AGENCY: Department of Health and Family Services

LFB PAPER #: 1170

ISSUE: Disease Aids

ALTERNATIVE: A2, B2&3, C2 and D1&3

SUMMARY:

Alt. A2 eliminates the waiting lists instituted by the governor. While waiting lists are not good, if we have to do this, then go with the governor (A1). Currently, no waiting lists would be triggered, but we don't want this in the stats. Stay away from A3, the governor tried this in the budget & the legislature took it out.

Alt. B 2&3 deletes the cap for kidney disease services & prohibits providers from "balance billing" (providers require enrollees to contribute to the cost of services beyond copayments).

C2 eliminates the HIRSP program from the payor of last resort requirements.

D1&3 allows DHFS to promulgate emergency rules to make the above changes.

The WI Chronic Disease Program (WCDP) funds medical services for eligible state residents with end-stage renal disease, cystic fibrosis and hemophilia.

There are no income requirements, but enrollees with family incomes exceeding specific amounts pay annual deductibles and a portion of covered expenses (coinsurance) based on family size and income.

The program is considered the payer of last resort, but currently there are no requirements that participants apply for other programs (i.e. BadgerCare) prior to enrolling in this program. One program, HIRSP, could cause problems because it requires a 6 month waiting period and has high premiums.

2001-03 biennial budget provides $9,864,000 GPR to the program. DHFS estimates $762,500 more than amount budgeted will be required to fully fund the program.

The program is funded from a biennial appropriation. Committee could delete Governor's recommendation for waiting lists, and review potential funding needs next year when more information will be available about the rebate revenue available to offset state costs.

DHFS staff ideas the reduce costs: a.) allow DHFS to reduce reimbursement rates for kidney disease services and b.) strengthen current provision that establish the WCDP as a payer of last resort.

Could permit DHFS to review and revise the sliding scale to determine patient liability as frequently as necessary (currently every 3 years).

Allow DHFS to reduce reimbursement rates (health care providers oppose), but need to modify to prohibit "balance billing"

The bill would require DHFS to promulgate rules to contain the costs of assistance under the disease aids program, and provide that such rules may include managed care requirements. DHSF says this will enable them to use methods that managed care organizations use to contain costs.

Rule making process may take 9-12 months, so committee could modify to give DHFS emergency rule-making authority to implement changes.

BY: Nicole

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

February 28, 2002 Joint Committee on Finance Paper #1170

Disease Aids (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 55, #13]

CURRENT LAW

The Wisconsin chronic disease program (WCDP) funds medical services for eligible state residents with end-stage renal disease, cystic fibrosis and hemophilia.

There are no income requirements individuals must meet to enroll in these programs. However, enrollees with family incomes that exceed specified amounts are required to pay annual deductibles (currently $792 for inpatient services and $100 for outpatient services provided to persons enrolled in the chronic renal disease program and 0.75% to 4.0% of the family's income for persons enrolled in the cystic fibrosis and hemophilia programs), in addition to a portion of covered medical expenses, referred to as "coinsurance." The coinsurance amounts are equal to a percent of charges for medical services, and are based on family size and income, as shown in the attachment to this paper. To ensure that needs for treatment of patients with lower incomes receive priority within the availability of funds, DHFS is required to revise the coinsurance schedule every three years.

The following services are eligible for reimbursement under the disease aids program.

Chronic Renal Disease

- Inpatient and outpatient dialysis and transplant treatment;
- One pre-transplant dental examination, diagnosis and x-ray;
- Kidney donor transplant-related medical services;
- Certain prescription medications;
- Certain home supplies; and

- Certain laboratory and x-ray services.

Adult Cystic Fibrosis

- Inpatient and outpatient services directly related to the disease;
- Certain physician services;
- Certain laboratory and x-ray services;
- Certain prescription medications; and
- Certain home supplies.

Hemophilia Home Care

- Recipients are eligible to receive services for blood derivatives and supplies necessary for home care.

Generally, the disease aids program is considered the payer of last resort. However, there are no requirements that participants apply for other programs for which they may be eligible prior to enrolling in the disease aids program. Instead, the following statutory criteria apply: (a) for treatment of cystic fibrosis, persons must only meet the financial requirements established by DHFS by rule; (b) for aid to kidney disease patients, recipients must have no other form of aid available from Medicare or other insurance; and (c) for hemophilia treatment services, reimbursement is subject to costs which are not payable by any other state or federal program or under any grant, contract or other financial arrangement.

In the 2001-03 biennium, $4,932,000 GPR is budgeted annually for the program.

GOVERNOR

Modify the disease aids program to reduce state program costs, as follows:

Waiting lists. Authorize DHFS to establish waiting lists for enrollment in the disease aids program if the amounts that are available for disease aids are insufficient to provide assistance to all persons who are eligible to receive assistance. Authorize DHFS to assign priorities to persons who are on waiting lists, based on criteria that DHFS would promulgate by rule.

Rates for Kidney Disease Services. Repeal the current requirement that the state pay for services provided under the kidney disease program at rates equal to the allowable charges under the federal Medicare program.

Payer of Last Resort. Specify that assistance under the WCDP may only be provided to an individual if he or she has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible. Require DHFS to promulgate rules to

define these other state-funded health care assistance programs, but specify that these programs would include medical assistance, the heath insurance risk-sharing plan, BadgerCare, SeniorCare and any other state-funded programs under which assistance may be payable for the treatment of kidney disease, cystic fibrosis or hemophilia. In addition, for the treatment of cystic fibrosis, specify that costs would be reimbursed for treatment, only if those costs are not reimbursable under Medicare or private health insurance.

Rules. Require DHFS to promulgate rules to contain the costs of assistance under the disease aids program. Provide that the rules could include managed care requirements.

DISCUSSION POINTS

Program Participation and Costs

1. In 2000-01, 6,802 persons were enrolled in the WCDP, including 6,473 individuals with chronic renal disease, 182 individuals with hemophilia and 147 individuals with cystic fibrosis. Approximately 41% of persons enrolled in the program received state-funded benefits in 2000-01, the rest either incurred no expenses that were covered under these programs, or their expenses did not exceed the required deductibles.

2. While there are no income eligibility criteria individuals must meet to enroll in the program, individuals with higher family incomes are required to pay a larger share of costs, as shown in the attachment.

