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May 30, 2013 Joint Committee on Finance Paper #320

MA Cost-to-Continue Reestimate
(DHS -- Medical Assistance and Related Programs)

[LFB 2013-15 Budget Summary: Page 198, #2]

CURRENT LAW

The state's medical assistance (MA) program pays certified healthcare providers for the wide range of primary, preventive, acute, and long-term care services they provide to MA recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law, and under the terms of the state plan it submits to the federal Centers for Medicare and Medicaid Services (CMS) for review and approval.

The program has two primary components. The first, called EBD MA, provides elderly, blind, and disabled individuals access to a comprehensive set of healthcare services through the MA standard plan, including physician services, prescription drugs, inpatient and outpatient hospital services, and nursing home services. Some EBD MA participants also receive non-traditional long-term care services through Family Care and the other home- and community-based waiver programs. The second main component of the MA program is BadgerCare Plus, which provides coverage (typically through the standard plan) to low-income children, their parents, and pregnant women. In total, approximately 1,080,800 individuals were enrolled in MA and the MA-related programs (excluding SeniorCare) in April 2013. Of that total, approximately 209,000 were enrolled in EBD MA programs and 741,000 were enrolled in BadgerCare Plus. The remaining enrollees were participating in MA-related subprograms such as the family planning only services program, the Core Plan for childless adults, Well Woman MA, or the Medicare savings plans.

MA benefit expenditures are funded by a combination of GPR, federal matching funds, segregated revenues from the MA trust fund, the hospital assessment fund, and the critical access hospital assessment fund, and several program revenue sources. The federal matching funds are based on the state's federal medical assistance percentage (FMAP). That FMAP is adjusted

annually under a formula in federal law that compares a three-year average of Wisconsin's per capita income to national per capita income. In the current federal fiscal year, Wisconsin's standard FMAP is 59.74%, meaning that federal matching funds finance approximately 60 cents of each dollar the program spends for MA-eligible benefits. Higher FMAPs can and do apply to some enrollees (such as children whose benefits are funded through the Children's Health Insurance Program) and for some services (such as family planning services).

GOVERNOR

Provide $333,518,800 ($239,430,600 GPR, $86,183,700 FED, $10,457,500 PR, and -$2,553,000 SEG) in 2013-14 and $757,294,800 ($424,199,200 GPR, $326,684,000 FED, $8,755,100 PR, and -$2,343,500 SEG) in 2014-15 to fund the projected costs of providing benefits under the state's MA and MA-related programs (excluding SeniorCare) during the 2013-15 biennium, based on current law. For purposes of this item, "current law" means the funding amounts do not reflect any proposed changes to state MA law, particularly with respect to program eligibility standards. To the extent the bill would change those standards, for instance, the income eligibility levels for parents and other caretaker relatives under BadgerCare Plus, those proposed changes will be addressed in a subsequent LFB budget paper.

DISCUSSION POINTS

1. The funding provided in this MA cost-to-continue item is based on current law eligibility and expenditure trends. Under temporary program changes that went into effect July 1, 2012, DHS is currently applying premiums to non-pregnant, non-disabled adults in BadgerCare Plus and transitional MA that begin at 3.0% of family income for those at 133% of the FPL and increase to 9.5% of family income for those at 300% of the FPL or higher. The bill would codify the Department's authority to apply these premiums through December 31, 2013. It would then repeal that authority effective January 1, 2014. The administration indicates that the bill section that repeals the Department's authority to apply the new premium schedule effective January 1, 2014 should be deleted from the bill, and the Department should be authorized to seek the necessary federal approval to continue to apply the new premium schedule after December 31, 2013.

2. Additional information about the MA program has become available since the administration developed its original cost-to-continue projections. This information includes several months of additional enrollment and expenditure data, as well as updated projections regarding payments made to or received from the federal government. Based on this information and additional review and analysis by this office and DHS, a number of adjustments should be made to the MA cost-to-continue funding levels in the bill. Several of the most significant adjustments are identified below. For each item, the adjustment is stated in terms of the estimated GPR impact in the 2013-15 biennium, compared to the GPR funding provided in the Governor's original MA cost-to-continue item.

