AGENCY: Department of Commerce

LFB PAPER #: 1136

ISSUE: Creation of a Grants Management Office

ALTERNATIVE: #4 – Delete the Governor's recommendation

SUMMARY:
As part of the Build Wisconsin Initiative, the Governor proposes the creation of a grants specialist to serve as a clearinghouse for Wisconsin businesses interested in acquiring Federal and State grant money within the Department of Commerce.

Because of the budge shortfall and the Governor's state hiring freeze, coupled with the fact that there is no specific projected return on this expenditure, the Governor's recommendation should be deleted.

BY: KATY

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February 28, 2002 Joint Committee on Finance Paper #1136

Grants Management Office (Commerce)

[LFB Summary of the Governor's Budget Reform Bill: Page 29, #5]

CURRENT LAW

The Department of Commerce is the state's primary agency for the delivery of integrated services to businesses. Commerce's purpose is to (a) foster the retention and creation of new jobs and investment opportunities in Wisconsin; (b) foster and promote economic business, export and community development; and (c) promote public health, safety and welfare through effective and efficient regulations, education and enforcement.

GOVERNOR

Provide $26,000 GPR in 2001-02 and $56,300 GPR in 2002-03 and 1.0 unclassified GPR grants management specialist to establish a grants management office in Commerce. The unclassified position would be appointed by the Commerce Secretary, who would also determine the salary for the position.

DISCUSSION POINTS

1. Commerce would be required to operate the grants management office for the following purposes: (a) to identify public and private sources of grants; (b) to serve as a clearinghouse for federal and state grants and privately-funded grants; (c) to offer training and assistance in pursuing grants to governmental agencies, nonprofit organizations, school boards, operators of charter schools, and governing bodies of private schools.

2. The proposed grants management office is related to the Governor's "Build Wisconsin" initiative that brings together state agencies, educational institutions, business leaders

and organized labor to develop a strategic business plan for economic growth in Wisconsin. The "Build Wisconsin" initiative is lead by the Secretary of Commerce and is directed to create an economic development plan that: (a) builds on Wisconsin's current economic base; (b) expands the state's economy; (c) increases wages for workers, (d) increases business and individual productivity; (e) increases investments in the state; (f) positions Wisconsin for high-tech growth; and (g) addresses regional economic needs by helping local economic development agencies thrive and grow. Each component of the state plan has specific initiatives to be implemented. One of the initiatives is to create a single point of contact for state government to assist businesses and to address economic opportunities. The grants management office could provide a centralized location for providing information and training that would help state businesses access state and federal financial assistance programs. The office could also help the state to focus its efforts in attracting more federal grants and contracts.

3. The grants specialist position would establish a clearinghouse for information and provide training to assist businesses, governmental and nonprofit entities in obtaining federal, state and private sector financial aid. The position would develop materials for guidance in applying for financial assistance and also provide direct assistance, such as answering questions. Finally, the individual would hold training conferences for interested parties in different regions of the state. The grants specialist position would be an unclassified position for the following reasons: (a) to highlight the importance of the office and the effort to obtain additional federal contracts as part of the Build Wisconsin initiative; (b) to provide more flexibility to allow the position to be filled more quickly; and (c) to provide more responsiveness to state and local government agencies and to the Legislature.

4. It is estimated that, under current law provisions, there will be a gross general fund deficit of -$974.5 million at the end of the biennium and, in addition, a statutory balance of $142.8 million is required. Thus, to address the projected deficit and maintain the required statutory balance, the general fund needs to be improved by $1,117.3 million. To address the deficit, the Governor imposed a hiring freeze on executive agency GPR positions and introduced his budget reform bill that would require most state agencies to reduce 2001 Act 16 GPR appropriations by 3.5% in 2001-02 and 5.0% in 2002-03. Under the bill, Commerce would be required to reduce GPR expenditures by $694,600 in 2001-02 and $992,300 GPR in 2002-03. Given this fiscal situation, it could be argued that priority should be placed on controlling state government spending and employment. From this view, provision of additional funding and a position to create a grants management office in Commerce should be postponed until the state's fiscal condition improves.

5. The Bureau of Business Development has an area development manager located in each of eight regions covering the entire state. The managers work directly with businesses on start-up and expansion plans and provide information on financial resources, environmental regulations, buildings and sites, labor availability and wage rates, utilities, taxes, and transportation. They also act as mediators in disputes between business and government. The area development managers regularly visit employers in their areas, including those considered troubled because of declining sales, declining employment or other factors. It could be argued that responsibilities of the area development managers include providing businesses with information and training related to

obtaining financial assistance from the state and federal governments. As a result, the need for additional funding and a position to provide similar services could be questioned.

6. If the function of the proposed grants management office is viewed as essential, responsibilities of other Commerce bureaus or offices could be expanded to incorporate that function. One alternative would be to require the Department's Business Development Assistance Center to perform the activities envisioned for the proposed grants management office. The Business Development Assistance Center is staffed by eight persons and provides assistance to individuals and businesses that request information on the process of obtaining state permits required for a particular business activity. The Center does not issue permits but through its toll-free hotline serves as a clearinghouse for information. Other related activities include; (a) expediting the process of permit application, review and issuance; (b) monitoring the status of applications and agreements; (c) providing advocacy services; and (d) providing mediation and dispute resolution. The small business ombudsman provides information about financing alternatives and government regulations to small businesses. The small business clean air assistance program is also administered through the Business Development Assistance Center. This program assists small businesses in conforming with the federal Clean Air Act. The Center's information clearing house responsibilities could be expanded to include providing information and training related to obtaining federal, state and private financial assistance for businesses, government entities and nonprofit organizations.

7. If the Committee decides to provide the Department with additional funding and a position to establish a grants management office, it may wish to provide a classified, rather than unclassified, grants specialist position. Generally, unclassified positions in state agencies are limited to the Secretary, Deputy Secretary, Executive Assistant and division administrators. The proposed unclassified grants management specialist position would be selected by the Secretary of Commerce. If the position was classified there would be a formal position description including defined responsibilities. A standard competitive recruitment process would be followed to fill the position. An argument could be made that requiring that the position be classified would provide more structure and guidance to the hiring process, while not detracting from the agency's ability to hire a qualified individual.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation to provide $26,000 GPR in 2001-02 and $56,300 GPR and 1.0 unclassified GPR grants management specialist position to establish a grants management office in the Department.

2. Modify the Governor's recommendation to provide $26,000 GPR in 2001-02 and $56,300 GPR and 1.0 classified GPR grants management specialist position to establish a grants management office in the Department.

3. Delete the Governor's recommendation for additional resources but require the specified functions of the proposed grants management office to be performed by existing staff of

the Business Development Assessment Center.

Alternative 3	GPR
2001-03 FUNDING	- $82,300
2002-03 POSITIONS	-1.00

4. Delete the Governor's recommendation.

Alternative 4	GPR
2001-03 FUNDING	- $82,300
2002-03 POSITIONS	-1.00

Prepared by: Ron Shanovich

MO# 4

(2)	BURKE	(Y)	N	A
	DECKER	(Y)	N	A
	~~MOORE~~	Y	N	A
	SHIBILSKI	(Y)	N	A
	PLACHE	(Y)	N	A
	WIRCH	(Y)	N	A
	DARLING	(Y)	N	A
	ROSENZWEIG	(Y)	N	A
(1)	GARD	(Y)	N	A
	KAUFERT	(Y)	N	A
	~~ALBERS~~	Y	N	A
	DUFF	(Y)	N	A
	WARD	(Y)	N	A
	HUEBSCH	(Y)	N	A
	HUBER	(Y)	N	A
	COGGS	(Y)	N	A

AYE 14 NO 0 ABS ____

Child Abuse and Neglect Prevention Board

(LFB Summary of the Governor's Budget Reform Bill: Page 26)

LFB Summary Item for Which an Issue Paper Has Been Prepared

Item #	Title
1	Program Revenue Lapse (see Paper #1121)

Board on Aging and Long-Term Care

(LFB Summary of the Governor's Budget Reform Bill: Page 19)

LFB Summary Item for Which an Issue Paper Has Been Prepared

Item #	Title
1	3.5% and 5.0% Budget Reductions (see Paper #1120)

Health and Family Services

(LFB Summary of the Governor's Budget Reform Bill: Page 49)

