

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 <u>Mgmt. Services</u>	<u>Expenditures*</u>
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	<u>108,042</u>
<b>TOTAL</b>		<b>\$11,874,829</b>

\*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.

<u>Alternative 1</u>	<u>FED</u>
1997-99 FUNDING (Change to Bill)	- \$1,099,200

2. Maintain current law.

<u>Alternative 2</u>	<u>FED</u>
1997-99 FUNDING (Change to Bill)	- \$1,099,200

MO# Alt 1

Prepared by: Amie T. Goldman

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
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

AYE 16 NO 0 ABS 0

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.

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.

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

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.

<u>Alternative A2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
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.

<u>Alternative B1</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
<b>1997-99 FUNDING (Change to Bill)</b>	- \$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

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.

<u>Alternative C1</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
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.

<u>Alternative C2</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
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.

<u>Alternative C3</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
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.

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

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

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
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

AYE/6 NO 0 ABS 0

no action  
necessary

MO# A2

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
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

AYE 8 NO 8 ABS 0

MO# B2

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
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

AYE \_\_\_\_\_ NO \_\_\_\_\_ ABS \_\_\_\_\_

MO# C3

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
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

AYE 8 NO 8 ABS 0

MO# C1

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
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

AYE 8 NO 8 ABS 0

MO# B1

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
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

AYE 3 NO 12 ABS 1

MO# D1

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
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

AYE 15 NO 0 ABS 1

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.

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

Prepared by: Amie T. Goldman

# ATTACHMENT 1

## Current Wisconsin Medicaid Copayments

	<u>Amount of Copay</u>
<b>Chiropractic Services</b>	
• 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
<b>Dental Services (including orthodontia)</b>	
• 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
<b>Disposable Medical Supplies</b>	
• each item (no monthly limit)	\$0.50
<b>Durable Medical Equipment</b>	
• 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
<b>Hearing</b>	
• audiological testing	\$1.00
• each purchased item	\$3.00
• each accessory or repair	\$1.00
<b>HealthCheck Screen</b>	
• children under age 18	no copay
• recipients age 18, 19 and 20	\$1.00
<b>Hospital</b>	
• 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)
<b>Medications</b>	
• 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 (copayment limited to \$30 per year per provider) **\$2.00**

**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.

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

Prepared by: Amie T. Goldman

MO# AK 1

2	BURKE	(X)	N	A
	DECKER	(X)	N	A
	GEORGE	(X)	N	A
	JAUCH	(X)	N	A
	WINEKE	(X)	N	A
	SHIBILSKI	(X)	N	A
	COWLES	(X)	N	A
	PANZER	(X)	N	A
1	JENSEN	(X)	N	A
	OURADA	(X)	N	A
	HARSDORF	(X)	N	A
	ALBERS	(X)	N	A
	GARD	(X)	N	A
	KAUFERT	(X)	N	A
	LINTON	(X)	N	A
	COGGS	(X)	N	A

AYE 15 NO 0 ABS 1

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

<u>Source</u>	<u>Total FTE Positions</u>	<u>GPR Positions</u>	<u>FED Positions</u>
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	<u>4.0</u>	<u>2.00</u>	<u>2.00</u>
<b>Total</b>	<b>10.5</b>	<b>5.25</b>	<b>5.25</b>

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.

<b>Alternative 2</b>	<b>FED</b>
<b>1997-99 FUNDING (Change to Bill)</b>	<b>\$165,000</b>
<b>1998-99 POSITIONS (Change to Bill)</b>	<b>2.00</b>

Prepared by: Amie T. Goldman

MO# Alt 2

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
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

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

- Education
- Public service announcements
- Outstationing of eligibility workers
- Training for eligibility workers, providers
- Local community interactions
- Developing and distributing new publications
- Outreach

### 75% Match Rate

- Hiring new eligibility workers
- Identifying potential TANF/MA recipients
- State/local organizational changes
- Intergovernmental activities
- Eligibility systems changes
- Design of new eligibility forms
- 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

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.

<u>Alternative 1</u>	<u>GPR</u>
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.

<u>Alternative 2</u>	<u>GPR</u>
1997-99 FUNDING (Change to Bill)	\$702,400

3. Maintain current law.

Prepared by: Amie T. Goldman

MO#			
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
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

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

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

AYE 15 NO 0 ABS 1

**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.

<u>Alternative 1</u>	<u>GPR</u>	<u>FED</u>	<u>TOTAL</u>
1997-99 FUNDING (Change to Bill)	\$712,000	- \$712,000	\$0

2. Maintain current law.

Prepared by: Amie T. Goldman

MO# A1 + 1

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

<u>Item #</u>	<u>Title</u>
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

### LFB Summary Items to be Addressed in Subsequent Papers

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

MO# remove item 10

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

AYE 7 NO 8 ABS 1

MO# \_\_\_\_\_

BURKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DECKER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GEORGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
JAUCH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WINEKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SHIBILSKI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COWLES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PANZER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
JENSEN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OURADA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HARSDORF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ALBERS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GARD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
KAUFERT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LINTON	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COGGS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

AYE \_\_\_\_\_ NO \_\_\_\_\_ ABS \_\_\_\_\_

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

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
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

AYE 15 NO 0 ABS 1

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.

