

Health and Family Services

Medical Assistance

(LFB Budget Summary Document: Page 252)

LFB Summary Items for Which Issue Papers Have Been Prepared

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To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Overview of Medical Assistance Program Expenditures (DHFS -- Medical Assistance)

DISCUSSION POINTS

1. The medical assistance program is jointly financed with state and federal funds and administered by the state within federal guidelines pertaining to eligibility, types and range of services, payments levels for services and administrative operating procedures. Payments for services are made by the state to the individuals or entities that furnish the services.

The program supports the costs of providing acute and long-term care to persons who are aged, blind, disabled, children, members of families with dependent children and pregnant women who meet specified financial and nonfinancial criteria. Persons enrolled in the MA program are entitled to have payment made by the state for covered, medically necessary services furnished by certified providers.

2. The state receives matching payments from the federal government for expenditures made for covered services and administration. The rate of federal matching funds, or federal financial participation (FFP), is based upon a formula which compares a state's per capita income to national per capital income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. Wisconsin's per capita income has been increasing relative to the national per capital income over the past few years and, therefore, its FFP has been declining. In federal fiscal year (FFY) 1996-97, Wisconsin's FFP rate was 59.0%. For FFY 1997-98, Wisconsin's FFP is 58.84% and in FFY 1998-99 it is expected to be 58.55%.

3. Approximately \$4.9 billion (all funds) is budgeted for MA program benefits in the 1995-97 biennium. Of this total, approximately \$907.9 million in 1995-96 and \$943.9 million in 1996-97 represents state GPR funding for the program. The GPR MA benefits appropriation is a biennial appropriation. Therefore, any surplus (deficit) which occurs in the first year of the

biennium is carried forward to the second year of the biennium. Any surplus (deficit) remaining in the appropriation at the end of the biennium is credited to the state's general fund.

4. A number of factors make it difficult to budget for the MA program. Fluctuations in the economy, the overall health of the population, and changes in medical technology and practice are not easily predicted and each of these factors could have a significant impact on overall program expenditures. In addition, over the course of the biennium, the Department implements administrative policies that affect program costs.

As recently as 1991-92, MA program expenditures exceeded the funding that was budgeted for the program in that year. However, over the past few years, actual program expenditures have been less than the budgeted amounts.

5. On April 24, 1997, this office prepared a memorandum for the Committee which, on a preliminary basis, identified a number of major GPR expenditure items of SB 77 that needed adjustment. The memorandum suggested that the medical assistance appropriation would lapse \$17.7 million, in 1996-97, more than was anticipated in the construction of SB 77. Also, it was indicated that the amounts budgeted for MA in 1997-99 overstated projected expenditures by \$12.6 million.

Since the April 24 memorandum, two things have occurred which will impact the MA appropriation for 1997-99. First, on May 5, 1997, the Joint Committee on Finance voted to expand eligibility for the healthy start program to cover children born after September 30, 1983, living in families with income up to 200% of the federal poverty level, effective January 1, 1998. The cost of this MA expansion is estimated to be \$34.5 million GPR for the biennium. Second, this office has now completed a thorough review of amounts needed in the MA appropriation under SB 77 for 1997-99. Current reestimates of MA benefit expenditures are \$31.1 million GPR less than the amounts in the bill.

The net effect of the healthy start expansion and the reestimate of 1997-99 MA benefit expenditures is to increase the MA benefits appropriation of SB 77 by \$3.4 million GPR. The information is shown in the following table.

[The table content is illegible due to extreme blurriness in the original document.]

**1997-99 MA Appropriation
(\$ in Millions)**

	<u>1997-98</u>	<u>1998-99</u>	<u>1997-99</u>
SB 77	\$905.3	\$916.5	\$1,821.8
Healthy Start Expansion	10.4	24.1	34.5
Reestimate	<u>-15.1</u>	<u>-16.0</u>	<u>-31.1</u>
Revised SB 77	\$900.6	\$924.6	\$1,825.2
 Revised vs. SB 77	 -\$4.7	 \$8.1	 \$3.4

The figures above reflect changes, to date, of the MA, GPR benefits appropriation for 1997-99. In addition, it is anticipated that the 1996-97 MA appropriation will lapse \$18.7 million above the opening general fund balance amounts reflected in SB 77. This is the sum of \$17.7 million from the April 24 memorandum, adjusted by an additional \$1.0 million in the recent reestimate.

The papers that follow this overview address issues related to the medical assistance program, as contained within the Governor's 1997-99 budget recommendations.

Prepared by: Amie T. Goldman

To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE**Medical Assistance Base Reestimate (DHFS -- Medical Assistance)**

[LFB Summary: Page 255, #2]

CURRENT LAW

In 1996-97, the adjusted base funding level for medical assistance (MA) benefits is \$943,855,900 GPR and \$1,561,417,000 FED.

GOVERNOR

Decrease MA benefits funding by \$70,418,600 (\$38,594,300 GPR and \$31,824,300 FED) in 1997-98 and \$44,275,100 (\$27,403,600 GPR and \$16,871,500 FED) in 1998-99 to reflect reestimates of the projected cost for MA benefits funding in the 1997-99 biennium under current law. This base reestimate incorporates the following major adjustments:

- a. *Reestimate of 1996-97 Base Year Costs:* Reduce base funding by \$37,533,300 GPR and \$50,415,700 FED in 1997-98 and \$14,838,200 GPR and \$14,140,600 FED in 1998-99 to reflect lower than projected spending for the 1996-97 base year than the budgeted amount.
- b. *Decreased Federal Matching Rate:* Increase GPR funding and decrease FED funding by \$7,895,400 in 1997-98 and by \$3,960,100 in 1998-99 to reflect a projected decrease in the federal matching rate, from the current rate of 59.17% to 58.84% in 1997-98 and 58.54% in 1998-99.
- c. *Higher IGT Payments:* Decrease GPR funding and increase FED funding by \$15,676,000 in 1997-98 and by \$8,169,400 in 1998-99 to reflect: (a) the effect of a recent

change in the claiming of federal matching funds under the intergovernmental transfer program for unreimbursed MA expenses of county-operated nursing homes; and (b) a reestimate of county losses available for use under the IGT program.

d. *Caseload Changes:* Decrease funding by \$1,733,600 GPR and \$2,035,600 FED in 1997-98 and by \$12,145,600 GPR and \$17,028,400 FED in 1998-99 to reflect projected changes in caseloads. Most of the decrease in caseload occurs in the AFDC-related group (families with dependent children).

e. *Intensity Changes:* Increase funding by \$8,453,200 GPR and \$12,846,400 FED in 1997-98 and \$3,789,500 GPR and \$10,088,200 FED in 1998-99 to meet higher projected average costs per MA-eligible resulting from such factors as greater use of MA services, use of new and more expensive services and a population shift to groups that heavily utilize MA services.

A summary of the Governor's caseload and service intensity assumptions are summarized in the following two tables.

SB 77
MA Caseload By Eligibility Category

Category	Actual 1995-96	Projected		Percent Change From Previous Year			
		1996-97	1997-98	1998-99	1996-97	1997-98	1998-99
Aged	50,846	49,659	48,470	47,195	-2.33%	-2.39%	-2.63%
Disabled	101,075	101,934	102,970	103,977	0.85	1.02	0.98
AFDC	253,068	223,955	201,708	177,198	-11.50	-9.93	-12.15
Other	66,786	76,875	85,476	94,669	15.11	11.19	10.76
Total Caseload	471,775	452,423	438,624	423,039	-4.10%	-3.05%	-3.55%

SB 77
MA Intensity, By Service Category

<u>Service</u>	<u>Projected Annual Change 1997-98 and 1998-99</u>
Dental	2.96%
Durable Medical Equipment/Supplies	3.53
Drugs	4.41
Family Planning	-9.27
Home Health Services	-3.05
Inpatient Hospital Services	2.94
Laboratory and X-Rays	2.44
Mental Health	19.99
Outpatient Hospital Services	0.21
Outpatient Hospital Services--Psychiatric	-10.60
Personal Care	2.35
Physicians	6.82
Therapies	-1.89
Transportation--Emergency	1.87
Transportation--Nonemergency	4.59
Other	2.66

DISCUSSION POINTS

1. In preparing its estimate of the costs to continue the MA program in the 1997-99 biennium, the administration reviewed 1995-96 actual spending for each MA service category and caseload data for each MA eligibility group. In addition, the administration identified historical changes in the average cost of services and used this information to prepare estimates of the cost to continue program changes implemented in the 1995-97 biennium.

2. This office used a similar methodology in developing cost estimates for the MA program in 1997-99. In addition to a reestimate of base funding for the program, this reestimate reflects adjustments related to projected caseload and service intensity for the 1997-99 biennium, based upon more recent information. The caseload projections were developed using information on actual caseloads through April, 1997, and a review of long-term trends in caseload growth. Intensity estimates were developed by reviewing changes in the average costs of services per eligible recipient during the past several years and information regarding programmatic changes during this time period.

3. The following table identifies current estimates of caseload and intensity changes for the 1997-99 biennium.

Reestimates of MA Caseload

Category	Actual	Projected			Percent Change From Previous Year		
	1995-96	1996-97	1997-98	1998-99	1996-97	1997-98	1998-99
Aged	50,846	49,373	48,139	47,176	-2.9%	-2.5%	-2.0%
Disabled	101,075	101,032	101,032	101,032	<0.1	0.0	0.0
AFDC	253,068	211,704	169,944	149,064	-16.3	-19.7*	-12.3*
Other	66,785	79,432	97,460	109,401	18.9	22.7*	12.3*
Total	471,775	441,541	416,575	406,673	-6.4%	-5.7%	-2.4%

*Note: Reflects a shift of individuals from the AFDC-related to the healthy start-related category. Therefore, the combined caseload reduction for these groups is projected to be -8.2% in 1997-98 and -3.3% in 1998-99.

Reestimates of MA Intensity

Service	Projected Annual Change 1997-98 and 1998-99
Dental	-1.50%
Durable Medical Equipment and Supplies	-1.00
Drugs	7.00
Family Planning	-2.76
Home Health Services	-1.00
Inpatient Hospital Services	0.00
Laboratory and X-Rays	0.00
Mental Health	5.00
Outpatient Hospital Services	1.33
Outpatient Hospital Services -- Psychiatric	-5.57
Personal Care	0.00
Physician and Clinic Services	1.18
Therapies	-2.00
Transportation -- Emergency	0.00
Transportation -- Nonemergency	5.36
Other	10.00

4. Based on current estimates of 1996-97 base funding and 1997-98 and 1998-99 caseload and intensity reestimates, funding provided in the bill should be decreased by a total of \$15,056,500 GPR and increased by \$19,889,400 FED in 1997-98 and decreased by \$15,967,700 GPR and increased by \$25,889,400 FED in 1998-99 from the amounts estimated by the Governor.

