To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Emergency Medical Services (EMS) Rates (DHFS -- Medical Assistance)

[LFB Summary: Page 258, #4]

CURRENT LAW

The state's medical assistance (MA) program covers certain emergency and non-emergency ambulance transportation services in cases where a recipient is suffering from an illness or injury that contraindicates transportation by other means.

Ambulance providers are paid the sum of a basic life support (BLS) rate and a per mile rate under a maximum fee schedule which recognizes cost differences between providers that operate in Milwaukee County, metropolitan areas and other areas of the state. Table 1 summarizes the current MA ambulance transportation rate structure.

TABLE 1

Current MA Rates Paid for EMS Transportation Services

	Statewide	Metropolitan	Milwaukee
BLS Rate	$76.51	$81.91	$109.29
Per Mile Rate	1.92	2.46	3.48

GOVERNOR

Establish an advanced life support (ALS) reimbursement rate for ambulance providers, beginning in 1998-99. Provide $608,400 ($251,800 GPR and $356,600 FED) in 1998-99 to support the projected costs of establishing this higher ALS rate. Table 2 summarizes the ALS rate structure recommended by the Governor.

TABLE 2

MA Rates Paid for EMS Transportation Services
SB 77

	Statewide	Metropolitan	Milwaukee
BLS Rate*	$76.51	$81.91	$109.29
ALS Rate (188% of BLS Rate)	143.84	153.99	205.47
Per Mile Rate	1.92	2.46	3.48

*Excludes Governor's recommended rate increase for non-institutional providers (1% in each year).

DISCUSSION POINTS

1. Basic life support (BLS) services are generally defined as emergency medical care rendered to an individual by a basic emergency medical technician (EMT). Authorized activities of a basic EMT include transportation of patients, administering devices to assist the patients' breathing, and defibrillation.

2. Advanced life support (ALS) services are generally defined as emergency medical care provided by an intermediate or advanced EMT. Authorized activities of an intermediate or advanced EMT include those of a basic EMT as well as administration of intravenous infusions, drawing of blood samples, and gastric and endotracheal intubation.

3. Of the 450 ambulance providers in the state, 115 providers (26%) are certified to provide ALS services. Approximately 70% of ALS certified providers are operated by municipalities.

4. Medicare and MA programs in other states have an EMS rate structure that differentiates between ALS and BLS services. Under medicare, the ALS rate is approximately 188% of the BLS rate. The Governor's recommended ALS rate is 188% of the current BLS rate.

5. Wisconsin's MA program pays medicare premiums, coinsurance and deductibles for individuals who are eligible for both MA and medicare. Because approximately 20% of all ambulance trips billed to MA on behalf of these MA/medicare dual eligibles are ALS trips, the funding budgeted in SB 77 assumes that 20% of all ambulance trips for the total MA population will be ALS trips. However, the 20% utilization rate reflects the experience of an elderly population, who may use ambulance services for non-emergency transportation more frequently than the general MA population. For example, when authorized by a physician, an ambulance may be used to transport an elderly individual from a hospital to a nursing home.

6. Information collected from Iowa, Michigan and Minnesota indicate that, in these states that have both BLS and ALS rates, at least 50% of MA ambulance trips are billed under the higher ALS rate. Based on a projected 50% utilization rate for ALS services, the estimated cost of establishing an ALS rate in Wisconsin equal to 188% of the BLS rate would be $1,631,100 ($674,900 GPR and $956,200) in 1998-99. This reestimate is $1,022,700 ($423,100 GPR and $599,600 FED) more than the amount budgeted for this item in SB 77.

This reestimate also reflects an expected decrease in ambulance utilization as a result of the AFDC/healthy start managed care expansion. Health maintenance organizations (HMOs) are responsible for reimbursing ambulance providers that serve MA recipients who are enrolled in HMOs. Therefore, the total fee-for-service cost for ambulance transportation is expected to decrease in the 1997-99 biennium.

7. The primary argument for establishing an ALS rate is to reflect the additional training and equipment necessary to provide ALS services. However, the current BLS rate structure already reflects, to some extent, the additional costs incurred by ALS ambulance operators. For example, the BLS base rate for services provided in Milwaukee County is approximately $33.00 higher than the statewide rate to account for the fact that the proportion of ALS ambulances in Milwaukee is greater than in the rest of the state. This factor could be an argument for retaining the current rate structure.

8. As an alternative to the Governor's recommendation, the Committee could establish the ALS rate at 120% of the current BLS rate, beginning in 1998-99. The estimated cost of establishing an ALS rate at this level would be $1,041,100 ($430,800 GPR and $610,300 FED). This is $432,700 ($179,000 GPR and $253,700 FED) more than the amount that is provided in the bill for this item, but $244,100 GPR and $345,900 less than the amount required to support the Governor's proposal, as reestimated. Table 3 summarizes a proposed ALS rate structure that is 120% of the current BLS rate.

TABLE 3

Alternative EMS Rate Structure

	Statewide	Metropolitan	Milwaukee
BLS Rate	$76.51	$81.91	$109.29
ALS Rate (120% of BLS Rate)	91.82	98.29	131.15
Per Mile Rate	1.92	2.46	3.48

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation. In addition, increase MA benefits funding by $1,022,700 ($423,100 GPR and $599,600 FED) in 1998-99 to reflect a reestimate of the costs of establishing an ALS rate at 188% of the BLS rate.

Alternative 1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$423,100	$599,600	$1,022,700

2. Modify the Governor's recommendation by establishing an ALS rate at 120% of the BLS rate. In addition, increase MA benefits funding by $432,700 ($179,000 GPR and $253,700 FED) in 1998-99 to reflect the costs of establishing this rate.

Alternative 2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$179,000	$253,700	$432,700

3. Maintain current law.

Alternative 3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $251,800	- $356,600	- $608,400

Prepared by: Amie T. Goldman

MO# Alt #2

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 12 NO 4 ABS____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Dental Sealants (DHFS -- Medical Assistance)

[LFB Summary: Page 265, #11]

CURRENT LAW

Currently, the state's medical assistance (MA) program provides coverage of dental sealants only in cases where children are referred for the service as a result of an early and periodic screening, diagnostic and testing (EPSDT) screen. Dental sealants are not covered unless this referral is made.

GOVERNOR

Provide $1,500,700 ($617,100 GPR and $883,600 FED) in 1997-98 and $16,700 ($6,800 GPR and $9,900 FED) in 1998-99 to establish dental sealants as a covered service for children under medical assistance.

DISCUSSION POINTS

Dental Sealants

1. Dental sealants are a plastic material applied to the chewing surface of molars. The plastic sealant bonds into the depressions and grooves (pits and fissures) of the chewing surfaces of the back teeth. The sealant acts as a barrier, protecting enamel from plaque and acids and, thereby, prevents the development of tooth decay on those surfaces.

2. Dental sealants are accepted by the dental community as an effective preventive service. Research has shown that dental sealants, which are applied correctly and are properly maintained, in combination with the effective use of fluoride, can completely prevent cavities in many children. One study found that approximately 70% of teeth which were not sealed would develop a cavity over a ten-year period, compared to approximately 22% of sealed teeth.

3. Thirty-eight of 39 states surveyed by DHFS reported coverage of dental sealants as an MA benefit. Attachment 1 summarizes the findings of this survey.

4. Preventive care can be less expensive than symptomatic treatment. A number of cost-benefit studies have attempted to quantify the monetary benefits of sealing children's teeth. These studies have found that the cost of sealing children's teeth are less than the future cost of filling cavities that may occur in unsealed teeth.

5. However, the cost of a prevention activity, such as the application of sealants, occurs when the service is delivered, while the benefits accrue over time. This time consideration is particularly relevant when budgeting for the MA program. While the costs of providing dental sealants would be incurred in the 1997-99 biennium, the benefits associated with this prevention activity will primarily occur in subsequent biennia. Further, because the MA-eligible population is not static, the cost savings of providing dental sealants is not fully realized by the MA program.

6. Current estimates of the net cost of providing dental sealants as a covered MA benefit are $594,900 ($244,600 GPR and $350,300 FED) in 1997-98 and $196,600 ($81,300 GPR and $115,300 FED). This estimate is $905,800 ($372,500 GPR and $533,300 FED) less in 1997-98 and $179,900 ($74,500 GPR and $105,400 FED) more in 1998-99 than the administration's estimate.

The current estimate of the net cost of providing dental sealants as a covered MA benefit reflects that: (a) many children who are eligible for this service are enrolled in HMOs and the bill assumes a fee-for-service cost for providing dental sealants to these children; and (b) the majority of the savings resulting from the addition of this preventive service will be realized beyond the 1997-99 biennium, while the bill assumes too much cost savings in 1997-99.

7. The state is obligated under contract to adjust the HMO capitation rate when a new MA service or benefit is added during the contract period. Under the Governor's recommendation, it is assumed that the coverage of dental sealants as an MA benefit would be effective on July 1, 1997. At that time, there will be six months remaining under the current HMO contract. However, the Governor's estimate does not account for a capitation adjustment for the HMOs if this benefit is added during the current contract period.