The table on the following page shows information on fiscal year 1999-00 program costs by the participants' income range. In the table, "participants" are enrollees for which claims were submitted, rather than the total number of persons enrolled in the program. The table shows that over 90% of persons for whom claims were submitted lived in families with income less than $30,000 and over 90% of state-funded benefits were provided to these enrollees.

Wisconsin Chronic Disease Program
Participation by Income Range
Fiscal Year 1999-00

Income Range (Annual $)	Participants Number	Participants Percent of Total	Participants Cumulative Percent	Expenditures State Costs	Expenditures Percent of State Costs	Expenditures Cumulative Percent
$0-10,000	1,007	38.6%	38.6%	$1,015,859	24.7%	24.7%
$10,001-20,000	953	36.5	75.1	1,880,183	45.7	70.4
$20,001-30,000	410	15.7	90.8	827,550	20.1	90.5
$30,001-40,000	171	6.6	97.4	287,546	7.0	97.5
$40,001-50,000	43	1.6	99.0	72,867	1.8	99.2
$50,001-60,000	16	0.6	99.6	22,440	0.5	99.8
$60,001-70,000	5	0.2	99.8	8,051	0.2	100.0
$70,001-80,000	2	0.1	99.9	14	0.0	100.0
$80,001-90,000	2	0.1	100.0	975	0.0	100.0
$90-001-100,000	0	0.0	100.0	0	0.0	100.0
Over $100,000	1	0.0	100.0	458	0.0	100.0
Total	2,610	100.0%		$4,115,943	100.0%	

3. Over the years, it has been difficult to project program expenditures because of annual changes in caseload and average care costs. For example, the average reimbursement for an individual enrolled in the hemophilia program was $1,718 in 2001. However, DHFS recently had a claim for over $600,000 for a two- to three-day supply of a blood clotting factor. While DHFS has determined that most of the costs of this claim will be covered under Medicare, this claim demonstrates how unpredictable program costs are.

4. Historically, DHFS has administered the WCDP as an entitlement program. While DHFS has, and continues to, implement changes to reduce program costs, DHFS has sought supplemental funding when necessary to ensure that all persons who are eligible for benefits receive covered services. In fact, when the chronic renal disease program was created by Chapter 308, Laws of 1973, it was funded from a sum-sufficient appropriation. Chapter 308 included a provision that remains in current law that expresses the Legislature's intent to "assure that all persons are protected from the destructive cost of kidney disease treatment by one means or another."

5. 2001 Wisconsin Act 16 (the 2001-03 biennial budget act) provides a total of $9,864,000 GPR to fund the disease aids program in the 2001-03 biennium. DHFS estimates that $10,626,500 will be required to fully fund the program for the 2001-03 biennium, or $762,500 more than the amount budgeted for the program.

6. In its 2001-03 biennial budget request, DHFS had projected a need for additional funding for the WCDP. Instead of providing addition funding, the Governor included a provision in his 2001-03 biennial budget that would have authorized DHFS to revise the sliding scale to determine patient liability for costs as frequently as necessary to ensure that needs for treatment of

patients with lower incomes receive priority within the amounts budgeted. Currently, DHFS is required to review and revise the scale every three years. deductible scale

7. The Legislature deleted the Governor's recommendation and required DHFS to implement a drug rebate program for the WCDP as a means of reducing state program costs. At the time, it was estimated that DHFS would collect $923,600 in rebate revenue in the 2001-03 biennium to offset costs that would otherwise be funded with GPR.

8. DHFS staff continue to work at implementing the drug rebate program. Currently, DHFS estimates that the rebate will generate net savings of $450,000 in 2002-03, and $600,000 annually, thereafter.

Waiting Lists

9. To ensure that program costs do not exceed current funding budgeted for the program, the Governor included a provision that would authorize DHFS to establish waiting lists for the program if DHFS determines that funding is insufficient to meet projected program costs.

10. DHFS staff do not anticipate having to place individuals on waiting lists for the program at this time. Instead, DHFS staff expect other cost saving measures included in the bill, including allowing DHFS to reduce reimbursement rates for kidney disease services and strengthen the current provisions that establish the WCDP as a payer of last resort, would reduce program costs. In addition, DHFS staff are currently working on implementing other cost saving measures for the program that are described under Discussion Point #13.

11. While DHFS staff do not believe that it will be necessary to establish waiting lists in the 2001-03 biennium, it is possible that this will be necessary in 2001-03 and future biennia. Because the program is a payer of last resort, persons on a waiting list would probably have few opportunities to receive services elsewhere. Some may receive hospital services through charity care, others may be eligible for benefits from SeniorCare, the state's new drug assistance program for persons over the age of 65, which will begin offering benefits to enrollees on September 1, 2001. However, others may not be eligible for other publicly-funded programs.

12. Another option the Committee could consider, either instead of, or in addition to authorizing waiting lists, would be to restore the Governor's 2001-03 biennial budget proposal that would permit DHFS to review and revise the sliding scale to determine patient liability as frequently as necessary to ensure that the needs for treatment of patients with lower incomes receive priority within the amounts budgeted. This proposal would allow DHFS to review the coinsurance amounts, as needed, to ensure that eligible individuals would continue to receive assistance, but enrollees may have to contribute a higher proportion of their income to the cost of treatment.

13. DHFS is currently investigating a number of ways to reduce costs under the program, including: (1) increasing the current co-payment for drugs from $1 to $3 for generic drugs and $10 for brand-name drugs (this change is expected to reduce state costs by $240,900 annually); (2) reviewing covered drugs to see if there are less expensive, generic drugs available; (3) requiring

applicants to provide documentation to support status as a Wisconsin resident; and (4) trying to find less expensive suppliers for nutritional supplements.

14. The options that DHFS is pursuing could reduce program costs significantly, but it is not known how much savings would result from implementing these initiatives.

15. The program is funded from a biennial appropriation, which enables DHFS to fund costs in 2001-02 with funding appropriated in 2002-03 if 2001-02 costs exceeds the amount budgeted in that year. The Committee could delete the Governor's recommendation to authorize waiting lists for the program, and review potential funding needs next year when more information will be available about rebate revenue available to offset state costs and the effectiveness of other cost savings measures DHFS expects to implement.

