

Health Services

Medical Assistance

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May, 2019

Joint Committee on Finance

Paper #360

Medical Assistance Cost-to-Continue (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 163, #2]

CURRENT LAW

The medical assistance (MA) program, also known as "Medicaid," provides health care coverage to adults and children in families with household income below certain levels, and to elderly, blind or disabled individuals who have limited resources. Certified healthcare providers provide a wide range of services to program recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law through a state plan approved by the federal Centers for Medicare and Medicaid Services (CMS), and several federal waiver agreements.

The program has two primary components -- elderly, blind, and disabled (EBD) Medicaid and BadgerCare Plus. EBD Medicaid provides coverage to individuals who are elderly, blind, or disabled who meet the program's income and asset standards. Individuals may receive services provided under the state's long-term care waiver programs, such as Family Care and IRIS (Include, Respect, I Self-Direct), as well as acute care services, including physician services, prescription drugs, and inpatient and outpatient hospital services. Many individuals enrolled in EBD Medicaid also qualify for Medicare benefits. For these "dual eligible" individuals, the state's MA program pays for services not otherwise covered under Medicare, as well as Medicare's cost-sharing requirements.

BadgerCare Plus provides coverage to individuals and families that meet the program's income standards. In general, children and pregnant women in households with income up to 300% of the federal poverty level (FPL), and non-pregnant, non-disabled adults in households with income up to 100% of the FPL, qualify for Badger Care Plus. Enrollees primarily receive acute care services, such as hospital and physician services, prescription drugs, and maternity and prenatal care coverage.

MA also provides full benefit coverage to other individuals based on categorical status, rather than level of income or assets, or disability status. The largest group of individuals who are categorically eligible for Medicaid include individuals who qualify for benefits under the federal supplemental security income (SSI) program. Other categorically eligible groups include foster children and children for whom subsidized adoption assistance agreements are in effect. Under the well woman program, MA provides full coverage to woman who have been diagnosed with breast or cervical cancer and do not have other insurance.

Finally, MA has subcomponents that provide partial benefits, including Medicare cost sharing assistance (for individuals with limited assets and income who are Medicare eligible but do not meet the income and asset criteria for full MA benefits), family planning only services, emergency services only, and tuberculosis coverage.

As of April, 2019, approximately 1.1 million individuals were enrolled in full benefit or partial benefit MA programs. Of that total, approximately 780,000 were enrolled in BadgerCare Plus and 240,000 were enrolled in EBD Medicaid. The 80,000 remaining enrollees participated in other MA-supported programs, including limited benefit programs.

MA benefits are funded from the following sources: (a) state general purpose revenue (GPR); (b) federal matching funds (FED); (c) program revenues (PR), primarily rebate revenue provided by drug manufacturers; and (d) segregated revenues (SEG), primarily from the MA trust fund.

GOVERNOR

Provide \$192,551,700 (\$89,305,200 GPR, \$112,358,400 FED, -\$13,905,700 PR, and \$4,793,800 SEG) in 2019-20 and \$584,990,700 (\$264,657,600 GPR, \$249,975,200 FED, \$68,345,200 PR, and \$2,012,700 SEG) in 2020-21 to fund projected MA benefits under a cost-to-continue scenario.

DISCUSSION POINTS

1. The bill includes funding to reflect the administration's estimate of the cost of providing MA benefits during the 2019-21 biennium under a scenario in which no changes are made to program benefits, eligibility, or provider reimbursement rates (other than annual adjustments under payment methodologies for hospitals and nursing homes, and amounts set aside to fund future increases in capitation payments to managed care organizations to comply with federal requirements that states establish actuarially sound capitation rates). This "cost-to-continue" estimate is based on assumptions for dozens of parameters, but these assumptions generally fall into a few key categories: (a) average monthly enrollment for each of the MA eligibility groups; (b) utilization and cost of services provided on a fee for service basis; (c) managed care capitation rates; and (d) federal policy and formula changes, including changes to the federal matching percentage and Medicare premiums for dually-eligible MA members.

2. Although MA benefits are funded with four funding sources (GPR, FED, PR, and SEG), and all four are adjusted as a result of the cost-to-continue estimate, the primary focus of this paper is the estimated change to GPR-funded costs. Under the administration's cost-to-continue estimate, GPR funding would increase above the 2018-19 appropriation base by \$89.3 million in 2019-20 and \$264.7 million in 2020-21 for a total of \$354.0 million over the biennium. This estimate is \$140.7 million less than the amount included in the Department's budget request, submitted in September, 2018.

3. This paper provides a reestimate of the MA cost-to-continue budget, relying on more recent caseload and expenditure trends and current information for federal formula factors. Although some changes to the budget assumptions are warranted, the net change to the administration's estimate is relatively small. Compared to the bill, the reestimate increases total GPR funding by \$2.1 million over the biennium, the net effect of a decrease of \$6.6 million in 2019-20 and an increase of \$8.7 million in 2020-21. The following points provide a description of the principal changes, as well as summary information on the resulting estimate. The final section of this paper provides a discussion of the primary risks inherent in MA budget estimates, and alternatives for the Committee's consideration for mitigating those risks.

Caseload Estimates

4. The administration's program enrollment estimates are generally based on trends over the past one to three years. For eligibility groups enrolled in elderly, blind, and disabled Medicaid (EBD), this generally means increases of between 1.0% to 1.5% for nonelderly disabled enrollees, and approximately 2.5% for elderly enrollees. For BadgerCare Plus enrollment, the administration assumed that enrollment by parents and children would continue to decrease, in line with recent trends. Enrollment is assumed to decrease by 2% to 3% annually for parents, 1.0% to 1.5% annually for children, and 1.0% to 2.0% for pregnant women. Childless adult enrollment, in contrast, was projected to increase by 0.8% annually.

5. The reestimate makes several adjustments to caseload estimates, based on updated data on actual enrollment, and also adopting a somewhat more conservative approach to recent enrollment trends. With respect to enrollment in the EBD eligibility groups, the reestimate uses slightly slower growth assumptions for nonelderly adults and children, based largely on more recent information. For BadgerCare Plus, particularly the parent and children, the reestimate assumes that enrollment will remain relatively constant, rather than continue to decrease. Although enrollment in these categories has decreased over the 2017-19 biennium, and this could continue, there is a risk in budgeting based on an assumption that these trends will continue. For childless adults, the rate of growth is projected to be somewhat lower than the administration's estimates, at approximately 0.3% per year.

6. The attachment to this paper shows the caseload assumptions for both the administration's cost-to-continue budget and the updated estimate.

7. The reestimate incorporates updated enrollment information for the children's long-term support (CLTS) waiver services. The Governor's budget bill estimated CLTS enrollment to be 9,910 by June 30, 2021. However, as of April 30, 2019, 9,255 children were enrolled in CLTS, with an additional 963 children on the waiting list. Based on these more recent enrollment and waiting list numbers, the MA cost-to-continue reestimates projected CLTS enrollment to be 10,637 by June 30,

2021. DHS hypothesizes that the publicity surrounding the additional funding provided in the 2017-19 biennium to reduce the waiting list for CLTS services has resulted in more families applying for services, thus increasing the number of eligible children above initial projections.

Fee for Service Utilization and Managed Care Capitation Rates

8. The cost-to-continue estimate generally relies on recent trends in per person costs by eligibility and service category to estimate future fee for service utilization. The Department has now updated the per person costs with the more recent data, which are incorporated into the estimate. In general this update does not substantially change the service category spending estimates, independent from the caseload adjustments discussed above.

9. Along with the updates to service utilization, the Department recommends increasing estimates of manufacturer drug rebates to reflect current rebate trends. Although total gross drug expenditures would increase by \$62.0 million over the biennium, relative to the bill estimate (due primarily to higher enrollment), drug rebates would also increase, by a total of \$64.1 million. Consequently, net drug spending would decrease by \$2.1 million under the reestimate, relative to the bill.

10. The administration's estimate assumed 2.0% annual increases to capitation rates for BadgerCare Plus and SSI HMOs, as well as Family Care managed care organizations (MCO). This reestimate retains those assumptions as a reasonable approximation of HMO and MCO costs. Actual capitation rates are established each year based on service utilization data submitted by HMOs and MCOs.

Federal Formula Factors

11. In addition to caseload and intensity, MA benefit costs are affected by factors related to federal formulas. These include the federal medical assistance percentage (FMAP), the state's "clawback" payment, made by states to the federal government to partially fund Medicare Part D prescription drug benefits, and Medicare premiums and cost sharing assistance for dually-eligible MA beneficiaries.

Federal Matching Percentage

12. The federal medical assistance matching percentage is based on the relationship between the state's per capita income and the national average per capita income. Under the formula, a state with a per capita income equal to the national average has an FMAP of 55%, while states with a per capita income lower or higher than the average will have an FMAP that is higher or lower than 55%, respectively.

13. The administration's MA cost-to-continue estimates were based on projections of the state's FMAP for the 2019-21 biennium available at the time of the introduction of the bill. The estimate assumed an FMAP of 59.36% for both federal fiscal years (FFY) 2019-20 and 2020-21. Since the time of these estimates, the federal Bureau of Economic Analysis has published data on state and national 2018 per capita income. Incorporating this data into the FMAP calculation results

in a slight increase to the FFY 2020-21 FMAP, from 59.36% to 59.61%. Consequently, the state fiscal year 2020-21 FMAP rate is reestimated to be 59.55%, rather than 59.36%, as assumed in the bill. This change has the effect of reducing the GPR costs of MA program benefits by approximately \$19.5 million over the biennium and increasing FED costs by a corresponding amount.

14. The increased FMAP for FFY 2020-21 also has the effect of increasing the federal matching rate for services provided to children who are eligible for coverage under the children's health insurance program (CHIP). Federal law provides an enhanced FMAP for CHIP services. The enhanced CHIP FMAP is currently also subject to a temporary increase. The ongoing enhancement has the effect of reducing the state's share by 30%, relative to the standard FMAP. The temporary adjustment increased the CHIP FMAP by an additional 23 percentage points from FFY 2015-16 through FFY 2018-19, decreasing to an 11.5 percentage point increase in FFY 2019-20. No additional increase to the CHIP FMAP is provided in FFY 2020-21 and beyond.

15. The scheduled phase-down of the CHIP FMAP has the effect of increasing GPR costs, since the reduction in federal funds must be replaced with state funds. Over the biennium, the cost-to-continue estimate includes approximately \$91 million due to the phase-out of the temporary CHIP FMAP increase. However, the CHIP FMAP increase did produce significant state savings while it was in effect, and the additional costs in this biennium relative to the baseline, can be viewed as the result of the expiration of a provision that was, from the beginning, known to be temporary.

16. The following table shows both the standard and CHIP FMAPs, as well as the corresponding state share, on a state fiscal year basis. Since the state fiscal year does not completely overlap with the federal fiscal year, the FMAPs shown in the table differs slightly from the corresponding federal fiscal year FMAPs.

**Federal Medical Assistance Percentage (FMAP) Rates
By State Fiscal Year**

<u>State Fiscal Year</u>	<u>Title 19 (Most MA Services)</u>	<u>Title 21 (Children's Health Insurance Plan)</u>
2018-19		
State	40.78%	5.55%
Federal	59.22	94.45
2019-20		
State	40.64%	14.07%
Federal	59.36	85.93
2020-21		
State	40.45%	25.44%
Federal	59.55	74.56

Clawback Payments and Medicare Premiums

17. Since 2006, state Medicaid programs have been required to make a payment each year to fund a portion of the costs of the federal Medicare Part D program, in recognition that Part D results in state Medicaid program savings on drugs for dually-eligible enrollees. The amount of this "clawback" payment is based on a formula that is intended to equal 75% of each state's estimated savings. Year-to-year payments change based on the number of dually-eligible MA beneficiaries, the change in per capita drug spending under Part D, and the state's FMAP.

18. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for enrollees who are dually-eligible for Medicaid and Medicare. The administration's cost-to-continue estimate assumes growth in these costs based on recent trends and the information available at the time for premium levels.

19. The reestimate updates clawback payments using updated projections for the clawback payment formula factors and for the Medicare premiums. In total, these updates resulted in a slight reduction in the clawback payment estimate, but a slight increase in the Medicare premium payment estimate, such that the net effect is minimal.

Summary and Discussion of the Revised Cost-To-Continue Estimate

20. The revisions to the cost-to-continue estimate assumptions discussed in this paper, result in, relative to the bill, an increase of \$2.1 million to the GPR funding for MA benefits over the biennium, a total increase of \$75.0 million in combined GPR and FED funding, and an increase of \$139.8 million from all fund all sources. Relative to the MA base, GPR funding for MA would increase by \$356.1 million GPR over the biennium and by \$926.3 million from all fund sources. The following table shows the total funding by year and fund source under the reestimate, along with the corresponding change to the bill cost-to-continue estimate. (Note that this is not the total MA program funding for under the bill, since it excludes the fiscal effect of other items in the bill.)