3. *Clawback Payments to the Federal Government.* Prior to the introduction of Medicare Part D in January 2006, state MA programs provided prescription drug coverage for individuals who were fully eligible for MA and Medicare. Medicare Part D now provides that

coverage. In return, federal law requires states to make monthly payments to the federal government to help support Medicare Part D. The amounts of these "clawback" payments are adjusted annually. In an Issue Brief dated April 30, 2013, Federal Funds Information for States (FFIS) revised its estimates of states' clawback payments for calendar year 2014. Based on those revised estimates, the state's payments are projected to be approximately $10.3 million GPR less in the 2013-15 biennium than was assumed in the bill.

4. *Federal Medical Assistance Percentage (FMAP).* The funding in the bill assumed the state's standard FMAP in federal fiscal year 2015 would be 59.06%. In an Issue Brief dated March 28, 2013, FFIS estimated that Wisconsin's standard FMAP in federal fiscal year 2015 will be 59.19%. Converted to a state fiscal year basis for budgeting purposes, the FFIS estimate would reduce the amount of GPR needed to fund projected MA cost-to-continue expenditures by approximately $6.8 million in 2014-15, compared to the FMAP assumption used in the bill.

5. *CHIPRA Bonus.* The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided states the opportunity to receive performance bonus payments from the federal government for simplifying their MA and CHIP programs and successfully enrolling children who are eligible for MA. In the three ensuing years, Wisconsin received CHIPRA performance bonuses totaling approximately $80.0 million. DHS has used those funds either to satisfy departmental lapse requirements to the general fund or to directly support the MA program. Federal law authorizes the CHIPRA performance bonuses through federal fiscal year 2012-13. Consequently, if the state receives an additional CHIPRA bonus award, it would receive the award in state fiscal year 2013-14 only. DHS estimates that the state's bonus will be approximately $10.5 million. The bill did not make explicit provision for these funds. This reestimate would reduce GPR funding in the first year of the biennium by $10.5 million to reflect the anticipated receipt of this CHIPRA performance bonus payment.

6. *Family Care.* Under the Family Care program, the state pays managed care organizations (MCOs) to provide certain EBD MA enrollees long-term care services. Cost-to-continue funding in the bill assumed substantial increases in payments to Family Care MCOs in the upcoming biennium. Those increases were attributable in part to projected enrollment increases. Specifically, the bill assumed average monthly enrollment in Family Care would be 8.5% higher in 2013-14 than in 2012-13, and that it would increase by an additional 4.7% in 2014-15. Based on several more months of data, DHS has reduced its Family Care enrollment projection for 2012-13, and it has lowered its projected rates of enrollment growth for the two years of the upcoming biennium to 6.6% and 4.0%, respectively.

The bill's cost-to-continue funding also assumed that Family Care MCO rates would increase, on average, by approximately 5.5% in calendar year 2014 and 1.4% in calendar year 2015. DHS has since revised those projected increases to 3.7% and 2.9%, respectively. It should be noted that the actual capitation rates paid to Family Care MCOs in the upcoming biennium will be established through the Department's rate-setting process, which typically occurs late in the preceding calendar year. For example, the capitation rates for calendar year 2014 would typically not be established until late in calendar year 2013. In addition, federal law requires MA managed care rates to be "actuarially sound," meaning they must be developed in accordance with generally accepted actuarial principles and practices, and be certified as meeting that requirement by qualified

actuaries. For these reasons, the actual rates paid to Family Care MCOs may differ from the revised projections used to establish funding levels in this item.

Based primarily on the updated enrollment projections, and to a lesser extent on the revised capitation rate estimates, the Department recommends reducing funding for projected Family Care MCO payments in the 2013-15 biennium by approximately $49.5 million GPR, compared to the funding in the bill for those payments.