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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]





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 service for psychotherapy and AODA.

MO# 3003

BURKE	(X)	N	A
DECKER	(X)	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
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

Motion #3003

AYE 15 NO 0 ABS 1

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 be 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.

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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.

2030

MO#

2030

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
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

AYE 15 NO 0 ABS 1

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

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
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

AYE 4 NO 1 ABS 1

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

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

AYE 14 NO 1 ABS 1

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

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
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

AYE 9 NO 6 ABS 1

HEALTH AND FAMILY SERVICES

Supplemental Payments for Essential Access City Hospitals

Motion:

Move to provide \$300,000 (\$123,400 GPR and \$176,600 FED) in 1997-98 and \$300,000 (\$124,100 GPR and \$175,900 FED) in 1998-99 to increase total annual payments to essential access city hospitals (EACHs) from \$4,440,000 to \$4,740,000 annually.

Direct DHFS to modify its inpatient hospital state plan so that MA payments to EACHs would be made to any hospital that: (a) is an acute care general hospital with medical, surgical, emergency and obstetrical services available to medical assistance recipients; (b) is located in an inner city of the first class (Milwaukee); (c) has at least 15% of its inpatient discharges residing in the inner city area of the hospital; and (d) has over 15% of its total inpatient discharges attributable to MA patients. However, direct DHFS to continue to distribute \$4,400,000 annually to the hospital that currently qualifies for an EACH payment. The remaining \$300,000 annually would be distributed to all other hospitals that would qualify for an EACH payment under the modified formula.

Direct DHFS to expand the definition of qualifying inner-city areas to include the following zip codes: (a) 53204; (b) 53218; and (c) 53215. In addition, modify the formula for the allocation of EACH payments to replace references to "MA days" with "MA discharges."

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Note:

Currently, DHFS makes an annual supplemental MA payment to an EACH, which is defined as an acute care hospital with medical and surgical, neonatal intensive care, emergency and obstetrical services, located in the inner city of the first class (Milwaukee). An EACH must have 30% or more of its total inpatient days attributable to MA patients and must have 30% of its inpatient recipients residing in the inner city area of the hospital. Since the creation of the supplemental payment in 1991, the only hospital which has met the criteria for this supplemental payment is Sinai-Samaritan Hospital.

Under the state plan changes proposed in this motion, St. Michael Hospital and St. Joseph Hospital are likely to be eligible for the additional funding that would be provided under this motion.

[Change to Bill: \$247,500 GPR and \$352,500 FED]

MO# 6077

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

AYE 9 NO 7 ABS

# Health and Family Services

## Health

(LFB Budget Summary Document: Page 276)

### LFB Summary Items for Which Issue Papers Have Been Prepared

<u>Item #</u>	<u>Title</u>
1	Women's Health Initiative -- Screening and Public Awareness (Paper #440)
1	Women's Health Initiative -- Health Insurance Program for Uninsured Children (Paper #441)
3	State Immunization Supplement (Paper #442)
5	HIV/AIDS Insurance Program (Paper #443)
6	HIV/AIDS Program Reestimate (Paper #444)
9	Primary Health Care Service Grants (Paper #445)
10	Women, Infants and Children Supplemental Food Program Grant Match (Paper #446)
12	Abortion Publications (Paper #447)
14	WisconCare (Paper #448)

# Budget Memo

**Agency:** Health & Family Services - Health

## Staff Recommendations:

**Paper No. 440:** Alternatives 2 & 4 (together) *and 5* *Sen. Burke*

Comments: The details of this program need to be worked out better before the committee provides funding for it - make DHFS come back with a detailed plan. (See paragraphs 4 & 5 for support of our recommended alternatives)

In the staff meeting, no one wanted to authorize a "women's health officer position". We agree, and think alt 2, which allows further JFC review, would accomplish that. Also, a separate motion may be made to specifically say no position should be part of the plan.

Sen. Jauch may take the lead on this issue. Also, there may be an Assembly amendment to require insurance coverage for breast reconstruction operations that are directly related to a mastectomy.

