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May 24, 2011 Joint Committee on Finance Paper #341

Unspecified Program Changes to Medical Assistance (DHS -- Medical Assistance -- Services)

[LFB 2011-13 Budget Summary: Page 215, #3]

CURRENT LAW

Wisconsin's medical assistance (MA) program reimburses health care providers for the primary, preventive, acute, and long-term care services they provide to program recipients. In practice, the MA program is a collection of separate programs ranging from Family Care to BadgerCare Plus. The Department of Health Services (DHS) administers these programs under federal and state law, and under the terms of the state MA plan it submits to the federal Centers for Medicare and Medicaid Services (CMS).

Federal law requires participating state MA programs to cover certain groups of individuals. For instance, states must cover children under age six in families with income less than 133% of the federal poverty level (FPL), assuming they meet the program's non-financial eligibility requirements.[1] The same is true with respect to services. Federal law identifies a list of services state MA programs must cover, which include (but are not limited to) inpatient and outpatient hospital services, physician services, nursing home services, family planning services, and early and periodic screening, diagnostic, and treatment (EPSDT) services for children. Federal law also establishes requirements that govern many other aspects of state MA programs such as recipient cost-sharing, and the timing and the methods states use in reimbursing health care providers for services they deliver.

As is true of other states, Wisconsin's MA program serves individuals and provides services beyond the federally-mandated minimum requirements. In some cases, Wisconsin provides this expanded coverage through waivers of federal MA law that are negotiated between DHS and CMS. Examples of the state's current MA waiver programs include the community options waiver program, the community integration program, Family Care, the childrens' long-

[1] Attachment 1 provides information on the 2011 federal poverty levels, by family size.

term support waiver program, and the BadgerCare Plus Core Plan.

Benefit expenditures under the MA program are funded by a combination of GPR, federal matching funds, segregated revenues from the MA trust fund and the hospital assessment trust fund, and program revenues. The federal matching funds are based on the state's federal medical assistance percentage (FMAP). In recent years, Wisconsin's FMAP has been approximately 60%, excluding the temporary FMAP increase states received under the American Recovery and Reinvestment Act of 2009. This means that federal dollars typically support approximately 60% of most eligible MA benefit expenditures.

Under the federal Patient Protection and Affordable Care Act (PPACA), states risk losing their federal MA matching funds if they have in effect eligibility standards, methodologies, or procedures under their state MA plan, or under any waiver of such plan, that are more restrictive than the eligibility standards, methodologies, or procedures that were in effect on March 23, 2010. For adults, this maintenance of effort (MOE) requirement is in effect until the state has a fully operational health benefit exchange in place (presumed date of January 1, 2014). During the period January 1, 2011 through December 31, 2013, there is a limited exception to this MOE requirement for non-pregnant, non-disabled adults who are covered at the option of the state and who have incomes greater than 133% of the FPL. To invoke that MOE exception, a state must certify that it has a budget deficit in the state fiscal year in which the certification is made or is projected to have a budget deficit in the succeeding state fiscal year. For children under age 19, the MOE requirements remain in effect through September 30, 2019.

GOVERNOR

Reduce funding for MA benefits by $133,267,300 (-$55,971,300 GPR, -$86,196,000 FED, and $8,900,000 PR) in 2011-12 and by $333,313,400 (-$134,580,300 GPR, -$207,663,100 FED, and $8,930,000 PR) in 2012-13 to reflect the administration's estimate of the savings that would result by making various unspecified changes to the MA program.

DISCUSSION POINTS

1. The administration has indicated that it intends to make a number of changes to the MA program and that those changes will reduce MA benefit expenditures by approximately $466.6 million [all funds (AF)] during the 2011-13 biennium. The bill reduces funding for MA benefits by the amount of those anticipated savings.

2. The information provided to this office regarding these potential MA program changes consists primarily of brief narrative descriptions. Those descriptions group the changes into six categories. Attachment 2 provides the administration's narrative descriptions of those proposed changes, as well as the funding reductions associated with each category of changes. The table below summarizes that information.