Reestimated MA Cost-to-Continue Funding

	<u>Reestimate Funding</u>		<u>Change to Bill</u>		
	<u>2019-20</u>	<u>2020-21</u>	<u>2019-20</u>	<u>2020-21</u>	<u>Biennium</u>
GPR	\$3,187,475,100	\$3,378,168,400	-\$6,613,900	\$8,727,000	\$2,113,100
FED	5,678,446,900	5,856,654,000	16,147,900	56,738,200	72,886,100
PR	1,046,149,300	1,113,547,800	41,369,500	26,517,100	67,886,600
SEG	<u>586,740,900</u>	<u>576,283,900</u>	<u>2,316,200</u>	<u>-5,359,700</u>	<u>-3,043,500</u>
Total	\$10,498,812,200	\$10,924,654,100	\$53,219,700	\$86,622,600	\$139,842,300

21. The following table shows the change to the appropriation base under the cost-to-continue reestimate. Over the biennium, MA funding would increase by \$356.1 million GPR and \$917.4 million from all fund sources.

Cost-To-Continue Reestimate Change to Base

	<u>2019-20</u>	<u>2020-21</u>	<u>Biennium</u>
GPR	\$82,691,300	\$273,384,600	\$356,075,900
FED	128,506,300	306,713,400	435,219,700
PR	27,463,800	94,862,300	122,326,100
SEG	<u>7,110,000</u>	<u>-3,347,000</u>	<u>3,763,000</u>
 Total	 \$245,771,400	 \$671,613,300	 \$917,384,700

22. With limited exceptions, the medical assistance program is required by state and federal law to pay for the cost of all medically necessary services for program enrollees. If the amount of funding provided in the biennial budget is insufficient to fund these costs, the Department's options to administratively reduce costs are somewhat limited. In the event of a budget shortfall in MA, the Committee or the full Legislature may be required to act, either by increasing the MA appropriations or making statutory program changes to reduce costs. For this reason, there are risks associated with underestimating the MA budget. In order to provide some context for understanding these risks, the following points discuss some of the uncertainties involved in developing the budget estimates.

23. Chief among the risks to the MA budget estimate is the potential that a change to the state or national economy would result in job losses and a reduction in household income. Depending upon the timing of an economic downturn, the resulting increase in MA enrollment could cause benefit expenditures to exceed the reestimated budget.

24. While conditions may change in ways that increase MA costs above budget estimates, changing conditions can also lower costs below those estimates, as illustrated by the 2017-19 biennium MA budget. According to the Department's most recent estimates, GPR costs for MA benefits during the 2017-19 biennium will be lower than the amount budgeted by over \$213 million. There are multiple factors behind this reduction, which amounts to 3.4% of the biennial GPR budget for the program. For instance, the combination of below-expected gross drug spending and above-expected drug manufacturer rebates resulted in GPR savings of approximately \$160 million relative to budget estimates.

25. The budget for certain components of the MA program are particularly difficult to predict with confidence. In particular, drug manufacturer rebate payments vary widely from month to month. To illustrate, during the first 10 months of 2018-19, monthly rebate revenue has been more than \$150 million three times, but less than \$25 million four times. Likewise, it is not uncommon for payments to some providers to be made on an irregular schedule, resulting in large swings in expenditures from month to month. How these expenditure and revenue swings fall within a particular fiscal year can have a large bearing on whether the program ends in a budget surplus or deficit.

26. As with the 2017-19 MA budget estimates, the estimate presented in this paper (Alternative 1) adopts an overall cautious approach that allows for the possibility that MA costs will increase above recent trends, and to account for some level of unpredictability in expenditures or rebate revenues. However, the estimate does not account for the possibility of a significant recession,

which could result in budget deficit, depending upon the severity and timing.

27. The Committee could decide to mitigate the risks associated with an economic recession or other factors that increase GPR-funded MA costs by transferring an amount from the general fund to the medical assistance trust fund (MATF), to create a reserve. The MATF is a segregated fund used to finance a portion of the cost of MA benefits, which has the effect of offsetting GPR costs. The MATF collects revenues from a variety of sources, primarily provider assessments. Normally, the GPR budget is premised on the assumption that all available MATF revenues will be spent for benefits. Providing a transfer from the general fund to the MATF would establish a reserve that would remain unspent unless there is a GPR budget shortfall in the program. In that event, the Department could submit a request under s. 13.10 of the statutes to increase the MATF SEG appropriation, allowing the Department to spend the reserve for MA benefit costs. Any amounts of this reserve not used in the 2019-21 biennium would remain in the MATF and be available for future MA costs. Although the Committee could provide any amount for this purpose, one option would be to transfer \$50,000,000, which is equal to approximately 0.75% of the total GPR cost-to-continue budget for the biennium. (Alternative 2). Alternatively, the Committee could transfer one-half of this amount (\$25,000,000), to provide a smaller contingency reserve under the assumption that the underlying estimate provides a sufficient margin to allow the MA benefits budget to absorb some of the additional GPR cost associated with an economic recession (Alternative 3).

28. The Committee could determine that providing a reserve in the MA trust fund is unnecessary if the estimated 2019-21 biennium-ending balance in the general fund is deemed sufficient to account for budget contingencies in MA and any other GPR-funded programs.

ALTERNATIVES

1. Increase funding for MA benefits by \$53,219,700 (-\$6,613,900 GPR, \$16,147,900 FED, \$41,369,500 PR, and \$2,316,200 SEG) in 2019-20 and by \$86,622,600 (\$8,727,000 GPR, \$56,738,200 FED, \$26,517,100 PR, and -\$5,359,700 SEG) in 2020-21 to reflect a reestimate of MA benefits costs under a cost-to-continue scenario.

ALT 1	Change to	
	Base	Bill
GPR	\$356,075,900	\$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	<u>3,763,000</u>	<u>- 3,043,500</u>
Total	\$917,384,700	\$139,842,300

2. Adopt the appropriation changes in Alternative 1. In addition, transfer \$50,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 2	Change to	
	Base	Bill
GPR	\$356,075,900	\$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	<u>3,763,000</u>	<u>- 3,043,500</u>
Total	\$917,384,700	\$139,842,300
GPR-Transfer	\$50,000,000	\$50,000,000
SEG-Revenue	\$50,000,000	\$50,000,000

3. Adopt the appropriation changes in Alternative 1. In addition, transfer \$25,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 3	Change to	
	Base	Bill
GPR	\$356,075,900	\$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	<u>3,763,000</u>	<u>- 3,043,500</u>
Total	\$917,384,700	\$139,842,300
GPR-Transfer	\$25,000,000	\$25,000,000
SEG-Revenue	\$25,000,000	\$25,000,000

Prepared by: Jon Dyck
Attachment

ATTACHMENT

Projected Enrollment by Category for Cost-To-Continue Estimate Under the Bill and Under the Reestimate

	<u>Bill Estimates</u>		<u>Reestimate</u>	
	<u>2019-20</u>	<u>2020-21</u>	<u>2019-20</u>	<u>2020-21</u>
Elderly, Blind, Disabled MA				
Elderly	69,400	71,100	69,500	71,100
<i>Percent Change</i>	<i>2.5%</i>	<i>2.4%</i>	<i>2.5%</i>	<i>2.3%</i>
Disabled, Non-Elderly Adults	140,500	141,900	139,600	140,500
<i>Percent Change</i>	<i>1.1%</i>	<i>1.0%</i>	<i>0.6%</i>	<i>0.6%</i>
Disabled Children	33,500	33,600	32,600	32,600
<i>Percent Change</i>	<i>1.8%</i>	<i>0.3%</i>	<i>0.9%</i>	<i>0.0%</i>
EBD Total	243,400	246,600	241,700	244,200
<i>Percent Change</i>	<i>1.6%</i>	<i>1.3%</i>	<i>1.2%</i>	<i>1.0%</i>
BadgerCare Plus				
Children	447,800	443,400	454,700	454,700
<i>Percent Change</i>	<i>-1.3%</i>	<i>-1.0%</i>	<i>-0.2%</i>	<i>0.0%</i>
Parents	149,700	146,800	159,800	159,800
<i>Percent Change</i>	<i>-3.0%</i>	<i>-1.9%</i>	<i>1.3%</i>	<i>0.0%</i>
Childless Adults	150,900	152,100	150,700	151,000
<i>Percent Change</i>	<i>0.7%</i>	<i>0.8%</i>	<i>0.5%</i>	<i>0.2%</i>
Pregnant Women	19,500	19,300	19,600	19,600
<i>Percent Change</i>	<i>-2.0%</i>	<i>-1.0%</i>	<i>-2.0%</i>	<i>0.0%</i>
BadgerCare Plus Total	767,900	761,600	784,800	785,100
<i>Percent Change</i>	<i>-1.3%</i>	<i>-0.8%</i>	<i>0.2%</i>	<i>0.0%</i>
Other Full Benefit Groups				
Foster Children	21,300	21,900	21,000	21,400
<i>Percent Change</i>	<i>2.4%</i>	<i>2.8%</i>	<i>1.4%</i>	<i>1.9%</i>
Well Woman	500	500	500	500
<i>Percent Change</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.0%</i>
Total Full Benefit MA	1,033,100	1,030,600	1,048,000	1,051,200
<i>Percent Change</i>	<i>-0.5%</i>	<i>-0.2%</i>	<i>0.5%</i>	<i>0.3%</i>
Partial Benefit Groups				
Family Planning Only	41,200	41,700	39,800	40,200
<i>Percent Change</i>	<i>1.2%</i>	<i>1.2%</i>	<i>-0.5%</i>	<i>1.0%</i>
Medicare Cost Sharing	24,900	25,700	23,900	24,100
<i>Percent Change</i>	<i>2.9%</i>	<i>3.2%</i>	<i>0.0%</i>	<i>0.8%</i>
Total MA Enrollment	1,099,200	1,098,000	1,111,700	1,115,500
<i>Percent Change</i>	<i>-0.4%</i>	<i>-0.1%</i>	<i>0.4%</i>	<i>0.3%</i>



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May, 2019

Joint Committee on Finance

Paper #361

Hospital Supplement Payments (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 167, #4; Page 168, #5; Page 169, #6;
Page 170, #7; Page 170, #8]

CURRENT LAW

Wisconsin's medical assistance (MA) program reimburses hospitals for services they provide to MA recipients through various mechanisms that vary depending upon the type of hospital that provides the service. For the purposes of MA reimbursement, there are two types of general medical/surgical (GMS) hospitals and several types of specialty hospitals. GMS hospitals include acute care hospitals (ACHs) that are not critical access hospitals and critical access hospitals (CAHs). Critical access hospitals have 25 or fewer inpatient beds and are typically in rural areas where there are few other general hospitals. In Wisconsin there are 71 ACHs and 58 CAHs. Specialty hospital categories include psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals.

GMS and specialty hospitals receive a base payment for services, but may also receive supplemental payments. Base payments for ACHs and CAHs are generally based on the diagnosis and acuity of the patient for inpatient services and for the group or bundle of services provided for outpatient services. The base payment for specialty hospitals is based on a hospital-specific daily rate, tied to a percentage of the hospital's average costs.

Supplemental payments take several forms and can be either broadly or narrowly targeted. The two major supplements are hospital access payments and disproportionate share hospital (DSH) payments. The state share of access payments is funded with segregated revenue collected from assessments on hospitals, while the state share of DSH payments is funded with general purpose revenue (GPR). Several other smaller hospital supplemental payments are funded with assessment revenue.

Disproportionate Share Hospital Payments. The state makes DSH payments to hospitals for

which at least 6% of inpatient days are attributable to MA patients and which meet other criteria related to emergency and obstetrical services. DHS is required to allocate \$27,500,000 GPR annually for these payments, which when matched with federal funds, will total \$67,683,800 in 2018-19. All but one hospital receiving a payment is a GMS hospital.

For each qualifying hospital, the DSH payment is calculated using an add-on percentage, multiplied by the hospital's base inpatient payment. The add-on percentage is generally proportional to the hospital's MA patient days percentage, such that those hospitals with a higher proportion of MA patients have a higher percentage. However, the maximum payment that a hospital may receive in a year is \$4.6 million.

Hospital Assessment and Hospital Access Payments. DHS collects an assessment on hospitals (excluding psychiatric hospitals), based on a percentage of patient revenues. There are two separate assessments--one collected on large acute care and rehabilitation hospitals (hereafter "ACH assessment"), and another collected on critical access hospitals ("CAH assessment").

For the ACH assessment, the rate is set each year so that the total amount collected from hospitals equals \$414,507,300. In 2018-19 the rate is 0.92% of gross patient revenues.

