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Long-Term Care Changes
(DHS -- Medical Assistance -- Long-Term Care)

[LFB 2015-17 Budget Summary: Page 211, #1]

CURRENT LAW

Family Care. Family Care is a managed care program that provides long-term care services to qualifying low-income individuals who are elderly, physically disabled, or developmentally disabled, and who are eligible for medical assistance (MA). Under Family Care, the Department of Health Services (DHS) pays each participating managed care organization (MCO) a monthly capitated, risk-based payment to provide services to enrollees in a specified geographic service region. The MCOs may either contract with providers or provide the services directly to Family Care members. There are currently nine regional MCOs offering Family Care. Family Care is funded from state general purpose revenue (GPR), county contributions, and federal MA matching funds.

To qualify for Family Care, individuals must meet certain financial and functional eligibility criteria. Financial criteria include meeting the income and asset limits applicable to elderly, blind, and disabled Medicaid enrollees. An individual meets the functional eligibility criteria if the person's functional capacity requires a nursing home level of care, which is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance, or supervision, or the person's functional capacity is at the non-nursing home level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others. To determine functional eligibility, individuals must submit to a functional screen. Functional screens are completed by aging and disability resource centers (ADRCs). These screens assess an individual's ability to complete activities of daily living and instrumental activities of daily living, and are used to assess the individual's care needs.

Family Care is currently available in 57 of the state's 72 counties. In November, 2014, the Joint Committee on Finance (JFC) approved expansion of the program to an additional seven counties in northeastern Wisconsin. These counties are Brown, Door, Kewaunee, Marinette, Menominee, Oconto, and Shawano Counties. These programs will be phased into these counties beginning in June, 2015, to be completed by the end of calendar year 2015. The eight counties that have yet to offer Family Care are Adams, Dane, Florence, Forest, Oneida, Rock, Taylor, and Vilas counties.

IRIS. The IRIS (Include, Respect, I Self-Direct) program provides a self-directed alternative to Family Care. To qualify for IRIS, individuals must meet the same financial and functional eligibility criteria as under the Family Care program. Under IRIS, members receive a budget allocation based on their assessed care needs. A service plan is developed, and IRIS members determine who will provide services specified under the care plan, as well as the amount they will pay to service providers. IRIS is currently available in counties that offer Family Care.

PACE and Partnership. Under PACE, which is currently available in two counties, and the Family Care Partnership Program, which is currently available in 14 counties, the state offers integrated services, including long-term care services, acute and primary care services, and Medicare services. Under PACE, individuals attend a PACE center on a regular basis to receive health and long-term care services, and the enrollee's primary physician must be member of the PACE organization. Under Partnership, individuals receive comprehensive services in their homes or communities, and are permitted to retain their current primary care physician. Under the PACE and Partnership programs, individuals are limited to a network of providers from which they may obtain their primary and acute care services.

Legacy Waiver Programs. Qualifying individuals in the 15 counties in which Family Care and IRIS are not currently offered may receive MA-funded long-term care services through the legacy home and community-based waiver programs. These programs are known as the legacy waiver programs because they are the long-term care programs that Family Care and IRIS replaced in other counties. They include the GPR-funded (non-waiver) community options program (COP-Regular), the MA-funded community options waiver program (COP-W), and the community integration programs (CIP-IA, CIP-IB, and CIP-II). The legacy waiver programs are supported from a combination of GPR-funded contracts between DHS and the counties, and county funding, both of which are eligible for federal MA matching funds. The MA waiver agreements CMS approved for the legacy waiver programs permit counties to maintain waiting lists for these programs.

GOVERNOR

Reduce funding by $14,336,900 (-$6,000,000 GPR and -$8,336,900 FED) in 2016-17 to reflect changes to the Family Care and IRIS programs. The Department of Administration (DOA) indicates that this reflects approximately one percent of current spending on Family Care, IRIS, PACE, and Partnership to reflect a conservative estimate of anticipated savings associated with the proposed changes to the state's long-term care programs.

The bill requires DHS to request a waiver or waivers to make changes to the administration of the Family Care program, the requirements of entities who administer the Family Care program, and the services offered under the Family Care program. Additionally, the bill eliminates long-term care districts and requires a self-directed service option to be provided under the Family Care program. These proposed changes are described below.

Statewide Provision of Services. Require DHS to submit a request for a federal waiver from the Department of Health and Human Services (HHS) allowing for the administration of the Family Care program by statewide MCOs, unless DHS waives this requirement for a specific MCO. Require DHS to request a federal waiver allowing for the elimination of the competitive procurement process for MCOs, and, if approved, to contract for the statewide provision of services with any MCO that meets the statutory requirements for providing services.

Self-Directed Services. Require DHS to allow Family Care enrollees to self-direct services. Repeal statutory references to IRIS program services offered to individuals receiving post-secondary education on the grounds of an institution, and replace with references to the self-directed option under the Family Care program. Repeal all other statutory references to IRIS, and replace with references to the self-directed option under the Family Care program.

Primary and Acute Services in Family Care Program. Require DHS to request a waiver from HHS allowing for the inclusion of any primary and acute health services mandated under federal MA law, such as physicians' services, inpatient hospital services, and skilled nursing home services, that the Department chooses to offer as a benefit under the Family Care program. If approved by HHS, allow DHS to offer the approved services under the Family Care program.

Family Care Open Enrollment. Require DHS to request a waiver from HHS allowing enrollees to change MCOs only during a specified open enrollment period and, if approved, implement this provision.

MCO Contracts and Oversight. Require DHS to request a waiver from HHS to remove statutory requirements for MCOs under Chapter 648 ("Regulation of Care Management Organizations"), which specify the requirements for applying for, issuing, and suspending or revoking an MCO's permit, the role of the Office of the Commissioner of Insurance (OCI) and the Commissioner in regulating MCOs, reporting duties of MCOs, requirements for responsiveness of MCOs to OCI, the ability of OCI to examine, audit, or otherwise study the operations of an MCO, the responsibility of MCOs for the costs of such examinations and audits, the ability of OCI to refuse to disclose information, including reports, records, and information obtained through reports and during examinations regarding MCOs, the ability of OCI to enforce relevant regulations, processes related to disclosing management changes, protections related to enrollees of MCOs, and processes for insolvency funding of MCOs. Eliminate the transfer from OCI's general program operations appropriation to the DHS appropriation for oversight of MCOs. Repeal OCI appropriations related to the costs OCI may charge MCOs for employing experts to examine or review transactions, and for other costs related to analysis and financial monitoring of MCOs by OCI under current law. Eliminate the appropriation related to collections of expenses for insolvent or financially hazardous MCOs. Allow OCI to apply statutory regulations related to insurance providers, including provisions related to solvency

assessment, accounting and reserves, rate regulation, insurance marketing, and other general public policy provisions applicable to insurers, to MCOs. Permit OCI to promulgate rules regarding licensing MCOs as insurers and regulating the operations of MCOs as necessary. These provisions would be effective July 1, 2018.

Prohibit MCOs from investing risk reserve funds in time deposits, or in bonds or securities issued or guaranteed by the federal government or by a commission, board, or other instrumentality of the federal government.

Eliminate the requirement that, as a term of a contract with an MCO, an MCO must contract for the provision of services covered under the Family Care benefit with any community-based residential facility, residential care apartment complex, nursing home, intermediate care facility for the intellectually disabled, community rehabilitation program, home health agency, provider of day services, or provider of personal care that agrees to accept the reimbursement rate that the MCO pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the MCO requires of other providers with which it contracts to provide the same service. Eliminate the ability of DHS to prohibit MCOs from including provisions in contracts with Family Care service providers to return any funding for residential services, prevocational services, or supported employment services that exceed the costs of services to MCOs. These provisions would be effective July 1, 2018.