Rates for Kidney Disease Services

16. The bill would 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. This provision would allow DHFS to reduce reimbursement rates as a means of reducing program costs. Because DHFS staff have not determined what the revised rates would be, it is not possible to estimate the savings that would result from this provision.

17. Health care providers would likely oppose lower reimbursement rates. Further, DHFS staff indicate that, in some instances, providers are billing participants for the difference between DHFS reimbursement rates and the providers' usual and customary charges, despite the current statutory limits on the amount individuals are required to contribute toward the cost of their treatment.

18. The practice of "balance billing" would likely increase if reimbursement rates under the program were reduced. Therefore, the Committee could modify the bill to prohibit this practice of "balance billing" to specify that providers may not require enrollees to contribute to the cost of services they receive, other than to pay copayments and coinsurance amounts determined by DHFS.

Payer of Last Resort

19. The bill would specify that assistance may only be provided if an individual has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible. DHFS would be required to promulgate rules to define these other state-funded assistance programs, but would specify that these include medical assistance, the health insurance-risk sharing plan (HIRSP), BadgerCare, SeniorCare and any other state-funded programs under which such assistance may be available. In addition, for treatment of cystic fibrosis, the bill provides that only costs that are not reimbursable under Medicare or private health insurance would be reimbursed.

20. While the current disease aids program is generally considered a payer of last resort, DHFS does not have the authority to require persons to apply for all other programs for which they

may be eligible. Because the disease aid program offers limited services, individuals that are eligible for other programs would likely receive more comprehensive care under those programs than under the disease aids program. In addition, the extent to which individuals may be eligible for other programs could reduce overall state costs because the other health care programs are not fully supported with GPR, as under the disease aids program.

21. There could be some problems with the proposal to require individuals to apply for HIRSP before they apply for assistance under the disease aids program. Under HIRSP, there is a six-month waiting period before individuals with pre-existing conditions can become eligible. In addition, there is some concern that individuals may not be able to afford HIRSP premiums. For these reasons, the Committee could modify the Governor's bill to delete the requirement that individuals apply for HIRSP before they are considered eligible for the disease aids program.

Rules

22. The bill would require DHFS to promulgate rules to contain the costs of assistance under the disease aids program, and provide that such rules may include managed care requirements. The provision does not specify what managed care requirements would include. DHFS staff indicate that these provisions are intended to enable DHFS to use the same methods that managed care organizations use to contain costs, such as using drug formularies, and does not refer to requiring individuals to join managed care organizations.

23. The rule-making process may take nine months to a year to complete. In order for DHFS to reduce program costs as quickly as possible, the Committee could modify the bill to provide DHFS emergency rule-making authority to implement these changes. An agency may promulgate a rule as an emergency rule without the notice, hearing and publication requirements involved in the standard rule making process. An emergency rule remains in effect for 150 days, and an agency can extend the rule for up to 120 additional days.

ALTERNATIVES TO BILL

A. Waiting Lists

1. Approve the Governor's recommendation to: (1) authorize DHFS to establish waiting lists for enrollment in the disease aids program if the amount available for disease aids is insufficient to provide assistance to all persons who are eligible; and (2) authorize DHFS to assign priorities to persons who are on waiting lists, based on criteria that DHFS would promulgate by rule.

2. Delete the provisions in the bill regarding waiting lists.

3. In addition to either A1 or A2, authorize DHFS to review and revise the sliding scale to determine patient liability as frequently as necessary to ensure that the needs for treatment of patients with lower incomes receive priority within the amounts budgeted.

B. Rates for Kidney Disease Services

1. 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.

2. Delete the provisions in the bill regarding rates paid for kidney disease services.

3. In addition to either B1 or B2, prohibit health care providers participating in the disease aids program from collecting any reimbursement for services other than the copayments and coinsurance amounts established by DHFS.

C. Payer of Last Resort

1. Approve the Governor's recommendation to: (1) specify that disease aid assistance may only be provided if an individual has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible; (2) require DHFS to promulgate rules to define other state-funded assistance programs, but specify that these programs would include medical assistance, HIRSP, BadgerCare, SeniorCare and any other state-funded programs under which assistance may be available; and (3) provide that for the treatment of cystic fibrosis, only costs that are not reimbursable under Medicare or private health insurance would be reimbursed.

2. Modify the Governor's recommendation to eliminate the requirement that persons that apply for disease aids first apply for HIRSP.

3. Delete the provisions in the bill relating to the disease aids program as a payer of last resort.

D. Rules

1. Approve the Governor's recommendation to promulgate rules to contain the costs of assistance under the disease aids program, and require those rules to include managed care requirements.

2. Delete the Governor's provisions relating to the Department's authority to promulgate rules to contain costs in the program, including the explicit authority to include managed care requirements in the rules.

3. In addition to D1 or D2, modify the Governor's recommendation to grant DHFS emergency rule making authority for all provisions in the bill relating to the Departments rule-making authority under the disease aids program.

Prepared by: Carri Jakel

ATTACHMENT

Patient Coinsurance Liability for the Direct Cost of Treatment

Annual Family Income	Percent of Charges for Which Patient is Liable, by Family Size									
	1	2	3	4	5	6	7	8	9	0
$0 - 7,000	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
$7,001 - 10,000	2	1	0	0	0	0	0	0	0	0
$10,001 - 15,000	4	2	1	0	0	0	0	0	0	0
$15,001 - 20,000	7	4	2	1	0	0	0	0	0	0
$20,001 - 25,000	11	7	4	2	1	0	0	0	0	0
$25,001 - 30,000	14	10	7	5	3	2	1	0	0	0
$30,001 - 35,000	17	13	10	8	6	4	2	1	0	0
$35,001 - 40,000	20	16	13	11	9	7	5	3	2	1
$40,001 - 45,000	24	19	15	13	11	9	7	5	3	2
$45,001 - 50,000	29	24	20	17	15	13	11	9	7	5
$50,001 - 55,000	34	29	25	21	19	17	15	13	11	9
$55,001 - 60,000	39	34	29	25	23	21	19	17	15	13
$60,001 - 65,000	44	39	34	30	28	25	22	20	18	16
$65,001 - 70,000	49	44	39	35	32	29	27	25	23	21
$70,001 - 75,000	55	49	44	40	37	34	32	30	28	26
$75,001 - 80,000	61	55	50	46	43	40	37	35	33	31
$80,001 - 85,000	67	61	56	52	49	46	43	40	38	36
$85,001 - 90,000	74	68	63	59	56	53	50	47	45	43
$90,001 - 95,000	81	75	70	66	63	60	57	55	53	51
$95,001 - 100,000	88	82	77	73	70	67	64	62	60	58
$100,000+	97	91	86	82	79	76	73	71	69	67

