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Nursing Home Reimbursement (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 350, #3 (part)]

CURRENT LAW

The Department of Health and Family Services (DHFS) reimburses nursing homes for care provided to medical assistance (MA) recipients through payments based on a daily rate, adjusted for patient level of care. DHFS determines the daily rate annually, based on the amount of funding budgeted for MA nursing home reimbursement and projected costs for the state's nursing homes. Within statutory requirements, DHFS has significant discretion in establishing the formula it uses to determine nursing home payment rates. DHFS must provide public notice of any proposed changes to the nursing home formula as part of the process to amend Wisconsin's MA state plan.

State law requires DHFS to consider six cost centers and permits DHFS to consider a seventh, over-the-counter-drugs, when developing facility-specific daily rates. The six mandatory cost centers are: (1) direct care; (2) support services; (3) administrative and general; (4) fuel and other utilities; (5) property taxes, municipal services or assessments; and (6) capital. In general, nursing homes are reimbursed for their expenses in a given cost center as long as their costs per patient day do not exceed "targets" (maximum rates) that are based on the costs for all nursing homes in the state. Before 1999-00, these targets could not be less than the state median level, but 1999 Wisconsin Act 9 repealed this requirement, and instead, only requires DHFS to establish standards that take into account these costs.

GOVERNOR

Provide $152,100,100 ($89,358,800 FED and $62,741,300 SEG) in 2001-02 and $194,260,700 ($113,778,500 FED and $80,482,200 SEG) in 2002-03 to increase payments to nursing homes for services they provide to MA recipients. This funding would enable DHFS to:

(a) maintain the current supplemental payments DHFS makes to nursing homes operated by counties and other municipalities to offset a portion of their deficits ($37,100,000 annually); (b) increase these supplemental payments by $40,000,000 annually so that a total of $77,100,000 would be provided for this purpose in each year; and (c) provide rate increases for all nursing homes ($75,000,000 in 2001-02 and $117,160,700 in 2002-03). The following table summarizes how this additional funding would be allocated under the bill.

	2001-02	2002-03
Continue Current County and Municipal Supplements	$37,100,000	$37,100,000
Increase County and Municipal Supplements	40,000,000	40,000,000
General Rate Increases	75,000,000	$117,160,700
Total	$152,100,000	$194,260,700

County and Municipal Supplemental Payments. Specify that, if the state receives less than $115,200,000 of federal matching funds based on intergovernmental transfers (IGT funds) in a state fiscal year, DHFS could distribute no more than $37,100,000 in supplemental payments to county- and municipally-owned homes in that year. For the purpose of making these supplemental payments, define "operating deficits" as they are defined under the methodology DHFS used in December, 2000, which is the definition included in the current MA state plan for nursing home reimbursement. Specify that if the state receives $115,200,000 or more of these IGT funds in a state fiscal year, DHFS could distribute up to $77,100,000 in supplemental payments in that year.

Transition to a Case-Mix Payment System

In addition to the changes included in the Governor's budget, DHFS intends to implement a change in the formula to transition to a payment system that is based on levels of care of residents (case-mix), rather than using a cost-based system with maximum limits (targets). Under a case-mix system, every nursing home would be paid the same amount for a resident in a given care category, before any adjustments, such as a regional labor cost adjustment. DHFS plans to implement the case-mix system over a four-year period. In 2001-02, a nursing home's rate would be based on a weighted average of the two methods -- the payment under the case-mix method would have a weight of 25% while the current cost-based system would have a weight of 75%. In 2002-03, the weights would be 50% and 50%. The case-mix system is currently used by Medicare, and was implemented by Medicare beginning in 1998.

Although this change would not affect the total amount of funding required for MA nursing home reimbursement, it could have a significant redistribution effect. Increasing nursing home reimbursement, as proposed in the Governor's budget, could reduce the distributional effect for nursing homes that would be adversely affected by this formula change.

DISCUSSION POINTS

1. In 2000-01, it is estimated that MA spending for nursing homes, other than the three state Centers for the Developmentally Disabled, will total $913.5 million (all funds), including $278.6 million from state general purpose revenue (GPR). This amount represents approximately 35% of total estimated MA expenditures in that year.

2. On December 31, 1999, the most recent date for which information is available, MA was the primary payment source for 68% of nursing home residents (approximately 28,500 residents), Medicare was the primary pay source for 7% of nursing home residents and approximately 23% of nursing home residents paid for their care with their own funds.

3. Direct care is the largest cost center, and, on average, accounts for nearly 60% of a facility's payment rate. The support services cost center represents about 20% of the MA total rate a facility receives.

4. In 1999-01, DHFS provided two significant supplemental payments to nursing homes, in addition to the regular per diem rate that is based on the seven cost centers. First, 1999 Wisconsin Act 9 provided $8.3 million in 1999-00 and $11.1 million in 2000-01 to fund a "wage pass-through" of 5% for nurse's assistants. In order to receive this supplement, a nursing home was required to apply for the supplement and provide additional cost information to demonstrate that the supplement was used to increase total wages and fringe benefits of nurse's assistants over the previous year. DHFS may recoup payments if it determines that a facility that received a supplement did not meet this requirement. A nursing home can meet this requirement by increasing employee hours or fringe benefits, as well as by increasing wage rates.

5. The second supplement, which DHFS has paid in each year since 1989, is paid to county- and municipal-operated nursing facilities with operating costs that are not fully reimbursed by the regular MA per diem rate. In order to reduce these deficits, a base amount of $37.1 million in 2000-01 is budgeted to support supplemental payments to these facilities. In addition, county- and municipal-operated nursing homes may also receive total supplemental funding above $37.1 million if the actual amount of federal matching funds received exceeds the budgeted amounts.

6. Nursing home residents with Medicare as a primary payment source account for almost 7% of all nursing home residents. Before July 1, 1998, Medicare used a "retrospective cost" payment that would reimburse reasonable costs. Beginning on July 1, 1998, the Medicare payment system began moving to a prospective payment system that uses a nationally determined payment schedule for 44 care levels that is adjusted for regional cost variations. The change has been phased in over a three-year period.

7. Nursing home operators, through their trade associations, have raised a concern about the level of reimbursement nursing homes receive under MA. The Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging contracted with BDO Seidman to conduct a study on the financial condition of nursing home facilities in Wisconsin.

The report found that "for the rate year that ended June 30, 2000, only 17% of all nursing facilities were reimbursed their Medicaid costs; average Medicaid losses were almost $11 per patient day; and aggregate Medicaid losses for all Wisconsin facilities exceeded $100 million." The report also concluded that the financial condition of Wisconsin nursing homes has been adversely affected by: (a) the changes in Medicare payments under the new PPS system; (b) decreases in occupancy rates; and (c) labor shortages due to low unemployment rates.

8. The analysis in the BDO Seidman report concerning the relationship of cost and MA rates did not incorporate $39.6 million in supplemental payments made to county-owned nursing homes during 1999-00, nor did it reflect any payments that were available to nursing homes under the wage pass-through program. Further, at the time BDO was preparing its report, only 75% of the cost reports for Wisconsin nursing homes were available. Consequently, it is possible that the information BDO Seidman used was not representative of all nursing homes in the state.

9. This paper presents an analysis similar to the one conducted by BDO Seidman to explore the impact of the items that were not considered as part of the BDO Seidman study. In this analysis, the costs relative to reimbursement in the 1999-00 fiscal year represent estimates, since the cost figures are based on 1998 costs that are inflated to 1999-00, based on a national cost index for skilled nursing homes. More recent cost data are not available. The analysis uses actual 1999-00 per diem reimbursement rates, and actual supplemental payments to county- and municipally-owned nursing homes. Since the full amount budgeted for the 1999-00 wage pass-through payments was not awarded, this analysis assumes that each facility only received 75% of the possible amount for the wage pass-through.

10. This analysis found that 76% of nursing homes did not have their costs fully reimbursed under MA in 1999-00. Table 1 provides a frequency distribution to indicate the relative amount of the difference between costs and reimbursement rates. Table 1 indicates that 55.4% of nursing homes had 95% or more of their costs covered by MA payments, and that 76.9% of homes had 90% or more of their costs covered. On the other hand, 8.2% of homes had 80% or less of their costs covered, and 23.1% of homes had less than 90% of their costs covered.

TABLE 1

Estimated Percentage of Allowable Costs Covered by MA Reimbursement 1999-00

Percentage of Costs Covered	Number of Homes	Percentage of Homes
0% to 50%	2	0.50%
51% to 60%	1	0.25
61% to 70%	3	0.75
71% to 75%	12	2.99
76% to 80%	15	3.73
81% to 85%	23	5.72
86% to 90%	37	9.20
91% to 95%	78	19.40
96% to 100%	134	33.33
101% to 105%	97	24.13
Total	402	100.00%

11. This analysis was based on the 1999-00 fiscal year. In 2000-01, budgeted funding provided a 2% rate increase. Since this rate increase is less than the 3.8% projected increase for nursing home market basket, it is likely that, in 2000-01, the reimbursement rates fund a lower percentage of costs than indicated in the analysis for 1999-00.

12. Another way to consider the issue of the adequacy of MA nursing home rates is to examine changes in the targets or maximum limits for the most significant cost centers. The four largest cost centers, in order of relative size, are direct care, support services, administration/general, and capital.

13. Table 2 indicates the changes to these targets since the 1994-95 fiscal year. In 1994-95, the direct care target was 110% of the statewide median cost, and decreased to 102.3% in 1999-00 and to 100.3% in 2000-01. The targets for support services have also decreased, from 103.0% of the statewide median in 1994-95 to 102.0% in 1999-00 and to 95% of the statewide median in 2000-01. In 1994-95, the target for the administration/general cost center was set at 103% of the statewide median, and has decreased to 102.0% of the statewide median in 1999-00. For 2000-01, there will be two different targets. For homes with 40 or fewer beds, DHFS will set the target at 100% of the statewide median. For facilities with 40 or more beds, the target will be set at 91.2% of the statewide median. The difference in the two targets for the administration/general cost center is $1.26 per patient day.

14. Capital costs are limited in a different way than the three other primary cost centers. Full reimbursement of capital costs is limited to costs that do not exceed 7.5% of the replacement value of the nursing home. Partial reimbursement (20%) is provided for costs between 7.5% and 15% of the replacement value. The replacement value is limited to $50,100 per bed in 2000-01. The target for full reimbursement (currently 7.5%) has not changed since 1995-96 and was higher (8.9%) in 1994-95. The excess cost sharing percentage was 50% in 1994-95, and was reduced to 40% in 1995-96, and further reduced to the current 20% in 1997-98. The replacement value limit has increased each year.

TABLE 2

Nursing Home Targets/Maximum Limits
Major Cost Centers
1994-95 to 2000-01

Target as a Percentage Of Statewide Median	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	
Direct Care	110.0%	110.0%	103.0%	103.0%	102.3%	102.3%	100.3%	
Supportive Services	103.0	103.0	102.0	102.0	102.0	102.0	95.0	
Administration/General	103.0	103.0	102.0	102.0	102.0	102.0	91.2	(>=40 beds)
							100.0	(<40 beds)
Capital Costs								
(% of replacement value)	8.9%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	
(excess cost share)	50.0	40.0	40.0	20.0	20.0	20.0	20.0	

15. Another way to measure the adequacy of the MA reimbursement for nursing home services is to compare MA per diem rates with estimates of increases in the costs of providing nursing home services. Table 3 lists the average payments per patient day under several different categories for each year for the period beginning in 1995-96 through 1999-00. The first row of figures in Table 3 identifies, for each fiscal year, the average payment per patient day for all non-state nursing homes. Table 3 also includes the annual change in a national cost index for a skilled nursing home market basket.

16. Table 3 indicates that, for each year between 1995-96 through 1998-99, the increase in the average payment per day (3.3%, 3.8% and 5.5%) was higher than the increase in the SNF cost index (2.8%, 3.2% and 3.1%), but in 1999-00, the increase in the average payment per patient day (3.2%) was less than the increase in the cost index (4.4%). It is likely that the increase in payments rates in 2000-01 will be less than the increase in the index because the state MA rates were budgeted to increase by 2%, but projected inflation for nursing home services is 3.8%.

17. The SNF market basket does not adjust for increases in acuity levels. It may be that nursing homes require a rate increase above the SNF market basket rate increase because the care

needs of their patients are increasing, which requires higher staffing at these facilities. Nursing home administrators have argued that acuity levels have increased in recent years. However, it is not clear how this change in acuity should be factored in to make these comparisons.