5. The major factor accounting for the change is that caseload declines accelerated in 1996-97 and were not fully reflected in the Governor's estimate. The current estimate for base

MA spending in 1996-97 is \$16.9 million GPR less than estimated by the Governor. This difference is maintained in each year of the 1997-99 biennium.

6. The current estimate shows a decline in GPR costs for MA compared to the Governor, but shows an increase in federal costs. The reason for this disparity is that the Governor's estimate does not include the federal funds (\$52 million in 1996-97) that match locally-supported CIP IB slots.

7. The Committee should be aware that the dramatic declines in AFDC-related caseload may, in part, be attributable to misunderstandings related to MA eligibility among recipients, county workers and providers as a result of federal welfare reform and the Wisconsin Works program. To the extent that this is true, and DHFS is able to re-educate and re-enroll recipients through outreach, the caseload decline may be moderated. At this time, it is difficult to predict the effects of increased DHFS outreach efforts on MA caseload.

8. Because of this concern, the current estimate assumes a slowing of the historical decline in the AFDC/other (primarily healthy start) groups. The total number of eligibles in the AFDC and other groups declined from 317,172 in April, 1996, to 281,561 in April, 1997, a decline of 35,611 individuals (11.7%). The current estimate projects that this combined group will decline from 281,561 in April, 1997, to 267,404 in January, 1998, a decline of 14,157 over nine months, which represents an annual decrease of 6.7%. From January, 1998, to the end of the 1997-99 biennium, the estimate assumes a 3.3% decline in this combined group.

MODIFICATION TO BILL

1. Adjust MA benefits funding by deleting \$15,056,500 GPR and providing \$19,889,400 FED in 1997-98 and deleting \$15,967,700 GPR and providing \$25,889,400 FED in 1998-99 to reflect reestimates of the cost to continue the current MA program in the 1997-99 biennium.

<u>Modification</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$31,024,200	\$45,778,800	\$14,754,600

Prepared by: Richard Megna and Amie Goldm

MO#	<i>Modification to the Bill</i>					
JENSEN	Y	N	A	BURKE	Y	N A
OURADA	Y	N	A	DECKER	Y	N A
HARSDORF	Y	N	A	GEORGE	Y	N A
ALBERS	Y	N	A	JAUCH	Y	N A
GARD	Y	N	A	WINEKE	Y	N A
KAUFERT	Y	N	A	SHIBILSKI	Y	N A
LINTON	Y	N	A	COWLES	Y	N A
COGGS	Y	N	A	PANZER	Y	N A
				AYE	16	NO 0 ABS

To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

Revision to LFB Paper #422 -- Selected Provider Rate Increases (DHFS -- Medical Assistance)

[LFB Summary: Page 256, #3(part)]

Subsequent to the preparation of LFB paper #422, it was discovered the Governor's recommended 1% rate increase for non-institutional providers included services which are currently reimbursed under a cost-based formula. Reimbursement for federally qualified health centers (FQHCs), rural health clinics and end-stage renal disease services are reimbursed based on their costs and, therefore, should not have been included in the provider rate increase estimate.

In addition, a technical correction is required related to the rate increase provided for drugs. MA reimbursement for drugs is cost-based. Pharmacists and physicians are reimbursed the lesser of: (a) the usual and customary charge; or (b) the amount that would result using a variety of formulas, including the estimated acquisition cost minus 10%. Reimbursement for over-the-counter drugs is limited to the amount paid for non-prescription generic drugs. In addition, pharmacists and physicians are paid a dispensing fee for each prescription. Therefore, the 1% increase should apply to the dispensing fee, rather than to the total reimbursement for the prescription, as assumed in SB 77.

SB 77 provides \$2,184,800 GPR and \$3,128,500 FED in 1997-98 and \$4,419,800 GPR and \$6,259,800 FED in 1998-99 to support a 1% rate increase for non-institutional providers. The current estimated cost of a 1% rate increase for non-institutional providers is \$1,388,500 GPR and \$1,988,300 FED in 1997-98 and \$2,808,400 GPR and \$3,978,900 FED in 1998-99.

In addition, the box in Alternative 1a of that paper needs to be modified to accurately reflect the funding in the text.

The alternatives to LFB paper #422, as corrected, are as follows:

ALTERNATIVES TO BILL

1. Inpatient Hospitals

Revised 1a. Approve the Governor's recommendation to increase rates for acute care inpatient hospital services by 2.1% in 1997-98 and 2.5% in 1998-99. In addition, increase payment for allowable capital costs from 85% to 95%. Finally, increase MA benefits funding by \$99,800 (\$46,300 GPR and \$53,500 FED) in 1997-98 and \$220,600 (\$90,400 GPR and \$130,200 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

<u>Alternative 1a</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$136,700	\$183,700	\$320,400

1b. Modify the Governor's recommendation, relating to rate increases for inpatient hospital services, based on one of the options in the following table.

Alternative Hospital Rate Increases (As Reestimated)

<u>Rate Increase</u>		<u>Change to Bill</u>			
		<u>1997-98</u>		<u>1998-99</u>	
<u>1997-98</u>	<u>1998-99</u>	<u>GPR</u>	<u>FED</u>	<u>GPR</u>	<u>FED</u>
0%	0%	-\$2,115,600	-\$3,029,400	-\$4,717,500	-\$6,681,500
1	1	-1,086,100	-1,561,400	-2,640,400	-3,738,700
2	2	-56,700	-93,300	-542,600	-766,600
2.1*	2.5*	46,300	53,500	90,400	130,200
3	3	972,800	1,374,700	1,575,900	2,234,800

*Governor's recommendation as reestimated.

2. Non-institutional Providers

Revised 2a. Move the Governor's recommendation to provide a 1% increase in 1997-98 and an additional 1% increase in 1998-99 for all services provided by non-institutional providers. In addition, decrease MA benefits funding by \$1,936,500 (\$796,300 GPR and \$1,140,200 FED)

in 1997-98 and \$3,892,300 (\$1,611,400 GPR and \$2,280,900 FED) in 1998-99 to reflect the current estimated cost of this rate increase.

<u>Alternative 2a</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$2,407,700	- \$3,421,100	- \$5,828,800

Revised 2b. Modify the Governor's recommendation, relating to rate increases for non-institutional services, based on one of the options in the following table.

**Alternative Non-Institutional Provider Rate Increases
(As Reestimated)**

<u>Rate Increase</u>		<u>Change to Bill</u>			
		<u>1997-98</u>		<u>1998-99</u>	
<u>1997-98</u>	<u>1998-99</u>	<u>GPR</u>	<u>FED</u>	<u>GPR</u>	<u>FED</u>
0%	0%	-\$2,184,800	-\$3,128,500	-\$4,419,800	-\$6,259,800
1*	1*	-796,300	-1,140,200	-1,611,400	-2,280,900
2	2	592,300	847,900	1,225,000	1,737,500
2.5	2.5	1,286,500	1,842,100	2,653,600	3,761,700
3	3	1,980,800	2,836,200	4,089,300	5,795,600

*Governor's Recommendation as Reestimated

3. Pediatric Hospitals

3a. Approve the Governor's recommendation to provide \$2,000,000 annually to fund a 12.9% rate increase for hospitals that have more than 12,000 all-payer intensive care unit and general pediatric days per year.

3b. Modify the Governor's recommendation by deleting the requirement that the rate increase be provided to hospitals with more than 12,000 all-payer intensive care and general pediatric days per year. In addition, direct DHFS increase inpatient hospital reimbursement for pediatric services by \$2,000,000 annually.

3c. Maintain current law.

<u>Alternative 3c</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$1,650,100	- \$2,349,900	- \$4,000,000

Prepared by: Amie T. Goldman

MO# Alt #1A

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 15 NO 0 ABS

MO# Alt #2a

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 7 NO 9 ABS

MO# Alt #3a

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 12 NO 4 ABS

HEALTH AND FAMILY SERVICES

Non-Institutional Provider Rate Increases

Motion:

Provide \$722,000 GPR and \$1,033,700 FED in 1997-98 and \$1,490,000 GPR and \$2,113,000 FED in 1998-99 to support the costs of a 2% rate increase in 1997-98 and an additional 2% rate increase in 1998-99 for all services provided by non-institutional providers except dentists, and a 5% rate increase in each year for services provided by dentists.

Note:

Senate Bill 77 would provide a 1% increase in each year of the biennium for all services provided by non-institutional providers.

This motion would instead provide a 2% annual rate increase for noninstitutional providers except dentists, and a 5% annual rate increase for services provided by dentists.

[Change to Bill: \$2,212,000 GPR and \$3,146,600 FED]

MO# 1115

1 JENSEN	Y	N	A
2 OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 16 NO 0 ABS

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Home Rate Increases (DHFS -- Medical Assistance)

[LFB Summary: Page 256, #3 (part)]

CURRENT LAW

The Department of Health and Family Services (DHFS) reimburses nursing homes for care provided to medical assistance (MA) recipients through payments based on a daily rate adjusted for patient levels of care. The daily rate is determined annually by DHFS based on the amount of funding budgeted for MA nursing home reimbursement.

State law requires DHFS to make payments under six cost categories ("cost centers"), which include: (a) direct care; (b) support services; (c) administrative and general; (d) fuel and other utilities; (e) property taxes, municipal services or assessments; and (f) capital.

Under federal law, the MA program must reimburse nursing homes for costs incurred by efficiently and economically operated facilities. This requirement of federal law is often referred to as the "Boren Amendment" or "EEO requirement." In addition, payments to nursing homes may not exceed the amount that would be paid under medicare payment principles. Thus, federal MA payments to nursing homes are limited by the "medicare upper limit."

GOVERNOR

Provide \$50,975,000 (\$20,960,900 GPR and \$30,014,100 FED) in 1997-98 and \$81,297,500 (\$33,645,000 GPR and \$47,652,500 FED) in 1998-99 to increase MA payments to nursing homes.

Provide that aggregate payments to nursing homes, exclusive of increases due to higher recipient utilization of nursing home care and other specified items, would increase over the prior year payments by the lesser of 6.1% or \$50,975,000 in 1997-98 and by the lesser of 3.5% or \$30,322,500 in 1998-99. Because of the design of the nursing home reimbursement formula, which reimburses a nursing home's allowable costs up to established maximum rates based on median nursing home costs in the state, a nursing home may receive rate increases that are either higher or lower than the 6.1% and 3.5% for the respective years.