Administration's 2011-13 Savings Estimates for Unspecified MA Program Changes

	GPR	FED	PR	Total
Bringing the Coverage of Working Families Back in Line with Employer-Sponsored Insurance	-$47,260,000	-$72,490,000	$17,830,000	-$101,920,000
Reducing the Crowd-Out of Private Health Insurance	-12,560,000	-19,810,000	0	-32,370,000
Improving the Management of Care and Coordination with Medicare	-52,230,000	-79,780,000	0	-132,010,000
Realign Provider Incentives	-29,510,000	-46,070,000	0	-75,580,000
Improve Provider Integrity	-15,861,600	-24,139,100	0	-40,000,700
Making Reasonable Changes to Eligibility Criteria	-33,130,000	-51,570,000	0	-84,700,000
Biennium Total	-$190,551,600	-$293,859,100	$17,830,000	-$466,580,700

3. For several of these items, the administration has provided some additional information. For example, it appears that approximately $22,500,000 (AF) per year of the savings associated with Category 1 ("Bringing the Coverage of Working Families Back in Line with Employer-Sponsored Insurance") is expected to result from increasing the cost-sharing requirements for some MA recipients. The administration indicates that it is still finalizing those cost-sharing proposals.

4. With respect to Category 3 ("Improving the Management of Care and Coordination with Medicare"), a portion of the projected savings appears to relate to an initiative the administration refers to as "Virtual PACE." On April 14, 2011, CMS awarded DHS a $1 million federal grant to develop a long-term care pilot program to improve coordination of care for individuals eligible for both Medicare and Medicaid who would be eligible for care in a nursing home. According to the grant proposal, DHS intends to create a system in which it receives a capitated Medicare payment from the federal government and then provides a single capitated rate to another entity to provide all Medicare and Medicaid services required by the individual. DHS indicates the pilot program will initially begin in three to four sites that will each enroll 2,000 members.

5. The projected savings attached to Category 5 ("Improve Provider Integrity") appear to stem entirely from additional audit recoveries the administration believes will be generated by the addition of 15 new contracted auditor positions.

6. Aside from the narrative descriptions in Attachment 2, little, if any, additional information has been provided with respect to the potential MA program changes in Category 2 ("Reducing the Crowd-Out of Private Health Insurance"), Category 4 ("Realign Provider Incentives"), or Category 6 ("Making Reasonable Changes to Eligibility"). Regarding the latter, documents provided to this office by DHS show a reduction of 9,500 children in BadgerCare Plus beginning January 2012. The administration has indicated that this adjustment was made to reflect the anticipated impact of the program changes under consideration. It is not clear which children would be affected by those changes, nor is it clear the degree to which other enrollment assumptions

in the administration's cost projections were adjusted to reflect anticipated program changes.

7. Based on the limited information provided to date, it is not possible to determine whether the funding reductions in the bill associated with the administration's unspecified MA program changes are reasonable.

8. In certain respects, this item is similar to the unspecified MA funding reductions included in 2009 Act 28. Those Act 28 reductions required DHS to achieve over $600 million (AF) in savings in the MA program during the 2009-11 biennium, but did not specify how the Department was to realize those savings. The version of the 2009-11 biennial budget passed by the Legislature would have established a passive review process that required DHS to submit a plan to the Joint Committee on Finance prior to the Department's implementation of that plan. Governor Doyle vetoed those provisions.

9. The unspecified funding reductions in Act 28 led DHS to initiate its ForwardHealth rate reform initiatives. As part of those initiatives, DHS met with, and solicited proposals from, various stakeholder groups. The end product was a list of dozens of specific proposals DHS implemented administratively during the course of the 2009-11 biennium.

10. Reactions vary to the Department's efforts to realize the unspecified MA funding reductions in Act 28. Some have praised the Department's rate reform process for being an innovative, streamlined approach that relied upon the expertise of the administering agency (DHS) and the input of key stakeholder groups to develop valuable cost-saving measures. Others have expressed concerns about the process and outcomes. Those concerns include a perceived lack of transparency regarding the DHS decision-making process, the absence of effective legislative oversight, and an inability to document the savings that were actually achieved through the various initiatives.

