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Mandatory Enrollment in Managed Care Plans for MA Recipients who Receive SSI (DHFS -- Health Care Financing -- Payments, Services, and Eligibility)

[LFB 2003-05 Budget Summary: Page 219, #13]

CURRENT LAW

Federal Requirements. Under federal medical assistance rules, states may require medical assistance (MA) recipients to enroll in managed care plans, subject to certain limitations and exemptions. For example, states may not require the following groups to be enrolled in managed care plans: (a) recipients who are also eligible for Medicare ("dually-eligible" MA recipients); (b) most Indians who are members of federally-recognized tribes; and (c) certain groups of children who are under 19 years of age, including children who are eligible for SSI, and children who are in foster care or other out-of-home placement.

In addition, with certain exceptions, states that require MA recipients to enroll in managed care plans must give those recipients a choice of at least two plans. In areas of the state classified as "rural," a state may require MA recipients to enroll in a managed care plan if there is only one plan available, provided that the recipient has a choice of at least two physicians and the enrollee is permitted to obtain services from another provider in the following circumstances: (a) the services or type of provider necessary to meet the individual's care needs are not offered through the managed care network; (b) for up to 60 days, if the recipient's main provider of services is not a member of the provider network and will not join the network; or (c) the state determines that services are required outside of the provider network. Approximately 52 Wisconsin counties are classified as "rural" under the federal definition.

States may seek waivers of federal requirements regarding the mandatory enrollment of MA recipients.

Wisconsin's Program. Wisconsin requires some MA and BadgerCare recipients to enroll in managed care plans – low-income families with dependent children – in areas of the state where these families have a choice of plans. However, the state does not currently require other groups of MA recipients, including disabled individuals who receive supplemental security income (SSI) benefits and dually-eligible recipients, to enroll in managed care plans. Instead, these individuals may voluntarily enroll in managed care plans if such plans are available to them.

Independent Care (I-Care) in Milwaukee County is the only acute care managed program in the state that serves SSI-related MA enrollees. Under this program, care coordinators assess the medical needs of enrollees and develop case plans with enrollees and their providers. Individuals who are enrolled in I-Care receive certain benefits that are not available to MA enrollees who receive services on a fee-for-service basis, including ongoing care coordination services, exemption from copayments, more convenient access to transportation, and access to certain non-standard services.

In 2001-02, MA capitation payments to I-Care totaled $36.2 million (all funds). As of February, 2003, 5,345 individuals were enrolled in the I-Care program.

Approximately 10% to 12% of the total number of SSI-related MA enrollees who have the option to enroll in I-Care currently do so. Approximately 40% of the individuals enrolled in I-Care are dually eligible MA recipients, approximately 50% have a diagnosis of mental illness and 15% have a diagnosis of substance abuse.

GOVERNOR

Reduce funding by $2,010,300 (-$836,000 GPR and -$1,174,300 FED) in 2003-04 and by $37,269,100 (-$15,500,200 GPR and -$21,768,900 FED) in 2004-05 to reflect projected savings of MA benefits costs that would result if DHFS were to require adults who are eligible for SSI to enroll in managed care plans, including recipients who are in a geographic service region that contains only a single managed care organization as a service provider. Require DHFS to request, by January 1, 2004, from the Secretary of the U.S. Department of Health and Human Services, any waivers of federal MA laws necessary to implement this requirement.

In a March 17, 2003, letter to the Co-chairs of the Joint Finance Committee, the DOA Secretary requested that the Committee decrease MA benefits funding by $6,002,800 ($2,496,000 GPR and $3,506,800 FED) in 2003-04 and increase MA benefits funding by $9,842,500 (-$4,093,500 GPR and -$5,749,000 FED) in 2004-05 to reflect the administration's revised estimates of the cost savings of this item.

The DOA request, as contained in the March 17 letter, would require additional funding of $3,839,700 in 2003-05 ($1,597,500 GPR and $2,242,200 FED).