DISCUSSION POINTS

Effect of Rate Increases and Formula Changes

1. The aggregate rate increases of \$50,975,000 (or 6.1% rate, if lower) in 1997-98 and an additional \$30,322,500 (or 3.5% rate, if lower) in 1998-99 reflect the net increase with the formula changes recommended by the Governor. Consequently, the recommended formula changes would not reduce these recommended rate increases.

2. Questions have been raised as to whether the recommended funding increase or the recommended formula parameters would dominate if, once the actual data is utilized, the two were found to be inconsistent. Since the recommended funding level is based on the formula parameters applied to a prior year data set, the formula parameters recommended by the Governor may generate a lower level of funding than is provided in SB 77 when applied to the actual cost data. In this case, the recommended funding levels would control and the formula parameters would be adjusted to expend the full \$51.0 million (or increase rates 6.1%) in 1997-98 and \$30.3 million (or increase rates 3.5%) in 1998-99 budgeted to increase nursing home reimbursement. Although minimum limits for the cost center targets are specified in statute, the statutes do not specify the exact value of these formula parameters and, consequently, DHFS has the authority to adjust these formula parameters.

3. Under the MA nursing home formula, each home receives a payment rate that is relative to the actual costs of that home to the extent that those costs are within the cost center maximums in the formula. Because the maximums are related to statewide median costs for those items, not every home receives all of its costs. Also, because some homes are below the maximum and some are above, each home may receive a percentage rate increase that is much different than the average increase. Thus, even if the rate increase equals 6.1% in 1997-98 on average, an individual home may experience a much different rate increase. Although the Governor recommended a number of formula changes, the change with the largest impact is the reduction of the direct care target from 110% to 102%. This change will cause homes with higher than average direct care costs to experience proportionately lower rate increases than the average. Also, homes with a higher than average number of medicare patients will experience a lower than average increase.

EEO Requirement

4. A critical factor in establishing the reimbursement formula for nursing homes is the EEO requirement. Federal law does not specify methods the state must use to demonstrate compliance with the EEO requirement. States must develop their own methods for assuring that the rate of reimbursement established for nursing homes will be sufficient to meet the EEO requirement. To the extent the rate increase or other changes to the nursing home formula are not sufficient to meet EEO requirement, reimbursement for nursing homes may be challenged through legal action.

5. The method used by DHFS to ensure compliance with the EEO requirement is to establish the cost center targets at levels sufficient to reimburse all allowable projected costs for at least 50% of the nursing homes in each cost center. This test would require that, in general, the cost center targets would have to be at least 100% of the statewide median cost for each cost center. Since the Department must project costs (actual costs for the reimbursement period are not known when rates are set) for the rate period, setting the targets at 100% of the projected median cost may subject the state to some risk, if inflation is higher than anticipated. Setting the targets at 100% does not leave any margin for error.

6. The Governor's recommendation sets the targets for the cost centers at 102% of the statewide median. Since there is some uncertainty as to the level of costs in the reimbursement period, the Governor's recommendation could be viewed as close to the minimum amount of funding needed to meet the EEO requirement, given that some margin for error must be incorporated.

7. Although the Governor's recommended parameter values could be characterized as the minimum level for meeting the EEO requirement, it may be that the associated funding level is more than the amount required to fund rates under those parameter values. DHFS staff ran a simulation of the nursing home formula using the Governor's recommended parameter values on more recent cost information than was available when the budget was developed. This recent simulation suggests that the funding provided for nursing home rate increases could be reduced by \$8,266,500 (all funds) in 1997-98 and by \$8,555,800 (all funds) in 1998-99 while still meeting the state's test for complying with the EEO requirement.

8. Although the recent simulation is based on more up-to-date information, it is not based on the complete data set that will be used for setting 1997-98 rates. Not every home has submitted its 1995 cost report, which is the report that will be the basis for the 1997-98 rate calculation. Also, estimates of Wisconsin inflation, based on comparing unaudited 1996 and 1995 cost reports are not available at this time. However, the recent simulation is based on approximately 85% of all nursing homes, and DHFS utilized the highest adjustment for past estimates of Wisconsin inflation.

Historical Rate Increases

9. The recent federal budget agreement reached between the President and Congressional leaders includes, as a flexibility option, the repeal of the EEO requirement as one component of approximately \$16 billion in gross MA savings that must be realized over the next five years. However, this agreement is still in the early stages of the legislative process.

10. Tables 1 and 2 provide historical information on the level of reimbursement rates to nursing homes over the last several years. Table 1 reflects information from the annual survey of nursing homes for which 1995 is the last available year. Table 1 lists: (a) the average MA reimbursement rate for each of the different levels of care; (b) the average reimbursement rate for medicare and the private pay rate for the SNF level of care; and (c) the average total cost per day. It is difficult to compare these average cost figures to the changes in MA rates, since the rates are based on level of care, while the costs reflect a combination of all levels of care and groups.

TABLE 1
Average Reimbursement Rates
Annual Survey of Nursing Homes
1992-1995

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>Annual Rate Of Increase 1992 to 1995</u>
Medical Assistance					
Intensive Skilled Nursing (ISN)	\$90.54	\$93.18	\$96.90	\$100.70	3.6%
Skilled Nursing (SNF)	75.92	78.65	82.24	85.67	4.1
Intermediate Care (ICF-1)	63.28	66.14	69.18	72.55	4.7
Limited Care (ICF-2)	62.97	66.57	69.75	74.42	5.7
Personal Care (ICF-3)	47.10	51.77	50.12	61.13	9.1
Residential Care (ICF-4)	37.37	47.72	40.80	47.83	8.6
Developmental Disabilities (All)	<u>94.94</u>	<u>101.99</u>	<u>106.89</u>	<u>116.92</u>	<u>7.2</u>
Average MA (All Levels)	\$75.19	\$78.40	\$84.77	\$88.54	5.6%
Medicare SNF*	\$132.56	\$163.43	\$174.39	\$192.44	13.2%
Private Pay SNF	\$94.76	\$100.71	\$106.32	\$112.6	5.9%
Average Costs per Patient Day	\$94.88	\$99.48	\$104.35	\$108.21	4.5%

*The medicare rate includes costs for therapies, physician services and other costs that are separately bill for under MA.

11. Table 1 indicates that for the SNF level of care, which is the largest group, the average annual growth rate in the MA reimbursement rate was 4.1 % over the 1992 to 1995 period. For all levels of the care, the MA reimbursement rate increased at an average annual rate of 5.6%. By comparison, the private rate for SNF care increased 5.9% annually and the medicare rate by 13.2% annually. Average total patient costs over this period increased at an annual rate of 4.5%.

TABLE 2

**Average MA Reimbursement Rates After Patient Share
1992-93 to 1996-97**

	<u>FY 93</u>	<u>FY 94</u>	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>Increase FY 95 to FY 96</u>	<u>Increase FY 96 to FY 97</u>	<u>Annual Rate of Increase FY 93 to FY 97</u>
Skilled Nursing (SNF)	\$61.61	\$65.04	\$68.29	\$70.05	\$72.31	2.6%	3.2%	4.1%
Intermediate Care (ICF-1 & 2)	47.78	50.99	53.13	54.46	56.23	2.5	3.3	4.2
Personal Care (ICF-3)	33.16	37.98	38.39	39.00	38.00	1.6	-2.6	3.5
Residential Care (ICF-4)	24.30	20.34	17.76	16.05	11.24	-9.6	-30.0	-17.5
Developmental Disabilities (ALL)	<u>89.49</u>	<u>94.67</u>	<u>103.74</u>	<u>106.30</u>	<u>111.72</u>	<u>2.5</u>	<u>5.1</u>	<u>5.7</u>
All Levels	\$60.49	\$64.11	\$67.77	\$69.68	\$72.23	2.8%	3.7%	4.5%

Source: DHFS MA 543 Reports

12. Since the annual survey provides information only through 1995, Table 2 is included to provide an indication of the changes in reimbursement rates in the last two years. Table 2 shows the average reimbursement rate paid by MA by level of care. These reimbursement rates are net of patient share and thus, are less than the rates indicates in Table 1. The data in Table 2 does not provide as good of an indication of the change in reimbursement rates, since the changes may be influenced by changes in relative amounts of cost sharing from the MA recipients. Table 2 indicates that the MA reimbursement rate increases have increased at a lower rate over the last two years than in previous years. Table 2 shows that for all levels of care, the MA rate increased at 2.8% in 1995-96 and 3.66% in 1996-97.

Comparisons with Other Services

13. Rate increases for nursing homes have been larger than for other types of MA providers. Inpatient hospitals, which are also subject to the EEO requirement, received rate increases that averaged 2.75% in 1993-94 and 3.25% in 1994-95 and 3% annually in the 1995-97 biennium. The Governor recommends rate increases of 2.1% in 1997-98 and 2.5% in 1998-99 for inpatient hospitals for the 1997-99 biennium. Other than hospitals and nursing homes, there

have been limited rate increases for MA providers over the 1993-97 period. Selected non-institutional providers received a 1% rate increase in 1994-95 and the Governor recommends a rate increase of 1% per year for noninstitutional providers in the 1997-99 biennium.

14. Advocates of home- and community-based long-term care have argued that there is an institutional bias in funding MA-supported services. Nursing home care is an entitlement, while funding for the MA waiver programs, such as the community options waiver (COP-W) and the community integration program (CIP IB), are limited and subject to waiting lists for services.

15. The Governor's recommendations for community-based long-term care programs for 1997-99 are as follows: (a) provide \$272,000 GPR and \$389,500 FED in 1997-98 and \$821,300 GPR and \$1,163,200 FED in 1998-99 to increase the number of CIP IB placements by 75 in 1997-98 and by another 75 in 1998-99. (b) provide \$1,067,600 GPR and \$752,000 FED in 1997-98 and \$3,143,100 GPR and \$2,276,900 FED in 1998-99 for the COP program; and (c) increase the maximum rate paid to counties for the costs of a CIP IA placement made after July 1, 1997, to \$184 per day, from the current level of \$153 per day. DHFS is also pursuing a long-term care initiative that has as one of its goals the elimination of any bias for a particular type of long-term care and that funding would follow the recipient. DHFS plans to introduce legislation for the long-term care initiative in the Fall of 1997.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendations to provide \$50,975,000 (\$20,960,900 GPR and \$30,014,100 FED) in 1997-98 and \$81,297,500 (\$33,645,000 GPR and \$47,652,500 FED) in 1998-99 to increase MA payments to nursing homes.

2. Reduce funding in SB 77 by \$3,399,200 GPR and \$4,867,300 FED in 1997-98 and \$3,540,200 GPR and \$5,015,600 FED in 1998-99 to reflect more recent projections of the funding required to meet the EEO requirement.