LFB Summary Items for Which Issue Papers Have Been Prepared

Item #	Title
1	3.5% and 5.0% Budget Reductions (see Paper #1120)
2	Program Revenue Lapse (see Paper #1121)
3	Medical Assistance and BadgerCare Base Reestimates (Paper #1165)
5&6	MA Prescription Drugs -- Prior Authorization (Paper #1166)
9	Grants for Community Health Centers (Paper #1167)
10	Statewide Trauma Care System (Paper #1168)
11	Surveillance of Diseases and Potential Threats (Paper #1169)
13	Disease Aids (Paper #1170)
14	Care and Treatment Facilities Utility Costs (see Paper #1100)

LFB Summary Item to be Addressed in a Subsequent Paper

Item #	Title
17	Milwaukee County's Contribution for Child Welfare Services

LFB Summary Items for Which No Issue Paper Has Been Prepared

Item #	Title
4	Delay Payments to Managed Care Organizations
7	Fund Community Integration Program with IGT Revenue
8	HIRSP Reduction
12	Emergency Medical Services Terrorism Response Training Requirements
15	Fuel and Utilities Lapse Estimate
16	Foster Care and Adoption Assistance Reestimate
18	Community Aids

State of Wisconsin
Department of Health and Family Services

Scott McCallum, Governor
Phyllis J. Dubé, Secretary

HEALTH AND FAMILY SERVICES - RECOMMENDATIONS
February 28, 2002

Paper #1165 – Medical Assistance and BadgerCare Base Reestimates
Alternatives

Reasons against using the IGT funds are compelling:

- Using the current IGT balances to fund the MA and BadgerCare deficits will increase the GPR structural deficit.
- It will be necessary to substitute GPR for base costs currently funded from segregated IGT funds, beginning in the 2003-05 biennium, and to a much greater extent in future budgets as the amount of IGT funds the state receives decreases.
- Using IGT revenues to fund MA reimbursement to nursing homes should be a priority use of the IGT funds.

* It is critical to at minimum fund the first year level to address the deficit. (Alt. A 2 a)

Paper #1166 – MA prescription Drugs – Prior Authorization
A. Funding

Support Alternative A 1: Adopt Governor's recommendation to reduce MA and BadgerCare benefits to reflect anticipated reductions in MA and BadgerCare expenditures for prescription drug used by recipients.

B. Prior Authorization Committee

a. Prior Authorization Actively Practicing Physicians
Alternatives 2 a 1 are acceptable

b. Prior Authorization Advocate for MA Recipients

C. Representatives of the Pharmaceutical Manufacturing Industry

The advisory DHFS prior authorization committee will continue to accept testimony from pharmaceutical representatives when reviewing policies.

Paper #1167 – Grants for Community Health Centers

Support motion by Senator Rosenzweig for study of federal funding requirements for health clinics. Intent of motion is to study ways to capture more federal dollars. Report back to the Legislature no later than June 30, 2002.

Paper #1168 Statewide Trauma Care System

Support Alternative A1

- Governor's full budget proposal (A1)
- Alternate funding options that reduce the regional council funding are flawed because:

1. There is no set number of regions currently. There is a conceptual model based on patient referral patterns, but the basis for the regional set-up was voluntary, local self-selection, not a State driven mandate of geographical areas.
2. The regions need to be allowed to form on their own, rather than mandate patient flow, which will doom the system before it starts.
3. The number of regions being higher or lower does not necessarily mean a prorated cost saving. Seven regions serving 5.4 million people or 10 regions serving 5.4 million just means the sphere of input and participation becomes larger if there are fewer regions. Participant activities still remain, but there would be more participants in each region if the number were seven.

- Bioterrorism funding is not a good alternative because of the potential to be one-time funding with no ongoing source and because bioterrorism activities and trauma activities have similar themes, but different needs and activities.

- Would agree with statutory changes #1, 2 & 3. Disagree with #4 and 5.

Intoxicated Driver Program

An alternative in paper 1168 uses Intoxicated Driver program dollars. That decision should be made under paper 1171 which has not been forwarded by LFB to date.

Wisconsin last year was out of compliance with the Federal Synar law to prevent youth from purchasing tobacco products which could result in a maximum penalty of losing 40 percent of Substance Abuse Prevention and Treatment Block Grant dollars. The federal government has provided for an alternative option in the past and DHFS is negotiating for the alternative penalty option. In the past, this option requires states to invest state funds equal to each 1 percent of block grant non-compliance percentage which is approximately $2.9 million annually.

- The Department of Health and Family Services has researched potential sources, and the Intoxicated Driver Program supplemental/emergency fund is the state source that we have identified. However, to use this funding source requires a statutory language change.

- Using IDP supplemental/emergency funding of $1 million for youth tobacco reduction activities will impact 20 or more counties that apply for these funds each year to deliver services to approximately 665 individuals convicted of OWI offences who need treatment but lack funding.

- Senate Bill 360 was recently passed by the Senate and Assembly and requires DHFS to develop training materials for tobacco product retailers for training clerks. Funding is needed to implement provisions of SB 360 and to assist the state in coming back into compliance with the federal Synar law.

Paper #1169 Surveillance of Disease and Potential Threats (DHFS)

Support Alternative 1.

The need for additional epidemiologic capacity for communicable disease prevention and control in Wisconsin has been an issue long before the recognized need for bioterrorism preparedness. And it will be important even after the federal government ceases funding for bioterrorism preparedness. **Current funding for bioterrorism is one-time, without any guarantee about meeting future needs.** Wisconsin must increase its core epidemiologic capacity aside from its bioterrorism preparedness efforts.

Wisconsin has between 6,000-8,000 cases of disease are reported annually either as sporadically occurring cases or in outbreaks. Wisconsin must have the capacity to stimulate the prompt reporting of these cases, analyze the epidemiologic circumstances for each, determine appropriate control measures, implement those in concert with the 100 local health departments in the state and evaluate the effectiveness of those responses. DHFS must also train local health department staff regarding the epidemiologic techniques necessary to investigate suspected cases of reported diseases.

It is necessary to develop and maintain the epidemiologic foundation upon which other disease prevention and control activities, including bioterrorism, can be built.

Paper #1170 – Disease Aids

A. Waiting lists

Support Alternative A 1 to, if necessary, establish waiting lists if the amount available for disease aids is insufficient to provide assistance to all persons eligible and allow promulagating rules for prioritizing lists

B. Rules for Kidney Disease Services

Support Alternative B 1 and/or Alt. B 3. Approve the Governor's recommendation to repeal the current requirement that the state pay for services provided under the kidney disease program at rates equal to allowable charges under the federal Medicare program

C. Payer of Last Resort.

Support Alternative C 2. Under HIRSP, there is a six-month waiting period for individuals with pre-existing conditions. In addition, some of these individuals may not be able to afford the HIRSP premiums.

D. Rules

Support Alternative D 1 and/or D 3

AGENCY: DHFS

LFB PAPER #: 1165

ISSUE: Medical Assistance and BadgerCare Base Reestimates

ALTERNATIVE: First choice A3a
Second choice A2a
Third choice A1a,
Also B2, and C

SUMMARY:

Resist any efforts here to balance this with IGT money, especially the BadgerCare shortfall.

A3a fully funds the MA shortfall, and costs $51.9 million GPR **above** what the governor wants to do (his costs $74.3 million GPR over the biennium) this is the pie in the sky option & probably not realistic.

A2a funds the MA shortfall based on LFB's first year estimates, which are higher than the govs by $3.9 million each year (cost above the bill is $7.8 million GPR over the biennium)

A1a is the governor's recommendation & funds the MA shortfall based on his first year estimates and costs $74.3 million GPR over the biennium.

B2 funds the shortfall in the BadgerCare program and costs $5.6 million GPR.

Alt. C requires DOA to come back to JFC with a report by 9/1/02 on where we are with the actual costs of MA and BadgerCare and to find ways to reduce program costs.

BY: Cindy

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February 28, 2002 Joint Committee on Finance Paper #1165

Medical Assistance and BadgerCare Base Reestimates (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 50, #3]

CURRENT LAW

Medical Assistance. The state's medical assistance (MA) program funds acute and long-term care services to persons who are aged, blind, disabled, children, members of families with dependent children and pregnant women who meet financial and nonfinancial criteria. In 2001-02, most MA services are funded on a 41.25% GPR/58.75% FED matching basis.

GPR funding budgeted for MA benefits is budgeted in a biennial appropriation, which enables DHFS to expend funds budgeted in the second year of the biennium to fund costs in the first year if the first year appropriation is insufficient to fully support program costs.

