Legislative Fiscal Bureau

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BadgerCare Eligibility (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 353, #6]

CURRENT LAW

BadgerCare provides health insurance for low-income families and individuals who are ineligible for medical assistance (MA). However, BadgerCare is closely linked to MA in that BadgerCare recipients are eligible for all MA-covered services and receive those services from MA-certified providers. Many of the MA requirements for eligibility determinations, provision of services and payments to providers also apply to BadgerCare. BadgerCare is funded from a combination of state general purpose revenue (GPR), federal funds available under MA and the federal children's health insurance program (CHIP) and premium revenue paid by certain BadgerCare enrollees. For these reasons, BadgerCare could be described as an expansion of the MA program.

BadgerCare operates under waivers of federal MA and CHIP law approved by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). These waivers authorize the use of federal CHIP funds to provide family coverage to low-income families and to claim enhanced federal funding for a portion of the adults participating in the program. These waivers were granted by HCFA based on a plan submitted by DHFS to HCFA. Under the terms of the waivers, changes to the BadgerCare plan must be approved by HCFA or the waiver approval may be rescinded.

Financial Eligibility Criteria. Certain families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is at or below 185% of the federal poverty level (FPL). In 2001, 185% of the FPL is equivalent to $27,066 annually for a family of three. Once enrolled, a family's countable income may increase to 200% of the FPL before the family is no longer eligible for the program. There is no asset limit for BadgerCare eligibility. In some families, certain family members may be enrolled in MA, while the other members may be enrolled in BadgerCare.

Health Insurance Coverage. Families that have health insurance coverage or have had health insurance coverage within the three calendar months prior to application are not eligible for BadgerCare. If the family had health insurance coverage within the three calendar months prior to application, that family may be eligible if they meet the following good cause criteria:

- The family was covered by a group health insurance plan that was provided through an employer, and the employment was involuntarily terminated, unless the involuntary termination was as a result of the employee's incapacitation;

- The family was covered by a group health insurance plan, but the employee changed employers and the new employer does not offer family health care coverage;

- The family was covered by a group health insurance plan, but the employer discontinued health care coverage for all employees;

- The family has exhausted continuation coverage, as defined under the federal Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272);

- The family was covered by insurance that has ended due to the death or change in the marital status of the employee; and

- Any other reason determined by DHFS to be a good cause reason.

Since BadgerCare was implemented in July, 1999, 16,477 individuals have been denied BadgerCare eligibility as a result of having insurance coverage within the three months prior to application for BadgerCare.

Health Care Access. Families are not eligible for BadgerCare if the family has access or has had access to family coverage, at any time within the 18 calendar months prior to application, through an employer-sponsored group health insurance plan for which the employer pays at least 80% of the plan's costs, excluding any deductibles or copayments. Families with access to a state employee health plan are also not eligible for BadgerCare if that access was available at any time in the 18 months immediately preceding the application for BadgerCare.

The 18-month period does not apply if: (a) employment ended; (b) the employer discontinued health care coverage for all employees; (c) a family member was eligible for other health insurance or MA at the time the employee failed to enroll in the employer-sponsored health care plan and no member of the group was eligible for BadgerCare at the time; (d) the coverage ended due to the death or change in marital status of the employee; (e) any other reason determined by DHFS to be a good cause reason.

Eligibility Determination Process. Under a contract with the state, counties determine whether a family is eligible for MA or BadgerCare. All applicants are first screened for eligibility for MA. Any family members found eligible for MA are enrolled in MA. Any other family members that meet the BadgerCare criteria are enrolled in BadgerCare. The county

eligibility determination process involves gathering as much information from the applicant about his or her family's income, employment status and health insurance status as possible. This information is entered into the client assistance for reemployment and economic support (CARES) system. Based on the information provided to the county by the applicant and entered into CARES, a determination is made regarding whether or not a family is eligible.

Once enrolled, DHFS attempts to verify the employment and insurance information provided by the BadgerCare applicant. DHFS mails an employer verification of insurance coverage form to each applicant's employer. This form asks the employer to verify the insurance information provided by the applicant and collects information regarding the benefits provided under the employer's plan and the portion of the premium paid by the employer.

If the employer returns the form and indicates that the employer does provide to its employees health insurance coverage that meets the criteria for major medical health insurance, as defined in federal law and the employer supports at least 80% of the premium for that coverage, the individual is ineligible for BadgerCare and is disenrolled. Of the approximately 58,000 forms sent to employers for individuals initially enrolled in BadgerCare, a total of 32 cases were found to have access to health insurance where the employer paid at least 80% of the premium. As a result, these individuals were disenrolled from BadgerCare.

Additionally, DHFS matches applicants to data contained in a DHFS database of insurance coverage provided in Wisconsin. This database is made up of information reported to DHFS by insurance companies writing policies in Wisconsin. However, the database does not always accurately represent an enrollee's current health insurance coverage, since most insurance companies update the database on a monthly basis, but some companies may only update the database on a quarterly or semiannual basis. Additionally, self-insured insurance plans are not required to provide information for the database and therefore, individuals covered under these plans would not be included in the database.

GOVERNOR

Require DHFS, not later than January 1, 2002, to request a waiver from the federal Department of Health and Human Services (DHHS) Secretary to: (a) permit DHFS to verify whether a family or a child has access or has had access to employer-subsidized health care prior to enrolling the family or child in BadgerCare; and (b) increase the time period a family or a child is required to be without access to employer-subsidized health care before the family or child would be eligible for BadgerCare.

Specify that the waiver request would propose to increase the time period that a family must be without access to employer-subsidized health care before being eligible for BadgerCare. The waiver request would propose to increase the waiting period from three months to six months, with the following exceptions:

- If a family or child had access to employer-subsidized health care coverage during the six months immediately preceding the date of application for BadgerCare but no longer has access because the coverage was terminated through no fault of the family or the child, as determined by DHFS, the waiting period would be 45 days.

- If a family or child had access to employer-subsidized health care coverage during the six months immediately preceding the date of application for BadgerCare but no longer has access because the family or child has exhausted their COBRA coverage, the waiting period would be at least three months.

- If a family or child had access to employer-subsidized health care coverage during the six months immediately preceding the date of application for BadgerCare, but no longer has access because employment has been terminated, the waiting period would be at least three months.

DISCUSSION POINTS

1. The bill would require DHFS to request a waiver to verify an applicant's insurance information before enrolling the applicant and his or her family members in BadgerCare and to increase time period that an applicant would have to be without access to employer-subsidized health care from three months to six months the to be eligible for BadgerCare. The changes to BadgerCare recommended by the Governor do not appear to contradict provisions under federal law and regulations. However, such changes would have to be approved by HCFA since they represent a change to the state's BadgerCare plan as approved under the existing BadgerCare waivers.

Eligibility Waiting Period

2. The bill specifies that the waiver request would propose to increase the period of time that a family or child is required to be without access to employer-subsidized health care coverage before the family or child would be eligible for BadgerCare. However, in a letter to the Committee's Co-chairs dated March 21, 2001, the administration indicated that the language in the bill does not reflect the Governor's intent. The Governor intended to require DHFS to seek a waiver requesting to extend the period of time a family or child would have to be without health care coverage, rather than access, as specified in the bill. This change would be required to ensure that the bill reflects the Governor's intent.

3. By increasing the waiting period before a family could be eligible for BadgerCare, the administration hopes to prevent decisions by individuals and employers to discontinue health care coverage to become eligible for, or have their employees become eligible for BadgerCare. The phenomenon of replacing private health care coverage with publicly funded health care coverage is commonly referred to as "crowd out."

4. Most states use some waiting period during which a child would have to be without health care coverage before being eligible for a state's CHIP program. This is one of the only ways states can try to prevent crowd out. The National Conference of State Legislatures reports that, as of April, 2000, 14 states had three-month waiting periods, 15 states had six-month waiting periods and three states had 12-month waiting periods before a child could be eligible for coverage under these states' CHIP programs.

5. It is not known how many potential BadgerCare applicants the Governor's provisions would affect if HCFA approved the proposed changes to the waiting period for BadgerCare eligibility. It is likely that it would only affect a small portion of potential applicants, since a small portion of BadgerCare enrollees have income that suggests they would have access to health care coverage. As of March, 2001, approximately 34% of BadgerCare enrollees had income less than 100% of the FPL and approximately 85% had income less than 150% of the FPL.

6. While preventing crowd out may be an important policy objective, it is difficult to measure the extent to which this is occurring in Wisconsin since there is no common definition of crowd out and the difficulty in determining when an incident of crowd out has occurred. DHFS defines crowd out as action taken by an employer or an individual to discontinue health care coverage as a direct result of the presence or availability of publicly-funded health care programs. Others may define crowd out as any shift of funding for health care from the private sector to publicly-funded programs, whether or not that shift was the direct result of the availability of the program or not.

7. DHFS does not believe that crowd out is a problem in Wisconsin. When designing BadgerCare, DHFS met with representatives of the insurance industry and employers for advice in designing BadgerCare in its effort to prevent crowd out associated with employer-sponsored health care coverage. Additionally, DHFS requested the representatives of the insurance industry and employers to report any examples of crowd out so that DHFS could investigate. DHFS indicates that to date, DHFS has not received any reports from these individuals alleging crowd out.

8. The National Federation of Independent Businesses (NFIB) has indicated that, based on a recent survey of its members, the portion of small businesses that do not offer health insurance to their employees has increased from 23% in 1998 to 26% in 2000. However, NFIB indicates that these decisions are based on increasing health care costs, not the availability of BadgerCare. NFIB reports that almost 40% of small business owners saw a 25% increase in premiums for health care for their employees in 2000 and another 31% saw premium increases ranging from 16% to 25% in 2000.

9. Almost 90% of NFIB members indicate that they are aware of BadgerCare, but only 3% of those members' employees were enrolled in the program at the time of the survey, suggesting that small business employers are not encouraging their employees to participate in BadgerCare, or if they are, these efforts have not been successful.

10. It is not clear to what extent employers are interested in discontinuing health care coverage for their employees to take advantage of BadgerCare. State law requires that if an employer provides health care coverage to its employees, this coverage must be available to all employees. Therefore, if an employer chooses to discontinue health care coverage for its employees, it must do so for all its employees, including employees with income that would make them ineligible for BadgerCare.

11. Another reason that employers may wish to continue to provide health care coverage to employees is to remain competitive in the current tight labor market. Employers that do not offer new employees health care benefits are disadvantaged in recruiting workers compared with employers that offer such benefits. In a different labor market, maintaining a competitive edge by providing health care coverage may not be as important to employers.

12. The Governor's recommendations could be viewed as an effort to prevent crowd out should increasing health care premiums and threats of economic downturns combine in the future to force more employers to discontinue health care coverage for their employees. However, it is not clear that extending the waiting period before a family would be eligible for BadgerCare would influence employers' decisions to discontinue health care coverage should premiums continue to increase at their current rate and the economy continues to slow.

13. It is possible that if approved by HCFA, the provisions in the bill could affect an individual's decision to discontinue individually purchased family health care coverage in order to enroll in BadgerCare. However, it is reasonable to assume that very few families that meet the financial eligibility criteria for BadgerCare would be able to afford family health care coverage. Therefore, to the extent this provision would affect such decisions, it is likely that the impact on the BadgerCare caseload would be minimal.

14. The administration indicates that another reason for increasing the time period before an individual would be without health care coverage before being eligible for BadgerCare is to make the program's eligibility criteria more consistent with the state's group health insurance coverage for state employees. Most new state employees are eligible for state group health insurance coverage immediately upon employment, but many do not become eligible for the state's contribution towards health insurance premiums until after six months of service under the Wisconsin Retirement System.

However, not all new full-time state employees are subject to the six-month waiting period before the state begins making contributions towards health insurance premium costs. State constitutional officers, members and employees of the Assembly and Senate, justices of the Supreme Court, Court of Appeals or Circuit Court judges, district attorneys, University of Wisconsin faculty and staff and Wisconsin Conservation Corps crew leaders receive the employer contribution immediately upon hire. University of Wisconsin faculty and staff and members of the Legislature and their staff represent approximately 45% of the state's 66,604 positions authorized in the state's base for the 2001-03 biennium.

15. If the Governor's recommendations relating to the time period an individual would be without health insurance coverage were implemented, it is likely that there would be a one-time reduction in the caseload growth for the first several months that the provision would be implemented. It is likely that its effect on the overall BadgerCare caseload would be minimal.

Insurance Verification

16. The Governor's recommendations relating to insurance verification are intended to address concerns that some individuals are being improperly enrolled in BadgerCare because they have access to health care coverage or did have health care coverage within the three months preceding application for BadgerCare.