Elimination of Long-Term Care Districts. Require long-term care districts existing on June 30, 2015, to be dissolved before June 30, 2017, or before a date established by DHS, whichever is later. Prohibit any new long-term care districts from being created after June 30, 2015. Remove all statutory language regarding and references to long-term care districts, effective July 1, 2018.

Contingency Provision. Require that, if any of the waiver requests specified above are not approved, the Department continue to administer the Family Care benefit in accordance with current statutory requirements.

DISCUSSION POINTS

Recent Changes in Wisconsin's Long-Term Care System

1. In 1995, the Department of Health and Family Services (DHFS, now DHS) began an initiative to redesign Wisconsin's long-term care system. DHFS, with significant input from steering committees, released a preliminary proposal for system redesign in 1997. This proposal included the following components: (a) local resource centers operated by counties and tribal agencies or, if no county or tribal agency was interested in operating a resource center, private, non-profit organizations, that would provide one-stop shopping for information, counseling, and access to many services and supports; (b) consolidation of the current long-term care programs (now known as the "legacy waiver programs," including COP and CIP) into one flexible, comprehensive benefit, including acute care services and Medicare services; (c) coverage of the elderly, younger adults with

chronic illness or physical or developmental disabilities, and children with long-term care needs through two benefit levels based on functional capacity, including a comprehensive level, which would offer institutional support, and an intermediate level (mental illness would be covered under a separate, but linked, benefit); (d) a cost-sharing component for individuals based on ability to pay, and a provision allowing private pay clients to receive services at costs comparable to those paid by the State; and (e) public or private entities that would operate care management organizations (MCOs), which would be reimbursed under a capitation system and that would initially share risk with the state, but would later assume a greater share of the risk. DHFS withdrew the proposal for further review after public hearings, during which significant concerns were expressed regarding the prohibition of counties from serving as MCOs and entry points, and concerns regarding the integration of acute and long-term care services.

2. Although the implementation of the initial system was delayed, the 1997-99 biennial budget act authorized DHFS to implement a resource center pilot program. Under this program, resource centers operating in pilot program counties were required to serve as information clearinghouses for individuals seeking long-term care services and perform assessments of functional eligibility.

3. The 1997-99 budget adjustment act authorized DHFS to establish an MCO pilot program, under which long-term care services would be managed. While acute and primary care services were not included in the benefit, the MCOs were expected to monitor and coordinate these services as well. It was anticipated that MCOs would be reimbursed on a capitated basis in the future, although lump sum payments were provided at the time. The pilot counties that would serve as MCOs included Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. This act also required DHFS to submit final drafting instructions to the Legislative Reference Bureau for a proposed system for long-term care reform by July 31, 1998.

4. The following provisions were included in the final proposal, which was released on July 31, 1998: (a) the program would serve all elderly individuals and adults with disabilities; (b) resource centers would serve as a single entry point for information and eligibility screens, in accordance with the initial proposal; (c) services that would be offered included those offered under the legacy waiver programs, as well as assisted living, supported living, and supported employment, and a provision allowing family members to be paid to provide care in certain circumstances; (d) enrollees would be provided options for receiving services, including community options, nursing home options, and other residential options; (e) qualifying individuals would be allowed to choose to direct their own supports; (f) an MCO would manage all services identified in a care plan, be responsible for establishing a network of service providers, and would be provided reimbursement by DHFS on a risk-based, capitated basis; (g) the legacy waiver programs would be eliminated where an MCO was available; (h) enrollees would be required to share in costs, ranging from 0% to 100% based on ability to pay; and (i) a state long-term care council would be established to represent and provide advice to the Governor and Legislature on behalf of long-term care consumers.

5. 2007 Wisconsin Act 20 authorized DHS to expand the Family Care program statewide in all counties that choose to participate in the program, but required DHS to notify the Joint

Committee on Finance (JFC) under a 14-day passive review process if DHS proposes to contract with entities to administer the Family Care benefit in "geographic areas in which resides, in the aggregate, more than 29 percent of the state population that is eligible for the Family Care benefit." The program has since been expanded according to the schedule in Attachment 1.

2007 Wisconsin Act 20 also established a formula under which counties are required to make contributions to the program. In the first year that Family Care is offered in a county, the county must contribute the same amount it spent in 2006 on long-term care services for clients who would have been eligible for Family Care at that time. If this first year amount is less than 22% of the county's basic community aids allocation (BCA), the county will continue to contribute this amount as long as it participates in Family Care. If the first year amount is more than 22% of the county's BCA, the county will lower its contribution by 25% of the difference each year for four years, until its yearly contribution equals 22% of its 2006 BCA.

6. The federal Centers for Medicare and Medicaid Services (CMS) requires that Medicaid recipients in need of long-term care be provided an option with respect to the delivery of these services. In a December, 2007, letter from CMS to DHS approving its waiver renewal application for the Family Care program, CMS indicated that if Family Care enrollees were not considered to have a choice between two entities for enrollment, "the State would be out of federal compliance." Wisconsin began providing such an option in July, 2008, through the IRIS (Include, Respect, I Self-Direct) fee-for-service, self-directed services program.

7. Under 2009 Wisconsin Act 28 (the 2009-11 biennial budget act), 3.0 full-time equivalent positions were authorized for the Office of the Commissioner of Insurance (OCI) to provide oversight of MCO financial operations. A memorandum of understanding between DHS and OCI was finalized in January, 2010, which specifies the responsibilities of OCI related to ensuring that financial audits are conducted and the insolvency risk of each Family Care MCO is regularly assessed.

8. The 2011-13 biennial budget act established an enrollment cap on the Family Care, IRIS, PACE, and Partnership programs for the 2011-13 biennium, preventing enrollment in the programs from exceeding the number of enrollees as of June 30, 2011, and only permitting enrollment of new individuals if a person seeking enrollment in the programs was living in an institutional setting, such as a nursing home or intermediate care facility for the intellectually disabled, for more than 90 days and the facility was not licensed, an emergency existed, or the facility was closing or downsizing. The Department indicated at that time that it believed that the Family Care pilot counties had achieved efficiencies from care management, but that some of the newer counties that had only expanded the program recently had yet to achieve such efficiencies. The administration indicated that freezing growth in the program would allow the Department to explore other, potentially more cost-effective programs, such as self-directed models and integrated acute and long-term care models, and to implement such models for providing long-term care services moving forward. This provision also required the Department to conduct a study of the cost-effectiveness of the Family Care program.

9. In 2011, CMS directed the state to remove the Family Care enrollment cap because the cap had not been approved as a part of the current Family Care waiver, and could not be

implemented until a waiver specifying that provision was approved. CMS directed the state to immediately enroll individuals who had not been permitted to enroll, but were eligible to the entitlement programs, following implementation of the enrollment cap. Consequently, 2011 Wisconsin Act 127 removed the Family Care enrollment cap. This act also repealed the Committee's authority to approve future expansions through the passive review process. Consequently, the Committee must vote to approve all expansions under current law.

10. In 2011, the state was selected under a competitive application process to receive funding through CMS's "State Demonstrations to Integrate Care for Dual Eligible Individuals" to design a demonstration proposal to structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. The state's proposal was referred to as "Virtual PACE," and was intended to provide Medicare and Medicaid-funded care to fully dual eligible individuals over age 18 residing in nursing homes to ensure better physical and mental health and quality of life for individuals residing in such settings, as well as to increase the cost-effectiveness of service delivery. The pilot was scheduled to begin in January, 2013, in the southeastern region of the state, with statewide expansion anticipated by the third year. However, after continued negotiations with CMS, the grant funding was withdrawn because an agreement could not be reached regarding the structure of the program. Concerns related to the proposal included whether an entity would be willing to serve this group, given the limited number of dually eligible individuals that would be served under the program.