ACH hospital assessment revenue is deposited in the hospital assessment fund and a portion is used, along with federal matching funds, to make hospital access payments and other hospital supplements. DHS is required, in accordance with a statutory formula, to make total annual supplemental payments equaling the total amount collected through the assessment divided by 61.68%, which is \$672,028,700. Of this amount, \$654,028,700 is used for hospital access payments, while the remaining \$18,000,000 is used for other hospital supplemental payments. Hospital access payments are flat rate payments made in addition to the base reimbursement for inpatient and outpatient services. In 2018-19, the hospital access payment for inpatient services is set at \$4,027 for inpatient services (paid upon discharge) and \$318 for outpatient services (paid per visit), amounts that are recalculated each year to distribute the total amount of funding allocated for access payments. Access payments from this pool are paid to ACH hospitals but also to specialty hospitals other than psychiatric hospitals.

Any assessment revenue remaining in the hospital assessment fund after making the access payments is transferred to the medical assistance trust fund (MATF), where it is used for the state share of general MA benefits (including hospital base payments), offsetting what would otherwise be GPR expenditures. In 2018-19, an estimated \$164.5 million of the total \$414.5 million in assessment revenue will be transferred to the MATF.

The CAH assessment uses the same rate as the ACH assessment, but is applied to gross inpatient revenue, as opposed to total revenues. Unlike the ACH hospital assessment, which is a fixed total each year, the total amount collected under the CAH assessment changes. In 2018-19 CAH assessment collections will total \$6,582,600. The assessment revenue is used primarily, along with federal matching funds to make CAH access payments, totaling an estimated \$10,672,200 in 2018-19. CAH assessment revenue not used for access payments is used for a rural physician grant program and to offset GPR for general MA benefits.

Other Hospital Supplements. DHS makes several other targeted supplemental hospital

payments, two of which are affected by the bill. First, MA makes pediatric inpatient supplemental payments to hospitals that have more than 12,000 inpatient days in the hospital's acute care and intensive care pediatric unit, excluding neonatal intensive care. The UW Hospital and Clinics and Children's Hospital of Wisconsin each receive \$1,000,000 annually under this provision.

Second, DHS makes payments to rural hospitals that meet all of the qualifications for a DSH payment except that they lack obstetrical services. DHS is required to distribute \$250,000 GPR, plus associated federal matching funds for these payments. Payments are distributed under a formula similar to the one used for DSH payments. In 2018-19, DHS will make payments totaling \$613,000 to seven hospitals.

GOVERNOR

This paper discusses five items related to supplemental hospital payments under MA:

Disproportionate Share Hospital Payments. Provide \$71,428,600 (\$29,000,000 GPR and \$42,428,600 FED) annually to increase disproportionate share hospital (DSH) payments to hospitals under MA. Modify statutory provisions relating to the program by: (a) increasing, from \$27,500,000 to \$56,500,000 per year, the state share of payments, in addition to the federal matching funds, that DHS is required to pay to hospitals that serve a disproportionate share of low-income patients; (b) increasing, from \$4,600,000 to \$9,200,000 the maximum amount any single hospital can receive in each fiscal year; and (c) provide that a hospital that is a free-standing pediatric teaching hospital located in Wisconsin for which 50 percent or more of its total inpatient days are for MA recipients may receive up to \$12,000,000 in each fiscal year.

Acute Care Hospital Access Payments. Provide \$100,000,000 (-\$7,400,000 GPR and \$107,400,000 FED) annually to increase the total annual hospital access payments under MA. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from \$672,028,700 to \$772,028,700.

Critical Access Hospital Access Payments. Provide \$1,500,000 (-\$300,000 GPR and \$1,800,000 FED) annually to increase the total amount of critical access hospital (CAH) access payments under MA. Require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%.

Pediatric Inpatient Supplement. Increase MA benefits funding by \$10,000,000 (\$1,407,000 GPR and \$8,593,000 FED) in 2019-20 and \$10,000,000 (\$2,557,000 GPR and \$7,443,000 FED) in 2020-21 to fund a pediatric supplemental hospital payment. Authorize DHS, using a method determined by the Department, to distribute \$10,000,000 in each fiscal year to hospitals that are free-standing pediatric teaching hospitals located in Wisconsin, and for which 45 percent or more of their total inpatient days are for MA recipients.

Require DHS, using a method determined by the Department, to distribute a total sum of

\$2,000,000 each state fiscal year to acute care hospitals in Wisconsin that have inpatient days in the hospital's acute care and intensive care pediatric units that exceed 12,000 days in the second calendar year prior to the hospital's current fiscal year. Specify that, for the purposes of this calculation, days for neonatal intensive care units are not included.

Rural Critical Care Hospital Supplement. Provide \$615,800 (\$250,000 GPR and \$365,800 FED) annually to increase funding for supplemental payments made to rural critical care access hospitals under the MA program. Increase, from \$250,000 to \$500,000, the total amount of the state share of payments for the supplement. Delete the current law eligibility criteria for receiving a supplemental payment under the program, which is any hospital that does not have obstetric services, but would otherwise meet all of the requirements for a payment under the disproportionate share hospital payment program.

Specify, instead, that payments be made to hospitals that meet the following criteria: (a) the hospital is located in Wisconsin and provides a wide array of services, including emergency department services; and (b) in the most recent year for which information is available, the hospital charged at least six percent of overall charges for services to the medical assistance program for MA recipients. Specify that DHS may determine the amount of the payment based on MA charges as a percentage of total charges rather than, under current law, MA inpatient days as a percentage of total inpatient days.

DISCUSSION POINTS

1. Hospital payments, including both base payments and supplements, account for one of the largest expenditures categories in MA. In 2017-18, MA paid a total of approximately \$2 billion through the combination of base reimbursements and supplements. The following table shows total projected hospital payments broken down by base rate reimbursements, access payments, DSH payments, and other supplements.

Total 2017-18 MA Hospital Payments (\$ in Millions)

Base Rate Reimbursement*	\$1,279.2
Access Payments	642.9
DSH Payments	66.8
Other Supplements	<u>30.8</u>
Total	\$2,019.7

* Includes data on HMO payments to hospitals on a calendar year basis rather than fiscal year basis.

2. There are two commonly used measures of the adequacy of MA hospital payments. One is the ratio of the reimbursement rates paid to hospitals by commercial insurers to the reimbursement rates paid by MA (including base rates and supplements). The second is the relationship between total amount of MA reimbursement payments and total hospital costs attributable to MA patients. Both measures can be used to demonstrate that MA payments are comparatively low and to justify payment increases.

3. On an aggregate basis, DHS estimates that commercial insurance payment rates are two to three times higher than rates paid by MA. Because the prices charged to commercial insurers vary considerably by type of service, by hospital, and even by insurer within the same hospital, this ratio will also vary. Generally this ratio is higher for outpatient services than inpatient services.

4. The fact that MA payments are considerably less than commercial insurance payments means that hospitals receive less revenue per inpatient stay or outpatient service when the patient has MA coverage than if the coverage is provided through a commercial insurance policy. This may have implications for hospital revenues and the services that a hospital can offer to all patients. The higher the share of MA patients are of a hospital's total patient population, the greater that these impacts will be.

5. In addition to being below commercial insurance payment rates, the total of all MA payments to hospitals, including base rate reimbursement and supplements, is less than the hospitals' aggregate cost of care attributable to MA patients. On a statewide basis, MA hospital payments cover approximately 65% of hospital costs attributable to MA patients. This calculation can vary depending on methodological choices as to which costs and which revenues to consider. Nevertheless, just as there is no dispute that MA pays below commercial insurance rates, there is wide agreement that total MA payments are below average MA costs.

6. One publicly-reported measure of MA underpayment for hospitals can be found in hospitals' reports of community benefits spending. Under federal law, hospitals that operate on a nonprofit basis (which is the case for all but three general medical/surgical hospitals in Wisconsin) are required, as a condition of maintaining their tax exempt status, to devote resources to community benefits, with the goal of improving the health of their communities. Among other specific requirements, these hospitals must report their annual total spending for community benefits. In addition to any unreimbursed costs for charitable care and spending on community health initiatives, hospitals are allowed to count the shortfall between Medicaid patient costs and Medicaid payments. The Medicaid shortfall is the largest component of hospitals' community benefits spending, both nationwide and in Wisconsin. In 2017, Wisconsin hospitals reported a total of \$1.056 billion in Medicaid shortfalls, which was out of a total of \$1.797 billion in total community benefits.

7. Although increases to hospital supplements could reduce the MA shortfall (although this would also depend upon trends in hospitals' costs), hospitals would not necessarily increase other types of community benefit spending, since the federal law does not have minimum standards for this spending.

8. The total MA reimbursement as a percentage of total costs attributable to MA patients can vary widely by hospital, due to differences in how hospitals fare under the totality of the reimbursement policies, but also differences in underlying costs. In addition to differing with respect to various decisions on staffing, and investments in equipment and building capital, differences in hospital utilization can affect the percentage of costs that MA covers. For example, a hospital that has a low number of vacant inpatient beds may have lower costs per inpatient discharge than a hospital that has a higher number, all else being equal, making it more "efficient" by comparison. In this case, MA reimbursement may fully cover the MA costs or cover a higher percentage of costs attributable to MA patients, whereas the same reimbursement will cover a lower percentage of costs for the less

"efficient" hospital. For these reasons, the percentage of costs measure will vary based on factors that are unrelated to the actual amount of MA reimbursement.

9. The MA reimbursement as percent of hospital cost is a measure of the relationship between aggregate costs and aggregate payments, which should not be mistaken for the relationship between the costs and reimbursement associated with any individual MA patient. The hospital industry is characterized by having high fixed costs (costs that do not change based on the volume of services) as a percentage of total costs. For this reason, it may often be the case that it is to a hospital's advantage to serve additional patients, regardless of payer, since doing so generates revenue to offset its fixed cost investment. Hospitals are, of course, better off if the additional patients are commercially insured rather than covered under Medicaid since this would produce greater marginal revenue. Likewise, they benefit if Medicaid increases its reimbursement rates, since this increases their total revenue if the additional patients are MA enrollees. But as long as the MA reimbursement is higher than the marginal cost of serving a MA patient (the additional costs incurred due only to the patient's presence in the hospital), the hospital will benefit financially. MA takes advantage of this dynamic because it allows the program to pay lower reimbursement rates, thus minimizing costs to the program while also retaining access to hospital services for enrollees.

10. A potential disadvantage of maintaining lower reimbursement rates for MA is that hospitals may try to recover the revenue underpayment from MA by charging higher prices to commercial insurance plans. If the aggregate losses are recovered in this way, employers or individuals purchasing those plans will pay more for insurance. The extent to which hospitals can pass along MA losses to commercial insurance plans depends on having negotiating leverage over those plans that they have not otherwise exercised.

11. There is considerable debate among health economists and healthcare financial specialists regarding the impact of Medicaid (and Medicare) reimbursement on commercial insurance prices. There is no disagreement that Medicaid pays much less than commercial insurers, and as a consequence, that providers would prefer to have a higher share of the higher-paying commercially-insured patients. Rather, the debate centers around whether or not there is a causal link between the low reimbursement associated with Medicaid reimbursement and higher prices charged to commercial insurers. While some argue that it is inevitable that the relative losses associated with Medicaid reimbursement are shifted to commercial insurers, others propose that a provider's prices are largely determined by market forces independent of Medicaid policies. Individual providers will face different circumstances, and will likely respond differently depending on those circumstances.

12. In addition to, or instead of, passing along Medicaid losses to commercial insurance, hospitals may also respond in other ways. First, they could decline to take Medicaid patients, although this does not appear to be a likely outcome at this time. Second, they could seek to increase the volume of patients served to more efficiently utilize their facility, including by contracting with more commercial insurers. Third, they could constrain or reduce costs, either capital (building or equipment) or operations costs. If a hospital is unable to achieve greater efficiencies, constraining or reducing costs could result in a reduction in the volume or quality of services. Finally, a hospital could not respond with any particular strategy, in effect absorbing the losses, resulting in lower net revenues.

13. On a statewide basis, Wisconsin hospitals had net income (all revenues in excess of

expenses) of \$2.2 billion in 2017, which was 10.9% of expenses. Although this is an industrywide figure, individual hospitals' financial status varied, with some showing losses and others larger gains. Many hospitals are part of larger health systems, which means that net income at one hospital may be used to support the operation of other parts of the system, such as non-hospital clinics, nursing homes, or other hospitals.

14. Because hospitals may have several options when addressing MA revenue shortfalls in relation to cost, they may, conversely, respond in different ways to increases in MA supplemental payments. An increase in revenue may relieve pressure to seek to increase prices for commercial insurers, but hospitals may also increase costs or receive higher net earnings.

