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June 4, 2001 Joint Committee on Finance Paper #476

Treatment of Irrevocable Burial Trusts under MA (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 365, #17]

CURRENT LAW

Treatment of Burial Expenses Under MA. Under current law, persons who are 65 years of age or older, blind or disabled may qualify for medical assistance (MA) if their resources and income do not exceed specified limits. In determining whether an applicant meets the resource criteria, certain types of assets are excluded. One such excluded asset is an irrevocable trust used to fund a burial agreement with a value up to $2,500. If an applicant has an irrevocable trust with a value that exceeds $2,500, only the value of the trust that exceeds $2,500 is considered a countable asset.

In addition to the $2,500 irrevocable burial trust, other burial assets are excluded from countable assets for the purpose of determining MA eligibility, including: (a) burial plots of any value for any member of the immediate family; (b) burial spaces, which include vaults, caskets, mausoleums, urns, necessary and reasonable improvements upon the burial space such as headstones, and arrangements for opening and closing the gravesite for any member of the immediate family; (c) an insurance policy purchased for the insured person's funeral expenses; and (d) burial funds for the person and his or her spouse, not to exceed the difference of $1,500 less the sum of any excludable life insurance and the amount in any irrevocable burial trust.

Although MA resource limits exclude all types of prepaid funeral expenses, current law regulating funeral directors requires that any prepayments, except for cemetery lots, graves, outer burial containers preplaced into the burial excavation of a grave, cremation urns, mausoleum spaces or grave or cemetery lot markers or monuments, must be placed into trust. As a result, an MA applicant may not be able to cover the entire funeral and burial costs by purchasing a burial plot (or space), grave marker, and an irrevocable burial trust (which is limited to $2,500). However, if an individual is willing to use burial insurance, which has no limit, an individual may dedicate as much of their assets as he or she wants to arrange for funeral and burial arrangements.

Individuals may purchase burial insurance by making a lump-sum payment or by making monthly payments. If a burial policy calls for any excess proceeds to be paid to a secondary beneficiary, it is considered to be life insurance, rather than burial insurance, for purposes of MA eligibility. Similarly, if a policy calls for the proceeds to be paid to a private party that is expected, but not legally required to use the funds for the burial costs of the insured, the policy is considered to be life insurance for the purpose of determining MA eligibility. Although it is not tied to burial costs, an individual is allowed to exclude life insurance with a cash value of up to $1,500, which could serve to pay for funeral expenses.

Current law relating to burial insurance includes a number of provisions that are intended to protect consumers. For example, burial insurance must: (a) limit prices for services to no more than the prices in the funeral establishment's general price list required under the funeral industry practices regulations of the Federal Trade Commission; (b) indicate whether the prices are guaranteed; (c) indicate what is done with any funds remaining after funeral expenses have been paid; and (d) specify what services are to be provided.

All funds for a burial trust must be deposited with a bank, trust company, savings and loan, or credit union. The bank or other entity must be furnished with a copy of the burial contract. Upon receipt of a certified copy of the certificate of death, together with the written statement from the funeral director that the burial agreement was complied with, the bank or other entity must release the trust funds to the funeral director.

Current law requires that the person selling or offering for sale the burial services be made the beneficiary of the trust. The statutes do not specify what is done if a person's funeral and burial costs are less than the amount placed in the irrevocable burial trust. A person may designate a different beneficiary at any time prior to death, after written notice to the current beneficiary. An irrevocable burial trust may have a secondary beneficiary to receive any funds not used for the funeral. Often the secondary beneficiary is the person's estate, in which case DHFS may recover excess funds through the MA estate recovery program. If the beneficiary is a family member, any remaining funds would not be part of the person's estate and could not be pursued under the MA estate recovery program.

County-Funded Burial Expenses. Under current law, if any individual who is receiving public assistance benefits dies, and the estate of that recipient is insufficient to pay the funeral, burial and cemetery expenses for that recipient, the county or tribe is required to pay up to $1,000 in cemetery expenses and up to $1,500 for the funeral and burial expenses not paid by the estate of the recipient and other persons. The state is required to reimburse the county or tribe for these expenses. Funding to pay these costs is budgeted in the Department of Workforce Development (DWD). Reimbursement for funeral, burial and cemetery expenses in excess of $1,000 may be provided if DWD approves the reimbursement due to unusual circumstances.

If the total funeral and burial expenses for the recipient exceed $3,500, no payment for the funeral and burial expenses is required. Similarly, if the total cemetery expenses exceed $3,500, the county or tribe is not required to make any payment for the cemetery expenses of the recipient.

Funeral, burial and cemetery expenses may be provided only if the deceased individual was receiving benefits: (a) under a Wisconsin Works (W-2) subsidized employment position; (b) as a custodial parent of an infant age 12 weeks or under in the W-2 program; (c) under the MA program; or (d) under the supplemental security income (SSI) program. The state does not reimburse the funeral and burial costs of persons receiving general assistance (GA), but counties that have a GA program may provide funeral and burial assistance with their own funds. Usually, counties will mirror the state's reimbursement levels. If the state changes its reimbursement levels, counties, although not required, may match those increases.

Funeral and burial expenses may include all costs associated with the preparation of the body, purchase of a casket, burial clothing, and the employment of personnel for funeral and graveside services and transportation. Cemetery expenses may include cremation, cremation permits, interment, opening and closing of the grave, burial plot, perpetual care, use of a lowering device, tent, grass matting, chairs and body storage. When required by the cemetery, expenses may include a crypt, vault or concrete slab covering the top of a wooden box and a grave marker.

GOVERNOR

Increase MA benefits funding by $501,600 ($207,800 GPR and $293,800 FED) in 2002-03 to reflect the projected costs of increasing the maximum amount of an irrevocable burial trust that may be excluded from an MA applicant's countable assets, from $2,500 to $3,300. This change would first apply to burial trust agreements entered into on January 1, 2003.

DISCUSSION POINTS

1. Increasing the MA irrevocable burial trust limit may benefit funeral homes because MA recipients may be encouraged to set aside more of their resources for their funeral and burial costs. Although Wisconsin provides funding to counties for the funeral costs of MA recipients if they do not have resources for those services, the funding is limited to $1,500 for funeral and burial expenses and to $1,000 for cemetery expenses. The $1,500 for funeral and burial expenses may not cover the full costs of the funeral, and as a result, the funeral home may not be reimbursed for all of its costs. If more MA recipients place more funds in an irrevocable burial trust or other exempt asset, there may be fewer cases where a funeral homes would receive the lower maximum reimbursement level allowed for an indigent person.

2. In April, 1999, this office surveyed a small sample of counties to obtain information on the typical expenditures made for indigent funerals. At that time, the limit for funeral expenses was $1,000. From the information received, the limit of $1,000 for cemetery expenses appeared at that time to be adequate in most cases, although not always. On the other hand, counties indicated that funeral expenses typically exceeded the $1,000 payment limit. Brown County reported that the average charge for funeral services was $2,327 in calendar year 1998. Although each county varied, it appeared that at least 80% of the burials had funeral expenses in excess of the $1,000 maximum. One county reported that every burial involved funeral expenses that exceeded $1,000.

3. The May, 2001, issue of Consumer Reports contained an article on funeral costs, and found that "throughout the country, there are plenty of standard funerals -- with viewing, ceremonies, and an attractive casket-- costing $2,500 to $4,500, excluding cemetery charges." The survey found the median prices charged by small local chains were as follows: (a) $1,110 for immediate cremation with minimum casket/container; (b) $1,384 for immediate burial with minimum casket/container; (c) $3,099 for standard funeral with alternative casket/container; and (d) $4,067 for standard funeral with 20-gauge steel casket.

4. Increasing the maximum amount of an irrevocable burial trust from $2,500 to $3,300 may allow certain elderly and disabled MA applicants to become eligible for MA at an earlier date by allowing such individuals to exclude an additional $800 of assets, rather than requiring those assets to be used for the cost of their care. It is difficult to precisely estimate the fiscal impact of this change, since there is incomplete information on the use of burial trusts. In addition, since there is no limit on the amount of irrevocable burial insurance, it is not known whether increased use of irrevocable burial trusts would in part or in whole be offset by decreases in the use of burial insurance or the amount of funds used to pre-purchase a burial plot or grave marker.

5. A review of MA applications filed in February 1997, indicated that 16% of MA applicants (approximately 600) in that month reported having burial trusts, with an average value of $1,500. Since the average value of the burial assets was $1,500, the sample suggests that fewer than 300 applicants monthly would utilize any expansion in the limit for irrevocable burial trusts. In addition, any increased use of an irrevocable burial trust may be offset by a decrease in the use of burial insurance or other exempt assets. For some individuals, burial insurance, which has no limit, may be preferred. If it is assumed that 200 applicants per month had sufficient assets to utilize the $800 expansion in an irrevocable burial trust and that there were no offsetting changes in burial insurance or other exempt assets, MA costs would increase by approximately $960,000 ($398,400 GPR and $561,600 FED) annually. On the other hand, if only 60 applicants per month would benefit from the expansion, MA costs would increase by $288,000 ($119,500 GPR and $168,500 FED annually). The funding that would be provided in the bill ($501,600 all funds) is close to the midpoint of this range.

6. A possible secondary effect of increasing the limit for an irrevocable burial trust is that state costs for indigent funeral and burial costs would be reduced in the future, since the MA recipient would have additional funds in the irrevocable burial trust to support their own funeral and burial costs. Based on inquiries with counties, it appears that MA nursing home recipients often may have some of their assets directed to a burial trust or other burial items. Nursing homes and county workers typically advise MA applicants seeking MA coverage of nursing home services that it may be to their benefit to provide for burial expenses, since otherwise, their MA eligibility would be delayed until their assets have been depleted to MA eligibility levels. MA nursing home recipients make up a significant percentage of individuals receiving public assistance for burial costs. There are approximately 32,000 nursing home residents whose services are funded under MA. Based on a limited survey of counties, it appears that a significant proportion of recipients of public funds for burial costs have some burial funds or other assets to contribute to the cost of the

burial. Although it is a limited sample, perhaps 30% to 40% of recipients of public burial assistance have some burial funds or other resources to contribute to their burial expenses.

7. If the expansion of the limit for the irrevocable burial trust causes a net increase in MA expenditures, MA recipients would have a higher level of exempt resources to support their burial costs. The increase in burial resources, however, may not be fully recovered in lower burial assistance since: (a) some MA recipients may be trying to bypass divestment restrictions by putting more into burial funds than needed in the hope that excess funds are left to family members; (b) more is placed in the burial trust than is needed for burial expenses; and (c) the higher amount of burial resources may result in higher burial expenses (funeral and cemetery expenses could not each exceed $3,500 and remain eligible, though, for public assistance). In addition, any reduced public assistance funeral costs would not occur immediately, but at a later time. It might be expected that any savings would not occur for two to three years. In nursing homes, approximately 32% of discharges in a year are due to death.

8. In summary, the projected increase in MA costs would likely be partially offset by savings for state expenses for public burials. However, the savings would not be realized in the current biennium, and the savings would likely be less than the increase in MA costs. It is not known what portion of the increase in MA costs would be offset by funeral savings, but it may be reasonable to assume that the offsetting savings would range of 20% to 40%.

9. Although there are a number of exempt assets that may be used to fund funeral and burial expenses, increasing the limit for an irrevocable burial trust may provide potential MA recipients more flexibility in providing for their funeral and burial expenses. Since the average cost of standard funerals -- with viewing, ceremonies, and casket-- costs from $2,500 to $4,500 excluding cemetery charges, a limit higher than $2,500 may reasonable.

10. The estimated cost of increasing the limit from $2,500 to $3,300 on January, 2003 is $501,600 all funds. If the limit were to be increased further to $4,000 on January, 2003, the estimated additional cost would be $294,100 all funds ($122,000 GPR and $172,000 FED). These amounts represent the cost for six months. If these limits were in effect for the whole year, the annual cost would be twice these amounts.

11. The disadvantage of increasing the limit is that it increases the range of exempt assets, and would allow a number of persons to become eligible for MA sooner, and would increase MA expenditures. Given that there are a number of exempt assets, including all irrevocable burial insurance, irrevocable burial trusts up to $2,500, burial space and marker of any value, life insurance with a cash value of $1,500, and any assets up to $2,000, it could be argued that there are enough options for an individual to provide for their funeral costs, and that the current limit of $2,500 is sufficient.

ALTERNATIVES TO BASE

1. Approve the Governor's recommendation.

Alternative 1	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$207,800	$293,800	$501,600
[Change to Bill	*$0*	*$0*	*$0]*

2. Increase the irrevocable burial trust limit to $3,000 on January 1, 2003. Reduce MA benefits funding in the bill by $188,100 ($77,700 GPR and $110,400 FED) in 2003-03.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$130,100	$183,400	$313,500
[Change to Bill	*- $77,700*	*- $110,400*	*- $188,100]*

3. Increase the irrevocable burial trust limit to $3,500 on January 1, 2003. Increase MA benefits funding by $106,600 ($44,200 GPR and $62,400 FED) to reflect the projected costs of increasing the limit.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$252,000	$356,200	$608,200
[Change to Bill	*$44,200*	*$62,400*	*$106,600]*

4. Increase the irrevocable burial trust limit to $4,000 on January 1, 2003. Increase MA benefits funding by $294,100 ($122,000 GPR and $172,000 FED) in 2002-03 to reflect the projected costs of increasing the limit.

Alternative 4	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$329,800	$465,900	$795,700
[Change to Bill	*$122,000*	*$172,100*	*$294,100]*

5. Delete provision.

Alternative 5	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $207,800*	*- $293,800*	*- $501,600]*

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June 4, 2001 Joint Committee on Finance Paper #477

Reimbursement for Hearing Aid Services (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 366, #19]

CURRENT LAW

Under the state's medical assistance (MA) program, the Department of Health and Family Services (DHFS) pays hearing aid providers the lesser of the maximum reimbursement rate established by DHFS or the provider's net cash outlay cost. The net cash outlay cost is defined as the actual cost to the provider to purchase the hearing aid package, or the wholesale cost. However, the net cash outlay cost does not include any mailing or handling charges. The current maximum reimbursement rate for hearing aids is $246 for one ear and $492 or two ears. Additionally, DHFS pays a dispensing fee to providers for the cost of dispensing the hearing aid. The current dispensing fee is the lesser of the provider's usual and customary charges or $211 for one ear or $316 for two ears. Additionally, MA covers hearing aid batteries and the cost of repairing hearing aids.

In 1999-00, MA expenditures for hearing aids and supplies totaled $627,700. In calendar year 2000, 2,631 hearings aids were purchased under MA.

GOVERNOR

Provide $250,100 ($146,500 FED and $103,600 SEG) in 2002-03 to fund a 15% increase in the maximum reimbursement rate for hearing aid packages and repair services, effective July 1, 2002. The segregated funding provided for this increase would be available from the MA trust fund that would be created in the bill.

DISCUSSION POINTS

1. The Governor's budget bill would provide funding to support a 15% increase in the reimbursement rates paid for hearing aids and related services, including the dispensing fees, repair costs and supplies, beginning in 2002-03. The Governor recommends the increase to respond to difficulties MA recipients have finding suppliers willing to accept MA reimbursement for the purchase or repair of hearing aids. It is currently estimated that the cost to provide a 15% rate increase for hearing aid related services totals $362,600 ($212,100 FED and $150,500 SEG) in 2002-03. Therefore, if the Committee adopts the Governor's recommendations, the funding in the bill should be increased by $112,500 ($65,600 FED and $46,900 SEG) in 2002-03 to fully fund the projected cost of the Governor's proposal.

2. A review of wholesale catalogs for hearing aids and supplies suggests that the current maximum MA reimbursement rate for hearing aids ($246 for one ear and $492 for both ears) is inadequate to cover the wholesale costs of most hearing aids. Of the over 100 hearing aid prices reviewed, approximately 16% were available for less than $300 for one ear in 1999. Many low-technology hearing aids appear to be available in the $300-$400 range, while the cost of hearing aids with more modern technology, including programmable and digital aids, range from $500 to $1,500.

