Wisconsin Department of Administration
Division of Executive Budget and Finance

Fiscal Estimate - 2017 Session

☒ Original ☐ Updated ☐ Corrected ☐ Supplemental

LRB Number **17-5259/1**	Introduction Number **SB-742**

Description
intensive care coordination program in the Medical Assistance program

Fiscal Effect

State:

☐ No State Fiscal Effect
☒ Indeterminate
- ☐ Increase Existing Appropriations
- ☐ Decrease Existing Appropriations
- ☐ Create New Appropriations
- ☐ Increase Existing Revenues
- ☐ Decrease Existing Revenues
- ☐ Increase Costs - May be possible to absorb within agency's budget ☐ Yes ☐ No
- ☐ Decrease Costs

Local:

☐ No Local Government Costs
☐ Indeterminate
1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenue ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenue ☐ Permissive ☐ Mandatory
5. Types of Local Government Units Affected
   ☐ Towns ☐ Village ☐ Cities
   ☐ Counties ☐ Others 0
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected **Affected Ch. 20 Appropriations**

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEGS

Agency/Prepared By	Authorized Signature	Date
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Fiscal Estimate Narratives

DHS 1/29/2018

LRB Number **17-5259/1**	Introduction Number **SB-742**	Estimate Type **Original**
Description intensive care coordination program in the Medical Assistance program		

Assumptions Used in Arriving at Fiscal Estimate

This bill requires the Department to create and implement an intensive care coordination pilot project, which would reimburse hospitals and health care systems for intensive care coordination services provided to Medicaid recipients who use the emergency room frequently, for purpose of reducing overutilization. The Department is required to accept applications and select eligible hospitals and health care systems to receive reimbursement under this program. The application of selected entities must comply with all requirements specified in the bill. Entities must make enrollment in the program available to both individuals enrolled in Medicaid managed care programs and those receiving benefits on a fee-for-service basis. The bill allows hospitals and health care systems to specify, as part of their application to participate in the pilot program, the criteria by which they will define 'frequent emergency department utilization' for the purpose of enrolling Medicaid members in the pilot program. The bill requires the Department to seek federal approval to implement the program, if such approval is needed, but also includes the option to implement a fully State-funded program if the request for federal approval is denied. The bill also requires the Department to submit a report to the joint committee on finance summarizing program enrollment, costs for emergency department visits prior to and after implementation, and other program outcomes. The report must be submitted no later than 24 months after the pilot program is initially implemented.

Under the bill, the Department is required to reimburse selected hospitals and health care systems up to a maximum of $1,000 per enrollee for providing intensive care coordination services to individuals enrolled in the program during the 12-month pilot period specified in this bill. Specifically, the Department will reimburse pilot entities $250 per enrollee at the time of initial program enrollment. The pilot entity may receive an additional $250 per enrollee at the end of the first 6-month enrollment period if there is demonstrated progress in reducing emergency department visits for at least half of the enrollee population as compared to participants' emergency department utilization during the 6-month period prior to entering the program. Pilot entities may enroll each Medicaid participant in a second 6-month period and again receive reimbursement of $250 per enrollee at the time of enrollment with the possibility of another $250 per enrollee at the end of the 6-month period if reduction in emergency department utilization is once again demonstrated for at least half of enrolled participants. Total annual reimbursements for intensive care coordination services under the pilot program are limited to $1.5 million all funds per year. The bill directs the Department to fund these services from the amount allocated for this purpose in, but not vetoed from, 2017 Act 59.

Pilot program enrollees would be selected from among the approximately 800,000 Medicaid members statewide who are not enrolled in Medicare and have no other form of insurance responsible for covering emergency department visits. Around two-thirds of these individuals are members of a Medicaid managed care organization, while one-third receive Medicaid services on a fee-for-service basis. Of these members, approximately 15,200 had 7 or more visits to the emergency department in SFY 2016 for which the Medicaid program was the payer. The funding limitation specified in this bill would allow 1,500 Medicaid enrollees to receive intensive care coordination services under the pilot program.

The bill also requires the Department to calculate, for each participating entity, the Medicaid costs savings resulting from avoidance of emergency department visits. The amount of cost savings must be determined by subtracting the sum of intensive care coordination service payments made during the first six months of the program from the sum of costs that were expected to occur without intensive care coordination, but were avoided. If a positive savings amount is calculated at the end of the first six months of implementation, the Department shall disburse 25% of those savings to the hospital or health care system. If a positive cost savings is calculated at the end of the second six month period, the Department shall disburse to the hospital or health care system a share of the savings such that the total amount disbursed to that entity during the 12-month pilot period equals half of the total savings during all 12 months. Emergency service utilization can vary considerably over time at both the individual and group level, depending upon health needs and other factors. Intensive care coordination services is also anticipated to

increase the use of primary care services, adding an unknown amount of new primary care costs to the Medicaid program, and it is unknown whether these new costs will be greater or less than the foregone costs of emergency department services. Therefore, it is impossible to accurately estimate the total amount of savings, if any, that would accrue to the Medicaid program or the amount that would be paid to participating entities.

Implementation of an intensive care coordination pilot program would require changes to the State's Medicaid data information systems in order to manage data on participating providers and program enrollees, measure emergency services utilization, disburse provider payments, and determine potential Medicaid cost savings and associated payments to participating hospitals and health care systems. The Department estimates one-time information technology startup costs of at least $0.8 million all funds ($0.4 million GPR). The Department would also need position authority for an additional 2.0 FTEs, one IS Business Automation Specialist and one Program and Policy Analyst – Advanced, to carry out the additional programmatic and fiscal responsibilities associated with this program. Total annual costs for these two positions are estimated at $226,000 all funds ($113,000 GPR) per year.

In sum, it is estimated that this bill would result in one-time administrative costs of $0.8 million all funds ($0.4 million GPR), ongoing annual administrative costs of $226,000 all funds ($113,000 GPR), and would require a 2.0 FTE position authority increase. Although this bill specifies an annual limit of $1.5 million all funds ($0.75 million GPR) of expenditures under the intensive care coordination benefit, it is uncertain whether the program would generate any benefit savings to the Medicaid program. As a result, the total estimated fiscal impact of this bill is unknown.

Long-Range Fiscal Implications