Since DHFS requires time to formally notify recipients and providers about a new service, the Committee could establish January 1, 1998, as the effective date for the coverage of dental

sealants. In addition, if the benefit were effective January 1, 1998, the current HMO contract would not require an amendment. However, the addition of dental sealants as a covered MA benefit will be one of the many factors taken into consideration during the negotiation of the next HMO contract.

If the Committee establishes January 1, 1998, as the effective date of the service there will be a decrease in costs in 1997-98 and an increase in costs in 1998-99 from the bill. The cost increase in 1998-99 is due to the fact that there will be fewer sealants applied in 1997-98 and, therefore, reduced savings resulting from avoided cavities in 1998-99.

Access to Dental Services

8. Dental sealants may be an effective prevention service, but unless a child has access to a dentist and receives routine dental care, the addition of dental sealants as an MA benefit will be of limited value. Many dentists in Wisconsin are unwilling to accept MA patients for a variety of reasons, including: (a) low reimbursement rates; (b) high rates of missed appointments; and (c) prior authorization requirements for services that dentists consider medically necessary, such as braces and root canals.

9. HMOs that contract with the state for health services cover dental services for state employes as part of the state's uniform benefits package. However, the provision of dental services is optional for HMOs that contract with the state for providing services to MA recipients. Currently, there are HMOs that contract with the state for the provision of services to both MA recipients and state employes.

10. Currently, eight HMOs provide dental services to MA enrollees in certain counties. As of March, 1997, approximately 70% of all MA HMO enrollees were enrolled in an HMO that provided dental services. Attachment 2 provides a listing of the HMOs that have elected to provide dental services to MA enrollees.

If an HMO elects to provide dental services to MA recipients, the HMO is paid an additional dental capitation rate per enrollee. Under the current HMO contract, which expires December 31, 1997, the average dental capitation rate for children in the expansion regions is $5.77 per child per month.

SB 77 assumes that nearly all AFDC- and healthy start-related MA eligibles will be enrolled in HMOs by June 30, 1997, and that all HMOs will elect to cover dental services. Therefore, the dental capitation rate for nearly all AFDC- and healthy start-related eligibles is included in the base estimate of MA costs.

11. Some states require HMOs that provide services to MA recipients to include dental services as part of a comprehensive health package. Minnesota also requires HMOs that provide services to public employes to provide the same services to MA recipients. In order to improve

dental access for MA eligible children, the Committee could direct DHFS to require HMOs to cover dental services, beginning January 1, 1998. In addition, the Committee could direct DHFS to establish target dental utilization rates as part of the next HMO contract. For example, DHFS could require that HMOs improve dental access by 10% in calendar year 1998 and another 10% in 1999. This would be consistent with current DHFS policy to require by contract utilization targets for early and periodic screening, diagnostic and testing (HealthCheck) screens.

12. Other states, including Illinois and Minnesota, have utilized dental managed care as a means for improving access to dental services. In these states, dental services are excluded from the benefit package covered by HMOs and instead are contracted for with a single provider for the state's entire MA population.

Illinois currently contracts with a dental managed care organization to provide dental services to all MA recipients. The contract between this organization and the state establishes a utilization target. The managed care organization must provide dental services to 50% of the eligible population per year, or face financial penalties. The current dental capitation rate paid per child per month in Illinois under this contract is less than the current MA dental capitation rate in Wisconsin. Dentists are reimbursed by the managed care organization on a fee-for-service basis.

Minnesota plans to utilize dental managed care to provide dental benefits for all public employes and MA recipients enrolled in HMOs as of January 1, 1998. The state recently conducted a request for proposal (RFP) and three dental managed care organizations submitted a bid.

As a means of improving access to dental services for the states' MA population, the Committee could direct DHFS to exclude dental services from the basic HMO contract and, instead, contract for the provision of dental services for MA HMO enrollees with a single dental managed care organization, beginning January 1, 1998.

ALTERNATIVES TO BILL

A. Governor's Recommendation

1. Reduce MA benefits funding by $905,800 ($372,500 GPR and $533,300 FED) in 1997-98 and increase MA benefits funding by $179,900 ($74,500 GPR and $105,400 FED) in 1998-99 to reflect reestimates of the costs and savings of establishing dental sealants as an MA covered benefit on the bill's general effective date.

Alternative A1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $298,000	- $427,900	- $725,900

2. Modify the Governor's recommendation by establishing a January 1, 1998, effective date for the coverage of dental sealants under the MA program. Reduce MA benefits funding by $452,900 ($186,200 GPR and $266,700 FED) in 1997-98 and increase MA benefits funding by $331,600 ($137,200 GPR and $194,400) in 1998-99.

Alternative A2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $49,800	- $72,300	- $121,300

3. Maintain current law.

Alternative A3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $623,900	- $893,500	- $1,517,400

B. HMO Coverage of Dental Services

1. FAIL Direct DHFS to require HMOs to provide dental services for all MA HMO enrollees, effective January 1, 1998. In addition, require DHFS to require by contract target dental utilization rates.

2. FAIL Direct DHFS to exclude dental services from the benefit package provided by HMOs. Instead, direct DHFS to contract with a dental managed care organization for the provision of dental services for all MA HMO enrollees, beginning January 1, 1998.

3. Maintain current law.

Prepared by: Amie T. Goldman

MO# Alt #A2

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
1 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 ____

MO# Alt #B1

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
2 COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
1 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 2 NO 4 ABS ____

MO# A4 B2

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
2 COGGS	~~Y~~	N	A

1 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 6 NO 10 ABS ____

Senator Jauch

HEALTH AND FAMILY SERVICES

MA Dental Services Pilot Program

Motion:

Move to direct DHFS, in consultation with the major dental association in Wisconsin, to develop a pilot program, effective through June 30, 1999, for the provision of medical assistance (MA) dental services in Ashland, Douglas, Bayfield and Iron Counties. Direct DHFS to determine an estimate of the costs of providing MA dental benefits to MA recipients in this area in the absence of such a program, and provide this funding to an entity that would be responsible for providing dental services to all MA recipients in the four-county region.

Specify that: (a) each enrollee would identify their dental provider, and, if no dental provider is identified, a dental provider would be assigned to the recipient; (b) enrollees would be entitled to all dental services currently covered under the MA program.

Direct DHFS to seek any federal waivers necessary to implement this program. Specify that if, after receiving any necessary waivers, DHFS determines that the costs of the pilot program would not exceed the costs of providing MA dental services in these counties in the absence of the pilot program and that the pilot program would increase access to MA dental services for MA recipients, the Department would implement the program by January 1, 1998.

Note:

Under this pilot program, DHFS would contract with a program administrator that would: (a) accept a capitation payment from DHFS for each enrolled MA recipient; (b) enroll participating dentists; and (c) be required to coordinate activities such as outreach and patient education with county health departments. In addition, the program administrator would be responsible for paying participating dentists for all MA covered dental services provided to MA recipients in these four counties. Participating dental providers would be paid by the program administrator on a fee-for-service basis.

MA enrollees in Ashland, Douglas, Bayfield and Iron counties would be required to select a primary dental provider from among those participating in the pilot program and would receive all of their dental services from these participating dentists.

The pilot program would be evaluated based on its ability to: (a) improve access to dental services for MA recipients in these four counties; and (b) reduce the number of emergency room visits for dental services.

Motion #1034

VOTE OVER →

MO# 1034

JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
2 LINTON	Y	N	A
COGGS	Y	N	A
BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
1 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 ____

ATTACHMENT 1

Sealants As A Covered Service Under Medicaid

Alaska	Covered per tooth for children age 21 and under one annually.
Arizona	Covered for all non-carious permanent first molars.
Arkansas	Covered for first and second permanent molars only.
California	Covered for permanent first molars on beneficiaries age 8 and under; on permanent second molars up to age 14.
Colorado	Long list attached to survey (too length to list).
Delaware	100% coverage on sealants.
Florida	Covered for bicuspid initial placement and first and second permanent molars.
Georgia	Covered for first and second permanent molars (must be non-carious).
Hawaii	Covered for occlusal surfaces of permanent molars age 6-15.
Idaho	Covered for children ages 6-16; permanent molars, primary molars with prior approval only.
Illinois	Permanent molars ages 5-17.
Indiana	Covered for permanent and deciduous molars.
Iowa	Covered for only one application per tooth per lifetime ages 5-15.
Louisiana	Covered for first permanent molar through age 9, second permanent molar through age 15.
Maryland	Covered for occlusal surfaces of permanent teeth but not over restorations.
Massachusetts	Covered for age 21 and under.
Michigan	Covered for ages 5-15 on fully erupted first and second molars.
Missouri	Covered for silicate restoration including local anesthesia and treatment base.
Nebraska	Covered for molars and premolars within three years of eruption.
New Jersey	Covered for a one-time application limited to recipients age 16 and under.
New Mexico	Covered and limited to one application per permanent posterior tooth for recipients age 21 and under.
New York	Covered and restricted to previously unrestored permanent first and second molars with no signs of occlusal or proximal caries for patients ages 5-15.
North Carolina	Covered for primary and nearly erupted permanent premolars and first and second molars for ages 21 and under. Allow one in a lifetime replacement of sealants.
Ohio	Covered on permanent first and second molars for recipients age 18 and under.
Oklahoma	Covered for tooth numbers listed for caries-free virgin teeth for ages 8 and under, ages 13 and under and through age 14.
South Carolina	Covered on newly erupted molars, eight per lifetime.
South Dakota	Covered for first and second molars for age 20 and under with a 3-year time limitation.
Texas	Covered only on pits and fissures of permanent molars of children ages 14 and under, must be free of proximal caries and restorations.
Utah	Covered on premolars and molars for ages 0-18.
Vermont	Covered for first and second permanent molars for ages 5-21.
Washington	Covered for primary and permanent teeth for age 18 and under.
West Virginia	Covered for posterior permanent teeth only for children.
Wisconsin	Covered for children who have had an EPSDT screen during the previous year.
Wyoming	Covered for permanent molars with occlusal surfaces without caries and/or restorations.

