The Wisconsin Long-Term Care Coalition

Keep Our Care at Home

Testimony in response to DHS Family Care/IRIS 2.0 Concept Paper - 3/7/16

I am testifying on behalf of the Wisconsin Long-Term Care Coalition, which includes over 60 organizations: most of the major aging and disability advocacy organizations representing people receiving LTC services, as well as managed care organizations, ADRCs , and other stakeholders.

Much to admire in the Concept Paper

There is much for us to admire in the Concept Paper. In many areas, the Dept. has reached a similar conclusion to that of the stakeholders in the LTC Coalition, as we have described our ideas in the *Stakeholders' Blueprint for LTC Redesign*. Our points of agreement include:

-all of the elements in your Guiding Principles (although we would add a few more),
-your reaffirmation of the legislature's decision to retain the current FC and IRIS benefit packages,
-your decision to proceed with an RFP process for new IHAs instead of certification,
-your commitment to have multiple IHAs in each region as one of the safeguards in the event that an IHA ceases operation in a region,
-your decision to use the National Core Indicators for the new system,
-your announcement of the development of IHA scorecards,
-your decision to ensure that anyone self-directing their LTC services will have access to an independent certified IRIS Consultant Agency if they want that,
-your clarification that IHAs will be clearly responsible for ensuring that participants' behavioral health needs will be met,
-your commitment to continue ombudsman services, and
-your decision to allow year-round open enrollment and transfer among programs and IHAs.

More Specifics

It will come as no surprise to you that there are many areas in which we would encourage you to be more specific in your revised version of the Concept Paper before it is sent to the Joint Finance Committee. This includes some of the areas I already listed as positives, where the general idea sounds good, but it is not fleshed out in your paper. Here are the areas where we encourage you to provide more specifics:

-add to the Guiding Principles: integrated employment, prevention, and access to services regardless of where you live
-clarify that the current financial and functional eligibility requirements will remain the same in the new system (you said that in your first press release, but not in the Concept Paper)
-add some clarity to the term "adequate provider network", i.e. in every service category there must be multiple providers in every county that actually have the capacity to take on new clients
-say more about the" IHA scorecards": will they include the same quality indicators that you refer to elsewhere in the paper? Will they be consumer-friendly, i.e. presented in a way that will be intelligible to people using LTC services?
-clarify your position re the ADRC roles that are not listed in the Concept Paper: information and assistance, advocacy, benefits counseling, and short term service coordination

-when IHAs are providing in-house consultation for people choosing self-direction, will the IHAs be subject to the same requirements the independent ICAs have to meet? Will the IHA be required to have dedicated staff with specialized training doing self-direction consultation?
-if you're not going to use the term "budget authority", will you explain what type of authority people who self-direct will have over their individual budgets? Will you add the term "employer authority" to the paper"?
-re people who are dual eligible, will you state more clearly that people will be assumed to obtain their health care on a fee-for-service basis at the outset, and that they can opt in to a Medicare Advantage Plan if they choose to?
-if IHAs will be responsible for ensuring that people have access to a full range of behavioral health services, can you explain how people will access county-administered CSP and CCS services if their county chooses not to contract with an IHA?
-can you clarify that the ombudsman services will be independent of IHAs, ADRCs, and providers?
-can you clarify whether you have any strategies for addressing the LTC workforce crisis?
-can you clarify whether you have any strategies to improve on the current unsatisfactory transportation situation that many people in the LTC system face?
-can you flesh out your idea of care teams? In the paper it isn't clear whether the participant a) is a member of the team, b) will drive the planning process, and c) has some say about who is on the team. Without that clarification, the care teams as presently described could violate the Guiding Principle of "person-centered planning".
-add to your list of factors for the operational readiness review a positive track record in the areas of self-direction, cultural competency, integrated employment, and dementia care

Some Major Concerns

1. A difficult path for the current MCOs. We believe that 5 regions with 2 IHAs per region would give the existing MCOs a better chance to compete to become IHAs. It would also be more consistent with legislative intent. Our vision of the future is one in which consumers would have a choice between Wisconsin-based managed care organizations and big out-of-state insurance companies. It would also be helpful to have some idea of the risk reserve requirements, so the current MCOs could begin to assess their possibilities for the future. Delaying the announcement of specific regional boundaries also perpetuates the uncertainty about the future for MCOs and consumers.