7. *Include, Respect, I Self-Direct (IRIS).* IRIS is an alternative for individuals who are eligible for Family Care to receive long-term care services on a fee-for-service basis rather than through an MCO. In recent years, enrollment in the IRIS program has increased at much higher rates than enrollment in Family Care or PACE/Partnership. For instance, DHS estimates that average monthly enrollment in IRIS will be 7,500 individuals in 2012-13, an increase of approximately 43% over 2011-12. While that rate was impacted by the lifting of the enrollment cap in Family Care and related programs in April 2012, IRIS enrollment has continued to increase in recent months. Based on updated enrollment data, DHS now estimates that average monthly enrollment in IRIS will increase by approximately 29% in 2013-14 and 17% in 2014-15, rather than the 23% and 14% annual increases used to establish the original funding levels in the bill. Based on these revised enrollment projections, DHS recommends increasing the cost-to-continue funding in the bill for IRIS by approximately $13.0 million GPR.

8. *Prescription Drugs.* The bill's original cost-to-continue projection for MA prescription drug costs was based on DHS analysis which suggested that those expenditures were declining modestly during 2012-13. The administration incorporated that analysis into the bill's MA cost-to-continue item by setting the projected base-year level of drug expenditures at $593.7 million all funds (AF). DHS has since revised that base-year estimate to $624.9 million (AF), a figure more in line with updated projections for 2012-13. The GPR impact of this upward revision is approximately $22.9 million GPR over the biennium, compared to the cost-to-continue funding in the bill.

9. *Non-Emergency Medical Transportation (NEMT) Management.* Under provisions enacted as part of the 2009-11 state budget, DHS issued requests for proposals (RFPs) and eventually executed two separate contracts with Logisticare Solutions, LLC to manage NEMT services for MA recipients. The first contract covered most areas of the state except several counties in southeast Wisconsin. The second contract covered those southeast counties. Both contracts were originally intended to run through June 30, 2014. In November 2012, Logisticare gave notice of its intention to terminate the contracts. DHS has recently entered into a contract with Medical Transportation Management, Inc. (MTM) to provide NEMT management services on a statewide basis beginning August 1, 2013, and continuing through July 31, 2016. As with the Logisticare contracts, payment for NEMT management services under the MTM contract is made in the form of prospective monthly capitation rates based on updated MA enrollment data. Table 1 compares the contract rates under these three contracts. The MTM contract was not finalized when the administration developed its original cost-to-continue projections. The updated cost estimates for NEMT are approximately $7.2 million GPR greater than the cost-to-continue funding provided in the bill for these services.

TABLE 1

Monthly Capitation Rates for NEMT Management Services Under the DHS Contracts with Logisticare and MTM

	Logisticare Contract #1 (State ex. SE WI)	Logisticare Contract #2 (SE WI)	MTM Statewide Contract
EBD MA Enrollees	$11.45	$14.17	$16.86
BadgerCare Plus Children	$2.88	$0.86	$1.32
BadgerCare Plus Adults	$0.75	$1.10	$3.34

10. *Wisconsin Medicaid Cost Reporting (WIMCR) Program.* Under the WIMCR program, counties report to DHS their full costs for providing certain MA services. The MA program makes payment adjustments to those counties to reimburse them for the difference between their reported costs and the MA program's standard reimbursement rates. These WIMCR payments are funded by a combination of GPR and federal matching funds. The state, in turn, reduces each county's community aids basic county allocation (BCA) by the total amount of the WIMCR payment. The result has been a decrease in net GPR costs to the state because the WIMCR payments are funded in part by FED, but the reductions in BCA payments are 100% GPR. The state shares $19.25 million of the annual WIMCR savings with counties by reducing their BCA payment by $19.25 million less than the full amount of the WIMCR payment. DHS has recently indicated that the WIMCR claims it submitted to the federal government in fiscal years 2007-08 through 2010-11 were overstated because they were based on incorrect FMAPs. The Department estimates the required repayment to the federal government of these improperly claimed funds will cost approximately $21.88 million GPR in 2013-14.

