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TO: Representative Jon Richards
Room 118 North, State Capitol

FROM: Bob Lang, Director

SUBJECT: Senate Bill 380/Assembly Bill 477: Repeal Family Care Enrollment Cap

2011 Senate Bill 380 and Assembly Bill 477 are identical bills that would repeal provisions included in 2011 Wisconsin Act 32 that place an enrollment cap on the Family Care, Family Care Partnership, Program for All-Inclusive Care for the Elderly (PACE), and Include Respect I Self-direct (IRIS) programs. Senate Bill 380 was introduced on January 17, 2012, and referred to the Senate Committee on Health, Human Services, and Revenue. Assembly Bill 477 was introduced on January 18, 2012, and referred to the Assembly Committee on Aging and Long Term Care.

BACKGROUND

Family Care is a medical assistance (MA) program that provides long-term care services to qualifying individuals under a capitated, risk-based payment system. The program has two primary components -- aging and disability resource centers (ADRCs) and managed care organizations (MCOs). ADRCs are meant to be a gateway for all individuals in the state in need of long-term care services, providing "one-stop shopping" for information, assessments, functional eligibility determinations, prevention, wellness, and other services relating to long-term care. MCOs provide long-term care services to Family Care enrollees, either through contracts with providers or by providing care directly through their employees. These services include many of the services provided under home- and community-based waiver programs (legacy waivers), non-institutional long-term care services provided under the MA standard plan (commonly referred to as "card services"), and nursing home services.

If the Family Care benefit is offered in a county, eligible individuals must also have the option to instead self-direct their long-term care services through the IRIS program. Individuals enrolled in IRIS receive a monthly budget allocation and choose which long-term care services they receive, and which providers will render these services. The budget allocation cannot be

more or less than the cost of services that the person would have received if they had chosen to enroll in Family Care instead of IRIS. DHS operates both programs under waivers of federal MA laws granted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

Under these programs, individuals that meet both functional and financial eligibility standards are entitled to a full package of home- and community-based services designed to meet their needs. Family Care and IRIS benefits become an entitlement for all eligible individuals residing in a Family Care county 36 months after these benefits first become available. Family Care and IRIS benefits replace the legacy waiver services that were previously available in those counties. Consequently, while individuals who are eligible for Family Care and IRIS are not required to participate in these programs, eligible individuals who choose not to enroll in the programs do not have access to MA services that were previously provided under the legacy waiver programs. MA recipients who are not enrolled in Family Care may still receive medically necessary, MA-funded long-term care services through the standard set of Medicaid benefits, subject to certain limitations. Counties that have not yet chosen to join the Family Care program may continue to administer the legacy waiver programs.

The state offers two additional long-term care managed care programs in addition to Family Care. The Program for All-inclusive Care for the Elderly (PACE) and the Family Care Partnership (FCP) program are managed care programs that provide both acute health and long-term care services to elderly and disabled individuals who are eligible for nursing home care. Enrollment in the PACE program is limited to elderly individuals, ages 55 and older, while both elderly and disabled individuals may enroll in FCP. These voluntary programs are targeted to people that are eligible for both MA and Medicare (dual eligibles).

In the Family Care, FCP, and PACE programs, the state's MA program makes capitation payments to MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on each individual's level of functional eligibility, labor costs and administrative costs. In addition to the MA capitation rate, FCP and PACE agencies also receive a Medicare capitation rate for acute care services. As described above, IRIS participants receive a monthly budget allocation and control which services to receive and the amount of payment. A portion of the benefit costs in the Family Care program are offset by mandatory county contributions and savings attributable to the Family Care program's lower costs relative to the legacy waiver programs.

As MA eligible programs, the federal government contributes funding for capitation payments and budget allocations in the Family Care-related programs equivalent to Wisconsin's federal medical assistance percentage (FMAP). Historically, Wisconsin's FMAP has been approximately 60%. The remaining 40% is provided through state GPR or the county contributions.

Under current law, DHS is required to notify the Joint Committee on Finance, under a 14-day passive review process, if DHS proposes to contract with entities to administer the Family Care benefit in new geographic areas. If the Co-Chairs of the Joint Committee on Finance inform

the Department within 14 days that it has scheduled a meeting to review the contract, DHS may only enter into the contract if the Committee approves the contract or if the Committee fails to act on the proposed contract within 59 working days after the date of the Department's notification.

2011 WISCONSIN ACT 32

2011 Wisconsin Act 32, the biennial budget act, prohibited the Department of Health Services (DHS) from enrolling, in the service region of each Aging and Disability Resource Center, more persons into the Family Care, Family Care Partnership, PACE, or IRIS programs than the total number of persons participating in all of those programs in that ADRC service region on June 30, 2011. DHS can only enroll persons into the long-term care programs that are offered in that person's county of residence. The enrollment cap does not apply after June 30, 2013. Months during which the enrollment cap is in effect may not be counted toward the statutory requirement that the Department have sufficient capacity to offer the Family Care benefit to all entitled persons after the first 36 months the benefit is available in a county ("entitlement status").