<u>Alternative 2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$6,939,400	- \$9,882,900	- \$16,822,300

3. Adopt the funding modification contained in Alternative (2). In addition, specify that DHFS would not expend all of the funds provided for nursing home rate increases if the recommended cost center targets and other formula parameters could be funded at a lower cost, based on more complete data at the time DHFS sets the nursing home rates.

HEALTH AND FAMILY SERVICES

Direct Care Target for Nursing Home Reimbursement

Motion:

Move to modify Alternative 2 in LFB Paper #423 to add the provision that any part of the aggregate funding increase budgeted in 1997-98 for nursing home rate increases that is in excess of the amount needed to support the formula values recommended by the Governor be used solely to increase the direct care target above 102% of the statewide median.

Note:

Based on a recent simulation conducted by the Department, it is estimated that the recommended funding level for 1997-98 is \$8,266,500 higher than would be needed to fund the Governor's recommended formula values and comply with the federal EEO requirement. However, when all actual cost data is received, it may be the case that the net funding provided after the reductions under Alternative 2 may be more than needed to fund the Governor's formula values. This motion would direct that any excess funding be directed to increase the target for direct care.

MO# 2050

2 JENSEN	<input checked="" type="checkbox"/>	N	A
OURADA	<input checked="" type="checkbox"/>	N	A
HARSDORF	<input checked="" type="checkbox"/>	N	A
ALBERS	<input checked="" type="checkbox"/>	N	A
GARD	<input checked="" type="checkbox"/>	N	A
KAUFERT	<input checked="" type="checkbox"/>	N	A
LINTON	<input checked="" type="checkbox"/>	N	A
COGGS	<input checked="" type="checkbox"/>	N	A

BURKE	<input checked="" type="checkbox"/>	N	A
DECKER	<input checked="" type="checkbox"/>	N	A
GEORGE	<input checked="" type="checkbox"/>	N	A
JAUCH	<input checked="" type="checkbox"/>	N	A
WINEKE	<input checked="" type="checkbox"/>	N	A
SHIBILSKI	<input checked="" type="checkbox"/>	N	A
COWLES	<input checked="" type="checkbox"/>	N	A
PANZER	<input checked="" type="checkbox"/>	N	A

AYE 16 NO 0 ABS _____

<u>Alternative 3</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	- \$6,939,400	- \$9,882,900	- \$16,822,300

Prepared by: Richard Megna

MO# _____

*See Motion
2050 - modification
to A/H #2*

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE _____ NO _____ ABS _____

HEALTH AND FAMILY SERVICES

Funding for Additional COP-Waiver Placements

Motion:

Move to provide \$1,726,000 GPR and \$2,088,000 FED in 1998-99 to fund 800 additional placements that would be made under the community options medical assistance waiver (COP-W) program, beginning January 1, 1999.

Note:

SB 77 provides funding to support: (a) 400 additional placements in 1997-98 (120 regular COP and 280 COP-W placements), beginning January 1, 1998; and (b) an additional 400 placements in 1998-99 (120 regular COP and 280 COP-W placements), beginning January 1, 1999. In total, 800 additional slots would be provided by the end of the 1997-99 biennium.

This motion would provide an additional 800 COP-W placements, beginning on January 1, 1999. Together with the Governor's recommendation, this would provide a total of 1,600 additional placements by the end of the 1997-99 biennium.

[Change to Bill: \$1,726,000 GPR and \$2,088,000 FED]

MO# 1116

JENSEN	Y	N	A
ZOURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 8 NO 8 ABS _____

FAIL

To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Home Formula Adjustments (DHFS -- Medical Assistance)

[LFB Summary: Page 259, #5]

CURRENT LAW

The Department of Health and Family Services (DHFS) is required to reimburse nursing homes for care provided to medical assistance (MA) recipients according to a prospective payment system that is updated annually. The Department's payment methodology must reflect a prudent buyer approach under which a reasonable price, recognizing select factors that influence costs, is paid for services. DHFS must establish payment standards, using recent cost reports submitted by nursing homes, which reflect projected costs to be incurred by economically and efficiently operated facilities. In federal law, this requirement is referred to as the "EEO requirement" or "Boren Amendment."

GOVERNOR

Modify the MA reimbursement formula for nursing home providers as follows:

Direct Care Target. Reduce the required statutory standard for payments under the formula's direct care cost center to 100% of the median direct care costs of all facilities in the state, rather than the standard of 110% that is used under current law. Although the statutory minimum would be reduced to 100% of the median, the Governor recommends that DHFS establish the direct care cost center at 102% of the median for provider payments in 1997-98.

Other Cost Center Targets. Reduce the formula targets for the various cost centers, as follows: (a) for support services to 102% of the statewide median from the current level of

103%; (b) for administrative and general costs to 102% of the statewide median from 103%; and (c) for fuel and utilities to 102% of the statewide median from the current level of 115%.

Nursing Home Property Costs. Reduce the percentage of capital costs in excess of the target that are reimbursed to 20%, from the current level of 40%. Nursing homes with property costs (mortgage, lease and depreciation costs) in excess of the target would have less of their property costs counted in determining the nursing home's MA payment, resulting in a lower payment.

Classification of Medicare Days. Classify all medicare-funded nursing home days as intensive skilled nursing (ISN) days, rather than classifying only 12.5% of medicare-funded days as ISN days. This change to the classification of medicare-funded days would reduce the costs that are allocated to MA patients at a nursing home, which, in turn, would reduce the nursing home's MA reimbursement rate.

Direct Care Increment Payment. Increase the direct care increment from 93% to 150% of the median for facilities in the state. The direct care increment is a fixed amount equal to the estimated inflation rate times a percentage of the direct care costs of the median cost facility (as proposed, 150% of the median cost). This adjusts the direct care reimbursement rate to reflect the rate of inflation between the common period and the reimbursement period. Since nursing homes have fiscal years ending at different times, the reported costs of each nursing home must be adjusted to a common period.

Support Services Increment. Increase the direct care increment from 93% to 100% of the median for facilities in the state. This increment serves the same purpose as the direct care increment, but is applied to the support services cost center.

High MA Utilization Adjustment. Increase the additional payment for support services to nursing homes with a high percentage of MA residents by increasing the base add-on to a facility's per diem rate from \$0.25 to \$0.50 per patient day.

Rate on Rate for 1998-99. For 1998-99, per diem reimbursement rates would be determined by applying a uniform percentage increase (approximately 3.5%) to the prior year's per diem rate, subject to several adjustments as determined by DHFS. This would substitute for the cost basis approach for 1998-99 only, and in the following year, 1999-00, the cost basis approach would be used again.

DISCUSSION POINTS

Direct Care Target

1. Under current law, the direct care target must be set at 110% of the statewide median cost for direct care, except that if there is insufficient funding, the target can be set lower. The Governor recommends reducing the statutory requirement from 110% to 100% of the statewide median, and recommends that for 1997-98 the direct care target be set at 102% of the statewide median.

2. DHFS estimates that setting the direct care target at 102%, rather than 110%, will reduce nursing home payments by \$24.1 million annually. Nursing homes that have above average direct care costs will be adversely affected by this provision. The types of homes that have higher direct care costs are county-owned nursing homes and non-profit nursing homes. The county-owned nursing homes that are adversely affected by this provision may, to some degree, receive higher county supplemental payments as a result of lower MA per diem rates. County supplemental payments are based on the relative size of a county's operating loss.

3. The rationale for the current law provision which establishes a much higher target for direct care than the targets for other cost centers is that direct care is the most critical cost center in terms of providing adequate care to nursing home residents. A higher target will result in a larger percentage of nursing homes that will receive a sufficient reimbursement rate to cover their direct care staffing costs.

4. In support of the proposed lower target for direct care, it can be argued that a target set at 100% or above of the statewide median should be a high enough standard to ensure an adequate direct care staffing level. If half of the nursing homes in the state are able to provide direct care at or below the state target, then the rate provided by the state should be sufficient to meet EEO requirements. In addition, regulation of nursing homes and annual surveys will monitor and enforce MA staffing standards.

Classification of Medicare Days

5. In setting MA nursing home rates, DHFS currently does not collect information about other revenues, such as medicare and private pay, which offset nursing homes' costs. In order to estimate nursing homes' costs attributable to MA, medicare and private pay patients, DHFS currently classifies nursing home days under different levels of care, with ISN (intensive skilled nursing) as the highest level and SNF (skilled nursing facility care) as the second highest level. Currently, nursing homes are required to classify at least 12.5% of their medicare patient days as ISN, while the remainder are classified as SNF.

6. The Governor proposes that all medicare patient days be classified as ISN. This would result in a higher proportion of costs allocated to medicare patients and a lower proportion of costs allocated to MA patients.

7. The nursing home industry argues that most medicare patients would not meet the ISN standard and that it would be inaccurate to classify all patient days as ISN. A survey conducted by the nursing home industry in 1995-96 found that, on average, 12.5% of medicare patients would meet the ISN standard. This survey was used as the basis for the current policy of classifying 12.5% of medicare patient days as ISN days.

8. Medicare payments to nursing homes exceed the average ISN rate paid under MA. In 1995, the average medicare reimbursement rate was \$192.44 per day, while the average MA reimbursement rate for the ISN level of care was \$100.70 per day. However, the medicare rate includes services such as therapies and physician services, which are billed separately under MA. In 1995, MA nursing home residents had, on average, additional MA costs of \$7.34 per day.

9. If all medicare patient days are not classified as ISN days, more costs would be allocated to MA, and more funding would be needed to meet the EEO requirement. DHFS estimates that \$9.9 million more annually would be needed if current law were maintained.

Property Costs

10. Currently, nursing homes receive 40% of capital costs that exceed capital expenses allowed under the formula. Under the Governor's recommendation, this cost-sharing percentage would be reduced to 20%. DHFS estimates that this change reduces annual nursing home payments by \$1.8 million.

11. Newer nursing homes and homes with significant debt, generally proprietary homes, benefit from the existing formula provision on cost-sharing.

12. Elimination of the current formula cost-sharing provision would decrease MA reimbursement for facilities' debt and interest payments and increase funding available for resident care. Alternatively, it could be argued that reduced capital cost-sharing would lead, over time, to fewer facility improvements and outdated facilities which could result in lower quality of care for residents and increased violations related to the health and safety of facilities.