15. In any case, the proposed increases to hospital payments are small in relation to total hospital revenues, equivalent to less than 1% of total net patient revenues for state hospitals. Consequently, the increases would have relatively small impact on the share of MA costs covered by MA reimbursement.

Discussion of Proposed Supplemental Payment Increases and Alternatives

16. Upon introduction of the bill, the administration indicated that the GPR provided by the bill for the five hospital supplement payments items, as well as funding increases for other MA program and public health initiatives, is an allocation of state savings resulting from adopting the full Medicaid expansion. Because the Committee has excluded full Medicaid expansion from the bill, the state will not realize the GPR savings. If the primary justification for providing hospital supplement increases is tied to full MA expansion, the Committee could now determine that hospital supplement increases are no longer warranted.

17. Regardless of whether or not the state adopts full Medicaid expansion, increasing the hospital supplemental payments requires increasing GPR spending for those payments using funds that could otherwise be used for other purposes. As with all legislative budgetary decisions, the Legislature must weigh the benefits of increasing hospital payments against other priorities. The Committee could determine that providing increases for hospital payments is important enough to allocate GPR for that purpose. The following points provide a more detailed discussion the supplement payments proposals, as a whole and individually, along with alternatives for consideration.

18. The following table summarizes the proposed funding increases by year and fund source for the five hospital supplement items under the bill. Over the biennium, total hospital payments would be increased by \$367.1 million.

Supplement Item	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
DSH Payments	\$29,000,000	\$42,428,600	\$71,428,600	\$29,000,000	\$42,428,600	\$71,428,600
ACH Access Payments	-7,400,000	107,400,000	100,000,000	-7,400,000	107,400,000	100,000,000
CAH Access Payments	-300,000	1,800,000	1,500,000	-300,000	1,800,000	1,500,000
Pediatric Inpatient	1,407,000	8,593,000	10,000,000	2,557,000	7,443,000	10,000,000
Rural Critical Care	250,000	365,800	615,800	250,000	365,800	615,800
Totals	\$22,957,000	\$160,587,400	\$183,544,400	\$24,107,000	\$159,437,400	\$183,544,400

19. The proposed hospital supplemental payments would increase total hospital reimbursement by approximately 9%, compared to the current hospital payment base that includes base reimbursement and supplemental payments. However, the rate of the increase could vary widely by hospital, since the distribution of supplemental payments is not proportionate to current payments.

Disproportionate Share Hospital Payments

20. Disproportionate share hospital payments are intended to provide supplemental reimbursement for hospitals that serve relatively high numbers of MA recipients and uninsured, low-income patients. The rationale for DSH payments is that because publicly-funded programs, such as Medicaid and Medicare, tend to have lower reimbursement rates than private insurance, a hospital that has a large number of patients with coverage under these public programs is in a weaker financial position than a hospital that has fewer of these patients. The DSH payments are intended to compensate for this imbalance.

21. The current DSH payment program has been in place since 2013-14. The following table shows the GPR allocated each year for payments each year, plus the associated federal DSH matching funds and the total funding. The Governor's proposed funding for the 2019-21 biennium is shown as well for comparison.

**Disproportionate Share Hospital Payments
(\$ in Millions)**

<u>Fiscal Year</u>	<u>GPR</u>	<u>FED</u>	<u>Total</u>
2013-14	\$15.0	\$21.8	\$36.8
2014-15	15.0	21.9	36.9
2015-16	15.0	20.9	35.9
2016-17	15.0	21.1	36.1
2017-18	27.5	39.5	67.0
2018-19	27.5	40.2	67.7
2019-20*	56.5	82.6	139.1
2020-21*	56.5	82.6	139.1

*Proposed funding level.

22. Of the \$67.5 million of DSH payments distributed in 2018-19, 92% was provided to acute care hospitals, 6% was provided to critical access hospitals, and 2% was provided to the Milwaukee County Behavioral Health Complex.

23. As with other Medicaid spending, states receive federal matching funds for DSH payments, although the total amount of federal DSH funding available to each state is capped. In federal fiscal year FFY 2018-19, the state's total DSH allotment is \$108.8 million (a preliminary amount, subject to adjustment). The Governor's proposal would use \$82.6 million in each year, and so would not exceed the current federal limit.

24. Although the proposed draw on federal DSH funds would not exceed the state's current allotment, federal DSH limits could be lowered in the future. The federal Department of Health and Human Services is required by current federal law to reduce total DSH allotments by \$4 billion in FFY 2019-20 and by \$8 billion in FFY 2020-21, reductions of approximately 32% and 63%, respectively. For various reasons, the formula for these reductions generally does not affect Wisconsin's allotment as much as it does other states. Based on reduction simulations of a \$2 billion reduction presented by the Federal Funds Information for States, Wisconsin's allotment would decline by \$2.8 million. Assuming that the state's share of an \$8 billion total reduction would be of the same proportion, the Governor's proposed use of federal DSH funding during the 2019-21 biennium would remain below the state's allotment.

25. Federal DSH reductions were originally scheduled to occur beginning in FFY 2013-14, but have been delayed on several occasions, and so now would first apply in FFY 2019-20. Any additional delay would require enactment of federal legislation.

26. The DSH payment formula computes an add-on multiplier to each hospital's fee-for-service inpatient payments. The multiplier percentage increases as the MA inpatient percentage increases. For the 2018-19 distribution, this multiplier ranges from approximately 12% to 13% for hospitals with MA inpatient percentage of 6.0% to 7.0% up to 20% to 30% for hospitals with an MA inpatient percentage in the 18% to 30% range. The maximum DSH payment is \$4,600,000, which effectively caps the multiplier for larger hospitals with high MA utilization. In 2018-19, seven hospitals received the maximum payment.

27. Although the DSH payments are typically viewed as targeting funding to hospitals with high MA utilization, the state's DSH allocation formula spreads the available funding broadly, so that over two-thirds of GMS hospitals receive a payment. In 2018-19, 61 of the state's 71 non-CAH GMS hospitals and 29 of the state's 58 critical access hospitals received a DSH payment. On statewide basis MA patient days account for approximately 21% of all hospital inpatient days. Since a hospital receives a payment if its inpatient percentage is at least 6.0%, many hospitals with below-average MA utilization receive payments. Hospitals that do not qualify for a DSH payment either are below the MA inpatient threshold of 6% or do not meet the other requirements, such as offering emergency department and obstetrical services.

28. The bill would roughly double the total amount available for payments, from \$67.5 million to \$139.1 million annually. With this increase to total payments, the inpatient payment multipliers would increase to around 35% for hospitals near the minimum threshold to generally between 40% and 55% for hospitals with high MA utilization.

29. The bill would double the maximum payment from \$4,600,000 to \$9,200,000. For free-standing pediatric hospitals with a MA inpatient utilization above 50% (applicable to Children's Hospital of Wisconsin), the maximum payment would increase to \$12,000,000. DHS projects that with the combination of the increase to total payments and increases to the maximum cap, five hospitals would be paid the maximum.

30. Children's Hospital of Wisconsin (CHW) had an MA inpatient utilization percentage of 58% in 2017, the highest rate among state GMS hospitals. Because of its high MA utilization and high volume, CHW is arguably the most adversely affected by the current DSH payment maximum

payment of \$4,600,000. Based on its MA inpatient utilization, CHW would have a DSH add-on multiplier of 51% in 2018-19. Due to the payment cap, CHW's effective multiplier was 5.8%. The bill would establish a higher DSH cap for CHW in recognition of its particularly high share of MA patients.

31. The Committee may determine that the proposed funding increase for disproportionate share hospital payments is warranted in order to increase the share of hospital costs allocated to MA patients is reimbursed by the program (Alternative A1). Since the level of funding is not tied to any identified benchmark, the Committee could provide a different amount, after weighing the merits of increasing DSH payments against other potential uses of available GPR funds. The Alternatives section of this paper provides several alternatives in a table format. For each alternative, the maximum cap is adjusted in proportion to the change in funding.

Acute Care Hospital Access Payments

32. Hospital access payments are fixed amounts applied to each inpatient discharge or outpatient service. While access payments have the advantage of simplicity, there are disadvantages relative to disproportionate share hospital payments. DSH payments, within some limits, pay proportionately more for hospitals for that have a higher share of MA patients, and are scaled to the underlying base payment for the service. Thus, compared to access payments, DSH payments are more efficiently targeted to hospitals that experience higher rates of underpayment associated with MA.

33. The principal advantage of access payments, relative to DSH payments, is that the state can take advantage of higher federal medical assistance percentage (FMAP) in some cases, thus reducing state costs. While the state's standard FMAP applies to all DSH payments, the applicable FMAP for access payments depends upon the patient receiving the service. For most hospital services, the standard FMAP applies (59.36 % in 2019-20 and 59.55% in 2020-21), but a higher FMAP applies to hospital services for children covered under the federal Children's Health Insurance Program (CHIP). The CHIP FMAP is projected at 85.93% in 2019-20 and 74.56% in 2020-21. Based on the mix of MA patients currently receiving hospital services, DHS estimates that the blended average FMAP for all hospital access payments would be approximately 63.1% in 2019-20 and 61.5% in 2020-21, in the absence of any other changes. This difference between the standard FMAP and the higher blended FMAP results in state savings of approximately \$24 million in 2019-20 and \$12 million in 2020-21. [The reduction in the CHIP FMAP reflects the scheduled phase-out of a temporary increase to the CHIP FMAP that applied between FFY 2013-14 and FFY 2020-21. Since this phase-out is complete in FFY 2020-21, the CHIP FMAP in subsequent years should be similar to the 2020-21 rate.]

34. Although the bill would increase annual hospital access payments by \$100,000,000, GPR funding for MA benefits would be reduced by \$7,400,000 annually due to the interactive effects of other provisions in the bill, most significantly the decision to adopt full Medicaid expansion. The following points provide the background for understanding these effects.

35. Currently, childless adults are covered under the terms of a federal demonstration waiver. DHS does not make hospital access payments for childless adult hospital visits, a policy that effectively reduces the cost of childless adult coverage, in order to comply with federal "budget

neutrality" rules applicable to such waivers. That is, for the purposes of determining the amount of the access payments, DHS currently divides the total access payment pool by the projected number of MA hospital visits, excluding visits by childless adults.

36. Under the bill, childless adults would no longer be covered under the federal waiver, but instead the state would adopt the full Medicaid expansion as a standard (non-waiver) change to income eligibility thresholds. The standard coverage for childless adults would mean that federal budget neutrality rules would no longer apply and the MA program could begin making access payments for childless adults. Furthermore, with the adoption of full Medicaid expansion, the state could claim enhanced FMAP of 90% for these payments. Consequently, although total payments would increase, the use of 90% FMAP for a portion of those payments would reduce the overall state share.

37. The addition of childless adults to the access payment pool would increase the blended FMAP from 63.1% in 2019-20 and 61.5% in 2020-21 to a projected 69.0% in 2019-20 and 67.6% in 2020-21. The following table illustrates these changes.

	<u>2019-20</u>	<u>2020-21</u>
Current Law		
Total Access Payments	\$654,028,700	\$654,028,700
Blended FMAP	63.1%	61.5%
State Share	36.9%	38.5%
Access Payment FED	412,517,600	402,001,800
Access Payment SEG	241,511,100	252,026,900
Bill Changes		
Access Payment Increase	\$100,000,000	\$100,000,000
New Access Payment Total	754,028,700	754,028,700
New Blended FMAP	69.0%	67.6%
New State Share	31.0%	32.4%
Access Payment FED	519,917,600	509,401,800
Access Payment SEG	234,111,100	244,626,900
Change to Current Law		
FED Change	\$107,400,000	\$107,400,000
SEG Change	-7,400,000	-7,400,000

Note: The state share of access payments is paid from the segregated hospital assessment fund, thus the "SEG" designation in the table. A reduction in SEG used for this purpose has the effect of reducing increasing the amount of SEG funds available to offset GPR expenditures for other MA benefits.

38. The GPR savings under the bill is only possible with adoption of full Medicaid expansion and providing coverage for childless adults through a standard state plan amendment rather than through the current waiver. Without the enhanced FMAP for childless adults associated with full Medicaid expansion, a \$100,000,000 annual increase to access payments would require GPR increases of \$36,926,700 GPR in 2019-20 and \$38,534,600 GPR in 2020-21, relative to the base, and \$44,326,700 GPR in 2019-20 and \$45,934,600 GPR in 2020-21, relative to the bill (Alternative B2).

39. If the Committee decides that an increase to access payments is warranted, but at a lower level, the bill could be amended to reduce the size of the payment. In the absence of adopting full Medicaid expansion, a smaller increase in the total payment would still require an increase in state spending. A \$50,000,000 increase to the ACH access payment would require increases of \$18,463,300 GPR and \$31,536,600 FED in 2019-20 and \$19,267,300 GPR and \$30,732,700 FED in 2020-21, relative to the base. Relative to the bill, this would be an increase of \$25,863,400 GPR and a decrease of \$75,863,400 FED in 2019-20 and an increase of \$26,667,300 GPR and a decrease of \$76,667,300 FED in 2020-21 (Alternative B3).