11. In December, 2013, DHS submitted a report to the Joint Committee on Finance, which outlined the long-term care savings associated with the Family Care program in comparison with the legacy waiver programs. The report concluded that, if Family Care was made available in the 15-counties in which the program was not offered at that time, the state could save approximately $34.7 million (all funds) in the ten year period between 2013 and 2022 and that 1,600 people who were currently on waiting lists for community-based long-term care services in those 15 counties would receive services. The report ultimately recommended statewide expansion of the Family Care and IRIS programs to the 15 remaining counties.

12. In November, 2014, the Joint Committee on Finance voted to expand the programs to the seven northeastern counties, which will occur during calendar year 2015. The eight remaining counties that will not have Family Care and IRIS at the end of 2015 are Adams, Dane, Florence, Forest, Oneida, Rock, Taylor, and Vilas counties.

13. Table 1 shows enrollment in the state's long-term care programs by target group as of March, 2015, for Family Care, Partnership, and PACE, and as of December, 2014, for IRIS.

TABLE 1

Long-Term Care Program Enrollment, by Program and Target Group

	Frail Elderly	Developmentally/ Intellectually Disabled	Physically Disabled	Total
Number of Enrollees				
Family Care*	10,304	15,816	12,287	38,407
IRIS**	1,444	4,530	5,579	11,553
Partnership*	767	499	1,656	2,922
PACE*	344	37	264	645
Total	11,071	16,315	13,943	53,233
Percentage of Enrollees				
Family Care*	27%	41%	32%	100%
IRIS**	12	39	48	100
Partnership*	26	17	57	100
PACE*	53	6	41	100

*As of March, 2015
**As of December, 2014

Provision of Long-Term Care in Other States

14. Other states have adopted managed care models to provide long-term care services on both a regional and statewide basis. In Florida, long-term care was previously provided on a fee-for-service basis. In 2011, Florida adopted a new model for providing long-term care services, and in March, 2014, Florida enrolled the final region in its new statewide Medicaid managed care long-term care program. The new program consists of two components, a long-term care managed care program, which provides managed long-term care to enrollees, and a managed MA component, which offers primary and acute care services to enrollees. This program requires the following groups to enroll: (a) individuals who are 65 years of age or older and need a nursing home level of care; (b) individuals 18 years of age and older who are eligible for Medicaid due to a disability and need a nursing home level of care; and (c) individuals enrolled in certain waiver programs, including an Aged and Disabled Adult waiver, an Assisted Living Waiver, a Nursing Home Diversion waiver, and a Frail Elder Option, among others. Under the Florida model, individuals with developmental disabilities are served under a separate waiver. Services offered under the program include assisted living, adult day health care, personal care, and transportation. The program provides services on a regional basis, with different health maintenance organizations (HMOs) offering plans in each region. Recipients are permitted to change plans within 90 days of enrolling, for "good cause" reasons, or during an open enrollment period.

15. California, similar to Florida, previously provided services to some enrollees on a fee-for-services basis, and has since transitioned to offering a regionally-based, comprehensive managed care option. California adopted the Coordinated Care Initiative (CCI) in 2012 to integrate medical, behavioral, and long-term care services, as well as to provide increased potential for integrated care for dual eligibles (individuals eligible for both Medicare and Medicaid). The

initiative has two components, including a voluntary three-year demonstration program serving dual eligibles through a single health plan, and a managed care program that provides managed Medi-Cal benefits for most beneficiaries age 21 and older. These programs are only available in eight counties, and were offered beginning in 2014. The stated goals of the initiative include improving care coordination, and increasing service provision in home and community-based settings to create a sustainable, person-centered health care system.

16. New Mexico offers long-term care services through a managed care model known as Centennial Care. First offered in January, 2014, this program provides physical health, behavioral health, long-term care, and community benefits to eligible recipients. The program only provides acute care services to individuals with developmental disabilities, who continue to receive long-term care services under a separate waiver. Similar to the managed care programs provided in other states, under Centennial Care, individuals are permitted to change HMOs in the first 90 days, or during an annual open enrollment period. In addition, New Mexico offers Mi Via, a Medicaid self-directed waiver program that permits individuals to manage their own home and community-based services, supports, and goods within an approved care plan and budget.

17. While Iowa currently provides long-term care services to enrollees on a fee-for-service basis, the state is in the process of transitioning to a statewide, integrated care model. The Iowa Department of Human Services issued a request for proposals in February, 2015, seeking two to four organizations to provide comprehensive, managed services on a statewide basis. The intended goal of the project, entitled the Iowa High Quality Health Care Initiative, is to create a system of care that "delivers efficient, coordinated and high quality health care that promotes member choice and accountability in health care coordination." The new program will serve most Medicaid populations, including most individuals eligible for long-term care services. The program will include medical services, facility-based services, and home and community-based services, but will exclude dental services. The program is expected to be effective January 1, 2016, pending approval of a waiver by CMS.

Long-Term Care Changes in the Governor's Budget Bill

The following sections discuss policy and fiscal considerations related to the proposed changes in the bill

Statewide MCOs

18. Currently, nine MCOs offer the Family Care benefit on a regional basis, providing services to individuals within specified geographic service regions. Entities that offer the Family Care benefit consist of nonprofit organizations, private insurers, and long-term care districts. A long-term care district is a local unit of government created with the purpose of operating an MCO or an ADRC. A long-term care district is overseen by a long-term care district board, and has jurisdiction within the county or counties that created it, or the geographic area of the reservation of the tribe or band that created the district. There are currently seven long-term care districts, four of which are Family Care MCOs, one of which operates an ADRC, and two of which have no contract with DHS.

19. Certain geographic service regions overlap, offering individuals residing in those areas the choice between MCOs. Attachment 2 shows the current geographic service regions, and the MCOs that serve each region. Under current law, the Department solicits bids from organizations under a competitive, sealed procurement process to administer the Family Care benefit in a particular geographic service region.

20. The Governor's bill would permit DHS to contract with entities to offer the Family Care program statewide, unless it grants a waiver to a particular MCO to offer the Family Care benefit in a specified region of the state. The bill would eliminate the competitive, sealed procurement process by which the Department currently solicits MCO contracts, and permit the Department to contract with any provider that meets the requirements of MCOs to offer the Family Care program. Additionally, the bill would require long-term care districts existing on June 30, 2015 to be dissolved before June 30, 2017, and would prohibit new long-term care districts from being formed after June 30, 2015.

21. The Department has indicated its intent to contract with between two and four entities to offer the Family Care benefit on a statewide basis, rather than to allow for regional exceptions to this model. It also notes that it does not oppose current MCOs operating under the new model, as long as these entities meet the requirements for MCOs proposed in the bill. However, under the Department's interpretation of the current statutes relating to long-term care districts, MCOs operated by long-term care districts could not transition to the new integrated model. Further, the current MCOs would likely be unable to meet the risk reserve requirements of of the new integrated care organizations.

22. It is not known how many entities would choose to offer services on a statewide basis. The Alliance of Health Insurers, U.A., an association of insurance providers including Anthem Blue Cross and Blue Shield of Wisconsin, Humana, Inc., UnitedHealthCare of Wisconsin, and Molina Healthcare of Wisconsin, has indicated support for the Governor's recommended changes, but has advocated that the policy be modified to allow for the provision of integrated services on a regional basis.

23. Currently, there are no HMOs that offer Medicare or Medicaid services on a statewide basis. The BadgerCare Plus HMOs offer services in selected counties, as do the SSI managed care organizations. It has been argued that providers in some areas of the state may be reluctant to contract with a new integrated care entity due to their longstanding relationships with current HMOs.