3. As a result of low MA reimbursement rates, MA recipients that require hearing aids find it difficult to find providers willing to accept MA reimbursement for hearing aids. Since 1997, the number of hearing aids dispensed under MA has decreased by approximately 10%, from 2,619 in 1997 to 2,361 in 2001. This decrease has come at the same time that the number of MA recipients most likely to require hearing aids, (MA recipients over the age of 65) has remained relatively stable. Additionally, since MA reimbursement rates only allow for the purchase of hearing aids with the oldest technology, MA recipients find it difficult to find suppliers able to repair older technology hearing aids.

4. A comparison of Wisconsin's reimbursement rates for hearing aids compared with surrounding states indicates that Wisconsin's MA reimbursement rates for hearings aids are low. Illinois reimburses providers up to $400 for aids for one ear and $800 for aids for both ears. Iowa reimburses providers for the invoice cost of the hearing aids. Minnesota has no maximum reimbursement rates, but instead purchases hearings aids at volume discounts and permits providers to select hearing aids among the hearing aids available from the state.

5. With the Governor's recommendations, the reimbursement rate for hearing aids would increase from $246 for one ear to $283 and from $492 for both ears to $566. These reimbursement rates would still be lower than surrounding states and most hearing aids would continue to be unavailable for MA recipients.

6. The Committee could increase the reimbursement rate for hearing aid instruments beyond the increase recommended by the Governor. The following table identifies rates that would be paid for hearing aids for one ear and both ears if rates were increased by 15%, 30%, 50% or 100%.

Comparison of Reimbursements Rates for Hearing Aids Under Proposed Alternatives

Proposed Increase	Current	15%	30%	50%	100%
Reimbursement Rate					
One Ear	$246	$283	$320	$369	$492
Both Ears	492	566	640	738	984

7. 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

1. Adopt the Governor's recommendations to provide a 15% increase in the reimbursement rates for hearing aids and related services, as reestimated, by increasing funding in the bill by $112,500 ($65,600 FED and $46,900 SEG) in 2002-03.

Alternative 1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$212,100	$150,500	$362,600
[Change to Bill	*$65,600*	*$46,900*	*$112,500]*

2. Provide funds for a 30% increase in the reimbursement rates for hearing aids and a 15% increase in reimbursement rates for hearing aid-related services, by increasing funding in the bill by $308,500 ($180,300 FED and $128,200 SEG) in 2002-03.

Alternative 2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$326,800	$231,800	$558,600
[Change to Bill	*$180,300*	*$128,200*	*$308,500]*

3. Provide funds for a 50% increase in the reimbursement rates for hearing aids and a 15% increase in reimbursement rates for hearing aid-related services, by increasing funding in the bill by $557,700 ($326,100 FED and $231,600 SEG) in 2002-03.

Alternative 3	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$472,600	$335,200	$807,800
[Change to Bill	*$326,100*	*$231,600*	*$557,700]*

4. Provide funds for a 100% increase in the reimbursement rates for hearing aids and a 15% increase in reimbursement rates for hearing aid-related services, by increasing funding in the bill by $1,086,700 ($635,600 FED and $451,100 SEG) in 2002-03.

Alternative 4	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$782,100	$554,700	$1,336,800
[Change to Bill	*$635,600*	*$451,100*	*$1,086,700]*

5. Delete provision.

Alternative 5	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $146,500*	*- $103,600*	*- $250,100]*

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June 4, 2001 Joint Committee on Finance Paper #478

Provider Fraud and Abuse (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 366, #20]

CURRENT LAW

Provider Certification and Recovery of Payments. Under current law, the Department of Health and Family Services (DHFS) is responsible for establishing the criteria for certification of medical assistance (MA) providers, certifying those providers and reimbursing those providers for services they provide to MA recipients in accordance with criteria established in state and federal law, federal regulations and administrative rules. The criteria for reimbursement of services are described in handbooks available to MA-certified providers.

DHFS is required to recover money improperly or erroneously paid to a provider, after providing reasonable notice to the provider and the opportunity for a hearing. DHFS can recover improper and erroneous payments by offsetting or adjusting amounts owed to the provider, crediting the amount against a provider's future claims for reimbursement or by requiring the provider to make direct payment to DHFS or its fiscal agent.

DHFS is required to decertify or suspend a provider's certification under MA, if after giving reasonable notice to the provider and an opportunity for a hearing, DHFS finds that the provider has violated federal or state law or administrative rule and such violations are by law, regulation or rule, grounds for decertification or suspension. No payment may be made to a provider subsequent to its decertification or during a period of suspension.

Authority to Audit or Investigate and Issue Subpoenas. Currently, DHFS may appoint personnel to audit or investigate and report to DHFS on any matter involving violations or complaints alleging violations of statutes, regulations or rules applicable to MA and to investigate or audit providers to verify that the services or items were actually provided and the appropriateness and accuracy of claims submitted for reimbursement by providers. Employees appointed by the DHFS Secretary to conduct such investigations and audits have access to any provider's records, books, documents or other needed information. These employees may also

hold hearings, administer oaths, take testimony and perform all other necessary duties to bring such matters before DHFS for final adjudication and determination.

The DHFS Secretary may issue subpoenas for the production of any pertinent books, records or other information. A person refusing to obey any such subpoena may be jailed by order of a judge in a court of record in the county where the individual is served. Failure to obey the subpoena constitutes grounds for decertification or suspension of certification under MA.

MA Offenses. Persons convicted of committing fraud against MA or soliciting, offering, accepting or paying remuneration, including kickbacks, bribes or rebates, in connection with MA payments are subject to fines of more not than $25,000 and no more than seven years and six months in prison. Individuals convicted of helping others to commit fraud against MA are subject to fines of not more than $10,000 and no more than one year in jail. The Department of Justice (DOJ) operates a Medicaid fraud control unit (MFCU) that investigates cases alleging fraud in MA.

Transfer of Business, Liability for Repayment. If a provider is liable for repayment of improper or erroneous payments or overpayments under MA and that provider transfers all or substantially all of the assets of the business, both the transferor and the transferee of the assets are liable for the repayment. Prior to final sale, the transferee is responsible for contacting DHFS and ascertaining whether the transferor is liable for repayments under MA. These provisions supersede other statutory provisions regarding business corporations, nonstock corporations and cooperatives.

If a sale or transfer occurs and the applicable amount of any recovery is not paid in full, DHFS may proceed against either the transferor or the transferee. Within 30 days after receiving notice from DHFS, the transferor or the transferee must pay the amount in full. Upon failure to comply, DHFS may bring an action to compel payment. If the transferor fails to pay within 90 days after receiving notice from DHFS, DHFS may decertify or suspend that provider's certification.

Certification of Overpayments to DOR. At least annually, DHFS must certify to DOR the amount that DHFS may recover for incorrect payments for benefits paid under MA if the incorrect payment results from any misstatement or omission of a fact by a person applying for MA. This right of recovery is against the MA recipient and is limited to the amount of the benefits incorrectly paid. DHFS may only certify to DOR such amounts if it has provided sufficient notification to the MA recipient's last known address at least 30 days prior to when it certifies to DOR the amount to be recovered. Additionally, DHFS may only certify to DOR any amounts that have not been appealed or are no longer under appeal. Such certification to DOR allows the amount of any recovery against a person to be set off from any state tax refund that may be due that person.

DHFS Audit Operations. In 1999-00, DHFS recovered approximately $14.2 million (all funds) as a result of its provider auditing activities. DHFS has 45.0 positions in its Bureau of Health Care Program Integrity including nine financial auditors and seven nurse consultants that

conduct medical audit and review activities. These positions conduct between 15 and 20 on-site audits per month. DHFS uses a variety of information sources to determine which providers to audit, including external data provided by federal authorities, complaints and referrals from MA recipients and other providers. Additionally, DHFS uses internal resources to identify potential problem areas, including unusual claims activity and past performance of a provider. DHFS also randomly selects providers to be audited.

DHFS audits include pre-onsite, onsite and post-onsite activities.

Pre-onsite activities include the selection of the providers to be audited, development of an audit plan, preparation of data and sending an audit announcement letter to the provider two weeks in advance of the audit.

Onsite activities include an entrance conference, in which DHFS audit staff explain to the provider the steps involved in the audit, identify the types of documentation needed and the anticipated length of the audit. After completing the audit activities, an exit conference is held, in which DHFS audit staff discuss with the provider their preliminary findings and the timeline for the next steps.

The post-onsite activity includes providing a letter identifying the audit's preliminary findings and the amount DHFS intends to recover, if any. Forty-five days following the preliminary findings letter, if DHFS intends to seek recovery of payments, DHFS provides a letter indicating that it intends to recover any amounts identified in the audit and notifies the provider of the provider's right to a hearing.

If the audit uncovers any activities that suggest the provider is committing or has committed fraud, DHFS notifies the DOJ MFCU of its findings. If the audit uncovers any activities that suggest that professional standards are being violated, DHFS notifies the Department of Regulation and Licensing of its findings.

GOVERNOR

Decrease the MA benefits appropriation by $207,500 ($86,600 GPR and $120,900 FED) in 2002-03 to reflect projected MA benefits savings that would result by enacting the following statutory modifications, which are intended to reduce fraud and abuse by MA providers.

Limit on the Number of Certified MA Providers. Authorize DHFS to limit the number of providers of particular MA services that may be certified, or limit the amount of resources, including employees and equipment, that a certified provider may use to provide particular services to MA recipients, if DHFS finds that: (a) existing certified providers and resources provide services that are adequate in quality and amount to meet the need of MA recipients for the particular services; and (b) the potential for MA fraud and abuse exists if additional providers are certified or additional resources are used by certified providers.

Recoveries and Opportunity for a Hearing. Delete the requirement that DHFS provide an

opportunity for a hearing before recovering money improperly or erroneously paid to an MA provider. Instead, require DHFS to provide an opportunity for the provider to present information and argument to DHFS staff, before DHFS could recover money improperly or erroneously paid. Require DHFS to establish a deadline for payment of a recovery and require providers to pay interest on any delinquent recoveries at the rate of 1% per month or fraction of a month from the date of the overpayment.

Fees for Repeat Offenders. Authorize DHFS, after providing reasonable notice and an opportunity for a hearing, to charge a fee to a provider that repeatedly has been subject to recoveries because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar program requirements. The fee could not exceed $1,000 or 200% of the amount of any repeated recoveries, whichever is greater. The revenue from these fees would be used to partially support the costs of conducting provider audits and investigations.

Require a provider subjected to such a fee to pay it to DHFS within 10 days after receipt of the fee notice or the final decision after an administrative hearing, whichever is later. Authorize DHFS to recover any part of a fee not paid within the 10 days by reducing any payments owed to the provider for services provided. Further, authorize DHFS to refer any such unpaid fees not recovered to the Attorney General for collection. Specify that failure to pay such a fee is grounds for decertification as an MA provider. Specify that payment of the fee does not relieve the provider of any other legal liability for recovery, but payment of the fee is not evidence of violation of a statute or rule.

Revenue received from the payment of fees charged to repeat offenders under this provision would be credited to a new PR appropriation. The ability to charge providers a fee for repeated recoveries would first apply to repeated recoveries from the identical provider that are made on the bill's general effective date.

Restriction on Provider's Participation. Require DHFS to restrict a provider's participation in MA, rather than suspend a provider's certification, if after giving reasonable notice and opportunity for a hearing, DHFS finds that the provider has violated a federal statute or regulation or a state statute or rule and the violation is by statute, regulation or rule grounds for decertification or restriction. Require DHFS to suspend the provider pending a hearing if DHFS includes in its decertification notice findings that the provider's continued participation in MA pending the hearing is likely to lead to irretrievable loss of public funds and is unnecessary to provide adequate access to services to MA recipients. Require DHFS to issue a written decision as soon as practicable after the hearing. These provisions would first apply to violations of federal and state statutes, regulations and rules committed on the bill's general effect date.

Require Surety Bond as a Condition of Certification. Authorize DHFS to require, as a condition of certification, all providers of a specific service, to file with DHFS, a surety bond issued by a surety company licensed to do business in Wisconsin. Providers subject to this provision would be those that provide MA services for which providers have demonstrated significant potential to violate specified MA offenses, to require recovery or to need additional sanctions. Require that the surety bond be payable to DHFS in an amount that DHFS determines is reasonable

in view of amounts of former recoveries against providers of the specific services and DHFS' costs to pursue those recoveries.

Require DHFS to promulgate rules to specify: (a) those MA services for which providers have demonstrated significant potential to violate specified MA offenses; (b) the amount of the surety bonds; and (c) the terms of the surety bond, including amounts, if any, without interest to be refunded to the provider upon withdrawal or decertification from the MA program.

Certification of Overpayments to DOR. Modify the provision that requires DHFS to certify to DOR, at least annually, any amounts that are subject to recovery to include recoveries owed by an MA provider so that the amount of the recovery can be setoff from any state tax refund that may be due to the provider.

Transfer of Business Operations. Require DHFS to require a person who takes over the operation of a provider, to first obtain certification for the provider's operation, regardless of whether the person is currently certified. Authorize DHFS to withhold the certification until any outstanding recoveries are paid. Specify that before a person takes over the operation of an MA provider that is liable for repayment of improper or erroneous payments or overpayments, full recovery of the improper or erroneous payment or overpayment must be made. Upon request, DHFS must notify the provider or the person that intends to take over the operation of the provider as to whether the provider is liable for a recovery.

If a person takes over the operation of a provider and any applicable recoveries have not been made, in addition to withholding certification as a provider, DHFS may proceed against the person taking over the provider's operation. The person taking over the provider's operation must pay any applicable recovery in full within 30 days after the person receives notification from DHFS about any recovery. If full payment is not received within 30 days, DHFS may bring action to compel payment or decertify the person or restrict his or her participation in the MA program, or DHFS may do both.

Specify that whenever ownership of a nursing home or community-based facility is transferred to another person or persons, both the transferee and the transferor must comply with the above provisions, if the transferor was an MA provider. Under current law, only the transferee is responsible for complying with the provisions regarding recovery of payments before the transfer of a facility's ownership.

To take over the operation of a provider would mean to obtain any of the following: (a) ownership of the provider's business or all or substantially all of the assets of the business; (b) majority control over decisions; (c) the right to any profits or income; (d) the right to contact and offer services to patients, clients, or residents served by the provider; (e) an agreement that the provider will not compete with the person at all or with respect to a patient, client, resident, service, geographical area, or other part of the provider's business; (f) the right to perform services that are substantially similar to services performed by the provider at the same location as those performed by the provider; or (g) the right to use any distinctive name or symbol by which the provider is known in connection with services to be provided by the person.

These provisions would first apply to sales or other transfers completed on the bill's general effective date.

DHFS Access to Provider Personnel and Records. Specify that, upon request by DHFS audit staff, a provider must provide access to any provider personnel as needed. Specify that under the written request of the audit staff and upon presentation of such authority, providers and recipients must provide the audit staff access to any needed patient health care records of a recipient.

Specify that failure or refusal of a provider to accord DHFS auditors or investigators access to any provider personnel, records, books, MA patient health care records, or other requested documents or records constitutes grounds for decertification or suspension of the provider from participation in MA. Specify that no payment may be made for services rendered by the provider following decertification, during the period of suspension, or during any period of provider's failure or refusal to accord such access.

DHFS Authority to Subpoena Providers. Repeal the DHFS Secretary's authority to issue subpoenas to individuals who are required to provide specified information for the purposes of an audit, investigation, examination, analysis, review or other authorized functions relating to the program and provisions relating to the issuance and enforcement of such subpoenas.

DISCUSSION POINTS

1. The Governor's recommendations are intended to strengthen the Department's authority to recover overpayments or payments made in error that are identified as part of provider audits. DHFS indicates that the current statutes limit its ability to recover improper or overpayments, from providers of certain services that are not typically covered under other health care plans, such as Medicare or private insurance. Such services include specialized medical vehicle transportation, independent nursing and personal care services.

2. The bill reduces the MA benefits appropriations by $207,500 ($86,600 GPR and $120,900 FED) in 2002-03 to reflect the administration's estimate of the immediate savings that would be realized if the Governor's recommendations were enacted. However, enacting these provisions would likely generate long-term savings to MA by enabling DHFS to more effectively deal with those providers that repeatedly abuse the MA program by not following proper billing procedures and program requirements.

Additionally, DHFS indicates that these provisions would enable DHFS audit staff to more effectively focus their activities on identifying new instances of fraud and abuse, by reducing the amount of time the audit staff spend on known problem providers. This could be accomplished by strengthening DHFS' ability to act against these providers and increasing incentives for providers to comply with existing billing procedures and program requirements.