17. While it appears that, during the first year of BadgerCare implementation, a number of individuals were improperly enrolled in BadgerCare, DHFS has since taken steps to improve the eligibility determination process to minimize the number of individuals improperly enrolled in the program.

18. Health care insurance coverage and access are eligibility criteria under BadgerCare that do not affect eligibility for MA. Therefore, adding this new criteria to the eligibility determination process initially created some complications. The eligibility system and the claims payment system did not properly transfer information. Additionally, county workers were not as familiar with the procedures used to determine eligibility based on an individual's health care coverage or access. Many of these complications have been addressed through programming changes and eligibility worker training. DHFS indicates that it continues to monitor the eligibility determination process to ensure that it is operating properly.

19. Counties would likely incur additional administrative costs if counties are required to verify insurance information prior to enrolling an individual in BadgerCare. Because counties determine eligibility, the Governor's recommendation, if implemented, would require county eligibility workers to conduct the insurance verification, rather than having DHFS perform the verification function as a follow-up to enrollment.

From April 14, 2000, through April 16, 2001, approximately 26,000 applications for BadgerCare were approved. Assuming the additional workload associated with this requirement increased application processing time by one half-hour per application, the increased workload could cost counties approximately $305,000 (all funds) per year, assuming that 26,000 applications would be approved each year. Additionally, some programming changes may be necessary to certain information systems so that county eligibility workers would have access to additional insurance data collected by the state. As a result, some one-time costs would be associated with such changes.

20. It does not appear that this provision, if implemented, would have a significant impact on the length of time an individual would have to wait before finding out if they were eligible for BadgerCare, nor would it affect the date on which eligibility begins. Under both

federal and state law, MA and BadgerCare recipients are entitled to timely processing of applications. Administrative rule specifies that applications must be processed within 30 days of application, otherwise the applicant has a right to appeal the lack of a decision. Therefore, if a county worker is unable to verify insurance information within the 30 days of application, it appears that an assumption would have to be made as to whether the information provided by the individual is accurate. Once a determination of eligibility is made, that eligibility is retroactive to the first day of the month in which the individual applied for BadgerCare.

In *Grandberry v. Schmidt*, the U.S. Supreme Court found that if a presumption is made with regard to determining whether an individual is eligible for public assistance, which would include MA and BadgerCare, that presumption must be made in favor of the applicant. Therefore, it appears that if a county worker could not verify the insurance data within 30 days of the application, the worker would be required to assume that the individual is eligible for BadgerCare, assuming the individual meets all of the other eligibility criteria.

21. The Committee may wish to adopt the Governor's recommendations relating to insurance verification on the grounds that, as a matter of program integrity, DHFS should not be enrolling individuals in BadgerCare before the state can verify that they are eligible. Avoiding the risk of providing health care benefits to individuals that are not eligible to receive such benefits may outweigh the administrative costs of verifying information provided by applicants prior to eligibility determination. Since making such a change would not significantly affect the length of time an individual would have to wait for their application to be processed, there would be minimal effect to applicants.

22. Alternatively, the Committee could determine that requiring insurance verification prior to an eligibility determination would be an unnecessary burden to place on counties and that issues regarding the integrity of the eligibility determination process are more appropriately handled through quality assurance activities conducted by DHFS.

The Committee could require DHFS to annually conduct a sample of BadgerCare enrollees that would likely have access to insurance and to verify the insurance status of those individuals to ensure that the eligibility determination process is properly processing applications for BadgerCare. This process has been used by DHFS in the past to identify problems in the eligibility determination process. The Committee could require DHFS to report annually to the Committee on the results of its survey and on DHFS efforts to improve the integrity of the eligibility determination process. These reports could first be required beginning March 1, 2002.

23. Alternatively, if the Committee determines that the current eligibility determination process is appropriate and that any difficulties with the eligibility process are being appropriately handled by DHFS, the Committee could maintain current law.

ALTERNATIVES TO BASE

A. Extension of Waiting Period for Eligibility

1. Adopt the Governor's recommendations, as technically modified, to require DHFS to request a waiver extending the period of time that a family or child would have to be without health care coverage, rather than access to health care coverage.

2. Delete provision.

B. Insurance Verification

1. Adopt the Governor's recommendations.

2. Require DHFS to annually conduct a sample of BadgerCare enrollees that would likely have access to health insurance coverage to verify whether these individuals were properly enrolled in BadgerCare. Further, require DHFS to report annually, beginning March 1, 2002, to the Committee on the results of this survey and on DHFS efforts to improve the integrity of the eligibility determination process.

3. Delete provision.

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June 4, 2001 Joint Committee on Finance Paper #471

Governor's Prescription Drug Assistance Proposal (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 355, #7]

CURRENT LAW

Currently, there is no state prescription drug assistance program targeted to low-income seniors in Wisconsin.

GOVERNOR

Require DHFS and DOA to engage in the following activities that are intended to provide prescription drug assistance to certain individuals.

MA Prescription Drug Assistance Project. Require DHFS to request a demonstration project waiver from the Secretary of the U.S. Department of Health and Human Services (DHHS) to permit DHFS to expand MA to certain individuals at least 65 years of age and to limit MA coverage to prescription drugs only. Specify that the project would include the following provisions.

Eligibility. Specify that individuals who are at least 65 years of age, who are otherwise ineligible for MA and whose annual household income is no more than 185% of the federal poverty level (FPL), and have been without available prescription drug coverage, other than MA, for 12 months would be eligible for prescription drug coverage under the project. Eligible individuals would be issued a prescription drug card for the purchase of prescription drugs after applying on a form provided by DHFS and after paying a $25 annual program enrollment fee. Based on the 2001 FPL, annual household income equal to 185% of the FPL would be $15,892 for one person and $21,479 for a two-person family.

Deductibles. Specify that, once enrolled in the project, individuals would be required to pay the following deductibles before MA would provide prescription drug coverage on their behalf: (a) no deductible would be required for individuals with annual household income of no more than 110% of the FPL; (b) a $300 annual deductible would be required for individuals with annual household income above 110% of the FPL but no more than 130% of the FPL; (c) a $600 annual deductible would be required for individuals with annual household income above 130% of the FPL but no more than 155% of the FPL; and (d) a deductible equivalent to the MA reimbursement rate for each drug purchased would be required for individuals with annual household income above 155% of the FPL. All drugs purchased during the deductible period would be available to the individual at the reimbursement rate paid to pharmacies and pharmacists under MA.

For individuals enrolled in the project with household income above 155% of the FPL, the MA program would not pay a benefit on their behalf. Rather, they would only be eligible to purchase drugs at a discount from the retail price of the drugs purchased. This discount would be equivalent to the difference between the retail value of the drug purchased and the reimbursement rate paid by the MA program.

Copayments. Specify that, for individuals with annual household income at or below 155% of the FPL, after payment of any required deductibles, the individual would be required to pay a copayment of $10 for each prescription drug with a generic name and a copayment of $20 for each prescription drug with a brand name. Individuals with annual household income above 155% of the FPL would be responsible for the entire cost of the drug at the MA reimbursement rate.

Reimbursement for Pharmacies and Pharmacists. Specify that, from the MA benefits appropriations, DHFS would pay pharmacies and pharmacists the MA reimbursement rate, less the required copayments, for prescription drugs purchased by individuals enrolled in MA under the waiver, after payment of any required deductible. As a condition of participation in the MA program, a pharmacy or pharmacist could not charge an individual who is eligible for MA under the waiver and that presents a valid prescription order, an amount for that prescription that exceeds the applicable deductibles and copayments.

Prohibitions on Implementation. Prohibit DHFS from implementing the MA prescription drug project unless: (a) the DHHS Secretary grants a waiver consistent with the provisions in the bill and that waiver is in effect; and (b) sufficient state and federal funds are available for the program. Specify that, if the waiver is granted and a national prescription drug benefit program for seniors is created that would provide similar benefits to a similar population, DHFS could only implement the program if it first submits a plan for implementation that is approved by DOA and the Joint Committee on Finance. Provide that the Joint Committee on Finance could approve the plan under a 14-day passive approval process. If a waiver were granted, at the end of the period the waiver would be in effect, DHFS would be required to request any available extension of the waiver.

Other Provisions. Create a PR appropriation for receipt of revenue from the $25 annual enrollment fee paid by participants and specify that this revenue would be used to pay for administration of the waiver. Additionally, define "Medicare," "pharmacy discount rate," "poverty line," "prescription drug" and "prescription order" for purposes of the project.

The provision that requires DHFS to submit a waiver request that includes all of these program components would take effect on the bill's general effective date. The administration anticipates that, if the waiver were approved, the program would be implemented by July 1, 2002.

MA Bulk Purchase and Mail Order Delivery of Prescription Drugs and Supplies. Require DHFS to work with DOA to contract with a private entity for the bulk purchase and mail order delivery of prescription drug and medical supplies for MA recipients who have chronic conditions such as diabetes, asthma and hypertension. Specify that participation by MA recipients in the program would be voluntary. Specify that, if DHFS contracts with a private entity, the private entity would be required to administer and promote the bulk purchase and mail order delivery of prescription drugs, and telephone participants every three months to ascertain their progress in administering self-care. Specify that the bulk purchase and mail order delivery of drugs would be limited to MA-covered drugs.

Require DHFS to annually evaluate hospital and emergency room costs of MA recipients receiving prescriptions and supplies through the mail and determine the extent to which savings are achieved through the bulk purchase and delivery of prescription drugs and supplies to these individuals.

Prescription Drug Discount Program. Require DOA to contract with a private entity to administer a discount program for the purchase of prescription drugs by individuals, regardless of age or income, who pay nominal fees to the private entity. Specify that procurement provisions requiring state agencies to first obtain materials and services produced by prison industries and work centers for the severely handicapped when procuring contracts would not apply to this contract. Prescription drugs covered under this program would be limited to MA-covered drugs.

Promotion of Prescription Drug Assistance Plans and Federal Discounts. Require DHFS to conduct the following activities in order to promote private prescription drug assistance plans for individuals and access to federal discounts for prescription drugs for certain providers.

Promotion of Private Assistance Plans. Require DHFS, together with DOA, to promote private prescription drugs assistance plans in health information and on the state's Internet site. DHFS would promote plans that include offers by prescription drug manufacturers of specific no-cost or reduced-cost prescription drugs and private plans that offer prescription drug discounts to members.

Promotion of Federal Discounts on Prescription Drugs Available to Certain Providers. Require DHFS to inform those entities, including tribes and federally qualified health centers (FQHCs), that are eligible for a federal prescription drug discount about their eligibility for and the benefits of participating in the federal discount program and provide technical assistance to those entities in applying for and implementing the federal discount benefit. Further, require DHFS to analyze health care data in the state to identify areas that could be eligible for and benefit from the establishment of an FQHC and provide entities in those areas with information about and technical assistance in developing an FQHC.

Under federal law, certain health care providers receiving federal funds, such as FQHCs, family planning projects, certain hospitals serving a disproportionate share of MA recipients and low-income persons, entities providing services for the treatment of sexually transmitted diseases or tuberculosis and other entities are eligible to purchase prescription and over-the-counter drugs from manufacturers at a discount based on the value of rebates available under MA.

Multistate Purchasing of Prescription Drugs. Require DOA and DHFS to work together and in conjunction with other states and associations, to develop a multistate purchasing group for direct negotiation with prescription drug manufacturers to obtain rebate agreements, modeled in part, on the federal rebate agreements negotiated on behalf of states, for prescription drugs purchased under MA. Require that these rebate agreements must result, on average, in larger rebate amounts than received under the current rebate agreements negotiated on behalf of states.

DISCUSSION POINTS

Prescription Drug Assistance Project

1. Under the Governor's proposal, if a federal waiver is granted, DHFS would pay pharmacies for drugs provided to program enrollees from the MA benefits appropriation. However, the bill does not increase MA benefits funding to make these payments. Rather, the administration assumes that DHFS would be able to demonstrate savings to the MA program, either through the creation of the drug assistance program or other initiatives implemented as part of the demonstration project.

2. Revenue received from the payment of the annual enrollment fee would be used to fund the ongoing administrative costs of the program. The bill does not provide funding for the initial start-up costs for implementing the waiver program, which the administration estimates could total $1.5 million for necessary changes to the MA claims processing system. The administration anticipates that DHFS would use internal resources to fund any initial start-up costs or would request the Joint Committee on Finance to transfer funds from another appropriation under s. 13.10 of the statutes. It is also anticipated that any start-up costs would be eligible for 50% federal MA matching funds, since most MA administrative costs are funded on a 50% GPR/50% FED basis.