Direct Care and Support Services Increments

13. The direct care and support services increments serve to adjust the reimbursement rate based on costs from an earlier period to reflect the effects of inflation between the earlier period and the reimbursement period. In 1995-96, the inflation adjustment for direct care costs and support services was equal to 93% of the product of the anticipated inflation rate times the median direct care costs. The Governor proposes to increase these adjustments to 150% of the

median for direct care costs and 100% of the median for support services. The increase for the direct care increment is estimated to increase annual nursing home payments by \$10.1 million while the increase in the support services maximum is anticipated to increase payments by \$0.6 million annually.

14. Increasing the direct care and support services increments help to ensure that the state's target for meeting the EEO requirement will be met. The combination of reducing the targets for the direct care and other cost centers while increasing the direct care and support services increments is a less expensive way to meet the state's test for the EEO requirement.

High Medicaid Utilization Adjustment

15. The Governor proposes increasing the high MA utilization payment from \$0.25 to \$0.50 per day for facilities with a MA occupancy of at least 70%. The estimated cost of this provision is \$1.5 million annually. County-owned facilities are not eligible for this payment.

16. The increase in the high MA utilization adjustment would assist facilities that devote a larger than average proportion of their facility to the care of MA recipients and would help to compensate for the smaller proportion of private pay and other types of residents upon which to shift costs that are not allowed under the MA nursing home reimbursement formula. In addition, since the cost center targets would be reduced to levels closer to the minimum required under the EEO requirement, this change would help to insure that this requirement is met.

17. A summary of the fiscal effects of the various formula changes are identified in Table 1. Again, the aggregate funding/rate increases recommended by the Governor are the amounts/rates after the effect of these formula changes. The actual effect of these formula changes may vary from the amounts shown in the Table 1, since these estimates are based on cost reports from a year prior to the actual year of implementation. Also, these formula changes are interdependent and would change if a different combination of formula modifications were enacted. In combination, these formula changes would meet the state's current test for meeting the EEO requirement. Any further medications that would only reduce payments may result in a set of payments that would not meet that test.

TABLE 1**Estimated Annual Impact of Nursing Home Formula Changes**

	Fiscal Impact All Funds (In Millions)
Direct Care Maximum at 102% of the Median	-\$24.1
Support Services, Administration & General, Fuel & Utilities at 102% of the Median	-3.1
Classify All Medicare Days as ISN Days	-9.9
Reduce Cost Sharing for Property Costs to 20%	-1.8
Increase Direct Care Increment to 150% of the Median	10.1
Increase Support Services Increment to 100% of the Median	0.6
Adjust Payment to Reflect High MA Utilization	<u>1.5</u>
Total	-\$26.7

Rate on Rate for 1998-99

18. For 1998-99, the MA nursing home reimbursement rate would be determined by applying a uniform percentage increase (approximately 3.5%) to the prior year's per diem rate, subject to several adjustments as determined by DHFS.

19. A rate-on-rate increase was used for establishing the 1996-97 rates. However, facilities that are undergoing renovations or remodeling are not able to recapture any of these additional capital costs in the year of the rate-on-rate increase. Also, even when the reimbursement rate is again based on costs, the additional capital costs associated with the year of the rate-on-rate increase are never recovered.

20. To address this problem in 1995-96, DHFS allowed nursing homes who were significantly affected by this provision to make appeals to recover a portion of these unrecovered costs.

21. One option that would not have a significant net impact on MA nursing home expenditures would be to apply the rate-on-rate method only to operational costs, and retain the cost basis for capital costs. This would allow payments to reflect recent renovations while net MA costs would not increase, since for many nursing homes, the capital cost component declines due to repayment of loans and assets having been fully depreciated. This would redistribute capital cost payments from homes without any new capital projects to homes with new capital costs.

22. The cost to the state of deleting or modifying any of the recommended formula changes can be neutral (redistribute payment only) or could have a net cost or savings to the state. Although modifications to the recommended formula changes could be made without any net funding changes, in general, modifications to the recommended formula changes may require additional funds in order to meet the EEO requirement. For example, if the direct care target is increased above 102% of the median, as recommended in SB 77, and additional funding is not added, then payments for other cost centers would have to be reduced, which may result in insufficient funding for DHFS to reimburse the costs of those centers for at least 50% of the homes in the state.

ALTERNATIVES TO BILL

1. Adopt the Governor's recommended formula changes.
- 2a. Modify the Governor's recommendation by deleting or modifying one or more of the recommended nursing home formula changes but do not provide any additional funding for total aggregate payments to nursing homes. The change in payments shown in the table below from maintaining current law would have to be offset by other formula changes, as determined by DHFS.

	Fiscal Impact All Funds <u>(In Millions)</u>
Maintain Care Maximum at 110% of the Median	\$24.1
Maintain Support Services, Administration & General at 103% of Medium and Fuel & Utilities at 115% of the Median	3.1
Classify 12.5% of Medicare Days as ISN Days	9.9
Maintain Cost Sharing for Property Costs at 40%	1.8
Maintain Direct Care Increment at 93% of the Median	-10.1
Maintain Support Services Increment at 93% of the Median	-0.6
Maintain High MA Utilization Payment at 25¢ per day	<u>-1.5</u>
Total	-\$26.7

2b. Modify the Governor's recommendation by deleting or modifying one or more of the recommended changes. In addition, adjust aggregate funding to reflect the formula modifications so that offsetting change do not have to be implemented. The fiscal change to the bill of maintaining current law is as follows:

	Fiscal Change to Bill			
	1997-98		1998-99	
	GPR	FED	GPR	FED
Maintain Direct Care Maximum at 110% of Median	\$9,910,000	\$14,190,000	\$10,321,000	\$14,623,000
Retain Support Services, Admin. & General, at 103% and Fuel & Utilities at 115% of the Median	1,275,000	1,825,000	1,328,000	1,881,000
Classify 12.5% of Medicare Days as ISN Days	4,071,000	5,829,000	4,240,000	6,007,000
Maintain Cost Sharing for Property Costs at 40%	740,000	1,060,000	771,000	1,092,000
Maintain Direct Care Increment at 93% of the Median	-4,153,000	-5,947,000	-4,325,000	-6,128,000
Maintain Support Services Increment at 93% of the Median	-247,000	-353,000	-257,000	-364,000
Maintain High MA Utilization Payment at 25¢ per day	-617,000	-883,000	-642,000	-910,000

3. Modify the Governor's recommendation for using a rate-on-rate increase for 1998-99 by excluding the capital cost center from the rate-on-rate method and by requiring that the per diem rates for capital cost center be determined based on costs.

Prepared by: Richard Megna

MO# 11/13

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
AYE	<u>16</u>	NO	ABS

HEALTH AND FAMILY SERVICES

Clarification of Governor's Formula Recommendations

Motion:

Move to clarify that the nursing home formula changes recommended by the Governor would:

Rate on Rate Increase. Provide that the rate on rate increase in 1998-99 would consist of two parts: (1) a 1.75% percentage increase to the individual facility's rate; and (2) a flat amount equal to 1.75% times the average rate for all facilities in the prior year.

Direct Care Increment. The recommended increase in the direct care increment from 93% to 150% of the median be only applied to residents classified under a care level other than one of the four developmentally disabled levels.

Note:

The descriptions in Paper #424 of two of the Governor's recommended nursing home formula changes under medical assistance may not fully capture the all of the details of the recommended changes. This motion would clarify the Governor's recommendations in these two areas.

MO# 1586

1	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

2	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A

Motion #1586

AYE 16 NO 0 ABS _____

HEALTH AND FAMILY SERVICES

Direct Care and Support Service Targets for Nursing Home Reimbursement

Motion:

Move to modify the Governor's recommended MA nursing home formula changes to specify that \$8,003,000 of the aggregate funding increase budgeted for 1997-98 be used to increase the direct care target to 104% and the support service target to 103% of the respective statewide medians. In addition, delete \$108,400 GPR and \$155,200 FED in 1997-98 and \$112,800 and \$159,900 FED in 1998-99 to reflect lower funding for payments to nursing homes.

Note:

SB 77 provides \$50,975,000 (all funds) in 1997-98 and \$81,297,500 (all funds) in 1998-99 to support increased reimbursement of nursing home services in the 1997-99 biennium. Based on a recent simulation conducted by the Department, it is estimated that the recommended funding level for 1997-98 is \$8,266,500 higher than would be needed to fund the Governor's recommended formula values and comply with the federal EEO requirement.

This motion would modify the recommended formula changes to specify that \$8,003,000 of the funding provided in 1997-98 for nursing home rate increases be used to increase the direct care target to 104% and the support service target to 103% of the respective statewide medians. The remaining funds (\$263,500 in 1997-98) would be deleted from funding for nursing home rate increases.

An indirect effect of this formula change is that the amount of federal matching funds that DHFS claims based on unreimbursed expenses of county-owned nursing homes may decline, since counties would tend to receive a relatively higher share of payments resulting from increases in the targets for direct care and support service costs. For each additional dollar paid to county-owned nursing homes under the per diem rates, the amount of county unreimbursed expenses or losses would decline by \$1 and the state would lose approximately \$1.44 in matching federal funds under the intergovernmental transfer program (IGT).

Specifying that \$8,003,000 would be used to increase the direct care target would result in higher payments to counties of approximately \$3.4 million, which in turn, would reduce IGT claims by up to \$4.9 million. Since county-owned nursing homes would benefit to some degree

from other possible formula changes that expended the \$8,003,000, the net reduction to IGT claims would be less than \$4.9 million and would depend on the formula modification adopted.

It is uncertain if a reduction in IGT claims would affect the state or county-owned nursing homes. SB 77 specifies that any IGT claims above the amounts contained in the budget would be distributed to counties. Thus, if county losses are greater than projected, any loss in IGT funds would affect counties as long as the total amount of claims are within the medicare upper limit. However, if county losses are less than projected, any reduction in IGT claims would increase state GPR costs by the same amount.

[Change to Bill: -\$22,200 GPR, -\$315,000 FED and effect on IGT claims (See Text)]

MO# 2045

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
2 BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 8 NO 8 ABS _____

FAIL

HEALTH AND FAMILY SERVICES

Direct Care and Support Service Targets for Nursing Home Reimbursement

Motion:

Move to modify the Governor's recommended MA nursing home formula changes to specify that target for the direct care be increased to 103%. In addition, provide \$1,367,300 GPR and \$1,832,700 FED in 1997-98 and \$1,370,400 GPR and \$9,40,600 FED to fund the additional payments under these formula modifications.

Note:

An indirect effect of this formula change is that the amount of federal matching funds that DHFS claims based on unreimbursed expenses of county-owned nursing homes may decline, since counties would tend to receive a relatively higher share of payments resulting from increases in the targets for direct care and support service costs. For each additional dollar paid to county-owned nursing homes under the per diem rates, the amount of county unreimbursed expenses or losses would decline by \$1 and the state would lose approximately \$1.44 in matching federal funds under the intergovernmental transfer program (IGT).