3. Some provider groups have expressed concern that the provisions in the bill could be abused by DHFS if interpreted broadly and could unfairly treat providers participating in MA. However, two points should be made in response to this concern. First, MA is a program that

provides health care services to low-income families, the elderly and the disabled. As such, the program is not intended to guarantee providers a source of revenue to support their operations. Moreover, providers voluntarily participate in the program. Second, as the administrator of MA, DHFS would have an interest in using the authority provided in the bill in a judicious manner. If DHFS abuses this authority to the extent that providers no longer participate in the program, this could reduce MA recipients' ability to access services.

4. In February, 1999, the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) published its Comprehensive Plan for Program Integrity. In this document, HCFA indicates that promoting the integrity of Medicare and MA is a top priority and that promoting provider integrity is essential to ensure that beneficiaries obtain quality medical care cost effectively. HCFA indicates that previously, many providers have regarded participation in Medicare (and MA) as an entitlement, particularly because providers could obtain provider status and billing numbers without having to meet any standards to ensure that they are financially sound, accountable business partners. Once providers are billing Medicare (and MA), it has been difficult to find and penalize providers that are bad business partners or otherwise raise program integrity questions.

5. Applying these provisions to all provider groups would ensure that each group is treated equally. Additionally, while certain provider groups may currently be the target of DHFS audit efforts, applying the provisions to all provider groups assures that DHFS would be able to use these provisions with provider groups that become problematic in the future.

Limit on the Number of MA Providers and Resources

6. The bill would authorize DHFS to limit the number of providers of particular MA service that may be certified, or limit the amount of resources, including employees and equipment, which a certified provider may use to provide particular services, DHFS argues that restricting the number of certified providers or resources available to provide services would limit the ability of more providers to enter an already saturated market and encourage improper billings for services.

This argument was articulated in a March, 1994, Legislative Audit Bureau report on specialized medical vehicle transportation services. In its report, the Audit Bureau indicated that, according to health care researchers and financing experts, new providers entering a medical services market encourage increased service utilization and therefore increase program expenditures. New providers increase the availability of a service and, in seeking new clients, encourage those who might otherwise have continued to do without a service to use it. Therefore, the Audit Bureau's report noted, both new and established providers facing increased market competition have incentives to recruit new clients who might not otherwise use specialized medical transportation services funded under MA.

7. Representatives of some providers have expressed concern that this provision is too vague and it is unclear how DHFS would use this authority. However, the bill specifies that DHFS could only restrict the number of providers or resources if it found that existing certified providers and resources are adequate in quality and amount to meet the need of MA recipients and that the

potential for fraud and abuse exists if additional providers are certified or additional resources are used by certified providers.

8. If the Committee wanted to ensure that there was legislative review of the criteria DHFS would use in exercising this authority, the Committee could modify the bill to require DHFS to promulgate administrative rules specifying how DHFS would determine which providers and resources would be subject to such limitations.

9. Under the bill, it is possible that DHFS could determine that there are currently too many providers in an area that are certified to provide a type of MA service. However, these providers may depend on the continuation of MA payments to support their businesses. If the Committee determines that the Department's authority to limit the number of certified MA providers should not apply to current MA providers that first seek certification as MA providers on the bill's general effective date. Under this alternative, DHFS would be prohibited from discontinuing the certification of current MA providers, based on the criteria specified in the bill.

Opportunity for a Hearing

10. Currently, once DHFS notifies a provider of its intent to recover improper or erroneously paid claims, a provider has an opportunity for a hearing before DHFS can proceed with the recovery. Such hearings are held before an administrative law judge employed by the Department of Administration's Division of Hearings and Appeals. Such a hearing provides the opportunity for the provider to argue against the recovery before an impartial judge and to depose DHFS staff under oath. DHFS indicates that in calendar year 2000, of the 900 audits conducted by DHFS, providers in 45 of those cases used the opportunity for a hearing to plead their case to an administrative law judge.

11. Providers argue that the provision in the bill to eliminate the opportunity for a DOA hearing and to instead have providers argue to DHFS staff is not sufficient to maintain the providers' rights to argue fairly against a recovery. First, providers argue that DHFS is less likely to decide against itself than an impartial judge. Second, providers argue that without being able to depose DHFS staff, they are unable to ascertain all of the standards that were used during an audit.

Third, providers argue that, while providers always retain the ability to proceed against DHFS through the circuit courts, this process is costly for the provider. Additionally, the record a court would use to determine if a recovery was proper is based on the records established during the hearing. If the record is not properly established based on a meeting with DHFS because of the provider's inability to obtain certain information, then the court's ability to thoroughly review a decision is limited.

12. DHFS staff indicate that the primary purpose for including this provision in the bill is based on DHFS staff efficiency. When a provider exercises the right to a hearing before a recovery, the hearing is scheduled based on the convenience of the administrative law judge and DHFS staff must appear at the hearing at a time specified by a judge. These hearings often interrupt audits currently underway and therefore delay the completion of audits of other providers. By

eliminating the DOA hearing requirement, DHFS can schedule meetings with the provider and their representatives in between audits and at the convenience of DHFS staff.

13. The Committee could delete the provision from the bill that eliminates a provider's right to a hearing before DHFS could proceed with a recovery if it determines that the convenience of DHFS staff time is not a sufficient reason to deny providers the right to argue their case before an administrative law judge and the right to depose DHFS staff. Such rights assure that providers are able to argue their case fairly so that funds are not recovered improperly.

Fee for Repeat Offenders

14. DHFS staff indicate that the purpose of the provision to charge a fee to repeat offenders is to sanction providers that repeatedly violate MA reimbursement policies, regardless of the number of times that provider has been audited and subject to recoveries. These providers, DHFS argues, have no incentive to follow the MA reimbursement policies under current law, because the provider only risks recovery of an amount equal to the original payment. This limits the audit staff's ability to pursue other service areas and providers that require attention from DHFS auditors.

15. The bill does not specify how many times a provider would have to violate the same program or billing procedures to be subject to such a fee. Providers argue that violating billing procedures two or three times should not be sufficient to warrant payment of the fee provided in the bill. However, under the bill, the fee only applies to recoveries. Recoveries only occur as a result of audit findings, after the payment has already been made. Therefore, the fee would not apply in cases where the MA fiscal agent denied a claim up front because the claim did not meet the criteria for billing purposes.

16. DHFS indicates that if it audits a provider and finds that a provider is not properly billing or documenting their costs, that provider should come into compliance with billing requirements. Subsequent to an audit, providers are educated about what steps to take to ensure that future claims are properly provided, documented and billed.

Therefore, DHFS argues, if a provider is subsequently audited and has not changed its billing or documentation practices according to the findings of the first audit, it would be appropriate to subject that provider to the fee because the provider had failed to modify its procedures based on the first audit. This fee would not be applicable if the second audit finds other problems with the provider's billing procedures that were not uncovered in the first audit.

17. If the Committee determines that a provider that violates the same billing and program requirements after being audited should not be subject to a fee for those violations, it could delete this provision from the bill.

ALTERNATIVES TO BASE

1. Approve all of the Governor's recommended statutory changes and reduce MA benefits funding by $86,600 GPR and $120,900 FED in 2002-03 to reflect projected savings in MA benefit costs that would be realized with these changes.

Alternative 1	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	- $86,600	- $120,900	- $207,500
[Change to Bill	*$0*	*$0*	*$0]*

2. Modify the Governor's recommendations by selecting one alternative from each section.

A. Restrictions on the Number of Certified Providers and Resources

1. Adopt the Governor's recommendation to authorize DHFS to restrict the number of certified providers or resources used to provide particular services to MA recipients if DHFS makes specified findings.

2. Require DHFS to submit proposed administrative rules to the Legislative Council staff by the first day of the six month following enactment of the bill that specifies the criteria DHFS would use to restrict the number of certified providers and resources under the authority provided in the bill.

3. Specify that this provision would first apply to a provider that seeks certification as an MA provider on the bill's general effective date.

4. Adopt both 2 and 3.

5. Maintain current law.

B. Opportunity for a Hearing

1. Adopt the Governor's recommendation to eliminate a provider's opportunity for a hearing before DHFS could proceed with a recovery and instead specify that a provider could present information and argument to DHFS staff before DHFS could proceed with a recovery.

2. Maintain current law.

C. Fees for Repeat Offenders

1. Adopt the Governor's recommendation to authorize DHFS to charge a fee to a provider that repeatedly has been subject to recoveries because of the provider's failure to follow identical or similar billing procedures or program requirements.

2. Maintain current law.

3. Delete provision.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*$86,600*	*$120,900*	*$207,500]*

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June 4, 2001 Joint Committee on Finance Paper #479

Provider Certification Staff (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 369, #21]

CURRENT LAW

Under current law, DHFS is responsible for establishing the criteria for certification of medical assistance (MA) providers, certifying those providers and reimbursing those providers for services provided to MA recipients in accordance with criteria established in state and federal law, federal regulations and administrative rules.

The Bureau of Health Care Program Integrity (BHCPI) currently assigns 1.0 certification specialist to oversee provider certification policies and criteria. This position is responsible for developing policies and criteria for certification of providers, reviewing decisions on controversial or questionable applications submitted by providers seeking certification and coordinating with the Department of Regulation and Licensing (DRL) regarding standards for professional licensing standards and the status of a provider's professional license. The state's MA-fiscal agent, Electronic Data Systems, Inc., is responsible for processing paperwork submitted by providers seeking certification as an MA provider.

GOVERNOR

Provide $144,600 ($72,300 GPR and $72,300 FED) in 2002-03 and 2.0 positions (1.0 GPR position and 1.0 FED position), beginning in 2002-03, to address increased provider certification workload. The bill would provide 2.0 auditors for BHCPI to review applications for MA certification and recertification, conduct on-site reviews, verify information provided in the application and determine an applicant's ability to provide services to MA participants.

DISCUSSION POINTS

1. The requirements for certification of providers are identified in administrative rules. For most medical professionals, such as physicians, dentists, podiatrists, chiropractors, physical therapists and optometrists, holding a current license to practice is sufficient to become certified to provide services under the MA program. Other professionals, such as audiologists, occupational therapists, alcohol and other drug abuse treatment providers, must be accredited by national professional accrediting organizations or meet other professional certification requirements established by other agencies. MA certification standards are more extensive for providers of certain services where other such licensing, accrediting or certification standards are not available, such as providers of case management, personal care and specialized medical vehicle (SMV) transportation services.

2. Since 1992, the number of certified MA providers has increased from approximately 30,000 to over 42,000. The certification process has become more complex as a result of increased certification requirements for a number of provider groups, including home health agencies, durable medical equipment suppliers, agencies providing respiratory care services and specialized medical vehicle transportation services.

3. DHFS indicates that the 2.0 auditor positions would perform verification and investigative functions that the current 1.0 certification specialist is unable to do. These auditors would conduct background investigations on new applicants to determine if a provider has been convicted of fraud or terminated as a provider from MA or Medicare. Additionally, through on-site interviews, these auditors would verify the information provided on the certification application and determine if adequate supplies and inventory exist to provide services and that services are actually being performed.

4. In a February, 2001 report, the Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services recommended that the Health Care Financing Administration (HCFA), in conjunction with states, strengthen the certification standards for MA providers by duplicating or closely paralleling those used for Medicare. Specifically, the OIG report identified the need for states to independently verify information submitted by providers, conduct on-site visits to provider offices and verify whether a provider is excluded from participating in other federal programs, since federal law prohibits the distribution of federal funds to these providers. In its comprehensive plan for program integrity, HCFA indicates that it has been successful in identifying problem suppliers of durable medical equipment through the use of on-site visits for all new suppliers seeking certification under Medicare and intends to apply the use of on-site visits to other categories of providers.

5. DHFS indicates that its current auditor staff level is not sufficient to adequately verify information provided by providers on certification applications and conduct on-site visits as recommended by the OIG. Currently, only SMV transportation providers are subjected to on-site reviews prior to full certification. Once an SMV provider completes the application for certification and provides all the required information, that provider is given provisional certification for six

months, until an on-site review can be performed. These reviews are considered audits and can involve recovery of any payments made during the six months if the review determines that improper payments were made.

6. DHFS indicates that its efforts to improve the verification of provider information prior to certification would initially focus on those providers of services that are not otherwise regulated either by DHFS or the Department of Regulation and Licensing. DHFS would first modify the certification requirements for suppliers of durable medical equipment to specify that all new suppliers could not be certified until the on-site review was complete.

7. Consistent with the OIG recommendations, to prevent possible fraudulent activity, it may be appropriate to increase DHFS' resources to verify information on a provider's certification application prior to full certification. With the current DHFS staffing level, such providers may not be identified until after a provider has been paid for services. While DHFS can always proceed against a provider that commits fraud against MA, such post-payment recoveries may not always be easy to collect.

8. The bill would provide $144,600 (all funds) for costs associated with providing 2.0 auditor positions in 2002-03. However, it is estimated that the cost to provide 2.0 auditor positions would total $123,000 ($61,500 GPR and $61,500 FED) in 2002-03. Therefore, if the Committee chooses to authorize the positions recommended by the Governor, the funding in the bill should be reduced by $21,600 ($10,800 GPR and $10,800 FED) in 2002-03 to reflect reestimates of the costs of 2.0 auditor positions.

9. The Committee could provide $61,600 ($30,800 GPR and $30,800 FED) and 1.0 (0.5 GPR and 0.5 FED) auditor position to increase DHFS activities to verify information included with the certification application and increase on-site reviews of providers seeking certification. Such action would reflect a recognition that verification of information included in certification applications is a priority, but that sufficient information is not available to justify 2.0 auditor positions. Since these activities are not currently being performed, except with respect to SMV service providers, providing 1.0 position could be considered sufficient increase in resources to conduct such activities.

10. Finally, the Committee could delete the positions recommended by the Governor if it determines that sufficient information is not available to justify increasing verification activities related to provider certifications. If investigation of new applicants for certification is a priority, DHFS could reassign its existing audit staff to conduct these investigations. Such is the case with the current on-site reviews of SMV service providers. However, doing so would divert these staff from audits of existing providers.

ALTERNATIVES TO BASE

1. Adopt the Governor's recommendation to provide 2.0 auditor positions, beginning in 2002-03. In addition, reduce funding in the bill by $10,800 GPR and $10,800 FED to reflect reestimates of the costs of these positions.

Alternative 1	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$61,500	$61,500	$123,000
[Change to Bill	*- $10,800*	*- $10,800*	*- $21,600]*
2002-03 POSITIONS (Change to Base)	1.00	1.00	2.00
[Change to Bill	*0.00*	*0.00*	*0.00]*

2. Reduce funding by $41,500 GPR and $41,500 FED and delete 1.0 position (.50 GPR position and .50 FED position) in 2002-03 to provide 1.0 auditor position for BHCPI.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$30,800	$30,800	$61,600
[Change to Bill	*- $41,500*	*- $41,500*	*- $83,000]*
2002-03 POSITIONS (Change to Base)	0.50	0.50	1.00
[Change to Bill	*- 0.50*	*- 0.50*	*- 1.00]*

3. Delete provision.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$0	$0	$0
[Change to Bill	*- $72,300*	*- $72,300*	*- $144,600]*
2002-03 POSITIONS (Change to Base)	0.00	0.00	0.00
[Change to Bill	*- 1.00*	*- 1.00*	*- 2.00]*

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June 4, 2001 Joint Committee on Finance Paper #480

School-Based Health Services (DHFS -- Medical Assistance)

CURRENT LAW

1995 Wisconsin Act 27 established school-based health services as a medical assistance (MA) benefit. School-based health services are MA-eligible services provided to MA-eligible students by school districts, cooperative educational service agencies (CESAs) or the Wisconsin Schools for the Visually Handicapped or the Deaf. The services that can be reimbursed as school-based health services include: (a) speech, language, hearing and audiological services; (b) occupational and physical therapy services; (c) nursing services; (d) psychological counseling and social work services; (e) developmental testing and assessments; (f) transportation if provided on a day the student receives other school-based health services; and (g) durable medical equipment.