MO# A2, B2, C3, D2

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
(2) 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 ____

Representative Albers

HEALTH AND FAMILY SERVICES

HIRSP Plan Administrator

Motion:

Move to delete the current law requirement that the HIRSP plan administrator be the MA plan administrator, effective July 1, 2003, and instead require DHFS to competitively bid the contract for the HIRSP plan administrator. Specify that DHFS could only award the contract to a vendor that has systems in place that are compliant with final standards adopted under the administrative simplification provisions in the 1996 federal Health Insurance Portability and Accountability Act (HIPAA).

Further, delete $609,600 SEG in 2001-02 and $451,300 SEG in 2002-03 that was provided in Act 16 for administrative costs related to ensuring the HIRSP plan would be compliant with the HIPAA administrative simplification provisions.

Note:

Under current law, the MA plan administer must administer HIRSP. This motion would delete that provision and instead require that DHFS competitively bid the HIRSP plan administrator contract, beginning July 1, 2003. Further, this motion would prohibit DHFS from contracting with a vendor that was not already compliant with the final standards established under the HIPAA administrative simplification provisions.

Further, this motion would delete $609,600 in 2001-02 and $451,300 in 2002-03 in one-time funding budgeted from the HIRSP trust fund for administrative costs incurred by the current plan administrator to modify HIRSP systems to ensure its systems are in compliance with the HIPAA administrative simplification provisions. Under this motion, these funds would no longer be necessary to fund HIPAA compliance activities, since the new vendor would be required to provide HIPAA compliance systems under the terms of the new contract. However, DHFS indicates that it expects to use the $609,600 in 2001-02 to funds administrative costs for which no funding was provided in Act 16, including costs related to selection of a pharmacy benefits managers for HIRSP, additional actuarial services required by the HIRSP Board of Governors and costs associated with

higher than anticipated caseload.

Currently, DHFS contracts with Electronic Data Systems (EDS), the MA plan administrator, to perform various administrative tasks related to HIRSP, including processing claims from providers, premium billings and collection, data reporting, and customer service. The HIRSP contract is considered an add-on to the current MA contract, which expires on December 31, 2004, with an option to extend the contract through 2005.

HIPAA requires health plans, health care clearinghouses and health care providers who perform certain financial and administrative transactions electronically, to adopt national standards for electronic transmission of: (a) administrative and financial health care information; (b) unique health care identification numbers for providers, health plans, employers and individuals; (c) privacy and security of individual identifiable health care information; (d) electronic submission of claims attachments; and (e) enforcement. The standards are being developed by the U.S. Department of Health and Human Services and published as federal regulations. Final rules have been published related to electronic transactions and privacy. Health care providers, plans and clearinghouses are required to comply with the electronic transaction standards by October, 2002 and the privacy standards by April, 2003. Final rules for other standards have not yet been published.

[Change to Bill: -$1,060,900 SEG]

MO# 246

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
(2) GARD	(Y)	N	A
KAUFERT	(Y)	N	A
(1) 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 ____

WISCONSIN STATE SENATE
DAVE HANSEN
SENATOR – 30TH DISTRICT

State Capitol P.O. Box 7882 Madison, Wisconsin 53707-7882 Phone: (608) 266-5670

March 6, 2002

Members, Joint Committee on Finance
State Capitol

Dear Colleagues,

I write today to request your assistance in helping the community of Oconto in my district in their efforts to maintain a nursing home in their city.

The City of Oconto has had a nursing home for over fifty years. In April 2001, Beverly Healthcare informed the city that they would be closing their Oconto facility. The facility closed in October of 2001, and the residents were forced to move to other homes in Oconto Falls, Peshtigo, and Green Bay.

There are at least two nursing home operators interested in opening in Oconto. Without bed licenses, however, that is impossible, and Dave Lund of DHFS has made it clear the Department will not grant licenses for a home in Oconto. I understand the Department's desire to limit the number of elderly living in nursing home, and I agree with the overall goal of continuing to move toward community options and away from nursing facilities. The fact remains, however, that the City of Oconto has a very particular need and desire for a nursing home within their city limits. The community is very close-knit, and most families have lived and worked within the city for years, many for generations. Allowing seniors who need nursing home care to remain a part of the city's community is extremely important to the community as a whole.

Further, the Oconto nursing home property, which has been purchased from Beverly by an operator willing to reopen the home has provided a property tax base for a city in desperate need of these funds. Along with property tax revenue, the nursing home provided employment for approximately fifty people. The residual affect of losing those jobs will hurt the community greatly. For those who worked and lived in Oconto, it will mean finding work in other cities, commuting to the new job along often dangerous roads, buying milk and other necessities and filling their gas tanks in other cities, and meaning more time away from their family. Or even worse, these people may find it necessary to move to a community that can provide employment, hurting the housing and retail market within Oconto.

Given the short timeline it does not appear this bill will be available for a full vote in both houses before the close of session. For this reason, I respectfully ask for your assistance in helping my constituents by supporting a motion that may be introduced by either Representative Gard or Senator Burke. It is my hope that together we can help bring back lost jobs to Oconto as well as those citizens who were displaced by the closing of the Oconto facility.

Thank you for your consideration of my request.

Sincerely,

Dave Hansen

Dave Hansen
State Senator

Dh:jmw

Fax: (608) 267-6791 E-mail: sen.hansen@legis.state.wi.us

Representative Gard
Senator Burke

HEALTH AND FAMILY SERVICES

Nursing Home Bed Limit

Motion:

Move to require the Department of Health and Family Services to redistribute a number of nursing home beds that corresponds to the number of approved beds of a nursing home whose owner has transferred to another location, resulting in the loss of a nursing home within 15 miles of a city with a population of 4,474 in 1990 in a county with a population of 30,226 in 1990. Exempt this redistribution from the requirements of Subchapter II of Chapter 150 of the statutes, except require the applicant to submit an application that meets the requirement under s. 150.33(2). Provide that this redistribution may only occur if the beds are redistributed to a location in the city with a population of 4,474 in 1990 in a county with a population of 30,226 in 1990.

