**Legislative Fiscal Bureau**
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

January 26, 2012

TO: Members
Wisconsin Legislature

FROM: Bob Lang, Director

SUBJECT: Medical Assistance Program Status

This memorandum responds to numerous legislative inquiries and provides information on the status of the state's medical assistance (MA) program, including current cost projections and proposals the Department of Health Services (DHS) intends to implement to address a projected shortfall in funding for the program in the 2011-13 biennium.

**Current Cost Projections**

**Base Reestimate.** In its most recent quarterly report to the Joint Committee on Finance on the status of the MA budget, dated December 30, 2011, DHS reported a potential shortfall of $92.3 million GPR in the 2011-13 biennium. This projected deficit is $127.2 million GPR less than the shortfall DHS projected in its September, 2011, quarterly report to the Committee ($219.5 million GPR). The current estimate is based on actual expenditures through November, 2011, and reflects new information regarding the costs of certain services. The primary factors resulting in the reestimate from the September projection include: (a) reduced estimates of fee-for-service inpatient and outpatient hospital payments (-$28.3 million); (b) reduced estimates of the costs of Medicare Part A and Part B premiums the MA program pays on behalf of individuals eligible for both Medicare and Medicaid, commonly referred to as "dual eligibles" (-$23.6 million); (c) reduced estimates of Medicare deductibles and coinsurance the MA program pays on behalf of dual eligibles (-$35.6 million); (d) a correction in the savings estimate relating to Act 32 changes in the Wisconsin Medicaid cost reporting (WIMCR) program (-$25.0 million); (e) reduced estimates of drug rebate revenue the MA program will return to the federal government (-$18.5 million); and (f) reestimates of all other program costs ($3.8 million).

Compared to the September and Act 32 estimates, the current caseload estimates have not

changed significantly, with the exception of the number of adults with family income up to 200% of the federal poverty level (FPL) without dependent children who are enrolled in the Core plan. Although the funding budgeted in Act 32 assumed there would be an average of 43,000 adults enrolled in the Core plan in each year of the 2011-13 biennium, the current estimate assumes enrollment will continue to decrease to an average of 30,300 in 2011-12 and 26,300 in 2012-13. In October, 2009, DHS stopped enrolling new applicants into the program. Since that time, the total number of individuals enrolled in the Core plan has decreased due to attrition. As of December, 2011, there were 29,260 individuals enrolled in the Core plan. DHS has stated that it does not currently plan to begin enrolling individuals in the Core plan at any time during the 2011-13 biennium.

The current $92.3 million GPR deficit projection does not reflect two program changes that the Department intends to implement in the near future -- the cost of discontinuing the enrollment cap on Family Care and the state's related long-term care programs, and savings the Department expects to realize by implementing changes to the state's BadgerCare Plus program that have been preliminarily approved by the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS). These two items are described below.

**Cost of Discontinuing the Family Care Enrollment Cap.** On December 13, 2011, CMS sent a letter to the state's Medicaid Director indicating that it was continuing to review amendments submitted by the Department that would alter the current Family Care and self-directed supports waivers. CMS indicated that because the conditions of the current waiver includes an entitlement to waiver services, it was directing DHS to identify any individuals not currently enrolled onto the Family Care or self-directed supports waivers since the July 1, 2011, implementation of the enrollment cap and immediately enroll those individuals in the waiver programs. This directive applies to individuals living in any counties who were or would have been entitled to waiver services as of July 1, 2011, including individuals who were or would have otherwise been selected for enrollment from the other participating counties. It is estimated that the net cost of lifting the current cap would be approximately $71.8 million GPR in the current biennium ($8.6 million less than the $80.4 million GPR previously reported, based on a reestimate of the costs of serving individuals currently on waiting lists).

**Savings Resulting from Program Changes Preliminarily Approved by CMS.** DHS expects to realize savings totaling approximately $23.2 million GPR in the current biennium due to changes in the MA program that have been preliminarily approved by CMS as part of the state's Medicaid 2014 Waiver request. Act 32 directed DHS to request a waiver of a provision in the federal Patient Protection and Affordable Care Act (PPACA) that prohibits state MA programs from having in effect eligibility standards, methodologies, and procedures that are more restrictive than those in place on March 23, 2010. This provision is commonly referred to as the PPACA maintenance of effort (MOE) requirement. For adults, this MOE requirement is in effect until the DHHS Secretary certifies that a health benefits exchange is fully operational in the state (which is assumed to be January 1, 2014), while for children under the age of 19, the MOE requirement runs through September 30, 2011.