3. Under federal law, the DHHS Secretary is provided broad authority to waive

requirements of federal law for purposes of an experimental, pilot or demonstration project, which, in the judgment of the Secretary, is likely to assist in promoting the objectives of the MA program. Some of the federal law and regulations that would have to be waived in order to implement the demonstration project proposed in the bill include: (a) provisions which prohibit treatment of the elderly and the disabled differently in terms of eligibility and coverage of benefits under MA; (b) provisions that limit states' ability to restrict access MA benefits to only cover certain services; and (c) provisions that prohibit states from subjecting MA recipients to cost-sharing requirements that exceed nominal amounts. In addition, to receive a waiver, DHFS would have to demonstrate that federally-funded costs would not be greater than they otherwise would be in the absence of the waiver (cost neutrality).

4. The Governor's proposal to expand MA to provide prescription drug assistance to certain Wisconsin residents 65 years of age or older is an attempt to address an issue that has been debated by the Legislature since last session. The advantage of the Governor's proposal compared with other proposals under consideration by the Legislature is that the Governor's proposal would use the existing infrastructure of the MA program to expand coverage to certain low-income seniors without access to drug coverage. In doing so, federal MA funds could be available to partially fund the cost of extending coverage to these individuals.

5. However, implementation of the Governor's proposal is contingent on the availability of waivers of federal MA law and DHFS' ability to identify existing savings within the MA program to fund the costs of the expansion, since no funding is provided for the program in the bill. While DHFS Secretary Dubé indicated to the Committee during her testimony on the Governor's budget that such savings are available, it is not clear how such savings would be achieved.

6. In considering the Governor's proposal to address the issue of providing prescription drug assistance to Wisconsin seniors, the Committee could consider the advantages and disadvantages of the Governor's approach compared with alternative approaches recommended by legislators. A discussion of the issues relating to the creation of a prescription drug assistance program, including the Governor's proposal, is provided in LFB Paper #482.

7. In addition to the prescription drug assistance plan, the Governor's proposal would require DHFS to engage in certain activities to change the way prescription drugs are provided under MA and to increase residents' access to prescription drugs available at rates that are less than retail prices. The Governor's bill does not provide any funding to implement these requirements, nor is legislation necessary to authorize any of these proposals. The Committee could adopt any or all of these recommendations to ensure that DHFS conducts these activities.

8. Because legislation is not necessary to authorize DHFS to engage in the activities identified in the bill, deleting these requirements from the bill would not prevent DHFS from engaging in such activities. Therefore, if the Committee wants to ensure that DHFS does not engage in any of these activities, it could include a statutory provision that would explicitly prohibit DHFS from doing so.

MA Bulk Purchase and Mail Order Delivery of Prescription Drugs and Supplies

9. The Governor's proposal would require DHFS to work with DOA to contract with a private entity for the bulk purchase and mail order delivery of prescription drug and medical supplies for MA recipients who have chronic conditions, such as diabetes, asthma and hypertension.

10. It is possible that MA benefits costs could be reduced by providing such services. The administration estimates potential savings of up to $8.7 million annually (all funds) from drug sales, based on a proposal submitted by Health Alliance, a disease management company headquartered in Chicago. The savings would likely be available from reduced prices for prescription drugs purchased in bulk, rather than purchased through retail pharmacies. Additional savings could be available to the extent that the health of individuals participating in the program improves due to the regular delivery of maintenance drugs. The proposal would require that regular telephone contact be made to individuals participating in the program to assess the individual's progress in maintaining their health. Under the proposal, DHFS would be required to evaluate the proposal to determine the extent to which savings are achieved through the program.

11. However, opponents of mail order delivery of prescription drugs contend that mail order pharmacies can impair individuals' quality of care and encourage waste. Representatives of pharmacists across the state suggest that telephone contacts by a disease management organization cannot replace the interaction between a pharmacist and a patient in a retail setting where a pharmacist may be better able to ascertain an individual's progress in maintaining their health than over the telephone.

12. A study completed by the Medical Sciences College of Pharmacy at the University of Arkansas suggests that while mail order pharmacy services could provide lower prices for prescription drugs on a per unit cost, overall costs could increase because of increased use and waste by MA recipients.

Prescription Drug Discount Program

13. The Governor's proposal would require DOA to contract with a private entity to administer a discount program for the purchase of prescription drugs by individuals, regardless of age or income, who pay nominal fees to the private entity. No funding is provided for this purpose. The administration expects that DOA would contract with vendors that already have prescription drug discount plans available to individuals that pay certain fees.

14. The administration has identified a number of private plans that could be considered under such a proposal. One such plan, Rx Samaritan Prescription Drug Plan, provides a discount to members that pay a $3 fee per prescription unless the savings available on a purchase are less than $3. Membership is open to anyone and no fee is required to enroll. Another plan, ComCare, Inc., is available to anyone that pays an annual fee of $20 per person plus $0.85 per prescription. The discount available varies by plan.

15. While these plans would not provide the type of assistance available under other

proposals currently under consideration by the Legislature, these plans could provide some measure of relief to those individuals that would not qualify for any proposal adopted by the Legislature, including individuals that are under 65 years of age or have income above whatever income eligibility limit would be established under a state-funded plan.

Promotion of Prescription Drug Assistance Plans and Federal Discounts

16. The Governor's proposal would require DHFS to provide technical assistance to organizations, including FQHCs and tribes, about their potential eligibility for federal drug discounts. DOA estimates that the discounts available under the federal discount could be anywhere from 20% to 50% less than the rates available under MA for certain drugs. Therefore, if an FQHC were to purchase drugs on behalf of its clients through this federal discount program, uninsured clients could receive prescription drugs through the FQHC at significant discounts from retail prices.

17. Additionally, the Governor's proposal would require DHFS to provide technical assistance to entities that could become an FQHC in order to improve access to federal drug discounts available to FQHCs. This proposal would have the additional benefit of possibly increasing low-income and uninsured individual's access to comprehensive health care services in areas of the state not currently served by an FQHC. Because FQHCs are eligible for federal grant funding, such an increase in the number of FQHCs could increase federal funds available for health care services provided to low-income and uninsured individuals in the state.

18. The Governor's proposal would require DHFS, together with DOA, to promote private prescription drug assistance plans in health information and on the state's Internet site. There are a number of private assistance plans available, including discount programs available through pharmaceutical manufacturers and plans available through membership organizations, such as the American Association of Retired Persons.

19. While there are a number of Internet sites that provide such information, providing such information through health information materials and through the state's Internet site could make it easier for individuals to access such information by providing a single source for this information.

Multistate Purchasing of Prescription Drugs.

20. The Governor's proposal would require DOA and DHFS to work together and in conjunction with other states and association to develop a multistate purchasing group for direct negotiation with prescription drug manufacturers to obtain rebate agreements, modeled in part on the federal rebate agreements negotiated on behalf of states, for drugs purchased under MA. Such an effort could result in more rebate revenue available to the state for drugs purchased under a drug assistance program enacted by the Legislature. Additionally, such an organization could attempt to encourage congressional support to modify the manufacturer rebate formula in federal law to benefit state MA programs.

ALTERNATIVES TO BASE

1. Adopt all of the Governor's recommendations.

2. Adopt one or more of the following Governor's recommendations:

a. Require DHFS to request a federal demonstration project waiver to expand MA to provide prescription drug assistance to certain Wisconsin residents 65 years of age or older.

b. Require DHFS to contract with a vendor for the bulk purchase and mail-order delivery of drugs and supplies for MA recipients with chronic conditions.

c. Require DOA to contract with a private entity to administer a discount program for the purchase of prescription drugs by individuals, regardless of age or income.

d. Require DHFS to provide information to entities eligible for federal drug discounts about the availability of the federal discounts and to provide technical assistance to organizations that could become an FQHC.

e. Require DHFS, together with DOA, to conduct activities to promote private prescription drug assistance plans in health information and on the state's Internet site.

f. Require DOA and DHFS to work together and in conjunction with other states and associations to develop a multistate purchasing group for direct negotiation with manufacturers regarding drug rebates.

3. Delete provision.

4. In addition to adopting any of the alternatives under Alternative 2 or Alternative 3, prohibit DHFS from engaging in any of the activities identified under 2 a through f.

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June 4, 2001 Joint Committee on Finance Paper #472

Rates for Noninstitutional Services (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 359, #8]

CURRENT LAW

Under the state's medical assistance (MA) program, noninstitutional service providers are reimbursed at rates equal to the providers' usual and customary charges or the maximum providers rates established by the Department of Health and Family Services (DHFS) for each procedure or service, whichever is less.

GOVERNOR

Provide $20,518,600 ($12,054,700 FED and $8,463,900 SEG) in 2001-02 and $44,038,900 ($25,830,500 FED and $18,208,400 SEG) in 2002-03 to increase MA rates for most noninstitutional services. The administration indicates that half of these funds would be used to provide an across-the-board increase in each year for most noninstitutional services. The remaining funds would be used to support rate increases for selected noninstitutional services for which MA payments represent no more than 50% of the amount providers bill for these services. The segregated funding provided for these increases would be available from the MA trust fund that would be created in the bill.

Rates for the following noninstitutional services would be increased by up to 2.5% in 2001-02 and an additional 2.5% in 2002-03: (a) ambulance transportation; (b) certified nurse anesthetist; (c) chiropractic; (d) dental; (e) durable medical equipment and disposable medical supplies; (f) end-stage renal disease; (g) family planning; (h) HealthCheck; (i) home health; (j) hospice; (k) laboratory and x-ray; (l) mental health; (m) personal care; (n) physicians and clinics; (o) podiatry; (p) prenatal care coordination; (q) transportation by specialized medical vehicle; (r) therapies; and (s) vision. The 2.5% increases would be calculated on base funding for services

and would not reflect any of the targeted rate increases for providers. DHFS would determine which service categories and providers would be eligible for the additional rate increase.

DISCUSSION POINTS

1. The amounts provided in the Governor's budget bill do not reflect the effect of MA rates increases on BadgerCare costs. Because fee-for-service BadgerCare reimbursement rates are identical to MA fee-for-service reimbursement rates, increasing MA reimbursements rates will increase costs for BadgerCare. If the Committee adopts the Governor's recommendations, the funds should be distributed between BadgerCare and MA and the amounts in the bill should be increased by $404,200 FED in 2001-02 and $716,400 FED in 2002-03 to reflect the higher federal financial participation available under BadgerCare than MA. As a result, of the segregated funds provided in the bill, $7,806,900 in 2001-02 and $16,795,100 in 2002-03 would be budgeted to support MA costs and $657,000 in 2001-02 and $1,413,300 in 2002-03 would be budgeted to support BadgerCare costs.

2. In 2000-01, most rates for noninstitutional services were increased 1% across-the-board. No rate increase was provided for noninstitutional services in 1999-00.

3. DHFS indicates it intends to distribute the funds for targeted rate increases proportionately among the services with paid-to-billed ratios of no more than 50%. However, a portion of funds may be targeted to specific billable procedures. For example, DHFS may not increase rates for all types of physician services, but instead, make rate adjustments to address the reimbursement rates for certain types of office visits. An analysis completed by DHFS indicates that MA rates paid for new patient office visits are approximately 28% of physicians' billings, while MA pays approximately 64% of charges for office visits that focus on prevention for existing child clients. Under the Governor's bill, DHFS would use a portion of these funds for targeted increases, such as increasing reimbursements for new patient office visits to reduce disparities between rates.

4. Other categories of services that would likely be eligible for the targeted rate increases include some mental health services, some speech therapy services, ambulance services, anesthesia services, chiropractic, podiatry and laboratory services. If the funds for targeted rate increases were distributed proportionately among all provider groups eligible, it is likely that physician's services would receive over 75% of the funds targeted for such increases. However, it is not known specifically how much would be targeted for physician's services, since DHFS would use these funds to increase rates for specific types of physician services, rather than all physician services.

5. The Committee could consider allocating a portion of the funds provided in the bill to target those services that MA recipients have difficulty accessing because the reimbursement rates are not sufficient to attract enough providers to serve MA recipients. Dental services are often cited as an MA service area with significant access problems.

Dental Care Access

6. Federal law requires states to cover dental services for children enrolled in MA. States are not required to provide dental services to adults. Wisconsin's MA program covers dental services for both adults and children.

7. Total fee-for-service expenditures for MA dental services are estimated to be approximately $19.8 million in 2001-02 and $21.3 million in 2002-03. It is estimated that approximately 22% of MA-eligible individuals receive at least one dental service during the course of a year. This compares with approximately 60 to 70% of individuals in the general population that receive at least one dental service in a year.