TABLE 3

Average MA Per Diem Payments
1995-96 to 1999-00

Type of Nursing Home	1995-96	1996-97	1997-98	1998-99	1999-00	Average Annual % Increase
All Non-State Nursing Facilities	$86.88	$89.78	$93.20	$98.28	$101.45	
% increase over prior year		3.3%	3.8%	5.5%	3.2%	4.0%
All Skilled Nursing Facilities	$84.04	$87.03	$90.31	$95.21	$98.36	
% increase over prior year		3.6%	3.8%	5.4%	3.3%	4.0%
Non-State Facilities for the Developmentally Disabled	$119.41	$122.04	$129.23	$135.71	$139.23	
% increase over prior year		2.2%	5.9%	5.0%	2.6%	3.9%
Price Index for SNF market basket						
% increase over prior year		2.8%	3.2%	3.1%	4.4%	3.4%

18. In the last three years, there have been significant changes in the reimbursement methodology for Medicare. Beginning in July, 1998, Medicare began transitioning from a cost-based system to a case-mix system. It appears that the new payment system under Medicare has reduced payments to nursing homes. According to the 1999 survey of Wisconsin nursing homes, the average per diem rate for skilled nursing care decreased by 11% for Medicare-funded residents from calendar year 1998 to 1999. However, although the Medicare payment changes have resulted in lower payments, based on a recent GAO report, it appears that current Medicare payments should, in general, cover necessary costs. A GAO report issued September 5, 2000, concluded that aggregate Medicare payments "likely cover the cost of care needed...although some refinements to the present system are needed." The report stated that "Medicare policy changes have required many nursing homes to adjust their operations," especially those homes that "took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery."

19. Recently, Congress has provided several significant increases in Medicare rates. Although the increase varied, the therapy categories increased by 27% between October, 1999, and October, 2000, and increased by an additional 11% in April, 2001. The rehabilitation categories did not increase as much, but also increased significantly.

20. Utilization of nursing facilities has decreased since 1994. From 1994 to 1999,

inpatient days for nursing facilities decreased 10%, from 16.2 million to 14.6 million, while for facilities for the developmentally disabled other than the state Centers, inpatient days decreased 16%, from 848,973 in 1994 to 712,104 in 1999. In addition, the percentage of licensed beds that are occupied decreased from 90.6% in 1994 to 84.6% in 1999 for nursing facilities and from 93.5% to 92.1% for facilities for the developmentally disabled. As a result, nursing home costs per patient day may have been adversely affected, since facilities have a smaller base of residents over which to spread their fixed costs.

21. A final factor that may be affecting nursing homes is the relatively tight labor market, which has made if difficult for some nursing homes to recruit and retain staff. This contributes to increasing costs for nursing homes, since nursing homes may need to raise wages to attract staff and may have to employ more expensive, temporary help. In addition, staffing shortages might lead a nursing home to restrict admissions, since shortages might prevent a nursing home from having enough staff to care for new residents. Since the national labor market has also been tight, the upward pressures on wages may be reflected in the national cost index for the SNF market basket.

22. In the last fiscal year, 44 nursing homes in Wisconsin filed for bankruptcy in Wisconsin. This represented close to 10% of all nursing homes. Information on the number of bankruptcies in previous years is not available, but DHFS staff has indicated that the number of bankruptcies in previous years has been very limited. Nationally, approximately 12% of nursing homes are operating in bankruptcy.

23. An important question is whether the lower reimbursement level has lead to a decrease in the level of care provided by nursing homes. Table 4 lists statistics on the number of federal deficiencies and state violations over calendar years 1996 to 2000. Table 4 indicates that the total number of federal deficiencies and the number of federal actual harm deficiencies violations has not increased. However, there does appear to be increases in the most serious types of citations -- federal immediate jeopardy citations and state Class A violations. Also, there appears to be some upward trend in state Class B violations, which are not as serious as Class A, but is defined as a situation directly threatening to the health, safety or welfare of a resident.

TABLE 4

Nursing Home Citations
Calendar Year 1996 Through 2000

	1996	1997	1998	1999	2000
Total Federal Health Care Deficiencies	1,958	1,986	2,086	1,824	1,674
Federal Actual Harm Deficiencies	0	248	182	183	143
Federal Immediate Jeopardy	3	2	8	12	27
State Class A Violations	19	8	11	13	24
State Class B Violations	76	180	226	236	255

Regular Per Diem Nursing Home Rate – 2001-03

24. The Governor's recommends that $75,000,000 (all funds) in 2001-02 and $117,160,700 (all funds) in 2002-03 be provided for general per diem rate increases. Based on projected changes in utilization of nursing homes, this funding would provide estimated rate increases of 8.81% and 4.73%, respectively. The recommended rate increase are higher than current inflation rates. However, if the Committee determines that the current reimbursement level is inadequate, it may be appropriate to provide rate increases that exceed projected inflation rates in the 2001-03 biennium.

25. The additional $75,000,000 in 2001-02 is projected by DHFS to support a target of 104% for direct care, 95% for support services and administration and a capital limit of 9.5%. As noted previously, for the 2000-01 fiscal year, the target for direct care is 100.33%, for support services 95%, for administration 95% (100% for facilities with less than 40 beds), and for capital 7.5%.

26. The intent of the 4.73% increase in 2002-03 is to maintain the direct care targets and other targets at the level anticipated in 2001-02. Historically, nursing home costs have increased at a rate of 4% to 5% annually.

IGT & Nursing Home Agreement

27. The funding in the Governor's bill for nursing home rate increases reflects an agreement between the Department of Administration, Department of Health and Family Services, the Wisconsin Counties Association, Wisconsin Association of Homes and Services for the Aging and the Wisconsin Health Care Association. In addition to the funding increase for per diem rates, the agreement also specifies that supplemental payments to counties will be increased by $40,000,000 in each year.

28. The agreement further specifies that all new IGT funds would be devoted to the MA program, and that most of the IGT funds would be used for nursing home reimbursement. Further, the agreement calls for establishment of an interest-bearing MA trust account that would receive all IGT funds. The agreement would retain the current use of $78.1 million of IGT funds for offsetting state GPR costs for MA base expenditures related to past nursing home rate increases.

29. In exchange for committing these additional IGT funds for nursing homes, counties agreed to participate in a wire transfer to obtain these funds. As a result of a wire transfer in March, 2001, Wisconsin will receive a total of $372.7 million in IGT funds in 2000-01, which is an increase of $254.5 million over 2000-01 budgeted levels. Budgeted expenditures from IGT funds in 2000-01 will utilize $94.5 million of these IGT funds, leaving an estimated $278.2 million for expenditures in 2001-03. Under the agreement, Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties have agreed to continue to pursue their downsizing plans for their county-operated nursing homes.

30. The agreement was based on the assumption that Wisconsin would receive

additional IGT funds of $260 million in 2000-01, $190 million in 2001-02 and $155 million in 2002-03 above the current budgeted level of $118.2 million. The agreement stated that the parties would renegotiate a revised funding agreement if actual IGT revenues are significantly different from the assumed levels.

IGT Revenues

31. HCFA has raised questions about the validity of Wisconsin's previous methodology for claiming IGT, and has proposed regulations that would limit Wisconsin's and other states' expanded IGT claims that were recently submitted and approved. These actions by HCFA suggest that Wisconsin may only be able to make limited wire transfers to counties that are equal to the gap between what Medicare would reimburse county-owned nursing homes and actual MA payments (including the supplemental payments) made to these nursing homes. This gap will depend on future Medicare rates and future MA rates and supplemental payments, but it may be that total IGT revenues will be reduced to $50 to $100 million annually, and could eventually be eliminated.

32. However, it is possible that annual IGT revenue could equal or exceed the previous level of $118 million of IGT funds, due to a federal budget provision that was intended to provide Wisconsin and other states an eight-year transition period. However, HCFA may dispute the argument that the provision covers Wisconsin, and the resolution may depend on negotiations with HCFA or legal action. No final determination on this matter is expected in the near future.

33. Due to the IGT revenues the state received in 2000-01, Wisconsin will have $278.2 million available in the 2001-03 biennium. The Governor's budget bill would budget $383.8 million in IGT funds, although $33.1 million of those expenditures are contingent on annual IGT revenues of $115.2 million in each year of the biennium. Although there is uncertainty, IGT revenues of $75 million annually in 2001-03 might be assumed, which in combination with the opening balance would provide a total of $428.2 million of IGT funds for 2001-03.

Options for the Regular Per Diem Rate Increase

34. Because of the uncertainty of IGT revenues and the structural imbalance that would be created between future annual expenditures and revenues, the Committee may wish to reduce the Governor's recommended increases for nursing homes or to make part of the increase contingent on the receipt of additional IGT revenues.

35. Any reduction in the Governor's proposed rate increase may result in an increase in IGT revenue the state receives, since lower MA payments may increase the gap between what Medicare would pay and state MA payments. Assuming that county- and municipal-owned homes would receive 20% of any increase in nursing home payments, for every $1 reduction in nursing home payments IGT revenues may increase by $0.12. This increase in IGT revenues would depend on: (a) counties participating in the wire transfer; and (b) the amount of MA payments to county- and municipal-owned homes not exceeding what would be paid under Medicare.

36. The relative reimbursement level of nursing homes has declined over recent years.

Since MA residents are such a large part of the nursing home population (68% on average), the reimbursement level under MA is critical for the financial health of an average nursing home. Given this situation, it may be desirable to provide an increase that raises the relative reimbursement level and that exceeds inflation. In the past, nursing home costs have increased at an annual rate of 4% to 5%, and thus, a rate increase in excess of 5% would be needed to raise the relative reimbursement level.

37. The Governor recommends a rate increase of 8.81% in 2001-02 and 4.73% in 2002-03. If the rate increases were reduced to 7.81% in 2001-02 and 4.73% in 2002-03, there would be savings of $8,515,300 all funds ($3,512,600 SEG) in 2001-02 and $8,795,400 all funds ($3,649,900 SEG) in 2002-03 plus an estimated increase of $2,012,100 in IGT revenues. A reduction of the rate increase in the first year to a 7.00% rate increase, rather than 8.81%, would result in biennial SEG savings of $12,947,300 with an estimated increase in IGT revenues of $3,637,000.

38. A second option to generate savings would be to lower the rate increase in the first year, and increase the rate increase in the second year by the same amount and tie the higher, second year rate increase to the receipt of additional IGT revenues. This would provide the same amount of funding for nursing homes in the second year, which would be the base for future bienniums, and would result in only a one-time decrease in 2001-02 for nursing home reimbursement. Rate increases of 7.81% in 2001-02 and 5.73% in 2002-03 would produce savings of $3,405,200 SEG in the 2001-03 biennium with an estimated increase of IGT revenues of $970,800, and $20,505,100 all funds ($8,509,100 SEG) of the rate increase in 2002-03 could be tied to the receipt of additional IGT revenues. Rate increases of 6.81% and 6.73% would produce savings of $6,880,100 SEG in the 2001-03 biennium with an estimated increase of IGT revenues of $1,960,900, and $34,940,300 all funds ($14,499,300 SEG) in 2002-03 could be tied to the receipt of additional IGT revenues.

County Supplement

39. The Governor's budget proposes that $77,100,000 (all funds) annually, including be provided as supplemental payments to county-owned nursing homes, which represents an increase of $40,000,000 (all funds) annually compared to the base funding level. The Governor's budget specifies that the additional $40,000,000 of funding be contingent on the state receiving at least $115,200,000 of IGT funds in that same year, which represents the level of IGT revenues prior to the use of the wire transfer methodology.

40. County nursing homes serve approximately 20% of the MA nursing home residents in the state, and based on their share of MA patient days, could be expected to receive approximately 20% of any increase in regular per diem rates. Since county-owned nursing homes tend to have higher direct care costs and the agreement would focus most of the funding increase in the direct care area, county-owned homes may receive more than 20% of any regular per diem funding increase. County-owned nursing homes' share of the Governor's recommended funding increases might be expected to exceed $15,000,000 in 2001-02 and $23,500,000 in 2002-03.

41. The combined effect of the regular rate increase and the additional supplemental

payments of $40 million under the Governor's recommendations would likely allow total MA payments to equal total costs so that county-owned nursing homes would have all of their deficits reimbursed by the supplemental payments, assuming normal growth in costs.

42. Table 5 shows the history of county deficits and the allocation of IGT revenues that were derived based on those deficits. Table 5 indicates that supplemental payments to county-owned homes have been relatively flat and have declined as a percentage of their total deficits while, the amount allocated to offset the GPR costs of general rate increases has steadily increased.

TABLE 5

Intergovernmental Transfer Program
($ in Millions)

		Allocation of IGT Revenues		
Fiscal Year	Deficit Before Supplement	County Supplement	County Supplement as a % of Deficit	Offset to State GPR Costs for Nursing Home Rate Increases
1992-93	$47.2	$18.6	39.4%	$0.0
1993-94	43.1	37.1	86.1	5.4
1994-95	48.1	37.1	77.1	30.4
1995-96	56.4	37.1	65.8	26.1
1996-97	61.1	46.1	75.5	72.4
1997-98	65.8	40.2	61.1	53.9
1998-99	66.7	37.1	55.6	58.3
1999-00	73.6	39.7	53.9	65.3
2000-01	81.6	40.1	49.1	78.1
2001-02 (Gov.)	$77.1	$77.1	100.0%	$91.9
2002-03 (Gov.)	82.2	77.1	93.8	102.3

43. As indicated by Table 5, the Governor's budget would increase the amount of IGT revenues that are used by the state to offset the GPR costs of past nursing home increases. The amount used for this offset would increase from $78.1 million in 2000-01 to $91.9 million in 2002-03 and $102.3 million in 2002-03. Since the increases for nursing home reimbursement are separately supported by other IGT funds, the increase of the $78.1 million offset is effectively funding other MA service cost increases totaling $33.5 million in 2001-02 and $58.3 million in 2002-03.

