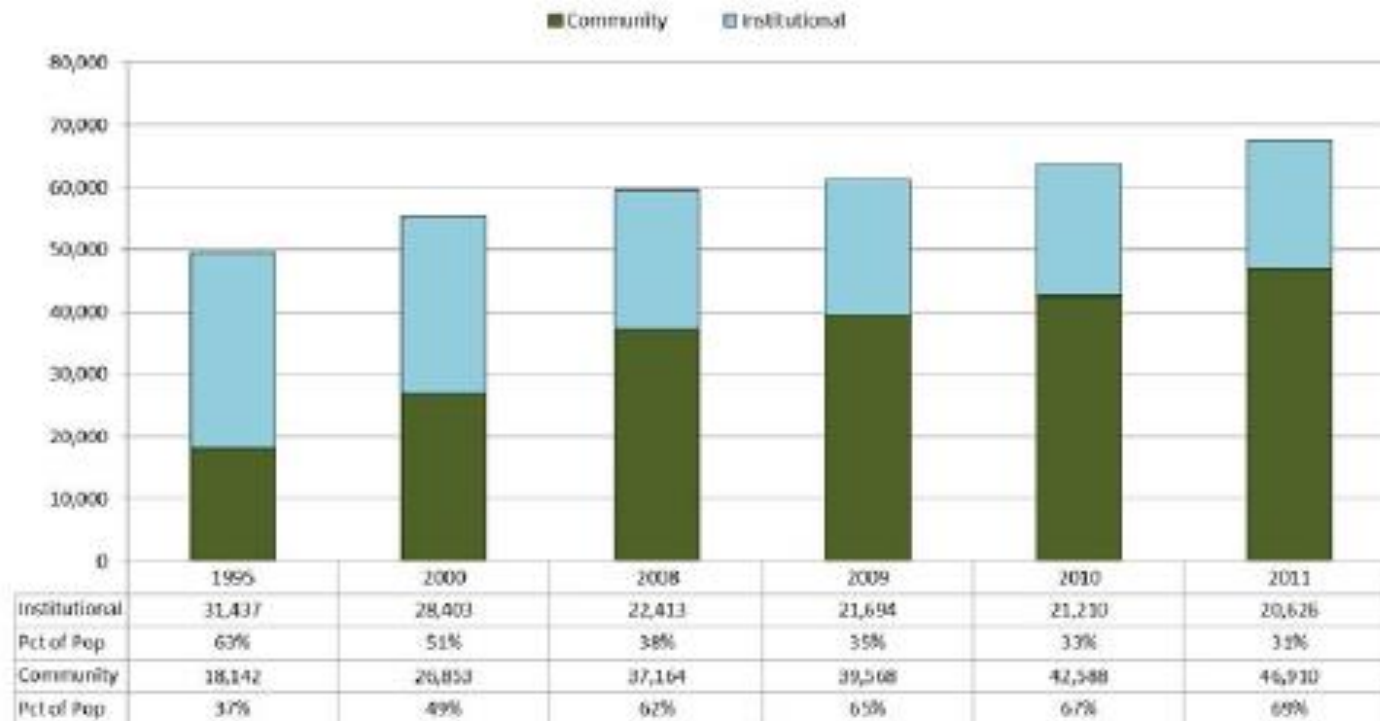
# FAMILY CARE IS LESS EXPENSIVE THAN FFS

**Chart 7: Comparative Cost Advantage of Family Care over Waiver in Waiver/FFS Counties**  
*(in millions)*



# SHIFT FROM INSTITUTIONAL TO COMMUNITY BASED SERVICES

**Chart 4: Publicly-Funded Adult Long-Term Care Population**  
**1995, 2000, 2008-11**  
*(end of year counts)*



\* Institutional population includes managed long-term care members residing in a nursing home or ICF-IDD.

# 2011 ENROLLMENT CAP

- Medicaid Programs Budget Shortfall (\$141M projected for 2012)
- Started enrollment cap in summer of 2011
  - On waitlist: 593 (60+), 1400 (18-59 with disabilities)
- Following the order of CMS, the state lifted the cap in late Feb 2012

# 2012 LONG-TERM CARE SUSTAINABILITY PROPOSAL

## ■ Rationale

- To address budget shortfall while lifting the temporary cap imposed in 2011

## ■ Major areas of proposed reform include:

- Reducing care management for individuals in residential facilities
- Reducing capitation rates
- Reducing administrative and care management cost
- Acuity-based guidelines for determining community residential services