8. In 2000, the Legislative Council established the Special Committee on Dental Care Access to examine ways to increase access to dental care by underserved populations in Wisconsin, particularly those enrolled in MA and BadgerCare. This Committee recommended increasing MA reimbursement rates for dental services to address the difficulty MA recipients have in accessing dental services. Additionally, this Committee recommended requiring MA to cover two dental cleanings per year for adults (currently only one per year is allowed) and to provide coverage of fluoride varnish under the early and periodic screening, diagnosis and treatment (EPSDT) benefit.

9. The recommendations of the Special Committee were incorporated into 2001 Senate Bill 166. SB 166 would provide $9,155,400 GPR and $13,039,600 FED in 2001-02 and $12,333,285 GPR and $17,387,100 FED in 2002-03 to fund these recommendations. This funding would increase funding for MA dental services by approximately 112% in 2001-02 and 139% in 2002-03, compared with current estimates of MA dental expenditures.

10. As an alternative to the Governor's recommendations, the Committee could require that DHFS allocate funding in the bill as follows: (a) 50% of the funds for an across-the-board rate increase; (b) 25% for targeted rate increases to providers with MA reimbursements representing no more than 50% of the providers' charges; and (c) 25% for dental rate increases.

11. The following table identifies how funds would be allocated if the Committee adopted the funding recommended by the Governor or half the funding level recommended by the Governor under the different scenarios.

Summary of Alternatives

	2001-02			2002-03		
	FED	SEG	Total	FED	SEG	Total
Governor's Funding Level*						
Alternative 1 (Governor's Bill)						
Across-the-Board Increases (50%)	$6,229,500	$4,232,000	$10,461,500	$13,273,500	$9,104,200	$22,377,700
Targeted Providers (50%)	6,229,500	4,231,900	10,461,400	13,273,400	9,104,200	22,377,600
Total	$12,459,000	$8,463,900	$20,922,900	$26,546,900	$18,208,400	$44,755,300
Alternative 2						
Across-the-Board (50%)	$6,229,500	$4,232,000	$10,461,500	$13,273,500	$9,104,200	$22,377,700
Targeted Providers (25%)	3,114,700	2,116,000	5,230,700	6,636,700	4,552,100	11,188,800
Dental Services (25%)	3,114,800	2,115,900	5,230,700	6,636,700	4,552,100	11,188,800
Total	$12,459,000	$8,463,900	$20,922,900	$26,546,900	$18,208,400	$44,755,300
50% of Governor's Funding Level						
Alternative 3						
Across-the-Board Increases (50%)	$3,114,800	$2,116,000	$5,230,800	$6,457,700	$4,552,100	$11,009,800
Targeted Providers (50%)	3,114,800	2,115,900	5,230,700	6,457,600	4,552,100	11,009,700
Total	$6,229,600	$4,231,900	$10,461,500	$12,915,300	$9,104,200	$22,019,500
Alternative 4						
Across-the-Board (50%)	$3,114,800	$2,116,000	$5,230,800	$6,457,700	$4,552,100	$11,009,800
Targeted Providers (25%)	1,557,400	1,058,000	2,615,400	3,228,800	2,276,100	5,504,900
Dental Services (25%)	1,557,400	1,057,900	2,615,300	3,228,800	2,276,000	5,504,800
Total	$6,229,600	$4,231,900	$10,461,500	$12,915,300	$9,104,200	$22,019,500

*As adjusted to reflect enhanced federal matching funds available under BadgerCare.

12. Under the Governor's recommendations, with the allocation between MA and BadgerCare, it is estimated that the across-the-board rate increase would total approximately 2.3%. If the Committee provided half of the funding recommended by the Governor, it is estimated that the across-the-board rate increase would total approximately 1.1%. If the Committee adopted Alternative 2, it is estimated that rates for dental services would increase by approximately 26% in 2001-02 and 22% in 2002-03. If the Committee adopts Alternative 4, it is estimated that the rates for dental services would increase by approximately a 14.2% in 2001-02 and 12% in 2002-03.

ALTERNATIVES TO BASE

1. Adopt the Governor's recommendations, but specify that of the funding provided, $11,118,900 FED and $7,806,900 SEG in 2001-02 and $23,677,500 FED and $16,795,100 SEG in 2002-03 would be budgeted in the MA benefits appropriation and the remainder would be budgeted in the BadgerCare benefits appropriations. In addition, increase the amount of federal funding budgeted in the bill by $404,200 FED in 2001-02 and $716,400 FED in 2002-03 to reflect that enhanced federal financial participation under BadgerCare. Of the funding provided, 50% would support the costs of an across-the-board increases in reimbursement rates for noninstitutional

services and 50% would be provided for rate increase targeted to services with reimbursements that represent no more than 50% of charges.

Alternative 1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$39,005,800	$26,672,300	$65,678,100
[Change to Bill	*$1,120,600*	*$0*	*$1,120,600]*

2. Adopt the funding amounts included in Alternative 1, but specify that, of the funding provided, 50% would support the costs of an across-the-board increase for noninstitutional services, 25% would be provided for rate increases targeted to services with reimbursements represent no more than 50% of charges and 25% would be targeted for rate increases for dental services.

Alternative 2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$39,005,800	$26,672,300	$65,678,100
[Change to Bill	*$1,120,600*	*$0*	*$1,120,600]*

3. Reduce funding in the bill by $10,057,100 ($5,825,200 FED and $4,231,900 SEG) in 2001-02 and $22,019,400 ($12,915,200 FED and $9,104,200 SEG) in 2002-03 and specify that 50% would be provided for across-the-board increases in reimbursement rates for noninstitutional services and 50% would be provided for rate increases targeted to services with reimbursements that represent no more than 50% of charges. Of the funding provided, $5,559,500 FED and $3,903,500 SEG in 2001-02 and $11,838,700 FED and $8,397,500 SEG in 2002-03 would be budgeted in the MA benefits appropriation. The remainder would be budgeted in the BadgerCare benefits appropriation.

Alternative 3	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$19,144,800	$13,336,100	$32,481,000
[Change to Bill	*- $18,740,400*	*- $13,336,100*	*- $32,076,500]*

4. Adopt the funding amounts included in Alternative 3, but specify that of the funding provided, 50% would be provided for an across-the-board increase for noninstitutional services, 25% would be provided for rate increases targeted to services with reimbursements represent no more than 50% of charges and 25% would be targeted for rate increases for dental services.

Alternative 4	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$19,144,800	$13,336,100	$32,481,000
[Change to Bill	*- $18,740,400*	*- $13,336,100*	*- $32,076,500]*

5. Delete provision.

Alternative 5	FED	SEG	TOTAL

2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $37,885,200*	*- $26,672,3000*	*- $64,557,500]*

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June 4, 2001 Joint Committee on Finance Paper #473

MA Hospital Payments (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 359, #9 (part)]

CURRENT LAW

Under federal law, MA payments for hospital services are limited in two ways. First, a state's total MA payments for hospital services are limited to the total amount that would have been spent for the same services under Medicare. This is known as the Medicare upper limit. This upper limit is calculated separately for inpatient services and outpatient services. Second, no hospital can be reimbursed for more than the total amount the hospital charges for services provided under MA.

Outpatient Hospital Services. Currently, the MA rate paid to a hospital for outpatient services is based on that hospital's costs from 1987, adjusted for inflation, capital costs and costs for outpatient mental health services provided by the hospital. A rural hospital may receive an adjustment to its outpatient reimbursement rate if it has a combined Medicare and MA utilization rate equal to or greater than 50% based on charges and: (a) the hospital is not located in a metropolitan statistical area (MSA) under Medicare; (b) as of January 1, 1991, Medicare classified the hospital in a rural wage area; (c) the hospital has not been permanently assigned MSA status as of July 1, 1993; and (d) Medicare does not classify the hospital as a rural referral center. In 1999-00, MA payments for outpatient hospital services totaled $44.3 million (all funds).

Inpatient Hospital Services. Inpatient hospital services under MA are paid based on a prospective payment system known as a diagnosis-related group (DRG) system. The DRG system 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.

Under the DRG system, the hospital determines the patient diagnosis and then bills MA for the hospital-specific DRG rate related to that condition and treatment. The methodology of calculating DRG rates and the adjustments are described in the MA inpatient hospital state plan prepared by DHFS. This plan is updated annually to reflect changes to the program. In 1999-00, MA payments for inpatient hospital services totaled $248.8 million (all funds).

Disproportionate Share Adjustments. Disproportionate share hospitals (DSHs) serve a disproportionate share of MA and low-income patients. These hospitals receive an adjustment to the hospital-specific base DRG rate to reflect the costs of serving a disproportionate share of MA and low-income, uninsured patients. In 2000-01, for qualifying hospitals, the minimum DSH adjustment is equal to 3% of a hospital's base DRG rate. The hospital with the highest MA utilization rate receives a 5.5% DRG adjustment.

Of total MA expenditures for inpatient hospital services in 1999-00, DSH adjustments totaled approximately $5.5 million and was distributed to 26 hospitals. To be eligible for a DSH increase, a hospital must serve a disproportionate share of low-income and MA clients. Additionally, a qualifying hospital must have at least two obstetricians who have staff privileges and who have agreed to participate in MA unless the hospital serves patients who are predominantly under age 18 or the hospital did not offer nonemergency obstetrical care as of December 31, 1987.

Prior to federal fiscal year 2000-01, the annual amount of federal DSH funds Wisconsin could expend was limited to $7.0 million. Under a change enacted as part of the FFY 2000-01 federal budget, some states, including Wisconsin, are eligible to receive a DSH allotment equal to 1% of the total federal MA funding paid to that state in FFY 2000-01. Beginning in 2001-02 and each year thereafter, the allocation will increase every year based on inflation. It is estimated that the state's federal DSH allotment will total $20,409,600 in 2001-02 and $21,103,500 in 2002-03.

The amount of the state's DSH allotment is important because these expenditures do not count towards the state's Medicare upper limit for inpatient services or the limit on reimbursements above a hospital's charges. However, under federal law, the total amount of funding that can be provided to a hospital, as a DSH adjustment, is limited to its unrecovered costs for serving MA and uninsured patients.

Hospitals do not separately identify costs for uninsured patients, but instead report unrecovered costs as charity care or bad debt. Charity care is care for which a hospital does not charge because it has been determined that the patient cannot afford to pay. Bad debt is defined as care for which payment is expected but the hospital is unable to collect. When calculating individual hospital maximum DSH allocations, DHFS uses the hospital's reported charity care as a proxy for a hospital's costs to serve the uninsured.

GOVERNOR

Provide $22,907,900 ($13,409,600 FED and $9,498,300 SEG) in 2001-02 and $24,199,400 ($14,103,500 FED and $10,095,900 SEG) in 2002-03 to fund increases in the maximum reimbursement rates paid to hospitals for outpatient services and increases in reimbursement rates for inpatient services provided by hospitals qualifying for DSH adjustments. SEG funding would be provided from the MA trust fund created in the bill.

This provision would use funds from the MA trust fund as the state's match for claiming additional federal DSH funding that is available, beginning in federal fiscal year (FFY) 2000-01. The amount of the federal funding provided in the bill is based on DHFS estimates of the additional federal DSH funding that would be available to the state in each year of the 2001-03 biennium.

Under the Governor's proposal, DHFS would: (a) increase inpatient hospital reimbursement rates to those hospitals that qualify as a DSH ($4,000,000 annually); (b) recalculate rates paid to most rural hospitals for outpatient services ($3,565,800 in 2001-02 and $3,809,400 in 2002-03); and (c) recalculate rates paid to most urban hospitals for outpatient services ($15,342,100 in 2001-02 and $16,390,000 in 2002-03).

The administration indicates that the outpatient services rate paid to a rural hospital would be recalculated so that in 2001-02, each hospital would be paid a rate equivalent to 100% of a hospital's costs for outpatient services. For urban hospitals, in 2001-02, the rate would be equivalent to approximately 93% of a hospital's costs for outpatient services. No additional rate increase would be available in 2002-03 for outpatient hospital services.

DISCUSSION POINTS

Outpatient Hospital Rates

1. The Governor's proposal to increase outpatient hospital reimbursement rates is intended to address inequities in the current outpatient reimbursement rate structure. Currently, outpatient rates for each hospital are based on a hospital's average outpatient costs in 1987, adjusted based on rate increases provided since then. Because the level of health care services available in outpatient settings has dramatically changed since 1987, the level of reimbursement for outpatient services varies significantly by hospital. Of the urban hospitals, MA reimbursement as a percent of costs ranges from 27% for Memorial Hospital in Hudson to 95% for Baldwin Area Memorial in St. Croix. Of the rural hospitals, reimbursement as a percent of costs ranges from 39% for Adams County Memorial Hospital to 100% for Door County Memorial Hospital and others.