44. The additional $40 million supplemental payment is contingent upon the receipt of at least $115.2 million of IGT revenues in that year which would provide $230.4 million to add to

the $278.2 million that would be available from 2000-01, which is a total of $508.6 million. This exceeds the $383.8 million of IGT revenues that would be needed for IGT-supported expenditures in the Governor's budget.

45. Although the budget provision would prohibit payment of the additional $40 million supplemental payment if IGT revenues are less than $115.2 million in a year and the state would not have to make that payment, Wisconsin may be able to perform a wire transfer that would generate IGT revenues of $50 to $100 million annually. However, the budgetary provision prohibits any additional supplemental payment. This would eliminate any incentive for the counties to cooperate in any wire transfers.

46. It may be desirable to amend the budget to state that if IGT revenues are less than $115.2 million, than an additional supplemental payment of up to $40 million could be made, contingent on the receipt of additional IGT revenues in that year, if recommended by the DHFS and approved by the Joint Committee on Finance. Alternatively, the amount of the additional supplemental payment could be tied to the amount of IGT revenues in that year.

47. If the additional county supplemental payment were tied to 34.7% of the IGT revenues received in that year, this would result in an additional supplement approaching $40 million as IGT revenues approach $115.2 million, and as a result, may be consistent with the IGT agreement with the counties.

48. A key factor in providing the additional supplemental payment to county-owned homes is to elicit their cooperation in participating in the wire transfers. In addition to this factor, the following arguments could be made:

- Supplemental payments have been flat for a number of years and have declined as a percentage of county deficits, even though IGT revenues have been increasing;

- County nursing homes are a key element in the state's ability to claim IGT revenues;

- A greater percentage of residents at county nursing homes exhibit challenging behaviors, which many private homes would not admit, and thus, county-owned homes provide a service for a group that may be difficult to place in other settings.

- County-owned homes tend to pay their workers at higher rates, which reduces turnover among staff and may contribute to better quality staff and care. Higher supplemental payments would help support these higher wages and the associated benefits.

49. There are several consequences to increasing the supplemental payments, especially if the supplemental payments completely reduce these homes' deficits. First, the incentive to become more efficient would be reduced if all or almost all of the deficit is covered. Second, the incentive for county nursing homes to downsize would be reduced. In the long-run, this may increase costs to the state's MA program.

50. For every $1 reduction in supplemental payments, IGT revenues could increase by $0.59. If county supplemental payments were reduced by $10 million, IGT revenues could increase by $5.9 million. As previously indicated, the increase in IGT revenues would depend on counties cooperating in the needed wire transfers.

51. If the Committee decides to reduce the Governor's proposed increase for county supplemental payments, it could use all or part of that reduction for additional increases for the regular per diem reimbursement rate.

52. Another alternative would be to use the funding for increasing community options program (COP) payments to counties that own nursing homes with deficits. This would provide these counties with resources to place individuals needing long-term care in the community, rather than an institution. This might help these counties to downsize their facilities, which might benefit the state by substituting less expensive care settings. The same formula that is used to distribute the county supplemental payments could be used to distribute the increase in COP funding, which would direct funding in proportion to the size of the county home's unreimbursed deficit.

53. The Governor's proposed $40 million increase in supplemental payments would be funded with approximately $16.5 million of IGT funds with the remainder funded by federal MA matching funds. If $16.5 million of IGT funds were provided to these counties as COP allocations, the counties could use those funds to support COP-waiver slots and CIP IB slots, which would also be eligible for federal matching funds under MA.

54. If county supplemental payments are reduced by $40,000,000, there would be a corresponding increase in the difference between the Medicare upper limit and MA payments. This would allow additional wire transfers of $40,000,000 and additional IGT claims of 59% of that amount --$23.6 million.

55. Since providing these additional COP dollars would still leave these counties with deficits for their nursing homes, this alternative would not be as attractive to these counties. However, this additional IGT revenue could be used to support, additional COP funding. If an additional $10 million of IGT funds were added to the $16.5 million, this would provide the counties a total of $26.5 million of COP funding that could be used to provide total MA waiver services of $64 million. This would leave the state an additional $13.6 million of IGT revenues in each year.

ALTERNATIVES TO BASE

A. Funding for Regular Per Diem Rate

1. Approve the Governor's recommendation to provide $75,000,000 ($44,062,500 FED and $30,937,500 SEG) in 2001-02 and $117,160,700 ($68,541,900 FED and $48,618,800 SEG) in 2002-03 provide rate increases of 8.81% in 2001-02 and 4.73% in 2002-03 for all nursing homes.

Alternative A1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$112,604,400	$79,556,300	$192,160,700
[Change to Bill	*$0*	*$0*	*$0]*

2. Modify the Governor's recommendation by deleting $8,515,300 ($5,002,700 FED and $3,512,600 SEG) in 2001-02 and $8,795,400 ($5,145,500 FED and $3,649,900 SEG) in 2002-03 to increase rates by 7.81% in 2001-02 and 4.73% in 2002-03. Increase estimated IGT revenues by $1,000,500 in 2001-02 and $1,011,500 in 2002-03.

Alternative A2	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$2,012,000	$2,012,100
[Change to Bill	*$0*	*$2,012,000*	*$0]*
2001-03 FUNDING (Change to Base)	$102,456,200	$72,393,800	$174,850,000
[Change to Bill	*- $10,148,200*	*- $7,162,500*	*- $17,310,700]*

3. Modify the Governor's recommendation by deleting $15,392,800 ($9,043,300 FED and $6,349,500 SEG) in 2001-02 and $15,899,100 ($9,301,300 FED and $6,597,800 SEG) in 2002-03 to increase 7.00% in 2001-02 and 4.73% in 2002-03. Increase estimated IGT revenues by $1,808,700 in 2001-02 and $1,828,500 in 2002-03.

Alternative A3	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$3,637,200	$3,637,200
[Change to Bill	*$0*	*$3,637,200*	*$3,637,200]*
2001-03 FUNDING (Change to Base)	$94,259,800	$66,609,000	$160,868,800
[Change to Bill	*- $18,344,600*	*- $12,947,300*	*- $31,291,900]*

4. Modify the Governor's recommendation by deleting $8,515,300 ($5,002,700 FED and $3,512,600 SEG) in 2001-02 and providing $258,800 ($151,400 FED and $107,400 SEG) in 2002-03 to increase rates by 7.81% in 2001-02 and 5.73% in 2002-03. In addition, specify that 1.00% of the 5.73% rate increase in the second year ($20,505,100 all funds) would be contingent on the receipt of at least $115.2 million of IGT revenue in both years of the biennium. Modify estimated IGT revenues by $1,000,500 in 2001-02 and -$29,800 in 2002-03.

Alternative A4	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$970,700	$970,700
[Change to Bill	*$0*	*$970,700*	*$970,700]*
2001-03 FUNDING (Change to Base)	$107,753,100	$76,151,100	$183,904,200
[Change to Bill	*- $4,851,300*	*- $3,405,200*	*- $8,256,500]*

5. Modify the Governor's recommendation by deleting $17,030,600 ($10,005,500 FED and $7,025,100 SEG) in 2001-02 and providing $349,600 ($204,600 FED and $145,000 SEG) 2002-03 to fund rate increases of 6.81% in 2001-02 and 6.73% in 2002-03. In addition, specify that

2.00% of the 6.73% rate increase in the second year ($34,940,300 all funds, $14,499,300 SEG) would be contingent on the receipt of at least $115.2 million of IGT revenue in both years of the biennium. Modify estimated IGT revenues by $2,001,100 in 2001-02 and -$40,200 in 2002-03.

Alternative A5	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$1,960,900	$1,960,900
[Change to Bill	*$0*	*$1,960,900*	*$1,960,900]*
2001-03 FUNDING (Change to Base)	$102,803,500	$72,676,200	$175,479,700
[Change to Bill	*- $9,800,900*	*- $6,880,100*	*- $16,681,000]*

B. County Supplemental Payment

1. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. In addition, approve the Governor's recommendation to provide $23,500,000 FED and $16,500,000 SEG in 2000-01 and $23,401,000 FED and $16,599,000 SEG in 2002-03 to increase the county supplemental payment by $40,000,000 annually, but specify that the additional $40,000,000 payment would be contingent on annual IGT revenues of $115,200,000 in the year of the payment.

Alternative B1	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$90,401,600	$63,798,400	$154,200,000
[Change to Bill	*$0*	*$0*	*$0]*

2. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. In addition, approve the Governor's recommendation to provide $23,500,000 FED and $16,500,000 SEG in 2000-01 and $23,401,000 FED and $16,599,000 SEG in 2002-03 to increase the county supplemental payment by $40,000,000 annually, but modify the contingency requirements to specify that if annual IGT revenues are less than $115,200,000, the additional IGT payment would be lowered to one of the following amounts:

(i) 34.7% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $40,000,000 as IGT revenues approach $115,200,000)

(ii) 30% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $35,000,000 as IGT revenues approach $115,200,000)

(iii) 25% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $28,800,000 as IGT revenues approach

$115,200,000)

(iv) 20% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $23,000,000 as IGT revenues approach $115,200,000)

(v) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B2	FED	SEG	TOTAL
2001-03 FUNDING (Change to Base)	$90,401,600	$63,798,400	$154,200,000
[Change to Bill	*$0*	*$0*	*$0]*

3. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. However, modify the Governor's recommendation by deleting $5,000,000 ($2,937,500 FED and $2,062,500 SEG) in 2000-01 and $5,0000,000 ($2,925,100 FED and $2,074,900 SEG) in 2002-03 to reduce the increase in the county supplemental payment to $35,000,000 annually. Increase estimated IGT revenues by $2,937,500 in 2001-02 and $2,875,100 in 2002-03. In addition, specify that the additional $35,000,000 payment would be contingent on annual IGT revenues of $115,200,000 in the year of the payment. If annual IGT revenues are less than $115,200,000, the additional IGT payment would be reduced to one of the following amounts:

(i) 30% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $35,000,000 as IGT revenues approach $115,200,000)

(ii) 25% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $28,800,000 as IGT revenues approach $115,200,000)

(iii) 20% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $23,000,000 as IGT revenues approach $115,200,000)

(iv) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B3	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$5,812,600	$5,812,600
[Change to Bill	*$0*	*$5,812,600*	*$5,812,600]*
2001-03 FUNDING (Change to Base)	$84,539,000	$59,661,000	$144,200,000
[Change to Bill	*- $5,862,600*	*- $4,137,400*	*- $10,000,000]*

4. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. However, modify the Governor's recommendation for the amount of the additional payment to delete $10,000,000 ($5,875,000 FED and $4,125,000 SEG) in 2000-01 and $10,000,000 ($5,850,200 FED and $4,149,800 SEG) in 2002-03 to lower the increase in the county supplemental payment to $30,000,000 annually. Increase estimated IGT revenues by $5,875,000 in 2001-02 and $5,750,300 in 2002-03. In addition, specify that the additional $30,000,000 payment would be contingent on annual IGT revenues of $115,200,000 in the year of the payment. If annual IGT revenues are less than $115,200,000, the additional IGT payment would be lowered to one of the following amounts:

(i) 25% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $28,800,000 as IGT revenues approach $115,200,000)

(ii) 20% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $23,000,000 as IGT revenues approach $115,200,000)

(iii) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B4	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$11,625,300	$11,625,300
[Change to Bill	*$0*	*$11,625,300*	*$11,625,300]*
2001-03 FUNDING (Change to Base)	$78,676,400	$55,523,000	$134,200,000
[Change to Bill	*- $11,725,200*	*- $8,274,800*	*- $20,000,000]*

5. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. However, modify the Governor's recommendation for the amount of the additional payment to delete $15,000,000 ($8,812,500 FED and $6,187,500 SEG) in 2000-01 and $15,000,000 ($8,775,300 FED and $6,224,700 SEG) in 2002-03 to lower the increase in the county supplemental payment to $25,000,000 annually. Increase estimated IGT revenues by $8,812,500 in 2001-02 and $8,625,400 in 2002-03. In addition, specify that the additional $25,000,000 payment would be contingent on annual IGT revenues of $115,200,000 in the year of the payment. If annual IGT revenues are less than $115,200,000, the additional IGT payment would be lowered to one of the following amounts:

(i) 20% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $23,000,000 as IGT revenues approach $115,200,000)

(ii) 10% of the amount of IGT revenues received in that year (this percentage would

result in an additional payment that would approach $11,520,000 as IGT revenues approach $115,200,000)

(iii) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B5	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$17,437,900	$17,437,900
[Change to Bill	*$0*	*$17,437,900*	*$17,437,900]*
2001-03 FUNDING (Change to Base)	$72,813,800	$51,386,200	$124,200,000
[Change to Bill	*- $17,587,800*	*- $12,412,200*	*- $30,000,000]*

6. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. However, modify the Governor's recommendation for the amount of the additional payment to delete $20,000,000 ($11,750,000 FED and $8,250,000 SEG) in 2000-01 and $20,000,000 ($11,700,500 FED and $8,299,500 SEG) in 2002-03 to reduce the increase in the county supplemental payment to $20,000,000 annually. Increase estimated IGT revenues by $11,750,000 in 2001-02 and $11,500,500 in 2002-03. In addition, specify that the additional $20,000,000 payment would be contingent on annual IGT revenues of $115,200,000 in the year of the payment. If annual IGT revenues are less than $115,200,000, the additional IGT payment would be lowered to one of the following amounts:

(i) 15% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $17,280,000 as IGT revenues approach $115,200,000)

(ii) 10% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $11,520,000 as IGT revenues approach $115,200,000)

(iii) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B5	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$23,250,500	$23,250,500
[Change to Bill	*$0*	*$23,250,500*	*$23,250,500]*
2001-03 FUNDING (Change to Base)	$66,951,100	$47,248,900	$114,200,000
[Change to Bill	*- $23,450,500*	*- $16,549,500*	*- $40,000,000]*

7. Adopt Alternative B4, except specify that the annual $10,000,000 reduction in additional county supplemental payment would instead be used to further increase the regular per diem nursing home reimbursement rate. Increase estimated IGT revenues by $4,700,000 in 2001-02

and $4,600,200 in 2002-03.