Schools provide the state's match for school-based health services. Prior to the 1999-01 biennium, of the federal matching funds received for school-based services, 60% was distributed to school providers and 40% was credited to the state's general fund. Under provisions of 1999 Wisconsin Act 9, in the 1999-01 biennium, after the first $16.1 million in federal MA matching funds available for school-based services, of any additional revenue received, 90% is distributed to school providers and 10% is credited to the state's general fund. Under current law, beginning July 1, 2001, 60% of all federal matching funds for school-based health services will be distributed to school providers and 40% will be credited to the state's general fund.

GOVERNOR

Estimate that MA reimbursements for school-based services deposited to the general fund would total $8.1 million annually.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING (Change to Base)	$500,800	$706,000	$1,206,700
[Change to Bill	*$500,800*	*$706,000*	*$1,206,700]*

3. Maintain current law.

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June 4, 2001 Joint Committee on Finance Paper #482

Prescription Drug Assistance Programs (DHFS -- Medical Assistance)

Informational Paper

A number of proposals have been introduced in both the 1999 and 2001 legislative sessions that would establish a prescription drug assistance program for some Wisconsin residents. In his 2001-03 biennial budget, the Governor included a proposal to use the medical assistance (MA) program to provide prescription drug coverage to certain elderly Wisconsin residents. Additionally, in February, the Senate adopted Senate Substitute Amendment 1 to 2001 Senate Bill 1, which would establish a prescription drug assistance program for Wisconsin residents 65 years of age or older with income at or below 300% of the federal poverty level. A number of bills have been introduced in the Assembly that would establish a prescription drug assistance program for certain Wisconsin residents. These bills are pending approval in the Assembly.

This paper is intended to assist the Committee and the Legislature in considering both the Governor's proposal and the legislative proposals by providing information on prescription drug use and the availability of coverage and other issues that could be deliberated.

Prepared by: Rachel Carabell

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SECTION 1

Background

As of April 2001, 26 states have established some type of prescription drug assistance program. Eleven of these programs were created before 1990. Many of the remaining programs were created since 1999. Additionally, many states have recently expanded their prescription drug assistance programs. The creation and expansion of these programs represent these states' response to significantly rising prescription drugs costs in the late 1990's and the lack of a prescription drug benefit available under Medicare.

According to the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), national expenditures for prescription drugs increased from $40.3 billion in 1990 to $116.9 billion in 2000, representing a 19% average annual increase over that time period. Much of this increase was funded by public and private third-party payers, including private health insurance plans and government health care programs. In 1990, public and private third-party payers paid approximately 41% of national prescription drug costs. In 1999, public and private third-party plans paid approximately 65% of these costs. Nonetheless, the increases in out-of-pocket costs for prescription drugs, from $23.8 billion in 1990 to $34.9 billion in 1999, have focused attention on those individuals that do not have third-party coverage for prescription drugs.

The increasing costs associated with prescription drugs are primarily a result of research and technological advancements that have significantly increased prescription drug utilization and costs. One of the largest groups affected by this trend are individuals without prescription drug coverage and individuals with high drug costs. Because these are national trends, many people believe that the problem is most appropriately addressed at the federal level. For a number of years, there has been congressional support to provide at least some Medicare enrollees with some prescription drug coverage to address the issue. However, to date, no federal legislation has been enacted. Due to the lack of federal action, many states have enacted programs to assist individuals, particularly Medicare enrollees, in paying for their prescription drugs.

Some of the programs established in other states and proposals currently being considered by Wisconsin's Legislature have focused on persons over the age of 65 ("seniors") as a way of targeting those most affected by the rising trend in prescription drugs. Seniors are most likely to be disproportionately affected by the increasing trend in prescription drug costs for two reasons. First, they rely more heavily on prescription drugs than non-elderly individuals and are more likely to have chronic conditions that require a daily routine of medications to maintain their health. Second, seniors are less likely to have third-party coverage for prescription drugs than nonelderly individuals.

Income and Prescription Drug Use Among Seniors

There are approximately 700,000 seniors in Wisconsin. Based on data available from the federal Social Security Administration, it is estimated that approximately 169,000, or 24%, of seniors live in households that have income that is at or below 150% of the federal poverty level (FPL). This compares with approximately 23% of all Wisconsin residents that live in households with income below 150% of the FPL, based on data available from the 1990 U.S. Census. In 2001, 150% of the FPL is equal to $12,885 annually for one person and $17,415 annually for two persons.

Seniors spend a significantly larger portion of their income on medications than the rest of the population. According to the U.S. Census Bureau, in 1998, all consumers spent approximately $346 annually, or 1% of their total household expenditures, on prescription and non-prescription drugs. Seniors spent $670 annually on prescription and non-prescription drugs, representing 2.7% of their total household expenditures.

Higher out-of-pocket drug costs for seniors is partly due to higher use of medications by this group. In a report issued in July 2000, the Kaiser Family Foundation indicated that the average number of prescriptions filled nearly triples from ages 45 to 75 years, from an average of 4.3 prescriptions per person to 11.4 prescriptions per person annually. As a result, average expenditures also increase with age. Even among seniors, age matters in terms of cost. According to data available from the 1996 Medicare Current Beneficiary Survey, average per capita spending for prescription drugs for individuals 65-69 years of age was $595 annually, compared to $729 for individuals 80-84 years of age.

The second reason that the increasing trends in prescription drug costs disproportionately affect seniors is because a higher proportion of them do not have third-party coverage of prescription drugs compared with nonelderly persons. This is primarily because seniors rely on Medicare as the primary source of their health care coverage and Medicare has never provided coverage of outpatient prescriptions drugs.

According to HCFA, in 1996, an estimated 23% of non-Medicare beneficiaries had no drug coverage at any time during the year, while approximately 31% of Medicare beneficiaries had no drug coverage at any time during the year. Additionally, the portion of Medicare beneficiaries without any drug coverage increases with age. Approximately 36% of Medicare beneficiaries, 80-84 years of age, had no prescription drug coverage in 1996, compared with 28% for Medicare beneficiaries, 65-69 years of age.

Data available from HCFA also indicates that the portion of Medicare beneficiaries without prescription drug coverage increases as income decreases. In 1996, 39% of Medicare beneficiaries with income between 100% and 150% of the FPL had no prescription drug coverage, compared to 25% of the Medicare beneficiaries with income above 300% of the FPL.

Additionally, the 1996 Medicare Current Beneficiary Survey found that Medicare beneficiaries living in urban areas were more likely to have drug coverage (69%) than beneficiaries living in non-metropolitan areas (54%).

Available Coverage for Prescription Drugs

There are a number of sources for prescription drug coverage for seniors. However, many seniors do not have access to these sources, or the coverage available from these sources is limited or expensive.

Employer-Sponsored Health Care. In 1996, employer-sponsored plans were the source of coverage for about 60% of the non-Medicare population and 28% of Medicare beneficiaries. Large size firms, firms with more than 1,000 employees, are the most likely to offer health care beneficiaries to their retirees. Based on an employer survey, approximately 41% of large firms offered health benefits to retirees in 1998. Surveys indicate that approximately 22% of firms with 500-1,000 employees offered health care benefits to retirees in 1999 and only 8% of firms with fewer than 200 employees offered such health care coverage in 1998.

The percentage of employers that offer health care coverage to retirees has decreased in recent years. According to HCFA, this is partly because of accounting rule changes that require firms to account for benefits promised to future retirees as a current liability, but rising health care costs in general, and prescription drug costs in particular, are also believed to be a contributing factor. In addition, according to different surveys, employers are increasing the portion of costs retirees must to pay for their health care coverage or increasing eligibility requirements before an employer would provide coverage to a retiree.

Medical Assistance. Certain low-income Medicare beneficiaries have coverage for prescription drugs because they also qualify for medical assistance (MA), which offers a comprehensive pharmacy benefit. However, not all Medicare beneficiaries enrolled in MA have prescription drug coverage. For "qualified Medicare beneficiaries" and "special low-income Medicare beneficiaries," MA only pays for certain Medicare premiums, coinsurance and deductibles. It does not pay for services for these individuals that are not covered under Medicare, including outpatient prescription drugs.

It is estimated that approximately 59,200 Wisconsin residents over 65 years of age currently have MA coverage for prescription drugs. All of these individuals would have income below 100% of the FPL.

Medicare. The Medicare program was established in 1965 under Title XVIII of the Social Security Act to provide health insurance for aged persons to complement the retirement, survivors, and disability insurance benefits available under social security. Medicare consists of two primary parts -- hospital insurance (HI), also known as Part A, and supplementary medical insurance (SMI), also known as Part B. Part A includes coverage of inpatient hospital, skilled nursing facility care, home health and hospice care. Part B is described as providing outpatient

care because it includes coverage of physician services, clinical laboratory tests, durable medical equipment, diagnostic tests and ambulance services. However, Part B does not cover outpatient prescription drugs.

In Wisconsin, there are approximately 777,000 individuals enrolled in Medicare Parts A and B, of whom approximately 690,000 are individuals at least 65 years of age. The rest are individuals that are under 65 years of age but qualify for Medicare due to a disability.

As part of the federal 1997 Balanced Budget Act, Congress created the Medicare+Choice program, also known as Part C. Under Medicare+Choice, beneficiaries can choose to participate in a managed care plan that covers services offered under both Parts A and B and often provides additional benefits. The ability of these plans to offer additional benefits is based on the Medicare payment rate. These rates are based on historical fee-for-service costs in each county and therefore the payment rate varies by county. An analysis conducted by the Department of Health and Family Services (DHFS) found that the Medicare+Choice monthly payment rates in Wisconsin were low relative to the rest of the country, averaging $382.48 for Wisconsin beneficiaries, compared to $488.45 nationally.

Because of the lower than average payment rates, Medicare+Choice plans in Wisconsin do not provide many additional services compared with plans in other states. For example, no Medicare+Choice plan in Wisconsin offers prescription drug benefits. This is likely the reason that Wisconsin's beneficiaries' participation in Medicare+Choice plans is low, 5.3% compared to 17.6% nationally in 2000.

Medicare Supplement Policies. According to the 1996 Medicare Current Beneficiary Survey, approximately 10% of Medicare beneficiaries receive limited prescription drug coverage through the purchase of supplemental Medicare policies, known as "Medigap" policies.

The Office of the Commissioner of Insurance (OCI) establishes, by rule, and in conformance with federal requirements, minimum coverage requirements for basic Medicare supplemental coverage, additional coverage provided under separate riders and "high deductible drug plans." First, every basic Medicare supplemental policy must provide coverage for at least 80% of charges for outpatient prescription drugs after the beneficiary pays a deductible of up to $6,250 in any calendar year. Thus, every Medigap policy provides prescription drug coverage for individuals, but only after the $6,250 deductible is met. These minimum coverage requirements apply to Medigap policies issued on or after September 1, 1994.

Second, outpatient prescription drug riders on a Medigap policy must cover at least 50% of charges for outpatient prescription drugs after the beneficiary pays a deductible of up to $250 per calendar year, up to a maximum of at least $3,000 in benefits for the insured per year. Only one of the individual Medigap policies available as of January, 2001, offers a rider for prescription drugs. The annual premium for this rider totaled $922, regardless of age.

HIRSP. The health insurance risk-sharing plan (HIRSP) offers health insurance coverage to individuals with adverse medical histories and others who cannot obtain affordable health care coverage in the private sector. Comprehensive prescription drug coverage is available under HIRSP, but individuals 65 years of age or older are not eligible to participate unless they applied for, and were enrolled in, HIRSP before they turned 65 years of age. Coverage is subject to payment of deductibles and coinsurance. As of March, 2001, there were approximately 10,800 individuals enrolled in HIRSP. Of these, 250 were 65 years of age or older.

SECTION 2

Components of a Prescription Drug Assistance Program

In developing a prescription drug assistance program, several issues should be considered including: (a) who would be eligible; (b) how the plan would be funded and how costs would be shared between the enrollees, the state, pharmacies and the pharmaceutical manufacturers; (c) how the program would be administered; (d) what features would maintain the integrity of the program; and (e) when such a program would first be available. This section identifies some of the issues that could be considered in developing a prescription drug assistance program. The section includes references to proposals that were, or are currently being considered by Wisconsin's Legislature, including the Governor's proposal in his 2001-03 budget bill.

Eligibility

There are a number of criteria that could be used to determine eligibility, including both financial and non-financial criteria. It may be appropriate to develop eligibility criteria that targets groups of individuals that are most likely in need of assistance with the purchase of prescription drugs, such as those that pay a significant portion of their income for prescription drugs, individuals with the lowest incomes, or individuals with multiple chronic conditions that require routine medications as a way to maintain their health.

Age. All of the current proposals would require enrollees to be at least 65 years of age. However, a proposal could include individuals who are under age 65 if those individuals are disabled or have chronic conditions that require maintenance medication. Of the 17 state prescription drug assistance programs reviewed by the U.S. General Accounting Office (GAO) in 1999, all but six provided coverage to individuals with disabilities, in addition to covering elderly individuals.

Many of the arguments for providing assistance to seniors could also apply to persons with disabilities. Prescription drug costs for the disabled are on average higher than prescription drug costs for seniors. For example, the New Jersey program provides coverage to both elderly individuals and individuals with disabilities. Under that program, in 2000, the average net benefit to an elderly enrollee was $1,116, while the average net benefit to a disabled enrollee was $1,974, according to the National Pharmaceutical Council.

Income Criteria. To ensure that assistance is targeted to those least able to afford purchasing prescription drugs, it may be appropriate to determine a maximum level of income at which individuals would be eligible for the program. This income maximum could be based on a percentage of the FPL or it could be established as a fixed amount. If the income maximum were based on a percentage of the FPL, the income level would automatically be indexed for

inflation, meaning the maximum level would increase each year, based on annual changes in the federal poverty level.

If the income maximum is based on a fixed amount, the percentage of the target population that would be eligible would likely decrease over time as incomes rise with inflation, but the income eligibility criterion would remain constant. Establishing a fixed amount, however, would not preclude the Legislature from adjusting the income limits in the future. According to the GAO, in 1999, seven state pharmacy assistance programs used a percentage of the FPL to determine income eligibility, another five used other income thresholds that could be adjusted for inflation. Two states had fixed amounts for the income eligibility requirement.

The following table identifies income levels as a portion of the current FPL.

Annual Income as a Percent of the 2001 Federal Poverty Level

Percent of the FPL	Income for a One-Person Household	Income for a Two-Person Household
100%	$8,590	$11,610
110	9,449	12,771
115	9,879	13,352
125	10,738	14,513
130	11,167	15,093
150	12,885	17,415
175	15,033	20,318
185	15,892	21,479
200	17,180	23,220
225	19,328	26,123
250	21,475	29,025
275	23,623	31,928
300	25,770	34,830
350	30,065	40,635

The GAO reported that income limits varied from 100% of the FPL to 225% of the FPL for state pharmacy assistance programs in effect in 1999. Since that time, however, a number of states have established prescription drug assistance programs or expanded existing programs to include individuals with higher incomes. For example, beginning in January, 2001, New York's program, which was initially created in 1986, increased its income eligibility limit from approximately 225% of the FPL to approximately 400% of the FPL for single individuals and approximately 430% of the FPL for two-person households.

Assets. None of the current proposals would consider an individual's assets when determining eligibility. However, of the current state pharmacy assistance programs, three

states--Maryland, Minnesota and Michigan--require individuals to meet an asset requirement in order to be eligible. Under Maryland's prescription drug assistance plan, the asset limit for individuals is $3,750 and $4,500 for couples. Minnesota's asset limit for an individual is $10,000. Michigan limits assets to $3,000, however the Michigan program will end later this year and be replaced by a new program. It is not known whether this new program will have an asset limit.

Under MA, for the elderly and the disabled, eligibility is limited to individuals with assets below $2,000 for an individual and $3,000 for a couple. However, certain assets are excluded, such as a car, a home, assets related to burial, including insurance, trusts, funds or plots. While no information is available to determine the effect of including an asset limit in any proposal, doing so would likely decrease participation in the program, reducing total program costs.

Including an asset limit could achieve a policy goal that funding budgeted for a prescription drug program only be used to benefit those that otherwise could not afford prescription drug coverage. However, establishing an asset limit would reduce participation in the program and would increase administrative costs to verify the information submitted by applicants.

Availability of Other Drug Coverage. Under the current proposals, both individuals with drug coverage and those without coverage would be eligible to participate. The proposals specify that the state-funded program would be a payer of last resort, meaning that coverage would be limited to costs not otherwise covered under another policy. Under the Governor's budget proposal, only individuals without drug coverage for the past 12 months, excluding eligibility for MA, would be eligible for the program.