24. Current MCOs indicate that the Family Care program was created with the intent of having MCOs offer services in regions of the state because the MCOs would be most familiar with local conditions and resources available within the region each MCO serves. They cite as reasons for a regional model: (a) the strong relationships they develop with local providers and the ability to ensure the availability and quality of the provider networks; (b) a knowledge of community resources that allows them to use natural supports to provide many services, which they believe improves customer satisfaction and reduces costs; and (c) the ability to have local offices and a regional presence, which increases their understanding of the culture and specific needs of clients in each region.

25. Opponents of the Governor's proposal cite the state's experience with the statewide contract for the provision of non-emergency transportation services to MA recipients as an example of some of the problems that could result if the state adopted a statewide contract for integrated, comprehensive health services. Several years ago, the state chose to discontinue the provision of these services on a fee-for-service basis and instead contract with a single vendor that receives capitation payments to manage non-emergency transportation services. This change was intended to achieve cost savings by improving the coordination services, enabling the state to receive greater federal cost-sharing for some transportation services previously provided by counties, and taking advantage of economies of scale in the delivery of these services.

On May 12, 2015, the Legislative Audit Bureau (LAB) released an audit of the state's non-emergency transportation services program, which was requested in response to complaints about access to rides, long wait times, and drivers who were late for pick-up. The LAB recommended that DHS implement additional standards regarding the number of provider no-shows and late arrivals that would be permitted, as well as additional performance standards with respect to hold times and dropped calls.

Changes to MCO Regulation

26. Under current law, MCOs are regulated by both OCI and DHS. MCOs apply for a permit from OCI, which monitors the solvency of the organization through receiving financial statements on at least a quarterly basis, conducting financial examinations on a rotating basis, and reviewing significant business plan changes. DHS is responsible for oversight as it relates to member quality of care and safety. DHS is also responsible for setting the annual capitation rates paid to MCOs and must ensure that these rates are actuarially sound to comply with federal law.

27. The Governor's proposal would require the new statewide entities to be licensed as insurers by OCI, including obtaining an insurance license to operate as an HMO. The new integrated care entities would be required to meet the financial requirements to which HMOs are currently subject. OCI indicates that entities seeking to be licensed as an HMO are subject to more complicated and substantive financial requirements than those that apply to MCOs.

28. Table 2 compares the financial requirements of organizations under current policy, with those of licensed HMOs, as would be required under the Governor's proposal.

TABLE 2

Financial Requirements of MCOs under Current Law, Proposed Changes
(As reported by OCI)

Description	Current	Proposed
Working Capital	3% of annual budgeted capitation	$750,000
Reserves	A tiered percentage of annual budgeted capitation, as specified in administrative rule.	Required surplus would be the greater of $750,000 or an amount equal to 3% of premiums earned in the previous 12 months. Security surplus would equal the compulsory surplus plus 40%, reduced by 1% for each $33 million of premium in excess of $10 million, or 110% of its compulsory surplus. Risk-Based Capital – Would be 300% or higher. The company action level is triggered when risk-based capital is below 300% with negative trend or if below 200% without a negative trend.
Solvency Fund	The greater of $250,000 or the amount stipulated in the DHS contract (currently $750,000).	HMOs are required to maintain the same compulsory surplus as other insurers under s. 51.80 or demonstrate that in the event of insolvency the following would be met: (1) enrollees hospitalized on the date of insolvency will be covered until discharged; and (2) enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or pre-existing limitation requirements.

29. It is likely that some of the current MCOs could not meet the reserve requirements for HMOs. As an example, OCI indicates that the requirements of insurers must, by nature, be more robust to ensure that these entities have sufficient reserves to account for the risk they incur associated with providing acute and primary care services. OCI indicated that when recent HMOs have become insolvent, they have had sufficient reserves to make creditors whole, while MCOs have not.

Primary and Acute Care Services

30. Under current law, Family Care and IRIS enrollees receive their long-term care services from these programs, and continue to receive acute and primary care services as MA "card services" on a fee-for-service basis. Enrollees in the state's long-term care programs that are eligible for both Medicare and Medicaid ("dual eligibles") receive many acute and primary care services through the Medicare program, with cost sharing requirements for certain dual eligible enrollees funded by the state Medicaid program.

31. Under the bill, the new, statewide MCOs would be required to offer primary and acute care services under the Family Care program, although the bill does not specify which primary and

acute care services would be offered by these entities. The bill also does not specify the new MCO's role with respect to providing Medicare-funded primary and acute services. Finally, the bill does not specify whether an individual would be required to have his or her primary and acute care services managed as a condition of receiving home and community-based long-term care services currently available under the Family Care and IRIS programs.

32. The MCOs argue that, under the current Family Care program, MCOs have a strong incentive to coordinate their members' acute and long-term care services care services, even though they are not responsible for providing or funding acute and primary care services. They indicate that care coordination improves the member experience, reduces the likelihood of long-term nursing home stays, and improves the member's overall health, which may limit other long-term care services that may be needed.

In its 2013 Long-Term Care Expansion report to the Committee, DHS noted that, "The impact of Family Care's service and funding models reach beyond the services that managed care organizations manage directly: the average cost of physician, hospital, personal care, and other acute and primary care services for Family Care members have also declined over the last three years." Because the Department has indicated that primary and acute care savings have already been realized due to the integrated care that the MCO provides, even though primary and acute services are not part of the Family Care benefit, it is unclear what additional savings would be realized or other benefits gained from the integration of these services.

33. Current Family Care enrollees have expressed concern that the bill may result in their needing to change their current primary and acute care services providers. Others are concerned that individuals may choose not to receive long-term care services under the proposed Family Care program if they are required to change primary or acute care service providers, or if they are required to have their acute and primary care services managed as a condition of receiving home and community-based services. The provisions in the bill do not specifically address these issues.

34. The current Family Care MCOs note that they have evaluated the possibility of explicitly including acute and primary services under the Family Care program. However, they cite concerns regarding obtaining the necessary insurance licenses, as well as the need to limit individuals to a provider network from which they may obtain primary and acute care services, associated with such a change.

35. In addition to the potential changes associated with provider networks, it is unclear the potential impact of the proposed policy on management of care for dual eligibles. Under federal law, states are prohibited from mandating that Medicare enrollees receive their Medicare-funded services in a managed care format. It not known whether the provisions in the bill, or any waiver agreement negotiated with CMS, would affect Medicare-funded services.

Any Willing Provider and Open Enrollment

36. Under current law, MCOs are required to contract with any provider that is willing to provide services at the MCO's rates that satisfies the MCO's requirements relating to quality of care and other criteria to which other providers that provide the same services are subject. In practice,

this provision prevents MCOs from excluding certain providers from their networks if those providers meet the MCO's quality standards and price requirements.

37. Under the bill, the "any willing provider" requirement would be repealed, allowing the new, statewide entities to contract with a limited number of providers to provide services to program enrollees.

38. OCI indicates that the any willing provider provision may increase an MCO's costs, in that it requires increased administrative expenses by an MCO to operate due to the coordination of a broader network. Therefore, eliminating this provision may lead to increased administrative efficiencies by permitting the new, statewide entities to contract with a limited network.

39. On the other hand, it could be argued that the unique needs of the populations enrolled in the state's long-term care programs require that they have access to a broad network of service-providers, including different specialists of which there may be a limited number providing services in the state, and that the elimination of this requirement removes a degree of choice and flexibility that improves the provision of services to this population.

40. Under current law, Family Care, PACE, Partnership, and IRIS enrollees are permitted to enroll or disenroll from an MCO at any time. Under the bill, the Department would be permitted to establish an open enrollment period, during which program enrollees could change entities in which they are enrolled. Enrollees would not be permitted to change MCOs except for upon an eligibility determination or during this period. The bill does not specify when the open enrollment period would be, or how often the open enrollment period would occur.