Critical Access Hospital Access Payments

40. Unlike the acute care hospital access payments, the total amount of the critical access hospital access payments changes each year since the amount collected from the CAH assessment changes. DHS projects that the CAH access payments (SEG and FED total) will be \$10,672,200 in 2018-19. Under the current law formula, total CAH access payments are projected to decline (due to a decline of CAH assessment revenues) to \$10,075,900 in 2019-20 and \$9,513,000 in 2020-21.

41. The bill would increase total access payments by modifying the statutory formula that determines the amount that DHS is required to distribute. As with the increase to ACH access payments, the bill is based on the assumption that the blended FMAP for all CAH payments would increase due to the combined effect of adopting full Medicaid expansion and making payments for childless adults services under the enhanced FMAP that comes with full expansion. Thus, while the bill assumes a total increase in CAH payments of \$1,500,000 annually, the state share of payments would decline by \$300,000 annually. A decline in the state share of payments, in turn, has the effect of reducing GPR expenditures by that amount.

42. As with the fiscal effect associated with the bill's ACH access payment changes, realizing GPR savings for the CAH access payments is only possible with the implementation of full Medicaid expansion and providing childless adult coverage through standard Medicaid coverage rather than through a waiver. Without full Medicaid expansion, a \$1,500,000 annual increase to CAH access payments would require increases of \$551,000 GPR and 949,000 FED in 2019-20 and \$570,000 GPR and \$930,000 FED in 2020-21, relative to the base. Relative to the bill, this alternative would require increases of \$851,000 GPR in 2019-20 and \$870,000 GPR in 2020-21 and corresponding FED decreases (Alternative C2).

43. As with the ACH access payment, the Committee may wish to provide an increase to the CAH access payment, but at a lower level. A \$750,000 increase in the payment would require increases of \$275,500 GPR and \$474,500 FED in 2019-20 and \$285,000 GPR and \$465,000 FED in 2020-21, relative to the base. Relative to the bill, this alternative would result in increases of \$575,500 GPR in 2019-20 and \$585,000 GPR in 2020-21 and decreases of \$1,325,500 FED in 2019-20 and \$1,335,000 FED in 2020-21 (Alternative C3).

Pediatric Inpatient Supplement

44. Although the bill would increase the total pool of ACH access payments by \$100,000,000, the amount of each payment per inpatient discharge or outpatient service would decrease, since the total pool of payments would need to be spread among a larger number of patients

once childless adults are included in the payment. Total access payments to most individual ACH hospitals would increase, since the gains associated with receiving a payment for childless adult services would offset the lower overall average. The notable exception is Children's Hospital of Wisconsin, which, since it does not provide adult services, would experience a reduction in total access payments.

45. DHS estimates that the bill's access payment provisions would reduce Children's Hospital of Wisconsin total access payment by approximately \$6.8 million on an annual basis. However, the proposed \$10.0 million pediatric inpatient supplement fully offset this reduction to provide a net increase of \$3.2 million.

46. Since the Committee has removed the Governor's full MA expansion from the bill (as well as the related provision to cover childless adults through standard Medicaid coverage rather than through federal waiver), the proposal to pay acute care hospital access payments for hospital services provided to childless adults may result in exceeding the federal waiver budget neutrality limits for childless adult coverage. Without the change to access payments, Children's Hospital of Wisconsin would not experience a decrease in access payments and, therefore, the primary rationale of the new proposed pediatric supplement would no longer be applicable.

47. Although the purpose of the new pediatric inpatient supplement would not apply if the MA expansion and access payment changes are not adopted, the Committee could still approve the Governor's recommendation to codify the current \$2,000,000 pediatric hospital supplement if it does not approve the new \$10,000,000 supplement for Children's Hospital of Wisconsin (Alternative D2).

Rural Critical Care Hospital Supplement

48. The rural critical care supplement was established by the 2017-19 biennial budget to assist hospitals that have an inpatient utilization rate that would qualify for a DSH payment, but do not qualify for a payment due to not offer obstetric services. In 2018-19, DHS distributed a total of \$614,900 to seven critical access hospitals under this provision.

49. The bill would double the GPR allotted for these payments from \$250,000 to \$500,000, which would roughly double the total payments to approximately \$1,230,000 annually.

50. In addition to the funding increase, the bill would change the criteria for receiving a rural critical care supplement. Instead of tying the payment to having MA patient inpatient days accounting for at least 6% of total inpatient days, the standard would be at least 6% of total patient gross charges, including both inpatient and outpatient services.

51. Based on current data on MA charges, the number of hospitals who would qualify for the rural critical care supplement would increase from seven to 24. With the addition of more hospitals to this program, all but six of the state's 58 critical access hospitals would receive either a DSH payment of a rural critical care supplement payment.

52. Although funding for the rural critical care supplement would be doubled, the hospitals receiving a grant under the current program criteria would experience a reduction in the amount of the supplement due to the additional hospitals qualifying for a payment. On May 1, 2019, DOA

submitted a letter to the Co-Chairs to request a change to this item. The letter indicates that it was the Governor's intent to provide an additional \$125,000 GPR annually so that the existing recipients of rural critical care supplement would not experience a payment reduction (Alternative E2).

ALTERNATIVES

A. Disproportionate Share Hospital Payments

The following table shows various DSH payment alternatives for the Committee's consideration, arranged by level of annual GPR funding commitment. For the purposes of these alternatives, the estimates of the federal matching funds reflects updated FMAP assumptions, which changes slightly the federal match associated with the Governor's proposal, relative to the bill. With each alternative 1b to 1d, the maximum payment applicable to all hospitals and to stand-alone pediatric hospitals is adjusted from the bill in proportion to the GPR funding change (rounded to the nearest \$100,000). These amounts are shown at the bottom of each column.

Alternatives for Disproportionate Share Hospital Payments

	(Bill)			
	Alternative A1	Alternative A2	Alternative A3	Alternative A4
Change to Base				
2019-20				
GPR	\$29,000,000	\$20,000,000	\$10,000,000	\$5,000,000
FED	<u>42,358,300</u>	<u>29,212,600</u>	<u>14,606,300</u>	<u>7,303,100</u>
Total	\$71,358,300	\$49,212,600	\$24,606,300	\$12,303,100
2020-21				
GPR	\$29,000,000	\$20,000,000	\$10,000,000	\$5,000,000
FED	<u>42,693,400</u>	<u>29,443,800</u>	<u>14,721,900</u>	<u>7,360,900</u>
Total	\$71,693,400	\$49,443,800	\$24,721,900	\$12,360,900
2019-21 Biennium				
GPR	\$58,000,000	\$40,000,000	\$20,000,000	\$10,000,000
FED	<u>85,051,700</u>	<u>58,656,400</u>	<u>29,328,200</u>	<u>14,664,000</u>
Total	\$143,051,700	\$98,656,400	\$49,328,200	\$24,664,000
Change to Bill				
2019-20				
GPR	\$0	-\$9,000,000	-\$19,000,000	-\$24,000,000
FED	<u>-70,300</u>	<u>-13,216,000</u>	<u>-27,822,300</u>	<u>-35,125,500</u>
Total	-\$70,300	-\$22,216,000	-\$46,822,300	-\$59,125,500
2020-21				
GPR	\$0	-\$9,000,000	-\$19,000,000	-\$24,000,000
FED	<u>264,800</u>	<u>-12,984,800</u>	<u>-27,706,700</u>	<u>-35,067,700</u>
Total	\$264,800	-\$21,984,800	-\$46,706,700	-\$59,067,700
2019-21 Biennium				
GPR	\$0	-\$18,000,000	-\$38,000,000	-\$48,000,000
FED	<u>194,500</u>	<u>-26,200,800</u>	<u>-55,529,000</u>	<u>-70,193,200</u>
Total	\$194,500	-\$44,200,800	-\$93,529,000	-\$118,193,200
Maximum Payment				
General Maximum	\$9,200,000	\$6,200,000	\$3,100,000	\$1,600,000
Standalone Pediatric	\$12,000,000	\$8,300,000	\$4,100,000	\$2,100,000

B. Acute Care Hospital Access Payments

1. Approve the Governor's recommendation to provide \$100,000,000 (-\$7,400,000 GPR and \$107,400,000 FED) annually to increase the total annual hospital access payments under MA. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from \$672,028,700 to \$772,028,700. [This fiscal effect of this alternative reflects an assumption that the state adopts full Medicaid expansion and provides childless adult coverage under a standard Medicaid plan amendment rather than through a federal waiver.]

ALT B1	Change to	
	Base	Bill
GPR	- \$14,800,000	\$0
FED	<u>214,800,000</u>	<u>0</u>
Total	\$200,000,000	\$0

2. Adopt the Governor's recommendation to provide an additional \$100,000,000 annually increase to total hospital access payments, but with funding modifications to reflect that the Governor's full MA expansion proposal has been removed from the bill. Increase funding by \$44,326,700 GPR in 2019-20 and \$45,934,600 GPR in 2020-21 and provide corresponding FED decreases, relative to the bill, to reflect the effect of providing the access payment increase with the standard federal matching percentage, rather than the enhanced federal match percentage associated with full Medicaid expansion.

ALT B2	Change to	
	Base	Bill
GPR	\$75,461,300	\$90,261,300
FED	<u>124,538,700</u>	<u>-90,261,300</u>
Total	\$200,000,000	\$0

3. Modify the Governor's recommendation to provide an increase to annual ACH access payments of \$50,000,000, instead of \$100,000,000, under a scenario without full Medicaid expansion. Decrease funding by \$50,000,000 annually, relative to the bill, which is the net effect of funding increases of \$25,863,400 GPR in 2019-20 and \$26,667,300 GPR in 2020-21 and decreases of \$75,863,400 FED in 2019-20 and \$76,667,300 FED in 2020-21. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 57.41%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from \$672,028,700 to \$722,028,700.

ALT B3	Change to	
	Base	Bill
GPR	\$37,730,700	\$52,530,700
FED	<u>62,269,300</u>	<u>-152,530,700</u>
Total	\$100,000,000	-\$100,000,000

4. Take no action.

ALT B4	Change to	
	Base	Bill
GPR	\$0	\$14,000,000
FED	<u>0</u>	<u>- 214,800,000</u>
Total	\$0	- \$200,000,000

C. Critical Access Hospital Access Payments

1. Approve the Governor's recommendation to provide \$1,500,000 (-\$300,000 GPR and \$1,800,000 FED) annually to increase funding for critical access hospital access payments and require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%.

ALT C1	Change to	
	Base	Bill
GPR	- \$600,000	\$0
FED	<u>3,600,000</u>	<u>0</u>
Total	\$3,000,000	\$0

2. Adopt the Governor's recommendation to provide a \$1,500,000 annual increase to total critical access hospital access payments, but with funding modifications to reflect that the Governor's full MA expansion has been removed from the bill. Increase funding by \$851,000 GPR in 2019-20 and \$870,000 GPR in 2020-21 and provide corresponding FED decreases, relative to the bill, to reflect the effect of providing the access payment increase with the standard federal matching percentage rather than the enhanced federal match percentage associated with full Medicaid expansion.

ALT C2	Change to	
	Base	Bill
GPR	\$1,121,000	\$1,721,000
FED	<u>1,879,000</u>	<u>- 1,721,000</u>
Total	\$3,000,000	\$0

3. Modify the Governor's recommendation to provide an increase to annual CAH access payments of \$750,000, instead of \$1,500,000, and under a scenario without full Medicaid expansion. Decrease funding by \$750,000 annually, relative to the bill, which is the net effect of funding increases of \$575,500 GPR in 2019-20 and \$585,000 GPR in 2020-21 and decreases of \$1,325,500 FED in 2019-20 and \$1,335,000 FED in 2020-21. Require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 57.41%, instead of, under current law, the amount of the assessment divided by 61.68%.

ALT C3	Change to	
	Base	Bill
GPR	\$1,121,000	\$1,160,500
FED	<u>1,879,000</u>	<u>- 2,660,500</u>
Total	\$3,000,000	-\$1,500,000

4. Take no action.

ALT C4	Change to	
	Base	Bill
GPR	\$0	\$600,000
FED	<u>0</u>	<u>- 3,600,000</u>
Total	\$0	-\$3,000,000

D. Pediatric Inpatient Supplement

1. Approve the Governor's recommendation to increase MA benefits funding by \$10,000,000 (\$1,407,000 GPR and \$8,593,000 FED) in 2019-20 and \$10,000,000 (\$2,557,000 GPR and \$7,443,000 FED) in 2020-21 and authorize DHS to distribute \$10,000,000 annually to hospitals that are free-standing pediatric teaching hospitals for which 45 percent or more of their total inpatient days are for MA recipients. In addition, approve the Governor's recommendation to codify an existing \$2,000,000 pediatric hospital supplement payment.