On November 10, 2011, the Joint Committee on Finance, acting under authority provided in Act 32, approved the Department's MOE waiver request, together with other proposed modifications to the MA program that, if implemented, would not conform to current statutes. On December 9, 2011, CMS notified DHS that it was prepared to approve several components of that waiver request as they apply to non-disabled, non-pregnant adults with income above 133% of the FPL. These provisions include:

- Application of the 9.5% affordability test with respect to employer sponsored insurance that meets minimum benefit standards;

- Premium increases for the adult family members up to 5% of family income, for adults in families with income greater than 150% of the FPL; and

- A 12-month restrictive re-enrollment period for MA eligibility for the adults who fail to make a premium payment.

In its December 9, 2011, letter, CMS indicated that Wisconsin has the flexibility to make these changes under an exception to the PPACA MOE requirement that allows states to fully or partially restrict MA eligibility for non-disabled, non-pregnant adults with incomes over 133% of the FPL if the state certifies that it has a state budget deficit in the current year or that it is projected to have a state budget deficit in the upcoming state fiscal year. On December 29, 2011, the Secretary of the Wisconsin Department of Administration submitted to DHHS a certification to that effect.

In addition, the CMS letter of December 9, 2011, indicated that it would approve the state's request to end coverage for recipients whom the state has determined to be ineligible for MA 10 days after they have received an adverse action notice, rather than extending coverage through the end of the month, as is the Department's current practice.

Act 32 includes a provision that states that if the Department's MOE waiver request does not receive federal approval before December 31, 2011, DHS "shall reduce income levels on July 1, 2012, for the purposes of determining eligibility to 133% of the federal poverty line for adults who are not pregnant and not disabled, to the extent permitted under [PPACA]." Under current law, these individuals are eligible for BadgerCare Plus if their income does not exceed 200% of the FPL. Although CMS did not approve all of the components in the Medicaid 2014 Demonstration waiver by the December 31, 2011, deadline, it is the administration's position that CMS has preliminarily approved enough of the Department's request to consider the waiver "approved." Consequently, DHS has indicated that it does not intend to eliminate MA eligibility for all non-disabled, non-pregnant adults in families with income between 133% and 200% under this provision in Act 32. Should the administration decide to proceed otherwise in the future, such changes to the program's eligibility requirements could be accomplished with the approval of the Joint Finance Committee under the authority it was provided in Act 32 to implement program changes that are inconsistent with the current MA statutes, or through separate legislation.

**Proposed Program Changes to Address Projected Shortfall**

If DHS implements the two sets of changes identified immediately above (lifting the Family Care enrollment cap and implementing the MOE waiver items preliminarily approved by CMS on December 9, 2011), the projected deficit for the MA program in 2011-13 increases to approximately $140.9 million GPR. The Department is pursuing potential savings opportunities that, if implemented, could reduce that projected shortfall. These savings initiatives fall under the following three categories: (a) proposed modifications to BadgerCare Plus submitted by DHS to CMS in November, 2011, that have not yet been approved; (b) proposed changes to Family Care and services provided to elderly, blind and disabled (EBD) MA populations; and (c) other program changes DHS is intending to implement as a matter of policy and that would require no additional legislative approval. Each of these groups of savings proposals is discussed below.

**BadgerCare Plus Proposals Pending with CMS.** The total estimated savings that would result from the BadgerCare Plus program modifications DHS submitted to CMS in November, 2011, and is continuing to pursue was $116.7 million GPR. By subtracting the savings DHS expects to realize from the items CMS has preliminarily approved, DHS estimates that it could realize an additional $93.5 million in GPR savings in the 2011-13 biennium if CMS approves all of the remaining items.

The items pending before CMS represent significant changes to the state's BadgerCare Plus waiver agreement, federal law, and CMS policies, especially with respect to coverage of children. DHS has estimated that if all of the changes requested in the Medicaid 2014 Waiver request were approved, approximately 29,100 children would no longer be enrolled in the program, either because they would no longer be eligible, or because their families would disenroll them in response to the higher premiums proposed under the waiver request. In addition, DHS has proposed requiring almost all BadgerCare Plus recipients with family income between 100% and 200% of the FPL to switch from the Standard Plan to a new Alternative Benchmark Plan, which would have more limited benefits and substantially increased cost-sharing requirements compared to the Standard Plan. It is not known how or when CMS will respond to these still-pending items.