41. It may be argued that establishing an open enrollment period is consistent with other health plans, including the state's other Medicaid programs, and that individuals enrolled in the state's long-term care programs should not be exempt from the requirements to which other enrollees are subject. Conversely, it could be argued that the unique and changing needs of individuals enrolled in the state's long-term care programs require flexibility to enroll in and disenroll from programs at will, such that these enrollees have the flexibility to move among programs as their care needs change.

Self-Directed Services Option

42. Under current law, individuals who meet functional and financial eligibility criteria are offered the option to enroll in Family Care or IRIS, the self-directed services option.

43. For individuals who select the IRIS program, the results of a functional screen are used to assign a monthly budget amount. In addition to the functional screen, the independent consulting agency (ICA) completes additional assessments to determine the individual's needs related to specific services, such as personal care and home health services.

44. Following completion of the functional screen and any other necessary screens related to the provision of specific services, IRIS enrollees work with an IRIS consultant to identify the individual's goals and outcomes, and to develop a care plan that specifies what services the

individual needs to achieve the specified goals and outcomes in the care plan. The consultant assists the individual in determining what services may be provided through informal, unpaid supports, such as family and friends, and what services the individual needs that may not be available through informal supports. The consultant then assists the individuals in determining which services will be provided within the individual's budget allocation. Consultants note that the budget is considered the payer-of-last-resort for services that cannot be provided informally. Additionally, all services provided must link back to a specified goal or outcome in the care plan. Table 3 provides a breakdown of IRIS service expenditures by service category for calendar years 2011 through 2014.

TABLE 3

IRIS Service Expenditures
($ in Millions)
Calendar Years 2011-2014

	2011	2012	2013	2014
Supportive Home Care	$64.3	$87.8	$115.2	$136.8
Home Health Care	12.8	23.3	37.4	56.8
Non-Nursing Home Residential Care (including CBRFs, AFHs, and RCACs)	10.8	13.3	16.3	16.7
Transportation	4.9	6.9	7.9	8.9
Respite Care	4.8	6.8	8.8	10.5
Day Center Services	3.1	5.8	8.3	10.3
Adult Day Care	3.7	3.1	2.4	1.3
Prevocational Services	2.3	3.2	4.0	4.2
Other Allowable MCO Services	2.6	2.4	1.7	0.5
Daily Living Skills Training	1.3	1.9	2.8	3.3
Supported Employment	1.4	1.6	1.7	1.6
DME and Supplies	0.9	1.4	1.9	2.4
All Other Services	1.2	1.2	1.7	2.3
Total	$113.9	$158.6	$210.1	$255.7

45. The fiscal employer agent (FEA) assists IRIS enrollees in managing the financial transactions associated with the enrollee's employer authority, and maintains records regarding budget allocations and spending. Table 4 shows the average budget amount and the average monthly spend for IRIS participants for calendar year 2014.

TABLE 4

Average Monthly IRIS Budget and Spending, 2014

	Intellectually/ Developmentally Disabled	Frail Elderly	Physically Disabled	All Groups
Average Monthly Budget	$3,809	$1,816	$1,582	$2,443
Average Monthly Spending	3,069	1,576	1,365	2,029
Spending as a Percentage of Budget	81%	87%	86%	83%

46. The bill would remove statutory references to the IRIS program, and instead require the Department to offer Family Care enrollees an option to self-direct care under the Family Care program. The administration indicates that this provision was not intended to eliminate the IRIS program, but to provide IRIS services under the Family Care program. As there are no provisions in the bill that further specify how the self-directed care option might work, such details would be developed as part of the state's waiver request.

47. Under current law, individuals have an option to self-direct under the Family Care program. This option differs from IRIS, in that individuals in IRIS have both budget authority, which refers to decision-making authority over one's budget amount, and employer authority, which refers to controlling the portion of Medicaid dollars used for hiring direct support workers. Under the Family Care self-directed option, individuals only have employer authority and partial budget authority. Additionally, under the IRIS program, individuals are permitted to self-direct all services, while under the Family Care self-directed option, individuals are only permitted partial self-direction. Table 5 compares the self-directed option under the Family Care program with the IRIS program.

TABLE 5

Comparison of Self-Directed Services Options in Wisconsin

	IRIS	Family Care Self-Directed Option
Services	IRIS enrollees may self-direct all services.	Family Care members are permitted to self-direct all services, except residential care and care management, but are subject to some constraints in deciding which services they will receive base on the Resource Allocation Decision (RAD) guidelines, which are used to determine what services are most effective and cost-effective in achieving a member's long-term care outcomes.
Budget Authority	IRIS enrollees are told the amount of their budget, and have authority to decide how to allocate the budget to pay for the long-term care services specified in the care plan.	Family Care members have budget authority for the service(s) they choose to self-direct. They are given service authorization for a specific number of hours for that service, and are not permitted to change the hours or transfer a portion of their budget to or from a service category. They are also restricted to specified wage scales set by the MCO.
Network of Providers	There are no restrictions, other than a background check, on who may provide services.	Enrollees have some flexibility in choosing who will provide services in the service category the enrollee is self-directing. Family members may provide services.
Service Authorization	The participant authorizes the services and supports, with an IRIS consultant providing support in determining which services will be purchased within the guidelines of allowable supports and services.	In Family Care, the member's interdisciplinary team (IDT) makes the decision about what services are authorized, and how much of each service the person will receive. The member is a part of the IDT.

48. DHS indicates that approximately 8,000 individuals self-directed at least one service under Family Care in calendar year 2014. The services that are most commonly self-directed include supportive home care, financial management, which includes services related to fulfilling employer responsibilities of the member, and transportation. In IRIS, there are no restrictions on who may provide services to an individual, other than that the individual must pass a background check. DHS indicates that no information is available regarding limits that MCOs may place on self-direction within the Family Care benefit, beyond the information provided in Table 5.

49. As previously indicated, the bill is unclear regarding the nature of the self-directed services option that would be offered under Family Care, including what services could be self-directed, from whom individuals could obtain services, and the extent of the employer and budget authority that would be permitted under the program. Therefore, it is not known whether the self-directed services option under Family Care would be similar to the current IRIS option.

50. Under current law, individuals participating in the IRIS program are permitted to pay relatives or friends to perform services, such as personal care services. The relative or friend is

subject to the same restrictions as other providers under the IRIS program, including providing the amount and type of services as specified in the individual's care plan, being required to pass a background check to provide services, and being required to fill out a time card, which is signed by both the IRIS enrollee and the employee, and verified by the FEA.

51. Some have expressed concern related to potential fraud in the IRIS program, due to the ability of individuals to compensate relatives or friends to provide services. Concerns have been expressed that some IRIS enrollees may be signing off on time cards for services that were not provided for employees that are relatives or friends, and that these arrangements are causing increased costs to the program. Some argue that potential fraud in the IRIS program would be better managed under the purview of an entity that manages care, such as an integrated care entity, as proposed in the bill.

52. Others argue that these claims of fraud are largely unsubstantiated and that the Department has engaged in efforts to increase its fraud prevention related to the IRIS program. In particular, since August, 2013, DHS and the IRIS ICA and FEA have worked in conjunction with the Office of the Inspector General (OIG) in DHS and the Department of Justice on the Fraud Allegation Review and Assessment (FARA) process to develop a structured process to address fraud allegations in the IRIS program. Under FARA, there is an increased emphasis on informing participants of their responsibilities related to the program and investigating any fraud allegations in accordance with standardized procedures and reporting mechanisms. Table 6 outlines the actions taken as a result of different types of fraud allegations. Fraud that is unsubstantiated refers to fraud allegations unsupported by the facts collected during FARA, abuse refers to FARA cases wherein facts supporting the allegations of fraudulent activity were found, but no facts indicate that it was intentional, and substantiated fraud refers to cases in which the facts collected during FARA support the fraud allegations and indicate that it was committed knowingly and willfully.