By limiting eligibility only to individuals without drug coverage, a proposal would target those most in need of coverage and limit costs. However, if coverage would be limited to only those without drug coverage, it is likely that some "crowd out" would occur. Crowd out is the phenomenon of shifting privately funded health care benefits to publicly funded programs. It is reasonable to assume that some individuals would discontinue their current coverage to be eligible for coverage under a state program, if they determined that the state program had more generous benefits. However, most alternative coverage includes coverage of services other than prescription drugs. Therefore, these individuals would have to determine whether it is advantageous to discontinue coverage for a variety of services and costs to receive more generous coverage of prescription drugs.

On the other hand, it may be desirable to provide coverage to individuals with other coverage, since many individuals with drug coverage have high out-of-pocket costs, either because their other coverage requires payment of large deductibles or places limits on the amount of coverage available. The 1996 Medicare Current Beneficiary Survey indicates that, on average, individuals with drug coverage pay for approximately 35% of their total drug costs out-of-pocket.

The cost to provide coverage to individuals with other drug coverage would vary significantly, depending on the proposal. Proposals with lower deductibles would have significantly higher costs because more persons enrolled in the program would meet the deductible, even with other available coverage. However, for proposals with higher deductibles, the effect of covering individuals with other coverage would be significantly less, since fewer of these individuals would meet the plan's deductible.

Residency. It is reasonable to require that, as a condition of eligibility, an enrollee be a resident of Wisconsin. However, under some proposals, the definition of residency would only require that the individual maintain a permanent home in Wisconsin and provide evidence of domiciliary intent by having a state driver's license, or by voting and paying income taxes in the state. It may be reasonable to specify that to be eligible, an individual must be considered a resident for some period of time before being eligible, perhaps 30 days to six months. This may be appropriate if there is concern that individuals could relocate from other states to enroll in Wisconsin's program. Generally, the programs in surrounding states -- Minnesota, Iowa, Illinois and Indiana -- are limited in terms of eligibility and availability of benefits, compared with the proposals currently being considered by Wisconsin's Legislature.

Spend Down. Some proposals include a provision that would enable individuals with annual household income above the income limit, but who meet the other eligibility criteria, to be eligible to enroll in the program if, after deducting their out-of-pocket costs for prescription drug covered under the program from their income, they have income at or below the income limit. These individuals are referred to as persons that "spend down" to the income eligibility limit.

No data is available to identify the potential costs associated with proposals to include individuals that spend down to the income limit. For purposes of developing cost estimates for current proposals, it is assumed that such a provision would add an additional 5% to the costs of the program. In addition, it is anticipated that including a spend down feature in a program would increase administrative costs, since applicants would be required to document previous spending on drugs.

Out-of-Pocket Expenses. Some states have developed eligibility criteria partially based on the portion of an individual's income that is spent on prescription drugs. For example, under one of Maine's programs, for individuals with out-of-pocket drug expenditures representing at least 40% of income, the income limit increases by approximately 25%. Such an approach could be used as an alternative to a spend down provision as a way to ensure that those with high out-of-pocket drug costs relative to their income receive coverage. To date, none of the current proposals include such options.

Eligibility Period. Each of the current proposals would have annual eligibility periods, meaning that once determined eligible, an individual would remain eligible for 12 months. Individuals would have to reenroll in order to remain eligible for the program following the 12-month eligibility period. Each proposal require enrollees to pay an enrollment fee, ranging from

$20 to $25, annually. Revenue from these fees would be used to fund the program's administrative costs.

Enrollment Period. Under each of the proposals, individuals could enroll at any time during the year. In an effort to manage enrollment in the program, enrollment could be limited to a four, six, or eight-week period each year. Once the program is implemented, projecting costs each year would be much more reliable if enrollment were limited to a specific period of time. However, a limited period for annual enrollment could be perceived as a barrier for those in need of assistance and therefore, could limit participation in the program.

Participant Cost-Sharing

Cost-sharing components require participants to share in the cost of drugs purchased under a prescription drug assistance program. Deductibles and copayments are often used by private insurance plans to reduce overall costs and discourage inappropriate or excessive use of services.

Deductible. A deductible is the amount that an individual must pay out-of-pocket before benefits would be paid on an individual's behalf. Plans that do not require payment of a deductible before coverage is available are sometimes referred to as plans that provide "first dollar" coverage, meaning coverage is available on the first dollar spent for services. Deductibles are not as common among publicly funded health plans. For example, under MA and BadgerCare, individuals are not required to pay a deductible before receiving services. However, under the state's health insurance risk-sharing plan, deductibles apply.

Only four of the state prescription drug assistance programs require some recipients to pay a deductible before being eligible for services. The Illinois and Minnesota programs have monthly deductibles, meaning the individual must pay a certain amount (between $15 and $35) per month before the individual is eligible for benefits. The New York and Pennsylvania programs require deductibles for those at higher income levels.

Most of the current proposals require at least some individuals to meet a deductible requirement. The Governor's budget proposal includes several deductible options. For individuals below 110% of the FPL, no deductible would be required. Individuals with income of at least 110% of the FPL but less than 130% of the FPL would be required to pay a $300 annual deductible. Individuals with income of at least 130% of the FPL, but less than 155% of the FPL would be required to pay a $600 annual deductible. Another approach is to require everyone enrolled to pay a deductible, such as under 2001 AB 120, which would require every enrollee to pay an $840 deductible annually before the state pays a claim.

Each current proposal would require pharmacists to charge participants no more than the program's payment rate for each drug purchased during the deductible period. Therefore, every enrollee would receive a discount on drugs purchased during a deductible period, even if the individual does not have sufficient drug costs to reach the deductible. The amount of the

discount would vary, depending on the payment rate for each drug relative to the retail price of the drug. In no case would the program payment rate exceed the retail cost of the drug.

Copayments. Copayments represent the portion of a drug's cost that must be paid by a participant for each purchase after the deductible is met. Copayments could be established at a fixed amount per prescription, such as $5, or a percent of the prescription price, such as 20%. If a health care or other prescription drug plan has a fixed copayment per prescription, it will most often have at least two different copayments, depending on whether the purchased drug is a brand-name drug or a generic drug. Under private plans, lower copayments are typically required for generic drugs to encourage the use of generics when available to control costs.

Under private plans, establishing copayments as a percent of the drug's purchase price to determine the copayment encourages utilization of generic drugs, since the more expensive the drug, the more the participant would pay. However, because some prescriptions are quite expensive, requiring individuals to pay 20% of the cost could a be significant cost for some individuals. Requiring a fixed amount per prescription limits a participant's liability per prescription.

The current proposals have various copayment requirements, but all are based on fixed amounts per prescription. It would be possible to develop a program that would require a copayment of a fixed amount or a percentage, whichever is less. For example, a proposal could require copayments of $20 for brand name drugs, $10 for generic drugs, or 20%, whichever is less. If a participant purchased a generic drug with a reimbursement rate of $15, the copayment would be $3, or 20% of the cost of the drug. Under this same proposal, an individual that needs a brand name drug for which no generic is available with a reimbursement rate of $250, the copayment would be $20.

Establishing different copayments for brand name and generic drugs would not likely increase utilization of generic drugs, if DHFS were authorized to use the same cost and utilization control procedures it uses for the MA program. Approximately 67% of the drugs purchased under MA are generic drugs, compared with 30-40% for private insurance plans and some state prescription drug assistance programs. Under MA, pharmacists are required to substitute a generic drug when a brand name drug is prescribed and a generic drug is available, as allowed under current law. However, if a physician that prescribed the drug provides a handwritten indication that the brand name is medically necessary, the pharmacist may not substitute a generic drug for the brand name drug. Using this cost control procedure, the MA program maximizes use of generic drugs. Most of the proposals authorize DHFS to use the same cost and utilization control procedures as available under MA.

Reimbursement Rate

The current proposals specify that the reimbursement rate paid under these programs would use the same pricing structure used under MA. Under MA, pharmacies are reimbursed the lower of the provider's usual and customary charge or the estimated acquisition cost (EAC)

of the drug, plus a fee for the pharmacists' cost to dispense the drug. The total amount reimbursed to the pharmacist represents the EAC plus the dispensing fee, less $0.50.

Currently, the EAC for most 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 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 apply under limited circumstances.

Currently, on average, MA reimburses pharmacies at a rate that is approximately 77% of the pharmacies' usual and customary charges, or the retail price of the drug. This represents a 23% average discount from the retail price.

Some current proposals would specify that the reimbursement rate for prescription drugs would be equal to AWP less a 5% discount or the MAC listed price, whichever is less. Additionally, pharmacies would receive the MA dispensing fee. Other proposals would specify that the reimbursement rate would be the MA payment rate plus 5% and the dispensing fee. For purposes of estimated costs, these payments are determined to be approximately equivalent, providing an average discount of 18% from retail prices.

However, the Governor's budget includes a proposal to reduce the MA reimbursement rate for most prescription drugs, from AWP-10% to AWP-15%. If enacted, the estimated cost for proposals based on the MA payment rate plus 5% would be reduced to reflect the change to the MA reimbursement rate. Proposals that specify a payment rate of AWP less a 5% discount or the MAC listed price would not be affected by the Governor's recommendations.

One of the arguments for providing a reimbursement rate that is greater than the MA reimbursement rate is to offset the loss in revenue that pharmacies would receive, since drugs purchased under some proposals would have previously been purchased at retail prices. As indicated, this would be an average discount of approximately 18% that would be absorbed by pharmacies.

However, research indicates that individuals with prescription drug coverage use significantly more drugs than individuals without coverage. Based on the 1996 Medicare Current Beneficiary Survey, in 1995, Medicare enrollees without drug coverage spent an average of $432 annually on prescription drugs, compared to individuals with drug coverage ($689), or approximately 60% more. Therefore, while pharmacies would likely receive a lower reimbursement per prescription compared to retail, if a prescription drug program were enacted, it is reasonable to assume that the volume of prescriptions sold would increase by as much as 60% for those individuals that previously had no coverage.

Manufacturer Rebates

Under MA, each state prescription drug assistance program and most private health insurance plans receive rebate revenue from manufacturers. Under MA, the manufacturers sign rebate agreements with the U.S. Department of Health and Human Services on behalf of the state MA programs. Federal law defines how the rebate amount is calculated. This revenue represents approximately 18% of prescription drug expenditures under Wisconsin's MA program.

Each of the proposals would require that only prescription drugs manufactured by companies that sign rebate agreements with the state would be covered. Further, these provisions specify that the rebate agreements must be based on the rebate formula identified in federal law.

Each state with a prescription drug assistance plan has entered into rebate agreements with manufacturers. In some states, some manufacturers were reluctant to sign the rebate agreements if the state's program did not specify that a rebate agreement was required for the manufacturer's drug to be covered under the program. For example, programs in Minnesota and New York had some difficulty in this regard. Both states have since modified their programs to specify that only drugs manufactured by companies that enter into rebate agreements are covered. After those changes were made, almost all manufacturers have signed the rebate agreements.

Coordination with Medical Assistance

While it is expected that any prescription drug assistance program would be closely coordinated with MA, the Legislature could decide not to link the administration of these two programs. Many states with prescription drug assistance programs chose not to link their drug assistance program with MA to avoid the possible stigma associated with MA as a public welfare program. As a result, these states have separately contracted for administration of the program and have placed the responsibility for administration of the program with an agency other than the agency that administers the state's MA program.

Administration

Under the current proposals, DHFS would administer the program but would contract with a vendor for many of the administrative functions. The costs to administer a prescription drug program would include: (a) enrollment processing; (b) claims processing; (c) outreach and customer services; (d) contract monitoring; (e) monitoring rebate agreements with manufacturers; and (f) coordination of benefits with other third-party payers. These costs could vary significantly, depending on the features of the proposal.

Start-Up Costs. There would be one-time costs to establish a new program. These costs would include staff time to establish a request-for-proposal and negotiate a contract with a

vendor to perform many of the administrative functions. Programming changes would be required to the current MA claims processing system or for development of a separate system. Additionally, staff time would be required to secure rebate agreements with pharmaceutical manufacturers.

Each of the current proposals, other than the Governor's budget proposal, would appropriate $2.0 million GPR in the first year of the biennium to address these one-time costs. One proposal would provide $2.0 million GPR in the Joint Committee on Finance supplemental appropriation to fund DHFS start-up costs after DHFS submits a plan for the use of the funds. Other proposals would appropriate $1.0 million GPR directly in DHFS so that DHFS can begin program implementation immediately upon enactment of legislation and provide another $1.0 million GPR in the Committee's supplemental appropriation to fund start-up costs after DHFS submits a plan for the use of the funds.

The proposal included in the Governor's budget would not provide any funds for start-up costs. The administration indicates that it anticipates that, if enacted, DHFS would request the Joint Committee on Finance to transfer funds for this purpose from other appropriations using its authority under s. 13.101 of the statutes, if sufficient base funding were not available.

Ongoing Costs. Under the current proposals, ongoing costs would be funded from an annual enrollment fee paid by enrollees. The amount of the fee would vary from $20 to $25 annually. The amount of revenue available from the fee would vary depend on the number of individuals enrolled in the program.

Based on information obtained from other states, it appears that the ongoing administrative costs to operate a prescription drug assistance program average between 2% and 3% of a program's budget for benefits paid under the program. New York's plan, which has a $252 million program budget, provides $6 million, or 2.3%, for administration. Pennsylvania's plan, with a $359 million budget in 2002, is budgeting $9.5 million, or approximately 2.6%, for administration. While both of these plans have been in operation for a number of years and have much larger enrollment than projected under any of the current proposals, these programs have components which require participants to pay a deductible, which is similar to many of the current proposals being considered.

However, a comparison of other states' administrative costs can be misleading in terms of estimating DHFS' costs to administer a prescription drug program. For example, current MA policies on prior authorization and the use of drug utilization review require resources to administer. Both of these components would help to control benefit costs in the program by encouraging use of lower cost drugs when available and appropriate, but would likely add a program's administrative costs. It appears that both the New York and Pennsylvania programs do not use prior authorization to the extent used under Wisconsin's MA program, nor does the New York program perform extensive drug utilization reviews. Therefore, administrative costs as a portion of Wisconsin's program budget could be higher than these programs to the extent the

MA cost and utilization control procedures are used in any prescription drug assistance program that would be enacted in Wisconsin.

Eligibility and Enrollment. The state contracts with counties to determine eligibility under MA. Under federal law, eligibility determinations for MA must be performed by public employees and cannot be contracted out to a private entity.

If a prescription drug program were enacted, it may be desirable to separately contract for enrollment processing, rather than use the current MA process performed by counties to ensure that the enrollment process is cost effective.

Alternatively, some current proposals have components that would allow individuals to spend down to the income limits. This component is more administratively complex to process. Since counties have experience determining eligibility for individuals that spend down to the MA eligibility limits, it may be advantageous to have counties determine eligibility under a prescription drug proposal if it includes a spend down component. However, private entities could develop the capacity to determine eligibility for individuals that spend down and it may be more cost-effective to competitively bid for enrollment processing, regardless of whether or not a program has a spend down provision.

Program Integrity Features

Two features of the MA program could be incorporated into a prescription drug program to minimize potential abuse of the program and thus reduce program costs.

Penalties for Fraud and Abuse. Requiring DHFS to promulgate rules relating to prohibitions on fraud that are substantially similar to MA could prevent individuals that otherwise might be motivated to abuse the program from committing such abuses. To ensure that there would be enforcement of these prohibitions, the proposals could specify the penalties for violations under rules promulgated by DHFS. Some current proposals specify that individuals furnishing prescription drugs in violation of the rules promulgated by DHFS could be fined not more than $25,000 or imprisoned for not more than seven years and six months, or both. Other individuals found to violate these prohibitions could be fined not more than $10,000 or imprisoned for not more than one year in county jail, or both.

Because the Governor's budget proposal would expand the MA program, any prohibitions on fraud or abuse and any penalties for such fraud or abuse would apply to individuals that would participate in the program established in the Governor's bill.

Estate Recovery. A proposal could include an estate recovery provision to ensure that individuals participating in the program contribute appropriately to the cost of services provided under such a program, after death through payments from their estates. Estate recovery is currently used under the MA, community options program and disease aids program for such purposes.