**Proposals to Reduce Costs of Family Care and Services for EBD Populations.** In January, 2012, the Department made public several proposals that it estimates would reduce costs of MA-funded services by $71.9 million GPR in the 2011-13 biennium. Those proposals, several of which are described below, can be implemented administratively by DHS without further legislative authorizations.

First, DHS estimates that it could save approximately $36.0 million GPR in 2012-13 by reducing the number of individuals admitted to nursing homes and hospitals as a result of non-compliance with their medication regimen. Numerous studies have been prepared which indicate that various medication management interventions can reduce medicine costs. A number of these studies have been referenced by DHS.

To generate its projected savings, DHS proposes to spend approximately $1.4 million GPR

on medication dispensers to place in the homes of approximately 6,700 elderly, disabled, and mentally ill MA recipients. The Department assumes that 23% of nursing home admissions in Wisconsin are due to medication non-compliance and that medication dispensers can reduce non-compliance by 98%. Through the use of medication dispensers, the Department concludes that it can reduce the number of nursing home admissions related to medication non-compliance from 1,679 individuals to 34 individuals annually. In addition, DHS assumes it can reduce monthly hospital admissions by 10% (or 120 admissions in 2012-13) among disabled individuals eligible only for MA.

As noted above, the Department's estimate for the medication dispenser proposal relies on two key assumptions -- that 23% of nursing home admissions in Wisconsin are caused by medication non-adherence and that medication dispensers can reduce the number of nursing home admissions related to medication non-adherence by 98%. DHS cites a 1984 article by Lee R. Strandberg in the American Health Care Association Journal as the source of the 23% estimate. In the article, Strandberg cites the findings of a 1981 assessment by Oregon's Department of Health Services, which found that 90% of Oregon's nursing home residents did not manage or administer their own medications and that 24% of those individuals did not have similarly severe scores in the other 24 areas assessed. This study may have limited relevance to the DHS proposal for several reasons, including the study's age, the possibility that Oregon's population may not be similar to Wisconsin's, and that Wisconsin has had managed care for many years while Oregon did not in 1981. Wisconsin's current nursing home population is much smaller and has greater care needs (acuity) than it had 30 years ago. In addition, the Oregon study's findings suggest a link between medication adherence and nursing home admissions, but the article does not provide evidence of causation. Although medication management might have been the most severe need for the individuals assessed, they may have actually been admitted to a nursing home for any number of other reasons.

In addition, this office was able to find one study that specifically attributed a medication dispenser with increasing medication adherence to nearly 98%. As part of their innovations exchange project, the Agency for Healthcare Research and Quality in DHHS has posted on their website a profile titled "Electronic and Telephone Reminders Increase Medication Adherence in Adults with Uncomplicated Hypertension." The profile summarizes a study conducted by The Center for Connected Health in Boston, Massachusetts in 2009 with funding by Vitality, Incorporated, a maker of medication dispensers. In the study, the researchers compared the level of medication adherence of a control group to that of a treatment group that was provided with an electronic pill bottle cap that flashed when the participant was supposed to take their hypertension medication. If the participant did not take their medication within one hour the system beeped and called the telephone number chosen by the participant to remind them. Under these conditions, the treatment group reported 86.3% adherence, while the control group reported 61% adherence. When participants were paid an incentive of $15 for every month they achieved at least 80% adherence, the study reported nearly 96% adherence.

As with the Oregon study, the results of the medication dispenser study described above may not be a reliable predictor of effectiveness for Wisconsin's elderly and disabled MA population.

Foremost, the study's findings suggest that the medication dispenser in conjunction with financial incentives increased compliance from the control group's 61% adherence to the treatment group's 96%. This would indicate a 35 percentage point increase in medication adherence as a result of the treatment, whereas the Department is assuming a 98 percentage point increase in adherence through its proposal. It should also be noted that the Center for Connected Health study did not report findings regarding the effectiveness of medication dispensers at reducing the number of nursing home admissions.

The study's participants had an average age of 50 years, were relatively affluent, had wireless Internet access, and had uncomplicated hypertension with no comorbid conditions. As part of their hypertension treatment, participants were required to take a single pill once a day. The profile on the DHHS website also notes that the specific system tested works best when a patient has four or fewer medications. It is not clear what extent these characteristics correspond to Wisconsin's elderly, blind, and disabled MA population.