ALT D1	Change to	
	Base	Bill
GPR	\$3,964,000	\$0
FED	<u>16,036,000</u>	<u>0</u>
Total	\$20,000,000	\$0

2. Decrease funding by \$10,000,000 annually (-\$1,407,000 GPR and -\$8,593,000 FED) in 2019-20 and -\$2,557,000 GPR and -\$7,443,000 FED in 2020-21) to reflect the deletion of the pediatric inpatient supplement, but approve the Governor's recommendation to codify an existing \$2,000,000 pediatric hospital supplement payment.

ALT D2	Change to	
	Base	Bill
GPR	\$0	-\$3,964,000
FED	<u>0</u>	<u>- 16,036,000</u>
Total	\$0	-\$20,000,000

3. Take no action.

ALT D3	Change to	
	Base	Bill
GPR	\$0	- \$3,964,000
FED	<u>0</u>	<u>- 16,036,000</u>
Total	\$0	- \$20,000,000

E. Rural Critical Care Hospital Supplement

1. Approve the Governor's recommendation to provide \$615,800 (\$250,000 GPR and \$365,800 FED) annually to increase funding for supplemental payments made to rural critical care access hospitals under the MA program and modify the formula for making the grants to increase the number of eligible hospitals.

ALT E1	Change to	
	Base	Bill
GPR	\$500,000	\$0
FED	<u>731,600</u>	<u>0</u>
Total	\$1,231,600	\$0

2. Modify the Governor's recommendation by providing an additional \$307,900 (\$125,000 GPR and \$182,900 FED) annually to ensure that all hospitals that currently receive a rural crisis care hospital supplement payment do not receive reduced payments due to the modification to the formula.

ALT E2	Change to	
	Base	Bill
GPR	\$750,000	\$250,000
FED	<u>1,097,400</u>	<u>365,800</u>
Total	\$1,847,400	\$615,800

3. Take no action.

ALT E3	Change to	
	Base	Bill
GPR	\$0	-\$500,000
FED	<u>0</u>	<u>-731,600</u>
Total	\$0	- \$1,231,600

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Joint Committee on Finance

Paper #362

Crisis Intervention Services and Regional Crisis Stabilization Facility Grant Program (Health Services -- Medical Assistance and Behavioral Health)

[LFB 2019-21 Budget Summary: Page 171, #9 and Page 221, #1]

CURRENT LAW

All counties are required to have an emergency mental health service program, also known as crisis intervention service, to respond to individuals experiencing a crisis. At a minimum, emergency programs must offer 24-hour crisis telephone service and 24-hour in-person service on an on-call basis. Telephone service must be staffed by mental health professionals or paraprofessionals or by trained mental health volunteers, backed up by mental health professionals.

In order to receive reimbursement under the state's medical assistance program (for services provided to persons who are eligible under that program), an emergency mental health services program must have additional features, such as a mobile crisis team for on-site in person response, walk-in services, and short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis. All but six counties (Bayfield, Douglas, Florence, Iron, Trempealeau, and Vernon are the exceptions) have a crisis intervention service that meets MA certification criteria or participate in a multi-county certified program.

As with some other county-administered mental health services, counties are responsible for the nonfederal share of the MA reimbursement for crisis intervention services.

A law enforcement officer (or a person authorized to take a child or juvenile into custody under the state's children code or juvenile code) may take a person into custody if the officer has cause to believe all of the following: (a) the person is mentally ill or drug dependent; (b) the person evidences a substantial probability of physical harm to himself or herself or to others, including an inability to satisfy his or her basic needs due to mental illness or drug dependency; and (c) taking

the person into custody is the least restrictive alternative appropriate to the person's needs.

Once a person is in custody, the county department of human services must conduct a crisis assessment, either in person, by telephone, or by telemedicine or video conferencing technology, to determine if the person meets the criteria for emergency detention. If, following this assessment, the county department agrees for the need for detention, the person must be delivered to an approved treatment facility, if the facility agrees to take the individual, or to a state mental health institute. The Winnebago Mental Health Institute, in Oshkosh, is the state's designated treatment facility for subjects of emergency detention. DHS charges counties a daily rate and some service add-on fees to cover the cost of the care and treatment services provided at Winnebago. The Milwaukee County Behavioral Health Division operates an emergency detention facility for Milwaukee County residents.

GOVERNOR

Crisis Intervention Services under MA. Increase MA benefits funding by \$9,210,100 (\$6,960,700 GPR and \$2,249,400 FED) in 2019-20 and by \$28,047,900 (\$18,420,300 GPR and \$9,627,600 FED) in 2020-21 to reflect estimated costs of provisions in the bill that would increase the state's share of the cost of county crisis intervention services provided to MA recipients.

Require DHS to reimburse crisis intervention providers for MA-eligible services provided after January 1, 2020, an amount equal to the total federal and nonfederal share of costs, minus a county maintenance of effort contribution, if the services are provided in a county that elects to deliver crisis intervention services on a regional basis according to criteria established by the Department. Establish the county maintenance of effort for crisis intervention services equal to 75% of the county's expenditures for crisis intervention services under MA in 2017, as determined by the Department. Specify that any amount of the nonfederal share of crisis intervention services paid by the state may not be counted as a county cost for the purpose of claiming federal reimbursement for unreimbursed county costs.

Modify the statutory description of "mental health crisis intervention services" by deleting the reference to "mental health" and instead specifying that such services are for the treatment of mental illness, intellectual disability, substance abuse, and dementia. DHS indicates that this broader definition of crisis intervention services is, in practice, consistent with the current use of these services.

Regional Crisis Stabilization Facility Grant Program. Provide \$2,500,000 GPR in 2020-21 for a new grant program to fund regional crisis stability facilities for adults. Create an annual, sum certain appropriation for the program and require DHS to establish criteria for stabilization facilities for adults and to award grants under the program.

DISCUSSION POINTS

1. The bill includes two provisions relating to mental health crisis response. One provision would change the state's medical assistance program reimbursement policy for crisis intervention

services, while the other would provide grant funding to support regional crisis stabilization facilities. Since both provisions are intended to address some of the same issues and can be considered part of the administration's overall mental health crisis strategy, they are discussed together in this paper.

Crisis Intervention Services under Medical Assistance

2. Under DHS administrative code, a "crisis" is defined as a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. As defined in this rule and used in this context, a "mental disorder" includes psychiatric conditions, but also dementia and substance addiction. The current statutory provisions pertaining to the MA crisis intervention service refers to "mental health" crisis, which is potentially more limiting than the definition of "mental disorder" in the administrative rule since it does not encompass situations relating to dementia and addiction. The Governor's bill would broaden the definition of crisis intervention services to include mental illness, intellectual disability, substance abuse, and dementia. The Department indicates that this change is intended to align the statutes with administrative code and how crisis intervention services are used in practice.

3. Crisis intervention services involve the assessment, intervention, and stabilization of an individual experiencing a crisis stemming from a mental disorder. Services can be provided at any location, including in a person's home, a school, hospital, nursing home, or public place. Services that are normally rendered by a mental health professional in the course of regular treatment (such as psychotherapy sessions) are not considered crisis intervention services.

4. Crisis services include the initial contact and stabilization, but can also include follow-up service planning. Follow-up interventions may include the development of a crisis plan and providing linkages to other providers for ongoing treatment and support, with the goal of reducing the risk of a continuation or worsening of the crisis, and the need for hospitalization.

5. Medical assistance reimburses for crisis intervention services rendered to individuals who are enrolled in the program. Services are reimbursed on an hourly or daily basis. Hourly rates vary between \$53 and \$88, depending upon the professional level of the provider, while the daily rate is \$83.

6. Counties submit crisis intervention claims to MA for services provided to individuals enrolled in MA. The program reimburses the counties only for the federal share of the claim, meaning that the nonfederal share remains a county responsibility. In addition to the claim payment, crisis intervention service is one of several mental health services provided by counties for which the counties submit annual cost reports to DHS for unreimbursed costs (costs above the total claim reimbursement). Counties receive an additional payment equal to approximately 83% of the federal share of these unreimbursed costs. The remainder of the federal claim is deposited in the MA trust fund and used to offset GPR costs for MA benefits.

7. DHS recently prepared a report, in collaboration with county behavioral health agencies, entitled *Toolkit for Improving Crisis Intervention and Emergency Detention Services*. The report

identified numerous "obstacles to improvement" in the current crisis response system, including: (a) lack of staff and funding for crisis response; (b) limited availability of crisis beds; (c) lack of communication between behavioral health agencies, families, hospitals, and law enforcement; and (d) delays in crisis team response due to large coverage areas.

8. Although counties are required to have a crisis intervention service and most have a service that meets more stringent criteria for MA certification, DHS believes that the amount of county resources allocated for these services is highly variable. As a result, the county programs vary in their capacity to respond to crisis situations and have adopted different standards and procedures.

9. DHS argues that one of the consequences of variability in crisis intervention services is that some counties do not have the capacity to respond appropriately to all crisis situations. Many counties do not have mobile crisis teams, for instance, that can travel to the location of a crisis, or a designated facility to provide crisis stabilization services. As a result, DHS believes that some crisis situations that could be addressed with crisis intervention services instead become the sole responsibility of law enforcement agencies.

10. The Department's crisis intervention report identifies collaboration with law enforcement agencies as an important part of an effective crisis response system, and notes that many law enforcement agencies have taken steps to train officers to recognize and respond appropriately to mental health crisis situations. However, the county crisis intervention service includes mental health professionals in order to provide the full range of crisis stabilization services that law enforcement agencies are not in a position to provide. DHS argues that a more robust county crisis intervention system, with more consistent standards and protocols, could reduce the burden of mental health crisis on the justice system, including law enforcement, courts, and county jails.

11. The Department also argues that a comprehensive crisis intervention system can be one component of a strategy to reduce the need for emergency detention in a psychiatric hospital or state mental health institute. A crisis response team is most effective if it has the capacity to respond in a timely fashion to a person experiencing a crisis and is able to both provide stabilization services as well as follow-up planning and referral to ongoing treatment and support. Ideally, a rapid and comprehensive response to a crisis can help connect the person with community resources on a voluntary basis, thus reducing the likelihood that the person will require involuntary commitment.

12. The budget proposal is intended to address some of the Department's concerns with the current crisis intervention system. Beginning January 1, 2020, the state would assume a portion of the cost of the nonfederal share of MA-funded crisis intervention services. The Department believes that if the state assumes a portion of the cost, access to quality crisis intervention services will no longer be limited by county financial constraints.

13. In order to receive state funding for crisis intervention services, counties would be required to deliver crisis intervention services on a regional basis according to criteria established by DHS. The bill would not establish any specific criteria, but DHS suggests, for instance, that each participating county or multi-county provider could be required to have crisis response teams with the ability to respond at all times.

14. The administration's crisis intervention proposal is similar to a provision included in the 2013-15 biennial budget relating to the comprehensive community services (CCS) MA benefit. CCS is a psychosocial rehabilitation program for persons with severe mental illness or substance abuse disorder, providing intensive treatment in combination of various supportive services. Beginning in 2014, the state assumed the nonfederal share of CCS costs from the counties, provided that services were provided on a regional basis in accordance with DHS criteria.

15. For the purposes of CCS, DHS requires counties with a population of 350,000 or less to offer program services as part of a multi-county regional model. Requiring regional collaboration is intended to improve the efficiency of service delivery, particularly for smaller and rural counties. Currently there are 63 counties that participate in a multi-county CCS program. The three counties above the population threshold (Dane, Milwaukee, and Waukesha) are considered to meet the regional delivery requirement for the purposes of MA reimbursement as single-county CCS providers. The Department indicates that the crisis intervention benefit would use the CCS regionalization model, with the goal of increasing the efficiency and consistency of these services. Unlike the proposed crisis intervention initiative, the state pays the full nonfederal share of CCS.

16. The administration's fiscal estimate assumes that the total utilization of crisis intervention services would increase by 20% in 2019-20 and 30% in 2020-21 above the baseline trend, based on the assumption that counties that currently have less developed crisis intervention programs would expand services. The GPR increases in the bill reflect the impact of this growth, as well as the state assuming the county share, net of the county maintenance of effort. The FED increases reflect the growth in the use of crisis intervention services resulting from the expansion of those services.