Notwithstanding the provision described above, Act 32 authorized DHS to enroll any individual into the Family Care, Family Care Partnership, PACE, or IRIS programs who is relocated from a nursing home, intermediate care facility for the mentally retarded (ICF-MR), or State Center for People with Developmental Disabilities if the individual has resided in the facility for at least 90 days, the facility is not licensed, an emergency exists, or the facility is closing or downsizing, during the period of the enrollment cap.

Further, Act 32 prohibited DHS from proposing to contract with entities to administer the Family Care benefit in a county in which the Family Care benefit was not available on July 1, 2011, unless DHS determines that administering the Family Care benefit in such a county would be more cost-effective than the county's current mechanism for delivering long-term care services. This prohibition is in effect from July 1, 2011, through June 30, 2013.

Act 32 provided the Department with $12,639,000 ($5,000,000 GPR and $7,639,000 FED) in 2011-12 and $12,600,800 ($5,000,000 GPR and $7,600,800 FED) in 2012-13 to provide long-term care services and support items that are offered in the Family Care program to individuals who are on the waiting list for a Family Care-related program and who are in urgent need of long-term care services, as determined by DHS. These funds may be used to serve individuals until the individual is permanently enrolled in one of the programs. To date, virtually none of these funds have been expended.

Finally, Act 32 required the DHS Secretary to study the cost-effectiveness of the Family Care, FCP, IRIS, and PACE programs. As described in statute, the study must compare the cost-effectiveness of each program to each of the other programs, the cost-effectiveness of each program to standard MA benefits, and the cost-effectiveness of the care that individuals receive before they enroll in a long-term care program to the care that the individuals receive in a long-term care program. DHS must submit its findings of this study to the Joint Committee on

Finance.

As of January 1, 2012, nine MCOs provided services in 57 counties and 35 ADRCs provided services in 59 counties. Family Care, PACE, and Family Care Partnership currently serve approximately 43,400 individuals. Thus, at this time, the Family Care program is not available in 15 counties.

BILL SUMMARY

Senate Bill 380 and Assembly Bill 477 ("the bill") would repeal all of the Act 32 provisions described above, except for the requirement that the DHS Secretary study the cost-effectiveness of each of the long-term care programs and present the findings of that study to the Joint Committee on Finance. As required under current law, both prior to and after the Act 32 changes, DHS would have to submit any proposed Family Care expansions to the Joint Committee on Finance under the passive review process described above.

FISCAL EFFECT

The Department estimates that the GPR cost of repealing the enrollment cap would be $81.9 million. Applying the unused $10 million GPR provided in Act 32 for emergency cases to the repeal of the cap reduces the amount needed to $71.9 million GPR. The bill would not increase funding to support the costs of repealing the enrollment cap. Instead, the Department proposes to implement several initiatives to reduce costs of Family Care and other MA-funded services to the state's elderly and disabled MA populations. The Department's estimates of savings from these initiatives approximately equal the estimated cost of repealing the enrollment cap in the 2011-13 biennium.

Cost of Repealing Enrollment Cap. In a December 13, 2011, letter to DHS, CMS indicated it was reviewing the state's proposed waiver amendment to implement an enrollment cap in the Family Care-related programs but added that "until specific approval of an amendment is received, the State is required to continue to operate the waiver as described in the currently-approved 1915(c) waiver application." CMS specified that because Wisconsin's currently approved waiver includes entitlement to waiver services, it is "directing the State to identify any individuals not currently enrolled onto the Family Care or Self-Directed Supports waivers since the July 1, 2011, implementation of the newly instituted enrollment caps, and immediately enroll those individuals in the waiver programs." In order to be in compliance with the CMS directive, the letter indicates that DHS is required to enroll "individuals living in any counties who had or would have had an entitlement to the waivers as of July 1, 2011, and includes individuals who were or would have otherwise been selected for enrollment from the other participating counties." The letter closes by outlining three areas that CMS continues to review in the proposed waiver amendment, including compliance with the maintenance of effort (MOE) requirements in PPACA, the level of tribal consultation regarding the enrollment cap, and any other CMS concerns the state must address.

If the state does not comply with the CMS directive, one possible repercussion is a

reduction in federal MA matching funding that would be available to support MA benefits costs. In the past, CMS has withheld federal matching funding from states that have not complied with its directives. It is estimated that approximately $798 million FED in 2011-12 and $952 million FED in 2012-13 will be used to support services provided under the Family Care, Family Care Partnership, PACE, and IRIS programs.

The Department indicates that, if the bill is enacted, it would immediately begin enrolling individuals on the bill's effective date and that those months during which the cap was in place will count toward each county's 36-month phase-in period for entitlement. Prior to Act 32, counties were required to incrementally enroll new Family Care participants over the course of 36 months, after which all financially and functionally eligible individuals would be entitled to the Family Care and IRIS benefits and could be enrolled immediately. In addition to establishing the enrollment cap, Act 32 also required that any month for which the enrollment cap was in place could not be counted toward a county's 36-month phase-in period. If the bill is passed and the Department adheres to its expressed intent, any county that would have reached entitlement status during the duration of the enrollment cap would be deemed to have reached entitlement on the effective date of the bill.