Alternative B7	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$9,300,200	$9,300,200
[Change to Bill	*$0*	*$9,300,200*	*$9,300,200]*
2001-03 FUNDING (Change to Base)	$90,401,600	$63,798,400	$154,200,000
[Change to Bill	*$0*	*$0*	*$0]*

8. Adopt Alternative B5, except specify that the annual $15,000,000 reduction in additional county supplemental payments would be used to further increase the regular per diem nursing home reimbursement rate. Increase estimated IGT revenues by $7,050,000 in 2001-02 and $6,900,300 in 2002-03.

Alternative B8	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$13,950,300	$13,950,300
[Change to Bill	*$0*	*$13,950,300*	*$13,950,300]*
2001-03 FUNDING (Change to Base)	$90,401,600	$63,798,400	$154,200,000
[Change to Bill	*$0*	*$0*	*$0]*

9. Approve the Governor's recommendation to provide $21,796,200 FED and $15,303,800 SEG in 2001-02 and $21,704,400 FED and $15,395,600 SEG in 2002-03 to continue the base $37,100,000 annual county supplemental payment. However: (a) delete the Governor's recommendation to increase county supplement payments by $40,000,000 annually (-$16,500,000 SEG and -$23,500,000 FED in 2001-02 and -$16,599,000 SEG and -$23,401,000 FED in 2002-03); and (b) to increase COP funding by $26,500,000 SEG and $37,742,400 FED and in 2000-01 and $26,699,000 SEG and $37,498,800 FED in 2002-03 for a special COP allocation that will be distributed to counties based of the amount of unreimbursed deficits of county- and municipal-owned nursing homes. Increase estimated IGT revenues by $23,500,000 in 2001-02 and $23,401,000 in 2002-03. Specify that this distribution is contingent on the receipt on annual IGT revenues of $115,200,000 in the year of the payment. If annual IGT revenues are less than $115,200,000, the additional IGT payment would be reduced to one of the following amounts:

(i) 20% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $23,000,000 as IGT revenues approach $115,200,000)

(ii) 15% of the amount of IGT revenues received in that year (this percentage would result in an additional payment that would approach $17,280,000 as IGT revenues approach $115,200,000)

(iii) An amount recommended by DHFS and approved by the Joint Committee on Finance.

Alternative B9	FED	SEG	TOTAL
2001-03 REVENUE (Change to Base)	$0	$46,901,000	$46,901,000
[Change to Bill	*$0*	*$46,901,000*	*$46,901,000]*
2001-03 FUNDING (Change to Base)	$75,241,300	$53,099,000	$128,340,300
[Change to Bill	*$28,340,300*	*$20,000,000*	*$48,340,300]*

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June 4, 2001 Joint Committee on Finance Paper #467

Estimated IGT Revenues and Creation of IGT Trust Account (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 350, #3 (part)]

CURRENT LAW

The state reimburses county- and municipal-owned nursing homes, as well as other types of nursing homes, for services provided to medical assistance (MA) recipients under a per diem rate based on past costs. Although the per diem rate reflects costs at each individual nursing facility, the MA reimbursement formula contains maximum payment limits that are based on statewide median costs. Consequently, nursing homes may not be reimbursed for all of their costs of serving MA recipients.

Costs paid by local governments may be used as the state match for federal MA funds. Consequently, the unreimbursed expenses of county- and municipal owned nursing homes related to MA residents can serve as the state match for claiming federal MA funds. Wisconsin's use of unreimbursed expenses of county- and municipal-owned nursing homes to claim additional federal MA matching funds is referred to as the state's intergovernmental transfer (IGT) program.

Under 1999 Wisconsin Act 9, the amount of federal matching funds based on unreimbursed expenses of county- and municipally-owned nursing homes the state received under the IGT program was estimated to be $105.0 million in 1999-00 and $118.2 million in 2000-01. The IGT revenues projected in Act 9 were based on the assumption that the Department of Health and Family Services (DHFS) would continue to use the certified losses of county- and municipal-owned nursing homes as the state match for federal MA funds. It was not anticipated that the state would use electronic transfers of funds between the state and counties to secure these IGT funds.

For example, the Committee could use a portion of this projected balance to fund the projected shortfall in the state-funded MA benefits appropriation, which is estimated to be $49.4 million ($31.7 million in 2001-02 and $17.7 million in 2002-03). If these surplus IGT funds are not used to address this shortfall, GPR funding will need to be added to the bill for this purpose.

Alternatively, the Committee could budget all of these surplus IGT funds for MA benefits in the 2001-03 biennium to: (a) address the projected MA benefits shortfall ($49.4 million); and (b) reduce GPR funding in the bill for MA benefits by $14.3 million in 2001-02. These GPR funds could then be used to address the projected general fund deficit.

5. The Governor's recommendations relating to the creation of a MA trust fund and reserving IGT revenues is based on an agreement made between the Department of Administration, DHFS, the Wisconsin Counties Association, the Wisconsin Association of Homes and Services for the Aging and the Wisconsin Health Care Association. The agreement specifies that all new IGT funds would be devoted to the MA program, and that IGT funds would be used for nursing home reimbursement. Further, the agreement calls for establishing an interest-bearing MA trust account that would receive all IGT funds. The agreement commits to providing new funding of $115.0 million (all funds) in 2001-02 and $157.2 million (all funds) in 2002-03 for nursing home reimbursement. In terms of IGT revenue, this would require $143.2 million in the 2001-03 biennium. The agreement would permit the state to continue to use $78.1 million of IGT funds annually to offset state GPR costs for MA base expenditures related to past nursing home rate increases.

7. In exchange for the additional funding for nursing homes, counties agreed to participate in a wire transfer to obtain these additional IGT funds. Under the agreement, Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties will continue to pursue their plans to downsize their county-operated nursing homes.

8. The agreement was based on the assumption that Wisconsin would receive additional IGT funds of $260 million in 2000-01, $190 million in 2001-02 and $155 million in 2002-03 above the current budgeted level of $118.2 million. The agreement stated that the parties would renegotiate a revised funding agreement if actual IGT revenues were significantly different from the assumed levels.

9. Although the state needs the counties to participate in the IGT electronic transfers, the counties have a significant interest in continuing to participate with the state in securing these IGT funds. The Governor's budget would provide substantial rate increases to nursing homes, based on the expectation that the state would continue to receive enhanced IGT funds in the 2001-03 biennium. While it would still be possible to fund the nursing home rate increases recommended by the Governor based on the current estimates, the Governor's proposed rate increases could be reconsidered in light of the current projections, as referenced in the agreement.

10. The Committee may wish to adopt the Governor's recommendations relating to the creation of the trust fund because depositing these revenues in the trust fund, rather than using them to fund costs in this biennium, would make these revenues available to substitute for base IGT funds currently budgeted for the MA program in future years if, as expected, these IGT revenues are no longer available. In this way, reserving these funds at this time would reduce the need for the state to commit additional GPR funds to support MA base costs if the state's ability to claim IGT funds is reduced or eliminated in the future.

11. The Committee could also address both the need for the state to use the IGT funds now and to reserve future IGT claims for the trust fund by: (a) retaining the Governor's recommendations to create a segregated trust fund; and (b) specifying that $63.7 million of the IGT funds the state has already received be lapsed to the general fund.

ALTERNATIVES TO BASE

1. Adopt the Governor's recommendations relating to establishing a MA trust fund.

2 Adopt the Governor's recommendations relating to establishing a MA trust fund. However, require DOA to lapse $63,700,000 of IGT revenue to the general fund on June 30, 2003.

Alternative 2	GPR-Lapse
2001-03 REVENUE (Change to Base)	$63,700,000

3. Delete the Governor's recommendations relating to establishing a MA trust fund. In addition, require DOA to lapse $63,700,000 of IGT revenue to the general fund on June 30, 2003.

Alternative 3	GPR-Lapse
2001-03 REVENUE (Change to Base)	$63,700,000

Prepared by: Richard Megna

ATTACHMENT

History of IGT Claiming

Wisconsin first began claiming additional federal MA funds in 1985-86. Initially, the state claimed an amount that was less than the federal share of the accumulated deficits of county- and municipal-owned nursing homes. This limited type of claiming continued until 1992-93, when the state claimed $18.6 million in additional federal MA funds based on $47.2 million of certified losses. The $18.6 million claimed was equal to 39% of the accumulated deficits, while the federal matching share in that year was 60%. During this period, all of the additional federal matching funds were distributed to county- and municipal-owned nursing homes as supplemental payments under the state's federal financial participation (FFP) program.

Beginning in 1993-94, the basis for claiming and the use of IGT funds changed significantly. First, the amount of additional federal matching funds claimed by the state began to exceed 60% of the total deficits incurred by county- and municipal-owned facilities. This increased claiming was based on the relationship between the state and federal matching funds rate (approximately 41% GPR/59% FED). Specifically, it was determined that a dollar of state matching funds could be used to claim $1.44 of federal matching funds (0.59/0.41 = 1.44). Since unreimbursed expenses of county- and municipal owned nursing homes could serve as the state match, $1.00 in unreimbursed county costs could be used to claim $1.44 of federal matching funds. This method of claiming was used through the 1999-00 fiscal year, when the state used $73.2 million of certified losses to claim $108.7 million of IGT funds.

In addition to changing the method used to claim federal matching funds, beginning in 1993-94 the state began using part of the IGT funds for supporting the state GPR costs of general nursing home rate increases. Of the $108.7 million in IGT funds in 1999-00, county- and municipal-owned nursing homes received $39.7 million in supplemental payments, while the remaining $69.0 million was used by the state to pay for the state's share of MA costs of general nursing home payments.

Although federal regulations allow states significant discretion in setting reimbursement levels for MA nursing home services, federal rules limit total MA payments to the amount that the state estimates would have been paid under Medicare payment principles. This limit is commonly referred to as the Medicare upper limit (MUL). Currently, the MUL test is applied in aggregate to each group of nursing homes so that the MUL is applied to privately owned (profit and nonprofit) nursing homes and county- and municipal-owned nursing homes as a group. Thus, if MA payments to private nursing homes are less than what would be paid under Medicare principles, county- and municipal-owned nursing homes can be paid more because the aggregate payment to both types of facilities is compared with the Medicare upper limit. There has always been a separate Medicare upper limit test for state-owned nursing facilities to limit the state's reimbursement of its own facilities.

New Federal Regulations

On January 12, 2001, the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) published a final rule to modify the MUL for nursing homes. This change establishes an additional MUL test that will be applied separately to non-state, public nursing facilities. This change will prevent the use of any difference between the federal upper limit and the actual MA payments to private facilities from supporting higher payments to county- and municipal-owned nursing homes.

The new federal rule includes transitional provisions that allow states to retain the current level of claiming at least to September 30, 2002, and provides for certain states to gradually comply with the new requirements over a longer transition period. The length of the transition period varies by the date when the state first had an approved MA state plan amendment that is not compliant with the new regulations. For states with approved plan provisions that were effective on or before October 1, 1992, current excess payments will first be reduced in each state's 2003-04 fiscal year, reducing the excess payments by increments of 15% each year, which would completely phase out the excessive payments by each state's 2009-10 fiscal year. For states with approved plan provisions that are effective after October 1, 1992, and before October 1, 1999, current excess payments will first be reduced in each state's 2002-03 fiscal year, reducing the excess payments by 25% each year, which would completely phase out the excess payments by each state's 2005-06 fiscal year.

Under the January, 2001, rule, it was not clear which transition period would apply to Wisconsin, because: (a) recent MA deferral letters from HCFA suggested that Wisconsin did not, in fact, have any approved plan provision; and (b) the federal regulation did not clearly define what is meant by an approved plan and whether significant modifications to an existing plan would be considered approved based on the original plan date or the date the modification was approved. Wisconsin had an approved plan for using county losses to claim federal IGT funds before 1992, but significantly changed the basis for the state's claiming in 1993-94.

