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SSI Managed Care Expansion
(DHFS -- Medical Assistance -- Long-Term Care)

[LFB 2005-07 Budget Summary: Page 253, #2]

CURRENT LAW

The 2003-05 biennial budget act reduced medical assistance (MA) benefits funding by $35.4 million (-$14.7 million GPR and -$20.7 million FED) to reflect savings DHFS expected to realize as a result of requiring certain MA recipients who were eligible for supplemental security income (SSI) to enroll in managed care plans, beginning in January, 2004. The proposal assumed that enrollment would be mandatory for SSI-only MA recipients and that the expansion would occur on a statewide basis. During the budget process, advocacy groups raised several concerns about the administration's proposal. In trying to address some of these concerns, DHFS did not implement the proposal. Instead, DHFS began voluntary enrollment of SSI-eligible individuals in managed care plans, in April, 2005, in Milwaukee County only.

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

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

services is not a member of the provider network and will not join the network; or (c) the state determines that services are required outside of the provider network. Approximately 52 Wisconsin counties are classified as "rural" under the federal definition.

In Wisconsin, all low-income families with dependent children participating in MA and BadgerCare are required to enroll in managed care plans in areas of the state where these families have a choice of plans and where the plans are accepting new MA and BadgerCare recipients. The state does not currently require other groups of MA recipients, including disabled individuals who receive SSI benefits and dually-eligible recipients, to enroll in managed care plans. Instead, these individuals may voluntarily enroll in managed care plans if such plans are available to them.

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

GOVERNOR

Reduce funding by $3,220,500 (-$1,359,100 GPR and -$1,861,400 FED) in 2005-06 and reduce funding by $9,285,500 (-$3,957,500 GPR and -$5,328,000 FED) in 2006-07 to reflect the administration's estimates of the projected savings in MA benefits costs as a result of: (a) expanding the SSI managed care program in Milwaukee and Dane Counties, beginning in April, 2005; (b) implementing a modified care management program at the Marshfield Clinic to serve approximately 28 surrounding counties, beginning in July, 2005; and (c) expanding the SSI managed care program to southeastern Wisconsin and La Crosse County beginning in January, 2006, and to the Fox River Valley area beginning in April, 2006.

DISCUSSION POINTS

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

2. In addition to improving care for MA recipients, requiring certain MA recipients to enroll in managed care could significantly reduce MA benefits costs because the capitation rates that are paid to managed care providers are typically discounted 5% from the estimated fee-for-service costs for this population. These cost savings are limited in the first year of implementation;

however, because of the overlap in fee-for-service claims for the same population that occurs for up to 13 months after an individual enrolls in a managed care plan.

Barriers to Implementation

3. Advocates of the existing fee-for-service system argue that the SSI-only, MA eligible population would be disadvantaged under a managed care system for the following reasons: (a) mandatory enrollment removes participants' choice of services and providers; (b) capitation rates provide managed care organizations with an incentive to minimize costs; (c) the capitation rates may not be sufficient to support the care needs of enrollees; and (d) current provider-participants relationships may be disrupted.

4. DHFS addresses these concerns by establishing case-mix adjusted capitation rates that are based on a Chronic Illness and Disability Payment System to ensure that those managed care organizations that are serving individuals with higher level of care needs are reimbursed at a higher rate than those organizations serving individuals with lower acuity levels. DHFS would also establish several continuity of care provisions, including requiring managed care organizations to: (a) continue to cover any medications that an enrollee is currently taking until a physician prescribes a new medication; (b) permit enrollees to receive services from their existing providers for 60 days after enrollment or until the month following the completion of the individual's assessment and case plan; and (c) support prior approved authorizations for 60 days after enrollment or until the month following the completion of the assessment and case plan.

5. The Department's success in expanding managed care to this population is also dependent upon managed care organizations' commitment to participate. Four managed care organizations in Milwaukee County are participating in the expansion, including I-Care, Managed Health Services, United Health Care of Wisconsin, and Abri Health Plan. One managed care organization, the Community-Supported Living Alliance (CSLA), will participate in the expansion in Dane County.

6. Managed care organizations argue that, without sufficient enrollment, it would not be beneficial for them to serve the SSI population. In order to address this concern and the concerns of other advocates, DHFS is proposing to automatically enroll SSI, MA-only eligible individuals in managed care plans, requiring those individuals to maintain enrollment for two months, and then permitting enrollees to "opt-out" of managed care within the first four months of participation or continue to participate in the managed care plan for the remainder of the year.