Currently, the MA estate recovery program allows the state to recover MA payments for nursing home care, hospital care, personal care services, home- and community-based waiver services and related hospital and prescription drug services provided to recipients age 55 years and over. State law requires the state to file claims against the estate of a MA recipient to recover certain costs, except in cases that would cause undue hardship. The Governor's budget bill would expand estate recovery under MA to seek recovery for all services provided under the MA state plan to noninstitutionalized recipients 55 years and older.

Effective Date

Most of the current proposals would specify that the prescription drug assistance program would make benefits first available on March 1, 2002. The Governor's proposal does not specify an effective date, but the administration anticipates that it could begin by July 1, 2002.

It is reasonable to assume that once a program is enacted, the earliest that DHFS would be able to implement a program would be nine to 12 months from the effective date of the legislation. This assumption is based on past experience of the time needed for DHFS to implement new programs and based on the number of tasks that would need to be completed before a program would first be available.

SECTION 3

Cost Factors

This section discusses the major cost components of a prescription drug assistance program, factors affecting future costs of such a program, ways to address growth in the program and possible options to address action at the federal level regarding prescription drug coverage for Medicare beneficiaries.

Major Cost Components

The major factors contributing to the costs of the current proposals include: (a) the estimated number of individuals eligible for the program; (b) the amount of a deductible and other cost-sharing components; and (c) whether some enrollees would be exempt from a deductible. The following section describes how these factors would affect the estimated costs under some of the current proposals.

Estimated Number of Eligible Individuals. The number of people eligible for the program would depend on whether the program is limited to seniors or whether individuals under age 65 with disabilities would be eligible, and the maximum income an individual could have to be eligible. Additionally, if individuals with other drug coverage are eligible, participation would be significantly greater than if eligibility is limited only to persons without drug coverage.

According to the 1999-00 State of Wisconsin Blue Book, there are approximately 700,000 Wisconsin residents 65 years of age or older. Of this number, it is estimated that approximately 60,000 are enrolled in MA. No recent information is available on Wisconsin residents by income. For purposes of estimating the number of individuals eligible for the prescription drug proposals, this office used national information available from the federal Social Security Administration. Based on this data, the following table identifies the estimated number of Wisconsin residents, not enrolled in MA and 65 years of age or older, by income.

Estimated Wisconsin Residents 65 Years of Age or Older Not Enrolled in MA

Household Income as a Percent of the FPL	Estimated Number of Individuals
At or Below 100%	13,400
At or Below 150%	109,200
At or Below 185%	175,000
At or Below 200%	200,000
At or Below 250%	278,200
At or Below 300%	338,300
All Incomes	640,000

According to HCFA, there are approximately 88,000 Wisconsin residents under age 65 that are enrolled in Medicare because of a disability. Of this number, it is estimated that approximately 40,000 are enrolled in MA. Therefore, there are an estimated 48,000 individuals with disabilities in Wisconsin that are not enrolled in MA. These estimates do not include individuals with disabilities that are able to work and therefore would not qualify for Medicare or MA. No data is available to estimate the income distribution of these individuals.

The estimated number of individuals eligible has a significant impact on the cost of a proposal. For example, 2001 Senate Substitute Amendment 1 to Senate Bill 1 would provide coverage to elderly residents with income at or below 300% of the FPL and has an estimated annual cost of approximately $105.9 million. If eligibility were limited to individuals at 250% of the FPL, the estimated cost would be reduced to $92.1 million. 2001 Assembly Bill 120 would provide eligibility to individuals at or below 185% of the FPL. If AB 120 were modified to extend eligibility to individuals at or below 250% of the FPL, the estimated cost would increase from $26.4 million to $38.7 million.

Deductibles and Cost-Sharing. The amount of a deductible has a significant effect on the cost of a proposal. For example, the program that would be created in AB 120 would have an $840 deductible. It is estimated that approximately 39,500, or 44% of those enrolled, would have expenditures that meet the deductible. If all other elements of AB 120 remained the same, but the deductible were reduced to $600, an estimated 54,600, or 61% of those enrolled would have expenditures that exceed the deductible. This change would increase estimated annual program expenditures from $26.4 million to $35.3 million.

The amount of any required copayments can significantly affect the estimated cost of a proposal. For example, SSA 1 to SB 1 would require individuals to pay a copayment of $10 for each brand name drug purchased after the deductible and $5 for each generic drug purchased after the deductible. If these copayments were increased to $7.50 for each generic drug and $15 for each brand name drug, estimated annual program expenditures would decrease from $105.9 million to $94.5 million.

Deductible Exemption. Under AB 120, all individuals would be required to have drug expenditures that meet the deductible before the state would make payments on their behalf. AB 132 and SSA 1 to SB 1 would exempt individuals with household income at or below 175% of the FPL from paying a deductible under the proposals. Under SSA 2 to SB 2, individuals at or below 150% of the FPL would be exempt from the deductible requirement. Under the Governor's proposal, individuals with income at or below 110% would not be required to pay a deductible. For these individuals, the proposals would provide first dollar coverage, meaning the state would provide a payment on the first dollar spent by these individuals for drugs purchased under the program.

Whether or not certain individuals would be exempt from paying a deductible and the level at which individuals would be exempt can have a significant effect on the estimated cost of a proposal. For example, the estimated cost of AB 132 would decrease from $105.9 million to

$88 million if the proposal were modified to only exempt individuals at or below 125% of the FPL. AB 120 estimated costs would increase from $26.4 million to $47.2 million if individuals at or below 125% of the FPL would be exempt from the deductible requirement.

Future Costs

If a proposal is enacted, program costs would be expected to grow significantly in each year, based on enrollment growth and increasing average costs per enrollee. The reasons for this are varied and several options to address these rising costs could be considered.

The percentage of personal health care expenditures represented by drugs is increasing, from 5.6% in 1980 to 9.4% in 1999. Since 1996, national spending on prescription drugs has increased by an average of 18.5% annually, compared with an average increase of 6.3% annually for all personal health care expenditures, according to HCFA. Additionally, HCFA projects that the conditions that accelerated prescription drug costs since 1995 will continue over the next decade, although the effect of the conditions in the latter period of this decade is assumed to be less than in the initial period. Therefore, any prescription drug assistance program that would be enacted would likely experience significant growth in demand for benefits over the next ten years.

Several trends are affecting the recent increases in spending on prescription drugs. The National Institute for Health Care Management found that the increase in prescription drug spending is attributable to: (a) an increase in the number of prescription drugs dispensed (42%); (b) a replacement of lower cost drugs with higher-priced drugs (36%); and (c) price increases (22%).

Number of Prescriptions Dispensed. A Kaiser Family Foundation (KFF) report noted that the number of prescriptions dispensed in the United States increased from 7.3 billion in 1992 to 9.6 billion in 1998. The annual number of prescriptions dispensed per person increased from 1.9 to 2.6 over that same time period. The KFF report indicates that this trend is partially attributable to an increase in the average age of the population and an increase in the number of health care professionals who may prescribe medications. In 1984, the median age of the U.S. population was 31.1 years. By 1998, the median age increased to 35.2 years. The number of physicians per 1,000 persons increased from 2.25 in 1985 to 2.70 in 1997.

Promotional spending by pharmaceutical manufacturers has also contributed to this trend. Spending on promotion includes; (a) sales calls to physicians and other professionals authorized to prescribe medication; (b) presentations at professional meetings and events; and (c) direct-to-consumer advertising. Between 1995 and 1998, the KFF report indicates that promotional spending by manufacturers increased an average of 15.2% annually, with the largest increases in direct-to-consumer advertising (53.4% annually over that time period).

Availability of Higher Cost Therapies. The number of new drugs available on the market has been increasing since the 1980's. For the period 1980 through 1984, the average number of

new drugs approved by the Food and Drug Administration (FDA) in each year was 19.0. For the period 1989 through 1994, the average number of new drugs approved increased to 25.2. Between 1995 and 1998, the average number had increased to 37.5.

Spending on research and development has resulted in the development of drug therapies for a number of conditions for which drug treatment was previously not available, such Alzheimer's disease, cancer and AIDS. Other drugs are being developed that represent improvements to older therapies, including treatment of hypertension, ulcers and depression. The Pharmaceutical Research and Manufacturers of America (PhRMA) reports that total expenditures for research and development by major pharmaceutical manufacturers increased from $2.0 billion in 1980 to $21.1 billion in 1998. PhRMA indicates that the percent of sales spent on research and development has also been increasing, from 8.9% in 1980 to 16.9% in 1998.

The increase in the number of new drugs approved is also the result of changes in the FDA's drug approval process that have been implemented in the 1990s. The average length of time for a new drug to be approved has decreased from 2.7 years in 1986 to 1.0 year in 1998. This is partly the result of enactment of the 1992 federal Prescription Drug User Fee Act, which authorized the FDA to charge manufacturers a fee for approval of new drugs. The FDA increased the number of reviewers and support staff at the Center for Drug Evaluation and Research, the agency responsible for review and approval of new drugs, by several hundred to expedite the review process.

Cost increases occur when individuals switch from lower cost therapies to the newer, higher priced therapies. For example, Prozac, the first of a new class of drugs to treat depression, has an average cost per day of $2.12. Prozac is currently under patent protection. The average cost of Elavil, a brand name drug that treats depression, but is no longer under patent, is $0.71 per day. The prescription drug costs for an individual would increase by approximately 300% if that individual switches from Elavil to Prozac. Prozac's patent protection will expire in August of this year. As a result, it is expected that generic forms of Prozac will be available later this year, which will reduce the cost of Prozac. If individuals currently prescribed Prozac do not switch to higher cost drugs under patent protection, then these individuals' drug costs would decrease. However, if these individuals switch to newer therapies to treat depression, drug costs for these individuals would not decrease and may instead increase.

While a drug is still on patent, the pharmaceutical manufacturer can charge any price for that drug. Once a drug is no longer on patent, the market determines the price of a prescription drug. The differences in prices between newer therapies on patents and older therapies that are no longer under patent can be significant, as shown in the example described above. Attachment 1 to this paper is a table included in Factors Affecting the Growth of Prescription Drug Expenditures, published by the National Institute for Health Care Management, July, 1999. The attachment identifies the price of new drugs, compared with older therapies used to treat a variety of conditions.

Price Inflation. According to the KFF report, increased prices charged by manufacturers, wholesalers or pharmacies have had less of an effect on increased prescription spending than other factors. The report indicates that between 1996 and 1998, inflation for existing drugs increased between 1.6% annually and 3.2% annually. However, the increase in the average price per prescription increased between 6.5% and 9.2% annually for that same time period as a result of the other trends described above.

Cost and Utilization Control Features

There are several features that could be incorporated into a prescription drug assistance program that could partially offset some of the trends described above. Many of these features are used in MA to control expenditures.

Formularies. The use of formularies by private insurance plans is one effective way to reduce the use of higher cost drugs when lower cost alternatives are available. Formularies are the list of drugs that are covered by the plan. Closed formularies may not cover the cost of higher-priced drugs when less costly alternatives are available. Formularies can also be used in conjunction with copayments to encourage the use of lower cost therapies. For example, a private insurance plan may require copayments of $5 for each generic prescription. Copayments of $15 would be required for brand name drugs if included on the plan's formulary, or 50% of the cost of the drug if not included on the plan's formulary.

Federal law requires MA programs to cover drugs manufactured by companies that enter into rebate agreements with HCFA on behalf of the states. Therefore, states are prohibited from establishing closed formularies under MA.

Prior Authorization and Therapeutic Substitution. Prior authorization can be used to encourage the use of lower cost alternatives when such alternatives are available. Prior authorization is a feature in many health care plans, including MA, that requires the pharmacy to obtain prior approval from a plan before it provides a product or service in order to receive reimbursement for that product or service.

Under Wisconsin's MA program, pharmacists are required to receive approval of certain drugs from DHFS before they may be reimbursed. This may be done electronically for most drugs. According to DHFS, prior authorization is used to: (a) prevent potential drug abuse or misuse; (b) prohibit reimbursement for drugs used for cosmetic purposes only; (c) encourage the use of therapeutically equivalent drugs when generics are available in that classification.

Under MA, the use of prior authorization to encourage the use of therapeutically equivalent drugs has been targeted to certain classes of drugs. Under this targeted use of prior authorization, approval will only be provided if the pharmacist can indicate that the patient has already tried one of the therapeutically equivalent, lower-cost drugs. If the individual had tried one of the other alternatives and had an adverse reaction or it was not effective, then the prior authorization is granted. The prior authorization transaction occurs on-line and in real time,

meaning that the pharmacist is able to request prior authorization through an on-line computer system. The system is designed to provide a response to the pharmacist almost immediately.

Use of prior authorization in this way has provided some dramatic results. In September, 1999, DHFS implemented targeted prior authorization of Axid and Pepcid, two brand name drugs that are used to treat ulcers. In order to receive approval of Axid or Pepcid, a patient must have tried and failed two other medications, Ranitidine or Cimetidine, for 30 days or had an adverse reaction to either of these drugs. Ranitidine and Cimetidine are generic drugs in the same class as Axid and Pepcid. DHFS reports that since this change was made, prescriptions for Pepcid and Axid decreased over 65%. Expenditures in this category increased by 1.4% from 1998-99 to 1999-00 despite an 11.9% increase in the number of prescription drugs dispensed. DHFS estimates that the use of prior authorization in this instance saved the MA program over $1.0 million in its first year.

DHFS has also used targeted prior authorization for a certain type of pain-reliever, non-steriodal anti-inflationary drugs (NSAIDs), effective July 15, 2000. In 1999, MA spent over $6.5 million on NSAIDs. For the period January through March, 2000, the average cost of generic NSAIDs was approximately $11, while the average cost for a brand-name NSAID was over $60. Therefore, to the extent prior authorization encourages an increase in the use of generic NSAIDs, the potential savings to MA could be significant.

Because of the potential savings available through the use of targeted prior authorization, as demonstrated in MA, any proposal should provide the administering agency the authority to generate savings through therapeutic substitutions.

Generic Substitution. Under state law, pharmacists may provide a generic substitute in place of a brand name drug without permission from a patient's physician unless the physician indicates the brand name drug is medically necessary. Under MA, such substitution is required, unless the prescribing physician hand writes on the prescription form that the brand name is medically necessary. As a result, MA's use of generic drugs compared with brand name drugs has been much lower than most other plans. Approximately two-thirds of drugs reimbursed under MA are generic drugs, although more recently the portion has decreased due to the increasing availability of newer drugs not available in generic form. Other plans, including other state prescription drug assistance programs and private health care plans that do not require automatic generic substitution, typically experience generic use of approximately 40%.

Some individuals are concerned that generics are not as safe or effective as brand name drugs. According to the FDA, generic drugs contain exactly the same active ingredients as the brand name counterpart and are just as safe and effective. The FDA indicates that approval of generic drugs requires substantially the same level of review as its approval for brand name drugs. For example, the FDA indicates that a firm seeking to sell a generic drug must show that its drug delivers the same amount of active ingredient in the same timeframe as the original product. The FDA further indicates that there is no evidence that generic drugs cause more side effects than the brand name counterpart. The FDA indicates that it monitors reports of adverse

drug reactions and has found no difference in the rates of adverse reactions between generic and brand-name drugs. Attachment 2 to this paper is a copy of an article published by the FDA's Center for Drug Evaluation Research that describes the review process for approval of generic drugs and addresses certain myths about generic drugs.

Drug Utilization Review. Federal law requires MA programs to have a drug utilization review (DUR) program. There are three components to a DUR program: (1) prospective DUR; (2) retrospective DUR; and (3) and education.

Prospective DUR assists pharmacists in screening certain drug categories for potential drug therapy problems. These problems include therapeutic duplication, drug interactions, early and late refills, cumulative side effects, contraindications for pregnancy, certain diseases and specific ages. Prospective DUR is required before a drug is dispensed. Information provided by the MA program is available to the pharmacist through the on-line system.

Retrospective DUR provides for ongoing periodic examination of paid claims data and other records to identify patterns of fraud, abuse, overuse and inappropriate or medically unnecessary care associated with specific drugs or groups of drugs.

The third component, education, is used by DHFS to educate prescribing professionals and pharmacists on common drug therapy problems to improve prescribing and dispensing practices. The MA program convenes a board of practicing physicians and pharmacists from around the state to review and approve all criteria used for both prospective and retrospective DUR.