ATTACHMENT 2

HMO Coverage of Dental Services for MA Enrollees as of March, 1997

County/HMO	Provides Dental
Brown	
Compcare	Yes
Network Health Plan	Yes
United Health	No
Calumet	
Network Health Plan	Yes
United Health	No
Fond du Lac	
Dean Care	No
Genesis	No
Network Health Plan	Yes
United Health	No
Unity	No
Green Lake	
Dean Care	No
Network Health Plan	Yes
United Health	No
Jefferson	
Dean Care	No
Genesis	Yes
Mercy Care	No
Physicians Plus	No
Kenosha	
Compcare	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Manitowoc	
Compcare	Yes
Genesis	No
Network Health Plan	Yes
Milwaukee	
Compcare	Yes
Family Health Plan	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Outagamie	
Network Health Plan	Yes
United Health	No
Ozaukee	
Compcare	Yes
Genesis	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Racine	
Compcare	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Sheboygan	
Compcare	Yes
Genesis	Yes
Network Health Plan	Yes
Walworth	
Compcare	Yes
Dean Care	No
Mercy Care Health Plan	No
Washington	
Compcare	Yes
Dean Care	No
Genesis	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Waukesha	
Compcare	Yes
Family Health Plan	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Waupaca	
Network Health Plan	Yes
Security Health Plan	No
United Health	No
Waushara	
Network Health Plan	Yes
United Health	No

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Case Management Services for Women Aged 45 through 64 (DHFS -- Medical Assistance)

[LFB Summary: Page 265, #12]

CURRENT LAW

Under current law, case management is a covered medical assistance (MA) benefit for an individual who: (a) has a developmental disability; (b) has a chronic mental illness; (c) has Alzheimer's disease; (d) is alcoholic or drug dependent; (e) is physically disabled; (f) is a child with severe emotional disturbance; (g) is age 65 or over; (h) is a member of a family that has a child at risk of physical, mental or emotional dysfunction; (i) is infected with HIV; (j) is infected with tuberculosis; (k) is a child eligible for early intervention services; or (l) is a child with asthma.

Case management services assist individuals in accessing, coordinating and monitoring an array of services, including services covered by MA and services provided under other programs. These services are provided by qualified public and private, nonprofit agencies, if a county or municipality elects to make these services available. The MA program pays the federal share of the cost of these services (approximately 59% of the total cost of providing these services). Counties must provide the state MA match (approximately 41% of the total cost) by using funds provided through other programs, such as the community options program or the family support program.

GOVERNOR

Expand eligibility for MA targeted case management services to include women aged 45 through 64 who are not residing in nursing homes or enrolled in managed care organizations and are not otherwise receiving case management services. Provide $549,000 FED annually to reflect the projected increase in federal MA matching funds that would be available to support these services.

DISCUSSION POINTS

1. The Governor has identified MA eligible women aged 45 through 64 as a medically under-served group that could benefit from case management services. The extension of the case management benefit to these women is intended to facilitate medical care coordination. For example, if a women were missing medical appointments due to a lack of transportation, a case manager could help the woman access public transportation.

2. However, virtually all women enrolled in MA who are: (a) aged 45 through 64; (b) not residing in nursing homes; and (c) not enrolled in health maintenance organizations (HMOs) are women who are already included in current targeted case management groups. Very few women aged 45 through 64 qualify for MA based on AFDC-related criteria, and most of the women who do qualify for MA under the AFDC-related criteria are enrolled in an HMO as a result of the state's managed care expansion.

The majority of the women in this age range qualify for MA due to a physical or developmental disability or a mental illness. Individuals with disabilities and/or a mental illness are currently eligible for MA targeted case management services.

3. 1995 Wisconsin Act 27 (the 1995-97 biennial budget act) expanded targeted case management services to include: (a) families who have a child at risk of physical, mental or emotional dysfunction; (b) children who are eligible for medical assistance and who receive early intervention services under the Birth-to-Three program; and (c) children with asthma.

4. A review of calendar year 1996 billing data indicates that counties elect to provide case management services to targeted groups to varying degrees. The following table summarizes the number of counties which provided case management services for each eligible targeted case management group and total expenditures for case management services provided to each group in calendar year 1996.

MA Targeted Case Management Utilization
Calendar Year 1996

	No. of Counties Providing Case Mgmt. Services	Expenditures*
Individuals with developmental disabilities	64	$3,860,970
Individuals receiving Birth-to-Three services	38	503,553
Individuals receiving AODA services	25	525,990
Individuals with mental illness	54	2,875,887
Individuals with Alzheimer's disease	4	1,751
Individuals with tuberculosis	0	0
Individuals with physical disabilities	55	728,678
Individuals age 65 or older	59	681,942
Children with severe emotional disturbance	38	2,429,426
Children with asthma	1	316
Individuals in families at risk	14	158,274
Individuals with HIV or AIDS	5	108,042
TOTAL		$11,874,829

*Counties supported approximately 40% of these total costs.

This table illustrates that counties elect to target case management services primarily to MA recipients who are disabled or mentally ill and children with severe emotional disturbances.

5. In estimating the projected number of additional women that would receive case management services under the Governor's bill (approximately 1,800 per year), DHFS staff estimated the total number of women eligible for MA who are not in nursing homes or HMOs, subtracted the estimated number of women who are currently receiving case management services, and assumed that 10% of the remaining women would require and receive targeted case management services.

However, this analysis assumes that: (a) the reason this population does not currently receive case management services is due to ineligibility for the benefit; (b) all counties will choose to make this service available; and (c) counties will begin making these services available beginning in July, 1997.

6. Because virtually all MA-eligible women aged 45 through 64 currently qualify for case management services, it is estimated that the additional case management services these women would receive under this proposal, and corresponding federal matching funds, would be minimal. Consequently, the Committee could adopt the Governor's recommendations to add

women aged 45 through 64 as a separate group eligible for MA targeted case management services, but delete the estimates of additional federal MA funds that would be received.

Alternatively, the Committee could deny the Governor's recommendation to create a separate targeted case management group for women aged 45 through 64. Instead, DHFS could encourage counties to provide additional case management services to these women and other groups of MA recipients currently eligible for targeted case management services.

ALTERNATIVES TO BILL

1. Adopt the Governor's recommendation to add women aged 45 through 64 as a group eligible for MA targeted case management services and adjust funding to reflect cost reestimates of expanding targeted case management services to this group.

Alternative 1	FED
1997-99 FUNDING (Change to Bill)	- $1,099,200

2. Maintain current law.

Alternative 2	FED
1997-99 FUNDING (Change to Bill)	- $1,099,200

MO# Alt #1

Prepared by: Amie T. Goldman

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 16 NO 0 ABS ____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Medical Assistance Copayments (DHFS -- Medical Assistance)

[LFB Summary: Page 269, #17]

CURRENT LAW

Federal law permits states to require medical assistance (MA) recipients to share in the cost of receiving certain MA services through the payment of a flat, nominal fee (copayment) per service. However, federal regulations establish maximum copayments for services and exempt some groups from copayments, including: (a) recipients under the age of 18; (b) categorically needy persons enrolled in health maintenance organizations; (c) services relating to pregnancy; (d) institutional services if individuals are required to spend all their income for medical expenses, except for the amount exempted for personal needs; and (e) emergency, family planning and hospice services.

A complete listing of copayments applicable to services offered under Wisconsin's MA program is provided in Attachment 1.

GOVERNOR

Decrease MA benefits funding by $1,654,600 ($678,400 GPR and $976,200 FED) in 1997-98 and $3,478,400 ($1,426,000 GPR and $2,052,400 FED) in 1998-99 to reflect the projected cost savings of: (a) creating a copayment for specialized medical vehicle (SMV) services and free-standing ambulatory surgery services; and (b) increasing current copayments to the maximum amount permitted under federal law, excluding prescription and over-the-counter (OTC) drugs.

A. MODIFY CURRENT COPAYMENTS

Discussion Points

1. It is the provider's responsibility to collect copayments. However, no participating provider may deny services to an MA recipient because of the recipient's inability to pay copayments. In effect, a recipient's failure to pay a copayment reduces the provider's reimbursement for that service by the copayment amount.

2. Federal law establishes maximum copayments for services in relation to the state's MA payment for the service, as shown in the following table.

State's MA Payment for Service	Maximum Recipient Copayment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Federal law also permits states to determine an average or "typical" payment for a service and to set the copayment level based on this average. For example, rather than establishing separate copayments for each disposable medical supply item, states can calculate the typical reimbursement for disposable medical supplies and then charge one uniform copayment for all disposable medical supplies. States commonly use this formula for determining a copayment level for prescription drugs.