2. Quality standards without enforcement. We are glad to see the references to outcome-based quality review and the planned use of the National Core Indicators. But there is only mention of pay-for-performance incentives for good performance. There is no reference to enforcement, penalties, remediation strategies, or performance improvement plans for IHAs which demonstrate poor performance. We believe it is naïve to assume that pay-for-performance measures by themselves will ensure adequate quality for all consumers of LTC.

3. The possible sunset of the "any willing provider" requirement after three years. We understand that the budget language only required a 3 year extension of this requirement. But we know that this was a crucial protection for people when the state transitioned from a county-based system to Family Care. There were MCOs at that time who told some county-contracted providers (especially small ones) that the MCO had decided to leave them out of their MCO provider networks. This would have resulted in many people being forced out of their homes (when the group home or apartment was owned or leased by their provider), and many other people losing decades-long relationships with providers they knew and valued. The "any willing requirement" was the only thing standing in the way. If this requirement sunsets in Year 4, we fully expect that disruption to happen to thousands of people. There is also substantial concern that people will

not be able to retain their current physicians in the new system. In short, we consider the "any willing provider requirement" essential to preserving real choice in the new system.

4. A radical change in the IRIS budgeting process. The legislature promised that "IRIS will look just like it does now in the new system". There are four essential features of that promise: a) retaining a role for certified independent ICAs, b) budget authority, c) employer authority, and d) the unique IRIS budgeting process which has been refined over several years. The Concept Paper makes no reference to preserving any part of the current IRIS budgeting process, and instead it proposes a very different process in which people would be expected to develop their individual plan before their budget is calculated. That would leave people completely in the dark regarding the resources that will be available to them when they are asked to develop an individual plan. It also opens the door for the person to identify certain services in their plan and then the IHA gives them set dollar amounts for each type of service. This is much more like the Family Care budgeting process than the IRIS budgeting process. This would greatly reduce the spending flexibility available to the person (which is a key factor in people currently under-spending their IRIS budgets by 17%) and would amount to a violation of budget authority. We encourage the Dept. to retain a budgeting model based on the current IRIS model, as the legislature intended.

5. No responsibility assigned for keeping institution populations down. The paper says there will be required reporting of institution admissions and relocations. That's a good start, but what if an IHA has a trend of increasing institution admissions? What will DHS do? Will there any effective deterrent to that? What about people who want to move out of institutions? Will there be adequate funding to ensure that funding does not become an insurmountable obstacle? Who will be responsible for ensuring compliance with the "most integrated setting" requirement of the ADA? IHAs? Counties? DHS? The Concept Paper doesn't say. This is not only a concern for advocates. Recent CMS rules suggest that it will need to be clearly addressed in Wisconsin's waiver proposal later this year.

6. No caps on profits or administrative cost. During the budget, the Legislative Fiscal Bureau analysis of the governor's budget indicated that Wisconsin will have to adjust its capitation rates upward to meet the "profit requirements" of the insurance companies. How much profit can they make? How much increased Medicaid spending will that require? At what point will excess profits threaten the sustainability of the new system? Consumers are also concerned that excessive spending on administrative costs will deplete the portion of the funding that is left to pay for services. Can DHS give them any reassurance about that?

7. No indication of the new capitation rates. We understand that it is premature to expect specific capitation rates at this point, but it would be useful to know if people can expect comparable levels of funding for the LTC portion of their services to what they receive now, and to know what proportion of the revenues to IHAs will be allocated to LTC services (vs. primary and acute care).

8. Gradual phase-in. The Concept Paper does not clearly indicate that DHS will implement the first region and learn from all the inevitable start-up glitches before starting up the next region. Given the experience of expanding Family Care in various parts of the state a handful of counties at a time and encountering substantial start-up problems every time, it is easy to predict that going from 0 to 72 counties too quickly with a completely new system and new managed care corporations will result in huge problems.

9. Engaging stakeholders. The paper describes the stakeholder engagement to date, but it fails to mention that most of the people in the current LTC system never got clear notice of what was in the governor's budget proposal, what the legislature enacted, or what is in the current Concept Paper. We would encourage the Dept. to clarify its commitment to continue and expand the dialogue with stakeholders and consumers in the development of the new federal waiver, during the implementation phase, and beyond.

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Wisconsin Long-Term Care Coalition