Note:

Section 150.31 of the statutes establishes a statewide limit on the number of nursing home beds at 51,795 and a statewide limit on the number of beds in facilities that primarily service persons with developmental disabilities at 3,704. DHFS may adjust these limits under certain circumstances prescribed in Subchapter II of Chapter 150 of the statutes.

Currently, DHFS is required to review applications for approval of nursing home beds, hold a public meeting on the request, and may approve or reject the application based on statutory criteria. In considering the application, DHFS must consider cost containment as its first priority in applying statutory criteria and may not approve any project unless the applicant demonstrates:

- The MA funds appropriated are sufficient o reimburse the applicant for providing the nursing home care;

- The cost of providing an equal number of nursing home beds or an equal expansion would be consistent with the cost at similar nursing homes, and the applicant's per diem rates would be consistent with those of similar nursing homes;

- The project does not conflict with the statewide bed limit;

- A need for additional beds in the health planning area where the project would be

located;

- The project is consistent with local plans for developing community-based services to provide long-term care;

- Health care personnel, capital and operating funds and other resources needed to provide the proposed services are available;

- The project can be undertaken with the period of validity of the approval and completed within a reasonable period thereafter;

- Appropriate methods alternative to providing nursing home care in the health planning area are unavailable;

- The quality of care to be provided is satisfactory, as determined by DHFS investigations, materials submitted by the applicant and recommendations from affected parties concerning the quality of care provided in nursing homes owned or operated by the applicant; and

- For a project that would result in the relocation of nursing home beds, there are other adequate and appropriate resources available in the counties served by the nursing home to serve the nursing home residents who would be displaced by the relocation.

This motion would provide for the redistribution of nursing home beds for a facility in the City of Oconto in Oconto County and would exempt an applicant for these beds from the requirements of Subchapter II of Chapter 150, except the requirement that the application state certain information required under s. 150.33(2).

MO# 325

(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 16 NO 0 ABS ____

State Representative
Spencer Black

State Capitol
P.O. Box 8952
Madison, WI 53708
(608) 266-7521

March 5, 2002

Representative Scott Jensen
Speaker of the Assembly
211 West, State Capitol
Madison, WI 53702

Dear Mr. Speaker:

Representative Spencer Coggs is unable to vote at this morning's Joint Finance Committee meeting due to a conflict of interest. Pursuant to Assembly Rule 9, I am asking you to appoint Representative Mark Miller to temporarily replace Representative Coggs for part of the Joint Finance Committee meeting scheduled for today.

Sincerely,

Spencer Black
Assembly Minority Leader

Mcginnis, Cindy

From: Mari Freiberg [mfreiberg@wphca.org]
Sent: Thursday, February 28, 2002 11:19 AM
To: mark.grapentine@legis.state.wi.us
Cc: svlewis@wphca.org; barbara.worcester@legis.state.wi.us; rep.coggs@legis.state.wi.us; radlogl@dhfs.state.wi.us; cindy.mcginnis@legis.state.wi.us
Subject: Paper 1167 - Rosenzweig motion

Mark:

I've heard that Senator Rosenzweig will be offering a motion to #1167 to ask for support to study ways that Wisconsin can bring more federal resources to our state through the Consolidated Community Health Center Grant program. Obviously, we believe that capturing additional federal resources is critical to supporting the health care safety net and our Health Centers will continue to do all they can to secure additional grant dollars through this vitally important federal program.

Just so you're aware, we already have a signed cooperative agreement (mandated by the US Department of Health and Human Services) with the Department of Health and Family Services to work on ways to expand the health care safety net. The agreement is through the DHHS, Bureau of Primary Health Care. The Bureau's main concern is expansion of the health care safety net, with a specific focus on Section 330-funded Community Health Centers. Certainly, your motion will stress the importance of DHFS working in partnership with Wisconsin's Health Centers through this already established DHFS (Primary Care Office)/Primary Care Association signed MOA.

Because I haven't spoken with you about this, I want to reiterate three issues that I think are very important in the Finance discussion today.

Federal funds are to be used for the expansion of services, expansion of users or the creation of new Health Center sites. A Health Center must demonstrate within its grant application that federal funds would be used to expand services in order to help reach President Bush's goal of doubling the amount of patients treated at Health Centers. These funds cannot be used to supplant loss of state funding.

Receiving federal funding is a competitive process. Health Centers in each state can individually apply for federal funding but there is no guarantee that even one dollar of this new funding will reach Wisconsin. The program has operated for over 30 years in this competitive grant fashion and WI Health Centers already bring in over $10 million annually through this process.

The federal grant is intended to support a portion of Health Center services. For every one dollar of the federal contribution, a Health Center is expected to leverage three dollars from other sources.

It is vitally important that the Committee reinstates the full $3 million for the State Community Health Center Grant program. As an editorial in the Feb. 21 La Crosse Tribune accurately pointed out, eliminating these grant dollars will likely only shift and increase costs to the health care system.

- Mari

Mari Freiberg
Associate Director
WI Primary Health Care Association
49 Kessel Court, Suite 210
Madison WI 53711
Ph - (608)277-7477, extension 228
Fax- (608)277-7474
email - mfreiberg@wphca.org
web site: www.wphca.org

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

February 26, 2002

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Budget Issue Papers

This packet contains 2001-03 budget issue papers, prepared by this office, on those agencies scheduled for the Committee's February 28, 2002, executive session on Special Session Assembly Bill 1.

- Department of Military Affairs
- Department of Veterans Affairs
- Court of Appeals*
- Circuit Courts
- Supreme Court
- Judicial Commission*
- Ethics Board
- Elections Board
- Department of Justice
- District Attorneys*
- Department of Corrections
- Truth-in-Sentencing
- Department of Financial Institutions
- Department of Workforce Development
- Department of Agriculture, Trade and Consumer Protection
- State Fair Park
- Tourism
- Wisconsin Housing and Economic Development Authority

(over)

- Department of Commerce
- Child Abuse and Neglect Prevention Board
- Board on Aging and Long-Term Care
- Department of Health and Family Services

*There are no provisions in Special Session Assembly Bill 1 regarding this agency.