DISCUSSION POINTS

1. Enrollment in a managed care plan may improve the quality of care some MA recipients receive, compared to services recipients receive through fee-for-service providers. Managed care organizations contend that their MA enrollees benefit from: (a) the addition of case management services; (b) increased coordination of care; and (c) access to services that are not available to other MA recipients.

2. In addition to improving care for MA recipients, requiring certain MA recipients to enroll in managed care could significantly reduce MA benefits costs because the capitation rate that would be paid to support services to this population would be discounted from the estimated fee-for-service costs for this population.

3. Opponents of the Governor's proposal have raised concern about the effect of this policy change on participants. They argue that: (a) mandatory enrollment removes participants' choice; (b) capitation rates may not be sufficient to support the care needs of enrollees; and (c) current provider-participant relationships may be disrupted. Further, it is argued that DHFS is unlikely to achieve the savings assumed by the administration.

Quality of Care

4. MA recipients who receive services on a fee-for-service basis are entitled to receive all of the medically-necessary services that are covered under the state's MA program. However, they may receive these services from many independent providers. Individuals enrolled in managed care plans are entitled to receive all of the services that are available to other MA recipients, but may also receive additional services, such as care coordination and case management services that are intended to meet all of the enrollee's needs. Individuals enrolled in managed care plans have a care coordinator and a primary care physician who monitor the enrollee's care to ensure that the most appropriate care is provided. Participants receive a complete assessment of their needs within 60 days of enrollment in a plan.

5. In addition to care coordination and case management services, enrollees may benefit from the availability of services that are either not offered through other programs or would be enhanced through a managed care program. For instance, managed care enrollees currently have access to some transportation services that are not available to other MA recipients. In addition, expanded dental services may be included as part of the service package.

6. Those opposed to mandatory managed care enrollment argue that eliminating the choice of providers may not be in enrollees' best interests. They argue that SSI-eligible MA recipients with high care needs may not receive all the services they need through a managed care program because managed care plans have a financial incentive to minimize costs.

For instance, individuals diagnosed with a mental illness or substance abuse problems may currently receive county-supported, specialized services. Enrollment in a managed care organization would require these individuals to receive these services through the plan's network of

providers. This may disrupt the relationships they have with current providers.

7. In an article published in Health Care Financing Review (Fall, 2002), Ireys, Thornton and McKay reviewed and summarized the findings of recent research regarding the quality of care working-age adults with disabilities or chronic illnesses receive in MA managed care plans. This project, which was funded by the U.S. Department of Health and Human Services (DHHS), was intended to provide DHHS and state MA programs with guidance for future program and policy development.

The authors indicate that several elements have been identified as necessary to provide an effective care system for people with disabilities or chronic illnesses. Consumer advocates emphasize the importance of consumer choice and empowerment through a person-centered approach, integration across a full and flexible array of services within and outside a network to match services with clients' needs, and the use of interdisciplinary care teams.

Other identified components include: (a) systematic efforts to identify and assess people with disabilities or chronic illnesses before they experience adverse events, including training for primary care providers; (b) prevention and early intervention strategies to ensure clients receive timely care; (c) care provided by interdisciplinary teams that have experience with this population; (d) accessibility to urgent care services (24-hours per day); and (e) coordination and integration of medical care with social and support services.

8. In reviewing state MA programs, the authors cite research that suggests that "there is a growing sense that mandatory enrollment carries the risk of high consumer dissatisfaction and that this risk can be lessened with a carefully phased transition process and appropriate enrollment methods." Further, voluntary enrollment may lead to under-enrollment of people with more severe or costly conditions if these people believe that enrollment in managed care is not in their best interest.

On the other hand, the authors indicate that managed care plans that enroll a disproportionate number of people with special health care needs are at high risk for financial losses. If capitation rates are not adjusted to account for the specific care needs of an enrolled population, then plans may avoid enrolling this population, encourage disenrollment of high-cost individuals, or leave the MA market altogether.