3. Over time, as reimbursement levels for services have increased or decreased, the federally allowable copayment level for particular services has also increased and decreased. However, DHFS has not responded to these changes by adjusting copayment levels. Consequently, there are a number of services for which the established copayment amount is currently below the federally allowable maximum and a few services for which the established copayment amount is above the federally allowable maximum.

4. As shown in Attachment 1, the current copayment levels are determined based on actual reimbursement rates for some services and typical reimbursement levels for other services, including: (a) disposable medical supplies; (b) medications; (c) laboratory services; (d) x-ray services; and (e) diagnostic services.

Under the Governor's recommendation, copayments would be increased for a number of specific service codes for which the actual reimbursement has changed over time and for a number of services for which the typical reimbursement for the services has changed over time,

including: (a) the copayment for x-ray services would be increased from $2.00 to $3.00 has changed over time; (b) the copayment for diagnostic physician services would be increased from $1.00 to $2.00; and (c) the copayment for diagnostic laboratory services would be increased from $1.00 to $2.00.

5. MA recipients may be required to pay more than one copayment for services they receive during a single appointment. For example, for a doctor's visit, the recipient may be charged a separate copayment for the office visit and any laboratory tests or x-rays. However, the effect of these copayments on recipients may be moderated because the copayments are not typically collected at the time the service is rendered. With the exception of pharmacies, most providers bill MA recipients for copayments, rather than collect the copayments at the time of service.

No information is available relating to the percentage of copayments which are actually collected by providers. However, it is believed that many providers do not collect these copayments.

The impact of copayments is further moderated by the fact that the state has established cumulative maximum copayment amounts for some MA services. By statute, an MA recipient is not required to pay more than $5.00 per month, per pharmacy for prescription drugs. In addition to the statutory cumulative monthly limit for prescription drugs, DHFS has established cumulative limits on other copayments as a matter of policy. Current cumulative maximum copayments for other MA services are included in the information provided in Attachment 1.

6. The primary argument in support of copayments is that they require MA recipients to share in the cost of their health care services. It is argued that recipients should be responsible for supporting some portion, however nominal, of the costs of services they receive.

However, the MA recipients who are subject to copayments are primarily poor elderly and disabled individuals, who require the most health care services. In the 1997-99 biennium, the great majority of MA recipients who qualify for MA based on AFDC- or healthy start-related eligibility criteria will not be subject to copayments, because they will be enrolled in health maintenance organizations.

7. It is argued that the assessment of copayments will decrease utilization of unnecessary services. However, DHFS currently assesses copayments for some services and benefits for which a recipient cannot reasonably control utilization. For example, DHFS assesses a copayment for x-ray and diagnostic services, even though it is typically the physician, rather than a patient, who makes a determination as to whether an x-ray is required or whether a physician needs to provide diagnostic services.

In addition, there are a number of medical supplies subject to copayments, including reagent strips, which are unlikely to be over-utilized. Reagent strips allow individuals with diabetes to

perform blood glucose tests in their home. These tests are necessary for diabetics to monitor their blood glucose levels. In 1995-96, MA recipients utilized 638,000 packages of these strips. Under the Governor's recommendation, the copayment for reagent strips would be increased from $.50 to $2.00 per package.

8. Copayments may function as a barrier for utilization of necessary services. Many states assess copayments for a few selective services where over-utilization is most likely. Attachment 2 provides information on copayments assessed by all other states included in Wisconsin's Health Care Financing Administration (HCFA) region. As this attachment illustrates, Wisconsin's current copayment structure is more extensive than those of other states in the HCFA region. For these reasons, the Committee could deny the Governor's recommendation to increase current copayments to the federally allowable maximum.

9. Based on a reestimate of projected MA benefit savings resulting from the proposed copayment adjustments recommended by the Governor, MA benefits savings would be $360,300 ($146,700 GPR and $213,600 FED) in 1997-98 and $889,800 ($358,200 GPR and $531,600 FED) in 1998-99 less than estimated in the bill. This estimate and the estimate prepared for the bill assumes that 50% of the annual cost savings in the first year of the biennium to account for the time DHFS will require to implement these changes. Under this reestimate, approximately 56% of the MA benefits savings is attributable to the increased copayment for reagent strips.

The primary difference between this estimate and the estimate prepared for the bill is the elimination of a proposed increase to the diagnostic laboratory copayment due to the fact that the typical reimbursement for the service does not justify an increase in the copayment.

Alternatives to Bill

1. Modify Governor's recommendation to adjust current copayments to the federally allowable maximum by increasing MA benefits funding by $360,300 ($146,700 GPR and $213,600 FED) in 1997-98 and $889,800 ($358,200 GPR and $531,600 FED) in 1998-99 to reflect reestimates of the cost savings resulting from adjustments in current copayments.

Alternative A1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$504,900	$745,200	$1,250,100

FAIL

2. Delete the Governor's recommended increases in copayments for services currently subject to copayments and increase MA benefits funding by $1,220,800 ($500,500 GPR and $720,300 FED) in 1997-98 and $2,610,800 ($1,070,300 GPR and $1,540,500 FED) in 1998-99. In addition, increase MA benefits funding by $29,700 GPR and $42,500 FED in 1997-98 and $59,700 GPR and $84,600 FED in 1998-99 to reflect reductions in current copayments that exceed federally established maximum copayment levels.

Alternative A2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$1,660,200	$2,387,900	$4,048,100

B. DRUG COPAYMENTS

Discussion Points

1. A recent two-year study completed by a team of researchers headed by Alan L. Hillman, M.D., at the University of Pennsylvania assessed the relative effects of physician and patient financial incentives under managed care plans. The study demonstrated a relationship between drug copayments and individual drug spending. Specifically, researchers concluded that as copayments increased, spending on prescription drugs decreased. However, the study did not draw conclusions about the extent to which increases in drug copayments decreased spending for discretionary medications, compared with medically necessary medications. If the imposition of higher copayments reduces spending for medically necessary medications, a patients' health could be adversely affected, resulting in increases in other health-related costs.

2. While prescription drugs are an optional MA benefit, every state has elected to provide coverage of prescription drugs for all or some of portion of their MA population. Coverage of prescription drugs is considered to be cost effective for states. It is assumed that by ensuring that MA recipients can afford their prescription drugs, compliance will be improved and other health care expenditures can be avoided.

Many disabled and elderly individuals are required to take multiple medications. If the cost of these medications becomes too high for an individual, the individual may not fill his or her prescriptions. Failure to take medically necessary medications can result in acute health care crises, which may require expensive emergency room visits, or complicate existing health conditions.

For these reasons, the Governor did not recommend an increase in the drug copayment to the federally allowable maximum. However, it is not known how high a copayment must be in order for a patient to forgo medically necessary medications, rather than discretionary medications. Further, a similar argument for minimizing copayments could be made for all cost effective services that are currently subject to a copayment, including: (a) preventative dental services; (b) physical therapy services; and (c) diagnostic services, such as lab tests. The arguments for establishing a copayment on drugs are no different from the arguments in support of copayments for current services for which copayments are assessed.

3. The current drug copayment represents a small portion of the total cost of medications. The current copayment for prescription drugs is $1.00 per prescription with a $5.00 monthly limit per provider. The current copayment for OTC medications is $0.50 per

prescription. There is no monthly limit for OCT medications. In 1995-96, average annual drug expenditures for MA recipients who utilize this benefit were $1,249 for prescription drugs and $369 for OTC drugs.

The Committee could increase the drug copayment to the federally allowable maximum. The copayment for prescription drugs could be raised from $1.00 to $2.00 and the copayment for OTC drugs could be raised from $.50 to $1.00. If the Committee chose this alternative, it would be necessary to raise the monthly cumulative limit for prescription drugs from $5.00 per month to $10.00 per month per provider to realize the full savings resulting from an increase in the per prescription copayment. If the Committee increases the copayment level but does not increase the monthly cumulative limit, recipients would reach the limit after filling two prescriptions, rather than five, and DHFS would only collect $4 worth of copayments, which would be $1.00 less than the amount collected under the current copayment schedule.

In 1995-96, approximately half of all prescriptions covered by the MA program were subject to a copayment and a total of over $3 million (all funds) in savings was realized from drug copayments. Therefore, it is assumed that if the drug copayment were increased to the federally allowable maximum and the monthly cumulative limit were raised to $10.00, an additional $3 million annually in MA benefits savings would be realized.

Alternatives to Bill

1. Increase the copayments for prescription and over-the-counter drugs to the federally allowable maximum ($2.00 per prescription and $1.00 per over the counter drug). In addition, increase the monthly cumulative maximum copayment for prescription drugs from $5.00 per month per provider to $10.00 per month per provider. Finally, decrease MA benefits funding by $1,542,800 ($634,400 GPR and $908,400 FED) in 1997-98 and $3,085,600 ($1,276,700 GPR and $1,808,900 FED) in 1998-99 to reflect the savings resulting from this increase.

Alternative B1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $1,911,100	- $2,717,300	- $4,628,400

2. Maintain current law.

C. SPECIALIZED MEDICAL VEHICLES

Discussion Points

1. Specialized medical vehicles may be used to transport indefinitely disabled or blind individuals who are unable to take public common carrier or private motor vehicle transportation if the purpose of the trip is to receive covered MA services. An "indefinite disability" is defined by DHFS as a physical or mental impairment which includes an inability to move without personal assistance or mechanical aids, such as a wheelchair, walker or crutches or a mental impairment which prohibits the individuals from using common carrier transportation reliably or safely. All transportation services provided by SMVs must be prescribed by a physician.