These agencies have been scheduled for executive action by the Joint Committee on Finance on Thursday, February 28. The meeting will begin at 9:30 a.m. in Room 412 East, State Capitol.

BL/sas
Attachments

Military Affairs

(LFB Summary of the Governor's Budget Reform Bill: Page 64)

LFB Summary Items for Which Issue Papers Have Been Prepared

Item #	Title
1	Elimination of the Youth Challenge Program (Paper #1190)
3	Utility Costs (see Paper #1100)

LFB Summary Item for Which No Issue Paper Has Been Prepared

Item #	Title
2	Fuel and Utilities Lapse Estimate

AGENCY: Military Affairs

LFB PAPER #: 1190

ISSUE: Elimination of the Youth Challenge Program

ALTERNATIVE: Alt. 3 &/or Albers motion

SUMMARY: Burke

Alt. 3 maintains current law & saves the program. Rep. Albers has a motion to fund this, she worked with Moen on it.

BY: Cindy

Representative Albers
Senator Burke
Senator Shibilski
Senator Darling
Representative Duff
Representative Coggs

MILITARY AFFAIRS AND PUBLIC INSTRUCTION

Youth Challenge Program

[Alternative to LFB Paper #1190]

Motion:

Modify the Governor's recommendation by restoring the requirement that DMA operate the Youth Challenge program. Create a program revenue continuing appropriation under DMA for state matching funds for the Youth Challenge program funded from transfers from DPI and county governments. Estimate expenditures under this appropriation at $1,280,400 PR in 2002-03 and authorize 17.2 PR positions for the Youth Challenge program. Restore $1,912,600 FED in 2002-03 and 25.8 FED positions for the program.

Require DMA to calculate the average cost per cadet based on the number of enrolled cadets at the Youth Challenge Academy. Require DMA to submit information on each cadet to the public school district in which they would have been enrolled, based on the residence of their custodial parent or guardian.

Specify that the school district where a cadet's custodial parent or guardian resides at the time of the cadet's enrollment in the Youth Challenge Academy in the prior year could count that cadet as 1.0 FTE in its membership if that cadet was not counted under other membership provisions. Specify that, for each cadet enrolled at the Academy, DPI decrease the equalization aid (or other state school aid payments received by the district, if necessary) that would be paid to the relevant school district by either an amount equal to the current year revenue per pupil for the district under revenue limits or an amount equal to the average per-cadet cost at the Youth Challenge Academy, as calculated by DMA, whichever is less. Require DPI to ensure that the aid adjustment does not affect the amount of equalization aid determined to be received by the district for any other purpose. Specify that these adjustments not be considered in determining a school district's revenue limit. Require DPI to remit the total funding withheld from school districts under these provisions to DMA for crediting to the new PR appropriation.

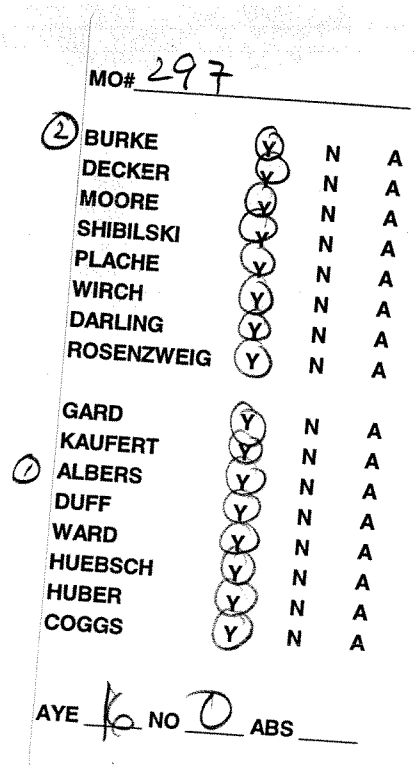
If the amounts received from school district payments are insufficient to cover the average

costs of a student, require DMA to notify the county of the residence of the youth, based on the residence of their custodial parent or guardian. Require the county to make a payment to DMA's program revenue appropriation for the support of the Youth Challenge program in the amount of insufficient school district payments from state-funded Youth Aids.

Note:

Under this motion, school districts would be able to count cadets enrolled in the Youth Challenge Academy in the prior year in their membership. To the extent that these children would not otherwise have been included in school district membership, this would increase total statewide membership and thus increase the amount needed for the state's two-thirds funding goal. No data is available on the number of pupils enrolled in the Youth Challenge Academy who are already included in school district membership counts, so the fiscal effect of including new pupils in membership is indeterminate. For illustrative purposes, if none of the 193 cadets enrolled in the Academy in 2001-02 are included in any school district membership counts, including them in membership in 2002-03 could increase the state cost of two-thirds by approximately $320,000 in the first year and $960,000 on an ongoing basis.

[Change to Bill: $1,280,400 PR and $1,912,600 FED in 2002-03 and 17.2 PR and 25.8 FED positions]



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One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

February 28, 2002 Joint Committee on Finance Paper #1190

Elimination of the Youth Challenge Program (Military Affairs)

[LFB Summary of the Governor's Budget Reform Bill: Page 64, #1]

CURRENT LAW

Under s. 21.26 of the statutes, the Department of Military Affairs (DMA) is required to administer a Youth Challenge program for disadvantaged youth according to program guidelines established under the federal 1998 Defense Authorization Act. The program is funded on a 40% GPR/60% FED basis and is currently appropriated $1,175,800 GPR and $1,911,00 FED in 2001-02 and $1,280,400 GPR and $1,912,600 FED in 2002-03. A total of 43.0 FTE positions (17.2 GPR and 25.8 FED) is authorized for the program. Based on federal staffing guidelines, these positions include 21.0 FTE program administrative, instructional and counseling personnel and 22.0 FTE live-in youth counselors. Equipment and facilities of the Wisconsin National Guard may be used to carry out the program.

GOVERNOR

Delete $1,280,400 GPR and $1,912,600 FED in 2002-03 and eliminate 17.2 GPR and 25.8 FED positions to reflect the July 1, 2002, repeal of both the GPR-funded appropriation for the Youth Challenge program and the requirement that the Department operate the program.