Specifying that \$3,200,000 would be used to increase the direct care target would result in higher payments to counties of approximately \$1.4 million, which in turn, would reduce IGT claims by up to \$2.0 million.

It is uncertain if a reduction in IGT claims would effect the state or county-owned nursing homes. SB 77 specifies that any IGT claims above the amounts contained in the budget would be distributed to counties. Thus, if county losses are greater than projected, any loss in IGT funds would effect counties as long as the total amount of claims are within the medicare upper limit. However, if county losses are less than projected, any reduction in IGT claims would increase state GPR costs by the same amount.

[Change to Bill: \$2,737,700 GPR, \$3,773,300 FED and effect on IGT claims (see text)]

MO# 3002
 JENSEN Y N A
 OURADA Y N A
 HARSDORF Y N A
 ALBERS Y N A
 GARD Y N A
 KAUFERT Y N A
 LINTON Y N A
 COGGS Y N A

BURKE ~~Y~~ N A
 DECKER ~~Y~~ N A
 GEORGE ~~Y~~ N A
 JAUCH ~~Y~~ N A
 WINEKE ~~Y~~ N A
 SHIBILSKI ~~Y~~ N A
 COWLES Y ~~N~~ A
 PANZER ~~Y~~ N A
 AYE 15 NO 4 ABS _____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Homes -- Delicensing Beds and the Minimum Occupancy Standard (DHFS -- Medical Assistance)

[LFB Summary: Page 262, #6]

CURRENT LAW

Prior to 1995 Wisconsin Act 27, the medical assistance (MA) nursing home formula applied a minimum occupancy standard to the daily payment rate for only four of six cost centers (administration, fuel and utilities, property tax and capital costs). When determining the payment per patient day for these four cost centers for the current year, the total allowable costs from the base cost reporting period (an earlier period) were divided by either: (a) the actual adjusted patient days; or (b) patient days based on 91% of occupancy for that earlier period, whichever is higher. If a nursing home had an occupancy rate less than 91%, the allowed rate per patient day would be inadequate to recover all of the homes's costs and the formula would penalize nursing homes that did not fully utilize their facilities.

Provisions of Act 27 extended the minimum occupancy standard to the remaining two cost centers, direct care and support services, beginning in the 1995-96 fiscal year. These two cost centers represent approximately 75% of nursing home costs.

Under rules effective prior to 1995-96, a nursing home substantially below the 91% occupancy could avoid the effect of the minimum occupancy standard by relinquishing the use of either 25% of its licensed beds or 50 licensed beds. If a facility relinquished this number of licensed beds, its rate could be reestablished. However, future use of the relinquished beds would not be available to the facility.

When the Department of Health and Family Service (DHFS) established the rules for nursing home reimbursement for 1995-96 and 1996-97, DHFS included several "windows" that allowed nursing homes additional ways to reduce the number of licensed beds without meeting the threshold requirement of either 25% of licensed beds or 50 beds.

GOVERNOR

Authorize DHFS to approve a request by a nursing home to delicense any of the nursing home's licensed beds if the bed occupancy of the nursing home is below the minimum patient occupancy standard (currently 91%) so that the nursing home can avoid the effect of the minimum occupancy standard on its MA reimbursement. Specify that if DHFS approves the request, all of the following would apply:

- a. DHFS would be required to delicense the number of beds in accordance with the nursing home's request;
- b. DHFS would be prohibited from including the delicensed beds in the number of beds of the nursing home in determining the costs per patient day under the minimum occupancy standard;
- c. The nursing home would be prohibited from selling a bed that is delicensed;
- d. Every 12 months following the delicensure of a bed for which a nursing home has not resumed licensure, DHFS would be required to reduce the licensed bed capacity of the nursing home by 10% of all the nursing home's beds that remain delicensed, or by 25% of one bed, whichever is greater; and
- e. The nursing home could resume licensure of delicensed beds, unless the licensed bed capacity of the nursing home bed was reduced as provided under (d), 18 months after it notified DHFS in writing that it intended to resume licensure. Nursing homes would be prohibited from resuming licensure of a fraction of a bed. If a nursing home resumed licensure of a bed, DHFS would include those beds in the application of the minimum occupancy standard for purposes of the MA reimbursement rate calculation.

DISCUSSION POINTS

1. When 1995 Act 27 was passed, it was anticipated that the extension of the 91% minimum occupancy standard to direct care and support costs would reduce MA nursing home expenditures by approximately \$15.0 million (all funds) annually. Although it is not possible to determine to what extent these cost savings were realized, it is estimated that the windows

established by DHFS as a means of enabling nursing homes to avoid financial penalties resulting from the 91% occupancy standard resulted in a reduction of savings (all funds) of approximately \$11.0 million in 1995-96 and \$12.2 million in 1996-97.

2. DHFS offered nursing homes the following windows in 1995-96 to enable them to reduce their number of licensed beds to meet the 91% minimum occupancy standard.

- Any reduction in licensed bed capacity between June 30, 1995 and November 30, 1995;
- The proposed number of licensed bed reallocations to other facilities under an application under the resource allocation program (RAP) submitted between June 30, 1995, and November 30, 1995 (no adjustment would be made if the application is subsequently withdrawn or denied unless the nursing home reduced its licensed bed capacity by the same amount);
- An adjustment for licensed beds temporarily out-of-use due to renovation projects during the base reporting period;
- An adjustment for isolation beds that were vacant during the base reporting period; and
- Forty percent of the reduction in licensed bed capacity of non-county operated nursing homes during the period between February 14, 1995, and July 1, 1995.

3. For 1996-97, DHFS incorporated the reductions in 1995-96 and allowed the following additional adjustments or windows:

- Any reduction in licensed bed capacity between June 30, 1996, and October 30, 1996; and
- The proposed number of licensed bed reallocations to other facilities under an application under the RAP submitted between June 30, 1995 and November 30, 1995, or between June 30, 1996 and November 30, 1996. For applications submitted during the July 1 through November 30, 1995 time period, the RAP application must be declared complete by November 30, 1996 and approved by March 1, 1997. For applications submitted during the July 1 through November 30, 1996 time period, the RAP application must be declared complete and the project approved within 12 months of submission.

4. A nursing home that is substantially below the minimum occupancy standard that did not take advantage of the windows offered in 1995-96 and 1996-97 can avoid the effect of the 91% minimum occupancy standard by relinquishing the use of either 25% of its licensed beds

or 50 licensed beds. If a facility relinquishes this number of licensed beds, its rate can be reestablished. However, future use of the relinquished beds will not be available to the facility.

5. The Governor's proposal would allow facilities to delicense beds without any minimum threshold amount, and would only impose a gradual loss (10% per year) of the number of delicensed beds.

6. If every nursing facility took advantage of the Governor's provision for bed banking, it is estimated that MA nursing home expenditures would increase by \$4.5 to \$6.0 million, annually, if no other adjustments were made to the nursing home formula. However, it is unlikely that every facility would utilize this provision.

7. Since the 91% minimum occupancy standard applies to all cost centers, this requirement can have a substantial effect on a nursing home's reimbursement rate. Based on the most recent final cost reports for 354 of 440 facilities, there were 65 nursing facilities with an occupancy rate below 91%. Of these facilities, the lowest reported occupancy rate was 70.2%, which would result in a reduction to its MA payment of 23% below its allowable costs.

8. Some nursing homes have not taken advantage of the previous windows to reduce nursing home beds since lease agreements, mortgages or other contracts require some facilities to maintain their current licensed beds. These homes also would not be able to take advantage of the Governor's proposal for delicensing beds because of the annual 10% loss of their licensed capacity for any banked beds. Due to this constraint, the nursing home industry is seeking an amendment to the Governor's proposal that would exempt facilities with these legal contracts from the 10% annual loss in licensed capacity.

9. If an exemption to the 10% annual loss is provided to facilities with contracts requiring maintenance of its licensed bed capacity, an additional provision could be added for this group so that beds would not be banked without any potential penalty. If a facility with contracts delicens any of its beds, and subsequently returns any of those delicensed beds to service, the facility's reimbursement rate could be recalculated for the years in which the beds were delicensed and the difference in payments would be recouped.

10. The fiscal effect of the Governor's proposal for bed banking is difficult to determine for several reasons. First, it is not known how many nursing homes will utilize bed banking. Second, because DHFS has the administrative authority to modify the nursing home formula and attempts to adjust it so as to not expend more than the amounts budgeted for nursing home payments, it is possible that any individual formula change will be offset by administrative changes made by DHFS to maintain nursing home expenditures within budget. However, as demonstrated by the Department's implementation of the 91% occupancy standard in the 1995-97 biennium, administrative changes DHFS makes to the nursing home formula are not always cost neutral.

HEALTH AND FAMILY SERVICES

Use of Three-Year Average for
Minimum Occupancy Standard

Motion:

Move to modify the Governor's recommendations for delicensing nursing home beds and the minimum occupancy standard to require that the Department of Health and Family Services use a three-year average for the occupancy rate in applying the minimum occupancy standard.

MO# 1591

JENSEN	<input checked="" type="checkbox"/>	N	A
OURADA	<input checked="" type="checkbox"/>	N	A
HARSDORF	<input checked="" type="checkbox"/>	N	A
ALBERS	<input checked="" type="checkbox"/>	N	A
GARD	<input checked="" type="checkbox"/>	N	A
KAUFERT	<input checked="" type="checkbox"/>	N	A
LINTON	<input checked="" type="checkbox"/>	N	A
COGGS	<input checked="" type="checkbox"/>	N	A

BURKE	<input checked="" type="checkbox"/>	N	A
DECKER	<input checked="" type="checkbox"/>	N	A
GEORGE	<input checked="" type="checkbox"/>	N	A
JAUCH	<input checked="" type="checkbox"/>	N	A
WINEKE	<input checked="" type="checkbox"/>	N	A
SHIBILSKI	<input checked="" type="checkbox"/>	N	A
COWLES	<input checked="" type="checkbox"/>	N	A
PANZER	<input checked="" type="checkbox"/>	N	A

AYE 14 NO 2 ABS _____

ALTERNATIVES TO BILL

1. Approve the Governor's recommended statutory changes relating to delicensing of beds and the minimum occupancy standard.

2. Adopt the Governor's recommended statutory changes. In addition, create two provisions applicable to facilities that have entered into contracts prior to January 1, 1996, by: (a) exempting these facilities from the 10% annual reductions to licensed bed capacity for beds that are delicensed for the period of the contract; and (b) specifying that if the delicensed beds are returned to service in the future, the facility's reimbursement rate would be recalculated for the years in which the beds were delicensed and not subject to the 10% reduction and the difference in payments would be recouped.