17. The Department indicates that the projected increases in crisis intervention services is based on the initial rate of growth in CCS costs after the state assumed the nonfederal share of that program. The fiscal estimate should be characterized as an approximation since there is considerable uncertainty on how counties would respond to the new provision. The presumption is that there is considerable unmet need for crisis intervention that counties would begin to address given the incentives presented by the program changes. The magnitude of that unmet need, as well as the timing of the county's response is difficult to project with certainty.

18. As with CCS, one of the reasons cited for increasing crisis intervention services is that a more proactive approach to this particular service can reduce utilization of more costly services. While it is possible that the increased use of crisis intervention service would result in offsetting savings elsewhere in the program or result in savings to counties for other programs, it is difficult to assess likelihood or magnitude of these impacts. The fiscal estimate in the bill does not reflect any assumptions on reduced costs for other MA services or in other state or local programs.

19. Under the bill, counties that provide MA-certified crisis intervention services would continue to be required to contribute a portion of the cost of those services. For each county, the maintenance of effort (MOE) contribution would equal 75% of its 2017 crisis intervention expenditures. DHS indicates that the mechanism for collecting the county MOE has not been finalized, but suggests that one possibility to reduce the complexity of the process would be to deduct an amount from each county's annual human services funding contract. This funding would be used

to offset the state cost of MA reimbursement for crisis intervention services.

20. The decision to include a county MOE would be similar to other initiatives that involve the state taking over some portion of county responsibilities. An MOE is intended to ensure that state funding does not displace county resources. As an example, the 2017-19 budget included a provision that requires counties to maintain a level of spending of county resources for children's long-term care waiver services (CLTS). Unlike the proposed crisis intervention services MOE, the CLTS provision requires the MOE to be established at the full level of prior county expenditures, rather than a fraction of prior county expenditures.

21. In calendar year 2017, DHS estimates that the total county share of MA crisis intervention services claims was \$21.4 million. The county MOE under the bill would be calculated as 75% of that amount, or \$16.1 million.

22. While an MOE has the advantage of reducing state costs associated with the crisis intervention initiative, there are disadvantages to this approach. Because the proposed MOE is based on county spending at a fixed point in time, it would effectively lock in past patterns of uneven county effort. Consequently, counties that had put more resources into developing a comprehensive crisis response system would fare worse than counties who had put in fewer resources. Based on the manner in which DHS calculated the fiscal estimate for the bill, some counties would have no MOE since they had no federal claims for crisis intervention services in 2017.

23. Another disadvantage of the proposed MOE provision is that the use of just one year as the basis for the calculation could result in a county having an MOE that is not representative of typical annual expenditures over time. Particularly for small counties, expenditures can vary substantially from year to year based on random variation in the need for crisis services. Because 2017 might have been either a high utilization year or a low utilization year for a county, the MOE could be either substantially higher or substantially lower than the typical level of expenditures.

24. Representatives of county human services agencies have raised some concerns about the impact of the crisis intervention proposal. They indicate that for many counties the additional costs associated with expanding crisis intervention services would outweigh the additional reimbursement that they would receive from MA. This may particularly be the case since county crisis intervention programs provide services to individuals who are not eligible for MA, and so are not reimbursable. For these reasons, they indicate that the crisis intervention provision, as structured, does not provide sufficient incentive to accomplish the goals of expanding and standardizing county crisis intervention services.

25. In spite of these concerns, the Committee could take the approach of adopting the crisis intervention system as proposed on the grounds that some counties may decide to adopt the regional approach, but that no county would be required to participate. In this case, the Legislature could reconsider the issue in future biennia after seeing the impact of the policy. If it turns out that few counties participate, the state could adjust the incentives to encourage additional counties to expand their crisis service programs.

26. Given the opinion expressed by some county human service agencies that the incentives

created by the crisis intervention proposal are not sufficient to outweigh the additional county costs, an adjustment to the fiscal estimate may be warranted. The bill's fiscal effect is premised on the assumption that all counties with existing certified crisis intervention systems would participate. If only some counties participate, the anticipated growth in crisis services may not materialize, or may be delayed. Assuming that one-half of counties participate and crisis service growth occurs at one-half the assumed, rate, the funding increase would be \$3,043,000 (\$2,855,500 GPR and \$187,500 FED) in 2019-20 and \$10,353,600 (\$9,242,000 GPR and \$1,111,600 FED) in 2020-21. Relative to the bill, this would represent reductions of \$6,167,100 (-\$4,105,200 GPR and -\$2,061,900 FED) in 2019-20 and \$17,694,300 (-\$9,178,300 GPR and -\$8,516,000 FED) in 2020-21 (Alternative A1).

27. The 75% MOE (when using the 2017 expenditures as the basis for calculations) has the effect of saving the state an estimated \$16,071,100 on an annualized basis, compared to not having an MOE and if all counties participate. The state could, however, take the same approach as with CCS, by taking over the full nonfederal share of crisis intervention services, without establishing an MOE. This would create a stronger incentive for counties to participate in a regionalized system and free county resources to developing a stronger crisis response infrastructure, but would increase state costs, relative to the bill. Assuming that a full takeover of the nonfederal share would create the incentives necessary to result in the service expansion as anticipated by the Department, GPR costs would increase by an estimated \$8,035,500 GPR in 2019-20 and \$16,017,100 GPR in 2020-21 compared to the bill (Alternative A2).

28. If the Committee approves of the policy of having the state assume a portion of the cost of the nonfederal share of crisis intervention services with an MOE, it could approve the method of calculating the MOE as specified in the bill (Alternative B1). Alternatively, the MOE provision could specify that the calculation be based on a three-year average of county expenditures, rather than 2017 expenditures. This would reduce the impact of year-to-year variation in a county's expenditures on the MOE (Alternative B2).

Regional Crisis Stabilization Facility Grants

29. The bill would create a new grant program, funded at \$2,500,000 in 2020-21, to support regional crisis stabilization facilities for adults. The bill would require DHS to establish criteria for such facilities, giving the Department broad discretion to determine the staffing and treatment standards for such facilities.

30. The Department's Crisis Intervention Toolkit report recommends that the state and local governments establish residential crisis stabilization programs. These facilities are described as "low-cost, short-term, sub-acute programs for individuals who need support and observation to avoid high-cost, hospital-based acute care."

31. DHS indicates that currently a few larger counties operate crisis stabilization facilities for their residents, but that this is generally uncommon. For all but the largest counties, the cost to maintain a 24-hour facility is too great in relation to the expected utilization to justify the expense. The proposed grant program is intended to help support the start-up and operational costs of a crisis stabilization facility, possibly supported also with county funds. The Department envisions that these facilities could achieve greater efficiencies by accepting residents from across a multi-county region.

32. The current crisis stabilization facilities are licensed by the Department as a type of community-based residential facilities (CBRFs). Under DHS administrative rules, a CBRF has capacity for at least five individuals and provides treatment, care, or services in addition to room and board, including up to three hours per week of nursing services. CBRFs are commonly established to provide assisted living for disabled or elderly persons, but can also be designed for other purposes, such as crisis stabilization.

33. Crisis stabilization facilities are intended to reduce the need for hospitalization, including emergency detention, but would not serve as an alternative site for when involuntary emergency detention or civil commitment is required.

34. To the extent possible, existing regional crisis stabilization centers bill MA or commercial insurance for services. For more sparsely-populated counties, however, billing directly for services may not be sufficient to fully support the operation of a facility. The grant funds would be intended to support start-up costs for regional centers or provide ongoing support for centers that would not otherwise have the volume to remain self-sufficient on the basis of charges alone.

35. The Department indicates that the goal of the grant program would be to establish five regional crisis stabilization facilities for adults. The funding provided by the bill would allow the Department to make five grants of \$500,000 for each center. Based on existing CBRF costs, this amount would be equivalent to the amount needed to support between four and five beds without other sources of reimbursement, or between 20 and 25 beds statewide.

36. As with the MA crisis intervention services reimbursement initiative, the crisis stabilization center grant proposal is intended to support counties with the delivery of mental health services to their residents. The assistance of county efforts is likely to be most beneficial for counties with smaller populations or that face greater travel distance to existing facilities. More opportunities for subacute crisis stabilization may allow these counties to reduce the costs that they would incur for crisis services, including emergency detention. If the Committee agrees that the state should increase efforts to support county mental health systems, the proposed grant program for crisis stabilization centers could be approved (Alternative C1).

37. If the Committee determines that counties should retain substantial responsibility for funding mental health crisis services, including crisis stabilization facilities, the proposed grant program could be disapproved (Alternative C2).

ALTERNATIVES

A. Crisis Intervention Services Reimbursement -- State Funding and Level of County Maintenance of Effort

1. Approve the Governor's recommendation to: (a) increase MA benefits funding to reflect estimated costs of provisions in the bill that would increase the state's share of the cost of county crisis intervention services provided to MA recipients; (b) create a county MOE requirement equal to 75% of each county's 2017 expenditures for crisis intervention services; and (c) modify the statutory

definition of crisis intervention services to match the definition used in current administration rules. Reduce funding by \$6,167,100 (-\$4,105,200 GPR and -\$2,061,900 FED) in 2019-20 and \$17,694,300 (-\$9,178,300 GPR and -\$8,516,000 FED) in 2020-21 to reflect a reestimate of the impact of the incentives created by the policy.

ALT A1	Change to	
	Base	Bill
GPR	\$12,097,500	-\$13,283,500
FED	<u>1,299,100</u>	<u>-10,577,900</u>
Total	\$13,396,600	-\$23,861,400

2. Approve the Governor's recommendations with respect to crisis intervention services, but modify the proposal by deleting the county MOE requirement. Increase funding in the bill by \$8,035,500 GPR in 2019-20 and \$16,017,100 GPR in 2020-21 to reflect the state fiscal effect of eliminating the MOE.

ALT A2	Change to	
	Base	Bill
GPR	\$49,433,600	\$24,052,600
FED	<u>11,877,000</u>	<u>0</u>
Total	\$61,310,600	\$24,052,600

3. Take no action.

ALT A3	Change to	
	Base	Bill
GPR	\$0	-\$25,381,000
FED	<u>0</u>	<u>-11,877,000</u>
Total	\$0	-\$37,258,000

B. Method of Calculating County Contribution

1. Approve the Governor's recommendation to calculate the county MOE based on 2017 county expenditures.

2. Modify the calculation of county MOE by specifying that the MOE is the annual average county expenditures in 2016, 2017, and 2018.

C. Regional Crisis Stabilization Facility Grant Program

1. Approve the Governor's recommendation to provide \$2,500,000 GPR in 2020-21 for a regional crisis stabilization facility grant program.

ALT C1	Change to	
	Base	Bill
GPR	\$2,500,000	\$0

2. Take no action.

ALT C2	Change to	
	Base	Bill
GPR	\$0 - \$2,500,000	

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May, 2019

Joint Committee on Finance

Paper #363

Physician and Behavioral Health Services (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 172, #10]

CURRENT LAW

The medical assistance (MA) program pays certified health care providers for primary, preventive, acute, and long-term care services they provide to enrollees. These providers include individual practitioners as well as hospitals, nursing homes, and local governmental entities such as county human services departments and school districts. MA enrollees are entitled to receive covered, medically necessary services furnished by these providers. Eligibility for MA is based on meeting financial and/or disability status criteria.

GOVERNOR

Provide \$22,471,900 (\$8,732,800 GPR and \$13,739,100 FED) in 2019-20 and \$46,642,500 (\$18,217,800 GPR and \$28,424,700 FED) in 2020-21 to increase MA reimbursement rates for mental health, behavioral health, and psychiatric services provided by physicians and medical clinics. The funding in the bill is based on the administration's expectation that rates would be increased effective January 1, 2020.

DISCUSSION POINTS

1. MA pays health care providers, such as physicians, dentists, and hospitals, for services they provide to MA recipients. These payments are often referred to as "provider reimbursement," although in most cases the MA program pays a pre-established maximum fee, rather than an amount equal to the provider's usual and customary charges or the provider's cost of providing the service. Provider reimbursement occurs either on a fee-for-service (FFS) basis, or under a managed care model

through a health maintenance organization (HMO). FFS payments for most non-institutional services are generally based on a maximum fee schedule, which specifies the amount of the reimbursement by medical procedure code and type of provider. HMOs may establish their own reimbursement policies for contracted providers, although they generally follow the FFS schedule.

2. In contrast to maximum fee schedule rates for physicians and other non-institutional providers, the reimbursement rate methodologies used for hospitals and nursing homes are updated annually and include cost-based increases to a portion of the reimbursement formulas. The funding for these increases is provided in the biennial budget as part of MA cost-to-continue estimate. Any non-institutional provider increases must be either provided as part of separate budget decision items or implemented by the Department from within the existing budget for MA benefits.