DISCUSSION POINTS

1. The Youth Challenge program is a 22-week residential program operated at Fort McCoy for youths aged 16 to 18 who are either high school dropouts or habitual truants who will not graduate from high school. Following the residential phase of the program, there is a 12-month phase where graduates are matched with mentors who offer support and guidance to the graduates. The overall goal of the program is to aid these youths in learning life skills, increasing their

employment potential and preparing them for the high school equivalency degree exam.

2. The origin of the program dates to the 1993 Defense Authorization Act, which provided seed monies for programs in 10 states. Wisconsin was not among the states initially funded by that federal legislation. However, the state did receive funds for a more modest six-week residential program that was piloted in 10 additional states for youths who had not yet dropped out of school but were deemed in danger of doing so.

3. The 1998 Defense Authorization Act established the Youth Challenge program on a permanent basis, provided funding to expand the program beyond the original 10 states, and eliminated the six-week pilot programs. The federal Act also established a state matching requirement in order to secure the federal funding. A 25% state match was initially required for the 1998-99 fiscal year, with an additional 5% state match required in each successive fiscal year until the permanent 40% state/60% federal funding ratio was achieved for the 2001-02 fiscal year, and thereafter.

4. The DMA Youth Challenge program was first authorized under 1997 Wisconsin Act 237 (the 1998 budget adjustment act), which directed the agency to administer the program, provided the necessary GPR matching funds and authorized 43.0 FTE positions for program support. Both 1999 Wisconsin Act 9 and 2001 Wisconsin Act 16 provided the necessary additional state matching funds required by the federal legislation for the program's continuation in each successive biennium.

5. Since the inception of the state Youth Challenge program, seven 22-week classes have been completed at Fort McCoy. Youth Challenge Class VIII is currently in session. The following table summarizes, on a fiscal year basis, the number of program applicants, enrollees and graduates since the first cadet class in September, 1998. There are two cadet classes in each fiscal year.

Youth Challenge Program
Enrollment and Graduation Statistics
(1998-99 through 2001-02)

Fiscal Year	Applicants	Enrolled	Graduates	Number Receiving High School Equivalency
1998-99	427	221	154	114
1999-00	382	202	149	135
2000-01	360	207	153	132*
2001-02	159 **	97 **	74**	68**

*2000-01 classes are still completing the post-residential phase of the program; additional high school equivalency diplomas are possible.

**2001-02 figures for graduates and number receiving a high school equivalency diploma reflect fall, 2001, Class VII participants only. Class VIII is currently in session. A total of 158 individuals applied for Class VIII and 96 have been enrolled.

6. The following table characterizes the cost of the state's Youth Challenge program, on both a cost per enrollee basis and a cost per graduate basis for the 1998-99 through 2000-01 fiscal years, the last fiscal years for which complete expenditure data is available.

Youth Challenge Program Costs
(1998-99 through 2000-02 Actual Costs per Enrollee)

Year	# of Cadets	GPR Expenditures	GPR Per Cadet	FED Expenditures	FED per Cadet	Total Expenditures	Total per Cadet
1998-99	221	$543,800	$2,461	$1,625,700	$7,356	$2,169,500	$9,817
1999-00	202	798,400	3,952	1,939,200	9,600	2,737,600	13,552
2000-01	207	1,022,200	4,938	1,977,400	9,553	2,999,600	14,491

(1998-99 through 2000-02 Actual Costs per Graduate)

Year	# of Cadets	GPR Expenditures	GPR Per Cadet	FED Expenditures	FED per Cadet	Total Expenditures	Total per Cadet
1998-99	154	$543,800	$3,531	$1,625,700	$10,556	$2,169,500	$14,088
1999-00	149	798,400	5,358	1,939,200	13,015	2,737,600	18,373
2000-01	153	1,022,200	6,681	1,977,400	12,924	2,999,600	19,605

7. The increasing GPR costs and the decreasing FED costs on both a per enrollee and a per graduate basis are primarily attributable to the increasing GPR match requirement during the three fiscal years covered by the data. As a point of comparison, the program appears to be significantly less costly, on a per member basis, than the costs incurred by youths housed in the state's juvenile correction facilities. For example, for the 2000-01 fiscal year, the daily per capita cost (based on average daily population figures) for residential care at a juvenile correctional institution was $183.76 per day. For the total number of youths enrolled in 2000-01 in the residential care portion of the Youth Challenge program, the daily per capita cost amounted to $94.10 per day.

8. In addition to these cost characteristics, the program has reported the following results: (a) 60 graduates have earned certified nursing assistance credentials; (b) all graduates are qualified in first aid and cardiopulmonary resuscitation by the American Red Cross; (c) cadets have performed over 48,000 hours of community service while at Fort McCoy; and (d) 71 graduates have entered military service.

9. The apparent rationale for the elimination of the Youth Challenge program relates to the program's total cost relative to the other GPR-funded core responsibilities at DMA. The agency states that the readiness of the Wisconsin Army and Air National Guard (as well as the Division of Emergency Management) to perform their state and federal missions and to plan, prepare and respond to state emergencies is the Department's core function. In the agency's view, the Youth Challenge program is the only National Guard function that is not related to the Department's core readiness mission. At a time when the agency must reduce GPR funding commitments, the Youth Challenge program "was the only one we could give up without damaging readiness."

10. If the Committee believes that, on balance, these considerations have merit, then it could approve the Governor's recommendation to eliminate the program, effective July 1, 2002.

11. Arguments in favor of retaining the Youth Challenge program include the fact that the program is the only state-sponsored, residential program involving mentoring that is designed specifically for youths who are at risk of not completing high school. Based on the first three fiscal years of operation of the program, it could be argued that the program, on balance, has been successful in this regard. In each fiscal year, 69.7%, 73.8% and 73.9%, respectively, of all enrollees graduated from the program. Further, in each fiscal year, 51.6%, 66.8% and 63.8%, respectively, of all enrollees received a high school equivalency degree. Also, 60% of the cost of the program is federally financed. Finally, to the extent that the program serves to keep at-risk youths out of the correctional system, the program is less costly than that of the correctional system.