**Paper No. 441:** Alternatives 2(a)(b)(c) & 3 *Decker* *Burke* *separate*

Comments: You may want to set the stage for a future K-2 motion by admonishing the state for not helping all eligible kids get MA - this is not a good way to save state money. You may also want to advocate for some type of expansion of MA eligibility for kids (or at least a study of the issue). (See paragraphs 2, 3, 5 and 6 for support of our recommended alternatives)

Cindy is talking to Reimer. She thinks his ideas can be looked at in the study, or taken care of under a different paper.

**Paper No. 442:** Alternative *46* *Decker* *Burke*

Comments: You need to speak up on this issue. It's part of your K-2 initiative, and you should know the details (i.e. alt 7 is referenced in your press release from Friday). However, any option other than 1 or 2 would probably be ok (i.e. #7 probably won't pass). We think alt 4 would be an especially good compromise, and so do other staff. (See entire paper - the various funding mixes are complicated - for support of our recommended alternative)

Also, Sen. Moen's Committee (Health, Human Services, etc.) recently voted 5-1-1(not voting) to maintain current law (i.e. alt 7) (Sen. Fitzgerald was the no vote).

The State Medical Society distributed memo today opposing the governor's recommendation to cut funding for immunizations.

Probably best to move #7, and get votes on this, rather than agreeing to compromise right away.

**Paper No. 443:** Alternative 1 (Funding)  
Alternative 7 (Copayments)

*Jensen  
Burke*

Comments: AIDS lobbyist supports these recommendations. (See paragraphs 2, 7 & 8 for support of our recommended alternatives)

**Paper No. 444:** Alternative 1

*Jensen  
Burke*

Comments: Panzer or Wineke will offer AIDS lobbyist's motion (i.e. alt 1 plus extras). (See highlighted sentences for support of our recommended alternative)

**Paper No. 445:** Alternative A

*2  
Decker  
Burke*

Comments: Linton is worked up about this issue. She apparently wants alt 4, and so does Cindy in our office. Julie and I think alt 2 is better, from a state fiscal standpoint, but really any alternative other than 1 is ok with us (also, the K-2 press release hinted that you would try for something like alt 4). The Milwaukee Dept. Of Health gets a fair amount of money under this program and it should not be eliminated completely - like the governor wants. (See paragraphs 5, 6 & 9 for support of our recommended alternative).

Also, to be righteously indignant, you may want to use the Dept.'s argument against them (i.e. funding has been cut back so much it's really insignificant now - means we should restore funding to previous levels so it's not insignificant. A few thousand dollars might not mean much to a bureaucrat in Madison, but it means a lot to these small public health agencies).

Also, Sen. Moen's committee (Health, Human Services, Aging, etc.) recently voted 5-1-1 to maintain current law (i.e. alt 4). Shibilski may take the lead, but his staff was not well prepared on this matter.

**Paper No. 446:** Alternative 3

*Decker  
Burke*

Comments: Take a stand and push for a \$5/per person/per summer increase in the fresh vegetable allotment. (See paragraph 6 for support of our recommended alternative).

Emphasize additional federal funding will be available if program expands - especially to Marathon and Brown Counties.

**Paper No. 447:** Alternatives 3 & 4 (together) #2

Comments: This option seems the safest politically, but from a policy standpoint alt 5 would be good too. (See paragraphs 1 & 2 for support of our recommended alternative)

At staff meeting, alt 5 (i.e. delete funding) was top choice. Also, 7<sup>th</sup> Circuit Ct of Appeals will probably overrule Judge Crabb if she invalidates the law.

**Paper No. 448:** Alternative <sup>2 +</sup>  $\beta$  (or Decker/Kaufert motion)

Comments: While it would be a good idea to expand the program to other counties, we don't think that would fly with the committee. So, we've recommended a more conservative approach. (See paragraphs 3 & 4 for support of our recommended alternatives)

Sen. Moen's committee recently voted 3-2-2 to delete the governor's recommendation, provide more money for WisconCare and make funding available on a competitive grant basis. Alt. 4 probably comes the closest to doing what Sen. Moen is recommending.

Decker and Kaufert will have a motion to reconstruct WisconCare to a competitive grant program with some additional twists (Barb says John Bartkowski supports this).

\*\*\*

**Special Note:** Under LFB Summary items for which no issue papers have been prepared - Sen. Moen's committee voted 4-1-1 to not approve item #8 (Office of Health Care Information) and have it introduced as a separate bill, because a Leg Council Special Committee has recommended legislation on the topic and should be allowed to proceed with their consensus version.

Also, Sen. Moen's committee voted 5-0-2 to approve the elimination of one FTE position under item #11, but they want to make sure current law is maintained and DHFS is required to collect and disseminate information about adverse neonatal outcomes.

(Motion has been prepared to do both of these things)

*Senen motion = no religious discrimination*

*all*

*Dental Services = Senen motion*