2. With the funding provided under the Governor's recommendations, outpatient rates for each hospital would be recalculated in 2001-02 based on current cost data and are estimated to equal reimbursement for approximately 93% for urban hospitals and 100% for rural hospitals. Rates for hospitals with current payment rates above these levels would not be affected by the Governor's

proposal. Rates would not be recalculated again in 2002-03.

3. The amount of the increased reimbursements available under the Governor's proposal would vary by hospital. A number of hospitals could receive substantial increases, while others would receive small or no increases, depending on what portion of the hospital's costs is reimbursed under current outpatient rates. Attachment 1 identifies estimates of the portion of each hospital's costs that are reimbursed under current MA rates.

4. The Committee may determine that it is appropriate to provide funding for outpatient reimbursement rates to reduce differences between hospitals in the percent of costs reimbursed under MA. However, the Committee may want to consider whether it is appropriate to distinguish between urban and rural hospitals as a group, as the Governor's proposal does.

5. Under MA, rural hospitals are defined based on federal criteria defining rural and urban hospitals under Medicare. Rural hospitals are located in counties that are not associated with a metropolitan statistical area (MSA), as defined under Medicare. Attachment 2 to the paper identifies urban and rural counties, based on the whether the county is located in an MSA.

6. It is estimated that under current law, on average, MA reimburses rural hospitals for approximately 73% of their outpatient costs. By comparison, MA reimburses urban hospitals, on average, for approximately 66% of their outpatient costs. In addition, hospitals designated as critical access hospitals by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) receive 100% reimbursement of costs. To be designated a critical access hospital, a hospital must be in a rural area, make available 24-hour emergency care, provide not more than 15 inpatient beds providing inpatient services for not more than four days and meet certain staffing requirements.

7. Rural hospitals receive higher reimbursements as a percentage of costs under MA, partly because rural hospitals can be eligible for an adjustment to the outpatient reimbursement rate if the hospital has a combined Medicare and MA utilization rate equal to or greater than 50% based on the hospital's charges. The amount of this adjustment can vary from 15% to 39%, depending on the portion of the hospital's charges attributable to MA clients.

8. To determine which hospitals are most in need of targeted reimbursements for services, it may be appropriate to look at the ability of hospitals to shift costs to other payers. MA reimbursements for services are generally lower than reimbursement rates paid by private health insurance plans. It is, therefore, assumed that providers shift some of the costs for services provided to MA clients to private payers. Table 1 compares rural and urban hospitals' gross patient revenue received in 1999, the percent of gross patient revenue from difference sources, and net income and uncompensated care a percent of gross patient revenue.

TABLE 1

Comparison of Hospital Financial Statistics
Fiscal Year 1999

	Rural Hospitals	Urban Hospitals
Gross Patient Revenue (in millions)	$1,839	$8,141
Source of Revenue		
Medicare	47.5%	41.1%
Private Insurance	41.0	44.6
MA	5.6	7.7
Other	5.9	6.6
	100.0%	100.0%
Net Income as a Percent of Gross Patient Revenue	4.1%	3.9%
Uncompensated Care as a Percent of Gross Patient Revenue	3.0%	2.9%

Source: 1999 Guide to Wisconsin Hospitals, DHFS

9. As Table 1 indicates, rural hospitals tend to receive a larger portion of gross patient revenue from Medicare than urban hospitals. Urban hospitals receive a larger portion of gross patient revenue from MA, but also receive a larger portion of revenue from private insurance. There is no significant difference between net income and uncompensated care as a portion of revenue for rural or urban hospitals.

10. Since MA revenue represents a relatively small percentage of total revenue for both urban and rural hospitals, increasing MA rates for hospitals has a relatively small effect on total hospital revenues. However, if the Committee wishes to reduce disparities in current outpatient payment rates, it could provide some SEG funding from the MA trust fund that would be created in the bill, but not distinguish between rural and urban hospitals as a group.

11. However, because total outpatient reimbursements for rural hospitals are significantly less than outpatient reimbursements for urban hospitals, the cost to increase reimbursement rates for rural hospitals is significantly less than for urban hospitals. Table 2 identifies the estimated costs to increase current outpatient hospital rates for both urban and rural hospitals at various percents of estimated costs.

TABLE 2

Alternative Increases for Outpatient Rates

Rate Increase	2001-02			2002-03		
	SEG	FED	Total	SEG	FED	Total
85% of Estimated Costs						
Urban hospitals	$4,441,100	$6,325,300	$10,766,400	$4,743,000	$6,686,600	$11,429,600
Rural hospitals	809,700	1,153,200	1,962,900	864,700	1,219,100	2,083,800
95% of Estimated Costs						
Urban hospitals	$6,646,200	$9,465,700	$16,111,900	$7,097,900	$10,006,500	$17,104,400
Rural hospitals	1,230,200	1,752,100	2,982,300	1,313,800	1,852,200	3,166,000
Governor's Proposal						
Urban hospitals	$6,368,200	$8,973,900	$15,342,100	$6,845,100	$9,544,900	$16,390,000
Rural hospitals	1,480,100	2,085,700	3,565,800	1,590,900	2,218,500	3,809,400

12. The estimates included in Table 2 assume that hospitals with current payment rates above the percents identified in the table would not be affected. Additionally, the estimates reflect current projections that total reimbursements for outpatient hospital services will increase by approximately 6.2% in 2002-03, based on current trends in the MA caseload and utilization of outpatient hospital services.

Outpatient Hospital Reimbursements Rates Effect on HMO Payments

13. The Governor's recommendations did not take into account the effect that increases in hospital reimbursements would have on health maintenance organizations (HMOs) that participate in the MA program. Because payments to HMOs for services are based on the rates that would be paid if the equivalent level of services were provided under a fee-for-service approach, DHFS would require additional funds to ensure that HMOs are not adversely affected by increased rates paid to hospitals.

14. HMOs serve MA and BadgerCare clients based on negotiated contracts with DHFS. Payments are based on a discount of the fee-for-service equivalent for the population served. Current statewide composite discounts are estimated at 8.4% for the AFDC and Healthy Start populations, 17.4% for Healthy Start pregnant women and 2.9% for the BadgerCare population.

15. DHFS and representatives of HMOs have expressed concern that if payments to HMOs are not adjusted to address the impact of the outpatient hospital rate increase, a number of HMOs may not continue to participate in the MA and BadgerCare programs. If a number of HMOs discontinue participation, it is likely that MA and BadgerCare costs would increase, since the portion of the MA and BadgerCare populations enrolled in HMOs would likely decrease. To ensure that the discount rates reflected in the current rates paid to HMOs are not affected by increases in

the Governor's bill, it is estimated that the funding in the Governor's bill would have to be increased by approximately 47% in 2001-02 and approximately 88% in 2002-03 for an increase of approximately $11.2 million SEG over the biennium.

16. Rather than increasing funding provided in the bill to ensure that the HMO discount is not affected by the increase, the Committee could direct DHFS to allocate a portion of the funding provided for outpatient hospital services to funding for HMO payments so that the discount is not affected by the increase. This would effectively reduce funding that would be provided for outpatient hospital reimbursements paid under fee-for-service by approximately 41% over the biennium.

Outpatient Hospital Reimbursement Effect on Funding for BadgerCare

17. The Governor's recommendations did not take into account the impact that increases in hospital reimbursements would have on the amounts paid for outpatient hospital services under BadgerCare. Since the rates paid under BadgerCare are equal to the rates paid under MA, the increases in reimbursement rates in the Governor's bill would proportionately increase expenditures under BadgerCare. It is estimated BadgerCare expenditures would increase by approximately $1.5 million GPR as a result of the increases proposed in the Governor's budget. Therefore, if the Committee chooses to increase funding for outpatient hospital services, the Committee could specify that, of the funds provided, a portion would be budgeted in the BadgerCare program benefits appropriation to ensure that funding budgeted for BadgerCare is sufficient to meet program expenditures.

Disproportionate Share Hospital (DSH) Payments

18. As Table 1 indicates, on average, revenue from MA does not represent a significant portion of revenue for either urban or rural hospitals. However, for those hospitals with a disproportionate share of MA or low-income clients, federal law allows states to make DSH adjustments to hospital reimbursement rates to account for the reduced ability these hospitals have to shift costs to private resources.

19. The Governor's proposal would increase total reimbursements to hospitals that qualify for DSH payments by $4.0 million annually. It is estimated that under the Governor's proposal, the minimum DSH adjustment to a hospital's DRG would increase from 3% to 4%. Table 3 identifies the administration's estimate of how the $4.0 million would be distributed based on hospitals currently meeting the DSH criteria and the Department's current methodology for distributing DSH funds. Because the DSH adjustment represents an increase to each paid claim for inpatient services, the actual amount paid may vary, based on actual inpatient claims paid over the biennium.

TABLE 3

Estimated Distribution of Governor's Proposal to Increase DSH Allocations

Hospital	Location	Annual Amount
Children's Hospital	Milwaukee	$1,735,349
Sinai Samaritan	Milwaukee	986,071
State Mental Health Institutes	Madison/Winnebago	300,000
Froedtert Memorial Lutheran Hospital	Milwaukee	234,266
St. Luke's Memorial Hospital	Racine	195,901
St. Mary's Hospital	Milwaukee	143,764
Milwaukee County Mental Health	Milwaukee	94,106
Regions Hospital	St. Paul, Minnesota	24,835
Brown County Hospital	Green Bay	18,551
Miller Dwan Medical Center	Duluth, Minnesota	16,616
Children's Health Care	Minneapolis, Minnesota	15,548
Rogers Memorial Hospital	Oconomowoc	11,821
Bellin Psychiatric Hospital	Green Bay	10,910
Gillette Children's Hospital	St. Paul, Minnesota	10,248
Boscobel Area Health Care	Boscobel	8,283
Libertas	Green Bay	7,627
Hennepin County Medical Center	Minneapolis, Minnesota	7,279
Children's Health Care	St. Paul, Minnesota	3,926
Swedish American Hospital	Rockford, Illinois	117
Total		$3,825,218

20. A number of the hospitals eligible for DSH payments are either psychiatric hospitals or hospitals located outside of Wisconsin. Children's Hospital of Wisconsin would receive approximately 45% of the increase in DSH payments under the Governor's proposal. This is primarily because Children's Hospital has one of the highest MA utilization rates in the state. However, Children's Hospital has over 62% of its gross patient revenue from private sources. Only one other hospital has more of its gross patient revenue from private sources. Additionally, Children's Hospital reported net income of $16.3 million in 1999. This suggests that Children's Hospital has a greater ability to shift costs not funded under MA to private sources of revenue than most other hospitals.

21. However, other hospitals eligible for DSH funds could be considered in need of additional DSH funds. For example, Sinai Samaritan in Milwaukee and St. Luke's Memorial in Racine had a net loss of income in 1999--almost $10.0 million for Sinai Samaritan and over $815,000 for St. Luke's Memorial. These losses represent an approximately -5.1% profit margin for Sinai Samaritan and a -1.8% profit margin for St. Luke's Memorial. These two hospitals would

receive approximately 31% of the increased DSH allocation proposed in the Governor's budget. Froedtert Memorial Lutheran Hospital in Milwaukee, which had net income of $24.7 million in 1999, or a 7.4% profit margin, would receive 6% of the increased allocations. The remaining 14 DSH-eligible hospitals would receive approximately 10% of the additional DSH funds.

22. The ability to increase DSH payments is the result of a recent change in federal law that increased Wisconsin's allocation of federal DSH funds. Previously the state's federal DSH allocation was limited to $7.0 million annually. Federal DSH funds are available at the same matching rate as other federal MA matching funds, approximately 59%. The availability of the DSH funds allows payments to DSH-eligible hospitals to exceed federal upper limits on payments to hospitals. The total estimated increase in federal DSH funding is approximately $13.4 million in 2001-02 and $14.1 million in 2002-03. The increase in DSH allocations included in the bill would increase federal DSH expenditures by approximately $2.3 million annually. Therefore, the DSH allocations could be increased above the amount included in the Governor's bill.

23. If the Committee does not act to increase DSH allocations above the level proposed in the bill, DHFS would still be able to claim the additional federal DSH funds. This is possible because, under current law, the state makes hospital payments for Milwaukee County's general assistance medical program (GAMP) and the essential access city hospital (EACH) supplement, which would qualify as DSH allocation. Currently the GAMP and EACH payments do not use federal DSH funds since the state's DSH allocation had been limited to $7.0 million until the recent federal law change.