The federal 2000-01 budget act (Public Law 106-554) included a provision that requires the eight-year transition period to apply to states with a state MA plan provision or methodology which: (a) was approved, deemed to have been approved, or was in effect on or before October 1, 1992 (including any subsequent amendments or successor provisions or methodologies and whether or not a state plan amendment was made to carry out such provision or methodology after such date) or under which claims for federal financial participation were filed and paid on or before such date; and (b) provides for payments that are in excess of the upper payment limit test established under the final regulation required under (a) or which would be noncompliant with such final regulation if the actual dollar payment levels made under the payment provision or methodology in the state fiscal year which begins during 1999 were continued.

One of the states that is intended to be covered by this provision is Wisconsin. However, HCFA's challenge to Wisconsin's current IGT claims, which is described in the next section, makes this uncertain.

Federal Deferrals of Wisconsin 's Past IGT Claim

HCFA has deferred a portion of the state's IGT claims for 1999-00 on the basis that the state did not have sufficient MA payments to support all of the additional federal funds. Although county losses can serve as the state-match for the federal claims, HCFA has indicated that the state must actually make MA payments to support those claims. HCFA allowed the $44.8 million of the IGT claim, which is equal to 59% of the certified losses, since the certified losses represent expenditures on nursing services to MA recipients. However, the remaining IGT claims of $64.9 million were deferred, since HCFA found that there were no other payments to the counties (no electronic transfer or other types of payments to support the claim).

The IGT deferrals for 1999-00 have not affected the state's cash receipts. Wisconsin has received these funds. However, if the deferrals are sustained and Wisconsin's claims are disallowed, Wisconsin will have to return those federal funds. HCFA has not made a final decision, and there is no date by which HCFA must make the decision.

The deferral issue for 1999-00 has a much broader effect than the loss of $64.9 million in 1999-00. If Wisconsin's IGT claims for 1999-00 were allowed, Wisconsin would qualify for one of the longer transition periods and would be able to sustain IGT claims for a longer period.

Electronic Transfer Method

There are numerous states that receive additional federal funding using county-owned nursing homes, but those states use a different method than Wisconsin. These other states use the following procedure: (a) a determination is made of the gap between what would be paid under Medicare principals and the actual MA payments to nursing facilities: (b) counties that own and operate a nursing home electronically transfer an amount equal to the gap to the state; (c) on the same day, the state returns that same amount to the counties, which is considered an MA payment to their nursing facilities; and (d) the state claims MA federal matching funds equal to the state federal share times the amount of the electronic transfer. The federal matching funds based on the electronic transfer are available for any use by the state, since the MA payment to the counties has already been made and financed by the transfer to the state.

On February 13, 2001, DHFS filed a modification to its state plan amendment for 2000-01 nursing home reimbursement that included a change to its IGT claiming methods. This modification serves two purposes. First, it responds to the concerns raised by HCFA that lead to the 1999-00 IGT deferrals. Second, the modification allows Wisconsin to expand the amount of its IGT claims to the full amount allowed under the Medicare upper limit. The modification indicated that Wisconsin would adopt the method of using electronic transfers that between the state and counties to maximize the amount of allowed MA nursing home payments.

Three counties agreed to participate in the electronic transfer, and in early March, a total transfer of $637 million was made, which would support a total IGT claim of up to $376.9 million in additional federal matching funds.

On May 9, 2001, Wisconsin's plan amendment was approved by HCFA. Due to adjustments in the calculation of the Medicare upper limit, Wisconsin will receive additional IGT revenues totaling $254,520,600, rather than $258,700,000, as projected under the Governor's budget.

HCFA's Proposed Fourth Transition Category

On April 3, 2001, HCFA proposed a rule to modify the transition periods specified in the January, 2001, final rule. HCFA received comments on the proposed rule through May 3, 2001. To date, HCFA has not published the final rule.

The proposed rule would establish a new transition period for states, including Wisconsin, that submitted MA state plan amendments before March 13, 2001, that do not comply with the new upper payment limits that were effective on that date and were approved on or after January 22, 2001. For these states, a one-year transition period that would end on the later of March 13, 2001, or one year after the approved effective date of each state plan amendment, would apply.

HCFA has indicated that this proposed rule would affect the following states: Florida, Georgia, Illinois, Kentucky, Michigan, Missouri, New Jersey, North Carolina, Pennsylvania and Wisconsin. Thus, it is HCFA's view that Wisconsin would only be able to claim additional IGT funds under the new mechanism for one year.

In describing the proposed rule, HCFA stated that the intention of the new rule is to apply the shorter one-year transition period only to the portion of spending that is above the amount that was previously approved. This suggests that Wisconsin's current level of IGT claims ($118 million) might be retained for several years as long as HCFA determines that Wisconsin had an approved plan for the prior mechanism. If HCFA disallows Wisconsin's 1999-00 IGT claim, it would be based on HCFA's determination that Wisconsin did not have an approved plan to claim more than 60% of the certified losses of county- and municipal-owned facilities.

HCFA could modify the proposed rule for a fourth transitional period, based on the comments the agency received through May 3 and reaction by members of Congress. In addition, it is possible that HCFA's proposed rule violates the provision in the P.L. 106-554 which DHFS indicates was intended to provide certain states, including Wisconsin, a longer transition period that would not begin until the state fiscal year that begins after September 30, 2002 (Wisconsin's 2003-04 state fiscal year).

IGT Revenues in 2003-04 and Beyond

Even if Wisconsin is provided an eight-year transition period, Wisconsin will receive limited IGT revenues in 2003-04 and future years. The federal rules, as well as P.L.106-554, limit the amount of payments above the new MUL requirement to 85% of the amount of claims that were above the new MUL in 1999-00. Wisconsin's IGT claims totaled $108.7 million in that year, but not all of this payment exceeded the new MUL requirement. Assuming that $65

million exceeded the new MUL and taking 85% of that amount, Wisconsin's ability to claim IGT above the new MUL would be limited to $55 million in 2003-04 under the most optimistic scenario. Each year after 2003-04, this amount would have to be reduced by another 15%.

It is unlikely that additional information will be available on the status of the state's IGT claiming before the 2001-03 biennial budget is passed. HCFA's view is that Wisconsin's new IGT claim is subject to the proposed one-year transition period, since it was authorized under a recently approved amendment. In addition, it appears that HCFA views the state's former method of claiming IGT funds as invalid, and thus, Wisconsin is not protected by any transitional provisions that would allow Wisconsin's old IGT level to be retained for a transitional period. There is possible that the IGT revenues in 2001-02 and subsequent years would be limited to the amount allowed under the new federal upper limit rule --the difference of what Medicare would pay county- and municipal-owned nursing homes and actual state MA payments to those facilities.

Wisconsin's ability to receive IGT revenue beyond what would be allowed under the new Medicare upper limit may rest on the argument that P.L. 106-554 requires that states with plan amendments adopted before 1992 (and including successor provisions) are required to be provided a transitional period that would first require payments to be restricted under the new rule beginning in 2003-04. If Wisconsin's new plan amendment for the electronic transfers can qualify as a successor provision to Wisconsin's original FFP program, then Wisconsin might be entitled to the enhanced IGT claims in both years of the 2001-03 biennium, as projected in the Governor's budget.

Wisconsin may be able to use the provision in P.L.106-554 to negotiate some transition arrangement with HCFA. One possibility might be an agreement to allow Wisconsin to continue its old level of IGT claims. HCFA has the 1999-00 deferral of $65 million that could be used in the negotiation, and HCFA could seek deferrals for the two previous years as well.

If Wisconsin were restricted to the new Medicare upper limit rule, the amount of IGT revenues the state would receive would be limited to 59% of the difference between what Medicare would pay to county- and municipal-owned nursing homes and actual MA payments (including supplemental payments) to those facilities. This gap will depend on future Medicare rates and future MA rates and supplemental payments, but it may be in the range of $50 to $100 million, per year.

Due to the IGT revenues the state claimed in 2000-01, Wisconsin will have at least $278.2 million of IGT funds available. The worst case scenario is that the 1999-00 deferral progresses to a disallowance, and Wisconsin is required to pay back the $65 million for 1999-00 and excess amounts for the two prior years, which in total would be approximately $175 million. If the state were required to pay back the $175 million, there would be a balance of $103.2 million of IGT revenues plus any new IGT revenues that could be generated under the new MUL regulation ($50 to $100 million a year).

Given the length of time that has transpired without any further action on the 1999-00 deferral, this might suggest that HCFA may not pursue this deferral any further and may be using the deferrals as method to ensure that Wisconsin complies with HCFA's desire to end claiming of additional federal funding. In the past, HCFA has used deferrals as a way to achieve future compliance rather than a method to collect overpayments. Also, other states had much larger claims for additional federal matching funds than Wisconsin, and will be able to continue claiming for several years under the transitional provisions. At this point, it may be reasonable to assume that the deferral for 1999-00 will not be pursued unless Wisconsin would be able to claim enhanced IGT funding in 2001-02 and 2002-03.

Although there is a possibility that there would be less IGT revenues available, it is reasonable to assume that Wisconsin would have $278.2 million of IGT revenues to begin the 2001-03 biennium. Also, under the new MUL rule, Wisconsin may be able to claim IGT revenues of $50 million to $100 million per year, depending on Medicare rates and MA reimbursement of county- and municipal-owned nursing homes. For the purpose of preparing this estimate, it was assumed that the state would be able to claim $75 million in IGT funds in each year of the 2001-03 biennium.

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Labor Cost Adjustment for Nursing Home Reimbursement (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 353, #4]

CURRENT LAW

Under state law, the Department of Health and Family Services (DHFS) is required to reimburse nursing homes for care provided to MA recipients according to a prospective payment system that DHFS updates annually. The Department's formula must reflect a prudent buyer approach, under which a reasonable price, recognizing select factors that influence costs, is paid for service of acceptable quality. DHFS must establish payment standards, using recent cost reports submitted by nursing homes.

When DHFS constructs the prospective daily payment rate, both patient levels of care and categories of expenditures are considered. State statutes require that DHFS consider six cost centers and permit DHFS to consider a seventh, over-the-counter-drugs, when developing facility-specific nursing home rates. The six mandatory cost centers are: (1) direct care; (2) support services; (3) administrative and general; (4) fuel and utilities; (5) property taxes, municipal services or assessments; and (6) capital.

In general, DHFS pays nursing homes for their expenses in a given cost center as long as their expenses per patient day do not exceed "targets" (maximum rates) that are based on the costs for all nursing homes in the state. State statutes require that the target for direct care be adjusted to reflect regional differences in labor costs. Currently, DHFS is transitioning to a regional labor cost adjustment that uses the Medicare hospital labor cost index. The transition began in 1999-00 by using a weighted average of the old and new labor indexes with a one-third weight for the new Medicare labor factor. In 2000-01, the Medicare labor factor will have a two-thirds weight. DHFS had intended to fully implement the Medicare labor index in 2001-02.

GOVERNOR

Eliminate the requirement that DHFS establish standards (targets) for payment of allowable direct care costs that are adjusted by DHFS for regional labor cost variations.

DISCUSSION POINTS

1. Direct care is the largest cost center and on average, accounts for nearly 60% of a facility's payment rate. The next largest cost center is support services, which represents about 20% of the total rate.

2. In 2000-01, adjustments for labor costs had various effects on nursing homes, ranging from a 6% decrease in a facility's target, to an increase of 18%.

3. Elimination of the labor cost adjustment would result in the redistribution of MA nursing home payments, but would not affect the total level of MA payments made to nursing homes.

4. Under the Medicare labor cost index, there are 14 different regions in Wisconsin that include 13 standard metropolitan statistical areas (SMSAs), centered on such urban areas as Milwaukee, Madison and Appleton/Oshkosh, and a rural classification that encompasses the remaining areas of the state.

5. Under the old labor adjustment index, there were three rate regions (high, moderate and low). However, the basic geographical areas were counties, and in some cases, parts of counties based on the first three digits of the area's zip code. Under the old system, the geographical divisions allowed for variation between rural areas, while the Medicare divisions place all areas outside of SMSAs into one division -- balance of state.

6. Table 1 shows the different categories and their respective labor index values. Each of the labor indexes has been standardized so that each index is centered on 1.0. An index value of less than 1.0 would mean that the facility's target has been adjusted below the standard amount, while an index above 1.0 would mean that the facility's target is adjusted above the standard amount. For example, if the standard target for direct care is $62.90 per patient day, an index value of 0.95 would mean that the nursing home with that index value would be subject to a lower target of $59.76 per patient day ($62.90 x 0.95), while a home with an index of 1.10 would be subject to a target of $69.19 ($62.90 x 1.1). Table 1 also indicates the number of facilities and number of MA patient days under each of the categories. It should be noted that the classification of areas under the old labor index includes a number of hold harmless adjustments, under which an area was retained in the high or moderate labor region when the formula indicated that the region should have been placed in a lower cost category.