BadgerCare. BadgerCare funds the same services that are offered under MA to certain individuals who are not eligible for MA. Individuals initially eligible for BadgerCare cannot have household income that exceeds 185% of the federal poverty level (FPL). Once enrolled, a family's countable income may increase to 200% of the FPL before the family is no longer eligible for the program. Additionally, to be eligible for BadgerCare, an individual must meet certain nonfinancial eligibility criteria regarding health care coverage. MA policies regarding the types of services available and payment for those services apply under BadgerCare as well.

In 2001-02, approximately 32.4% of the costs of BadgerCare benefits are funded with GPR, the rest is funded from federal funds the state receives under the state children's health insurance program (CHIP) and MA and premiums paid by participating families with income that exceeds 150% of the FPL.

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 may not be greater than necessary to ensure that

sufficient funding is available to meet program costs. 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." Further, implementation of the enrollment trigger requires approval from federal authorities under the terms of the waivers of federal law under which BadgerCare operates.

Intergovernmental Transfer Program Revenues. The state uses federal MA matching funds it claims under the intergovernmental transfer (IGT) program to support a portion of the state's share of MA and BadgerCare costs. These funds are deposited to a segregated trust fund, the MA trust fund, and budgeted to partially fund the state's share of MA costs.

GOVERNOR

Medical Assistance Base Reestimate. Provide $37,187,100 GPR annually to address an anticipated deficit in the MA benefits appropriation. Based on current federal financial participation rates, it is estimated that the increase in state spending will increase federal MA matching funds by $52,963,400 FED in 2001-02 and $52,344,900 FED in 2002-03.

BadgerCare. No provision.

DISCUSSION POINTS

1. This office has reviewed expenditure and caseload data for the MA and BadgerCare programs through December, 2001. Based on this review, it is estimated that the costs of these programs could exceed the amounts budgeted in Act 16 by approximately $144.2 million ($41.3 million GPR, $102.7 million FED and $0.2 million PR) in 2001-02 and $197.9 million ($90.7 million GPR, $106.4 million FED and $0.8 million PR) in 2002-03. The GPR portion of this increase represents approximately 5.9% of the total GPR budgeted for MA and BadgerCare in Act 16 for the 2001-03 biennium.

2. This projected shortfall is largely due to increases in enrollment that have occurred since the Act 16 projections were developed last spring. The attachment to this paper identifies the funding provided for MA and BadgerCare in Act 16 compared with current estimates and the caseload estimates used to project funding provided in Act 16 and the current caseload estimates for both programs.

3. As can be seen in the attachment, the biggest difference between the Act 16 caseload projections and current projections is reflected in the MA AFDC-related caseload. Enrollees in this category are members of families with household income that does not exceed the income limits under the former AFDC program. The AFDC income limit for a family of three is $647 per month, equivalent to approximately 52% of the FPL for a family of that size, based on the 2002 FPL. As of December, 2001, there were over 170,000 individuals enrolled in MA under the AFDC-related

criteria, an increase of more than 20,000 from six months earlier.

The MA AFDC-related average monthly caseload has decreased every year from a high of approximately 301,000 in 1991-92 to a low of approximately 144,000 in 1999-00, but increased to over 146,000 in 2000-01. The caseload projections used in Act 16 assumed modest growth in the AFDC-related caseload over the 2001-03 biennium, approximately 2.2% in 2001-02 and 2.3% in 2002-03. Current estimates project that caseload will increase by approximately 16.1% in 2001-02 and 17.4% in 2002-03.

4. The Department of Administration estimates that the MA program will have a deficit of $37,187,100 GPR in 2001-02, but has not reestimated the cost of the MA program in 2002-03. Additionally, the administration does not project a deficit in BadgerCare in 2001-02, and like MA, has not reestimated BadgerCare costs in 2002-03. The Governor recommends: (a) funding the projected 2001-02 MA deficit: (b) increasing GPR funding for MA benefits by an identical amount in 2002-03; and (c) waiting until January, 2003, to determine how much funding, if any, will be necessary to fund both programs in 2002-03. DOA staff indicate that there remains considerable uncertainty over future caseload for the programs, and that, if a 2002-03 deficit is projected next January, it can be addressed next spring.

5. There are several reasons why DHFS cannot significantly reduce MA benefits costs to ensure that costs do not exceed the amounts appropriated for the program. First, the program's eligibility standards and covered services are specified in state and federal law. As an entitlement program, DHFS cannot place eligible individuals on waiting lists for services. Second, DHFS staff indicate that the Department has no authority to reduce provider rates as a means of addressing a projected shortfall because doing so would be contrary to decisions made as part of the Legislature's budget deliberations. For these reasons, DHFS staff indicate that, if no additional funding were provided to support MA benefits in the 2001-03 biennium, or the additional funding recommended by the Governor were insufficient to support projected program costs, it would continue to administer the current program without changes with the expectation that the Governor and Legislature would provide additional funding at a later date to fully fund the program in the 2001-03 biennium.

6. Unlike MA, state law specifies that BadgerCare is not an entitlement program. However, the program operates under the conditions specified in two waivers of federal law approved by the Health Care Financing Administration (now, the Centers for Medicare & Medicaid Services, or CMS). The first waiver, approved in January, 1999, authorized a demonstration project, which allowed the state to use federal MA-matching funds to provide family coverage under BadgerCare. The second waiver, approved in January, 2001, authorized the use of federal funds allocated to the state under CHIP to support costs for adults enrolled in BadgerCare with income above 100% of the FPL. Before the second waiver was approved, CHIP funds could only be used to support costs for children enrolled in BadgerCare.

CHIP funds are available at a higher federal matching rate than under MA, 71% vs. 59%. By authorizing the use of CHIP funds to support BadgerCare costs for some adult enrollees, rather

than MA funds, the second waiver allows the state to reduce GPR support for the costs of these enrollees. Based on current cost and caseload projections, the GPR savings available from the use of CHIP funds, rather than MA funds, for costs for adults with income above 100% of the FPL is estimated at over $7.0 million in 2001-02 and over $9.0 million in 2002-03. Under the terms of the waivers, changes to the BadgerCare program must be approved by CMS or the waiver approval may be rescinded.

7. Even though the statutes specify that BadgerCare is not an entitlement program, implementation of the "enrollment trigger" is not a desirable option since, under the terms and conditions of the second waiver, DHFS cannot close enrollment, institute a waiting list or decrease eligibility standards while the second waiver is in effect, otherwise the second waiver is terminated. In this case, the state incurs a financial penalty because the state would be required to revert to using federal MA matching funds to support costs for adults with income above 100% of the FPL, rather than CHIP funds. Additionally, because under the terms of the first waiver, use of the enrollment trigger only applies to new enrollees and not existing enrollees, the extent to which DHFS could reduce the eligibility limits enough to generate sufficient savings to address a projected deficit is limited.

8. Several options are presented for the Committee's consideration to address the projected deficits in the MA and BadgerCare programs.

First, the Committee could adopt the Governor's recommendation to increase GPR funding for MA in 2001-02 and 2002-03 by an amount equal to the projected shortfall in the first year and to provide no funding for BadgerCare at this time. The Committee could then consider the need to provide additional funding for MA and BadgerCare in the spring of 2003.

Projected MA and BadgerCare benefits costs for the rest of the biennium are sensitive to the assumptions used about future caseload. For example, current projections assume that the MA AFDC-related caseload will increase by 1.5% per month from January, 2002 through September, 2002, and 0.75% from October, 2002, through the remainder of the biennium. These assumptions represent an approximate midpoint of average growth over the last four to twelve months. However, if these assumptions were modified to instead reflect average growth for January through September, 2002, based on the most recent four-month period (2.15% per month) and slowing growth beginning in October, 2002 (1.075% per month), the projected deficit in MA increases from approximately $126 million GPR to over $138 million GPR over the biennium. Alternatively, if caseload growth were to slow to only 0.75% per month from January, 2002, through the remainder of the biennium, the projected deficit in MA decreases to approximately $115 million GPR over the biennium.

The disadvantage to providing funding in both years equal only to the first year projected deficit is that it is most likely that the amounts budgeted in 2002-03 will not be sufficient to meet 2002-03 costs. Based on the current estimate, the amount of funding that may be required at that time, above the amounts provided in the bill, will be $57.6 million GPR for both programs. The actual amount necessary to fund 2002-03 costs could be much greater or less, due to the uncertainty

of continued caseload growth in 2002-03.