2. The Governor recommends establishing a new copayment for SMV services. However, current state law prohibits DHFS from establishing copayments for specialized medical services. Senate Bill 77 does not repeal this prohibition. In order to implement the Governor's recommendation, this provision should be repealed.

3. The administration believes that there is unnecessary utilization of SMV services. The proposed $2.00 copayment for SMV services is intended to discourage overutilization and to curb abuse of these services. The maximum allowable copayment for these services under federal law would be $3.00. Therefore, the Committee could establish this new copayment at $3.00. However, the administration believed that assessing the maximum copayment would place too great a hardship on recipients.

4. Based on a reestimate of projected benefit savings resulting from the Governor's proposed SMV copayment, MA benefit savings $241,800 ($99,900 GPR and $141,900 FED) in 1997-98 and $438,700 ($203,400 GPR and $283,300) in 1998-99 more than estimated in the bill.

Alternatives to Bill

FAIL

1. Modify the Governor's recommendation to establish a $2.00 SMV copayment by decreasing MA benefits funding by $241,800 ($99,900 GPR and $141,900 FED) in 1997-98 and $438,700 ($203,400 GPR and $280,300 FED) in 1998-99 to reflect reestimates of the benefit savings resulting from the Governor's recommendation to establish a copayment on SMV services. In addition, repeal the current statutory prohibition on SMV copayments.

Alternative C1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $303,300	- $422,200	- $725,500

2. Modify the Governor's recommendation by establishing a $3.00 SMV copayment and decreasing MA benefits funding by $463,600 ($191,100 GPR and $272,500 FED) in 1997-98

and $927,200 ($386,900 GPR and $540,300 FED) in 1998-99. In addition, repeal the current statutory prohibition on SMV copayments.

Alternative C2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $578,000	- $812,800	- $1,390,800

3. Delete the Governor's recommendation to establish a copayment for SMV services. Increase MA benefits funding by $430,200 ($176,400 GPR and $253,800 FED) in 1997-98 and $860,300 ($352,700 GPR and $507,600 FED) in 1998-99.

Alternative C3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$529,100	$761,400	$1,290,500

D. AMBULATORY SURGERY CENTERS

Discussion Points

1. Ambulatory surgery centers are facilities that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization. Services performed in these centers are services which require general or local anesthesia and post-anesthesia observation time. They are services which could not be performed safely in an office setting, including: (a) hernia repair; (b) breast biopsy; and (c) carpal tunnel surgery.

2. Currently, there is no copayment for free standing ambulatory surgery services. Under the bill, free standing ambulatory surgery centers, which provide outpatient surgery services, would be subject to a $3.00 per visit copayment. Outpatient services, including surgery, provided in hospitals are currently subject to a $3.00 per visit copayment. Therefore, assessing a copayment on outpatient surgery performed in ambulatory surgery centers would be consistent with the current DHFS policy to assess copayments for outpatient surgery in outpatient hospitals.

Alternatives to Bill

1. Modify Governor's recommendation to establish a $3.00 copayment for ambulatory surgery centers by decreasing MA benefits funding by $7,300 ($3,000 GPR and $4,300 FED) in 1997-98 and $14,600 ($6,000 GPR and $8,600 FED) in 1998-99 to reflect reestimates of the MA benefits savings of this proposal.

Alternative D1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $9,000	- $12,900	- $21,900

2. Delete the Governor's recommendation to establish a $3.00 copayment for free standing ambulatory surgery centers. Increase MA benefits funding by $1,500 GPR and $2,200 FED in 1997-98 and $3,000 GPR in 1998-99 and $4,300 FED in 1998-99.

Alternative D2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$4,500	$6,500	$11,000

Prepared by: Amie T. Goldman

MO# B1

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 3 NO 12 ABS 1

MO# A1#A2

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 8 NO 8 ABS

MO# A1#C1

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 8 NO 8 ABS

MO# A1#C3

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 8 NO 8 ABS

VOTE OVER →

MO# D1

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 1

Senator Decker

HEALTH AND FAMILY SERVICES

Copayment for Reagent Strips

Motion:

Move to modify Alternative A1 of LFB paper #432 by providing $196,800 GPR and $281,800 FED in 1997-98 and $396,000 GPR and $561,100 FED in 1998-99 to maintain the current copayment for reagent strips ($.50 per package).

Note:

SB 77 would increase the copayment for reagent strips from $.50 to $2.00. This motion would maintain the copayment at its current level and restore funding that represents the MA benefits savings associated with the copayment increase proposed in SB 77.

[Change to Bill: $592,800 GPR and $842,900 FED]

MO# 1117

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
1 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 0

ATTACHMENT 1

Current Wisconsin Medicaid Copayments

	Amount of Copay
Chiropractic Services	
• services costing up to $10.00	$0.50
• services costing $10.01 to $25.00	$1.00
• services costing $25.01 to $50.00	$2.00
Dental Services (including orthodontia)	
• services costing up to $10.00	$0.50
• services costing $10.01 to $25.00	$1.00
• services costing $25.01 to $50.00	$2.00
• services costing over $50.00	$3.00
Disposable Medical Supplies	
• each item (no monthly limit)	$0.50
Durable Medical Equipment	
• items costing up to $10.00	$0.50
• items costing $10.01 to $25.00	$1.00
• items costing $25.01 to $50.00	$2.00
• items costing over $50.00	$3.00
Hearing	
• audiological testing	$1.00
• each purchased item	$3.00
• each accessory or repair	$1.00
HealthCheck Screen	
• children under age 18	no copay
• recipients age 18, 19 and 20	$1.00
Hospital	
• inpatient (maximum of $75.00 per stay)	$3.00 (per day)
• outpatient (includes all services provided in the hospital, including pharmacy and therapy services)	$3.00 (per visit)
Medications	
• each covered over-the-counter drugs (requires a doctor's prescription) (no monthly limit)	$0.50
• All other medications ($5.00 limit per month, per pharmacy)	$1.00

Mental Health/Alcohol and Other Drug Abuse Therapy

• each 60 minutes of individual mental health, alcohol and other drug abuse (AODA), family therapy, and collateral interviews (mental health/AODA/biofeedback limited to the first 15 hours or $500 of services per calendar year)	$2.00
• each 60 minutes for each member of group therapy (mental health/AODA/Biofeedback limited to the first 15 hours or $500 of services per calendar year)	$0.50
• each 60 minutes of psychiatric evaluation	$1.00

Physical, Occupational, or Speech Therapy

(not provided in hospital)

• services costing up to $10.00	$0.50
• services costing $10.01 to $25.00	$1.00
• services costing $25.01 to $50.00	$2.00
• services costing over $50.00	$3.00

(No copayment after the first 30 hours or $1,500 of services per therapy type, per calendar year)

Physician and Nurse Practitioner Services

• each evaluation and management visit, hospital admission, or consultation	$1.00 to $3.00
• each surgery service	$3.00
• each lab service	$1.00
• each x-ray service	$2.00
• each diagnostic service	$1.00
• each nuclear medicine service	$2.00

(copayment limited to $30 per year per provider)

Podiatry

• each evaluation and management visit	$1.00
• each lab service date	$1.00
• each x-ray service	$2.00
• each surgery service	$3.00
• each mycotic condition/nail procedure	$3.00
• each routine foot care visit	$1.00
• each casting, strapping, or taping procedure	$3.00

Rural Health Clinics

• each visit	$2.00

(copayment limited to $30 per year per provider)

Transportation

• each nonemergency ambulance trip	$2.00

Vision Care

Optometric Services

• each evaluation and management service	$2.00 to $3.00
• each special and low vision service, test or therapy	$0.50 to $1.00
• each contact lens service	$3.00

Eyeglasses

• new	$3.00 per complete pair
• replacement of frame, lens or temple	$2.00
• each repair	$0.50

Copayments do not apply to:

- recipients under 18 years old
- recipients in HMOs
- pregnant women when the services are pregnancy-related
- family planning services and supplies
- nursing home residents
- emergency services

ATTACHMENT 2

Medical Assistance Copayments
HCFA Region V

Illinois (Categorically and Medically Needy Recipients)

Inpatient Hospital Stays

$3.00 per day	$325 per day or more
$2.00 per day	Above $275 but less than $325 per day
No copayment	$275 per day or less

Indiana (Categorically Needy Recipients)

Transportation Services

$0.50 - $2.00 depending on the reimbursement rate for the service

Pharmacy Services

$0.50 for each generic drug

$0.50 - $3.00 for each brand name drug depending on the reimbursement rate

Emergency Room Services

$3.00 copayment for nonemergency services provided in a hospital emergency room

Michigan (Medically Needy Recipients)

Vision Services

$2.00 per visit

Dental Services

$3.00 per visit

Podiatry Services

$2.00 per visit

Hearing Aids

$3.00 per hearing aid

Pharmacy Services

$1.00 per prescription

Chiropractic Services

$1.00 per visit

Minnesota

No copayments

Ohio

No copayments

Note: Under federal law, the following groups are exempt from copayments: (a) pregnancy-related services provided to pregnant women; (b) institutionalized individuals; (c) individuals under the age of 18; (d) family planning services; (e) emergency services; (f) services provided to categorically eligible MA recipients in HMOs.