Second, DHS estimates that it could reduce costs by approximately $14.1 million GPR by reducing the number of Family Care-related enrollees who receive residential care from 39% currently, to 36% of enrollees. This would entail either diverting or assisting 1,600 individuals who would otherwise receive residential care (in assisted living facilities, for example) to instead receive long-term care services in their homes. For each individual who is diverted or relocated, the Department estimates it would save approximately $1,869 (all funds) per month, which reflects the difference in benefit costs between residential and non-residential enrollees who are elderly. The Department has indicated a number of ways it could use to realize these savings, including more restrictive criteria for allowing enrollees to enter residential settings through Family Care and the I Respect, I Self-direct (IRIS) program.

While DHS indicates it can begin to implement and generate savings from these changes immediately in the IRIS program, in the Family Care, PACE, and Partnership programs the Department will not be able to generate GPR savings for the state until capitation rates for the MCOs are adjusted to reflect these reduced service costs. DHS intends to reduce calendar year 2013 capitation rates to reflect any reductions in service costs, including reduced use of residential services, and will monitor MCO costs in 2012 to determine if calendar year 2012 rates can be adjusted as well.

Third, DHS believes it can reduce the number of new enrollees that enter Family Care-related programs. The Department estimates it can save approximately $12.3 million GPR in 2012-13 by creating prevention programs and short-term community interventions that will reduce the number of enrollments related to difficulties with falling and chronic disease self management by 1,200 individuals. The estimate is based in part on the $2,127 (all funds) per member per month net costs of individuals on the waitlist.

Fourth, the Department estimates that it can save approximately $6.2 million GPR in 2012-13 by increasing the number of nursing home residents that voluntarily relocate to community-based settings by 1,194 individuals. Approximately 50% of the voluntary relocations would be

allocated to the Money Follows the Person demonstration which provides an 80% FMAP for the first year of services an individual receives in the community after relocating from a nursing home. DHS indicates it intends to initiate a concentrated effort to identify fee-for-service nursing home residents with relatively low acuity and inform them of the alternatives available to them in the Family Care-related programs. It should be noted that the GPR share of expenditures for these individuals will increase after their first year in the community, but total GPR costs will remain lower than their current nursing home costs.

Fifth, DHS intends to save approximately $1.2 million GPR in 2012-13 by adjusting budget allocations for some individuals enrolled in IRIS. When an individual enrolls in IRIS, they receive a monthly budget allocation based on their level of care needs. In July, 2010, DHS adjusted its budget allocation methodology after it determined that the method it had been using was resulting in allocations that were larger than the cost of services the individuals would receive in Family Care. As a result, the program now consists of two groups of enrollees -- those whose allocations were determined under the first methodology and those whose allocations are determined using the post-2010 methodology. DHS intends to reduce by 10% the budget allocation for those individuals who are still receiving allocations based on the initial methodology.

Finally, DHS expects to realize savings totaling $2.0 million GPR in 2012-13 to reflect multiple changes to Family Care benefits, Family Care administration, improved employment opportunities for disabled youth, and increased counseling for disabled youth and their families as the youth reaches adulthood. The Department expects each of these items to generate savings of approximately $0.5 million GPR in 2012-13. Some of the proposed changes include providing enrollees with more cost information about the program, increasing the emphasis on an enrollee's natural supports, increased MCO flexibility in care management, and a pilot program with the Division of Vocational Rehabilitation to provide employment services for Family Care-related enrollees with disabilities.

**Proposals DHS Intends to Implement Administratively.** DHS intends to implement some program changes in the 2011-13 biennium that will not require legislative action or CMS approval. Examples of these items include increased auditing activities, implementing systems changes to increase federal claims, and creating a pilot program to coordinate care for individuals who are eligible for both MA and Medicare by integrating both MA and Medicare funding and services. In total, DHS believes these initiatives could reduce MA benefits costs by approximately $75.2 million GPR in the 2011-13 biennium. A listing of these initiatives, together with estimated implementation dates and the Department's estimates of savings relating to each of these proposals, is provided in Attachment 1. Little information is available regarding the savings estimates for the proposal.

**Summary**

Attachment 2 summarizes the estimated costs and savings of the items described in this memorandum. The attachment shows that if the Department lifts the enrollment caps in Family Care and IRIS and only achieves the MOE savings items preliminarily approved by CMS, the MA

program would have an estimated $140.9 million GPR deficit in the 2011-13 biennium. The agency's ability to remain within budget depends to a large extent on its success in realizing the estimated savings from its proposed changes. Given that much of those savings depend either on still-pending CMS determinations, or the success of initiatives such as the medication dispenser proposal, careful monitoring of the program's ongoing budget status is warranted during the remainder of the current biennium.