24. The segregated funding provided in each of the alternatives would be provided from the MA trust fund that would be created in the bill. Revenues from the trust fund are MA matching funds the state receives under the nursing home intergovernmental transfer (IGT) program and replaces GPR that would otherwise be budgeted as the state match for these services.

ALTERNATIVES TO BASE

A. Outpatient Reimbursement Rates for Urban Hospitals

1. Adopt the Governor's recommendation to provide $15,342,100 ($8,973,900 FED and $6,368,200 SEG) in 2001-02 and $16,390,000 ($9,544,900 FED and $6,845,100 SEG) in 2003-03 to increase reimbursement rates for outpatient hospitals so that urban hospitals would receive reimbursements estimated at 93% of a hospital's costs for such services.

Alternative A1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$18,518,800	$13,213,300	$31,732,100
[Change to Bill	*$0*	*$0*	*$0]*

2. Reduce funding in the bill by $4,575,700 ($2,648,600 FED and $1,927,100 SEG) in 2001-02 and $4,960,400 ($2,858,300 FED and $2,102,100 SEG) in 2002-03 to increase

reimbursement rates for outpatient hospitals so that urban hospitals would receive reimbursements estimated at 85% of a hospital's costs for such services.

Alternative A2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$13,011,900	$9,184,100	$22,196,000
[Change to Bill	*- $5,506,900*	*- $4,029,200*	*- $9,536,100]*

3. Increase funding in the bill by $769,800 ($491,800 FED and $278,000 SEG) in 2001-02 and $714,400 ($461,600 FED and $252,800 SEG) in 2002-03 to increase reimbursement rates for outpatient hospitals so that urban hospitals would receive reimbursements estimated at 95% of a hospital's costs for such services.

Alternative A3	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$19,472,200	$13,744,100	$33,216,300
[Change to Bill	*$953,400*	*$530,800*	*$1,484,200]*

4. Delete the Governor's provision.

Alternative A4	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $18,518,800*	*- $13,213,300*	*- $31,732,100]*

B. Outpatient Reimbursement Rates for Rural Hospitals

1. Adopt the Governor's recommendation to provide $3,565,800 ($2,085,700 FED and $1,480,100 SEG) in 2001-02 and $3,809,400 ($2,218,500 FED and $1,590,900 SEG) in 2002-03 to increase reimbursement rates for outpatient hospitals so that rural hospitals would receive reimbursements estimated at 100% of a hospital's costs for such services.

Alternative B1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$4,304,200	$3,071,000	$7,375,200
[Change to Bill	*$0*	*$0*	*$0]*

2. Reduce funding in the bill by $1,602,900 ($932,500 FED and $670,400 SEG) in 2001-02 and $1,725,600 ($999,400 FED and $726,200 SEG) in 2002-03 to increase reimbursement rates for outpatient hospitals so that rural hospitals would receive reimbursements estimated at 85% of a hospital's costs for such services.

Alternative B2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$2,372,300	$1,674,400	$4,046,700
[Change to Bill	*- $1,931,900*	*- $1,396,600*	*- $3,328,500]*

3. Reduce funding in the bill by $583,500 ($333,600 FED and $249,900 SEG) in 2001-02 and $643,400 ($366,300 FED and $277,100 SEG) in 2002-03 to increase reimbursement rates for outpatient hospitals so that rural hospitals would receive reimbursements estimated 95% of a hospital's costs for such services.

Alternative B3	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$3,604,300	$2,544,000	$6,148,300
[Change to Bill	*- $699,900*	*- $527,000*	*- $1,226,900]*

4. Delete provision.

Alternative A4	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $4,304,200*	*- $3,071,000*	*- $7,375,200]*

C. Effect on HMO Payments

In addition to Alternatives A1, A2, A3, B1, B2 or B3, do one of the following:

1. Require DHFS to allocate a portion of the funding provided to increase outpatient hospital reimbursements, to fund adjustments in HMO payment rates to ensure that the current payment rate discount is not decreased as a result of increase in outpatient hospital reimbursements.

2. Take no action.

D. Funding for BadgerCare

1. Authorize DHFS to transfer funding from the MA benefits appropriation to the BadgerCare appropriation in each year of the 2001-03 biennium to ensure that sufficient funding is provided for increased costs in BadgerCare as a result of increases in the reimbursement rate for outpatient hospital services.

2. Take no action.

E. DSH Funding

1. Adopt the Governor's recommendations to increase funding for DSH allocations by $4,000,000 annually ($2,350,000 FED and $1,650,000 SEG in 2001-02 and $2,340,100 FED and $1,659,900 SEG in 2002-03).

Alternative E1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$4,690,100	$3,309,900	$8,000,000
[Change to Bill	*$0*	*$0*	*$0]*

2. Reduce funding in the bill for DSH allocations by $2.0 million annually ($1,175,000 FED and $825,000 SEG in 2001-02 and $1,170,100 FED and $829,900 SEG in 2002-03).

Alternative E2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$2,345,100	$1,654,900	$4,000,000
[Change to Bill	*- $2,345,100*	*- $1,654,900*	*- $4,000,000]*

3. Delete provision.

Alternative E3	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $4,690,100*	*- $3,309,900*	*- $8,000,000]*

Prepared by: Rachel Carabell

ATTACHMENT 1

Urban Hospitals

Hospital	City	County	Current MA Reimbursement as a Percent of Cost
Hudson Medical Center	Hudson	St. Croix	27%
Milwaukee County Mental	Milwaukee	Milwaukee	38
Gunderson Lutheran	La Crosse	La Crosse	42
St. Francis	Milwaukee	Milwaukee	44
St. Francis	Milwaukee	Milwaukee	46
St. Joseph's Hospital	West Bend	Washington	48
Meriter Hospital	Madison	Dane	49
St. Mary's	Racine	Racine	49
Mercy Medical	Oshkosh	Winnebago	50
Elmbrook Memorial	Brookfield	Waukesha	51
St. Elizabeth	Appleton	Outagamie	52
Mercy Medical Center	Janesville	Rock	53
Sacred Heart Rehab	Milwaukee	Milwaukee	53
Appleton Medical Center	Appleton	Outagamie	54
Calumet Medical Center	Chilton	Calumet	54
Beloit Memorial	Beloit	Rock	55
Luther Hospital	Eau Claire	Eau Claire	56
Holy Family	New Richmond	St. Croix	56
Fort Atkinson Memorial	Fort Atkinson	Jefferson	57
St. Vincent	Green Bay	Brown	58
St. Joseph	Milwaukee	Milwaukee	58
West Allis Memorial	West Allis	Milwaukee	59
Victory Memorial	Stanley	Chippewa	60
Watertown Memorial	Watertown	Jefferson	60
Sinai Samaritan	Milwaukee	Milwaukee	62
St. Mary's	Milwaukee	Milwaukee	62
Memorial Hospital	Burlington	Racine	62
Sheboygan Memorial	Sheboygan	Sheboygan	62
Belin Memorial	Green Bay	Brown	63
Libertas	Green Bay	Brown	63
St. Mary's	Superior	Douglas	63
Waukesha Memorial	Waukesha	Waukesha	63
Lakeland Medical Center	Elkhorn	Walworth	64
Sacred Heart	Eau Claire	Eau Claire	65
Columbia	Milwaukee	Milwaukee	65
Franciscan Skemp Health	La Crosse	La Crosse	66
North Central Health Care	Wausau	Marathon	66
Children's Hospital	Milwaukee	Milwaukee	67
Bloomer Medical Center	Bloomer	Chippewa	67
Belin Psychiatric	Green Bay	Brown	68
New London Family Medical	New London	Outagamie	68
Theda Clark	Neenah	Winnebago	70
Wausau Hospital	Wausau	Marathon	71
St. Mary's	Green Bay	Brown	71

Urban Hospitals

Hospital	City	County	Current MA Reimbursement as a Percent of Cost
St. Joseph's	Chippewa Falls	Chippewa	71%
Stoughton	Stoughton	Dane	74
Kenosha Memorial	Kenosha	Kenosha	74
University of Wisconsin	Madison	Dane	74
St. Luke's Medical Center	Milwaukee	Milwaukee	75
St. Michael	Milwaukee	Milwaukee	77
Brown County Mental Health	Green Bay	Brown	77
St. Luke's	Racine	Racine	79
Hartford Memorial	Hartford	Washington	79
Northwest General	Milwaukee	Milwaukee	81
St. Mary's Ozaukee	Meqon	Ozaukee	81
Memorial Community	Edgerton	Rock	88
River Falls Area	River Falls	St. Croix	88
Mendota	Madison	Dane	88
Community Memorial	Menomonee Falls	Waukesha	88
St. Nicholas	Sheboygan	Sheboygan	88
Froedtert Memorial	Milwaukee	Milwaukee	88
St. Mary's Hospital	Madison	Dane	88
Oconomowoc Memorial	Oconomowoc	Waukesha	88
Valley View	Plymouth	Sheboygan	88
Flambeau Medical Center	Park Falls	Price	92
Vencore Hospital	Greenfield	Milwaukee	95
Aurora Medical Center	Kenosha	Kenosha	95
Baldwin Area Medical Center	Baldwin	St. Croix	95

Rural Hospitals

Hospital	City	County	Current MA Reimbursement as a Percent of Cost
Adams County Memorial	Friendship	Adams	39%
Waupun Memorial	Waupun	Dodge	47
Grant Regional Medical Center	Lancaster	Grant	48
St. Joseph's	Marshfield	Wood	49
Tomah Memorial	Tomah	Monroe	50
St. Mary's	Kewaunee	Kewaunee	52
Community Hospital	Beaver Dam	Dodge	52
Columbus Community	Columbus	Columbia	53
Boscobel Area Hospital	Boscobel	Grant	54
Memorial Hospital of Taylor County	Medford	Taylor	54
Langlade Memorial	Antigo	Langlade	56
Cumberland Memorial	Cumberland	Barron	56
St. Clare	Baraboo	Sauk	58
Reedsburg Area Medical Center	Reedsburg	Sauk	61
Southwest Health Center	Platteville	Grant	61

Rural Hospitals

Hospital	City	County	Current MA Reimbursement as a Percent of Cost
St. Michael's	Stevens Point	Portage	62%
Myrtle Werth	Menomonie	Dunn	62
Sacred Heart	Tomahawk	Lincoln	63
Memorial	Neillsville	Clark	63
Vernon Memorial	Viroqua	Vernon	64
Memorial Hospital of Lafayette Co.	Darlington	Lafayette	64
Richland	Richland Center	Richland	65
Berlin Memorial	Berlin	Green Lake	66
Riverside Medical Center	Waupaca	Waupaca	67
Good Samaritan Medical Center	Merrill	Lincoln	68
Burnett General	Grantsburg	Burnett	69
Divine Savior	Portage	Columbia	70
St. Clare	Monroe	Green Lake	70
Hayward Area	Hayward	Sawyer	71
Apple River Hospital	Amery	Polk	74
Barron Memorial	Barron	Barron	75
Memorial Hospital of Iowa County	Dodgeville	Iowa	76
Ripon Medical Center	Ripon	Fond du Lac	76
St. Agnes	Fond du Lac	Fond du Lac	76
Tri County Memorial	Whitehall	Trempealeau	76
Rusk County Memorial	Ladysmith	Rusk	79
Memorial Medical Center	Ashland	Ashland	79
Black River Fall Memorial	Black River Falls	Jackson	83
Community Memorial	Oconto Falls	Oconto	87
Aurora Medical Center	Two Rivers	Manitowoc	87
Howard Young Medical Center	Woodruff	Oneida	87
Holy Family Medical Center	Manitowoc	Manitowoc	88
Hess Memorial	Mauston	Juneau	88
Indianhead Medical Center	Shell Lake	Washburn	88
Community Memorial	Spooner	Washburn	91
Sauk Prairie Memorial	Prairie du Sac	Sauk	92
Ladd Memorial	Osceola	Polk	92
Shawano Medical Center	Shawano	Shawano	94
St. Croix Valley	St. Croix Falls	Polk	95
Bay Area Medical Center	Marinette	Marinette	96
Prairie du Chien Memorial	Prairie du Chien	Crawford	96
Riverview Hospital	Wisconsin Rapids	Wood	98
Franciscan Skemp Healthcare	Arcadia	Trempealeau	100
Chippewa Valley Hospital	Durand	Pepin	100
Eagle River Memorial	Eagle River	Vilas	100
St. Joseph's	Hillsboro	Vernon	100
Osseo Area Hospital	Osseo	Trempealeau	100
St. Mary's	Rhinelander	Oneida	100
Lakeview Medical Center	Rice Lake	Brown	100
Franciscan Skemp Healthcare	Sparta	Monroe	100
Door County Memorial	Sturgeon Bay	Door	100
Wild Rose Community Memorial	Wild Rose	Waushara	100

ATTACHMENT 2

Urban Counties*

Brown
Chippewa
Calumet
Dane
Douglas
Eau Claire
Kenosha
La Crosse
Marathon
Milwaukee
Ozaukee
Outagamie
Pierce
Racine
Rock
St. Croix
Sheboygan
Waukesha
Washington
Winnebago

Rural Counties*

Adams
Ashland
Barron
Bayfield
Buffalo
Burnett
Clark
Columbia
Crawford
Dodge
Door
Dunn
Florence
Fond du Lac
Forest
Grant
Green
Green Lake
Iowa
Iron
Jackson
Jefferson
Juneau
Kewaunee
Lafayette
Langlade
Lincoln
Manitowoc
Marinette
Marquette
Menominee
Monroe
Oconto
Oneida
Pepin
Polk
Portage
Price
Richland
Rusk
Sauk
Sawyer
Shawano
Taylor
Trempealeau
Vernon
Vilas
Walworth
Washburn
Waupaca
Waushara
Wood

* Urban counties are defined as counties located in a Metropolitan Statistical Area, as defined under Medicare. Rural counties are all other counties.