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Validation of Hospital DRG Claims (DHFS -- Medical Assistance)

[LFB Summary: Page 270, #18]

CURRENT LAW

Under Wisconsin's medical assistance (MA) program, payment for most inpatient hospital services is based on a prospective payment system known as a diagnosis-related group (DRG) system. A DRG system, which is the type of hospital payment system used by the medicare program, pays hospitals based on a patient's diagnosis and/or the nature of the services furnished in relation to that diagnosis. However, the DRG system allows for certain hospital-specific costs and circumstances to be considered as part of the rate calculation.

The DRG payment system covers acute care hospitals and hospital institutions for mental disease. MA payment for inpatient hospital services provided at the two state mental health institutes and Sacred Heart Rehabilitation Hospital in Milwaukee is not based on the DRG system. Instead, these hospitals are paid on a per diem basis to reflect the special nature of the patient mix at these facilities.

Under the DRG system, the hospital determines the patient diagnosis and then bills MA for the DRG related to that condition and treatment.

GOVERNOR

Reduce MA benefits funding by $2,000,000 ($822,400 GPR and $1,777,600 FED) in 1997-98 and $2,000,000 ($827,700 GPR and $1,172,300 FED) in 1998-99 to reflect the projected cost savings of implementing a system to electronically audit and validate inpatient DRG hospital

claims. No funding is provided in the bill to support additional administrative costs of implementing the system.

DISCUSSION POINTS

1. Recent articles in the Wall Street Journal have focussed on the U.S. Department of Health and Human Services (HHS), Office of the Inspector General's investigations into the practice of "upcoding" under the medicare DRG system. HHS has targeted hospital fraud as a major area of inquiry.

Under the medicare system, upcoding is the practice of upgrading the seriousness of a medical condition by filing medicare bills under the DRG code that will maximize payment to the hospital. The Wall Street Journal article concludes that this practice "appears to be endemic in the industry." In fact, an entire consulting industry has evolved to help hospitals use the DRG system more advantageously. Hospitals can utilize computer software programs, such as "Optimizer" and "Strategist," which offer a step-by-step guide to maximizing claims under the DRG system. Similar to the practice of maximizing deductions on tax returns, many of these upcoding practices are entirely legal.

2. However, according to these articles and DHFS staff, the system is subject to abuse and it is clear that, in some instances, claims are manipulated in such a way that the DRG payment is inappropriately increased. It is these instances of inappropriate upcoding which are the target of the HHS inquiry.

3. The practice of DRG upcoding is not limited to the medicare system. DRG upcoding can affect any insurer, including commercial insurers and medical assistance programs, which utilize a DRG system as the basis for inpatient hospital payments.

4. The Department of Health and Family Services (DHFS) intends to implement a DRG validation audit program for Wisconsin's MA program. The steps of this audit program would include the following:

- Submission of hospital claims for review by a computer software program that would identify claims which are candidates for an audit. This would be accomplished by applying specific rules to hospital claims data in order to identify statistical outliers. For example, the software would identify hospitals that submit a larger than expected number of claims for "DRGs with complications," compared to "DRGs without complications."

- After the software identifies a patient claim that should be audited, the actual medical chart for that patient would be reviewed by nurses who are specifically trained in DRG auditing, in order to confirm or disconfirm the diagnosis that was submitted.

- When the review indicates a discrepancy, the new diagnoses would be run through the fiscal agent DRG system and a new DRG payment is calculated.

- The difference between the original DRG payment and the new DRG payment would be presented to the hospital and a recovery of the difference would be requested.

5. The experience of an organization which has been administering a similar audit system for commercial insurers indicates that hospitals accept the findings of the audit approximately 90% of the time. This audit program also provides for an appeals process and necessary physician consultations.

6. If DHFS were to implement a DRG audit program, it could audit claims received in the upcoming fiscal years as well as claims submitted in prior years. DHFS staff indicate that it would be reasonable to retroactively audit claims as far back as five years. If DHFS were to submit current and past claims for review by the audit software program, it is estimated that approximately 10,000 claims would be targeted for an audit in each year of the biennium.

7. DHFS currently contracts with a number of organizations for the performance of various audit and administrative functions related to the MA program. One of these organizations recently estimated that the annual cost of administering a DRG audit program that targets approximately 10,000 claims would be $766,000. It is estimated that these annual savings resulting from the administration of this audit program would be approximately $3.0 million (all funds). The net savings of the DRG audit program would be $2,234,000 (all funds) annually.

8. The administration projected savings totalling $2.5 million annually and increased administrative costs of $0.5 million annually to support this initiative. However, Senate Bill 77 reduces MA benefits by $2,000,000 (all funds) annually; funding was inadvertently omitted to support increased MA administration costs, which are supported on a 50% GPR/50% FED basis.

ALTERNATIVES TO BILL

1. Modify funding in SB 77 by: (a) increasing funding for MA administration by $766,000 ($383,000 GPR and $383,000 FED) annually to fund costs associated with administration of a DRG audit system; and (b) reducing MA benefit funding by $411,200 GPR and $588,800 FED in 1997-98 and by $413,600 GPR and $586,400 FED in 1998-99 to reflect reestimates of the costs and savings associated with implementing a system to electronically audit and validate inpatient DRG hospital claims.

2. Maintain current law.

Alternative 2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$1,650,100	$2,349,900	$4,000,000

Prepared by: Amie T. Goldman

MO# Alt 1

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

AYE 15 NO 0 ABS ____

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Medical Assistance Eligibility Unit (DHFS -- Medical Assistance)

[LFB Summary: Page 272, #23]

CURRENT LAW

Provisions of 1995 Wisconsin Act 27 transferred the responsibility for the administration of economic support programs from the Department of Health and Family Services (DHFS) to the Department of Workforce Development (DWD), effective July 1, 1996. Prior to this date, staff in the DHFS Division of Economic Support (DES) were primarily responsible for medical assistance (MA) eligibility determination policy and analysis. At the time DES was transferred, 1.0 full time equivalent (FTE) policy analyst position that otherwise would have been transferred to DWD was retained by DHFS and transferred to the Division of Health (DOH) to work on MA eligibility issues.

GOVERNOR

Provide $121,200 ($60,600 GPR and $60,600 FED) annually to support 2.5 positions (1.25 GPR positions and 1.25 FED positions), beginning in 1997-98, to form a new MA eligibility unit in the DHFS Bureau of Health Care Financing. These positions would be transferred from DWD to reflect that DHFS, rather than DWD, is currently responsible for implementing all MA eligibility policies and procedures. Reduce funding and position authority in DWD by a corresponding amount.

DISCUSSION POINTS

1. DHFS, DWD and the Department of Administration (DOA) have agreed that because DHFS administers the MA program, the responsibilities of MA eligibility policy should remain with DHFS. However, under Act 27, only 1.0 FTE position was retained by DHFS to perform this function.

2. The following MA eligibility responsibilities remain with DHFS after the transfer of DES: (a) promulgating administrative rules related to MA eligibility changes; (b) preparing training materials; (c) completing policy analysis of federal MA laws; (d) assuming responsibility for legal decisions and liability issues associated with eligibility decisions; (e) communicating with staff in the DHFS Office of Strategic Finance about MA eligibility changes; (e) communicating eligibility policy changes to all interested parties; (f) coordination with other agencies, particularly DWD; and (g) responding to and interpreting eligibility policy questions.

3. In addition, DHFS must ensure compliance with federal laws and regulations relating to MA eligibility. As a result of the recent federal welfare reform legislation which eliminated the aid to families with dependent children (AFDC) program and the separation of Wisconsin Works and the MA program, the MA eligibility determination process has become more complex.

4. Currently, the Bureau of Health Care Financing (BHCF) is devoting approximately 10.0 FTE positions to work on MA eligibility issues, particularly those which relate to federal welfare reform and the separation of the W-2 and MA programs. These staff resources are being diverted from existing work requirements, including: (a) general management of BHCF; (b) administration of the estate recovery program; (c) implementation of changes to processing and operations through the MA fiscal agent; (d) policy analysis of MA benefits; and (f) administration of the managed care expansion.

5. Due to this unanticipated increase in MA eligibility-related workload, the DHFS Secretary has requested the establishment of a 10.5 FTE (5.25 GPR positions and 5.25 FED positions) eligibility unit. MA administrative costs, including eligibility staff, are eligible for a 50%FED/50%GPR match. The Department of Administration, DHFS and DWD have agreed that the unit should be staffed in the following manner:

Proposed MA Eligibility Unit Staffing

Source	Total FTE Positions	GPR Positions	FED Positions
Current DOH MA eligibility analyst position	1.0	0.50	0.50
DWD staff transferred to DHFS under SB 77	2.5	1.25	1.25
Proposed transfer of an additional 3.0 FTE positions from DWD to DHFS	3.0	1.50	1.50
Reallocation of 2.0 GPR DHFS general operations positions and corresponding increase in FED positions	4.0	2.00	2.00
Total	10.5	5.25	5.25

6. The current proposal advanced by the administration would not increase GPR costs or positions, since this workload would be addressed through the transfer of current staff from DWD to DHFS and reallocations of staff within DHFS. In addition, the state can claim additional federal matching funds by reallocating 2.0 GPR current positions and using these funds to create 2.0 FED additional positions to meet this workload.