Attachments

## ATTACHMENT 1

### Program Changes DHS Intends to Implement as a Matter of Policy
### GPR Only -- $ in Millions

| Program Change | Estimated Implementation Date | Savings Estimate in 2011-13 Biennium |
|---|---|---|
| Personal Care Payment Policies | 3/1/2012 | $2.3 |
| Enhanced Third Party Liability Identification | Fall 2011 | 3.6 |
| Federal Claiming Enhancements | 3/1/2012 | 5.0 |
| Implement Enhanced Ambulatory Grouping System for Outpatient Hospital Reimbursement | Jan 2013 | 1.6 |
| Auditing Enhancements | 1/1/2012 | 14.9 |
| Managed Care and Fee-for-Service Payment Review | Fall 2011 | 2.0 |
| Pay for Performance -- Health Maintenance Organizations Reimbursement | 3/1/2012 | 0.7 |
| Pay for Performance -- Hospital Reimbursement | Spring 2012 | 5.0 |
| Physician Rate Change for Certain Services Provided in a Hospital | 3/1/2012 | 1.3 |
| Reimbursement Modification for Consultation Services | 3/1/2012 | 1.2 |
| Recovery Audit Contractors | Early 2012 | 3.0 |
| Wisconsin Medicaid Cost Reporting System (WIMCR) Changes | 2012 | 19.2 |
| Virtual PACE | 1/1/2013 | 3.4 |
| Non-Emergency Medical Transportation Management System for HMO Enrollees in Southeast WI | 9/1/2012 | 3.0 |
| Maximize Drug Rebate Collections | Spring 2012 | 3.0 |
| WI Pharmacy Quality Collaborative | Spring 2012 | 1.0 |
| Asset Test Enhancement | Spring 2012 | 3.0 |
| Eligibility Determination Integrity | Fall 2012 | 2.0 |
| Total | | $75.2 |

## ATTACHMENT 2

### Summary of the Status of the MA Program
### GPR Only -- $ in Millions

| | 2011-13 Biennium |
|---|---|
| **Shortfall Estimates** | |
| DHS -- September, 2011 | -$219.5 |
| DHS December, 2011 (Based on Actual Expenditure and Caseload through November) | -92.3 |
| Difference | $127.2 |
| Factors Resulting in Change from September to December | |
| Inpatient and Outpatient Hospital Payments | $28.3 |
| Medicare Part A and Part B Premium Payments for Dual Eligibles | 23.6 |
| MA Payments for Deductibles and Coinsurance for Dual Eligibles | 35.6 |
| Correct Savings Estimate Relating to WI Medicaid Cost Reporting Program | 25.0 |
| Reestimate Drug Rebate Revenue that Must Be Paid to CMS | 18.5 |
| Other | -3.8 |
| Total | $127.2 |
| December 2011 Estimated Shortfall (Assumes no Program Changes) | -$92.3 |
| Estimated Cost of Removing Family Care Enrollment Cap, as Required by CMS ($80.4 million less $8.6 million Cost Reestimate) | -71.8 |
| Maintenance of Effort Items Approved by Joint Committee on Finance in November, 2011 and Approved by CMS on December 9, 2011 | 23.2 |
| **Total Estimated MA Shortfall** | **-$140.9** |
| **Potential Program Savings Identified by DHS** | |
| 1. Program Changes Approved by Joint Committee on Finance in November, 2011 | |
| a. Maintenance of Effort Items | $67.0 |
| b. Alternative Benchmark Plan | 26.2 |
| c. Patient Centered Medical Homes | 0.3 |
| Subtotal | $93.5 |
| 2. Items Identified by DHS Relating to Family Care and Other MA Services for Elderly and Disabled Populations | |
| a. Medication Management -- Automatic Dispensing | |
| i. Reduced Nursing Home Admissions | $27.4 |
| ii. Reduced Hospital Admissions | 8.6 |
| b. Reduce Costs of Residential Services | 14.1 |
| c. Reduced Enrollment in Long-Term Care Programs due to Increase in Falls Prevention, Chronic Disease Self-Management, Short-Term Community Interventions | 12.3 |
| d. Increase Voluntary Relocations from Nursing Homes (1,200 in 2012-13) | 6.2 |
| e. Reestimate Costs of Individuals Using Self-Directed Supports (IRIS) | 1.3 |
| f. Family Care Benefits | 0.5 |
| g. Employment Supports | 0.5 |
| h. Youth in Transition | 0.5 |
| i. Family Care Administration and Program Efficiencies | 0.5 |
| Subtotal | $71.9 |
| 3. Program Changes DHS Intends to Implement Administratively | $75.2 |