TABLE 6

IRIS Fraud Allegations and Responses

Unsubstantiated	Abuse	Substantiated
Educate and monitor	Amended level of support for future use	Involuntary disenrollment
Flagged in payroll system	Changed agency that provides service	IRIS exclusion list for future use
Increased monitoring	Changed personnel working with participant	Mandate agency
Payment issued	New timesheet	Mandate support broker
	Payment modified	Recoupment of funds
	Payment withheld	Reduction in service
	Reduction in service	Refer to DHS
	Stop payment on issued funds	
	Terminated service	

53. According to DHS, in 2014, 285 cases of fraud were reported about 273 participants or their employees. Approximately 48.8% of these cases were reported by IRIS staff and 14% by IRIS participants. Nine participants were disenrolled due to substantiated fraud between August,

2014 and December, 2014. The types of fraud with 50 or more reported cases included billing hours not worked (222 instances), falsifying a long-term care functional screen (53 instances), and forging signatures (52 instances). Table 7 shows a breakdown of the outcomes of the reported cases of fraud in 2014.

TABLE 7

IRIS Fraud Allegations, 2014

Outcome	Number of Cases	Percentage
Abuse	64	22%
Fraud substantiated	62	22
Fraud unsubstantiated	42	15
Insufficient information to determine	55	19
In progress	41	14
Not opened for FARA	21	7
Total	285	100%

54. The IRIS ICA indicates that it has also undertaken extensive quality controls to ensure the prevention of fraud in the program. IRIS consultants note that when an individual is first enrolled in IRIS, they undergo a comprehensive program overview, where they learn about the program and the consequences associated with intentional fraud.

55. In addition, the IRIS FEA, which is responsible for assuring that all services are paid according to an individual's plan and assisting enrollees in managing all fiscal requirements, such as paying providers and assuring that employment and tax regulations are met, indicates that it has extensive fraud prevention procedures in place. These fraud prevention procedures include the following: (a) all new participants receive "welcome calls" from trained customer service representatives, who supplement IRIS-supplied training on participant roles and responsibilities; (b) during enrollment, the FEA utilizes the ForwardHealth Portal to verify that participants are eligible for Medicaid; (c) all participants are required to sign the Wisconsin Medicaid Program Provider Agreement and Acknowledgement of Terms and Participation, which further outlines the responsibilities of self-directed employers in the IRIS program; (d) a signed rate change form and updated individualized services and supports plan (ISSPs), which governs the funds authorized in each participant's budget, is required to process any change in pay rate or service codes for participants; (e) a background check process is in place that governs how background checks on participant-hired workers are performed; (f) each month, an HR-paperwork audit is completed for each new participant-hired worker that reviews key elements of their enrollment paperwork, including application, I-9, W-4, Social Security Number, and direct deposit information; (g) front-end verification of key time report data points is conducted, including participant name, worker name, number of hours to be paid, types of services, authorized time frame, participant address, date of receipt, and dated signatures for participants and workers; (h) if a participant-hired worker submits a time report that cannot be processed, the participant and worker are alerted; (i) payroll

claims greater than $2,500 require confirmation against time reports to be processed; (j) time reports are reviewed multiple times, including being audited by a different department; (k) the system automatically checks for any duplicate time reports in process; (l) "Over Budget Reports" are produced on a monthly basis to monitor which participants are spending beyond their budget, and payments that are beyond the acceptable limits are truncated to fall within acceptable limits; (m) all vendor claims made for participants are audited to confirm reasonableness of the claim information, authorization on the participant's plan, and calculated accuracy of payment amount; (n) the FEA employs a dedicated Fraud Resolution Specialist, who is responsible for detecting fraudulent activity, including by reviewing data for unusually high service hours; (o) fraud allegations are reported to OIG; and (p) participants who are found to have committed fraud are dis-enrolled from the program and their workers terminated.

56. However, some may argue that it is not the cases of fraud that are being reported, but any potential instances of fraud that are unreported that reflect broader concerns related to accountability and oversight in the IRIS program, and which merit consideration of providing for the administration of the IRIS program within the Family Care benefit, as proposed under the Governor's budget. It is unknown how many cases of fraud in IRIS are unreported.

Potential Fiscal Effect of Proposed Changes

57. The bill reduces funding to the state's MA-supported long-term care programs by approximately $6 million GPR and $8.3 million FED in 2016-17 to reflect anticipated savings associated with the proposed changes to the long-term care system. DOA indicates that this estimate is based on the assumption that there would be approximately 1% savings to current expenditures for Family Care, PACE, Partnership, and IRIS associated with the proposed long-term care changes. Table 8 provides projected spending for these programs in 2014-15, as reported by DOA, as well as 1% of current expenditures for these programs. The administration indicates that it rounded down the 1% savings to provide a conservative estimate of projected savings for this biennium, and that the 1% savings was not based on a particular model or another state's experiences.

TABLE 8

Projected Family Care, IRIS, PACE, and Partnership Expenditures, 2014-15

	GPR	All Funds
Family Care	$546,111,800	$1,316,748,400
IRIS	144,125,900	341,448,700
PACE/Partnership	60,317,000	145,401,500
Total	$750,554,700	$1,803,598,600
1% of Expenditures	$7,505,500	$18,036,000

58. The administration indicates that a significant impetus for the proposed changes to the state's long-term care system is the aging of the state's population. In a December, 2013 report to the Joint Committee on Finance regarding the expansion of the state's long-term care system, DHS

indicated that the aging population of Wisconsin is growing rapidly, and that this group is projected to grow from approximately 900,000 in 2015 to over one million by 2020.

Federal statistics show that, not only is the population of older individuals increasing, but individuals are living longer. According to the U.S. Census Bureau, the life expectancy in the United States in 1998 was 76.7 years, while the estimated life expectancy in 2015 is approximately 78.3 years, and this is expected to increase to 79.5 years by 2020.

59. Over the past decade, increasing numbers of older individuals have been relying on the state's long-term care system to provide home and community or institution-based supports as they age. The increased care needs of the disabled have similarly led to this population receiving increased support from the state's long-term care system. Table 9 shows GPR funding levels for major categories Medicaid-supported long-term care spending from 2011-12 through 2017-18.

TABLE 9

Actual and Budgeted GPR Long-Term Care Spending, Selected Programs, 2011-12 through 2016-17

	Actual			Projected		
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Institutional						
Nursing Homes*	$332,372,500	$331,390,500	$314,788,900	$322,112,200	$320,118,700	$318,093,200
ICFs-ID	60,560,900	52,656,000	51,361,900	50,254,300	50,869,600	50,957,100
Subtotal	$392,933,400	$384,046,500	$366,150,800	$372,366,500	$370,988,300	$369,050,300
Home and Community-Based						
Family Care	$303,470,100	$401,557,700	$435,791,300	$453,854,700	$503,762,900	$543,331,900
IRIS	68,096,500	91,333,700	117,378,900	143,987,400	175,093,800	195,446,500
PACE/Partnership	63,488,500	65,156,700	56,572,400	59,233,400	65,181,700	70,119,500
Legacy Waivers	39,318,700	39,253,200	40,957,900	45,822,300	30,507,100	29,735,900
Children's Waivers	24,321,600	23,696,500	23,958,800	29,402,200	30,592,500	31,549,700
Subtotal	$498,695,400	$620,997,800	$674,659,300	$732,300,000	$805,138,000	$870,183,500
TOTAL	$891,628,800	$1,005,044,300	$1,040,810,100	$1,104,666,500	$1,176,126,300	$1,239,233,800

* Includes state veterans homes

60. The administration indicates that the proposed changes to the state's long-term care programs are intended to address the significant state expenditures on long-term care services through two main approaches: (a) reducing costs due to the management of primary and acute care services for this population; and (b) reducing costs due to the increased administrative efficiencies and economies of scale that would be realized from offering these programs through several organizations on a statewide basis.

