Survival Coalition
of Wisconsin Disability Organizations

P.O. Box 7222, Madison, Wisconsin 53707

Overview of FL, KS, CA long term care (LTC) approaches in contrast to Wisconsin model

WHAT POPULATIONS (OLDER ADULTS, PEOPLE WITH PHYSICAL DISABILITIES, MENTAL HEALTH POPULATIONS, DEVELOPMENTAL DISABILITIES, INCOME-BASED MEDICAID ELIGIBLE), ARE INCLUDED AND EXCLUDED[1] IN MANAGED LONG TERM CARE PROGRAMS?

FLORIDA

Florida requires older adults (age 65+) with nursing facility level of care and individuals (over age 18) who are eligible for Medicaid because of disability, and other populations[2] to enroll in its Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program unless they are enrolled in an exempted waiver program. There is a separate waiver for people with developmental disabilities; they are excluded from mandatory enrollment. Florida's Managed Long-Term Care Program covers approximately 87,000 older adults and people with disabilities, about 50,000 of whom were in nursing homes when Florida transitioned to managed long-term care.[3] The Statewide Managed Long-Term Care Program only provides long-term care services; there is a separate Managed Medical Assistance Program (MMA) that provides primary and acute care services to over 3 million Medicaid recipients.[4] This means that older adults and people with physical disabilities who want to receive both long-term care services and primary and acute care services, need to participate in both programs.

Florida also has six population specific/condition specific waiver programs[5]. There are caps on the number of people receiving services under the Developmental Disabilities waiver and people on waiting lists. Some services, including supported employment, are available under the DD waiver, but are not offered in the managed care system. When Florida received approval from the federal government to begin their new Statewide Managed Long-Term Care program, they received approval to cap enrollment in the home and community-based services portion of the waiver at 36,795 people.[6]

[1] Any population specific waiver may cap the number of people covered and maintain a wait list. There is no national repository for the numbers of people on a waiting list or served under each specific waiver.
[2] http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/SMMC_LTC_Snapshot.pdf
[3] http://health.wusf.usf.edu/post/feds-give-ok-medicaids-frail-elderly-enter-hmos
[4] http://www.ahca.myflorida.com/Medicaid/statewide_mc/
[5] http://ahca.myflorida.com/Medicaid/hcbs_waivers/index.shtml
[6] http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf

KANSAS

KanCare is not a specific aging and long-term care program. KanCare includes virtually all Medicaid populations under its statewide system, with certain home and community based services available only to defined long-term care populations. People with intellectual/developmental disabilities were only recently added (February 2014), and KanCare now includes services provided through the Home and Community Based Services waiver for this population. KanCare serves more than 360,000 Kansans.[7]

CALIFORNIA

California's 8 county Coordinated Care initiative primarily serves older adults and people with physical disabilities who are duly eligible for Medicaid/Medicare or rely on Medicaid for long-term services and supports (LTSS)[8]. California has a separate waiver for people with developmental disabilities, and this population is excluded from this demonstration project. Several other sub populations—including residents in 20 specific rural zip codes and participants in other waivers—were also excluded from the Coordinated Care Demonstration project[9]. Enrollment in Los Angeles is capped at 200,000 participants.[10]

There are currently 123,079 Californians enrolled in the Coordinated Care Initiative. For some populations, enrollment in the Coordinated Care Initiative is voluntary. The latest enrollment report shows that a total of 178,701 people have opted out of participating in this program. This number includes voluntary disenrollment.[11]

WISCONSIN

Wisconsin has a managed long term care model that includes older adults, people with physical disabilities, and people with developmental disabilities; Family Care provides a consistent benefit package to all long term care participants.

Family Care and IRIS currently serve nearly 55,000 older adults and individuals with developmental or physical disabilities, all of whom qualify for a nursing home level of care. These programs, unlike acute and primary health care, provide daily personal supports (such as help with bathing, dressing, and meal preparation), and transportation and support for work and community activities.

Each participant has an individual person centered plan that itemizes needs/goals and directs which services are/are not applicable to each person. Family Care is operating in 57 counties,

[7] http://www.kancare.ks.gov/whats_kancare.htm
[8] Full listing of populations included and excluded from California's Coordinated Care Demonstration project http://www.calduals.org/wp-content/uploads/2013/03/CCI-Participating-Populations.pdf
[9] http://www.calduals.org/wp-content/uploads/2013/03/CCI-Participating-Populations.pdf
[10] http://www.calduals.org/wp-content/uploads/2013/03/MOU-FACT-SHEET.pdf
[11] http://www.calduals.org/wp-content/uploads/2015/02/CMC-Enrollment-Dashboard-Feb-2015-FINAL.pdf

with an additional 7 counties transitioning to Family Care by 2016. IRIS is Wisconsin's self-directed long-term care program and is the alternative to managed care model, and is available in all counties where there is Family Care.