Based on the number of staff DHFS has currently reallocated to work on MA eligibility issues (10.0 FTE positions) and the importance the administration places on ensuring that individuals who are eligible for MA remain covered, the requested staffing for the new MA eligibility unit appears reasonable. Consequently, the Committee could modify the Governor's recommendation by: (a) transferring an additional 3.0 FTE positions from DWD to DHFS (1.50 GPR positions and 1.50 FED positions) and $72,800 GPR and $72,800 FED annually; and (b) transferring 2.0 GPR positions and $82,500 GPR annually from the DHFS general administration appropriation to the Division of Health and providing $82,500 FED to support 2.0 FED positions, beginning in 1997-98, to staff a new MA eligibility unit in the Bureau of Health Care Financing.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation to transfer 2.5 FTE positions (1.25 GPR positions and 1.25 FED positions) from DWD to DHFS.

2. Modify the Governor's recommendation by authorizing the transfer of an additional $72,800 GPR and $72,800 FED annually and 3.0 FTE positions (1.5 GPR positions and 1.5 FED positions) from DWD to DHFS. In addition, transfer $82,500 GPR annually and 2.0 GPR positions, beginning in 1997-98, from the DHFS general administration appropriation to the Division of Health and provide $82,500 FED annually to create 2.0 FED positions, beginning in 1997-98, to staff a new MA eligibility unit in the Bureau of Health Care Financing.

Alternative 2	FED
1997-99 FUNDING (Change to Bill)	$165,000
1998-99 POSITIONS (Change to Bill)	2.00

Prepared by: Amie T. Goldman

MO# Alt #2

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

AYE 15 NO 0 ABS 1

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Medical Assistance Administrative Costs Resulting from Federal Welfare Reform (DHFS -- Medical Assistance)

CURRENT LAW

P.L. 104-193, the recent federal welfare reform legislation, authorized $500 million on a one-time basis to support medical assistance (MA) administrative costs states will incur as a result of the separation of the MA program and economic assistance programs. Previously, individuals who were eligible for aid to families with dependent children (AFDC) were categorically eligible for MA. This legislation replaces the AFDC program with a temporary assistance to needy families (TANF) block grant program. In Wisconsin, the AFDC program will be replaced with the Wisconsin Works employment program, supported by TANF funds. P.L. 104-193 also made changes regarding MA eligibility for legal immigrants, as well as for certain children who would qualify for MA as a result of meeting SSI-related eligibility criteria.

Every state will be allocated a minimum of $2.0 million, which can be claimed with a 10% state match. The minimum allocations for the states represent 20% of the total $500 million in funding. The remaining 80% will be allocated based on a formula comprised of the following factors: (a) state AFDC caseload (60%); (b) state MA administrative expenditures (20%); (c) SSI children in the state (10%); and (d) SSI immigrants in the state (10%). The state match rate for funding provided through the formula is 25% for certain activities and 10% for other specified activities.

GOVERNOR

No provision.

DISCUSSION POINTS

1. Wisconsin's total federal award is approximately $7,023,800, which is available on a one-time basis. States are required to utilize the federal funding within 12 quarters of the date on which their TANF state plan is in effect and no earlier than October 1, 1996. Because Wisconsin's state plan was approved effective August 22, 1996, these funds will need to be claimed and expended in the 1997-99 biennium.

2. The following table summarizes the activities that are eligible for a 90% and 75% federal matching rate.

90% Match Rate	75% Match Rate
• Education	• Hiring new eligibility workers
• Public service announcements	• Identifying potential TANF/MA recipients
• Outstationing of eligibility workers	• State/local organizational changes
• Training for eligibility workers, providers	• Intergovernmental activities
• Local community interactions	• Eligibility systems changes
• Developing and distributing new publications	• Design of new eligibility forms
• Outreach	• Other activities, as approved by the Secretary of DHHS

3. Due to the fact that the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) did not issue final regulations relating to the administration of these funds until May 14, 1997, DHFS has not yet had the opportunity to finalize a detailed budget for these activities. However, DHFS intends to conduct activities that are eligible for the 90% federal match. The attachment to this paper is a preliminary plan developed by DHFS staff for the use of these funds. Based on Wisconsin's allocation of $7,023,800 of federal funds, the state would be required to provide $702,400 GPR in 1997-98 as a match to claim these funds.

4. The AFDC-related MA caseload declined by over 19% between March 1, 1996 and March 1, 1997. It is believed that this decline is attributable, in part, to misunderstandings by recipients, service providers and county workers about the delinkage of AFDC and MA. As a means of addressing this issue, on April 7, 1997, the Secretaries of DHFS and the Department of Workforce Development issued a press release clarifying that individuals who are MA eligible cannot be denied coverage, regardless of that individual's status under pay for performance or Wisconsin Works. In addition to the press release, DHFS has tried to disseminate similar information through direct communication with county workers, MA recipients and service providers.

5. As a result of the elimination of the AFDC program and the separation of Wisconsin Works and the MA program, the MA eligibility determination process has become more complex. In order to accommodate the separation of the two programs, the Department has been required to make a number of administrative modifications, particularly to its computer systems. DHFS

Representative Gard

HEALTH AND FAMILY SERVICES

MA Administrative Costs

Motion:

Move to modify Alternative 2 of LFB paper #435 to provide $234,100 GPR and $2,341,300 FED in 1997-98 and place $468,300 GPR and $4,682,500 FED in the Committee's supplemental appropriation, subject to release to DHFS following approval of a detailed budget submitted by DHFS, to support the one-time costs associated with federal welfare reform.

MO# 2008

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 1

Motion #2008

has also reallocated significant staff time to this function, and developed several work groups to address numerous administrative and policy issues facing the Department as a result of the federal welfare reform legislation.

6. In a letter addressed to the Co-Chairs of the Committee dated April 21, 1997, the DHFS Secretary requested that GPR funds be provided as a 10% state match in order to claim the federal funds available to support increased MA costs associated with federal welfare reform.

7. As an alternative to providing these funds directly to DHFS, the Committee could place $702,400 GPR in its supplemental appropriation for release to the Department after a final detailed budget for the use of these funds has been developed. Once the final budget has been developed, DHFS could submit its proposal to the Governor and Committee under s. 13.10 for release of funds.

ALTERNATIVES TO BILL

1. Provide $702,400 GPR and $7,023,800 FED in 1997-98 to support one-time MA costs associated with federal welfare reform.

Alternative 1	GPR
1997-99 FUNDING (Change to Bill)	$702,400

2. Place $702,400 GPR to be used as the state match for federal funds provided to support the one-time costs associated with federal welfare reform in the Joint Finance Committee's supplemental appropriation, subject to release to DHFS following approval of a detailed budget submitted by DHFS.

Alternative 2	GPR
1997-99 FUNDING (Change to Bill)	$702,400

3. Maintain current law.

Prepared by: Amie T. Goldman

See motion 2008

MO#_____

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 _____

ATTACHMENT

Wisconsin Allocation of $7 Million Enhanced Match Fund Under P.L. 104-193 Draft Plan

Educational Activities
- Information Campaign
- Fact Sheets

Public Service Announcements (PSAs)
- Information Campaign

Outstationing of Eligibility Workers
- FQHCs
- Disproportionate Share Hospitals
- Tribal Health Centers
- Migrant Health
- Milwaukee Healthy Start Outstations
- Major Medical Practices
- Other

Training
- Information Campaign
- Healthy Start Outreach (BPH)
- WIC Agencies
- Head Start
- Day Care Providers
- HMO Enrollment Specialists
- Hotlines
  - SSI
  - Healthy Start/HealthCheck/WIC (MCH)
  - Bilingual Workers

Developing and Disseminating New Publications
- Medicaid Eligibility Brochures

Local Community Activities
- Community Meetings
- Consumer Protection Workgroup
- Immigrant and Refugee Associations

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Federal Matching Rate for MEDS Contract (DHFS -- Medical Assistance)

CURRENT LAW

Federal law requires states to operate a drug utilization review (DUR) system for their medical assistance (MA) programs. The DUR system retrospectively reviews drug utilization by MA recipients with high drug expenditures, such as elderly individuals and nursing home residents. When the DUR system identifies patterns that suggest over-prescribing, DHFS staff educate providers and attempt to improve prescribing practices.

GOVERNOR

No provision.

DISCUSSION POINTS

1. An enhanced 75% federal financial participation rate (FFP) was available to states for the operation of DUR systems for calendar years 1991 through 1993. Beginning January 1, 1994, the FFP was reduced to 50%. Due to an error by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Wisconsin continued to receive the 75% FFP after that date.

2. On February 12, 1997, DHFS received a letter from HCFA stating that the FFP would be reduced from 75% to 50%, effective retroactively to September, 1996. However, the funding provided in SB 77 was based on the assumption that the state would continue to receive 75% FFP for the operation of the DUR system in the 1997-99 biennium.