7. Counties have also expressed concerns about being excluded from managed care organization networks. Currently, counties serve as providers of mental health services. Under the proposed expansion plans, community support program (CSP), targeted case management, comprehensive community services (CCS), and crisis intervention services would be carved-out of the capitation rate in Milwaukee County, while CCS and crisis intervention would be carved-out in Dane County.

8. Certain populations would also be excluded from the managed care expansion requirements, including community-based waiver participants, individuals under the age of 18, and individuals enrolled in other managed care programs, including PACE and WPP. In Dane County, individuals who are mentally retarded would also be excluded from managed care enrollment.

Quality of Care

9. At a recent National Conference of State Legislatures conference on "Managed Long Term Care: Past, Present and Future," presenters Brian Burwell of Medstat and Paul Saucier of the University of Southern Maine identified the benefits and challenges of managed care programs over the fee-for-service system. These benefits included: (a) more value per dollar expended; (b) payment for individuals and not for services; (c) improved care management; (d) more focused accountability for outcomes; and (e) greater budget predictability.

10. The challenges identified by the presenters included: (a) potentially serving a high-cost population with complex needs; (b) lack of supply of managed care organizations willing to participate who are knowledgeable about the population; (c) a complex regulatory and waiver environment at CMS for applying a managed care model to dual eligibles; and (d) political resistance from providers who prefer not to have an intermediary.

11. MA recipients who receive services on a fee-for-service basis are entitled to receive all of the medically necessary services that are covered under the state's MA program. However, they may receive these services from many independent providers. In contrast, individuals enrolled in managed care plans are assigned a care coordinator and a primary care physician who monitor the enrollees' care to ensure that the most appropriate care is provided. Participants in managed care programs receive a complete assessment of their needs within 60 days of enrollment in a plan.

12. Individuals enrolled in managed care plans may have access to additional services or enhanced services that are not available to the fee-for-service population, such as care coordination and case management services, greater transportation options, and expanded dental services. In addition to these benefits, DHFS indicates that SSI-eligible individuals participating in the managed care expansion would not be subject to copayments.

13. In an article published in Health Care Financing Review (Fall 2002), Ireys, Thornton, and McKay reviewed and summarized the findings of recent research regarding the quality of care working-age adults with disabilities or chronic illnesses receive in MA managed care plans. The authors identify several elements as necessary to provide an effective care system for people with disabilities or chronic illnesses. For instance, consumer advocates emphasize the importance of consumer choice and empowerment through a person-centered approach, integration across a full and flexible array of services within and outside a network to match services with client's needs, and the use of interdisciplinary care teams.

14. Other components that were identified as necessary for success include: (a) systematic efforts to identify and assess people with disabilities or chronic illnesses before they

experience adverse events, including training for primary care providers; (b) prevention and early intervention strategies to ensure clients receive timely care; (c) care provided by interdisciplinary teams that have experience with this population; (d) accessibility to urgent care services (24-hours per day); and (e) coordination and integration of medical care with social and support services.

15. According to "Health Care State Rankings 2005," based on information published by the Centers for Medicare and Medicaid Services, in 2003, Wisconsin was ranked 39th among states in the percentage of MA recipients enrolled in managed care plans at 47.2%. In comparison, Michigan was ranked 2nd with 99.4% of MA recipients enrolled in managed care, while Minnesota was ranked 26th with 65.6% of its MA recipients enrolled in managed care. Although Wisconsin's percentage of MA recipients enrolled in managed care plans is significantly lower than that of neighboring states, these percentages are based on the entire MA population, including low-income families, and not just the SSI-eligible MA recipients.

Potential Cost Savings

16. MA costs for individuals enrolled in managed care plans may be less than the costs of providing services on a fee-for-service basis. Capitation rates for managed care programs, such as I-Care, the program for all-inclusive care for the elderly (PACE) and the Wisconsin Partnership Program (WPP), were originally established based on the cost of the fee-for-service equivalent, less a discount of at least 5%. The current capitation rates vary based on age, gender, level of care need, eligibility group, and Medicare Status. In calendar year 2004, the state paid I-Care a base capitation rate of $827 per month for MA-only eligible individuals enrolled in the program who received SSI cash payments, $529 per month for Medicare-eligible individuals who received SSI cash payments, $1,143 per month for MA-only eligible individuals who did not receive SSI cash payments, and $522 per month for Medicare-eligible individuals who did not receive SSI cash assistance. In calendar year 2004, the average base capitation payment was $716 per month.

17. The administration's projected savings assume that: (a) 90% of the SSI-only adult MA population would be automatically enrolled in managed care plans with enrollment being phased-in over 10 months; (b) 35% of those automatically enrolled would choose to opt-out of the managed care option within the first three months; (c) 10% of the dually-eligible population would voluntary enroll in managed care plans with enrollment being phased-in over 10 months; (d) capitation rates would be set at an approximate discount of 5.5% over fee-for-service costs; and (e) there would be an overlap of capitation payments and fee-for-service claims for approximately 13 months.

18. The administration applied the savings assumptions described in the previous paragraph to the areas of proposed expansion to determine the projected MA benefits cost savings in 2005-07. The savings calculations were based on the following expansion plans: (a) Milwaukee and Dane Counties, beginning in April, 2005; (b) Marshfield Clinic, beginning in January, 2005; (c) La Crosse and Southeastern Wisconsin in January, 2006; and (d) cities in the Fox River Valley area in April, 2006.

19. The timing of these expansions and the likelihood of them occurring will affect the amount of savings that could be generated from this initiative. The managed care expansion in Milwaukee began in April, 2005, but the expansion to Dane County has been delayed to start in July, 2005. According to DHFS, the Marshfield Clinic expansion timeline is uncertain but unlikely to begin before July, 2005. Further, although there has been interest for expansion in La Crosse, Kenosha, and Racine Counties, the timelines for these expansions are not certain. Finally, DHFS indicates that there is potential for expansion in the Fox River Valley area, but the development of a managed care system for the SSI-eligible population is time-intensive.

20. The Committee may wish to hold the Department accountable for generating the savings identified in its original SSI managed care expansion plans, since the bill would delete funding for benefits based on the assumption that these expansions would occur. Under this alternative, DHFS would be required to demonstrate that it has generated savings by other means if the expansions do not occur as originally proposed. Because the MA program is funded by a sum certain appropriation, the Governor's funding reduction poses the risk of creating a deficit in the MA program.

21. As part of the 2003-05 biennial budget, the Legislature adopted the Governor's recommendation to reduce MA benefits funding by $35.4 million (all funds), based on the expectation that DHFS would implement the SSI managed care expansion statewide, beginning in January, 2004. However, the expansion did not begin until April, 2005, and was implemented on a much more limited scale. The Department's failure to realize these assumed savings contributed to the MA shortfall in 2004-05. Since the expansion in Milwaukee County began on schedule, and DHFS plans to begin the expansion in Dane County in July, it would be reasonable to assume MA benefits savings for these two expansion initiatives.

22. By excluding the administration's projected savings as a result of expanding managed care into the other areas, DHFS would not be prohibited from pursuing these expansions. The Committee could encourage the expansion of managed care into other areas of the state without relying upon savings that may or may not be generated depending on whether or not the plans are implemented. Under this alternative, DHFS could generate additional savings to the extent that the Department implements the expansion in other areas.

ALTERNATIVES

1. Approve the Governor's recommendations.

2. Modify the Governor's recommendations to increase MA benefits funding by $3,037,800 ($1,282,000 GPR and $1,755,800 FED) in 2005-06 and by $3,065,500 ($1,312,600 GPR and $1,752,900 FED) in 2006-07 to reflect the projected cost savings of implementing the SSI managed care expansion in Milwaukee and Dane Counties. In addition, direct DHFS to pursue expansion opportunities in other areas of the state.

Alternative 2	GPR	FED	TOTAL
2005-07 FUNDING (Change to Bill)	$2,594,600	$3,508,700	$6,103,300

3. Delete the Governor's recommendations.

Alternative 3	GPR	FED	TOTAL
2005-07 FUNDING (Change to Bill)	$4,663,600	$6,303,100	$10,966,700

4. In addition to adopting either Alternative (1) or (2), require DHFS to submit a report to the Joint Committee on Finance by January 1, 2007, that identifies: (a) the status of the SSI managed care initiative and the Governor's initiative to expand managed care for low-income families, including information that compares the Governor's budget assumptions regarding enrollment and cost savings with the enrollment and savings DHFS realized through June 30, 2006, and projections through 2006-07; and (b) other initiatives DHFS has implemented to realize savings in the MA program that were assumed under this initiative in AB 100.

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