12. If the Committee does choose to adopt the Governor's recommendation and eliminate the Youth Challenge program, effective July 1, 2002, it may wish to provide transitional funding to phase-down the post-residential portion of the program for current enrollees. Currently, the program supports graduates from the residential phase of the program for 12 months following graduation. For Class VII, which graduated on December 15, 2001, post-residential mentoring extends to December 15, 2002. For the current Class VIII, graduation will occur on June 8, 2002, and the post-residential phase will extend until June 8, 2003. Federal guidelines require that case management reports for graduated cadets during the mentoring phase be reported for the purpose of federal program evaluation.

13. DMA estimates that the cost of this on-going reporting requirement would be $70,000 ($28,000 GPR and $42,000 FED) for 1.0 FTE position ($36,000), contract employee case managers ($24,000) and associated supplies and services ($10,000). If the Committee believes that this transitional funding and position should be provided, it could modify the Governor's recommendation to retain sufficient funding resources for this purpose. Additionally, 1.0 FTE position associated with the program would be retained on a one-year project basis to staff this function.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation.

2. Modify the Governor's recommendation by: (a) retaining the Youth Challenge program's GPR-funded appropriation through June 30, 2003; (b) providing $28,000 GPR and $42,000 FED in 2002-03 for the purpose of providing federal reports during the post-residential portion of the Youth Challenge program for current enrollees; (c) retaining 1.0 FTE position [0.4 GPR/0.6 FED] on a one-year project position basis for this purpose; and (d) authorizing the Department to continue these program phase-out functions through June 30, 2003.

Alternative 2	GPR	FED	TOTAL
2001-03 FUNDING	$28,000	$42,000	$70,000
2002-03 POSITIONS	0.40	0.60	1.00

3. Delete the Governor's recommendation.

Alternative 3	GPR	FED	TOTAL
2001-03 FUNDING	$1,280,400	$1,912,600	$3,193,000
2002-03 POSITIONS	17.20	25.80	43.00

Prepared by: Darin Renner

Veterans Affairs

(LFB Summary of the Governor's Budget Reform Bill: Page 104)

LFB Summary Items for Which Issue Papers Have Been Prepared

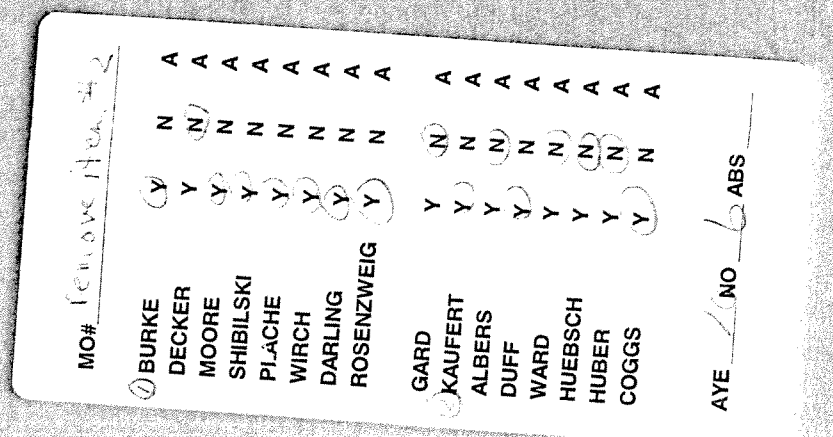
Item #	Title
1	Segregated Revenue Transfer (see Paper #1121)
3	Wisconsin Veterans Museum Funding Reduction (see Paper #1120)
4	Wisconsin Veterans Tribute Memorial Funding (Paper #1270)

LFB Summary Item for Which No Issue Paper Has Been Prepared

Item #	Title
2	"Victorious Charge" Civil War Monument Funding Elimination

remove this item

$50,000 matching grant to Milwaukee Arts Board for ies



AGENCY: Department of Veterans Affairs

LFB PAPER #: 1270

ISSUE: Wisconsin Veterans Tribute Memorial Funding

ALTERNATIVE: 3

SUMMARY:

This was match money approved in Act 16. This money has already been paid out, so there's no funding to capture here.

If we want to capture the GPR, it would have to come out of the Vets Museum general program operations. They already took a $9,200 hit yesterday.

BY: Cindy

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

February 28, 2002 Joint Committee on Finance Paper #1270

Wisconsin Veterans Tribute Memorial Funding (DVA)

[LFB Summary of the Governor's Budget Reform Bill: Page 104, #4]

CURRENT LAW

The Department of Veterans Affairs was appropriated $3,000 GPR in 2001-02 under its veterans memorial grants appropriation to fund a one-time grant to the Wisconsin Veterans Tribute Memorial at Cadott in Chippewa County for the repair and replacement of flags, if the Memorial provided matching funds of $3,000.

GOVERNOR

Delete one-time funding of $3,000 GPR in 2001-02 for a matching grant to the Wisconsin Veterans Tribute Memorial for the repair and replacement of flags at the Memorial.

DISCUSSION POINTS

1. The Wisconsin Veterans Tribute Memorial met the match requirement and requested release of the state GPR funding on January 29, 2002. The Department released the grant funds, as required under Act 16, on February 21, 2002. Consequently, there are no remaining funds that may be deleted from the agency's veterans memorial grants appropriation.

2. As a result of this grant payment, the Committee should delete the Governor's recommendation.

3. If the Committee believes that an offsetting reduction should be imposed elsewhere in the Department's budget so that there is no net loss to the general fund as a result of the recent grant payment, the Committee could reduce the Wisconsin Veterans Museum general program operations appropriation by $3,000 GPR in 2001-02. This is the only significant GPR-funded state operations

appropriation under the agency. The Governor has already recommended a $9,200 GPR reduction to this appropriation, but for 2002-03 only. A $3,000 GPR reduction in 2001-02 would represent 0.4% of the appropriation.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation

2. Modify the Governor's recommendation by reducing the Wisconsin Veterans Museum general program operations appropriation by $3,000 GPR in 2001-02 rather than deleting one-time funding of $3,000 GPR in 2001-02 for a matching grant to the Wisconsin Veterans Tribute Memorial for the repair and replacement of flags at the Memorial.

3. Delete the Governor's recommendation

Alternative 3	GPR
2001-03 FUNDING	$3,000

Prepared by: Darin Renner