~~3.~~ Maintain current law.

Prepared by: Richard Megna

MO# AH#3 — withdrawn

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

² BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE _____ NO _____ ABS _____

MO# AH#2

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
² JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 15 NO 1 ABS _____

To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Intergovernmental Transfer Program (DHFS -- Medical Assistance)

CURRENT LAW

Under Wisconsin's intergovernmental transfer program (IGT), the state certifies counties' MA allowable expenditures and claims federal matching funds for those expenditures at the regular federal MA matching rate (approximately 59% FED).

Prior to the 1993-95 biennium, use of the IGT was limited to the county federal financial participation (FFP) program, under which DHFS distributed all federal funds generated by county nursing home unreimbursed expenses to county nursing homes. In 1992-93, \$15.0 million of federal funding was generated under the FFP program.

Beginning in 1993-94, the amounts of IGT claims increased significantly. In 1993-94, Wisconsin claimed \$49.0 million under the IGT, while in 1996-97, DHFS plans to claim a total of \$109.7 million under the program. The 1996-97, IGT funds will be used to fund: (a) \$37.1 million in special supplemental payments to county-owned nursing homes; and (b) \$72.6 million in state GPR costs for MA payments to all nursing homes.

GOVERNOR

Maintain base IGT funding for supplemental payments to counties at the current level of \$37.1 million annually. In addition, maintain the provision that any IGT funds in excess of budgeted amounts will be allocated as additional county supplemental payments.

DISCUSSION POINTS

1. The IGT program has grown substantially since 1992-93. Table 1 illustrates the expansion of IGT claims and the distribution of the additional federal MA funds generated under the program. In conjunction with the expansion, the state began using part of the IGT funds for support of general nursing home rate increases and other MA costs.

TABLE 1
Intergovernmental Transfer Program Based on Unreimbursed Expenses of
County-Operated Nursing Homes
1992-93 to 1997-99
(In Millions)

<u>Fiscal Year</u>	<u>County Certified Losses</u>	<u>Accrued Federal Matching Funds Available (IGT)</u>	<u>IGT Used As County Supplemental Payments Paid in Current Year</u>	<u>IGT Used as an Offset to State GPR Costs for MA Paid in Current Year</u>	<u>Total IGT Used as a County Supplemental Payment or Offset to State GPR Costs Paid in Current Year</u>
1992-93	\$46.3	\$70.6	\$15.0	\$0.0	\$15.0
1993-94	43.1	65.9	52.1	5.4	57.5
1994-95	48.1	72.1	55.7	30.4	86.1
1995-96	52.2*	77.3	37.1	26.1	63.2
1996-97 **	59.2	85.7	37.1	72.7	109.8
1997-98	63.6	91.0	41.7	50.4	92.1
1998-99	68.0	96.4	37.1	58.3	95.4

*County losses in 1995-96 totaled \$56.4 million, but only \$52.2 million was used due to concerns of exceeding the medicare upper limit.

**Since the estimated IGT available in 1996-97 was higher than the budgeted amount of \$81.2 million, an additional \$4.6 million will likely be paid to counties in 1997-98.

2. An important constraint for claiming IGT funds is the federal limitation that total MA payments, which would include the county match and federal IGT funds, cannot exceed the amount that the state estimates would have been paid under medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "medicare upper limit." For both nursing homes and hospitals, Wisconsin is close to the upper limit.

In 1995-96, Wisconsin did not claim all the IGT that was possible due to upper limit concerns. In 1996-97, there is an estimated gap of \$21.8 million. Because of the higher rate increases for nursing homes that are designed to catch up for past inflation, it is anticipated that the gap will narrow in 1997-98.

3. In the 1995-97 biennium, the amount of IGT funds allocated for supplemental payments to county-operated facilities totaled \$37.1 million annually. In addition, the 1995-97 biennial budget act provided the potential for additional supplemental payments to county-operated facilities if IGT funds were higher than projected in the budget. In the 1995-96 fiscal year, although unreimbursed expenses for county-operated facilities were greater than projected, the Department did not claim more IGT funds because of concerns about violating the medicare upper limit for nursing home payments. It is likely that additional county supplemental payments will be made in 1996-97; based on estimates in SB 77, there is approximately \$4.6 million that will be available for counties in 1996-97 under this provision. These payments will be made in the 1997-98 fiscal year.

4. Senate Bill 77 assumes that a total of \$91.0 million in 1997-98 and \$96.3 million in 1998-99 in IGT funds will be available, based on projected losses by counties. The budget does not modify amounts budgeted for county supplemental payments (\$37.1 million annually). The remainder (\$50.4 million in 1997-98 and \$58.3 million in 1998-99) would be used to offset state MA costs. As was the case for 1995-97, any IGT funding above these budgeted amounts would be reserved for supplemental payments to county-owned nursing homes.

5. Some counties have expressed concerns about the use of IGT funds for general rate increases and have maintained that all or more of the federal funding based on county unreimbursed expenses should be directed solely to county nursing homes.

6. The amount of IGT funds that can be claimed by the state is dependent on two factors: (a) unreimbursed county nursing home expenses; and (b) the medicare upper limit. Federal funds would not be provided based on county unreimbursed expenses if the state's MA nursing home expenditures exceed the medicare upper limit. Unreimbursed expenses of non-county nursing homes allow the state to claim additional IGT dollars based on county unreimbursed expenses. Because non-county nursing home unreimbursed expenses under the medicare upper limit are used to claim additional IGT funds, county unreimbursed expenses are not the only factor responsible for generating IGT funds.

7. In 1995-97, the IGT payment of \$37.1 million to county nursing homes exceeded the standard federal match of 59% for county nursing home unreimbursed expenses. However, in 1997-99, based on estimated unreimbursed losses of \$63.6 million in 1997-98 and \$68.0 million in 1998-99, the county would receive \$37.5 million in 1997-98 and \$40.1 million with a 59% match compared to \$37.1 million under current law.

8. In addition to unreimbursed expenses, counties receive payments through the MA nursing home formula for reimbursed expenses. Table 2 compares the reimbursement rates under MA between governmental (county), nonprofit and proprietary nursing homes, which were reported in the 1995 survey of nursing homes. The figures in the survey do not include the effect of the special county nursing home supplements, but Table 2 includes an estimated amount for these payments.

TABLE 2

**Average Per Diem Rates By Level of Care
December 31, 1995**

	<u>Proprietary</u>	<u>Nonprofit</u>	<u>Governmental</u>	
			<u>Unadjusted</u>	<u>Adjusted</u>
Skilled Care	\$82.71	\$86.84	\$90.38	\$104.24
Intermediate Care (ICF 1)	69.36	71.82	78.72	92.58
Developmentally Disabled	108.27	127.86	119.12	132.98

Note: The adjusted governmental rate includes the estimated effect of the \$37.1 million in special county nursing home payments.

9. The following arguments could be made for providing a larger share of IGT funds to county nursing homes:

- IGT funds are based on county nursing home expenses.
- Current supplemental payments to county nursing homes are less than the total of their reimbursed expenses, and beginning in 1997-98, the current \$37.1 million will be less than 59% of the counties' unreimbursed expenses.
- County homes' higher costs are due, in large part, to higher labor costs. Federal reimbursement for these costs allow counties to meet labor costs and allow higher wages and fringe benefits to be paid to county nursing home employees.
- To the extent that federal dollars reduce county expenditures on nursing homes, county tax levies can be reduced.

10. Alternatively, it could be argued that:

- The portion of the IGT funds not provided to the county nursing homes could not be claimed without the gap in the medicare upper limit due to non-county unreimbursed expenses.
- Based on 1995 data and including the effect of the county special payments, county nursing homes were reimbursed at a rate that, in general, was higher for a resident classified at the same level of care as in non-county facilities.

- The operating deficit reduction program encourages inefficiency, because costs in excess of the MA formula are recouped by counties.

11. The Committee could provide counties some additional supplemental payments so that the payments would be equal to the product of the federal sharing percentage for MA (approximately 59% currently) and the total amount of county certified losses. This would provide an estimated \$37.5 million in 1997-98 and \$40.1 million in 1998-99. Basing the supplemental payment on a percentage of county losses would maintain an incentive for counties to certify losses for IGT claims, and could allow elimination of the current provision that provides that IGT claims above budgeted amounts would be reserved for county payments.

ALTERNATIVES TO BILL

1. Maintain current law by: (a) maintaining the amount of funding for special supplemental payments to counties at the current level of \$37.1 million; and (b) specifying that any additional federal MA funds that were not anticipated prior to the enactment of the biennial budget act or other legislation would be paid to county-owned nursing homes in addition to the \$37.1 million, subject to the limit that the total of all special payments could not exceed the size of the home's deficit.

2. Modify the Governor's recommendation by providing total supplemental payments to counties equal to the product of the federal sharing percentage for MA (59% currently) and the total amount of county certified losses. This would provide an estimated \$37.5 million in 1997-98 and \$40.1 million in 1998-99 in supplemental payments to counties and increase MA benefits costs by \$400,000 GPR in 1997-98 and \$3,000,000 GPR in 1998-99. Specify that individual supplemental payments to counties would be allocated based on the current formula. In addition, repeal the current provision that all IGT claims above budgeted amounts would be used for county supplemental payments.

Alternative 2	GPR
1997-99 FUNDING (Change to Bill)	\$3,400,000

Prepared by: Richard Megna

MO# Alt #1

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 14 NO 2 ABS

HEALTH AND FAMILY SERVICES

Consultant to Determine Medicare Upper Limit for Nursing Homes

Motion:

Move to require the Department of Administration to hire a consultant to determine and recommend to the Department of Health and Family Services the amount that should be used for the medicare upper limit for nursing home payments under the medical assistance program, beginning for the 1997-98 fiscal year. Specify that DHFS would not be required to accept the recommendations of the consultant.

Note:

Under federal regulations, the state's aggregate payments for inpatient nursing home services under medical assistance may not exceed the amount that the state estimates would have been paid under medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "medicare upper limit."

The medicare upper limit has been a factor in the amount of federal MA matching funds that DHFS has claimed based on unreimbursed expenses of county-owned nursing homes under the intergovernmental transfer program (IGT). These federal matching funds are often referred to as "IGT claims." In 1995-96, Wisconsin did not fully utilize the unreimbursed expenses of county-owned nursing homes due to concerns of exceeding the medicare upper limit.

This motion would require the Department of Administration to hire a consultant to estimate the medicare upper limit for nursing home payments under medical assistance. DHFS would not be required to adopt the amount recommended by the consultant. The motion would not provide any funding to DOA to hire the consultant. Consequently, DOA would be required to internally reallocate funding to support the costs of the consultant.