11. *Personal Care Expenditures*. MA expenditures for personal care services have increased at rates well above general program trends in recent years. For example, monthly fee-for-service personal care expenditures in the past four months (January 2013 - April 2013) have averaged $21.2 million (AF), compared to $18.0 million (AF) in the preceding six months. Based on these trends, fee-for-service personal care expenditures are projected to total approximately $233.4 million (AF) in the current fiscal year. The cost-to-continue funding in the bill assumed those expenditures would total $219.6 million (AF). Funding levels should be adjusted to reflect the updated expenditure projections for 2012-13. The estimated GPR impact of that adjustment is approximately $15.0 million, compared to the cost-to-continue funding in the bill.

12. *ACA-Related Enrollment Effects*. Several aspects of the Patient Protection and Affordable Care Act (ACA) are projected to impact enrollment in the state's MA program beginning January 1, 2014. Those potential impacts include the following: (a) the requirement that states use modified adjusted gross income (MAGI) to count household income when determining MA eligibility for some individuals, and disregard 5% of an applicant's household income when making those determinations: (b) the existence of a federally facilitated exchange (FFE) and federal premium and cost-sharing assistance for lower-income individuals may prompt some employers to drop coverage for their employees; and (c) some individuals who are currently eligible for MA but

who are not enrolled may enroll beginning in 2014 due to their interaction with the FFE or other reasons. DHS has developed a model that estimates these ACA-related enrollment effects under different assumptions. One variable the model can adjust for is the income eligibility level for various MA groups. For purposes of establishing MA cost-to-continue funding levels in the bill, DHS incorporated the projected ACA-related enrollment impacts under an assumption that eligibility for parents and caretaker relatives in BadgerCare Plus would be 133% of the federal poverty level (FPL) rather than 200%, as is current law. In addition, it appears a computational error was made when incorporating those projected ACA-related enrollment effects into the bill's MA cost-to-continue estimate. When the item is adjusted to incorporate the DHS model's projected ACA-related effects for parents and caretakers at 200% of the FPL, the resulting fiscal effect is to reduce the projected cost-to-continue by approximately $11.1 million GPR.

13. The adjustments described above, in addition to a number of other recommended adjustments based on updated enrollment and expenditure information, would add approximately $21.4 million GPR to the MA cost-to-continue funding provided in the bill. These changes are summarized in Table 2.

TABLE 2

Adjustments to MA Cost-to-Continue Funding

	Adjustments to GPR funding in MA Cost-to-Continue Item ($ in millions)		
	2013-14	2014-15	Biennium
1. Reduce projected Family Care costs	-$20.1	-$29.4	-$49.5
2. Revise projected ACA-related enrollment effects	-4.9	-6.2	-11.1
3. Incorporate projected CHIPRA performance bonus in 2013-14	-10.5	0.0	-10.5
4. Reduce projected clawback payments	-1.1	-9.2	-10.3
5. Increase projected FMAP in 2014-15	0.0	-6.8	-6.8
6. Increase projected costs for NEMT management services	3.7	3.5	7.2
7. Increase projected costs for IRIS	3.5	9.5	13.0
8. Increase projected costs for personal care expenditures	7.0	8.0	15.0
9. Repay estimated WIMCR claiming error	21.9	0.0	21.9
10. Increase projected costs for prescription drugs	12.2	10.7	22.9
11. All other adjustments:	16.1	13.5	29.6
Total	$27.8	-$6.4	$21.4