In the 8 remaining counties that have not yet come into Family Care, those counties operate under "legacy waivers" (CIP/COP) and the county is running the system in partnership with the state; long term care participants in these counties may/may not have access to the same supports available in Family Care counties, and many people are on waiting lists for services.

RATES OF PEOPLE LIVING IN INSTITUTIONAL SETTINGS IN OTHER STATES

FLORIDA

In the most recent report by the Kaiser Family Foundation, there were 72,373 Floridians living in a certified nursing facility.[12] There are still two state-run institutions for people with developmental disabilities in Florida that house 657 residents[13]. There are 20,934 individuals on the waitlist for Home and Community Based Waiver services as of August 15, 2014[14]. In 2012, Florida spent over $2.7 billion on nursing facilities and over $300 million on ICF-IDs[15].

After a 14 year moratorium on constructing new nursing homes, Florida's Agency for Health Care Administration recently approved the construction of 22 new facilities and expansion of 11 existing ones, totaling more than 2,600 beds and $400 million in construction in 25 counties.[16]

KANSAS

Prior to enacting KanCare, Kansas had the sixth highest percentage of seniors living in nursing homes in the country[17]. Kaiser Family Foundation reports that 18,497 Kansans reside in a certified nursing facility[18]. The most recent data available for Kansas shows the state Medicaid budget spent $440 million on nursing facilities and $65 million on ICF-IDs.[19]

CALIFORNIA

California's Department of Developmental Services currently operates four State developmental centers (DCs) which are licensed and certified as Skilled Nursing Facility (SNF), Intermediate Care Facility/Mentally Retarded (ICF/MR), and General Acute Care hospitals (GAC). The Department

[12] http://kff.org/other/state-indicator/number-of-nursing-facility-residents/#map
[13] http://www.fddc.org/sites/default/files/deinstitution2015final.pdf
[14] http://www.fddc.org/sites/default/files/waiverposition2015Final.pdf
[15] http://kff.org/medicaid/state-indicator/spending-on-long-term-care/?state=FL
[16] http://www.orlandosentinel.com/business/os-cfb-nursing-home-approval-20150305-story.html
[17] http://www.kancare.ks.gov/download/Kansas_1115_Waiver_Concept_Paper.pdf
[18] http://kff.org/other/state-indicator/number-of-nursing-facility-residents/#map
[19] http://kff.org/medicaid/state-indicator/spending-on-long-term-care/?state=KS

also operates a smaller, state-operated community facility (CF) licensed as an ICF/MR facility.[20] These state-run institutions serve 1,131 people.[21]

The most recent data available for California shows the state Medicaid budget spent $4.4 billion on nursing facilities and nearly $1 billion on ICF-IDs.[22]

According to Kaiser Family Foundation, 100,065 Californians reside in a certified nursing facility.[23]

WISCONSIN

Since Family Care started, spending on long-term care has declined from 53% to 43% of the total Medicaid budget, the number of people in nursing homes (the most expensive form of care) has decreased by 11,000 persons, Medicaid paid nursing home days have seen a 35% decrease, and the percentage spent on institutional care has gone from 62% to 31%.

WERE THESE STATES USING FEE-FOR-SERVICE FOR LONG TERM CARE?

FLORIDA

Prior to Florida's transition to managed care older adults and people with physical disabilities, predominantly accessed long-term care services through fee-for-service Medicaid.[24] People with Developmental Disabilities—currently on a separate waiver and excluded from mandatory participation in Florida's managed long term care program—use a resource allocation tool called iBudget to determine services, level of services, and a budget amount for each individual to use for the full year.[25] Many of the services are accessed in a fee-for-service model.

KANSAS

Effective January 1, 2013, Kansas's Medicaid program moved from a fee-for-service program model to a managed care program model[26]. With the implementation of KanCare, Kansas began to transition away from institutional care and toward Home and community-based services.[27] Prior to February 2014, people with intellectual/developmental disabilities (I/DD) were covered under a Medicaid Home and Community Based Services (HCBS) waiver; HCBS services for I/DD had been done on a fee-for-service basis.