11. In light of the experience with the unspecified MA funding reductions in Act 28, members may consider the degree of oversight they wish this Committee to exercise over the changes the administration indicates that it intends to make to the MA program. In that regard, members could note that during his presentation before the Committee on April 6, 2011, DHS Secretary Smith stated that the Department's decision-making process would be transparent, and that DHS would provide the Committee information regarding any federal waivers the Department intends to request prior to the Department submitting those requests to CMS. If the Committee believes that this would provide adequate oversight, it could approve the funding reductions in this item without modification. Doing so would not exempt the Department from obtaining such legislative authorization otherwise required to implement these or other changes to the MA program.

12. If, however, the Committee wishes to exercise additional oversight over that process, it could expressly require DHS to submit any federal waiver requests to the Committee for its review and approval before the Department could submit those waiver requests to CMS. Specifically, the Committee could establish a passive review process which would: (a) require DHS to submit any federal waiver request to the Committee before the Department could submit the request to CMS, and (b) allow DHS to submit the waiver request to CMS unless the Committee

schedules a meeting within 14 days of receiving the proposed request and at that meeting either rejects or amends the request. If the Committee selects this option, it could specify that this passive review process would be in addition to any other legislative authorization required for the Department to request and implement the waiver at issue.

13. The Committee could further enhance its ongoing oversight of any changes the administration makes to the MA program, as well as its fiscal oversight of the MA program in general, by requiring DHS to submit quarterly reports to the Committee that contain the following information: (a) updated descriptions of any MA program changes implemented by the Department, including a description of any amendments to the state MA plan; (b) updated estimates of the projected savings associated with those changes; and (c) updated projections of total MA benefit expenditures during the biennium and an analysis of how those projected expenditures compare to the funding provided in the corresponding biennial budget.

14. Alternatively, the Committee could reject the funding reductions in the bill that are associated with the administration's unspecified MA program changes. Members could select this option based on the lack of supporting documentation provided by the administration, both with respect to the precise nature of those changes and the reasonableness of the funding reductions attached to those changes. If the Committee selects this alternative it should add $133,267,300 ($55,971,300 GPR, $86,196,000 FED, and -$8,900,000 PR) in 2011-12 and $333,313,400 ($134,580,300 GPR, $207,663,100 FED, and -$8,930,000 PR) in 2012-13 to the funding in the bill for MA benefit expenditures.

ALTERNATIVES

1. Adopt the Governor's proposal to reduce funding for the MA program by $133,267,300 (-$55,971,300 GPR, -$88,196,000 FED, and $8,900,000 PR) in 2011-12 and by $333,313,400 (-$134,580,400 GPR, -$207,663,100 FED, and $8,930,000 PR) in 2012-13 to reflect the administration's estimate of the savings that will be achieved by making various unspecified changes to the MA program. This option does not approve any specific MA program changes the Department may pursue, nor does it exempt the Department from obtaining legislative authorization otherwise required to implement those changes.

2. Modify provisions in the bill to do one or more of the following.

a. Establish a passive review process, which would (a) require DHS to submit any federal waiver request, together with estimates of the projected savings of enacting the waiver, to the Committee before the Department could submit the request for federal approval, and (b) permit DHS to submit such waiver requests to CMS unless the Committee schedules a meeting within 14 working days of receiving the proposed request and at that meeting either rejects or amends the request. Specify that this passive review process would not exempt DHS from obtaining legislative authorization otherwise required in order for the Department to request, and if granted to implement the federal waiver at issue.

b. Require DHS to submit quarterly reports to the Committee that contain the following information: (a) updated descriptions of any MA program changes implemented by the

Department, including a description of any amendments to the state MA plan; (b) updated estimates of the projected savings associated with those changes; and (c) updated projections of total MA benefit expenditures during the biennium and an analysis of how those projected expenditures compare to the funding provided in the corresponding biennial budget.