14. The adjusted cost-to-continue funding amounts in Table 2 include funding for BadgerCare Plus and SSI managed care HMO rates. The bill's cost-to-continue item includes funding for a 3.0% "intensity" adjustment to those HMO rates in calendar years 2014 and 2015. In addition, the bill includes funding for a 2.0% increase to those rates in calendar year 2014 (which remains in the rates in calendar year 2015) to compensate these HMOs for an excise tax that will be imposed on health insurers beginning in 2014 under the ACA. The ACA established the total amount to be collected from health insurers nationally by that excise tax in terms of dollars ($8.0 billion in 2014 and $11.3 billion in 2015), rather than as a percentage of premium revenues. The 2.0% adjustment to HMO rates related to this excise tax increases the revised cost-to-continue item by approximately $13.4 million GPR in the upcoming biennium. The administration has identified

a January 31, 2012 report by Milliman, Inc. as the source of the bill's 2.0% adjustment. In that report, Milliman estimated the impact of the ACA excise tax on Wisconsin MA managed care premiums to be in the range of 1.7% to 1.8% during the period 2014 through 2018. The Milliman report also cited an American Academy of Actuaries Practice Note indicating that "state-mandated assessments and taxes" are to be considered in an actuary's certification of MA managed care premiums. Other reports reviewed by this office have also referenced that Practice Note, and have estimated premium impacts comparable to those prepared by Milliman. As with Family Care MCO rates, the actual rates paid to BadgerCare Plus and SSI managed care HMOs will be established through the Department's rate-setting process and may differ from the projections used to establish funding levels in the bill.

15. The administration submitted a budget errata report dated March 14, 2013, indicating that an adjustment should be made to correct an error in the amounts appropriated under s. 20.435(4)(xe) in the Chapter 20 appropriation schedule. That is a SEG appropriation relating to the critical access hospital assessment fund. The errata indicates that the amounts in the Chapter 20 schedule for that appropriation should be increased by $437,900 SEG in 2013-14 and reduced by $3,258,500 SEG in 2014-15 to correct that error.

16. Table 3 shows an updated fund condition statement for the MA trust fund. The updated condition statement incorporates the correction to the critical access hospital assessment appropriation as requested in the administration's errata, as well as several other adjustments recommended by DHS. The largest of these other adjustments reduces the amount expected to be transferred from the UW system to the MA trust fund under an intergovernmental transfer (IGT) program from $17.0 million to $13.0 million in each year of the 2013-15 biennium. In total, the recommended adjustments would reduce the projected revenues to the MA trust fund by $4,739,900 SEG in 2013-14 (to $388,668,600), and by $4,356,900 SEG in 2014-15 (to $385,446,000).

TABLE 3

MA Trust Fund Condition Statement

	Actual		Projected		
	2010-11	2011-12	2012-13	2013-14	2014-15
Beginning Balance	$497,400	$4,970,900	$10,046,100	$0	$0
Revenues					
Transfers from Other Funds					
Hospital Assessment Fund	$202,312,000	$146,834,800	$145,287,900	$139,830,400	$139,337,700
Critical Access Hospital Fund	6,172,100	4,908,800	-1,229,600	1,969,600	1,811,200
Permanent Endowment Fund	50,000,000	50,000,000	50,000,000	50,000,000	50,000,000
Provider Taxes Deposited Directly to MA Trust Fund					
Nursing Home Bed Assessment	$80,723,700	$79,980,000	$78,761,300	$77,488,500	$76,074,300
Ambulatory Surgical Center Assessment	16,600,000	16,618,100	16,600,000	16,600,000	16,600,000
Federal MA Funds Deposited to MA Trust Fund					
Wisconsin Medicaid Cost Reporting	$0	$0	$0	$25,611,700	$24,454,400
Health Check-Eligible Services Provided by Residential Care Centers	9,500,000	7,870,900	7,500,000	7,000,000	7,000,000
Nursing Home Certified Public Expenditure Program	53,477,200	54,388,200	48,884,000	52,000,000	52,000,000
Hospital Certified Public Expenditure Program	8,883,900	6,589,200	5,400,000	5,400,000	5,400,000
Claims for County-Supported Services During Period of Enhanced Federal Match	6,645,100	0	0	0	0
Claims for Services Provided by UW Physicians Transferred from UW System	25,000,000	16,721,400	15,400,000	13,000,000	13,000,000
Revenue Reductions					
Interest to the General Fund	-$204,100	-$50,300	-$31,600	-$231,600	-$231,600
Required Transfer to the General Fund	-7,021,400	0	0	0	0
Net Revenue	$452,088,500	$383,861,100	$366,372,000	$388,668,600	$385,446,000
Expenditures	$447,615,000	$378,785,900	$376,418,100	$388,668,600	$385,446,000
Ending Balance	$4,970,900	$10,046,100	$0	$0	$0