9. A second option for the Committee is to fully fund the projected shortfall in the MA and BadgerCare programs as part of this budget reform bill. Increasing funding for these programs at this time ensures that the funding will be available to meet current projected program costs. Further, it would not increase costs for MA and BadgerCare -- the costs for benefits provided under these programs will be incurred regardless of whether funding is provided as part of this bill to fund projected costs. If actual caseload growth or costs are less than currently projected, any additional GPR budgeted for MA would lapse to the general fund and would be available to support costs in the 2003-05 biennium. Finally, by providing additional funding for BadgerCare at this time, it is less likely that DHFS will be required to implement the BadgerCare enrollment trigger to ensure that costs do not exceed the amounts budgeted for the program.

10. If the Committee wants to fund all or a portion of the projected shortfall in the MA and BadgerCare programs, it could fund these costs either with GPR or segregated funds from the MA trust fund (revenue the state claimed under the IGT program). On February 25, 2002, this office notified the Committee of the resolution to several issues regarding the state's claiming federal MA matching funds under the IGT program. The February 25 memorandum indicated that, under the Governor's budget recommendations, the projected balance in the MA trust fund would be approximately $427.8 million at the end of the 2001-03 biennium and -$21.9 million at the end of the 2003-05 biennium.

11. There are two primary arguments against using IGT revenue to support the projected MA and BadgerCare shortfalls. First, because the state claims IGT revenues based on the difference between what nursing homes would receive based on Medicare payment principals and what the state's MA program pays nursing homes, using IGT revenue to fund MA reimbursement to nursing homes should be a priority use of IGT funds, rather than to fund projected MA and BadgerCare deficits. The current projected deficit in MA is primarily due to increases in the number of low-income families that have enrolled in the program during the past year, not due to increases in the number of MA nursing home residents. Further, there is little justification for using IGT revenues to support the costs of BadgerCare, since there are few nursing home costs incurred by BadgerCare enrollees.

Second, based on the Governor's budget reform bill, there will be a projected deficit in the MA trust fund of approximately $21.9 million by the end of the 2003-05 biennium, even if there were no rate increases for nursing homes or other health care providers funded from this source in the 2003-05 biennium. It will be necessary to substitute GPR for base costs currently funded from segregated IGT funds, beginning in the 2003-05 biennium, and to a much greater extent in future biennia as the amount of IGT funds the state receives continues to decrease. In this way, using current IGT balances to fund the projected MA and BadgerCare deficits will increase the GPR structural deficit in 2003-05.

12. In light of the current uncertainty over projected MA and BadgerCare costs for the rest of the biennium, the Committee could consider several options and recommendations offered

by the administration at a future date, when additional actual enrollment and caseload data are available. At that time, the Committee could also consider reducing MA rates paid to providers to reduce the amount of state funding that would otherwise be necessary to fund any projected deficit.

For example, the Committee could direct DOA to submit a report to the Committee by September 1, 2002, that would identify: (a) the administration's estimates of the costs of MA and BadgerCare in the 2001-03 biennium and the amount of additional funding, if any, that would be required to fully fund these programs through the 2001-03 biennium; (b) options to reduce program costs in 2002-03 that the Committee could consider and approve that would not require statutory changes relating to eligibility and coverage, but would include proposals to reduce provider rates, both selectively and across-the-board, in 2002-03, including the feasibility of implementing rate reductions retroactively to July 1, 2002; (c) the administration's projections of annual IGT revenue and balances in the MA trust fund through June 30, 2005; and (d) the administration's recommendations to address any projected shortfall in the MA and BadgerCare programs in the 2001-03 biennium. This report could be submitted, together with the Department of Administration's recommendations, under a 14-day passive review process.

In addition, statutory changes would be necessary to: (a) authorize the Committee to modify the 2002-03 provider rates that were established as part of the Act 16 budget deliberations; and (b) authorize the Committee to transfer funding from the unallocated balance of the MA trust fund to fund any projected shortfall in the MA and BadgerCare programs in the 2001-03 biennium.

ALTERNATIVES TO BILL

A. Medical Assistance

1. *Fund MA Based on Governor's First Year Estimate*

a. Adopt the Governor's recommendations to provide $37,187,100 GPR annually and $52,963,400 FED in 2001-02 and $52,344,900 FED in 2002-03 to address an anticipated deficit in the MA benefits appropriation. The annual GPR amounts reflect the administration's estimate of the projected deficit in the 2001-02 fiscal year.

b. Modify the Governor's funding recommendations by funding the state share of these costs with segregated IGT revenues, rather than GPR.

Alternative A1b	GPR	SEG	TOTAL
2001-03 FUNDING	- $74,374,200	$74,374,200	$0

2. *Fund MA Based on Current First Year Estimate*

a. Increase funding in the bill by $3,926,300 GPR and $43,565,000 FED in 2001-02

and $3,926,300 GPR and $5,526,700 FED in 2002-03 to address an anticipated deficit in the MA benefits appropriation. The annual GPR amounts reflect the current estimate of the projected deficit in the 2001-02 fiscal year.

Alternative A2a	GPR	FED	TOTAL
2001-03 FUNDING	$7,852,600	$49,091,700	$56,944,300

b. Modify Alternative A2a by funding the state share of these costs with segregated IGT revenues, rather than GPR.

Alternative A2b	SEG	FED	TOTAL
2001-03 FUNDING	$7,852,600	$49,091,700	$56,944,300

c. Modify Alternative A2b by: (a) funding the state share of these costs with segregated IGT revenues, rather than GPR; and (b) substituting the Governor's recommended GPR funding increase with segregated IGT revenues.

Alternative A2c	GPR	FED	SEG	TOTAL
2001-03 FUNDING	- $74,374,200	$49,091,700	$82,226,800	$56,944,300

3. *Fully Fund Current MA Deficit*

a. Increase funding in the bill by $3,926,300 GPR and $43,565,000 FED in 2001-02 and $48,045,700 GPR and $37,601,300 FED in 2002-03 to fully fund current estimates of MA costs in the 2001-03 biennium.

Alternative A3a	GPR	FED	TOTAL
2001-03 FUNDING	$51,972,000	$81,166,300	$133,138,300

b. Modify Alternative A3a by funding the state share of these costs with segregated IGT revenues, rather than GPR.

Alternative A3b	GPR	FED	SEG	TOTAL
2001-03 FUNDING	- $74,374,200	$81,166,300	$126,346,200	$133,138,300

B. BadgerCare

1. Adopt the Governor's recommendation to provide no additional funding for

BadgerCare at this time.

2. Provide $179,300 GPR, $6,208,800 FED and $191,800 PR in 2001-02 and $5,427,100 GPR, $16,474,300 FED and $783,200 PR in 2002-03 to fully fund the current projected costs of BadgerCare benefits in the 2001-03 biennium.

Alternative B2	GPR	FED	PR	TOTAL
2001-03 FUNDING	$5,606,400	$22,683,100	$975,000	$29,264,500

3. Modify Alternative B2 by funding the state share of these costs with segregated IGT revenues, rather than GPR.

Alternative B3	FED	PR	SEG	TOTAL
2001-03 FUNDING	$22,683,100	$975,000	$5,606,400	$29,264,500

C. Report to Committee

In addition to any of the alternatives under "A" and "B," direct DOA to submit a report to the Committee by September 1, 2002, that would identify: (a) the administration's estimates of the costs of MA and BadgerCare in the 2001-03 biennium and the amount of additional funding, if any, that would be required to fully fund these programs through the 2001-03 biennium; (b) options to reduce program costs in 2002-03 that the Committee could consider and approve that would not require statutory changes relating to eligibility and coverage, but would include proposals to reduce provider rates, both selectively and across-the-board, in 2002-03, including the feasibility of implementing rate reductions retroactively to July 1, 2002; (c) the administration's projections of annual IGT revenue and balances in the MA trust fund through June 30, 2005; and (d) the administration's recommendations to address any projected shortfall in the MA and BadgerCare programs in the 2001-03 biennium. Require the report to be submitted, together with the DOA's recommendations, under a 14-day passive review process.

In addition, authorize the Committee to modify the 2002-03 provider rates that were established as part of the Act 16 budget deliberations and to transfer funding from the unallocated balance of the MA trust fund to fund any projected shortfall in the MA and BadgerCare programs in the 2001-03 biennium.