61. The inclusion of primary and acute care services in the managed care model could provide savings to the state's MA program. An analysis by one for-profit insurance company that would potentially be eligible to provide services under the proposed model projected savings of $5.8

million in 2016-17, $75.5 million in 2017-18, and $105.4 million in 2018-19 on spending for populations enrolled in the home and community-based long-term care programs due to the integration of acute and primary care services with long-term care services, as well as administrative efficiencies associated with adopting a statewide model.

62. However, it is likely that much of the potential savings of the proposal would be realized by the Medicare, rather than Medicaid, program. Currently, approximately 80% of individuals enrolled in Family Care are dual eligibles. For these individuals, most of the primary care services they receive are funded from Medicare, rather than MA.

63. In addition, the administration argues that savings would be realized related to the administration efficiencies associated with having fewer providers offer services on a statewide basis. In an April, 2011, audit of the Family Care program, the Legislative Audit Bureau indicated that there is a significant difference in caseloads for employees of the various MCOs, which suggests that efficiencies could be gained through standardization of certain practices across MCOs. However, it is unclear the magnitude of potential efficiencies that could be gained in this area, and whether these efficiencies would meet the administration's estimates of potential savings for the 2015-17 biennium associated with adopting this model.

64. In addition, the current MCOs are non-profit entities, for which DHS utilizes policy adjustments, or adjustments to the capitation rates established in the rate-setting process, to limit "profit". The Department indicates that annual surplus for these entities are generally limited to approximately 2% to 3%. It has been argued that, because for-profit HMOs typically have greater profit margins than the current MCOs, they would require higher capitation rates for providing services to the current Family Care population, which may reduce the potential savings associated with this proposal.

65. Further, the administrative allowance for HMOs is currently contractually established at 12-14% of the base payment for HMOs providing BadgerCare Plus, depending on which group is served, and 10% for HMOs providing SSI managed care. On the other hand, the administrative allowance currently provided in the Family Care contract is established based on fixed cost components that vary based on the size of the MCO, and variable costs that are provided as a per member, per month payment for each enrollee. The current Family Care MCOs indicate that this equates to an administrative allowance of approximately 4%. Accordingly, it is unclear whether there would be additional costs associated with increasing the administrative allowances for entities that would administer the program under the new model, which could potentially eliminate some of the administrative savings the state could realize.

66. Finally, the Department indicated in its December, 2013, report to the Committee regarding long-term care expansion that its analysis of long-term care expansion "shows that these programs, in coordination with the Department's long-term care programs and initiatives, provide the capacity to manage the growth of long-term care costs while ensuring that Wisconsin residents have timely access to quality long-term care services without compelling entry into a nursing home." Based on this assessment, it is unclear whether there are significant cost concerns related to the state's current long-term care programs, or the methods by which the proposed changes would address any potential problems.

67. Other states have generally experienced savings associated with adopting an integrated model of home and community-based long-term care changes. For example, Iowa projects savings of $51.3 million for the last six months of state fiscal year 2016 associated with implementing the Medicaid Modernization initiative. However, this savings is associated with modifying the provision of services for all Medicaid populations, rather than just those populations receiving long-term care. Further, this initiative involves transitioning from a fee-for-service long-term care delivery system to a managed care-based model, whereas most individuals that receive MA long-term care services in Wisconsin already receive those services through a managed care model. Additionally, it is questionable whether the living arrangements of those receiving long-term care services in Iowa are comparable to those receiving long-term care services in Wisconsin. According to the Nursing Home Data Compendium 2013 Edition published by CMS, the estimated percentage of state residents above age 65 in a nursing home in 2012 in Iowa was 4.8%, as compared with 3.2% in Wisconsin.

68. As there is insufficient information available that could be used to produce a reliable estimate of the fiscal effect of the bill's provisions to modify the delivery of long-term care services, the Committee could restore the funding reduction in the bill relating to this item (Alternative 2). In LFB Budget Paper #358, relating to the statewide expansion of Family Care, it is indicated that additional GPR savings could be realized from statewide expansion of the Family Care and IRIS programs from program revenue generated from required county contributions to offset GPR spending in the MA program. It is estimated that at approximately $5.7 million would be available from these county contributions in 2016-17. Therefore, if the Committee chooses to adopt the Governor's recommendations related to the proposed long-term care changes, and to restore funding reductions under the Governor's budget associated with these changes, the Committee could offset most of the GPR that would be restored by adopting the proposed statewide Family Care expansion.

Potential Policy Effects of Proposed Long-Term Care Changes

69. In addition to considering the potential fiscal impact of the proposed long-term care changes, the Committee may wish to consider potential policy effects related to the quality and availability of services, long-term care service providers, and related issues.

70. First, it is not known what the potential impact that the proposed changes would have on the provision of long-term care services between the time at which the budget bill is enacted and the implementation of any approved waiver. In April, 2015, Gemini Cares, a home care agency based in Slinger, WI that operates in 40 counties, announced that it will discontinue its operations. The organization, which employs approximately 700 individuals, cited certain state policies, including inadequate reimbursement rates and the proposed long-term care changes, as reasons for closing its operations. While the agency did not state the proposed long-term care changes as the sole reason for closing, this example highlights the uncertainty facing the current service providers and MCOs. Further, the current MCOs have not signed contracts for calendar year 2016, and would not do so until December, 2015. If the provisions in the bill are approved, it is possible that MCOs would choose not to sign a contract for calendar year 2016, given the potential inability to operate under the new model. Under this scenario, the state would need to find new MCOs for individuals receiving long-term care services in any affected regions of the state until the new model would be

implemented.

71. Additionally, under the recent expansion of the Family Care and IRIS programs to the seven northeastern counties, two MCOs and the IRIS ICA and FEA are preparing to begin operations in these counties. The MCOs currently expanding to this region have noted difficulties with hiring employees, as well as difficulty in counseling current legacy waiver enrollees regarding their options when the Family Care and IRIS programs expand to their counties under the current system, which they attribute to the proposed long-term care changes. The level of uncertainty associated with this proposal could, therefore, potentially present challenges in transitioning those counties to Family Care and IRIS in the current calendar year, particularly if additional changes are imminent shortly after the expansion is complete.

72. Further, if the proposed changes would be adopted, the current long-term care system, including the regional MCOs, would be eliminated. However, it is unclear whether the Department has a contingency plan if the proposed changes were unsuccessful and the current system had already been eliminated. Some have argued that the state could find itself in this position if the Department is unable to contract with a sufficient number of HMOs in all regions of the state to offer choice among providers, which CMS has generally required of the state's home and community-based long-term care programs.

Some may argue the state has experienced such a situation previously. In October, 2012, UnitedHealthCare terminated its BadgerCare Plus contract due to receipt of insufficient rates to serve that population. The entity was providing BadgerCare Plus to 174,000 individuals at that time. These individuals were later enrolled in other HMOs. If a similar situation were to occur following implementation of the proposed long-term care changes, it is not known whether another entity could maintain services to these individuals.

75. Four options are presented for the Committee's consideration, including adopting the Governor's recommendations (Alternative 1), adopting the Governor's recommendations but restoring funding that the bill would delete (Alternative 2), adopting the Governor's recommendation but requiring the department to submit a proposed waiver to the Committee for approval prior to submittal to CMS (Alternative 3), deleting the provision but requiring the Department to study the issues presented in this paper and report to the Joint Committee on Finance no later than July 1, 2016 with recommendations to modify the state's long-term care programs (Alternative 4), and deleting all of the provisions in the bill relating to this item (Alternative 5).