17. Table 4 shows the MA enrollment assumptions used to develop the funding adjustments to the bill's MA cost-to-continue item as described above. Note that as with the funding adjustments themselves, the enrollment assumptions shown in Table 4 do not incorporate any of the bill's proposed changes to MA eligibility standards. Those proposed changes will be addressed in a subsequent LFB issue paper.

TABLE 4

Average Monthly MA Enrollment by Major Eligibility Groups
2011-12 (Actual) and 2012-13 through 2014-15 (Projected)
MA Cost-to-Continue Reestimate

	Actual 2011-12	Projected 2012-13	Projected 2013-14	Projected 2014-15
Elderly	36,900	35,800	34,300	33,400
% Change from Prior Year	-1.5%	-3.0%	-4.2%	-2.6%
Disabled				
MA Only	90,800	92,500	94,500	96,400
Dual Eligible	85,800	89,400	93,500	98,300
% Change from Prior Year	176,600	181,900	188,000	194,700
	4.5%	3.0%	3.4%	3.6%
BC+ Children	477,300	480,000	496,400	528,500
BC+ Parents/Caretakers	264,000	251,600	256,900	275,400
BC+ Pregnant Women	21,000	20,600	20,600	20,600
BC+ Total	762,300	752,200	773,900	824,500
% Change from Prior Year	2.1%	-1.3%	2.9%	6.5%
BC+ Core Plan	28,800	20,700	16,000	12,500
% Change from Prior Year	-36.2%	-28.1%	-22.7%	-21.9%
BC+ Basic Plan	3,000	1,700	800	0
% Change from Prior Year	-31.5%	-43.3%	-52.9%	-100.0%
Foster Children	17,300	17,600	18,100	18,400
% Change from Prior Year	1.0%	1.7%	2.8%	1.7%
Well Woman MA	890	980	1,080	1,100
% Change from Prior Year	14.4%	10.1%	10.2%	1.9%
Family Planning Only Services Program	67,300	73,300	75,500	76,200
% Change from Prior Year	14.2%	8.9%	3.0%	0.9%
Limited Benefit Medicare Beneficiaries	19,600	20,400	21,500	22,600
% Change from Prior Year	8.6%	4.1%	5.4%	5.1%
Total MA Enrollment	1,112,690	1,104,580	1,129,180	1,183,400
% Change from Prior Year	1.4%	-0.7%	2.2%	4.8%

MODIFICATION

Explanation: Modify funding in the bill for the MA cost-to-continue item by increasing funding by $37,038,900 ($27,760,700 GPR, $20,396,000 FED, -$5,749,000 PR, and -$5,368,800 SEG) in 2013-14 and by decreasing funding by $4,833,200 ($-6,378,200 GPR, $15,093,800 FED, -$8,006,300 PR, and -$5,542,500 SEG) in 2014-15 to reflect the

adjustments identified in this paper. In addition, delete the bill section that would repeal the Department's authority to apply the new premium schedule to non-pregnant, non-disabled adults with family incomes greater than 133% of the FPL effective January 1, 2014, and authorize DHS to seek the necessary federal approval to continue to apply that premium schedule after December 31, 2013.

	Change to Bill Funding
GPR	$21,382,500
FED	35,489,800
PR	- 13,755,300
SEG	- 10,911,300
Total	$32,205,700

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