3. Delete provision. Provide $133,267,300 ($55,971,300 GPR, $86,196,000 FED, and -$8,900,000 PR) in 2011-12 and $333,313,400 ($134,580,300 GPR, $207,663,100 FED, and -$8,930,000 PR) in 2012-13 to restore those proposed funding reductions.

ALT 3	**Change to Bill** Funding
GPR	$190,551,600
FED	293,859,100
PR	- 17,830,000
Total	$466,580,700

Prepared by: Eric Peck
Attachments

ATTACHMENT 1

2011 Federal Poverty Levels, by Family Size

Persons in Family	100% FPL	133% FPL	150% FPL	200% FPL
1	$10,890	$14,484	$16,335	$21,780
2	14,710	19,564	22,065	29,420
3	18,530	24,645	27,795	37,060
4	22,350	29,726	33,525	44,700
5	26,170	34,806	39,255	52,340
6	29,990	39,887	44,985	59,980
7	33,810	44,967	50,715	67,620
8	37,630	50,048	56,445	75,260

ATTACHMENT 2

	Administration's Description	Projected Biennium Savings GPR	Fed	PR	Total
Category #1: Bringing the Coverage Of Working Families Back in Line with Employer-Sponsored Insurance	The department is moving away from a one-size-fits-all approach to benefit design under the current program in order to provide working families Medicaid coverage that is more comparable to the coverage provided by employers, at a cost that is still affordable to low-income enrollees. The department will develop systems to encourage individual responsibility by assisting recipients in making healthy lifestyle choices, managing their benefits effectively and avoiding unnecessary care. This plan will expand the use of the benchmark plan, which is based on the most widely-subscribed commercial plan in the state, and revise cost sharing requirements to be more comparable with private health insurance coverage while still ensuring affordability by capping copayments, coinsurance and premiums at five percent of family income.	-$47,260,000	-$72,490,000	$17,830,000	-$101,920,000
Category #2: Reducing the Crowd-Out Of Private Health Insurance	In addition to making the coverage provided to working families more comparable to employer-sponsored insurance, eliminating the incentive to choose Medicaid over private health insurance options, the department will implement reforms to reduce the crowd-out of private health insurance. The Medicaid program was created to act as a safety net for individuals without access to health care coverage. The department will re-evaluate the definition of access to affordable health insurance and require individuals to enroll in other available coverage prior to enrolling in Medicaid. For BadgerCare Plus, this will include young adults who are now eligible for coverage under their parents' policies. For SeniorCare, this will require individuals to enroll in Medicare Part D as a condition of eligibility for SeniorCare.	-$12,560,000	-$19,810,000	$0	-$32,370,000*

* Excludes SeniorCare/Part D savings.

	Administration's Description	Projected Biennium Savings GPR	Fed	PR	Total
Category #3 Improving the Management Of care and coordination with Medicare	The department will develop innovative models of service delivery, including health homes, to more effectively manage the care provided to recipients. Those improvements are intended to improve the health status of recipients, reduce avoidable complications and minimize the provision of unnecessary services. In addition, the department will implement systems to coordinate care across Medicaid and Medicare for dual eligibles, to leverage additional resources and better meet the needs of recipients.	-$52,230,000	-$79,780,000	$0	-$132,010,000
Category #4 Realign Provider Incentives	No additional description provided.	-$29,510,000	-$46,070,000	$0	-$75,580,000
Category #5 Improve Provider Integrity	No additional description provided.	-$15,861,600	-$24,139,100	$0	-$40,000,700
Category #6 Making Reasonable Changes To Eligibility Criteria	In lieu of reducing eligibility, as allowed under PPACA, the department is preparing a package of reasonable, targeted eligibility changes to ensure that program resources are targeted to those who are most in need and have no other means to access health care. These include reviewing the standards for state residence, revising retroactive eligibility and grace period policies and enforcing current policies to improve the accuracy of eligibility determinations.	-$33,130,000	-$51,570,000	$0	-$84,700,000
	Biennium Totals	-$190,551,600	-$293,859,100	$17,830,000	-$466,580,700