ALTERNATIVES

1. Adopt the Governor's recommendations.

2. Adopt the Governor's recommendations. In addition, increase MA benefits funding by $14,336,900 ($6,000,000 GPR and $8,336,900 FED) in 2016-17 to restore funding that would be deleted in the bill.

ALT 2	Change to Bill
GPR	$6,000,000
FED	8,336,900
Total	$14,336,900

3. In addition to Alternative 1 or Alternative 2, require DHS to submit a proposed waiver to the Joint Committee on Finance for modification and approval prior to submittal to CMS. Specify that DHS may only submit a waiver request as approved by the Joint Committee on Finance to CMS.

4. Delete the Governor's recommendations related to Family Care and IRIS. Restore $14,336,900 ($6,000,000 GPR and $8,336,900 FED) in 2016-17. In addition, direct the Department to study the proposed long-term care changes under the budget bill with input from current long-term care enrollees, their representatives, and providers, and provide a comprehensive report that addresses any potential cost savings, service changes, and other implications for long-term care enrollees to the Committee no later than July 1, 2016.

ALT 4	Change to Bill
GPR	$6,000,000
FED	8,336,900
Total	$14,336,900

5. Delete provision. Restore $14,336,900 ($6,000,000 GPR and $8,336,900 FED) in 2016-17.

ALT 5	Change to Bill
GPR	$6,000,000
FED	8,336,900
Total	$14,336,900

Prepared by: Stephanie Mabrey
Attachments

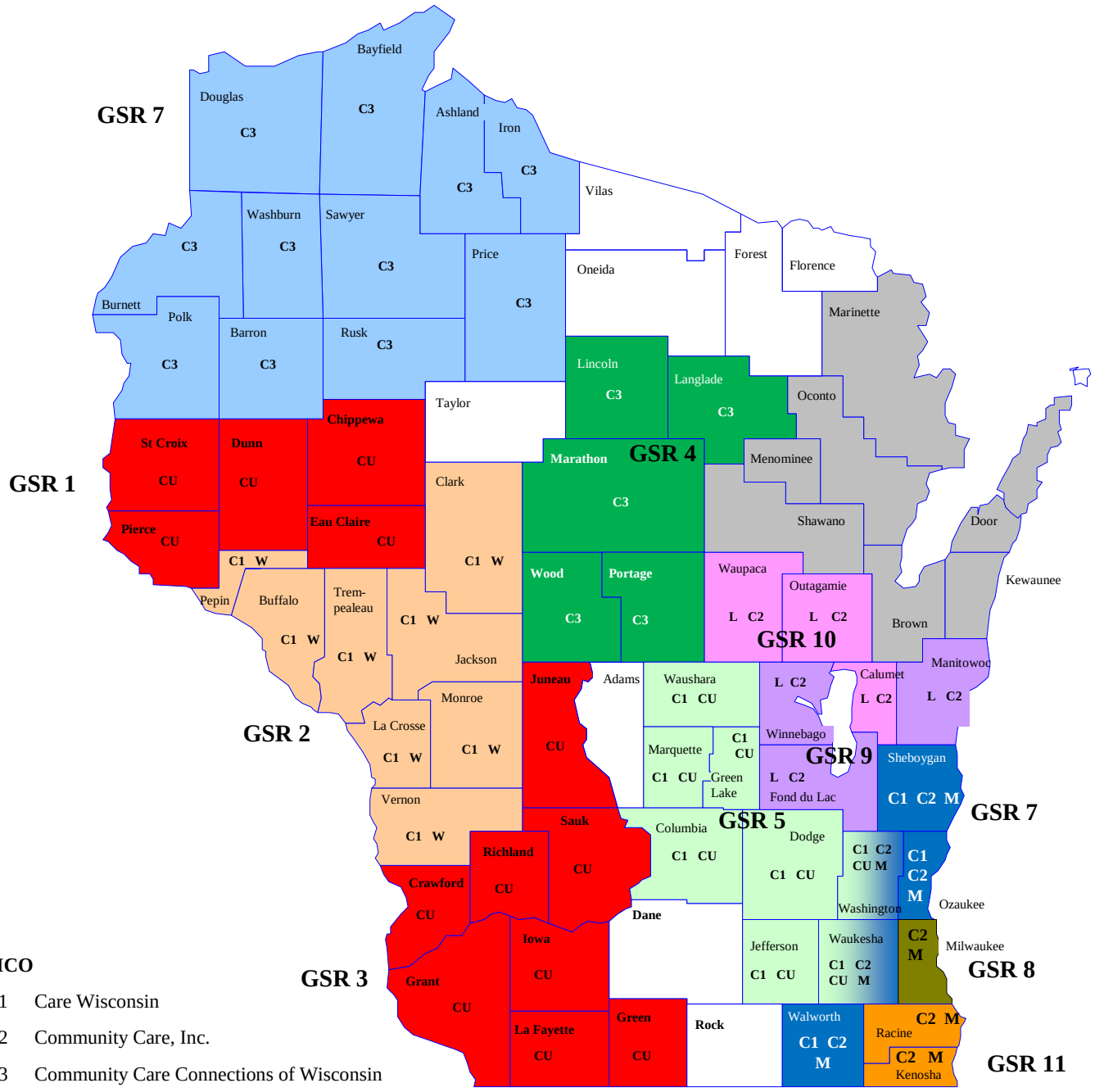
ATTACHMENT 1

Family Care Expansion Schedule

County	Start Date	County	Start Date
Fond du Lac	2/1/2000	Crawford	7/1/2009
La Crosse	4/1/2000	Juneau	7/1/2009
Portage	4/1/2000	Lafayette	7/1/2009
Milwaukee - Elderly	7/1/2000	Rusk	7/1/2009
Richland	1/1/2001	Iron	8/1/2009
Racine	1/1/2007	Price	8/1/2009
Kenosha	2/1/2007	Sawyer	8/1/2009
Sheboygan	2/1/2008	Walworth	10/1/2009
Columbia	3/1/2008	Milwaukee - Disabled	11/1/2009
Ozaukee	3/1/2008	Calumet	1/1/2010
Washington	4/1/2008	Grant	4/1/2010
Chippewa	5/1/2008	Iowa	4/1/2010
Dunn	6/1/2008	Manitowoc	4/1/2010
Waushara	6/1/2008	Outagamie	4/1/2010
Marquette	7/1/2008	Waupaca	7/1/2010
Pierce	7/1/2008	Winnebago	7/1/2010
Waukesha	7/1/2008	Langlade	1/1/2011
Dodge	8/1/2008	Lincoln	4/1/2011
Green Lake	8/1/2008	Door	6/1/2015
Jefferson	9/1/2008	Kewaunee	6/1/2015
Sauk	9/1/2008	Brown	7/1/2015
St. Croix	9/1/2008	Marinette	8/1/2015
Eau Claire	11/1/2008	Oconto	9/1/2015
Marathon	11/1/2008	Shawano	10/1/2015
Vernon	11/1/2008	Menominee	11/1/2015
Jackson	12/1/2008	Adams	-
Green	1/1/2009	Dane	-
Monroe	1/1/2009	Florence	-
Wood	1/1/2009	Forest	-
Trempealeau	2/1/2009	Oneida	-
Buffalo	3/1/2009	Rock	-
Pepin	3/1/2009	Taylor	-
Clark	4/1/2009	Vilas	-
Barron	5/1/2009		
Douglas	5/1/2009		
Burnett	6/1/2009		
Polk	6/1/2009		
Washburn	6/1/2009		
Ashland	7/1/2009		
Bayfield	7/1/2009		

ATTACHMENT 2

Family Care Geographic Service Regions
January, 2015



MCO

C1 Care Wisconsin

C2 Community Care, Inc.

C3 Community Care Connections of Wisconsin

CU ContinuUs

L Lakeland Care District

M Milwaukee County Department of Family Care

W Western Wisconsin Cares