Prepared by: Rachel Carabell and Charlie Morgan

Attachment

ATTACHMENT

Medical Assistance and BadgerCare Reestimates
($ in Millions)

Funding

	Act 16		Current Estimate		Difference		
	2001-02	2002-03	2001-02	2002-03	2001-02	2002-03	2001-03
Medical Assistance							
GPR	$1,106.7	$1,023.8	$1,147.8	$1,109.0	$41.1	$85.2	$126.3
FED	2,041.6	2,173.8	2,138.1	2,263.7	96.5	90.0	186.5
SEG	155.1	296.9	155.1	296.9	0.0	0.0	0.0
Total	$3,303.4	$3,494.5	$3,441.0	$3,669.6	$137.6	$175.2	$312.8
BadgerCare							
GPR	$48.0	$52.2	$48.2	$57.7	$0.2	$5.4	$5.6
FED	95.5	104.2	101.7	120.6	6.2	16.5	22.7
SEG	0.3	0.7	0.3	0.7	0.0	0.0	0.0
PR	3.0	3.3	3.2	4.1	0.2	0.8	1.0
Total	$146.8	$160.4	$153.4	$183.1	$6.6	$22.7	$29.3

Average Monthly Caseload

	Act 16		Current Estimate		Difference	
	2001-02	2002-03	2001-02	2002-03	2001-02	2002-03
Medical Assistance						
Aged	42,251	40,793	43,794	43,778	1,543	2,985
Blind/Disabled	97,325	97,306	99,304	101,043	1,979	3,737
AFDC-Related	148,846	152,280	169,949	199,478	21,103	47,198
Other	143,987	154,044	146,961	155,559	2,974	1,515
Total	432,409	444,423	460,008	499,858	27,599	55,435
BadgerCare						
Children	26,485	28,231	27,923	34,406	1,438	6,175
Adults	60,319	64,325	62,447	68,972	2,128	4,647
Total	86,804	92,556	90,370	103,378	3,566	10,822

MO# C change from 14day passive review to B.10 request

(2)	BURKE	(Y)	N	A
(1)	DECKER	(Y)	N	A
	MOORE	(Y)	N	A
	SHIBILSKI	(Y)	N	A
	PLACHE	(Y)	N	A
	WIRCH	(Y)	N	A
	DARLING	Y	(N)	A
	ROSENZWEIG	Y	(N)	A
	GARD	Y	(N)	A
	KAUFERT	Y	(N)	A
	ALBERS	Y	(N)	A
	DUFF	Y	(N)	A
	WARD	Y	(N)	A
	HUEBSCH	Y	(N)	A
	HUBER	(Y)	N	A
	COGGS	(Y)	N	A

AYE 8 NO 8 ABS ____

Ala Bl-Gard (Gov. no motion needed)

MO# B2

(2)	BURKE	(Y)	N	A
(1)	DECKER	(Y)	N	A
	MOORE	(Y)	N	A
	SHIBILSKI	(Y)	N	A
	PLACHE	(Y)	N	A
	WIRCH	(Y)	N	A
	DARLING	Y	(N)	A
	ROSENZWEIG	Y	(N)	A
	GARD	Y	(N)	A
	KAUFERT	Y	(N)	A
	ALBERS	Y	(N)	A
	DUFF	Y	(N)	A
	WARD	Y	(N)	A
	HUEBSCH	Y	(N)	A
	HUBER	(Y)	N	A
	COGGS	(Y)	N	A

AYE 8 NO 8 ABS ____

language to give JFC to supplant BadgerCare as a means to address any short fall

MO# ____

	BURKE	(Y)	N	A
(2)	DECKER	(Y)	N	A
	MOORE	(Y)	N	A
	SHIBILSKI	(Y)	N	A
	PLACHE	(Y)	N	A
	WIRCH	(Y)	N	A
	DARLING	(Y)	N	A
	ROSENZWEIG	(Y)	N	A
(1)	GARD	(Y)	N	A
	KAUFERT	(Y)	N	A
	ALBERS	(Y)	N	A
	DUFF	(Y)	N	A
	WARD	(Y)	N	A
	HUEBSCH	(Y)	N	A
	HUBER	(Y)	N	A
	COGGS	(Y)	N	A

AYE 16 NO 0 ABS ____

AGENCY: DHFS

LFB PAPER #: 1166

ISSUE: MA Prescription Drugs – Prior Authorization

ALTERNATIVE: A1, B2a(1) b(2) and c(2)

SUMMARY:

Alt A1 supports the govs provision for savings realized through prior authorization. DHFS thinks they can make the savings. Although there's no data to indicate DHFS could actually save this much money from PA's, which would mean they'd have to make cuts elsewhere in the MA budget.

The alternative under B designate what the make up of the prior authorization committee should be. B2a(1) is to put 2 practicing physicians on the committee; b(2) puts an MA recipient advocate on the panel that has sufficient clinical knowledge to make decisions about drug authorizations; and c(2) takes the drug manufacturer rep off the committee & instead directs DHFS to accept testimony from such individuals when it does its review of prior authorization policies.

BY: Cindy

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February 28, 2002 Joint Committee on Finance Paper #1166

MA Prescription Drugs -- Prior Authorization (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 51, #5 & #6]

CURRENT LAW

Under federal law, pharmaceutical manufacturers may enter into agreements with the U.S. Department of Health and Human Services (DHHS), on behalf of state medical assistance (MA) programs, to provide rebates for drugs purchased by beneficiaries enrolled in state MA programs. Additionally, state MA programs must provide coverage of prescription drugs produced by manufacturers that enter into rebate agreements with DHHS, except that states may exclude coverage of a drug if the prescribed use is not for a medically accepted indication or used for certain purposes, such as weight loss or gain, promotion of fertility, smoking cessation or cosmetic purposes.

States may subject any drug covered under its MA program to prior authorization requirements, meaning that a pharmacy must receive prior approval from the program before reimbursement would be available for a drug purchased by an MA recipient. Federal law requires that a state's prior authorization process must provide responses to requests by telephone or other telecommunication device within 24 hours of a request's submission and provide for dispensing of at least a 72-hour supply of a covered drug in an emergency situation.

The Department of Health and Family Services (DHFS), in accordance with federal law, requires prior authorization for some prescription drugs purchased by MA recipients to: (a) prevent potential drug abuse or misuse; (b) prohibit reimbursement for drugs used for cosmetic purposes only; and (c) encourage the use of lower cost, therapeutically equivalent drugs when appropriate. Current prior authorization requirements apply to certain prescription drugs used to treat ulcers, pain relief, hypertension and congestive heart failure and stimulants, hormone therapy drugs, and drugs used to promote fertility and to treat impotence. For most drugs, prior authorization is available electronically and a response to a request for prior authorization is available almost immediately.

Many private health plans require enrollees to use certain drugs by creating formularies (a list of drugs covered by a health plan), or encourage enrollees to use certain drugs by requiring enrollees to pay a larger portion of the costs of a drug if it is not considered a preferred drug by the plan. State MA programs are prohibited from using formularies or preferred drug lists in this way, since MA programs must cover all drugs produced by manufacturers that enter into rebate agreements with DHHS on behalf of states and cannot require recipients to make copayments that are more than nominal in amount. However, many states, including Wisconsin, use prior authorization to encourage the use of lower-cost, therapeutically-equivalent drugs by requiring prior authorization for single-source innovator drugs when a therapeutically-equivalent drug is available generically within the same classification. Single-source innovator drugs are drugs for which a patent is pending for the drug's chemical compound.

Therapeutically-equivalent drugs are not the same as generic drugs. A drug is a generic equivalent if, as determined by the U.S. Food and Drug Administration, the chemical compound of the active ingredients are identical to the innovator drug and its manufacturing facility meets standards for quality assurance. Generically-equivalent drugs are only available after an innovator drug no longer has patent protection.

Therapeutically-equivalent drugs are drugs that treat a condition in the same manner as other drugs, but the chemical compound of the drugs' active ingredients are different. Such differences in the chemical compound may affect the types or degree of a side-effect or effect the potential risks associated with a certain type of medication. An example of drugs in a category usually considered to include therapeutically-equivalent drugs would be proton pump inhibitors. These drugs, which block the transport of hydrogen ions into the stomach, can be effective at treating ulcers. Drugs in this category include well-known brand name drugs, such as Prilosec, Prevacid and Nexium.

There is no agreed upon standard for determining when a drug is therapeutically-equivalent to another. Further, a single-source innovator drug may be the most appropriate drug for certain individuals based on certain risk factors and potential side effects. Therefore, states and private health plans that use formularies or prior authorization requirements to encourage the use of lower-cost, therapeutically-equivalent drugs develop standards to determine when the use of a single-source innovator drug is appropriate and should be approved for reimbursement. Most health plans use a committee of medical professionals to identify those drugs to be included on a formulary and the standards used for approving drugs subject to limits. These committees are usually referred to as pharmacy and therapeutics committees.