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June 4, 2001 Joint Committee on Finance Paper #474

Reimbursement Rates for Prescription Drugs (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 360, #10]

CURRENT LAW

Federal regulations require that states' medical assistance (MA) programs reimburse pharmacies at a rate equal to the lesser of the provider's usual and customary charge or the estimated acquisition cost (EAC) of the drug, plus a reasonable fee for the pharmacists' cost to dispense the drug. In Wisconsin, in addition to the reimbursement for EAC and the dispensing fee, the reimbursement to pharmacies is reduced by $0.50, based on provisions enacted in 1995 Wisconsin Act 27.

Currently, the EAC for brand name drugs is based on the average wholesale price (AWP), as reported in the First Databank Blue Book, less a 10% discount. Generic drugs are priced according to the maximum allowable cost (MAC) list. This list is initially developed by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), based on a survey of prices at which generics are available from wholesalers. DHFS modifies the list to include additional drugs based on information available to DHFS about the price of generic drugs.

The dispensing fee for most prescriptions is $4.88. Other dispensing fees are paid under limited circumstances. Because 1995 Act 27 requires that total reimbursements for drugs must be reduced by $0.50, the dispensing fee is often identified as $4.38, rather than $4.88.

Currently, on average, MA reimburses pharmacists 77% of the pharmacists' usual and customary charges, or the retail price of the drug.

GOVERNOR

Reduce MA benefits funding by $11,521,700 ($4,781,500 GPR and $6,740,200 FED) in 2001-02 and $17,650,300 ($7,324,900 GPR and $10,325,400 FED) in 2002-03 to reflect projected savings in MA benefits costs that would result by reducing the MA reimbursement rates DHFS pays to pharmacies and pharmacists for brand name prescription drugs. Under the proposal, DHFS would reimburse pharmacies and pharmacists for these drugs at a rate equal to AWP - 15%, rather than AWP-10%, plus the applicable dispensing fee. DHFS would continue to pay pharmacies and pharmacists for generic prescription drugs a rate equal to the price listed in the MAC list, plus the applicable dispensing fee.

DISCUSSION POINTS

1. It is currently estimated that MA benefit costs would decrease by $17,370,100 ($7,165,200 GPR and $10,204,900 FED) in 2001-02 and $19,507,200 ($8,095,000 GPR and $11,412,200 FED) in 2002-03 if the Governor's proposal is approved. This reestimate reflects revised estimates of MA prescription drug costs in the 2001-03 biennium under the MA base reestimate prepared by this office. Therefore, if the Committee adopts the Governor's recommendation, the funding in the bill should be reduced by an additional $5,848,400 ($2,383,700 GPR and $3,464,700) in 2001-02 and $1,856,900 ($770,100 GPR and $1,086,800 FED) in 2002-03.

2. The Governor's proposal to reduce reimbursement rates for brand name prescription drugs addresses two issues in MA drug reimbursements. First, it would reduce costs for prescription drugs to partially offset rapidly rising prescription drug costs. Second, it would reduce the disparity between the MA reimbursement rate and rates paid by other plans that provide third-party coverage of prescription drugs.

3. The following table identifies total MA drug and rebate revenue for the 1998-99 and 1999-00 fiscal years and estimated reimbursements and rebate revenue for 2000-01 through 2002-03. Additionally, the table identifies total drug expenditures as a percent of total MA expenditures.

MA Drug Expenditures ($ in Millions)
Fiscal Years 1998-99 through 2002-03

	Actual		Projected		
	1998-99	1999-00	2000-01	2001-02	2002-03
Drug Reimbursements	$259.3	$325.9	$362.6	$418.0	$469.4
Manufacturer Rebates	-49.3	-58.2	-72.0	-82.9	-92.8
Total Drug Expenditures	$210.0	$267.7	$290.6	$335.1	$376.6
Percent of Total MA Expenditures	8.1%	9.5%	9.7%	10.9%	11.8%

4. It is estimated that approximately 80% of prescription drug expenditures under MA are for the purchase of brand name drugs.

5. Reducing reimbursement rates to pharmacies is one way to reduce MA prescription drug costs. DHFS has used other ways to minimize cost increases, while ensuring MA recipients have access to appropriate medications, by targeting the use of prior authorization and implementing automatic generic substitution. Generic substitution is required unless a prescribing physician indicates in his or her own handwriting that a brand name drug is medically necessary. Both of these cost and utilization control features are discussed in more detail in LFB Paper #482.

6. Because rising prescription drug costs are beyond the control of pharmacies, reducing reimbursement rates paid to pharmacies could be viewed as an inappropriate response to rising costs. The causes for rapidly rising prescription drug costs are complex and are primarily a result of national trends in the increasing availability of newer, higher cost drug therapies. The availability of these new drugs are primarily the result of research and technological advances by pharmaceutical manufacturers.

7. Further, most of the costs of prescription drugs are not paid to cover the pharmacies' service costs, but rather the costs of the product itself. The Kaiser Family Foundation reports that $0.74 of every retail dollar paid to a pharmacy is for the manufacturer's costs. The remainder is provided for the pharmacy ($0.23) and the wholesaler ($0.03).

8. However, the Committee may find it appropriate to reduce reimbursement to pharmacies to address the disparity between what MA currently pays pharmacies for brand name drugs and what other third-party payers reimburse pharmacies.

9. A recent report by Novartis Pharmaceutical Corporation indicates that, in 1999, the health maintenance organization (HMO) industry standard reimbursement rates for prescription drugs averaged AWP-14%, with commercial and MA HMO plans paying on average AWP-14% and Medicare HMO plans paying on average AWP-15%. For all three types of HMO plans, the minimum discount was AWP-9% and the maximum discount was AWP-18%.

10. Drug Topics.com, an on-line newsmagazine for pharmacists, reported a similar reimbursement level. According to Drug Topics.com, based on a survey of 446 employers representing more than 15 million beneficiaries, the average reimbursement to community pharmacies was AWP - 13% in 1999. The average dispensing fee that year was $2.30. According to the survey, 60% of employers surveyed paid either AWP-12% or AWP-13%, but over 20% paid AWP-15% or less.

11. Two studies, one by the U.S. Department of Health and Human Services, Office of the Inspector General and another study conducted on behalf of the Kentucky Department for Medicaid Services found that pharmacies' average acquisition cost for most brand name drugs is approximately AWP-18%. Both studies found small differences between chain and independent pharmacies, but the Kentucky study found no difference in acquisition costs for urban and rural

pharmacies.

12. Based on these studies, it appears that a reimbursement rate of AWP-15% would provide an average margin of 3% of the AWP price for drugs purchased under MA, compared with approximately 8% of AWP under current reimbursement rates.

13. The margin between the acquisition cost and the reimbursement rate, together with the dispensing fee, represents the pharmacies' total reimbursement for service costs. Therefore, in reviewing reimbursement rates paid for prescription drugs, it may also be worthwhile to review the amount of the dispensing fee paid to pharmacies. The current MA dispensing fee for most drugs is $4.88. This fee is then reduced by $0.50, for a total dispensing fee of $4.38.

14. The Novartis Pharmaceutical Corporation report indicates that the average dispensing fee paid by HMOs to retail and independent pharmacies in 1999 was $1.93 for brand name drugs and $2.13 for generic drugs. Dispensing fees ranged between $0.50 and $4.09 for brand name drugs and $1.00 and $6.13 for generic drugs. The Drug Topics.com report indicates that the average dispensing fee in 1999 was $2.30. Therefore, the dispensing fee paid by Wisconsin's MA program appears to be above average, but within the range of dispensing fees paid by other third-party payers.

15. Some representatives of pharmacies have expressed concern that studies identifying a pharmacy's acquisition costs as purely the invoice cost, or wholesale cost, do not take into account a pharmacy's true acquisition costs. Distribution costs and some overhead costs are not included in acquisition costs defined in these studies.

16. Compared with other states, Wisconsin's current MA reimbursement rates appears to be equivalent to the rates paid in many other states. The attachment to this paper identifies other states' MA reimbursement rates for drugs in 1999, as identified by the National Pharmaceutical Council. In 2000, 21 states paid AWP-10% for some drugs purchased under MA. However, a number of states, including, Colorado, Connecticut, Indiana, New Jersey, North Carolina, South Carolina, Oregon, Washington and Wyoming, have recently proposed reducing pharmacy reimbursement rates. Most of these proposals are pending approval by either the Governor or the Legislature in those states.

17. Virtually all eligible pharmacies are certified to participate in MA. Of these, approximately 86% submitted claims in the current fiscal year. Some representatives of pharmacies have indicated that a reduction in the MA reimbursement rate for prescription drugs would likely result in some pharmacies choosing to discontinue participation in the MA program. However, since reducing MA rates to AWP-15% would bring the MA rates in line with most other third-party payers, it is not clear why it would be disadvantageous for pharmacies to continue to participate in MA, compared with other health care plans.

18. Further, it appears that, for most pharmacies, a reduction in the MA reimbursement rate would not affect a significant portion of the pharmacy's revenues. According to Novartis

Pharmaceutical Corporation in Wisconsin, MA reimbursements represents 8.5% of total retail revenue for pharmacies in 1999. Because MA represents a small portion of revenue for most pharmacies, it is reasonable to conclude that a reduction in the MA reimbursement rate would not significantly affect total revenue for pharmacies.

19. However, some pharmacies, particularly in larger urban areas with higher concentrations of MA recipients, could be disproportionately affected by reductions in the MA reimbursement rates, since revenue from MA would likely represent a larger portion of total revenue for these pharmacies.

20. If the Committee does not want to reduce reimbursement rates to the level proposed in the Governor's bill, the Committee could reduce the reimbursement rates to AWP-12.5% or AWP-11% identifies the change to base for each of the alternatives.

Estimated Change to MA Base Funding Under Each of the Alternatives

	2001-02			2002-03		
Alternative	GPR	FED	Total	GPR	FED	Total
1. AWP-15% (as reestimated)	-$7,165,200	-$10,204,900	-$17,370,100	-$8,095,000	-$11,412,200	-$19,507,200
2. AWP-14%	-5,732,100	-8,164,000	-13,896,100	-6,476,000	-9,129,800	-15,605,800
3. AWP-12.5%	-3,582,600	-5,102,400	-8,685,000	-4,047,500	-5,706,100	-9,753,600
4. AWP-11%	-1,433,000	-2,041,000	-3,474,000	-1,619,000	-2,282,500	-3,901,500
5. AWP-10% (current law)	0	0	0	0	0	0

ALTERNATIVES TO BASE

1. Adopt the Governor's recommendation, as reestimated, by reducing funds budgeted for MA benefits by an additional $5,848,400 ($2,383,700 GPR and $3,464,700 FED) in 2001-02 and $1,856,900 ($770,100 GPR and $1,086,800 FED) in 2002-03 to reflect a reestimate of the reduction in MA expenditures as a result of the Governor's recommendations.