Any drug assistance program should include a DUR component to assist in managing program costs and to help to ensure that the drugs purchased under the program are being used safely, effectively and appropriately.

Other Provisions

Several other issues should be considered that would affect the Legislature's commitment to fund increasing costs.

Sum Sufficient versus Waiting Lists. A proposal could either provide funding from a sum certain appropriation or a sum sufficient appropriation. If a sum certain appropriation is provided, expenditures under the program are limited to the amounts appropriated by the Legislature. If a sum sufficient appropriation is provided, expenditures are not limited to any amount other than the amounts necessary to meet the needs of the program.

The use of a sum sufficient appropriation would ensure that any individual that is eligible to participate and applies would be enrolled in the program. However, if a sum sufficient appropriation is created, there could be significant risk to the general fund, since the estimated cost of any proposal is considerably uncertain. Much of the data that has been used to estimate the projected costs of proposals is up to five years old and therefore does not reflect the most

recent trends discussed above. Additionally, the data is primarily based on national data extrapolated to Wisconsin. Therefore, the estimated costs of any proposal could be significantly over or under the actual costs. The draw on the state's general fund could be significant if actual costs exceed projections.

A sum certain appropriation minimizes the risk to the state's general fund because the amounts spent would be limited to the amounts appropriated by the Legislature. However, it is not clear what would happen if actual costs exceed projections if a sum certain appropriation is provided. If costs exceed projections and the Legislature does not appropriate additional funding, it is presumed that DHFS would have to establish waiting lists so that expenditures do not exceed the amounts appropriated for the program.

Limits on Benefits. An alternative to the use of waiting lists would be the use of limits on benefits. The Committee could authorize DHFS to place limits on the amount of benefits available per person should actual costs exceed the amounts appropriated. Using this authority would be one way to ensure that everyone that would apply and be found eligible would receive some assistance, but would ensure that the program would be able to stay within budget.

Alternatively, if a sum certain appropriation is provided and no provision specifying whether waiting lists or limits on benefits are authorized, it is unclear what would happen. For two programs established in the 1997-99 biennial budget where expenditures exceeded the amounts budgeted, the Legislature provided additional funding to prevent the use of waiting lists or reducing eligibility limits. The Joint Committee on Finance has twice transferred additional funding for kinship care in order to address waiting lists in certain counties. Additionally, 2001 Wisconsin Act 1 provided an additional $11.2 million GPR for BadgerCare to ensure that the eligibility limit for the program was not reduced. If such a situation occurs in a prescription drug program, the Legislature could address such a problem by appropriating additional funds or modifying the program.

Federal Action

It is not known whether Congress will act to address the demand for prescription drug coverage for Medicare beneficiaries in the current session. The President has proposed the creation of a block grant program to states that could be used to create prescription drug assistance plans in each state or be used in conjunction with existing programs in those states that already have such programs. Congress appears poised to address the program at the federal level rather than a state-based approach. However, there is much disagreement among members of Congress in terms of the approach such action should follow.

If any proposal enacted by the Legislature specifies that the program would be a payer of last resort, any drugs purchased under the program would first be reimbursed under a Medicare benefit or other federal program and only costs not reimbursed by Medicare or other federal program would be paid under the state program. This is consistent with the MA program, which

is a payer of last resort. For individuals eligible for both MA and Medicare, Medicare is first billed for services and MA only pays for those services that are not reimbursed under Medicare.

A proposal could be developed that would require DHFS to submit a report to the Governor and the standing committees of the Legislature if it certifies that a federal benefit is available that provides substantially the same coverage as available under the state program. The report could provide a comparison of the federal benefit and the benefit available under the state program and identify options for modifying or repealing the state program in order to conform with the federal benefit.

Another option would be to specify that any state program would sunset if DHFS certifies that a federal benefit is available that provides substantially the same benefit and coverage as the state program.

ATTACHMENT 1

Price of New Drugs Compared to Old Drugs, by Therapeutic Category, 1998

Therapeutic Category	Top Two New Drugs in Therapeutic Category	Price of New Drug	Average Price of Old Drugs	Price of New Drug Relative to Average Price of Older Drugs
Antidepressants	Zoloft	$76.08	$48.82	155.8%
	Paxil	$70.59		144.6%
Anti-ulcerants	Prevacid	$112.46	$86.99	129.3%
	Prilosec	$122.80		141.2%
Antibiotics, broad based	Zithromax	$39.19	$25.99	150.8%
	Cefzil	$57.53		221.3%
Cholesteral reducers	Lipitor	$75.59	$71.89	105.1%
	Zocor	$98.26		136.7%
Calcium blockers	Norvasc	$55.64	$49.57	112.3%
	Sular	$33.29		67.2%
Antihypertnensive drugs	Cozaar	$49.64	$40.03	124.0%
	Diovan	$44.64		111.5%
Beta-blockers	Coreg*	$89.32	$26.49	337.1%
Sex hormones	Prempro*	$28.10	$26.53	105.9%
Oral antidiabetics	Glucophage	$48.54	$27.27	178.0%
	Rezulin	$142.82		523.8%
Antihistamines	Claritin	$61.79	$65.27	94.7%
	Zyrtec	$51.57		79.0%
Analgesics, non-narcotic	Imitrex	$153.58	$20.64	744.2%
	Ultram	$42.15		204.2%
Oral contraceptives	Desogen*	$27.02	$29.57	91.4%
Bronchodilators	Serevent*	$60.75	$27.54	220.6%

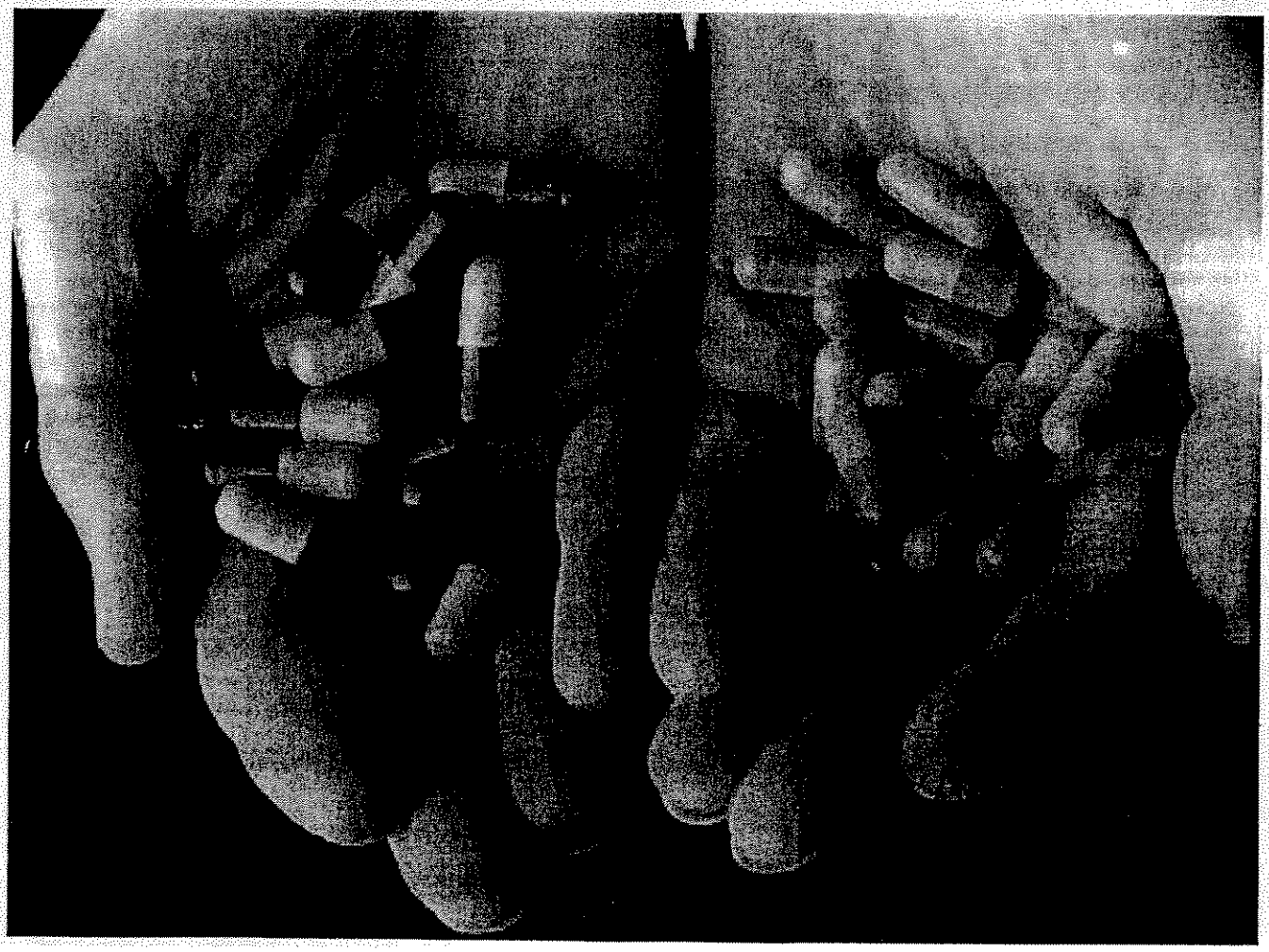
Therapeutic Category	Top Two New Drugs in Therapeutic Category	Price of New Drug	Average Price of Old Drugs	Price of New Drug Relative to Average Price of Older Drugs
Antiseizure	Neurontin	$97.15	$44.16	220.0%
	Lamictal	$167.50		379.3%
Respiratory steroids (inhaled)	Flonase	$46.95	$51.48	91.2%
	Rhinocort	$36.63		71.2%
Antipsychotics	Zyprexa	$242.66	$42.12	576.1%
	Risperdal	$141.58		336.1%
Fungicides	Lamisil	$182.01	$31.22	582.9%
	Sporanox	$195.65		626.6%
HIV Antivirals	Viracept	$516.03	$318.68	161.9%
	Zerit	$252.77		79.3%
Oral cold preparations	Claritin 12 hour	$48.76	$17.30	$281.8%
	Allegra - D	$41.85		241.8%

*Note: Only one new drug introduced between 1993 and 1998 in therapeutic category.

Source: Barents Group LLC analysis of Scott-Levin Source Prescription Audit Data.

FDA Ensures **Equivalence of Generic Drugs**

The quality standards for approval of drugs sold in the United States are uniform, whether they are for generic or brand-name drugs. "Since generic drugs generally sell for less than brand-name drugs, many people falsely believe that generics must be inferior to brand-name products," says Doug Sporn, Director of FDA's Office of Generic Drugs. "Generic drugs contain exactly the same active ingredients as the brand-name drug and are just as safe and effective."



Despite the strict standards imposed by the FDA for approval of generic drugs, and their enforcement of these standards, a number of misconceptions about generic drugs persist (See "Myths and Facts about Generics" to the right).

New drugs, like other new products, are developed under patent protection. The patent protects the investment in the drug's development by giving the company the sole right to sell the drug while the patent is in effect. When patents or other periods of exclusivity on brand-name drugs expire, manufacturers can apply to the FDA to sell generic versions.

"Much of FDA's review of generic drugs and brand name drugs is the same," Sporn explains (See "Same FDA Requirements for Brand-Name and Generic Drugs" below). There are eight major parts to the FDA's review of a firm's application to sell a generic drug:

- There must be an FDA-approved brand-name drug that is the "same" as the proposed generic. The generic must have the same active ingredient or ingredients and the same labeled strength as this reference product. It must have the same dosage form—tablets, patches and liquids are examples of dosage forms. It must

Same FDA Requirements for Brand-Name and Generic Drugs

	Brand-Name Drug	Generic Drug
For reformulations of a drug or generic versions of a drug, FDA reviews data showing the drug is bioequivalent to the one used in the original safety and efficacy testing.	✔	✔
FDA evaluates the manufacturer's adherence to good manufacturing practices before the drug is marketed.	✔	✔
FDA reviews the active and inactive ingredients used in the formula before the drug is marketed.	✔	✔
FDA reviews tests of the active ingredient or ingredients.	✔	✔
FDA reviews tests of the actual drug product.	✔	✔
FDA reviews the drug's labeling.	✔	✔
Manufacturer must seek FDA approval before making major manufacturing changes or reformulating the drug.	✔	✔
Manufacturer must report adverse reactions and serious adverse health effects to the FDA.	✔	✔
FDA periodically inspects manufacturing plants.	✔	✔
FDA monitors drug quality after approval.	✔	✔

Myths and Facts about Generic Drugs

MYTH: *Generics take longer to act in the body.*

FACT: The firm seeking to sell a generic drug must show that its drug delivers the same amount of active ingredient in the same timeframe as the original product.

MYTH: *Generics are not as potent as brand-name drugs.*

FACT: FDA requires generics to have the same quality, strength, purity, and stability as brand-name drugs.

MYTH: *Generics are not as safe as brand-name drugs.*

FACT: FDA requires that all drugs be safe and effective and that their benefits outweigh their risks. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risk-benefit profile as their brand-name counterparts.

MYTH: *Brand-name drugs are made in modern manufacturing facilities, and generics are often made in substandard facilities.*

FACT: FDA won't permit drugs to be made in substandard facilities. FDA conducts about 3,500 inspections a year to ensure standards are met. Generic firms have facilities comparable to those of brand-name firms. In fact, brand-name firms account for an estimated 50 percent of generic drug production. They frequently make copies of their own or other brand-name drugs but sell them without the brand name.

MYTH: *Generic drugs are likely to cause more side effects.*

FACT: There is no evidence of this. FDA monitors reports of adverse drug reactions and has found no difference in the rates between generic and brand-name drugs.

"Since generic drugs generally sell for less than brand-name drugs, many people falsely believe that generics must be inferior to brand-name products."

— Doug Sporn, Director of FDA's Office of Generic Drugs

be administered the same way, for example, swallowed as a pill or given as an injection.

- The manufacturer must show the generic drug is "bioequivalent" to the brand-name drug (See "What Is Bioequivalence?" below).
- The generic drug's labeling must contain information that is essentially the same as that of the approved drug.
- The firm must fully document the generic drug's chemistry, manufacturing steps, and quality control measures. Each step of the process must be detailed for FDA review.
- The firm must assure the FDA that the raw materials and the finished product meet USP specifications, if these have been set. The USP, or U.S. Pharmacopoeia, is the nonprofit, scientific body chartered by Congress to set standards for drug purity in this country.
- The firm must show that its generic drug is stable under extremes of heat and humidity before it can be sold. Once on the market, the firm must continue to monitor the drug's stability. The firm must show that the container and its closure system won't interact with the drug. Firms making sterile drugs must submit sterility assurance data and data showing microbiologic integrity of these products.
- The firm must provide a full description of the facilities it uses to manufacture, process, test, package, label and control the drug. It must certify that it complies with federal regulations about current good manufacturing practices and undergo FDA inspection of the manufacturing facility to assure compliance.
- Before FDA approves a generic drug, it usually conducts a product-specific inspection at the proposed manufacturing site to make sure the firm is capable of meeting its application commitments and to ensure the firm can manufacture the product consistently.

"Generic competition helps keep the cost of drugs down," Sporn says. "It also encourages the research-based drug companies to keep finding newer and better medicines that have patent protection."

When retired federal auditor Stuart Addison goes to the pharmacy in Margate, Fla., he has the pharmacist fill his prescriptions with generic drugs. "My motivation is to keep the prices down," Addison said, noting that his insurance plan helps pay for his prescriptions. "My pocketbook isn't directly affected; but, in the long run, I'm helping keep insurance premiums down." Generic drugs save consumers an estimated $8 to $10 billion a year at retail pharmacies (according to the Congressional Budget Office). Even more billions are saved when hospitals use generics.

"FDA-approved generic drugs are bioequivalent and therapeutically equivalent to their brand-name counterparts," says Sporn. "People can use them with total confidence."

What Is Bioequivalence?

Generics are not required to replicate the extensive clinical trials that have already been used in the development of the original, brand-name drug. These tests usually involve a few hundred to a few thousand patients. Since the safety and efficacy of the brand-name product has already been well established in clinical testing and frequently many years of patient use, it is scientifically unnecessary, and would be unethical, to require that such extensive testing be repeated in human subjects for each generic drug that a firm wishes to market. Instead, generic applicants must scientifically demonstrate that their product is bioequivalent (i.e., performs in the same manner) to the pioneer drug.