Currently, DHFS convenes a committee to review proposals to change policies and standards for prior authorization requirements for prescription drugs used by MA recipients before such proposals are acted upon by the DHFS Secretary. This committee includes five pharmacists, three physicians and a nurse. Three of the pharmacists are DHFS consultants, one is a faculty member of the University of Wisconsin-Madison, School of Pharmacy and one is a DHFS employee. The three physicians and the nurse are all DHFS employees. None of the current members are actively practicing their trade, meaning they do not see patients.

Other cost-saving measures used by DHFS to reduce prescription drug expenditures include educational efforts to inform prescribers about the costs and relative effectiveness of certain prescription drugs, incentive payments to pharmacies for services provided to MA recipients which result in savings to MA, automatic substitution of a generic drug when available, except in cases where a prescriber indicates that the brand name version of a drug is medically necessary, and payments to pharmacists for disease management activities associated with MA recipients diagnosed with asthma. Additionally, as required under federal law, DHFS operates prospective and retrospective drug utilization reviews which attempt to identify abusive utilization of prescription drugs, over- or underutilization of prescription drugs and identifies circumstances in which a prescription is contraindicated, based on other medications a recipient may be taking.

Under the terms of the two federal waivers under which BadgerCare operates, all MA policies regarding the use of and reimbursement for prescription drugs apply under BadgerCare as well.

GOVERNOR

Reduce funding for MA and BadgerCare benefits by $3,809,200 ($1,551,100 GPR and $2,258,100 FED) in 2001-02 and $29,220,000 ($11,994,200 GPR and $17,225,800 FED) in 2002-03 to reflect reductions in MA and BadgerCare expenditures for prescription drugs used by MA and BadgerCare recipients. The administration indicates that, through the use of prior authorization requirements and other cost-saving measures, MA and BadgerCare costs for prescription drugs would be reduced by these amounts. This item includes: (a) reducing MA benefits funding by $2,477,100 GPR and $2,103,700 FED in 2001-02 and $11,522,900 GPR and $16,219,700 FED in 2002-03; and (b) reducing BadgerCare benefits funding by $74,000 GPR and $154,400 FED in 2001-02 and $471,300 GPR and $1,006,100 FED in 2002-03.

Additionally, require the DHFS Secretary to create a prescription drug prior authorization committee to advise DHFS on issues related to prior authorization decisions made concerning prescription drugs used by MA recipients. Require the Secretary to appoint as members at least all of the following: (a) two physicians who are currently in practice; (b) two pharmacists; (c) one advocate for MA recipients; and (d) one representative of the pharmaceutical manufacturing industry.

DISCUSSION POINTS

Savings Available from the Use of Prior Authorization

1. The administration indicates that the funding reductions included in the bill relate to anticipated savings in prescription drugs expenditures under MA and BadgerCare that would primarily result from the expanded use of prior authorization implemented over this biennium. To the extent such savings are not available from prior authorization, the administration indicates that

DHFS would be required to reduce drug expenditures in other ways.

2. Several opportunities to reduce prescription drug expenditures could be available over the biennium as several drugs are expected to lose patent protection. These include the following well-known drugs: (a) Prilosec, a proton pump inhibitor used to treat ulcers; (b) Prozac, an antidepressant classified as a selective serotonin reuptake inhibitor (SSRI); (c) Mevacor, a cholesterol-lowering drug classified as an antihyperlipidemics; and (d) Claritin, a non-sedating antihistamine. Claritin is not expected to lose patent protection until late in the biennium. Therefore, any potential savings available from prior authorization requirements on similar drugs would not likely be available until the next biennium.

3. DHFS plans to submit proposals to its prior authorization committee supporting the implementation of prior authorization requirements on patented drugs in the proton pump inhibitors category, antihyperlipidemics and non-sedating allergy treatment categories to be implemented once drugs in these categories become available generically. In addition, DHFS is considering recommending to its committee that prior authorization be required for sedative and hypnotic drugs. DHFS indicates that it does not intend to pursue prior authorization requirements for SSRIs due to concerns expressed by advocates for individuals with mental illness that restricting access to prescription drugs is inappropriate for individuals with mental illness. Nonetheless, DHFS expects some savings to be available due to reduced prices on generic Prozac and continues efforts to educate prescribers on the effectiveness of generic Prozac relative to other SSRIs.

4. The MA program is not guaranteed savings from prior authorization for several reasons. First, although patents for all of these drugs are expected to expire over the biennium, court challenges and certain federal provisions that allow for extensions of patent protection could allow these drugs to retain their patent protection beyond the current expiration dates, thereby providing uncertainty about when savings would first be available. Second, prior authorization policies for these new categories of drugs have not yet been reviewed by DHFS' prior authorization committee nor acted upon by the DHFS Secretary. The extent to which savings would be available could vary significantly, depending on the review of this committee and the decisions made by the DHFS Secretary.

5. Health care researchers and policymakers across the country advocate the effective use of prior authorization in MA programs to limit the use of higher-cost prescription drugs when lower-cost alternatives are available and appropriate as one of the most effective ways to reduce health care costs for prescription drugs.

6. Prior authorization policies and formularies are often seen as a way to counter manufacturers' direct-to-consumer advertising, which has increased nationally from approximately $790 million in 1996 to almost $2.5 billion in 2000, according to the Kaiser Family Foundation's updated Prescription Drug Trends Chartbook. Many contend that such advertising has unnecessarily increased demand for the most expensive pharmaceuticals. Pharmaceutical manufacturers argue that such advertising simply provides information, which empowers patients and fosters communication between physicians and patients. Ultimately, the manufacturers argue,

the determination of whether a drug is appropriate is up to a patient and his or her physician.

7. DHFS estimates that MA drug costs will be reduced by over $26 million over the 2001-03 biennium as a result of current prior authorization policies which limit the use of certain drugs to treat ulcers (histamine 2 antagonists), high blood pressure (ACE inhibitors) and pain medications primarily used to treat arthritis (nonsteriodal anti-inflammatory drugs, known as NSAIDs). These savings are achieved by moving market share from single-source innovator drugs to multiple-source drugs in the same classification, which are available generically.

8. Critics of prior authorization argue that such policies restrict MA recipients' access to appropriate prescription drugs and do not recognize the value of incremental innovation in medicine. These arguments are based on the premise that MA programs should cover the costs of the most appropriate drug used by an MA recipient, as determined by the patient and his or her physician. Therefore, any policies that place restrictions on access to more expensive drugs inappropriately interfere with the doctor-patient relationship.

9. It does not appear that DHFS' current use of prior authorization ignores the value of incremental innovation. Rather, by allowing single-source innovator drugs to be approved under some circumstances, such as when a lower cost alternative has been tried and found ineffective or inappropriate, or in some circumstances, when an individual is already stabilized on a single source innovator drug, DHFS' current prior authorization policies recognize that these drugs may be appropriate in those instances. However, in many instances, a lower-cost alternative may be just as appropriate.

10. Further, reducing costs for prescription drugs through the use of formularies and prior authorization can be ethical if done appropriately, according to an article by individuals at the Department of Clinical Bioethics at the Warren G. Magnuson Clinical Center at the National Institutes of Health. According to their analysis, accepting resource constraints must be one of the fundamental values of an ethical policy for pharmaceutical benefit management. "Step therapy," which the article defines as a policy that "permits the use of more costly medications only after less expensive drugs with the same indications have been tried and rejected because of therapeutic inefficacy or adverse reactions," is ethical if the policies are "developed through an inclusive, transparent decision-making procedure." By including physicians and patients in the decision-making process for controls on drug utilization, a program can foster trust between patients and physicians "collectively rather than individually," making the policy more ethically permissible.[1]

11. Other concerns have been raised that drug formularies and prior authorization policies can increase a health plan's costs in other areas, such as increased physician office visits, use of laboratory tests, hospital emergency rooms and inpatient hospital admissions. However, many evaluations of prior authorization and formularies have been inconclusive, criticized by researchers for poor evaluation design, or have focused on specific policies and then used to draw

[1] Burton, Stephan L., Randel, Lauren, Karen Titlow and Emanuel, Ezekiel J.; "The Ethics of Pharmaceutical Benefit Management;" *Health Affairs*, September/October, 2001.

conclusions about prior authorization in general. However, according to several researchers, one evaluation that did provide conclusive findings was based on a sound evaluation design and analyzed the use of prior authorization policies applicable to the types of prior authorization policies used by DHFS to encourage therapeutic substitution. This evaluation, reported in the New England Journal of Medicine, evaluated the use of prior authorization for NSAIDs used by Tennessee MA recipients. This evaluation found that "the prior-authorization program achieved its intended effect of materially decreasing Medicaid expenditures for pharmaceuticals without undesirable changes in the use of other types of medical care."