MO# 2025

2	JENSEN	Y	N	A
1	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
	COGGS	Y	N	A

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 14 NO 2 ABS

To: Joint Committee on Finance
From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Reestimate of GPR Revenue from MA Reimbursement for the State Centers (DHFS -- Medical Assistance)

CURRENT LAW

Most of the costs of operating the State Centers for the Developmentally Disabled ("Centers") are supported under the medical assistance (MA) program. The Centers' operating costs are budgeted as program revenue to reflect the transfer of funds from the MA program to the Division of Care and Treatment Facilities. However, certain indirect costs relating to the operation of the Centers, although reimbursable under MA, are budgeted with GPR funds, rather than MA funds. These costs include depreciation, interest expenses and certain administrative overhead costs. MA payment for these costs are deposited to the general fund and credited as GPR-earned. Typically, the actual amount of these GPR-funded costs are not determined until the year following the year in which these costs were incurred, when DHFS reconciles final actual costs with billed MA costs.

In 1995-96, MA reimbursements totalling \$6,799,200 were credited to the general fund as GPR-earned. This amount was based on estimated depreciation, interest and administrative overhead costs at the Centers for that fiscal year.

GOVERNOR

Estimate total MA reimbursements for deposit to the general fund of \$6,803,500, \$6,800,000 and \$6,940,000 for fiscal years 1996-97, 1997-98 and 1998-99, respectively.

DISCUSSION POINTS

1. DHFS has nearly completed reconciling 1995-96 actual costs for the Centers with MA reimbursement for those costs. The MA-reimbursable amounts expended for depreciation, interest and administrative overhead for 1995-96 is estimated to be \$8,376,400. This is expected to increase revenue deposited to the general fund by \$1,577,200 in 1996-97.

2. It is currently estimated that MA reimbursements for costs relating to the Centers will total \$8,127,000 in 1996-97 and 1997-98. These amounts represent an increase of \$1,327,000 in 1997-98 and \$1,187,000 in 1998-99, from the amounts assumed in SB 77.

MODIFICATION TO BILL

Increase estimated GPR-earned revenues by \$1,327,000 in 1997-98 and \$1,187,000 in 1998-99 to reflect reestimates of MA reimbursement to the general fund. In addition, increase projected revenues to the general fund in 1996-97 by \$1,577,200.

Modification	GPR
1997-99 REVENUE (Change to Bill)	\$2,514,000

Prepared by: Richard Megna

MO#

Modifications to the bill

1	JENSEN	<input checked="" type="checkbox"/>	N	A
	OURADA	<input checked="" type="checkbox"/>	N	A
	HARSDORF	<input checked="" type="checkbox"/>	N	A
	ALBERS	<input checked="" type="checkbox"/>	N	A
	GARD	<input checked="" type="checkbox"/>	N	A
	KAUFERT	<input checked="" type="checkbox"/>	N	A
	LINTON	<input checked="" type="checkbox"/>	N	A
	COGGS	<input checked="" type="checkbox"/>	N	A
2	BURKE	<input checked="" type="checkbox"/>	N	A
	DECKER	<input checked="" type="checkbox"/>	N	A
	GEORGE	<input checked="" type="checkbox"/>	N	A
	JAUCH	<input checked="" type="checkbox"/>	N	A
	WINEKE	<input checked="" type="checkbox"/>	N	A
	SHIBILSKI	<input checked="" type="checkbox"/>	N	A
	COWLES	<input checked="" type="checkbox"/>	N	A
	PANZER	<input checked="" type="checkbox"/>	N	A

AYE 16 NO 0 ABS _____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

County Support for Certain Residents at the State Centers (DHFS -- Medical Assistance)

[LFB Summary: Page 263, #8 (part)]

CURRENT LAW

Counties are required to pay 10% of the cost of care for residents at the State Centers for the Developmentally Disabled ("Centers") who are determined by an independent, professional review to be appropriate for community care. Current law does not specify how the Department of Health and Family Services (DHFS) is to determine who is appropriate for community care. However, DHFS rules define this to mean clients whose care needs can be met by noninstitutional services and for whom there is "adequate state and federal funding to support community services." DHFS policy requires counties to contribute to the costs of care for individuals whose care can be provided at costs below the average amount provided to counties for the costs of care of individuals participating in the community integration program (CIP IA).

GOVERNOR

Authorize DHFS to bill counties \$184 per day for services provided on or after December 31, 1997, to any resident, including persons who have been admitted for more than 180 consecutive days, if an independent professional review determines that the resident can be supported in the community at a cost of \$184 per day or less.

Increase estimates of revenue deposited to the state's general fund by \$458,500 in 1997-98 and \$479,000 in 1998-99 to reflect projected county contributions for the costs of care of residents at the Centers.

DISCUSSION POINTS

1. Even though DHFS has been authorized to bill counties for services provided at the Centers to individuals who are determined to be appropriate for community care since 1982, DHFS first began administering this provision in the current fiscal year, following the promulgation of rules in April, 1996, relating to county appeals of these independent professional reviews. To date, DHFS has not recovered any of its costs from counties.

2. Every six months, each Center resident is reassessed to determine whether his or her care needs can best be addressed at the Center or in a community-based setting. Based on initial determinations made by a physician and social worker with whom DHFS contracts, staff at the Centers estimate the costs of services that would be required to meet an individual's care needs in the community. If these costs are less than the current average CIP IA rate (currently \$153 per day), DHFS notifies the resident's home county of its intent to begin billing the county for services, beginning 180 days following county notification.

The county is provided the option of appealing the determination within 60 days following notification. Any appeal is reviewed by a team consisting of representatives of the Division of Care and Treatment Facilities, the Division of Supportive Living and county agencies. This team makes a recommendation on the validity of the appeal to the Administrator of the Division of Supportive Living, who must rule on the appeal within 45 days after receiving a written appeal.

3. Counties may appeal a determination based on guardian opposition to a placement outside of the Center. In such instances, charges to the county are typically postponed until after the next Watts review hearing (an annual hearing before a court to determine the appropriateness of a placement). If, at the hearing, the court orders the person to remain at the Center, the appeal is granted. However, if the court orders the person to return to the community, the 180-day period begins on the date of the court's notice to the county agency. In addition, DHFS may delay the effective date of the 10% charge back for up to 60 days for a person whose plan for community services has been approved by DHFS and is awaiting implementation.

4. DHFS intends to begin billing counties for care provided to eleven residents at Northern Center, for services provided on and after May 26, 1997. In June, DHFS expects a similar number of county billings for services provided to clients at Southern Center. Similarly, several individuals at Central Center will likely be identified under the review process, although residents at Central Center are more medically fragile and have greater care needs than residents at the other Centers.

Because these clients have been determined to be the most appropriate for community placement and the implementation of the assessment will create a greater incentive for counties to place residents under CIP IA, it may be reasonable to assume that, under current law, counties will be assessed for the care of an average of approximately 15 residents annually. Based on the current MA reimbursement rates for the Centers (approximately \$300 per day per resident), the estimated revenue that would be collected from counties under current law would be approximately \$164,300 annually (15 residents x \$30 per day x 365 days per year.)

6. Under SB 77, DHFS would be authorized to assess counties \$184 per day for services provided to these clients on and after January 1, 1998. This will likely increase: (a) the number of county appeals; and (b) the number of placements made by counties in order to avoid the daily assessment. It is estimated that this would reduce the number of individuals subject to the assessment by approximately 50%. The projected revenue that would be collected under this proposal would be \$334,000 in 1997-98 and \$503,700 in 1998-99. This represents a decrease of \$124,500 in 1997-98 and an increase of \$24,700 in 1998-99 from the amounts budgeted in the bill.

7. As an alternative to increasing the assessment to \$184 per day, effective January 1, 1998, the bill could be amended to increase the assessment to either: (a) \$124 per day, which would represent the state's share of the costs of caring for residents at the Centers ($\$300 \times .41$); or (b) \$48 per day, which would represent the state's share (41%) of the cost difference between the Center's rate and the proposed CIP IA rate [$(\$300 - \$184) \times .41$].

ALTERNATIVES TO BILL

1. Adopt the Governor's recommendation to increase the county assessment to \$184 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by \$124,500 in 1997-98 and increase revenue deposited to the general fund by \$24,700 in 1998-99 to reflect reestimates of the Governor's proposal.

<u>Alternative 1</u>	<u>GPR</u>
1997-99 REVENUE (Change to Bill)	- \$99,800

2. Modify the Governor's recommendation by increasing the county assessment to \$124 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by \$150,800 in 1997-98 and \$134,700 in 1998-99 to reflect the projected revenue that would be collected under this alternative.

<u>Alternative 2</u>	<u>GPR</u>
1997-99 REVENUE (Change to Bill)	- \$285,500

3. Modify the Governor's recommendation by increasing the county assessment to \$48 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by \$245,000 in 1997-98 and \$216,200 in 1998-99 to reflect the projected revenue that would be collected under this alternative.

Alternative 3	GPR
1997-99 REVENUE (Change to Bill)	- \$461,200

4. Maintain current law. Reduce revenue deposited to the general fund by \$294,200 in 1997-98 and \$314,700 in 1998-99 to reflect estimates of revenue that will be collected under the current 10% assessment (\$164,300 annually).

Alternative 4	GPR
1997-99 REVENUE (Change to Bill)	- \$608,900

Prepared by: Charles Morgan

MO# AVA 3

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
AYE	<u>9</u>	NO	<u>1</u> ABS

HEALTH AND FAMILY SERVICES

County Support for Certain Residents at the State Centers

Motion:

Move to prohibit DHFS from assessing a county for the costs of caring for any person at the Centers who is determined to be appropriate for community placement if the resident's guardian objects to the resident's placement in the community.

Note:

Currently, counties are required to pay 10% of the cost of care for individuals who are judged to be appropriate for community placement. By rule, a county may appeal an assessment based on guardian opposition to a placement in the community. In such cases, charges to the county are typically postponed until after the next Watts review hearing. If, at the hearing, the court orders the person to remain at the Center, the appeal is granted. However, if the court orders the person to return to the community, DHFS begins billing the county after a 180-day notification period.

SB 77 would authorize DHFS to bill counties ^{\$48}\$184 per day for services provided on or after December 31, 1997, to residents, including persons who have been admitted for more than 180 consecutive days, if an independent professional review determines that the resident can be supported in the community at a cost of ^{\$48}\$184 per day or less.

This motion would prohibit DHFS from assessing these charges in cases where the guardian objects to placement in the community.

MO# 1583

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A

AYE 10 NO 6 ABS _____