Alternative 1	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	- $15,260,200	- $21,617,100	- $36,877,300
[Change to Bill	*- $3,153,800*	*- $4,551,500*	*- $7,705,300]*

2. Modify funding in the bill by reducing MA benefit appropriation by $2,374,400 ($950,600 GPR and $1,423,800 FED) in 2001-02 and increasing the MA benefits appropriation by $2,044,500 ($848,900 GPR and $1,195,600 FED) in 2002-03 to reflect the estimated reduction in MA expenditures as a result of reducing the MA reimbursement rate for brand name prescription drugs from AWP-10% to AWP-14%.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	- $12,208,100	- $17,293,800	- $29,501,900
[Change to Bill	*- $101,700*	*- $228,200*	*- $329,900]*

3. Increase funding in the bill by $2,836,700 ($1,198,900 GPR and $1,637,800 FED) in 2001-02 and $7,896,700 ($3,277,400 GPR and $4,619,300 FED) in 2002-03 to reflect a decrease in the MA reimbursement rate for brand name prescription drugs from AWP-10% to AWP - 12.5%.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	- $7,630,100	- $10,808,500	- $18,438,600
[Change to Bill	*$4,476,300*	*$6,257,100*	*$10,733,400]*

4. Increase funding in the bill by $8,047,700 ($3,348,500 GPR and $4,699,200 FED) in 2001-02 and $13,748,800 ($5,705,900 GPR and $8,042,900 FED) in 2002-03 to reflect the estimated reduction in MA expenditures as a result of reducing the MA reimbursement for brand name prescription drugs from AWP-10% to AWP-11%.

Alternative 4	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	- $3,052,000	- $4,323,500	- $7,375,500
[Change to Bill	*$9,054,400*	*$12,742,100*	*$21,796,500]*

5. Maintain current law.

Alternative 5	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*$12,106,400*	*$17,065,600*	*$29,172,000]*

Prepared by: Rachel Carabell

ATTACHMENT

MA Pharmacy Payment and Patient Cost Sharing By State
2000

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Alabama	$5.40	AWP-10%; WAC+9.2%	$0.50-$3.00
Alaska	$3.45	AWP-5%	$2.00
Arizona*	-	-	-
Arkansas	$5.51	AWP-10.5%	$0.50-$3.00
California	$4.05	AWP-5%	G: $1.00; B: $1.00
Colorado	$4.08	AWP-10% or WAC+18%; whichever is lowest	G: $0.50; B: $2.00
Connecticut	$4.10	AWP-12%	None
Delaware	$3.65	AWP-12.9%	None
District of Columbia	$3.75	AWP-10%	$1.00
Florida	$4.23	AWP-13.25%	None
Georgia	$4.63	AWP-10%	$0.50
Hawaii	$4.67	AWP-10.5%	None
Idaho	$4.94 ($5.54 for unit dose)	AWP-11%	None
Illinois	G: $3.75; B: $3.45	AWP-10%, AWP-12% for multi-source drugs	None
Indiana	$4.00	AWP-10%	$0.50-$3.00
Iowa	$4.13-$6.42	AWP-10%	$1.00
Kansas	$4.50	AWP-10%	$2.00
Kentucky	OP: $4.75; LTC: $5.75	AWP-10%	None
Louisiana	$5.77	AWP-10.5%	$0.50-$3.00
Maine	$3.35 (+extra fees for compounding)	AWP-10%	$0.50-$3.00
Maryland	$4.21	Lowest of WAC+10% direct+10%; AWP-10%	$1.00
Massachusetts	$3.00	WAC+10%	$0.50
Michigan	$3.72	AWP-13.5% (1 to 4 stores), AWP-15.1% (5+ stores)	$1.00
Minnesota	$3.65	AWP-9%	None

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Mississippi	$4.91	AWP-10%	$1.00
Missouri	$4.09	AWP-10.43%	$0.50-$2.00
Montana	$2.00-$4.20	AWP-10%	G: $1.00; B: $2.00
Nebraska	$3.20-$5.05	AWP-8.71%	$1.00
Nevada	$4.76	AWP-10%	None
New Hampshire	$2.50	AWP-12%	G: $0.50; B: $1.00
New Jersey	$3.73-$4.07	AWP-10%	None
New Mexico	$4.00	AWP-12.5%	None
New York	B: $3.50; G: $4.50	AWP-10%	G: $0.50; B: $2.00
North Carolina	$5.60	AWP-10%	$1.00
North Dakota	$4.60	AWP-10%	None
Ohio	$3.70	AWP-11%	None
Oklahoma	$4.15	AWP-10.5%	$1.00-$2.00
Oregon	$3.91-$4.28 (based on annual # of Rx)	AWP-11%	None
Pennsylvania	$4.00	AWP-10%	$1.00-$2.00
Rhode Island	OP: $3.40; LTC: $2.85	WAC+5%	None
South Carolina	$4.05	AWP-10%	$2.00
South Dakota	$4.75 ($5.55 for unit dose)	AWP-10.5%	$2.00
Tennessee*	-	-	-
Texas	$5.27 + 2% of ingredient & dispensing fee	AWP-15% or WAC+12%, whichever is lowest	None
Utah	$3.90-$4.40 (based on geographic area)	AWP-12%	$1.00-$5.00
Vermont	$4.25	AWP-11.9%	$1.00-$2.00
Virginia	$4.25	AWP-9%	$1.00
Washington	$4.06-$5.02 (based on annual # of Rx)	AWP-11%	None
West Virginia	$3.90 (+ extra fees for compounding)	AWP-12%	$0.50-$2.00
Wisconsin	$4.88	AWP-10%	$0.50-$1.00
Wyoming	$4.70	AWP-4%	$2.00

WAC = Wholesalers Acquisition Cost; AWP = Average Wholesale Price; EAC = Estimated Acquisition Cost.
G = Generic; B = Brand Name; OP = Outpatient; LTC = Long Term Care.
*Within federal and state guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.
Source: As reported by state drug program administrators in the 2000 National Pharmaceutical Council Survey.

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June 4, 2001 Joint Committee on Finance Paper #475

Eligibility for Women Diagnosed With Breast and Cervical Cancer (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 362, #14]

CURRENT LAW

Generally, to be eligible for MA, an adult must meet certain income and asset criteria and: (a) have dependent children; (b) be disabled; or (c) be 65 years of age or older.

GOVERNOR

Provide $280,600 ($82,100 GPR and $198,500 FED) in 2001-02 and $1,340,400 ($392,100 GPR and $948,300 FED) in 2002-03 to support the costs of expanding MA eligibility to certain women diagnosed with breast or cervical cancer. Specify that effective January 1, 2002, a woman would be eligible for all MA benefits and services if she: (a) is not otherwise eligible for MA or BadgerCare; (b) is under 65 years of age; (c) is not eligible for creditable health care coverage, as defined under federal law; (d) has been screened for breast or cervical cancer under a U.S. Centers for Disease Control and Prevention (CDC) national breast and cervical cancers early detection grant program; and (e) requires treatment for breast or cervical cancer.

DISCUSSION POINTS

1. As reported in Health Care State Rankings 2001: Health Care in the 50 United States [Morgan Quitno Press, 2001], the American Cancer Society estimates that 192,200 women, including 3,600 in Wisconsin, will be diagnosed with breast cancer in the U.S. in 2001. Approximately 111 out of every 100,000 women have breast cancer. The American Cancer Society also estimates that 12,900 women, including 200 in Wisconsin, will be diagnosed with cervical cancer in the U.S. in 2001. Early detection and treatment appear to be the key to increasing the

chances of survival for both types of cancer.

2. Under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354), states may provide full MA coverage to women, under age 65, who do not have access to creditable health care coverage and require treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer if diagnosed under a grant from the CDC's national breast and cervical cancer early detection program. Under this option, women may be eligible for MA regardless of their income. States that exercise this option are eligible for enhanced federal matching funds equal to the enhanced matching rate available under the state children's health insurance program, currently 71.19% for Wisconsin, compared with approximately 59% for other categories of MA.

3. The overall goal of the CDC grant program is to reduce mortality from breast and cervical cancers. The grant funds clinical breast examinations, mammograms, pelvic examinations and Papanicolaou tests. Additionally, the grant can be used to support diagnostic services, such as surgical consultation and biopsies. The U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) indicates that over the last 10 years, the CDC grant has diagnosed over 8,600 breast cancers, 39,000 pre-cancerous cervical lesions and 660 cervical cancers.

4. In Wisconsin, the CDC grant funding is used in conjunction with the Wisconsin well woman (WWW) program, administered by the DHFS Division of Public Health. This program provides funds to local public health agencies for comprehensive health screenings for women, primarily 45 to 64 years of age, who are uninsured or underinsured and who have household income less than 250% of the federal poverty level.

5. While the CDC grant funds screenings for breast and cervical cancers and pre-cancerous conditions, it does not fund treatment once such conditions are identified. Because women screened under the grant program are uninsured or underinsured, they often find it difficult to get treatment or to pay for it. P.L. 106-354 was enacted to ensure that women diagnosed with breast or cervical cancers or pre-cancerous conditions can be treated for these conditions.

6. Treatment for breast cancer may involve: (a) a lumpectomy (local removal of the tumor) and removal of the lymph nodes under the arm; (b) a mastectomy (surgical removal of the breast) and removal of the lymph nodes under the arm; (c) radiation therapy; (d) chemotherapy; or (e) hormone therapy. Often, one or more of these methods are used in combination. Under MA, breast reconstructive surgery is covered after a mastectomy, subject to prior approval.

7. The bill provides $280,600 ($82,100 GPR and $198,500 FED) in 2001-02 and $1,340,400 ($392,100 GPR and $948,300 FED) in 2002-03 in the MA benefits appropriation to support benefit costs for women eligible for MA under the expansion. Of the funding provided, $9,800 ($4,900 GPR and $4,900 FED) in 2001-02 and $46,900 ($23,500 GPR and $23,400 FED) in 2002-03 is intended to support county administrative costs associated with determining MA eligibility women diagnosed with breast or cervical cancer. This funding is budgeted in the MA

benefits appropriations and should instead be budgeted in the appropriations for MA administrative costs.

8. If the Committee adopts the Governor's recommendations to provide full MA benefits to women diagnosed with breast and cervical cancer, funding budgeted in 2002-03 should be reduced by $249,200 ($72,900 GPR and $176,300 FED) in 2002-03 to fully fund the costs of the proposal, as reestimated by this office.

9. DHFS argues that it is necessary to provide funding for county administrative costs resulting from the MA expansion. The estimate is based on an assumption that the costs associated with determining MA eligibility total $36.37 per month per case. This is the same estimate used for county administrative costs associated with Family Care.

10. Under this expansion, counties would not be required to determine eligibility based on income, therefore determining initial eligibility should be a simplified task relative to other eligibility categories. However, because MA eligibility is only available while a woman would require treatment, counties would have to monitor a woman's progress to determine when she no longer requires treatment. DHFS has not yet established the criteria for determining when a woman requires treatment.

11. The Committee could delete the funding provided for administrative costs since the number of women eligible under this provision is expected to be relatively small (50 in 2001-02 and 110 in 2002-03). Additionally, the allocation for county eligibility administration is not a caseload-driven allocation, meaning that it is not regularly revised to reflect increases and decreases in the caseload. For example, after the implementation of W-2, when MA caseloads decreased significantly, the eligibility administration allocation was not decreased to reflect lower caseloads, nor was the allocation subsequently increased when those caseloads began rising.

12. It has been practice to provide additional funding to counties for eligibility administration when MA is significantly expanded or modified through new initiatives such as Family Care and BadgerCare. When smaller expansions are implemented, it has not been the practice to add new funding, such as when MA was expanded to cover individuals with tuberculosis in the 1995-97 biennial budget. Providing funding under this expansion could set a precedent to increase the allocation for county eligibility administration with each expansion of MA eligibility criteria.

ALTERNATIVES TO BASE

1. Approve the Governor's recommendations but reduce funding in the bill by $249,200 ($72,900 GPR and $176,300 FED) in 2002-03 to reflect the estimated benefit and administrative costs of expanding MA to cover certain women diagnosed with breast and cervical cancer. Additionally, transfer administrative funding from the MA benefits appropriations to the MA administration appropriations.

Alternative 1	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$401,300	$970,500	$1,371,800
[Change to Bill	*- $72,900*	*- $176,300*	*- $249,200]*

2. Approve the Governor's recommendations, but reduce funding in the bill by $9,800 ($4,900 GPR and $4,900 FED) in 2001-02 and $287,400 ($92,000 GPR and $195,400 FED) in 2002-03 to reflect the estimated benefit costs of expanding MA to cover certain women diagnosed with breast or cervical cancer. This alternative would not provide funding for county administrative costs associated with determining eligibility for MA.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$377,300	$946,500	$1,323,800
[Change to Bill	*- $96,900*	*- $200,300*	*- $297,200]*

3. Delete provision.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $474,200*	*- $1,146,800*	*- $1,621,000]*

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