After applying the unused emergency funding provided under Act 32, the Department estimates that the cost of lifting the cap on the Family Care-related programs would be $29,829,500 ($11,773,700 GPR and $18,055,800 FED) in 2011-12 and $149,271,500 ($60,096,700 GPR and $89,174,800 FED) in 2012-13. The estimate is based on a number of assumptions, which are described below.

The Department estimates that the net cost of each new enrollee in a Family Care-related program would be approximately $2,127 (all funds) per member per month. The net per member per month cost is estimated by starting with the average capitation payment per member per month across all of the Family Care-related programs and then deducting from this amount offsetting cost savings that the Family Care-related programs generate relative to other areas of the MA program, such as fee-for-service nursing home expenditures and the legacy waiver programs. The Department assumed that capitation payments for new enrollees would not begin until March of 2012.

DHS estimates the waitlist for Family Care-related services grew from 5,049 in July, 2011, to 6,740 individuals at the end of November, 2011, an increase of 1,691 individuals. A significant number of the individuals on the waitlist will not be financially eligible for Family Care-related services for a number of years. DHS indicates that the CMS directive does not require the Department to enroll individuals more rapidly into Family Care-related programs than is assumed under the current waiver with CMS. Under current law, individuals in counties that have not reached entitlement would be enrolled under the 36 month phase-in described above. DHS plans to continue this schedule. As a result of lifting the cap, the Department estimates that the total number of individuals enrolled in any Family Care-related program will increase by nearly 10,000 individuals, from approximately 43,165 individuals in February, 2012, to approximately 53,139 individuals in June, 2013. In addition to some individuals from the waitlist, these new enrollments will also include individuals from entitlement counties that are

not on the current waitlist.

Based on its analysis of the waitlist, DHS assumed that no more than 40% of individuals that have joined the waitlist since July, 2011, are currently eligible for the MA standard plan and could be immediately enrolled into the program. The Department assumed that the remaining 60% of individuals are either not yet financially eligible for Family Care-related services or will need to go through the financial eligibility process prior to receiving services. It should be noted that individuals needing a nursing home level of care can qualify for long-term care services, including Family Care-related services, at a higher income and asset threshold than is allowed for the MA standard plan. It is possible that more than 40% of the individuals that joined the waitlist since July, 2011, will need to be enrolled if they meet these criteria.

Depending on whether or not a county has reached entitlement status, the Department has established different methods for managing the growth in the waitlists when the cap is lifted. Over the course of four months, counties that have not reached entitlement will enroll all individuals that would have been enrolled if not for the enrollment cap, and will then return to enrolling individuals at the same rate as they did prior to the enrollment cap. Counties that have reached entitlement status while the cap has been in place are expected to enroll 40% of the individuals on their waitlist immediately and then return to a trend similar to what existed prior to the cap. The Department assumes that those counties that were at entitlement prior to the enrollment cap will immediately enroll the lesser of either (a) 40% of their current waitlist or (b) the cumulative projected enrollment during the enrollment cap based on historical trends.

Based on each county's Family Care start date and the 36 month phase-in period, 14 counties were entitled prior to the implementation of the enrollment cap. Another 15 counties reached entitlement status while the cap was in place and will be at entitlement if the enrollment cap is repealed. Of the remaining counties, 25 will reach entitlement in the 2011-13 biennium but after the cap is lifted, four counties would reach entitlement in the 2013-15 biennium, and 15 counties have yet to join the program. The total number of counties listed above is one greater than the number of counties in Wisconsin due to Milwaukee County operating two implementation schedules, one for its elderly population and another for its disabled population.

In its estimate, the Department assumed that the Joint Committee on Finance would approve expansion to seven counties as of January, 2013 (Brown, Door, Kewaunee, Marinette, Menominee, Oconto, and Shawano Counties). Due to the mandatory county contributions and offsetting savings in Family Care relative to the legacy waiver programs, expanding Family Care into new counties generates savings for the state in the short-term. However, as the number of Family Care recipients in a county exceeds the original number of legacy waiver recipients, aggregate costs begin to exceed the savings. The Department's estimate assumes that expansions approved by the Joint Committee on Finance would be at worst cost neutral in the current biennium.

Offsetting Savings. DHS indicates that it can fund the entire cost of repealing the Family Care enrollment cap through program changes both within and outside of the Family Care-related programs. DHS has attached savings estimates to some of these initiatives, but may

realize savings through other program changes. Total benefits funding for Family Care, Family Care Partnership, PACE, and IRIS, after the enrollment cap is lifted and the urgent needs funding is deducted, is estimated to be approximately $1,763 million ($705 million GPR and $1,058 million FED) in 2012-13. The Department estimates its proposals will generate savings of approximately $177.4 million ($71.9 million GPR and $105.5 million FED) in 2012-13, or approximately 10% of the estimated costs of Family Care-related programs.

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.

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