The Wisconsin Long-Term Care Coalition

Keep Our Care at Home

May 11, 2016

To: Senator Alberta Darling and Representative John Nygren, Co-Chairs, and Members, Joint Committee on Finance

From: Lynn Breedlove and Tom Frazier, Co-Chairs, Wisconsin Long-Term Care Coalition

Subject: Our Analysis of the Numbers behind Family Care/IRIS 2.0

On April 12, we sent a memo to the Joint Finance Committee on behalf of the Wisconsin Long-Term Care Coalition, encouraging the Committee to delay action on Family Care/IRIS 2.0 and ask the Department of Health Services (DHS) for more information on several issues. We are aware that several JFC members have also raised a number of questions and are still awaiting answers. Since the date of our memo, DHS has posted a new statement on the DHS website which mostly reiterates points from the DHS Concept Paper. But it also contains a projection of $300 million in savings over the next 6 years compared to the current program.

We have now had the opportunity to review DHS' documentation in support of that projection, and to also review the letter from the state's actuary which DHS has often referred to as the basis for the recommendation to have only three large regions.

Our Conclusions Regarding the Projected Savings:

1. This is the first time that DHS has publicly acknowledged that there will be no savings in long term care (LTC) spending as a result of moving to Family Care/IRIS 2.0 (all the projected savings will be in primary and acute health care). This confirms what aging and disability advocates have been saying since the beginning of the 2015-2017 budget session: substantial savings have already occurred in LTC spending as a result of the combined effects of DHS, MCOs, and the IRIS program over the last 15 years, and the current LTC models would continue to generate substantial savings if left intact. We now finally have formal confirmation from DHS of what we always believed: Family Care/IRIS 2.0 will not be a more effective engine of LTC savings than the LTC system we already have.

2. If the legislature and stakeholders had known that all the projected savings were limited to primary and acute health care, it would have made more sense to leave Family Care and IRIS alone, and examine the "cost drivers" in the health care arena. It is very possible that comparable savings on the health care side could be achieved through existing managed health care models such as SSI Managed Care or BadgerCare, without forcing 60,000 people to disenroll from their current LTC programs and putting all of Wisconsin's existing managed care organizations at risk of elimination.

3. The Family Care and IRIS 2.0 Concept Paper states that IHAs will be allowed to have profit margins of up to 2.5%. Over the past seven years, surpluses in the current Family Care program have averaged 1.12%. Increasing the allowable profits in Family Care and IRIS 2.0 has the potential to increase costs by roughly $200 million over the next six years when compared to the current Family Care program. These extra profits would not be required to stay within Wisconsin.

4. Primary and acute health care savings will only be achieved for the approximately 20% of enrollees who are Medicaid-only. Enrollees with dual eligibility (Medicaid and Medicare) will continue to receive their health care under the existing programs. Therefore 60,000 people will face significant disruption to gain limited savings from 20% of the enrollees.

5. DHS has reported earlier to the legislature that substantial health care savings have been achieved in the existing Family Care and IRIS programs. It is possible that some or all of the health care savings that DHS is projecting for Family Care/IRIS 2.0 could be achieved with statewide expansion of the existing LTC programs. It is also possible that expansion of the Partnership program would achieve additional health care savings.

6. The savings estimates do not take into account the variety of start-up and transition costs associated with the implementation of Family Care/IRIS 2.0 (including the period of time when both the current system and the new system will be operating simultaneously in each region). The savings projections also do not consider the lost return-on-investment of the start-up funding invested since 2001 in helping the existing MCOs and the IRIS program to come into existence. This is relevant since most or all of these MCOs will not survive the transition, and the freestanding IRIS program will be eliminated.

7. Projected savings in primary and acute health care are based on rate trends from the PACE/Partnership program rate report. That is a flawed method to project savings in Family Care/IRIS 2.0 since the PACE/Partnership population is not representative of the large majority of the Family Care/IRIS 2.0 population.

8. The projected savings include savings related to pharmacy benefits - - neither the current LTC system nor Family Care/IRIS 2.0 include pharmacy costs. DHS has explicitly stated that the IHAs will not be responsible for providing/paying for prescription drugs. DHS has not explained why these savings are included in their projections.

Our Conclusions Regarding the Milliman Actuarial Analysis for Future Regions:[1]

1. The Milliman analysis does not contain a recommendation for a specific number of regions. In light of the fact that big regions reduce the chances of survival for current Wisconsin MCOs, DHS should provide a stronger rationale for three regions ("zones"). Big regions will lead to the disappearance of most or all existing Wisconsin MCOs, which will lead to more disruption for LTC consumers.

2. The actuarial analysis focuses only on LTC costs; it does not factor in primary and acute care costs.

3. Milliman encourages DHS to take into account "consistency with BadgerCare and SSI" when determining the Family Care/IRIS 2.0 regions. Both of these programs have 6 regions - - DHS appears to have ignored that advice.

4. The Milliman analysis states that "Family Care Per Member Per Month cost by group reaches a fair level of confidence at relatively low membership levels." This suggests that smaller regions with fewer than the projected 20,000+ LTC participants/region in Family Care/IRIS 2.0 would not create significant fiscal instability for IHAs.

[1] "Wisconsin Long-Term Care Regional Cost Analysis" (November, 2015)

Conclusion

In its recent Editorial, the *Milwaukee Journal Sentinel* referred to Family Care/IRIS 2.0 as an "experiment." This is an appropriate term, given that no other state has implemented a similar model and operated it long enough to see if it actually produces better member outcomes or significant savings. Given the inherent risk in an experiment that will dramatically change the long term care and health care of 60,000+ older adults and people with disabilities, we believe that the bar should be set high for DHS to clearly prove that this disruption is justified, especially because DHS is not proposing a 5 county pilot (i.e. the way the original Family Care experiment started), but a complete statewide overhaul.

In light of the recent documents from DHS, we now know that:

-Family Care/IRIS 2.0 will not save any money on the LTC side;

-Potential increased profitability within the new system would reduce any projected cost savings.

-There are multiple flaws in the method DHS used to project health care savings;

-Some or all of the projected health care savings could potentially be obtained with the current Family Care and IRIS program, by using existing health care managed care models, and/or by expanding the Partnership program from its current 14 counties to a larger portion of the state; and

-The basis for the proposal to have three large regions is not clear in the actuarial study commissioned by DHS.

Consequently, we do not believe that DHS has met the burden of proof to justify moving forward on Family Care/IRIS 2.0.

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