TABLE 1

Comparison of Old and Medicare Labor Cost Indexes

Old Labor Index	Facility Count	Patient Days	Percent of Patient Days	Index Value (Average = 1.0)
High	180	5,063,661	48.0%	1.084
Moderate	164	4,206,211	39.8	0.970
Low	60	1,286,217	12.2	0.927
Total	404	10,556,089	100.0%	
Medicare Hospital Wage Index				
Minneapolis	14	230,024	2.2%	1.232
Madison	21	371,010	3.5	1.149
Duluth / Superior	7	185,953	1.8	1.122
Milwaukee	73	2,609,822	24.7	1.092
Kenosha	8	229,461	2.2	1.075
Janesville	9	284,596	2.7	1.072
Wausau	7	227,375	2.2	1.053
Racine	8	305,476	2.9	1.034
Green Bay	17	330,286	3.1	1.032
La Crosse	8	274,243	2.6	1.030
Appleton / Oshkosh	21	570,802	5.4	1.012
Eau Claire	14	299,800	2.8	0.983
Rural	186	4,374,640	41.4	0.950
Sheboygan	11	262,601	2.5	0.937
Total	404	10,556,089	100.0%	

7. The Governor's budget includes a provision to eliminate the statutory requirement that the target for direct care costs be adjusted to reflect regional labor cost variations. Eliminating the labor cost adjustment can be equated to establishing a single labor region for the state and can be represented by using a labor cost index of 1.0 for every facility. The fiscal impact of this change for individual nursing homes can be estimated to some degree by comparing the standardized labor index under the current system to 1.0. If a facility's current index is below 1.0, eliminating the labor cost adjustment could increase the facility's target. The expansion would be proportionately larger, the further the current index is below 1.0. In contrast, facilities that currently have indexes above 1.0 could face a reduction in their target that would be in proportion to the degree their index is above 1.0.

8. However, comparing labor indexes does not provide a complete picture of the estimated effect of the proposal, especially for individual nursing homes. Since the labor cost adjustment only affects the target or maximum limit for reimbursement, a nursing home with below average costs may not be limited by the target, and so, changes in the target may not have any effect on its reimbursement level.

9. A second complication is that, although the labor indexes are centered on 1.0 and a change to a new index will be mainly redistributive, it may not be totally cost neutral in terms of the sum of direct care payments. Since DHFS typically adjusts the formula to spend the amount budgeted for nursing homes, it can be assumed that, if the state moves to a different labor index, DHFS would make other formula adjustments if necessary to ensure that the amount of budgeted funds are expended.

10. Notwithstanding these complicating factors, comparing the relative change in the standardized labor indexes can approximate the potential impact of the Governor's proposal to establish a single, statewide labor region. Attachment 1 lists, by county, four labor indexes: (a) the old labor index, which was used 100% in 1998-99 and partially used in 1999-00 and 2000-01; (b) the labor index used in 2000-01, which is a weighted average of the old labor index (one-third weight) and the Medicare index (two-thirds weight); (c) the Medicare index, which under current law, would be used in 2001-02; and (d) a single labor region (index of 1.0 for all facilities), which, under the Governor's bill, would be used in each year beginning in 2001-02. Attachment 1 includes two columns that list the percentage changes between a single labor region index and: (a) the weighted labor index used in 2000-01; and (b) the Medicare index. These percentage changes indicate the approximate percentage changes in the target that would result by establishing a single labor region from the combination index in 2000-01 and from the Medicare index. Facilities that are constrained by the target would have their direct care payments changed by a similar percentage, while facilities that have costs below the target would not be affected.

11. Table 1 shows that the Governor's proposal to move to a single labor region in 2001-02 from the weighted index in 2000-01 would have significant changes on direct care targets. However, distributional shifts would also occur under the current transition to the Medicare labor index, since in 2000-01 the Medicare index was not fully phased-in. Under any option, except freezing the labor adjustment at the level in 2000-01, which does not reflect any consistent index of labor costs, there will be a significant distributional effect.

12. DHFS has the discretion to modify the nursing home formula within statutory restrictions and could moderate any distributional impact by phasing-in changes.

13. The factor that lead DHFS to shift from the old labor index to the Medicare index was that DHFS had difficulty in updating the index, since adverse movements between labor regions (from high to medium or medium to low) would lead to hold harmless provisions, which retained an area in a higher labor cost region, although the updating would indicate that the area should be in a lower cost region. As shown in Table 1, under the old labor index in the last year of its use, only 12.2% of the facilities were placed in the low labor region.

14. The rationale behind moving to the Medicare hospital wage index, which is used by Medicare for making labor cost adjustments for the Medicare nursing home payment system, is that the Medicare index would be a definitive and objective index that might avoid hold harmless adjustments that distort the labor cost adjustments. It also eliminated the need for DHFS to annually calculate and update a labor cost index. Another advantage of the Medicare index is that, once the

index is fully in place, annual changes would not likely be significant, as under the old index. Since the old index had only three categories, the movement from one category to another would result in a significant change in the labor adjustment, even though the wage level may not have changed that much (an area moving from the low end of the high cost group to the high end of the medium cost group). Under the Medicare index, each area is the same and the labor cost adjustment only changes by the amount of the estimated change in labor costs for that area.

15. One problem with the Medicare index is that all areas outside of SMSAs are classified under one category--balance of state. For nursing homes in some counties, this may not be representative of the level of their costs, and has or will cause a decline in their relative position in the labor cost adjustment. For example, under the old labor index, Jefferson County had a standardized labor index of 1.084. Jefferson County is located between two SMSAs--Milwaukee and Madison, but under the Medicare index is categorized under the balance of the state, which is comprised mainly of rural counties, and has a standardized labor index of 0.95 under Medicare. One might expect that the wage level in Jefferson County is higher than other counties that are not adjacent to two SMSAs, and nursing home operators in that county believe that the Medicare index is not fairly representing the level of costs in that area.

16. A second criticism that is made of the Medicare Index is that it is based on hospital wage rates, rather than nursing home wage rates. Medicare justifies the use of a hospital wage index on the argument that hospitals and nursing home employees represent the same labor market pool, since a nurse aide or nurse might be employed by either type of institution. However, although hospitals and nursing homes may have a number of similar occupations, there may be differences since the composition of those occupations are different and market conditions may be different for each type of type of occupation. For example, the relative number of nurses in hospitals is much higher than in nursing homes, and thus, variations in market conditions for nurses has a greater effect on hospital costs than nursing home costs.

17. HCFA is currently developing a wage index for nursing homes, and recently published the results of a nursing home wage index. However, HCFA found the nursing home index results to be unreliable, and at this point, HCFA is proposing that the hospital wage index be used for Medicare nursing home payments for the coming federal fiscal year. However, Medicare will work to improve the nursing home wage index, and when its reliability is improved, may used it for nursing home payments.

18. The Bureau of Labor Statistics (BLS) in the U.S. Department of Labor conducts an annual occupational survey which collects wages by region for various occupations. Included in the occupations are the following three health care service groups: (a) nurse aides, orderlies and attendants; (b) licensed practical nurses; and (c) registered nurses. Wage levels are published for the same regions as used by the Medicare hospital wage index. The wage data for each occupation is collected for all industries that employ these types of workers. Table 2 compares an index based on this wage data for regions in Wisconsin. The computed index is based on a weighted average of the regional wages for the three occupational categories, with the weights based on the relative employment pattern between RNs, LPNs and nurse aides in an average nursing home in Wisconsin.

It is interesting to note that the wage index based on the BLS data has a couple of marked differences with the Medicare hospital wage index.

TABLE 2

Comparison of the Medicare Hospital Wage Index and A Nursing Home Wage Index Based On Occupational Survey

Region	Medicare Index	Nursing Home Index Based On Occupational Survey	Percent Change
Minneapolis	1.23	1.24	0.3%
Madison	1.15	1.07	-7.2
Duluth/Superior	1.12	1.13	0.8
Milwaukee	1.09	1.07	-1.6
Kenosha	1.08	0.97	-9.7
Janesville/Beloit	1.07	1.02	-4.4
Wausau	1.05	1.05	-0.3
Racine	1.03	1.04	0.8
Green Bay	1.03	1.05	1.6
LaCrosse	1.03	1.00	-3.0
Appleton/Oshkosh	1.01	1.02	0.4
Eau Claire	0.98	1.01	2.4
Balance of State	0.95	0.97	2.0
Sheboygan	0.94	1.01	8.1

19. One alternative to using the Medicare hospital wage index is to compute an index based on the occupational wage data from the annual occupational employment survey (OES). This would allow DHFS to use an index that is based on a composition of nurse aides, LPNs and RNs that would reflect the pattern used in a nursing home. It would not require significant administration by DHFS and would provide an objective set of wage data. However, as with the Medicare index, all areas in the state that are not part of the 13 SMSAs would be placed in one category -- balance of state. While it is possible to assemble the wage data by county, such an estimate may not be reliable, since the number of observations would be too small in a number of cases and the sample was designed for the current categories.

20. The Federal Department of Labor, however, uses the OES data to compute five sub-regions within the balance of the state. The OES wage estimates for these five regions are used for determining the prevailing wage for alien labor certification (ALC). Federal rules prohibit an employer from hiring an alien at a wage rate below the prevailing rate.

Attachment 2 illustrates the five regions used for the ALC, while Table 3 shows the price

indexes for each of the five regions that are similar to the ones listed in Table 2 based on OES data. It should be noted that the BLS does not sanction the use of OES data for subregions of the areas used by the BLS. Also, program restrictions prevented the generation of wage estimates for registered nurses in three of the regions. This may be due to several reasons, such as confidentiality concerns or protocols that indicate unreliability in the estimate. In these three cases, the wage for RNs was set at the balance of state average to compute the estimates in Table 3. Although it might be expected that Region 2 -- West and Region 4 -- South would have high wage levels, it is somewhat surprising that the indexes are higher than adjacent SMSAs.

TABLE 3

A Nursing Home Wage Index Based On OES Survey Data
Balance of State Divided Into Alien Labor Certification Regions

Region	Wage Index
Balance of State	0.97
Region 1 - Northwest	0.96
Region 2- West	1.08
Region 3 - Central	0.95
Region 4 - South	1.10
Region 5 - Pennisula	0.97

Attachment 2 illustrates the member counties of each of the five regions

21. Another alternative is to compute an index from the information supplied in required nursing home cost reports. Since every nursing home that receives MA reimbursement must supply this cost report, the index would include wage information from most nursing homes in the state. Under this option, there would be the opportunity to compute an index for parts of the Medicare balance of state region. However, it may not be possible to build a reliable index for every county in the state.

22. One limiting factor in establishing geographical areas for a price index is that if the area is not very populated, it may be difficult to determine the general wage level of that area for nursing homes since there may be few nursing homes, and an unusual case may distort the results. For example, if the county has a large county-owned nursing home and only a few small private homes, the labor index may be dominated by the particular wage level in that county-owned nursing home, and may not be reflective of the general wage level in that county. As a result, a labor cost index for each county may be unreliable in less-populated counties.

23. Although developing and using a county-by-county index may be problematic, it may be possible to produce a reliable index for groups of counties that currently are in the balance

of state category under Medicare. However, the index for a specific county may be affected by the grouping of counties. Since there may be insufficient data to objectively determine what grouping of counties would be appropriate, the grouping of some counties would be somewhat arbitrary. There are 186 nursing facilities in the balance of the state area. If the balance of the state were divided into four or five regions, that would allow each region to have at least 30 facilities for the basis of a wage index.

24. The nursing home cost reports include data both on payroll expenditures and employee hours. The salary expenditure levels are audited, but currently the number of employee hours is not audited. As a result, there would be some uncertainty on the reliability of wage rates that would be calculated from the nursing home cost reports. Another drawback of using the nursing home cost reports for a cost index is that in several SMSAs, there are a limited number of nursing facilities. As can be seen in Table 1, Duluth/Superior, La Crosse, Wausau, Racine, Janesville/Beloit and Kenosha regions have 9 or fewer facilities. In the Janesville/Beloit SMSA, the Rock County nursing home makes up 34% of the nursing home patient days in that area. A cost index based only on nursing home cost reports would be heavily influenced by the wage rates of one facility.

25. Although regional wage indexes may be deficient in certain respects and may not accurately represent the wage level in all counties, there would be drawbacks to not having any labor adjustments. Wage levels do vary by region, and as a result, regions with higher wage levels would be disadvantaged by a system without regional adjustments. Although a facility may be efficient in its use of staff, high wage levels in its area increase a facility's salary costs and may push that facility's direct care costs above the target, and as a result, part of that facility's costs may not be reimbursed simply because it was located in a high wage area.

26. Table 4 compares the wage costs for a hypothetical nursing home that serves 92 residents (average for Wisconsin) and employs the average number of RNs, LPNs and nurse aides given the number of residents. Table 4 shows the impact on costs due to varying wage rates for employing the same staff pattern. The wage rates are based on the Bureau of Labor Statistics annual OES survey for 1999. Table 4 indicates the cost variations can be significant.