3. In his April 21, 1997 letter to the Committee's Co-Chairs, the DHFS Secretary requested that funding for MA administration be increased by $356,000 GPR annually, which represents the increased state share of the costs of operating the DUR system as a result of the reduced FFP.

4. Currently, the DUR system is funded through the Department's medical evaluations and decision support (MEDS) contract. SB 77 would maintain funding for this contract at the 1996-97 base amount. Base funding for the MEDS contract represents the costs of a contract developed with Unisys prior to the 1995-97 biennium. Since that time, Unisys lost the contract because it was unable to fulfill its contractual responsibilities. DHFS staff believe that Unisys was not able to meet its contractual responsibilities because it underbid its contract. Consequently, it is unlikely that there is sufficient funding allocated for this contract to support the increased cost of the DUR system. For this reason, the Committee may wish to provide $356,000 GPR annually and reduce federal funding by a corresponding amount to support the DUR system in the next biennium.

ALTERNATIVES TO BILL

1. Provide $356,000 annually to support the costs of the medical assistance DUR system and reduce federal funding by a corresponding amount.

Alternative 1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$712,000	- $712,000	$0

MO# Alt #1

2. Maintain current law.

Prepared by: Amie T. Goldman

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 1

HEALTH AND FAMILY SERVICES

Medical Assistance

LFB Summary Items for Which No Issue Papers Have Been Prepared

Item #	Title
7	Review of Nursing Home Capital Expenditures Under the Resource Allocation Program
8(part)	MA Waivers -- CIP IA and CIP IB
9	Impact of SSI Eligibility Changes on MA Benefits
~~10~~	Termination of MA Benefits
14	MA Contract Administration
15	Audit Staff
16	Coordination of Benefits
19	Pre-Admission Screening and Annual Resident Review
20	Specialized Motor Vehicles Transportation Services
21	MA Subrogation
22	MA Managed Care
24	MA Estate Recovery -- Joint and Payable-on-Death Bank Accounts
25	MA Eligibility
26	W-2 Health Plan Coverage of Over-the-Counter (OTC) Drugs
27	MA Appeal Process and Eligibility Determinations
28	Limit on MA Home Health Care Services
29	State Centers' MA Increases

VOTES 01 of 7

LFB Summary Items to be Addressed in Subsequent Papers

Item #	Title
13	Case Management and Crisis Intervention Services for Children in Milwaukee County
30	MA COP Waiver -- Federal Funding

MO# Delete Item #10

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
2 COGGS	~~Y~~	N	A
1 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 8 ABS 1

Representative Jensen
Senator Burke

HEALTH AND FAMILY SERVICES

MA Subrogation

Motion:

Move to delete provisions in the bill that specify that if DHFS is joined as a plaintiff in a personal injury lawsuit because of the provision of MA benefits to the injured party, DHFS need not sign a waiver of the right to participate in order to have its interests represented by the party. Regardless of whether DHFS participates in prosecuting the claim, if the plaintiff prevails, the portion of the proceeds of the claim that represent benefits paid under MA as a result of the occurrence of injury, sickness or death for which the claim arose must be paid to DHFS.

MO# 1588

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

AYE 15 NO 0 ABS 1

Motion #1588

Senator Decker

HEALTH AND FAMILY SERVICES

Medical Assistance Family Planning

Motion:

Move to direct DHFS to develop a proposal to expand access to family planning services currently covered under the MA program to all women between the ages of 15 and 44 who live in families with income under 185% of the federal poverty level. In addition, direct DHFS to seek approval of a demonstration waiver from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), and to implement the proposal by July 1, 1998.

Provide $840,000 GPR and $7,560,000 FED in 1998-99 to support the estimated costs of family planning services that would be provided under this proposal. In addition, provide $100,000 GPR and $100,000 FED in 1998-99 to support the administrative costs associated with this proposal.

Note:

The State of Michigan developed a demonstration project which extends MA coverage for family planning services to all women of childbearing age in families with income up to 185% of the federal poverty level. Under this demonstration project, Michigan expanded its current MA family planning benefit.

Under this motion, DHFS would develop a similar demonstration project, except the Wisconsin project would only include family planning services which are currently covered by the Wisconsin MA program. The motion would increase funding for MA benefits expenditures by $840,000 GPR and $7,560,000 FED in 1998-99 and MA administration by $100,000 GPR and $100,000 FED in 1998-99 to support projected costs of expanding these services.

The demonstration project would be designed to test the effectiveness of innovative intervention strategies aimed at reducing the number of unintended pregnancies and improving birth outcomes among low income women.

[Change to Bill $940,000 GPR and $7,660,000 FED]

Motion #1125

VOTE OVER →

MO# #1125

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
1 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 8 ABS ____

Representative Ourada

HEALTH AND FAMILY SERVICES

Medical Assistance Family Planning

Motion:

Move to direct DHFS to develop a proposal to expand access to family planning services currently covered under the MA program to all women between the ages of 15 and 44 who live in families with income under 185% of the federal poverty level. Direct DHFS to seek approval, by January 1, 1998, of a demonstration waiver from the U.S. Department of Health and Human Services, Health Care Financing Administration to implement this proposal.

Specify that, if DHFS receives approval of the demonstration waiver proposal, DHFS will submit legislation authorizing the implementation of this proposal to the appropriate standing committee of the Senate and General Assembly.

Note:

The State of Michigan developed a demonstration project which extends MA coverage for family planning services to all women of childbearing age living in families with income up to 185% of the federal poverty level. In addition, under this demonstration project, Michigan expanded its current MA family planning benefit. Under this motion, DHFS would develop a similar demonstration project, except the Wisconsin project would only include family planning services which are currently covered by the Wisconsin MA program.

The demonstration project would be designed to test the effectiveness of innovative intervention strategies aimed at reducing the number of unintended pregnancies and improving birth outcomes among low-income women.

MO# 1121

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 1 ABS 0

Motion #1121

Representative Ourada

HEALTH AND FAMILY SERVICES

In-Home and Community Psychotherapy Services

Motion:

Move to specify that, if permitted under federal MA law, at county option, if mental health services and alcohol and other drug abuse services under 49.46(2)(b)6f. are provided to recipients age 21 and over in their place of residence or other community settings, that the recipient's county must pay that portion of the cost of the service not provided by the federal government.

Note:

Based on this language, the Department would be required to promulgate changes to administrative code to remove the restriction on providing psychotherapy in the home or in other community settings, and identifying it as a covered service for psychotherapy and AODA.

MO# 3003

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 15 NO 0 ABS ____

Motion #3003

Representative Ourada

HEALTH AND FAMILY SERVICES

Community Based Psychosocial Services

Motion:

Move to direct DHFS to create an MA benefit which would be similar to the current MA community support program benefit, except that it would available to individuals whose mental health needs are less severe than individuals with chronic mental illness. In addition, direct DHFS to establish: (a) the scope of services; (b) recipient eligibility criteria; and (c) provider certification criteria for this benefit.

Specify that counties which elected to provide this benefit would be responsible for paying the state share of the MA cost for these services.

Note:

The purpose of Community Support Programs (CSPs) is to provide individuals with chronic mental illness effective and easily accessible treatment, rehabilitation, and support services. CSP services are provided in the community, as opposed to in clinics or institutions. It is thought that by helping long-term mentally ill persons better manage the symptoms of their mental illness, fewer institutional placements will be needed.

Chronic mental illness is defined as "a mental illness which is severe and degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration."

This new benefit would be targeted for individual whose mental health needs require more than outpatient counseling, but less than the current CSP services.

Motion #2030

MO# 2030

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 1

Representative Ourada

HEALTH AND FAMILY SERVICES

Distribution of Additional County Nursing Home Supplemental Payments

Motion:

Move to direct the Department of Health and Family Service to distribute any supplemental payments to county-owned nursing homes in excess of $37,100,000 in the following manner:

(a) first, based on the facility's proportion of all direct care operating deficits, net of any supplemental payments from the $37,100,000; and if funding exceeds the amount needed to fund all net direct care operating deficits, then

(b) secondly, based on the facility's proportion of all care operating deficits, net of any supplemental payments from the $37,100,000 and payments under (a).

MO# 2007

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 7 ABS 1

Representative Albers

HEALTH AND FAMILY SERVICES

Rural Medical Centers

Motion:

Move to direct DHFS to assist members of Wisconsin's congressional delegation in the preparation of federal legislation that, if adopted, would amend the Social Security Act to enable Wisconsin to operate a demonstration project for rural medical centers. Require that DHFS work with Wisconsin's congressional delegation to finalize this proposal by December 31, 1997.

Note:

1995 Wisconsin Act 98 established rural medical centers as a licensed health care entity. Because rural medical centers are not defined as a provider type in the Social Security Act, there are constraints under federal law relating to medicare and medical assistance reimbursement to rural medical centers.

MO# 2035

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 1 ABS 0

Representative Ourada

HEALTH AND FAMILY SERVICES

Transportation Services

Motion:

Provide $63,000 GPR in 1997-98 for DHFS to reimburse providers of transportation services for repayments of medical assistance overpayments that were made between January 1, 1992, and May 14, 1993, in situations where: (a) the provider's private pay rate was less than the usual medical assistance rate; and (b) the provider's private pay billings for a year were less than 10% of total billings for that year.

[Change to Bill: $63,300 GPR]

MO# 3000

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 9 NO 6 ABS ____