12. In considering these issues, the Joint Finance Committee may determine it is appropriate that, when a lower-cost alternative is available and appropriate, DHFS should encourage the use of that lower-cost alternative. This would be consistent with current administrative rules that specify that one of the purposes of prior authorization for any MA service includes its use to "determine if less expensive alternative care, services or supplies are usable." As a result, the Committee could adopt the Governor's provision to reduce MA and BadgerCare benefits as a result of possible savings available from prior authorization, despite uncertainty regarding the availability of such savings.

13. The administration indicates DHFS would be required to achieve the savings included in the bill, even if the savings did not materialize from prior authorization policies. Some methods DHFS could use to reduce prescription drug costs in the event savings are not available from prior authorization include increasing existing efforts to educate prescribers about the relative cost effectiveness of certain drug treatments, efforts to increase compliance with cost-savings measures (such as generic substitution) and increased use of pharmaceutical care management services and continued efforts to identify conditions appropriate for disease management efforts with the intention of improving overall health care. Additionally, the administration hopes to achieve savings in prescription drug costs through the availability of generic SSRIs. However, such efforts may not be sufficient to realize the savings assumed in the Governor's bill, particularly if DHFS does not implement prior authorization policies as proposed.

14. Other savings could be available by using mail-order delivery of prescription drugs used to treat chronic conditions or reducing reimbursement rates paid to pharmacies for prescription drugs. However, during the 2001-03 biennial budget debate, the Legislature did not adopt the Governor's recommendations to authorize the use of mail-order delivery of prescription drugs and approved a more limited a reduction in the reimbursement rate for prescription drugs than recommended by the Governor. Therefore, DHFS indicates that it would not implement such provisions without specific legislative approval to do so.

15. If the Joint Finance Committee does not wish to encourage greater use of prior authorization or other means to reduce MA drug costs, or determines that it is not appropriate to reduce the MA and BadgerCare benefits appropriation without the certainty that DHFS will reduce drug costs by corresponding amounts, it could restore MA and BadgerCare benefits funding that would be deleted in the bill ($13,545,300 GPR and $19,483,900 FED over the biennium).

Prior Authorization Committee

16. DHFS indicates that its current process for determining policies for prior authorization requirements is based on a review of scientific research and the clinical effectiveness of prescription medications. In determining whether to support the Governor's provision to require actively practicing physicians, an advocate for MA recipients and a representative of the pharmaceutical manufacturing industry, the Committee should consider the role such members would play on the DHFS committee and what effect the presence of such members would have on the recommendations made by the committee. The Governor's provision to require the DHFS committee to require at least two pharmacists is consistent with the current makeup of the DHFS committee.

17. One significant difference between the current structure of the DHFS committee and many private plans' committees is that DHFS' committee does not include any medical professionals currently in practice. The members are all either DHFS staff or paid consultants. By including at least two practicing physicians, the composition of the DHFS committee would be more similar to many private health plans' pharmacy and therapeutics committees. However, the Governor's recommendations to require that the DHFS committee include a representative of the pharmaceutical manufacturing industry and an advocate for MA recipients would add a perspective to the committee not typically included in pharmacy and therapeutics committees maintained by private health plans.

18. Based on conversations with pharmacy directors at several health maintenance organizations in Wisconsin and an official with the U.S. General Accounting Office (GAO), it appears that many pharmacy and therapeutics committees include actively practicing health care professionals. According to these individuals, actively-practicing medical professionals are most likely to have sufficient experience to consider all of the issues involved in making decisions about formularies and prior authorization, including understanding the needs of patients and the complex technical data associated with determining therapeutic equivalency among drugs.

19. The pharmacy directors also indicated that individuals that solely represent patients were not included on their pharmacy and therapeutics committees and that it is uncommon for patient advocates to be included on such committees. One director indicated that when patient representatives have been included on pharmacy and therapeutics committees, the experience has been disappointing and frustrating for the members on such committees. The information presented at most committee meetings is of such a clinical and technical nature, it is difficult for individuals without a medical background to understand and analyze the data provided to the committee. The pharmacy directors also indicated that actively practicing medical professionals are often the best advocates for the interests of patients because they have the medical expertise to interpret and analyze the data and have sufficient interaction with patients to understand the needs and concerns of patients.

20. Since the current DHFS committee does not include actively practicing medical professionals, the Joint Finance Committee could determine that it is appropriate to support the

Governor's recommendation that the DHFS committee include at least two actively practicing physicians. Additionally, the Joint Finance Committee could delete the provision to include an advocate for MA recipients on the DHFS committee, since actively practicing medical professionals could be the most effective at advocating for the interests of patients.

21. However, as indicated earlier, in their analysis of the ethics of pharmaceutical benefit management, individuals with Department of Clinical Bioethics at the Magnuson Center suggested that including patients in the decision-making process to establish controls on drug utilization makes the process more transparent and therefore, the policies established by that process are more ethically permissible. For this reason, the Committee could determine that it is appropriate to support the Governor's provision to require that the DHFS committee include an advocate for MA recipients. If the Joint Finance Committee adopts this provision, it could consider modifying it to ensure that the advocate for MA recipients has sufficient medical background to effectively evaluate the materials presented to the DHFS committee.

22. In deciding whether to adopt the Governor's recommendations regarding inclusion of a representative of the pharmaceutical manufacturing industry, the Joint Finance Committee may want to evaluate whether the interests of the pharmaceutical manufacturing industry would be consistent with or in conflict with the interests of the MA program and recipients.

23. Representatives of the pharmaceutical manufacturers have expressed concerns that, while pharmaceutical manufacturers are offered the opportunity to provide testimony to the DHFS committee under current practice, the perspectives of the manufacturers are not seriously considered by the DHFS Committee. The administration indicates that including a pharmaceutical manufacturing industry representative on the DHFS committee would provide a more formal role for the industry in deliberations on prior authorization policies.

24. However, DHFS indicates that its current committee does consider the input from pharmaceutical manufacturers and has modified proposals in response to information provided by manufacturer representatives. DHFS indicates that its original proposal to require prior authorization for certain pain reliever drugs known as NSAIDS, which treat the symptoms of arthritis, would have required prior authorizations for NSAIDs prescribed to MA recipients under 75 years of age. Based on evidence provided by manufacturers, the DHFS committee instead recommended prior authorization for NSAID prescriptions for MA recipients under 65 years of age. It was this recommendation that was adopted by the DHFS Secretary.

25. Based on conversations with HMO pharmacy directors and a GAO official, it appears highly unlikely that representatives of the pharmaceutical manufacturing industry would be represented on pharmacy and therapeutics committees that HMOs use to develop and administer drug formularies.

The pharmacy directors expressed concern over having pharmaceutical manufacturing representatives on such committees. They suggested that it would not be appropriate, since most representatives would have a conflict of interest -- a company representative would either represent

the interests of the manufacturer that produces one of the drugs under consideration, or would be a competitor of the manufacturer of one of the drugs in question.

However, one director indicated that having a representative of the industry as a whole (such as a representative from an organization representing pharmaceutical manufacturers), rather than a representative of a specific manufacturing company, would probably not create a conflict of interest and might improve manufacturers' understanding of the basis for decisions by such committees. However, this same director indicated that such representatives would likely not be supportive of most prior authorization or formulary policies, since most prior authorization and formulary policies are in conflict with manufacturers' interest to increase access to and sales of their drugs.

26. Concerns about conflicts of interest with drug manufacturer representatives are reflected in a document entitled "The Principles of a Sound Drug Formulary System," which has been adopted by the Academy of Managed Care Pharmacy, American Society of Health-System Pharmacists, the U.S. Department of Veterans Affairs, the National Business Coalition on Health and U.S. Pharmacopoeia. These principles state that formulary system policies should require pharmacy and therapeutics committee members to reveal, by signing a conflict of interest statement, economic and other relationships with pharmaceutical entities that could influence committee decisions. Further, these principles state that these committees should exclude product sponsor representatives from committee membership and from attending committee meetings.