---

[20] http://www.dds.ca.gov/DevCtrs/Home.cfm
[21] http://www.dds.ca.gov/DevCtrs/AllFacPop.cfm
[22] http://kff.org/medicaid/state-indicator/spending-on-long-term-care/?state=CA
[23] http://kff.org/other/state-indicator/number-of-nursing-facility-residents/#map
[24] http://kaiserhealthnews.org/news/florida-medicaid-managed-care-long-term-care/
[25] http://apd.myflorida.com/ibudget/basics.htm
[26] http://www.kancare.ks.gov/provider.htm
[27] http://www.kancare.ks.gov/download/Kansas_1115_Waiver_Concept_Paper.pdf

California

Most of the 1.2 million dual eligible in California currently receive both their medical and long-term care service benefits under fee-for-service. Although more than half of the 700,000 Medi-Cal-only seniors and persons with disabilities have been mandatorily enrolled in Medi-Cal managed care for their medical benefits, they also continue to receive most long-term care services under fee-for-service.[28] California cost savings estimates were based on transitioning from fee-for-service to managed care[29]. California specifically identified reduction of institutional care (reduced nursing home usage, provider rate reduction), reduction of fee-for-service costs, as well as increased use of HCBS services were identified as the methods of cost-savings[30].

Wisconsin

Wisconsin began delivering long-term care services through a managed care model in the late 1990s and early 2000s. The cost savings other states are achieving by moving from fee-for-service long-term care to managed care have already occurred in Wisconsin. Most long-term care participants access primary/acute health care on a fee-for-service basis: these services could be folded into the Family Care benefit using the existing Wisconsin regionally based MCO model.

Are there demonstrable cost savings to the state from this shift?

Florida

A Tampa Bay Times' PolitiFact published in September 2014, ruled that "there isn't enough data yet to evaluate if Florida is on track to save $1.8 billion" from making the switch to managed long-term care and Medicaid. PolitiFact indicated that the current cost savings from the plan came from a 5% rate cut to private providers.[31] Since Florida's plan aims to save money by transitioning both long-term care and general Medicaid participants to managed care, it is not reasonable for Wisconsin to base any potential cost savings off of Florida's model.

Kansas

The three KanCare HMOs lost $110 million in 2013 and $73 million in first half of 2014.[32] Despite losing money, the three HMOs requested roughly $40 million in performance bonuses.[33] Like

[28] http://www.lao.ca.gov/Publications/Detail/2694
[29] http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/Coordinated%20Care%20Initiative%20Fiscal%20Methodology.pdf
[30] http://www.dhcs.ca.gov/provgovpart/Documents/Duals/TBL/Coordinated%20Care%20Initiative%20Fiscal%20Methodology.pdf
[31] http://www.politifact.com/florida/promises/scott-o-meter/promise/602/reform-medicaid-with-a-federal-waiver/
[32] http://www.khi.org/news/article/mcos-continue-lose-money-kancares-second-year/

Florida, Kansas plans to save money by transitioning their entire Medicaid program to managed care. Any cost savings realized in Kansas are not indicative of cost savings Wisconsin could achieve by incorporating acute and primary care into long-term care.

CALIFORNIA

Unknown. The Coordinated Care Initiative isn't available statewide yet.

WISCONSIN

The percentage of the state's Medicaid budget spent on LTC dropped from 53% in 2002 to 43% in 2011. Annual Medicaid nursing home days dropped from 8.8 million in 2002 to 5.7 million in 2012, a 35% reduction saving taxpayers well over $300 million/year. The number of older adults in WI nursing homes has decreased by 9,000 since the reforms were put in place. The portion of Medicaid spent on nursing homes dropped from 62% to 31% over the same period.

WHO IS RUNNING THE STATE'S MEDICAID MANAGED LONG TERM CARE PROGRAM

FLORIDA

Florida's program divides the state into 11 different regions; different HMOs cover different regions. Some regions have only two choices. Florida has contracted with American Elder Care, Ameri- group, Coventry, Humana, Molina, Sunshine, and United Health care to run its Medicaid long term care program. There are two types of health plans: Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs).

KANSAS

Kansas has contracted with three national HMOs—Amerigroup, Sunflower, and United Healthcare to run Kansas's Medicaid health care programs for nearly all Medicaid beneficiaries. All three companies must provide services statewide.

CALIFORNIA

A mix of private HMOs and public (local initiative/county-based) entities operate plans. Some of the counties where this program exists have a set of competing commercial plans. Currently, there is no statewide plan. Most plans are confined to a county, but some span several counties.

WISCONSIN

8 Wisconsin based regional Managed Care Organizations administer the Family Care program. IRIS participants have their own budget based on their person centered plan, and IRIS consulting agencies help participants advise and manage their budgets. In the 8 counties without Family Care, counties administer the long-term care program.

---

[33] http://cjonline.com/news/2014-05-03/kancare-companies-searching-profit-second-year-contract

How long have these states been implementing the managed care programs that are being used as a model for Wisconsin's budget proposal?