TABLE 4

Comparison of Projected Wage Costs By Labor Region For an Average Wisconsin Nursing Home

Region	Wage Costs for Same Staffing Pattern	Difference from Wisconsin Average	Percent Change From Wisconsin Average
Minneapolis	$2,099,948	$359,504	20.7%
Madison	1,811,916	71,472	4.1
Duluth/Superior	1,922,246	181,802	10.4
Milwaukee	1,825,381	84,937	4.9
Kenosha	1,650,475	-89,969	-5.2
Janesville/Beloit	1,741,283	839	0.0
Wausau	1,784,707	44,262	2.5
Racine	1,770,682	30,238	1.7
Green Bay	1,782,330	41,886	2.4
LaCrosse	1,697,906	-42,538	-2.4
Appleton/Oshkosh	1,726,047	-14,397	-0.8
Eau Claire	1,710,020	-30,425	-1.7
Balance of State	1,647,027	-93,417	-5.4
Sheboygan	1,721,528	-18,916	-1.1
Wisconsin	$1,740,444		

27. If the Committee retains the requirement for a labor cost adjustment, a provision that would help to avoid any large changes in a single year would be to require that the Department annually update the index and use a three-year rolling average for the labor cost index. Although this would stabilize the adjustment, a nursing home in an area with rising costs would have to wait several years before the higher wage costs are fully recognized.

ALTERNATIVES TO BASE

1. Approve the Governor's recommendation to eliminate the requirement that DHFS establish standards (targets) for payment of allowable direct care costs that are adjusted by DHFS for regional labor cost variations.

2. Delete the Governor's recommendation to eliminate the requirement for regional labor cost adjustments for the direct care target.

3. Delete the Governor's recommendation to eliminate the requirement for regional labor cost adjustments for the direct care target. In addition, create one or more of the following statutory requirements:

a. Require that the wage index used by HCFA for Medicare nursing home payments be used for adjusting the target for direct care.

b. Require that the labor cost adjustment that is required for the direct care target be based on the wage levels for nurses and nurse aides, as reported by the annual OES survey conducted by the Bureau of Labor Statistics.

c. Modify (b) by requiring that the balance-of-state be divided into the same five regions as used by the U.S. Department of Labor for determination of the prevailing wage used for alien labor certification.

d. Require DHFS to use the annual nursing home cost report as the basis for constructing the labor cost adjustment.

e. Require DHFS to annually update the labor cost adjustment, and beginning in 2002-03, require DHFS to use a three-year rolling average of the labor cost adjustment.

f. Require DHFS to construct the labor cost adjustment on the basis of the following areas: (a) each of the 13 SMSA areas used by the Medicare hospital wage index: and (b) at least four but no more than five regions from the remaining counties, which must be made up of whole counties that are contiguous to at least one other county in the same labor region.

g. Require DHFS to submit for review and approval a plan to the Joint Committee on Finance that recommends a method to adjust the direct care target for regional differences in labor costs. Specify that DHFS submit the plan within 30 days of the bill's general effective date under a 14-day passive review process.

Prepared by: Richard Megna
Attachments

ATTACHMENT 1

Comparison of Labor Cost Indexes by County

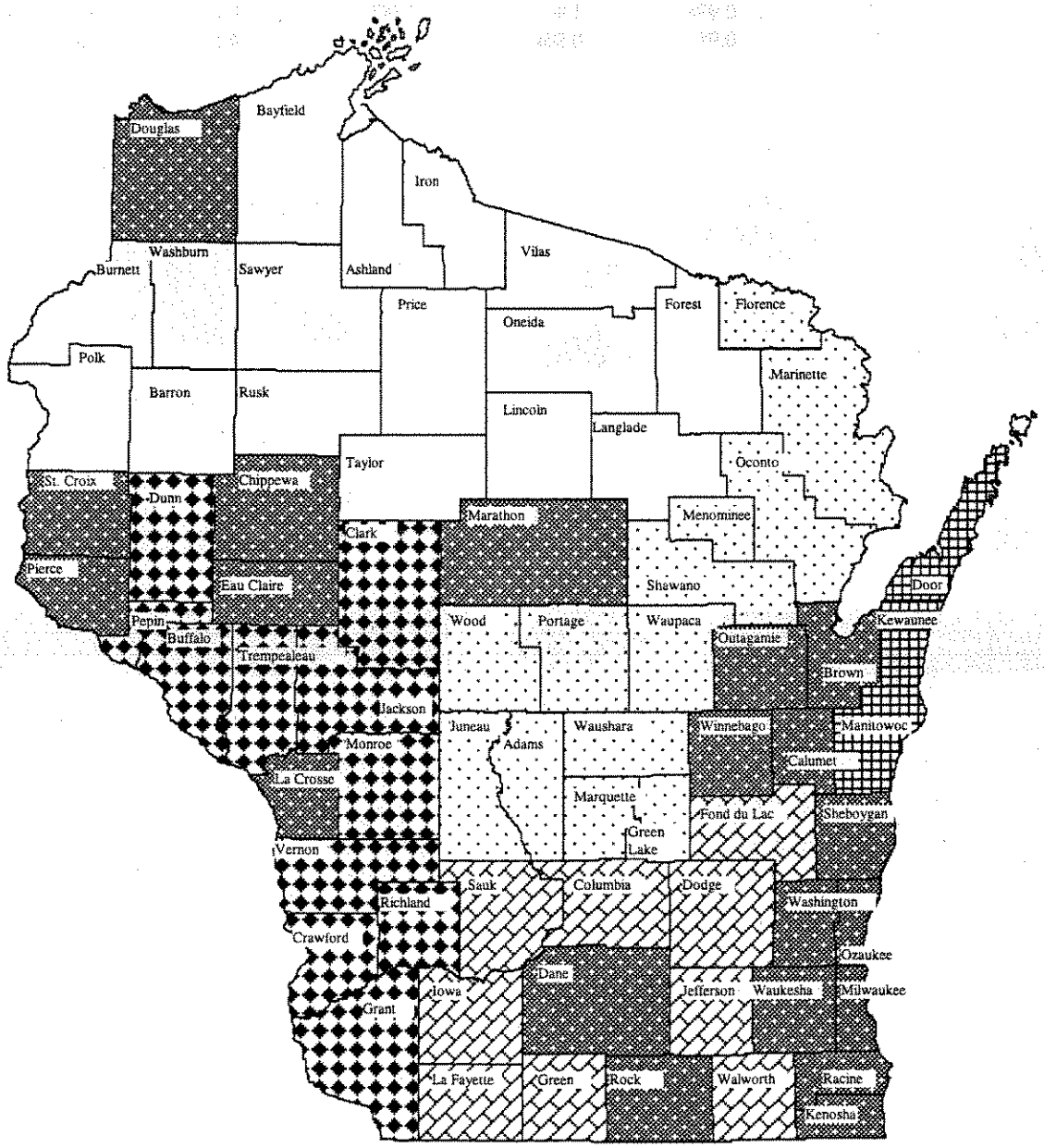
County	Old Labor Index (Used 100% in 1998-99)	Weighted Index (1/3 Old & 2/3 Medicare Used in 2000-01)	Medicare Index (Would be used 100% in 2001-02 under Current Law)	Single Labor Region Proposed for 2001-02	% Change Single Labor Region from 2000-01 Weighted	% Change Single Labor from Medicare	% Change Medicare from 2000-01 Weighted
Adams	1.084	0.995	0.950	1.000	0.5%	5.3%	-4.5%
Ashland	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Barron (547XX zip code)	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Barron (548XX zip code)	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Bayfield	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Brown	0.970	1.011	1.032	1.000	-1.1	-3.1	2.0
Buffalo (547XX zip code)	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Buffalo (548XX zip code)	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Burnett	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Calumet	0.970	0.998	1.012	1.000	0.2	-1.2	1.4
Chippewa	0.970	0.979	0.983	1.000	2.2	1.7	0.4
Clark	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Columbia	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Crawford	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Dane	1.084	1.127	1.149	1.000	-11.3	-13.0	1.9
Dodge	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Door	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Douglas	0.927	1.057	1.122	1.000	-5.4	-10.9	6.1
Dunn	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Eau Claire	0.970	0.979	0.983	1.000	2.2	1.7	0.4
Florence	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Fond du Lac (530XX zip code)	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Fond du Lac (549XX zip code)	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Forest	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Grant (535XX zip code)	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Grant (538XX zip code)	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Green	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Green Lake (549XX zip code)	0.970	0.957	0.950	1.000	4.5	5.3	0.7
Green Lake (539XX zip code)	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Iowa	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Iron	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Jackson	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Jefferson	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Juneau	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Kenosha	0.970	1.040	1.075	1.000	-3.8	-7.0	3.4

County	Old Labor Index (Used 100% in 1998-99)	Weighted Index (1/3 Old & 2/3 Medicare Used in 2000-01)	Medicare Index (Would be used 100% in 2001-02 under Current Law)	Single Labor Region Proposed for 2001-02	% Change Single Labor Region from 2000-01 Weighted	% Change Single Labor from Medicare	% Change Medicare from 2000-01 Weighted
Kewaunee	0.970	0.957	0.950	1.000	4.5%	5.3%	-0.7%
LaCrosse	0.970	1.010	1.030	1.000	-1.0	-2.9	2.0
Lafayette	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Langlade	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Lincoln	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Manitowoc	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Marathon	0.970	1.025	1.053	1.000	-2.5	-5.0	2.7
Marinette	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Marquette	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Menominee	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Milwaukee	1.084	1.089	1.092	1.000	-8.2	-8.4	0.2
Monroe	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Oconto	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Oneida	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Outagamie	0.970	0.998	1.012	1.000	0.2	-1.2	1.4
Ozaukee	1.084	1.089	1.092	1.000	-8.2	-8.4	0.2
Pepin	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Pierce	1.084	1.183	1.232	1.000	-15.4	-18.8	4.2
Polk (540XX zip code)	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Polk (548XX zip code)	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Portage	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Price	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Racine	1.084	1.051	1.034	1.000	-4.8	-3.3	-1.6
Richland	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Rock	0.970	1.038	1.072	1.000	-3.7	-6.7	3.3
Rusk	0.927	0.942	0.950	1.000	6.1	5.3	0.8
St. Croix	1.084	1.183	1.232	1.000	-15.4	-18.8	4.2
Sauk	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Sawyer	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Shawano	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Sheboygan	1.084	0.986	0.937	1.000	1.4	6.7	-5.0
Taylor	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Trempealeau (547XX zip code)	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Trempealeau (546XX zip code)	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Vernon	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Vilas	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Walworth	1.084	0.995	0.950	1.000	0.5	5.3	-4.5
Washburn	0.927	0.942	0.950	1.000	6.1	5.3	0.8
Washington	1.084	1.089	1.092	1.000	-8.2	-8.4	0.2
Waukesha	1.084	1.089	1.092	1.000	-8.2	-8.4	0.2

County	Old Labor Index (Used 100% in 1998-99)	Weighted Index (1/3 Old & 2/3 Medicare Used in 2000-01)	Medicare Index (Would be used 100% in 2001-02 under Current Law)	Single Labor Region Proposed for 2001-02	% Change Single Labor Region from 2000-01 Weighted	% Change Single Labor from Medicare	% Change Medicare from 2000-01 Weighted
Waupaca	0.970	0.957	0.950	1.000	4.5%	5.3%	-0.7%
Waushara	0.970	0.957	0.950	1.000	4.5	5.3	-0.7
Winnebago	0.970	0.998	1.012	1.000	0.2	-1.2	1.4
Wood	0.970	0.957	0.950	1.000	4.5	5.3	-0.7

ATTACHMENT 2

Alien Labor Certification Regions



SMSAs

Region 1 -- Northwest

Region 2 -- West

Region 3 -- Central

Region 4 -- South

Region 5 -- Penninsula

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June 4, 2001 | Joint Committee on Finance | Paper #469

BadgerCare Funding (DHFS -- Medical Assistance)

[LFB 2001-03 Budget Summary: Page 353, #5]

CURRENT LAW

BadgerCare funds health care costs for families with household income at or below 185% of the federal poverty level (FPL). Once enrolled, families can remain enrolled as long as their household income does not exceed 200% of the FPL. Individuals that are eligible for the state's medical assistance (MA) program are not eligible for BadgerCare. In 2001, 185% of the FPL is equivalent to $27,066 annually for a family of three.

As of March 31, 2001, there were 53,982 adults and 23,708 children enrolled in BadgerCare.

Funding. Base funding for BadgerCare program benefits totals $97,636,600 ($34,218,300 GPR, $61,758,100 FED and $1,660,200 PR) in 2000-01. Federal funding for the program is available under MA and the state children's health insurance program (CHIP). Federal MA funding is used to support services provided to adults with income at or below 100% of the FPL on a 41% GPR/59% FED cost-sharing basis. Federal CHIP funding is used to support services to children and the remaining adults on a 29% GPR/71% FED cost-sharing basis. Program revenue (PR) funding is available from premiums paid by families enrolled in the program with incomes above 150% of the FPL.