One way scientists demonstrate bioequivalence is to measure the time it takes the generic drug to reach the bloodstream in 24 to 36 healthy, normal volunteers. This gives them the rate of absorption—or bioavailability—of the generic drug, which they then compare to that of the pioneer drug. The generic version must deliver the same amount of active ingredients into a patient's bloodstream in the same amount of time as the pioneer drug.

Using bioequivalence as the basis for approving generic copies of drug products was established by the Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Waxman-Hatch Act. Brand-name drugs are subject to the same bioequivalency tests as generics when their manufacturers reformulate them.

Senator Burke

HEALTH AND FAMILY SERVICES – MEDICAL ASSISTANCE

Dental Access

Motion:

Move to incorporate the provisions of 2001 Senate Bill 166 (as modified to reflect the Committee's previous action on tuition assistance for the Marquette University School of Dentistry) and Senate Bill 167 into the budget bill.

Note:

Senate Bill 166 and 167 were introduced by the Joint Legislative Council based on the recommendations of the Legislative Council Study Committee on Dental Care Access.

Senate Bill 166

MA Benefits Funding for Dental Services. The bill would increase benefits funding under the medical assistance (MA) program to:

- Increase maximum reimbursement rates to the 75th percentile of the American Dental Association's fee schedule for the east north central region of the country, which includes Wisconsin ($8,614,000 GPR and $12,268,500 FED in 2001-02 and $11,629,000 GPR and $16,394,300 FED in 2002-03);

- Provide coverage of topical fluoride varnish as part of the early and period screening, diagnosis and treatment (EPSDT) program in the 2001-03 biennium ($162,900 GPR and $232,100 FED in 2001-02 and $325,900 GPR and $459,300 FED in 2002-03); and

- Increase from one to two the number of dental cleanings an adult MA recipient could receive in one year ($378,500 GPR and $539,000 FED in 2001-02 and $378,500 GPR and $533,500 FED in 2002-03).

Additionally, SB 166 would require MA to reimburse providers for dental services provided by dental hygienists provided within the scope of practice of a dental hygienist. No funding would be provided for this item.

MA Administration for Dental Services. SB 166 would provide $264,000 ($132,000 GPR and $132,000 FED) annually and 5.0 GPR positions, beginning July 1, 2001, to establish a licensed dental health professional in each of the five DHFS administrative regions of the state. These positions would perform dental health outreach services and would be funded as an MA administrative expense. Most MA administrative activities, including outreach activities, are funded on a 50% GPR/50% FED cost-sharing basis.

Tuition Assistance: Marquette University School of Dentistry. The bill would provide $558,000 GPR in 2001-02 and $783,000 GPR in 2002-03 to: (1) increase the maximum number of Wisconsin residents enrolled in the dental school who qualify for tuition assistance from 100 students to 160 students over a four-year period; and (2) increase the amount of tuition assistance for Wisconsin residents enrolled in the dental school from the current level of $10,670 per year to $15,000 per year.

The proposal assumes that the dental school would enroll an additional 15 Wisconsin residents each year over a four year period. When fully implemented, the cost of the proposal would be $1,233,000 GPR over the current base funding of $1,167,000 GPR.

During its deliberations on the 2001-03 biennial budget, the Joint Committee on Finance approved a motion to provide $175,100 GPR in 2001-02 and $350,100 GPR in 2002-03 to increase the maximum number of Wisconsin residents that qualify for tuition assistance from 100 to 160. Therefore, an additional $382,900 GPR in 2001-02 and $432,900 GPR in 2002-03 would be provided for this purpose.

Community Water Fluoridation. SB 166 would provide $25,000 GPR annually for DHFS to award annual grants to applying communities for: (1) purchasing water fluoridation equipment; (2) constructing additional building space to house water fluoridation equipment; and (3) funding salaries of employees who operate water fluoridation equipment.

Community Dental Services. SB 166 would provide $1,600,000 GPR annually to provide or expand community dental services. Qualified applicants would include entities that provide, or seek to provide, dental care services to low-income individuals that are not federally qualified health care centers. DHFS would give preference in awarding grants to applicants in areas that are located in dental health professional shortage areas. Grant recipients would be required to:

(a) make every attempt to collect appropriate reimbursement for its costs in providing dental services to persons who are eligible for and receiving BadgerCare, health care, MA or assistance for medical expenses under any other public assistance or have coverage under a private insurance program;

(b) prepare and utilize a fee schedule for the provision of its services consistent with locally prevailing charges that is designed to cover its reasonable costs of operation and prepare a

corresponding schedule of discounts to be applied to the payment of such fees, based on the patient's ability to pay;

(c) establish a governing board that, except in the case of an applicant that is an Indian tribe or band, is composed of individuals who are representatives of persons served by the applicant and a majority of whom are being served by the applicant. The board would: (1) establish policies surrounding the entity's program operations; (2) hold regularly scheduled meetings and keep minutes; (3) approve the selection or dismissal of an entity's director or chief executive office; (4) establish personnel policies and procedures, including employee selection and dismissal procedures, salary and benefit scales, employee grievance procedures and equal opportunity practices; (5) adopt policies for financial management practices, including a system to ensure accountability for resources, approval of an annual budget, priorities for eligibility for services, including criteria for the fee schedule and long-range financial planning; (6) evaluate the entity's activities including services utilization patterns, productivity, patient satisfaction, achievement of objectives, and development of a process for hearing and resolving patient grievances; and (7) adopt health care policies including scope and availability of services, location, hours of services and quality of care audit procedures.

(d) use any funds provided under the program to supplement, not replace, other available funds;

(e) implement a patient screening process to determine eligibility for MA, BadgerCare, and the devised payment schedule;

(f) provide oral health education in programs operated by and affiliated with DHFS, including the special supplemental food program for women, infants and children and head start; and

(g) provide dental screening, risk assessments and preventive dental treatment to pregnant women, infants, preschoolers and persons with disabilities, heart disease or lung disease or persons using psychotropic medication.

Senate Bill 167

Regional Dental Examinations. Newly authorize the Dental Examining Board, attached to the Department of Regulation and Licensing (DRL), to issue a dentist license to an applicant who has passed an examination of either a dental testing service approved by the Board or a regional dental testing service in the United States. Under current law, the Board is required to grant a dentist license to a person who does all of the following: (1) submits an application for licensure; (2) pays the specified fee; (3) submits evidence of graduation from an accredited dental school; (4) submits evidence that he or she has passed the national dental examination and the examination of a dental testing service approved by the board; (5) passes an examination administered by the board on the statutes and rules relating to dentistry; and (6) completes any other requirements established by the board by rule.

Licensure of Dentists from Other Jurisdictions. Require the Dentistry Examining Board to grant a license to practice dentistry to an applicant who is licensed in good standing to practice

dentistry in another state or territory of the United States or in Canada upon presentation of the license, payment of the required fee, and submission of evidence satisfactory to the Board that he or she has met all of the following conditions: (1) graduation from a school accredited by the American Dental Association's Commission on Dental Accreditation; (2) presentation of a certificate from each jurisdiction where the applicant has previously been licensed that no disciplinary action is pending and detailing any such action that has been imposed; (3) presentation of evidence that the applicant has been actively engaged in the practice of dentistry in one or more other jurisdictions for at least 48 of the last 60 months; (4) presentation of evidence that the applicant has completed a jurisprudence examination on Wisconsin statutory and administrative code requirements relating to dental hygiene; (5) presentation of evidence that the applicant has a current certificate of proficiency for cardiopulmonary resuscitation; (6) presentation of evidence that the applicant has disclosed all discipline ever taken against the individual shown in reports from the National Practitioner Data Bank and the American Association of Dental Examiners; and (7) the applicant has provided a satisfactory response during a personal interview with the Board that the Board may require to resolve any conflicts between the licensing standards and the applicant's application or to inquire into any discipline that was imposed against the applicant in any other jurisdiction.

Specify that the Board would be permitted to refuse to grant a license to an applicant following an interview if the Board determines that discipline that was imposed against the applicant in another jurisdiction demonstrates that the applicant is unfit to practice dentistry.

Current law specifies that the Board may grant a license to practice dentistry to a person who is licensed and in good standing in another state or U.S. territory or another country if the applicant meets the requirements for licensure established by the Board by rule and presents the license and pays the specified fee.

Dental Hygienist's Scope of Practice. Specify that a dental hygienist would be authorized to practice dental hygiene only if a dentist is present in the facility or pursuant to a dentist's oral or written prescription that meets the requirements set forth in current law, with two exceptions.

The first exception would authorize a dental hygienist to practice at a school for the education of dental hygienists without a dentist present in the facility and without a written or oral prescription. A dental hygienist may apply sealants on a patient at a school for the education of dental hygienists without a diagnosis or treatment plan by a dentist, if the dental hygienist has performed an oral risk assessment.

The second exception would authorize a dental hygienist to practice in the facility without a dentist present and without an oral or written prescription if the dental hygienist meets specified education and experience requirements and practice specified procedures. The dental hygienist would be authorized to perform those practices only in the following settings or circumstances: (1) for a school board or a governing body of a private school; (2) for a facility or a hospital that provides care for terminally ill patients; (3) for a local health department; (4) for a charitable institution open to the general public or to members of a religious sect or order; (5) for a nonprofit home health care agency; and (6) for a nonprofit dental care program serving primarily indigent, economically disadvantaged, or migrant worker populations. Under this second exception, the dental hygienist would be permitted to practice as specified in the bill if he or she

meets specified education and experience requirements and is certified by the Board in dental hygiene practice circumstances without a dentist present and without a prescription. Under the bill, an individual would be required to have two years experience as a dental hygienist and meet additional educational requirements in order to obtain the certificate.

Under current law, a dental hygienist may practice dental hygiene or perform remediable procedures only as an employee or as an independent contractor and only in one of the following eight specified settings or circumstances: (1) in a dental office; (2) for a school board or a governing body of a private school; (3) for a school for the education of dentists or dental hygienists; (4) for a nursing home or community-based residential facility, a hospital, a state or federal prison, county jail or other federal, state, county or municipal correctional or detention facility, or a facility established to provide care for terminally ill patients; (5) for a local health department; (6) for a charitable institution open to the general public or to members of a religious sect or order; (7) for a nonprofit home health care agency; and (8) for a nonprofit dental care program serving primarily indigent, economically disadvantaged or migrant worker populations. Generally, a dentist must be present in the facility or the practice is being performed pursuant to a dentist's written or oral prescription.

Delegation of Dentistry Practices. Authorize a dentist to delegate any dentistry practices not included in dental hygiene to a dental hygienist, except for those practices that are prohibited practices by a dental hygienist under current law. In order for the delegation to occur, the delegated acts must be ones that, in the opinion of the dentist and the dental hygienist, the dental hygienist is competent to perform based on his or her education, training, or experience. In addition, require the dental hygienist's performance of the practice to be inspected by a dentist.

Authorize the delegation of remediable dental procedures to unlicensed persons if certain requirements are met. Specify that the practice must be one for which delegation is not prohibited [removal of supra- or subgingival calcareous deposits, deep scaling or root planning, conducting an oral screening without the written prescription of a dentist, participating in the development of a dental patient's dental hygiene treatment plan or any other practice specified by rule of the Board]. Additionally, require that the person must have graduated from an accredited dental assisting program or have worked at least 1,000 hours during the preceding 12 months in a clinical dentistry setting. Further, stipulate that the dentist making the delegation must document in his or her records that the person has been trained or educated to do the dental practice. Finally, specify that the delegated practices must be ones that, in the opinion of the dentist and the individual to whom the practices are delegated, the individual is competent to perform based on his or her education, training, or experience.

Under current law, a dentist may delegate to an unlicensed person the performance of remediable procedures if certain conditions are met. In addition, a dentist may delegate to a dental hygienist the performance of remediable procedures and the administration of oral systemic premedications, local anesthesia, and subgingival sustained release chemotherapeutic agents, if certain requirements are met.

Educational Dentist's License. The bill would require the Board to grant a license to practice dentistry to an applicant who is a faculty member at a school of dentistry in Wisconsin if specified conditions are met. Marquette University School of Dentistry is the only school of

dentistry in this state. The person must present his or her license to the board, pay the required fee and submit evidence satisfactory to the Board that he or she has met the seven conditions specified in the bill, one of which is that he or she is a faculty member at a school of dentistry in this state. The Board would be permitted to refuse to grant a license to an applicant following an interview if the Board determines that discipline that was imposed against the applicant in another jurisdiction demonstrates that the applicant is unfit to practice dentistry. In addition, an educational dentist's license granted under the bill would no longer be in effect if the licensee ceases to be a full-time faculty member at a school of dentistry in this state.

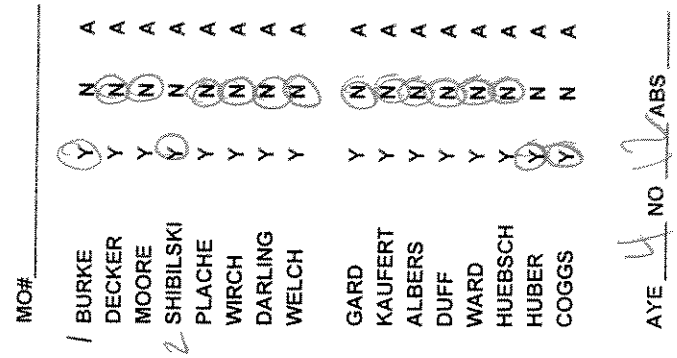
Oral Health Data Collection System. DHFS would be required to prepare a plan for development of a comprehensive oral health data collection system, and submit it to the Governor and Legislature by September 1, 2002. The plan would identify data to be collected, sources for which the data could be collected, costs of implementing the system and any statutory changes that would be needed to implement the system.

Report on Prior Authorization Under MA. DHFS would be required to prepare a report on its efforts to reduce prior authorization requirements for MA dental services and simplify the prior authorization process for these services. DHFS would be required to submit this report to the chief clerk of each house of the Legislature and to the Governor by the first day of the sixth month following the effective date of the bill.

Report on Community Dental Health Education Programs. The bill would require the Technical College System Board to prepare a report on the feasibility and cost of increasing the number of sites in the technical college system that offer community dental health education for dentists and dental hygienists. The Board would be required to submit this report to the chief clerk of each house of the Legislature and to the Governor on the first day of the sixth month following the effective date of the bill.

Dentist and Dental Hygiene Loan Reimbursement Programs. The bill would expand the physician loan assistance program (PLAP) to include dentists and the health care provider loan assistance program (HCPLAP) to include dental hygienists. The Rural Health Development Council would be expanded from 11 members to 13 members, including a dentist and dental hygienist. It should be noted, that in previous actions, the Committee has expanded the PLAP and HCPLAP to include dentists and dental hygienists, respectively. Additional funding of $50,000 PR in 2001-02 and $100,000 PR in 2002-03 in tribal gaming revenues was provided.

[Change to Bill: $25,818,500 GPR and $30,690,700 FED and 5.0 GPR positions]



HEALTH AND FAMILY SERVICES

Medical Assistance

Base Agency

LFB Summary Items for Which No Issue Paper Has Been Prepared

Item #	Title
1	Overview of Medical Assistance Benefits
3 (part)	Nursing Home Reimbursement and Creation of the Medical Assistance Trust Fund (only provisions relating to the treatment of unanticipated IGT revenues that would be retroactive as of July 1, 2000)
9 (part)	MA Hospital Payments
12	MA Administration Contracts and Agreements
13	Eliminate the MA Asset Limit for Low-Income Families
15	MA State Center Adjustments
16	MA Estate Recovery
18	Managed Care for Disabled Adults
22	DHCF Staff Funding Change
23	CIP IA Rate for New Placements
24	Community Services Deficit Reduction Benefits (CSDRB)

delete item 16

LFB Summary Item Addressed at a Previous Commi

Item #	Title
11	Eligibility Administration (Paper #1057)

approve all items except #16

MO# 2

BURKE	Y	N	A
DECKER	Y	N	A
MOORE	Y	N	A
SHIBILSKI	Y	N	A
PLACHE	Y	N	A
WIRCH	Y	N	A
DARLING	Y	N	A
WELCH	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
ALBERS	Y	N	A
DUFF	Y	N	A
WARD	Y	N	A
HUEBSCH	Y	N	A
HUBER	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS ____