

Summary of the Medicaid and BadgerCare Cost-Cutting Initiatives Proposed by the Department of Health Services

(October 10, 2011)

The following summary is our preliminary analysis of the changes proposed by the Department of Health Services (DHS) to cut about \$554 million of spending from Medicaid and BadgerCare. We will update this document after we have reviewed the proposals more carefully and as DHS answers some of the many questions about the specifics of the changes they are proposing. **Check our website (www.wccf.org) for revisions.**

This summary is limited to the new cost-saving measures proposed by DHS in late September. It does not include the specific cuts approved in the budget bill, such as the Family Care enrollment cap.

Eligibility Changes: (and the estimated savings)

Changes requiring a federal Maintenance of Effort (MOE) waiver - \$54.4 million GPR –

The language in the budget repair and budget bills requires DHS to seek a waiver from the provisions in the federal health care reform law (known as the Affordable Care Act, or ACA) which restrict the ability of states to reduce eligibility or make changes that suppress enrollment (such as increasing premiums). The following changes proposed by DHS require a waiver of the MOE requirements. The budget bill provides that if the state does not get a MOE waiver by December 31, 2011, DHS is required to reduce eligibility of parents and childless adults to 133% of the federal poverty level (from the current 200%), which would eliminate coverage of an estimated 53,000 adults, beginning on July 1, 2012.

- Restricting eligibility for people with access to private coverage** – DHS proposes eliminating eligibility for people who are currently insured or who have access to employer coverage if the employee or household contribution for the private coverage costs less than 9.5% of household income. (Our understanding is that this applies to adults over the poverty level and also to kids over 133% of poverty.) The table below provides several examples of how this very worrisome policy change would affect various families that have access to employer coverage, assuming their share of the cost is 9% of their income. It helps illustrate how the proposed change would price health insurance out of reach for many low-income Wisconsin families.

Family Size	Annual income	Hourly Income	Poverty Level	Current Premium (per month in BC+)	New Premium (if employee share is 9%)	Annual Increase
three: 1 parent & 2 kids	\$28,000	\$13.46	151%	\$10	\$210	\$2,400
four: 2 parents & 2 kids	\$34,000	\$8.18 x 2	152%	\$20	\$255	\$2,820
five: 2 parents & 3 kids	\$44,000	\$10.58 x 2	168%	\$54	\$330	\$3,312

- **Ending Transitional Medicaid** – The department proposes eliminating the Transitional Medical Assistance (TMA) category of eligibility, which is a welfare reform initiative that enables families below the poverty level to remain in the same category of BadgerCare coverage for 12 months after their income increases above the poverty level. Eliminating it appears to adversely affect roughly 81,000 BadgerCare participants. A minority of them will lose their BadgerCare coverage (e.g., adults over 200 percent of the poverty level, and some adults and kids who gain access to employer-sponsored insurance), while others will have increases in premiums and co-pays.
- **Broadening definition of family unit** – This change would count the income of all adults (except grandparents) in the definition of the household, though it's not clear whether the newly counted adults (such as a live-in boyfriend) would be counted for purposes of household size. This change would make some families ineligible, and it would increase premiums for others. It will add significantly to the workload of caseworkers and is likely to complicate the state's online application system by creating different family sizes and incomes for purposes of Medicaid (and BadgerCare) and other public benefit programs.
- **Increasing premiums** – The proposal would allow DHS to increase premiums to up to 5% of household income for coverage of adults and children in families above 150% of the poverty level. In addition to increasing premiums for adults between 150% and 200% of poverty, it would also initiate premiums for kids in that income range, who are currently exempt from premiums. For a single parent with two kids and a household income between 150% and 160% of the poverty level (for example, about \$14 per hour and \$29,000 per year), the proposal would increase the premium by about \$110 per month, or more than \$1,300 per year. (As noted above, under the first item, their premiums could be even higher, up to 9.5% of income, if the family has access to employer-sponsored coverage.) Increased premiums put insurance out of the reach of many low-income households, causing a sharp increase in the uninsured and an increase in uncompensated care costs that are shifted to other consumers.
- **12-month suspension of eligibility for failing to pay a premium** – An adult who misses a premium is currently suspended from BadgerCare for 6 months. The proposed change would extend the length of the suspension to 12 months, and it would broaden the suspension to include children in families with incomes above 150% of the poverty level (rather than just to adults). In light of the premium increases that will result from the previous two changes, missed payments and suspensions are likely to become far more common.
- **Ending retroactive eligibility** – This would end the current practice of allowing people to be covered for services they receive up to three months before applying. This would be a very expensive change for providers and some families, and is likely to increase the amount of uncompensated care, which is a cost that often gets shifted onto other health care consumers.
- **Ending presumptive eligibility** – Presumptive or “express” eligibility now allows children and pregnant women to be enrolled on a temporary basis, while their application is pending, in order to ensure they get timely care. DHS contends this will no longer be needed because the state is moving to what the department calls “real-time eligibility;” although some of the latest proposals (like the next item) would move the enrollment process in the opposite direction. If this is ended for pregnant women (as appears to be the intent), and not just for kids, that would be a blow to the state's efforts to help more women get timely prenatal care throughout their pregnancy and thereby combat infant mortality and reduce spending for low birth weight babies.
- **Requiring documentation of state residency** – This provision appears to be intended to beef up the current state residency requirement for eligibility by requiring documentation from program applicants. If so, this requirement will increase administrative costs and significantly slow the enrollment process, undermining the department's stated goal of

implementing “real-time eligibility.” In addition, this could significantly impede the enrollment of some applicants, such as the homeless.

- **Restricting eligibility of young adults** – This change would require young adults from the ages of 19 through 26 to be covered under their parents’ health insurance plan, not BadgerCare. It presumes (incorrectly, we believe) that all young adults have parents who are willing and able to add them to their private insurance, and that the adult child lives in the same area as their parent. If approved, this wouldn’t affect many young adults now because the cap on childless adult coverage has substantially reduced the number of people served; however, it could have a dramatic effect in 2014 and thereafter, if this restriction still applies when Medicaid eligibility is extended to all adults under 133% of the poverty level.
- **Speeding up eligibility terminations** – This proposal would end the practice of continuing coverage until the end of the month in which eligibility is lost. This change seems to presume that decisions that a person is ineligible will always be accurate (so time to remedy mistakes isn’t needed), and to presume that a person whose income increases can immediately enroll in other coverage.

Changes that affect eligibility but don’t require federal MOE waivers:

- **Divestment policy reforms - \$2.7 million GPR** – Through systems change and administrative rule-making, the Department will implement a series of systems and policy changes to prevent individuals from divesting assets in order to qualify for MA. Changes include partial refund discontinuation, revision of the penalty start date, and mandatory community spouse participation.
- **Asset test enhancement - \$3 million GPR** – The department will contract with a third-party vendor to obtain additional financial data to determine eligibility for MA. Additionally, DHS will work with financial institutions and stakeholders to provide additional data and determine accuracy and privacy of data. Like the previous initiative, this item isn’t relevant for BadgerCare and is aimed at deterring the use of creative new loopholes for sheltering assets.
- **Eligibility determination “integrity” - \$2 million GPR** – DHS will implement a series of system changes to increase efficiency and effectiveness of eligibility determination system, including using data sources (such as unemployment insurance system wage records) to proactively search for changes in members’ income or health insurance status and terminate eligibility in “real-time.”

Benefit changes: (Changes do not require federal MOE waivers.)

- **Alternative benchmark plan - \$10 million GPR** – Through a state plan amendment, DHS will enroll children and adults with income over 100% FPL in the Benchmark plan, with cost-sharing for individuals under 150% capped at 5% of household income and benefits more similar to those in the private market. Children would continue to have Early Periodic Screening, Diagnosis, and Treatment coverage.
- **Maximize drug rebate collections - \$3 million GPR** – The department will implement system changes to ensure that maximum drug rebate revenue collections from pharmaceutical companies are being collected – for drugs administered in physician’s offices and managed care organizations.
- **Wisconsin pharmacy quality collaborative participation - \$1 million GPR** – The goal of this item is to increase the number of pharmacists who provide medication therapy management services to Medicaid members – reforming benefit delivery and provider payment to coordinate the delivery of medications.