Federal Authority. BadgerCare operates under two waivers of federal MA and CHIP law approved by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). The first waiver, approved in January, 1999, authorized a demonstration project under MA, which allowed the state to use MA funds to provide family coverage under BadgerCare. The second waiver, approved in January, 2001, authorized the use of federal CHIP funds to support costs for adults with income above 100% of the FPL. The CHIP funds are available at a higher matching rate than available under MA, 71% vs. 59%,

thereby reducing the GPR match for these cases. These waivers were granted by HCFA based on a plans submitted by DHFS to HCFA. Under the terms of the waivers, changes to the BadgerCare plan must be approved by HCFA or the waiver approval may be rescinded.

Enrollment Trigger. Current law specifies that DHFS must establish a lower maximum income level for initial eligibility determinations if BadgerCare funding is insufficient to meet program needs based on projected enrollment levels. The adjustment must not be greater than necessary to ensure sufficient funding is available. DHFS cannot implement a change to the maximum income level for initial eligibility unless it first submits to the Committee its plans for lowering the maximum income level and the Committee approves the plan under a 14-day passive approval process. This process is known as the "enrollment trigger."

If the state implements the enrollment trigger, it cannot receive enhanced federal funding under the terms and condition of the January, 2001 waiver, for adults with income over 100% of the FPL. In addition, DHFS cannot close enrollment, institute a waiting list or decrease eligibility standards while the second waiver is in effect. If the state does so, the second waiver is terminated and BadgerCare authority reverts back to the terms of the original waiver. Under the terms of the original BadgerCare waiver, before DHFS could implement the enrollment trigger, DHFS would be required to submit a waiver amendment to HCFA no later than 90 days before it implements the trigger. If DHFS were no longer able to receive the enhanced federal matching rate for most adults enrolled in BadgerCare, GPR funding for the program would need to be increased by approximately $6.2 million in 2001-02 and $6.7 million in 2002-03 to fully fund the program.

Projected Deficit. In January, 2000, this office estimated that the cost to provide benefits under BadgerCare would exceed the amounts budgeted in Act 9 by approximately $13.2 million in the 1999-01 biennium. In the spring, 2000 legislative session, the Senate and the Assembly approved separate bills to address the projected shortfall, but neither house approved the other house's engrossed bill.

The 1999 Senate Bill 357, which was passed by the Senate in February, 2000, would have increased funding to address the projected shortfall.

1999 Assembly Bill 916, which was passed by the Assembly in March, 2000, would have created two options to address the projected shortfall. AB 916 would have authorized the Joint Committee on Finance to transfer funding, in the 1999-01 biennium, from any GPR appropriation, other than a sum sufficient appropriation, from any state agency, to fund the projected BadgerCare program deficit under specified. Additionally, the bill would have created a GPR, sum-sufficient appropriation to enable the Committee to supplement the BadgerCare benefits appropriation from unappropriated general fund revenues. The Committee could have used this appropriation to supplement the BadgerCare benefits appropriations without making a finding of an emergency, as required under s. 13.101 of the statutes. In addition, the Committee could have drawn funds from the general fund to support a supplement in an amount that would reduce the general fund balance below the balance amount required under s. 20.003(4) of the statutes.

In a letter dated June 2, 2000, former DHFS Secretary Leean sought guidance from the Co-chairs of the Joint Committee on Finance on whether or not to initiate the use of the enrollment trigger because the Legislature adjourned without enacting legislation to address the projected BadgerCare deficit. In a letter dated June 14, 2000, the Co-Chairs indicated to Secretary Leean that the Legislature would have an opportunity to address the projected deficit in January, 2001, and therefore, did not believe that it was necessary for DHFS to initiate the enrollment trigger.

In January, 2001, the Assembly and the Senate passed 2001 Senate Bill 18, which provided $11,512,200 GPR in 2000-01 to fund the projected deficit in BadgerCare. This legislation was enacted as 2001 Wisconsin Act 1.

GOVERNOR

Provide $43,201,500 ($12,554,800 GPR, $30,106,700 FED and $540,000 PR) in 2001-02 and $59,633,200 ($18,118,600 GPR, $40,774,600 FED and $740,000 PR) in 2002-03 to reflect a reestimate of the costs to fund BadgerCare benefits in the 2001-03 biennium. The bill would provide funding for BadgerCare benefits totaling $140,838,100 ($46,773,100 GPR, $91,864,800 FED and $2,200,200 PR) in 2001-02 and $157,269,800 ($52,336,900 GPR, $102,532,700 FED and $2,400,200 PR) in 2002-03.

DISCUSSION POINTS

1. Base funding for BadgerCare totals $97,636,600 ($34,218,300 GPR, $61,758,100 FED and $1,660,200 PR). Base funding for BadgerCare only represents the amount of funding budgeted in 1999 Act 9 and does not include the additional funding provided in 2001 Act 1.

2. It is estimated that the cost to fund BadgerCare benefits in the next biennium will be $145,802,400 ($48,005,300 GPR, $94,802,700 FED and $2,994,400 PR) in 2001-02 and $158,252,300 ($52,234,300 GPR, $102,724,600 FED and $3,293,400 PR) in 2002-03. The attachment to this memorandum identifies the current estimate and the difference between this estimate and base funding for the program and the funding provided in the Governor's budget.

Compared with the funding provided in the bill for BadgerCare benefits, the current estimate represents an increase of $4,964,300 ($1,232,200 GPR, $2,937,900 FED and $794,200 PR) in 2001-02 and $982,500 (-$102,600 GPR, $191,900 FED and $893,200 PR) in 2002-03.

3. The current estimate projects that the total number of persons enrolled in BadgerCare will be 81,170 on June 30, 2001, 90,461 on June 30, 2002 and 93,716 on June 30, 2003. This estimate assumes that caseload growth will decrease more slowly than the assumptions used in developing the estimate for the Governor's budget.

4. The Committee may want to consider modifying the current process for addressing projected shortfalls in BadgerCare program. While the current estimate is based on the best

information available at this time, the actual BadgerCare caseload could vary significantly from the levels assumed in the current estimate based on a variety of factors, including the state's economic performance over the next biennium. If the amount of funding provided is less than the amount necessary to fund the program in the next biennium, the Legislature would have to address a projected shortfall.

5. Under current law, if a shortfall is projected in BadgerCare, the statutes specify that DHFS must initiate the enrollment trigger. The Joint Committee on Finance does not appear to have the authority under s. 13.101 of the statues to transfer funding from another GPR appropriation to the BadgerCare appropriation for two reasons. First, in order to transfer funds under s. 13.101 of the statutes, the Committee must find that an emergency exists and it is not clear that a projected deficit in BadgerCare could be considered an emergency since the statue requires the use of the enrollment trigger if a deficit is projected. Further, the statutes specify that BadgerCare is not an entitlement program. Second, under general rules of statutory interpretation, if the statutes have a specific provision to address a situation, that provision supersedes more general authority provided in the statutes. Therefore, under these rules of interpretation, s. 13.101 of the statutes does not apply to projected shortfalls in BadgerCare, since the required use of the enrollment trigger is the specific provision required by statute when a shortfall is projected.

6. The Committee could determine that the use of the enrollment trigger should be eliminated as a requirement for addressing projected deficits. Eliminating the trigger would reflect a recognition that the use of the trigger is undesirable, considering both the loss of federal funding for BadgerCare and legislative support for the program. The state cannot implement the enrollment trigger without terminating the second BadgerCare waiver. If the second waiver were terminated, the amount of federal revenue available to fund BadgerCare would decrease by over $6.0 million annually.

7. Regardless of the Committee's decision regarding the enrollment trigger, the Committee could provide the Legislature additional options to address projected deficits in the future, rather than requiring the passage of separate legislation to fund those deficits. The Committee could authorize the Joint Committee on Finance to transfer funds from any other GPR appropriation to the BadgerCare appropriation under s. 13.101 of the statutes, if the Committee determines that funding for BadgerCare is insufficient to fund the benefit costs of the program and specify that the Committee does not have to find that an emergency exists to transfer the funding.

8. If the Committee determines that it is appropriate to eliminate the enrollment trigger, the Committee could delete the current BadgerCare GPR and FED appropriations and instead budget these funds in the MA benefits appropriations. Since BadgerCare is so closely linked with MA in terms of funding, eligibility requirements, the provision of services and reporting, it may be appropriate to budget the two programs in one appropriation. When BadgerCare was first established, it was determined that it was necessary to budget BadgerCare funding separately from MA because of the enrollment trigger. Without the enrollment trigger, it would no longer be necessary to budget funding for BadgerCare and MA separately.

Budgeting funding for both programs in a single appropriation would provide more flexibility in addressing future projected deficits in either program. DHFS could continue to monitor expenditures and caseloads for BadgerCare separately from other categories of MA-eligibility. Further, budgeting funding for both programs in the MA appropriations would recognize that BadgerCare is an extension of MA.

9. Regardless of the Committee's action on the enrollment trigger, the Committee could change the current BadgerCare GPR appropriation from a sum certain continuing appropriation to a sum certain biennial appropriation. In doing so, DHFS would be authorized to spend funding appropriated in either year of the biennium. Therefore, if a deficit was projected in the first year of the biennium, DHFS could spend funds budgeted in the second year to support first year costs. If funding budgeted for the biennium was insufficient to support BadgerCare costs, DHFS and the Legislature would be able to address the shortfall at the end of the biennium when the Legislature would be in session developing the budget for the following biennium. With a biennial appropriation, any funds remaining in the appropriation at the end of the biennium would lapse to the general fund. With a continuing appropriation, any funds remaining in the appropriation at the end of a fiscal year are carried forward for use in subsequent fiscal years.

ALTERNATIVES TO BASE

A. Funding Estimate

Increase funding in the bill by $4,964,300 ($1,232,200 GPR, $2,937,900 FED and $794,200 PR) in 2001-02 and $982,500 (-$102,600 GPR, $191,900 FED and $893,200 PR) in 2002-03 to fund costs for BadgerCare services provided in the 2001-03 biennium.

Modification	GPR	FED	PR	TOTAL
2001-03 FUNDING (Change to Base)	$31,803,000	$74,011,100	$2,967,400	$108,781,500
[Change to Bill	*$1,129,600*	*$3,129,800*	*$1,687,400*	*$5,946,800]*

B. Enrollment Trigger and Appropriations

1. Delete the current provision authorizing DHFS to establish a lower maximum income level for initial eligibility determinations if BadgerCare funding is insufficient to meet program needs based on projected enrollment levels. Additionally, authorize the Joint Committee on Finance, to transfer funds, under s. 13.101, of the statutes, from any other GPR appropriation to the BadgerCare appropriation if the Committee determines that funding for BadgerCare is insufficient to fund the benefit costs of the program and: (a) unnecessary duplication of function can be eliminated; (b) more efficient and effective methods for administering programs will result; or (c) legislative intent will be more effectively carried out because of such transfer, and that legislative intent will not be changed as a result of such a transfer. Specify that the Committee does not have to find that an emergency exists to transfer the funding. In addition, do one of the following:

a. Delete the current GPR and FED BadgerCare appropriations and instead budget funding for BadgerCare in the MA benefits appropriations and make corresponding statutory changes. Require DHFS to continue to monitor BadgerCare expenditures and caseloads separately from other categories of MA eligibility.

b. Maintain the current GPR and FED BadgerCare appropriations, but convert the GPR appropriation from a continuing appropriation to a biennial appropriation.

c. Maintain the current BadgerCare GPR appropriation as a continuing appropriation.

2. Maintain the current enrollment trigger, but authorize the Joint Committee on Finance, to transfer funds, under s. 13.101, of the statutes, from any other GPR appropriation to the BadgerCare appropriation if the Committee determines that funding for BadgerCare is insufficient to fund the benefit costs of the program and: (a) unnecessary duplication of function can be eliminated; (b) more efficient and effective methods for administering programs will result; or (c) legislative intent will be more effectively carried out because of such transfer, and that legislative intent will not be changed as a result of such a transfer. Specify that the Committee does not have to find that an emergency exists to transfer the funding. In addition, do one of the following:

a. Convert the current BadgerCare GPR appropriation from a continuing appropriation to a biennial appropriation.

b. Maintain the current BadgerCare GPR appropriation as a continuing appropriation.

3. Maintain current law.

Prepared by: Rachel Carabell
Attachment

ATTACHMENT

Estimate of 2001-03 Funding for BadgerCare

	2001-02				2002-03			
	GPR	FED	PR	Total	GPR	FED	PR	Total
Base	$34,218,300	$61,758,100	$1,660,200	$97,636,600	$34,218,300	$61,758,100	$1,660,200	$97,636,600
Governor's Bill								
Total Estimate	$46,773,100	$91,864,800	$2,200,200	$140,838,100	$52,336,900	$102,532,700	$2,400,200	$157,269,800
Change to Base	$12,554,800	$30,106,700	$540,000	$43,201,500	$18,118,600	$40,774,600	$740,000	$59,633,200
Current Estimate								
Total Estimate	$48,005,300	$94,802,700	$2,994,400	$145,802,400	$52,234,300	$102,724,600	$3,293,400	$158,252,300
Change to Base	$13,787,000	$33,044,600	$1,334,200	$48,165,800	$18,016,000	$40,966,500	$1,633,200	$60,615,700
Change to Governor	$1,232,200	$2,937,900	$794,200	$4,964,300	$-102,600	$191,900	$893,200	$982,500