27. Based on concerns about potential conflicts of interest, DHFS has indicated that the ideal candidate to represent the pharmaceutical manufacturing industry under the Governor's recommendations would be an individual not directly affiliated with one company, but rather, would be representative of the industry as a whole.

28. It is unclear whether an individual representing the industry as a whole would be able to be participate in deliberations on prior authorization policies to the extent the deliberations consider pricing information on drugs under consideration. According to a GAO official, representatives of the manufacturing industry are usually very careful to avoid participating in discussions about drug pricing policies in order to avoid potential violations of federal anti-trust laws. According to this official, the Federal Trade Commission has required pharmaceutical manufacturers that own pharmacy benefit management companies to establish fire walls between the manufacturing component of the business and the benefit management component of the business to ensure that the manufacturing component does not influence the benefit management component's process for making decisions about which drugs the benefit manager should cover. This issue has been similarly reported in the Wall Street Journal.

The administration argues that because the DHFS committee is only advisory to the DHFS Secretary, concerns about anti-trust issues or potential conflicts of interest are minimized. If it is necessary to address concerns about conflicts of interest or anti-trust issues, the administration indicates that one possible solution would be to establish two separate committees, one that would evaluate the clinical effectiveness of drugs under consideration for prior authorization and one that would consider pricing and coverage issues and the pharmaceutical representative could be included

on the committee evaluating clinical effectiveness of drugs but not pricing and coverage issues.

29. If the Joint Finance Committee decides not to adopt the Governor's recommendation to require the inclusion of a pharmaceutical manufacturer representative on the DHFS prior authorization committee, but wishes to ensure that the interests of manufacturers are considered by the committee, it could amend the bill to require the DHFS committee to consider input from representatives of a drug's manufacturer before submitting recommendations to the DHFS Secretary. This would be consistent with current DHFS practice.

30. In summary, DHFS' current approach to prior authorization appears to have yielded cost-savings to the MA program without adversely affecting the health of MA recipients by recognizing the value of more expensive drugs when appropriate. Additionally, under its current approach, DHFS has been responsive to the concerns of advocates for MA recipients with mental illness by not pursuing prior authorization on SSRIs and instead, is pursuing other efforts to maximize potential savings from generically-available SSRIs. Finally, modifying the makeup of the DHFS committee may make it more difficult for DHFS to generate savings in the MA and BadgerCare programs through the use of prior authorization. For these reasons, the Committee could determine that the Governor's provision is undesirable and delete it from the bill.

31. The alternatives under "A" in this paper relate to the Governor's recommendation to reduce MA and BadgerCare benefits funding to reflect savings DHFS would be required to generate in drug costs, either through increased use of prior authorization or other means. The alternatives under "B" relate to the Governor's recommendations regarding the prior authorization committee. The first alternative under "B" would approve all of the Governor's recommendations regarding the prior authorization committee. The second alternative presents several options to modify the Governor's recommendations and the third alternative would delete all of the Governor's recommendations relating to the DHFS prior authorization committee.

ALTERNATIVES TO BILL

A. Funding

1. Adopt the Governor's recommendation to reduce MA and BadgerCare benefits by $3,809,200 ($1,551,100 GPR and $2,258,100 FED) in 2001-02 and $29,220,000 ($11,994,200 GPR and $17,225,800 FED) in 2002-03 to reflect anticipated reductions in MA and BadgerCare expenditures for prescription drugs used by MA and BadgerCare recipients.

Alternative A2	GPR	FED	TOTAL
2001-03 FUNDING	$13,545,300	$19,483,900	$33,029,200

2. Delete the Governor's recommendation to reduce MA and BadgerCare benefits to reflect anticipated reductions in MA and BadgerCare expenditures for prescription drugs used by

MA and BadgerCare recipients.

B. Prior Authorization Committee

1. Adopt the Governor's provisions to require DHFS to establish a prescription drug prior authorization committee with members including at least two physicians, who are currently in practice, two pharmacists, one advocate for MA recipients and one representative of the pharmaceutical manufacturing industry.

2. Modify the Governor's provisions by adopting one from each of the following sections:

a. Actively-Practicing Physicians

(1) Adopt the Governor's provision requiring DHFS to include at least two physicians who are currently practicing on its prior authorization committee.

(2) Delete the Governor's provision regarding actively-practicing physicians.

b. Advocate for MA Recipients

(1) Adopt the Governor's provision requiring DHFS to include an advocate for MA recipients on its prior authorization committee.

(2) Adopt the Governor's provision regarding an advocate for MA recipients, but specify that the advocate have sufficient medical background to evaluate a drug's clinical effectiveness, as determined by DHFS.

(3) Delete the Governor's provision regarding the advocate for MA recipients and instead require the DHFS committee to accept testimony from such advocates in its review of prior authorization policies.

(4) Delete the Governor's provision regarding the advocate for MA recipients.

c. Representative of the Pharmaceutical Manufacturing Industry

(1) Adopt the Governor's provision requiring DHFS to include a representative of the pharmaceutical manufacturing industry on its prior authorization committee.

(2) Delete the Governor's provision regarding the representative of the pharmaceutical manufacturing industry. Instead require the DHFS committee to accept testimony from such representatives in its review of prior authorization policies.

(3) Delete the Governor's provision regarding a representative of the pharmaceutical manufacturing industry.

3. Delete all of the Governor's recommendations relating to the prior authorization committee.

Prepared by: Rachel Carabell

MO# A1; B2a(1), b(2) c(2)

(2)	BURKE	Y	N	A
	DECKER	Y	N	A
	MOORE	Y	N	A
	SHIBILSKI	Y	N	A
	PLACHE	Y	N	A
	WIRCH	Y	N	A
	DARLING	Y	N	A
	ROSENZWEIG	Y	N	A
	GARD	Y	N	A
(1)	KAUFERT	Y	N	A
	ALBERS	Y	N	A
	DUFF	Y	N	A
	WARD	Y	N	A
	HUEBSCH	Y	N	A
	HUBER	Y	N	A
	COGGS	Y	N	A

AYE 16 NO 0 ABS ____

Senator Rosenzweig

HEALTH AND FAMILY SERVICES

SeniorCare

Motion:

Move to modify SeniorCare provisions to: (a) clarify that MA recipients eligible as qualified Medicare beneficiaries, special low-income Medicare beneficiaries and additional low-income Medicare beneficiaries would be eligible for SeniorCare; (b) specify that the exclusion of MA enrollees in SeniorCare would not apply to SeniorCare participants enrolled in MA under a demonstration project; and (c) clarify that SeniorCare benefits are only available to the individual found eligible based on the eligibility criteria specified in statute. In addition, modify current provisions to authorize DHFS to use information it collects from insurance companies to determine eligibility under BadgerCare and to determine third-party liability for participants in Family Care and SeniorCare.

Note:

This motion would: (a) specify that certain Medicare beneficiaries eligible for certain MA benefits, but not prescription drug coverage, would be eligible for SeniorCare (as intended in Act 16); (b) clarify that if an MA waiver were approved to implement SeniorCare as an MA demonstration project, participants in the demonstration project would be eligible for SeniorCare (current statutes specify that MA recipients are not eligible for SeniorCare, but under a waiver, SeniorCare participants would be MA recipients); and (c) clarify that family members of SeniorCare participants are not eligible for SeniorCare benefits.

Under current law, insurance companies operating in this state are required to provide information from insurance records to DHFS to use to determine third-party liability for costs for MA beneficiaries with other health care coverage. Additionally, DHFS currently uses this information to verify eligibility information for BadgerCare applicants and to determine third-party liability for Family Care participants. This motion would authorize DHFS to use the information it collects from insurance companies for all of the purposes for which it is currently used and would authorize its use to determine third-party liability under SeniorCare as well.

These minor statutory changes would not affect the projected costs of SeniorCare, since these changes are consistent with the assumptions used to determine the funding provided in Act 16.

MO# 231

	BURKE	Y	N	A
	DECKER	Y	N	A
	MOORE	Y	N	A
	SHIBILSKI	Y	N	A
	PLACHE	Y	N	A
	WIRCH	Y	N	A
	DARLING	Y	N	A
(1)	ROSENZWEIG	Y	N	A
(2)	GARD	Y	N	A
	KAUFERT	Y	N	A
	ALBERS	Y	N	A
	DUFF	Y	N	A
	WARD	Y	N	A
	HUEBSCH	Y	N	A
	HUBER	Y	N	A
	COGGS	Y	N	A

AYE 16 NO 0 ABS ____