Payment reform: (Changes do not require federal MOE waivers.)

Ongoing cost savings

- **Reimbursement modification for consultation services - \$1.6 million GPR** – Through a state plan amendment, the department will change reimbursement for consultation services to 80% of current Medicaid rates.
- **Brand-name prescription drug reimbursement reform - \$2.3 million GPR (not towards total cuts needed)** – Through a state plan amendment, Medicaid will start using the Wholesale Acquisition Cost as the pricing benchmark for reimbursing pharmacies for brand-name drugs. The savings from this change will be reinvested in pilots with state pharmacies around quality improvements and outcomes.
- **Aligning personal care payment policies - \$2.7 million GPR** – Through a state plan amendment, the state will be aligning personal care fee-for-services with Family Care policies in part by revising travel reimbursement and adding codes for independent assessments of provided care. The cut in the travel reimbursement rate could have very adverse effects for individuals needing personal care in rural areas. In addition, it could have an indirect effect by putting downward pressure on wages and benefits for Family Care workers, which leads to costly turnover and disruptions in care.
- **Enhanced third party liability identification - \$3.6 million GPR** – The department will move to include self funded plans, limited benefit coverage, and other third party liabilities in their database, which is used to determine and ensure that the private insurance coverage liability is met before MA takes on the payer of last resort obligation.
- **Federal claiming enhancements - \$8.3 million GPR** – The department will review current policies for obtaining funds from the Federal government, and implement system enhancements and policy changes to allow DHS to more accurately claim federal funds.
- **Hospital Medicare Part A modification - \$6 million GPR** – Dual eligibles have both co-insurance and deductibles under Medicare Part A fully paid under Medicaid. This change would coordinate payments to remove discrepancies between Medicare and Medicaid payments to identify savings.
- **Implementation of enhanced ambulatory patient grouping system for outpatient Hospital Reimbursement - \$1.6 million GPR** – Through a state plan amendment, the state will move from one rate per day for all outpatient services to a grouping system for services based on the reimbursement rate the provider receives for the services – the Enhanced Ambulatory Patient Grouping System.
- **Increased auditing and auditing enhancements - \$14.9 million GPR (From 11-13 Budget)** – In the biennium budget, the department was funded for an additional 10 FTE contract auditors. In addition, the Department will implement extrapolation policies when fraud is identified and require provider/patient face-to-face contact for home care and durable medical equipment fraud.
- **Managed care/fee-for-service payment review - \$2 million GPR** – The department will review fee-for-services payments to determine if payments were incorrectly made for MA members in managed care. This is part of the increased auditing, fraud detection, and investigation efforts.
- **Pay for performance for HMOs - \$700,000 GPR** – For calendar year 2012, DHS will be withholding a 1.5% capitation rate, instead of 1%, from HMOs serving BadgerCare and SSI. HMOs that attain the pay for performance goals can potentially earn back a bonus, on top of their withheld amounts.

- **Pay for performance to hospitals - \$5 million GPR** – Through a state plan amendment, the state will continue the pay for performance and reporting started with hospitals and develop a series of further pay for performance measures. Funding comes from a 1.5% holdback from the state Medicaid budget for hospitals.
- **Physician rate change for certain services provided in a hospital - \$1.5 million GPR** – Through a state plan amendment, the state will be lowering physician reimbursement to 80% of the rate when services are provided in a hospital setting instead of an office setting.
- **Recovery audit contractors - \$3 million GPR** – In concert with the ACA, the department will contract with Recovery Audit Contractors to reduce improper Medicaid payments and prevent future improper payments.
- **Reimbursement equity - \$5 million GPR** – Through a state plan amendment, where guaranteed cost based reimbursement is necessary, the department will review reimbursement to ensure that providers are incentivized to provide cost-effective care. Advocates for people with disabilities have expressed a concern about reduced rates will be adequate to ensure services are available for individuals on Medicaid.
- **Specialty pharmaceutical management - \$2 million GPR during FY13** – Medicaid will pursue increased controls and monitoring of high-cost, injectable, infused, oral, or inhaled biotech medications that require patient monitoring and professional support, by reviewing where these drugs are administered, implementing utilization controls, and achieving discounts through preferred purchasing methodologies.