9. The authors also concluded that: (a) few studies have used health outcomes to compare differences between fee-for-service and managed care delivery systems for this population; and (b) the existing literature does not strongly indicate that working-age people with disabilities and chronic conditions have different cost and utilization outcomes, depending on whether they receive services through managed care plans or on a fee-for-service basis.

10. Many of the concerns raised by opponents of the Governor's proposal could be addressed as the state develops contracts with participating managed care plans. Since the managed care contracts identify what services would be provided to enrollees, and these new contracts have

yet to be signed, it is somewhat uncertain as to which services would be offered through managed care organizations and which would continue to be available on a fee-for-service basis.

The Committee may wish to direct DHFS to work with both advocacy groups and managed care organizations to ensure that the needs of the affected population are addressed and that adequate capitation rates are provided.

11. DHFS intends to exempt certain populations from mandatory enrollment, including MA-waiver, community support program, and Family Care enrollees. These populations were excluded from the savings calculations in the Governor's proposal.

Potential Cost Savings

12. MA costs for individuals enrolled in managed care plans may be less than the costs of providing services on a fee-for-service basis. Capitation rates for managed care programs, such as I-Care, the program for all-inclusive care for the elderly (PACE) and the Wisconsin Partnership Program, are based on the cost of the fee-for-service equivalent less a discount of at least 5%. The current capitation rates vary based on age, gender, level of care need, and the region in which an enrollee lives. In calendar year 2002, the state paid an average $744.82 per month for I-Care enrollees who received SSI cash payments and $504.61 per month for disabled enrollees who did not receive SSI cash payments.

13. In developing the projected savings in SB 44, the administration assumed that: (a) 90% of the SSI-only adult MA population would be required to enroll in managed care plans; (b) 40% of dually-eligible individuals and 40% of all eligible persons under the age of 18 would voluntarily enroll. The administration's revised proposal assumes that 34% of the adult, dually-eligible population will voluntarily enroll. However, only 10% to 12% of the eligible population currently voluntarily enrolls in managed care programs.

Further, the estimated 90% enrollment figure assumed for the total SSI-only population does not take into account the Department's current policy of only requiring individuals to enroll in managed care plans if more than one provider is available. Currently, 52 counties in Wisconsin meet the rural classification under federal law. Although DHFS could require individuals in these areas to enroll in a managed care plan if the Centers for Medicare and Medicaid Services approved a state plan amendment, DHFS has not yet decided whether it would require this population to enroll in managed care plan in areas where only one provider exists, even if the Governor's proposal is approved, funding is deleted from the MA benefits appropriation to reflect projected savings, and a MA state plan amendment is approved.

Ultimately, the savings that results from this provision would depend on the state's ability to encourage voluntary enrollment in managed care plans, and the discount rate that DHFS would negotiate with the HMOs.

However, since the Governor deleted MA benefits funding from the bill based on the administration's savings estimates, if DHFS is unable to achieve these estimated savings, the MA

program would have a projected shortfall equal to the difference between estimated and actual savings of this proposal. For this reason, the Committee could amend the bill to increase funding for MA benefits, as requested by the DOA Secretary in his March 17 letter, to reduce the funding shortfall that would occur if the agency is unable to achieve the projected savings.

ALTERNATIVES

1. Adopt the Governor's recommendations, as provided in SB 44.

2. Increase funding by $6,002,800 ($2,496,000 GPR and $3,506,800 FED) in 2003-04 and decrease MA benefits funding by $9,842,500 (-$4,093,500 GPR and -$5,749,000 FED) in 2004-05 to reflect the administration's revised estimates of the projected cost savings of this item.

Alternative 2	**GPR**	**FED**	**TOTAL**
2003-05 FUNDING (Change to Bill)	$1,597,500	$2,242,200	$3,839,700

3. Delete provision.

Alternative 3	**GPR**	**FED**	**TOTAL**
2003-05 FUNDING (Change to Bill)	$16,336,200	$22,943,200	$39,279,400

4. In addition to alternatives 1 or 2, require DHFS to work with both advocacy groups and managed care organizations in determining the services and capitation rates that would be provided under managed care contracts.

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