Florida

One year operating statewide, the earliest region to come online to the new system has been operating for just over two years.

The Long-term Care program was implemented on a regional basis, for the first region enrolling on August 1, 2013 and the final region enrolling on March 1, 2014. In 2011, the Florida Legislature directed its state Medicaid agency to create a Statewide Medicaid Managed Care (SMMC) program with two key components: the Managed Medical Assistance program and the Long-term Care program.

Kansas

Operating one-year for all populations.

The KanCare demonstration project launched in January 2013; in February 2014 DD population was added to KanCare. Kansas's first year of implementation resulted in a number of challenges, including a 570 person increase to the Home and Community-Based Services waiver waiting list (increasing the total waiting list to 3,141), a reduction in the number of Medicaid beneficiaries receiving home- and community-based services, and service providers not getting paid[34].

California

Less than one year, implementation is still on-going and the program is only actively enrolling participants in 7 counties.

California's Coordinated Care initiative was authorized in 2012-13 fiscal year; enrollment did not start until April 2014. Staggered enrollment has been phased in across different counties. This program is available in 7 of 58 counties. Enrollment is capped in Los Angeles County to 200,000.

Wisconsin

15 years (Family Care), 7 years (IRIS).

The current LTC system was the outgrowth of 4 years of intensive LTC Reform planning in the late 1990's ("Keep the Community Promise" campaign) involving LTC consumers and families, aging and disability advocates, counties and state officials. This process led to the proposed creation of Family Care in 5 pilot counties with (locally governed MCOs) by Gov. Tommy Thompson in the 1999-2001 budget, which was adopted by the legislature with resounding bipartisan support. The idea of "integrated care" (combining health care and long term care)

[34] http://media.khi.org/news/documents/2014/04/28/KanCare_Annual_Report_to_CMS_DY_ending_12_31_13_FINAL.pdf

was considered and strongly rejected at that time. (The vast majority of older people and people with disabilities were happy with their current doctors and opposed a forced change of doctor; they also did not want their long term care plans "over-medicalized".)

The reforms were designed to eliminate waiting lists, reduce admissions/utilization of nursing homes and other institutions, "bend the curve" on Medicaid spending increases while maintaining quality, reduce the portion of the state's Medicaid budget spent on LTC, and create locally-based 1-stop ADRCs to provide objective information and other valuable functions for any Wisconsin citizen independent of the MCOs and ICAs. As detailed below, the reforms have worked: Wisconsin has made huge progress on all of these fronts. Implementing the reforms was complex, so they were phased in gradually between 2000 and 2015. In 2008, Wisconsin added IRIS, a non-managed care model, to the LTC system, for people who want to self direct their LTC services. Letting people choose how they receive their services is a key component of Wisconsin's successful LTC system. The choice of Family Care or IRIS will soon be available in 64 counties.

WHAT ARE THE ADMINISTRATIVE COSTS OF THE HMOS/MCOS RUNNING STATE MANAGED LONG TERM CARE PROGRAMS?

HMO INDUSTRY STANDARD

The industry standard administrative overhead costs for HMOs are between 10 and 15%. Studies conducted on publicly traded plans entering the Medicaid managed care market, have found that publicly traded plans report some of the highest percentages of administrative costs and receive lower quality scores than other types of health plans.[35] We encountered several articles that highlighted the need for publically traded health plans to meet earnings expectations for their shareholders.

FLORIDA, KANSAS, CALIFORNIA (STATE CONTRACTS)

In Kansas and Florida, concerns have been raised regarding the ability of for-profit plans to remain profitable in the Medicaid market. As previously discussed, all three KanCare HMOs lost money in the first year of operation. Florida had originally piloted their Statewide Medicaid Managed Care Program in several counties. This pilot produced mixed results and several for-profit HMOs dropped out when they didn't make enough money.[36] Florida's contracts with

[35] http://www.commonwealthfund.org/publications/issue-briefs/2011/jun/financial-health-medicaid-managed-care

[36] http://www.tampabay.com/news/health/managed-care-firms-prepare-to-cash-in-on-medicaid-overhaul/2111041

HMOs allows for income-sharing, the private plans can keep up to 5% of the revenue they make. Once plans experience revenues above 6%, they must split the profit with the state.[37]

WISCONSIN

The portion of Family Care spending used for administrative costs is 4.2% (compared to Badger Care HMOs, which range from 10% to 15%). There is currently a 2% cap on profits for MCOs. Over the last 6 years, MCO profits have averaged 1.3%.

[37] http://www.floridahealth.gov/AlternateSites/Kidcare/council/12-2013/MedicaidManagedCareUpdate-AHCA.pdf