One-time cost savings (and wishful thinking?)

- **SSDI/SSI workload repayment - \$45 million GPR (one time)** – DHS will continue to work with other states and the U.S. Dept. of Health and Human Services to develop a demonstration project to recoup funding lost by systemic errors in the Social Security Administration's method for determining eligibility for federal disability benefits. WCCF agrees with DHS that states should receive this funding and we would be happy to work with the department to get the proper reimbursement for this spending. However, this has long been a state concern, and capturing the dollars in the current biennium is a longshot.
- **WI Medicaid cost reporting reforms - \$19.2 million GPR (one time savings)** – By transitioning from the current WI cost reporting claiming process from an all-funds payment to a certified public expenditure claim, the state expects to have a one-time GPR savings. This process would address state claims for federal match dollars for certain community-based MA services.
- **Implementation of the accelerated school-based services project - \$6.3 million GPR** – The state will update the Medicaid School Based Services reimbursement, such that the interim rates will better match actual costs. This will provide timelier claiming to school districts and the state expects a one-time increase in federal claiming.

Service delivery: (Changes do not require federal MOE waivers.)

- **Children in foster care medical home initiative - \$300,000 GPR** – This initiative will begin in 6 counties and include approximately 2,500 children in out-of-home care under the BadgerCare standard plan. Children will receive coordinated trauma-informed health assessment, and an individual treatment plan, including evidence-based mental health interventions. Certified Medicaid Health Systems will be reimbursed at an all-inclusive rate and held to performance-based measures. As in the case of many of the other medical home proposals (below), the concept sounds good, but the question is whether there are actually

providers who can and will provide the needed services for this population (at the price DHS is willing to pay).

- **Long-term care pilot program – Virtual PACE - \$3.4 million GPR** – This is a demonstration project for approximately 20,000 elderly and adults with physical or developmental disabilities who require a nursing home level of care and are dual eligible members. One capitation payment will be made to care coordinator (contracted entity) for preventive, primary, acute, behavioral health, and long-term care services.
- **Conversion of 1915(i) home and community based services to 1937 Benchmark Alternative Benefits Plan – budget neutral** – Through a state plan amendment, the state will transition 154 people with severe and persistent mental illness to a section 1937 Benchmark Alternative Benefits Plan in order to keep providing services to this population in the currently geographically limited area, and stay in compliance with the ACA's regulation on Home and Community Based Services being statewide with no limit on people accessing services.
- **Medical home for individuals leaving the correctional system - \$1 million GPR** – DHS will study feasibility of a medical home state plan amendment to coordinate care in a medical home model for those leaving correctional facilities.
- **Healthy birth outcome medical home for pregnant women - \$900,000 GPR** – Through a state plan amendment, the department will create a medical home model for women on fee-for-services Medicaid.
- **Medical home initiative for individuals with HIV/AIDS - \$200,000 GPR** – Through a state plan amendment, DHS will create a medical home model for individuals with HIV and AIDS.
- **Medical home for individuals with a mental health diagnosis - \$1.5 million GPR** – Through a state plan amendment, the department will create a medical home for individuals with a mental health diagnosis, to transition them from fee-for-service.
- **Medical home for individuals with two or more chronic conditions - \$1.5 million GPR** – Through a state plan amendment, DHS will create a medical home for individuals with two or more chronic conditions, to transition them from fee-for-service.
- **Non-emergency medical transportation management system - \$2 million GPR (already implemented)** – On July 1, 2011, DHS implemented a centralized transportation manager for all non-emergency MA member transportation.
- **Non-emergency medical transportation management system – Southeast WI HMO members - \$3 million GPR** – A request for proposals will expand the statewide transportation manager system to Southeast WI HMO members.
- **Birth to 3 program Benchmark Plan – budget neutral** – Through a section 1937 state plan amendment, the department will implement a benchmark benefit plan for children participating in the Birth to 3 program, to better leverage federal funding for certain services.

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