3. The last broad-based increase to the maximum fee schedule for most non-institutional medical services occurred in 2008. Effective with services provided on July 1, 2008, rates for physician and clinic services, medical equipment and supplies, mental health and substance abuse services, physical, occupational, and other therapy services, and other professional services (dentistry, vision, chiropractic, podiatry, etc.) were increased by 1.0%. At the same time, reimbursement rates for evaluation and psychotherapy services provided by psychiatrists were increased by 20%.

4. Since the 2008 increases, there have been a few other reimbursement rate increases targeted at specific non-institutional provider services. Most recently, DHS increased reimbursement rates for certain outpatient mental health and substance abuse services, effective January 1, 2018. In total, the Department estimated that total payments for the affected services would increase by approximately 28% as the result of these changes. Funding for this increase had not been included in the 2017-19 budget; the Department made the decision to increase reimbursement rates for outpatient mental health and substance abuse services to address provider shortages, using base funding for MA benefits.

5. Because of the delay between when services are provided and when claims are submitted, and the additional time needed to see clear trends in the utilization of services, it is still too early to determine what impact, if any, the 2018 reimbursement rate increases had on access to mental health and substance abuse services.

6. Although the Department implemented an increase to mental health and substance abuse reimbursement rates in 2018, these increases did not apply to evaluation and management procedure codes commonly used by psychiatrists for office visits. Instead, the increases applied primarily to individual and group psychotherapy and substance abuse counseling procedure codes.

7. The bill would increase funding for MA benefits for the purpose of reimbursement rate increases, but does not contain statutory or nonstatutory provisions directing the Department as to which services should be affected, how much to increase rates, or even whether to increase reimbursement rates. However, the lack of bill language relating to a provider reimbursement rate increase is not unusual for such increases enacted as part of budget bills. Typically, supporting documents submitted with Governor's bill, or the Legislative Fiscal Bureau summary of the final budget act indicates the intended purpose for increased funding.

8. The Governor's Budget in Brief indicates that the additional funding is intended for "physicians and medical clinics that provide mental health, behavioral health and psychiatric services."

9. Although the budget documents specify that the target of reimbursement rate increases would be physicians providing behavioral health services, the Department of Administration indicates that the intent of the funding was to provide funding for mental health services and physician or clinic services, including potentially physician services that are unrelated to behavioral health. In implementing reimbursement rate increases, DHS indicates that increases would be targeted to physician services for which a shortage of available providers creates access problems for MA enrollees.

10. Federal law requires state Medicaid programs to ensure that payments to providers "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

11. In 2015, the federal Centers for Medicare and Medicaid Services (CMS) published new regulations requiring state Medicaid programs to regularly monitor and report on access to medical services by beneficiaries who receive those services on a fee-for-service basis. These rules were intended to address concerns that, for various reasons, some Medicaid beneficiaries find it difficult to make medical appointments. One reason for this difficulty is that Medicaid programs may pay providers at a level that is too low for them to agree to accept Medicaid patients.

12. In response to the federal requirement, DHS prepared a report in 2016 on access to MA providers in Wisconsin. The report examines access in six broad categories: primary care, dental, physician specialty, behavioral health, obstetrics, and home health services. For each of these areas, the Department evaluated MA access using various measures, including the percent of providers enrolled in MA and the level of MA participation by enrolled providers.

13. The Department's access report findings relating to the primary care and behavioral health categories are most relevant to the Governor's proposed funding increase for provider reimbursement rates. For these core areas, DHS concludes that provider enrollment and participation in Medicaid is fairly high for primary care physicians, and psychiatrists. Among licensed physicians in the state 85% are enrolled as providers in MA and 72% of those enrolled are considered "active" in the program, meaning that they serve at least 26 MA patients. Among licensed psychiatrists, 81% are enrolled as providers in the program and 73% are active in the program. The report notes, however, that the Department faced some data limitations that may make it difficult to draw reliable conclusions on these measures alone. For instance, the data on primary care provider participation was collected during a period in which federal funding was made available to significantly increase Medicaid reimbursement for primary care services. This may have temporarily increased participation during the study period in a way that is not reflective of ongoing participation.

14. The Department also acknowledged comments of some stakeholders that the minimum threshold for the "active" participation measure -- 26 or more MA patients -- would amount to less than 2% of most primary care physician's total patients. For this reason, some physicians could be

considered active participants, but still have a relatively little involvement in the program.

15. Although a high percentage of psychiatrists are enrolled MA providers and are considered to be active in the program, the Department notes that MA enrollees may still have difficulty scheduling an appointment with a psychiatrist because of the overall shortage of psychiatrists in many parts of the state. That is, access to psychiatrists is a problem that extends beyond MA and, therefore, one which may not be possible to address through MA reimbursement rates alone.

16. In contrast to primary care services provided by physicians or psychiatric services, the Department's FFS access report shows that a substantial share of dentists in the state do not participate in MA. Just 37% of licensed dentists in the state are enrolled providers, and 47% are active in the program. The bill would provide reimbursement rate increases for dental services as part of a separate item. For a discussion of this issue, see LFB Paper #365.

17. HMOs that participate in MA are required by contract to have a network of providers that is sufficient to provide medical care for all enrolled members provide medical care to its enrolled members that is as accessible "in terms of timeliness, amount, duration, and scope" as those services are to FFS MA beneficiaries in the same region. HMOs are required, furthermore, to have written standards for access and must meet certain benchmarks for timeliness of and maximum travel distance to appointments.

18. HMOs must determine whether the reimbursement rates paid to contracted providers are sufficient to meet the contract access guidelines. In some cases, an HMO may decide that it is necessary to pay providers a higher rate than the FFS reimbursement rate. For some services, the Department makes adjustments to the monthly capitation rates paid to the HMOs in recognition that they pay their network providers rates that exceed the FFS rates.

19. The amount of funding provided by the bill for reimbursement rate increases is not tied to any apparent funding benchmarks. Furthermore, because neither the bill nor the administration's supporting documents are clear as to which specific services would be targeted, it is difficult to determine what the effect of the proposed increases would be. Nevertheless, a case can be made that some level of funding for reimbursement rate increases is needed, given that most payments have not been increased since 2008.

20. The administration estimates that the funding in the bill would allow for a rate increase for the targeted services of approximately 8.6% if the increases were applied uniformly to the broad physician/clinic and behavioral health service categories. However, the Department would have discretion to apply different percentage increases to procedure codes within these categories. For this reason, the actual percentage increase for the affected services cannot be known and so is not a meaningful metric for the proposed funding level.

21. Nevertheless, if the Committee agrees that funding for reimbursement rate increases for non-institutional services is warranted, it could provide this amount or a different amount after weighing the merits of this purpose against other funding priorities. The following tables show several alternative funding levels -- including an alternative with no increase -- in comparison with the bill.

The first table shows the change to base by year, while the second shows the same alternatives by the change to bill and to base on a biennial basis.

Reimbursement Rate Funding Alternatives, Change to Base by Fiscal Year

Alternative	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
Governor	\$8,732,800	\$13,739,100	\$22,471,900	\$18,217,800	\$28,424,700	\$46,642,500
A2	15,000,000	23,599,100	38,599,100	30,000,000	46,808,100	76,808,100
A3	10,000,000	15,732,800	25,732,800	20,000,000	31,205,400	51,205,400
A4	5,000,000	7,866,400	12,866,400	10,000,000	15,602,700	25,602,700
A5	0	0	0	0	0	0

Reimbursement Rate Funding Alternatives, Biennial Change to Bill and Base

Alternative	Biennial Change to Bill			Biennial Change to Base		
	GPR	FED	Total	GPR	FED	Total
Governor	\$0	\$0	\$0	\$26,950,600	\$42,163,800	\$69,114,400
A2	18,049,400	28,243,400	46,292,800	45,000,000	70,407,200	115,407,200
A3	3,049,400	4,774,400	7,823,800	30,000,000	46,938,200	76,938,200
A4	-11,950,600	-18,694,700	-30,645,300	15,000,000	23,469,100	38,469,100
A5	-26,950,600	-42,163,800	-69,114,400	0	0	0

22. A case could be made that the best approach for providing increases is to give the Department the discretion in determining which services are most in need of payment increases, based on a consideration of access issues. In this case, the Committee could approve the Governor's proposal, without specific direction (Alternative B1).

23. Alternatively, the Committee may want to include direction in a nonstatutory provision. The direction could range from targeted to more broad-based. Targeted increases can potentially have the greatest impact on access to specific services, while broad-based increases may be viewed as more equitable for all providers, but would have less impact on access with the same amount of total funding. Many approaches are possible, but the alternatives under part B offer some possibilities. First, the bill could be amended to require the Department to provide rate increases directed at services with identified access problems (Alternative B2). Second, the Committee could direct the Department to provide broad-based increases at a fixed percentage to physicians/clinics and those mental health services not previously increased in 2018, utilizing the funding provided under this item (Alternative B3). Finally, the Department could be directed to provide increases for all non-institutional services, other than services that are affected by other items, utilizing the funding provided under this item (Alternative B4).

ALTERNATIVES

A. Reimbursement Rate Funding Level

Choose from the biennial funding amounts shown in the following table.

Reimbursement Rate Funding Alternatives, Biennial Change to Bill and Base

Alternative	Biennial Change to Bill			Biennial Change to Base		
	GPR	FED	Total	GPR	FED	Total
Governor	\$0	\$0	\$0	\$26,950,600	\$42,163,800	\$69,114,400
A2	18,049,400	28,243,400	46,292,800	45,000,000	70,407,200	115,407,200
A3	3,049,400	4,774,400	7,823,800	30,000,000	46,938,200	76,938,200
A4	-11,950,600	-18,694,700	-30,645,300	15,000,000	23,469,100	38,469,100
A5	-26,950,600	-42,163,800	-69,114,400	0	0	0

B. Nonstatutory Directive for Funding Increases

1. Approve the Governor's proposal to provide funding increases for mental health, behavioral health, and psychiatric services provided by physicians and medical clinics (DHS discretion with no nonstatutory directive).
2. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases directed at services with identified access problems.
3. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases at a fixed percentage to physicians/clinics and those mental health services not previously increased in 2018.
4. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases at a fixed percentage to non-institutional services other than services affected by other items in the bill or services for which reimbursement rate increases were previously provided in 2018.

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May, 2019

Joint Committee on Finance

Paper #364

Community Health Benefit (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 172, #11]

CURRENT LAW

The medical assistance program (MA), also known as Medicaid, pays certified health care providers for primary, preventive, acute, and long-term care services they provide to enrollees. These providers include individual practitioners as well as hospitals, nursing homes, and local governmental entities such as county human services departments and school districts. MA enrollees are entitled to receive covered, medically necessary services furnished by these providers. Eligibility for MA is based on meeting financial and/or disability status criteria.

The state receives federal matching funds for services meeting the requirements under Title XIX of the Social Security Act. The federal medical assistance percentage (FMAP), which is the matching rate for eligible expenditures, is determined under a formula based on each state's per capita personal income in relation to the national average. Currently, Wisconsin's FMAP is approximately 59% to 60%. The federal government provides 50% FMAP for a state Medicaid administrative costs.

Federal law lists MA services that states are required to fund under their MA programs, as well as services that states may choose to fund, at their option, under their MA programs. These federally-defined services are commonly referred to as state plan services, since states indicate in their state MA plans which of the optional services their MA programs will cover. Examples of mandatory state plan services include physician services, inpatient and outpatient hospital services and nursing home services. Examples of optional state plan services include dental services, and physical therapy.

In addition to funding state plan services, states may fund other services not defined in federal law. However, states that choose to fund such services must seek waivers of federal law to enable them to receive federal MA matching funds to support these services. Many of the

services Wisconsin's MA program provides under its long-term care programs are "waiver services," since the state receives federal MA matching funds to support the services by entering into negotiated waiver agreements with the federal Centers for Medicare and Medicaid Services. Examples of Wisconsin's current long-term care waiver services include services provided by assisted living facilities, vocational services, and respite care.

GOVERNOR

Provide \$45,000,000 (\$22,500,000 GPR and \$22,500,000 FED) in 2020-21 to fund a new MA benefit, subject to federal approval, for nonmedical services that contribute to the determinants of health. Direct DHS to determine which specific nonmedical services that contribute to the determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit.

Specify that DHS is not required to provide these services as a benefit if the federal Department of Health and Human Services (DHHS) does not provide federal financial participation for these services.

DISCUSSION POINTS

1. According to the Executive Budget Book, the proposed community health benefit would consist of nonmedical services, including "housing referrals, nutritional mentoring, stress management, transportation services and other services that would positively impact an individual's economic and social condition."

2. The administration's community health benefit proposal is intended to address what are commonly known as the social determinants of health. Health care providers and health policy experts have increasingly recognized that a person's social and economic environment has a significant impact on his or her health outcomes, independent of any underlying physical or mental conditions.

3. As an example, the Massachusetts Medical Society notes that health determinants are shaped by the distribution of money, power, and resources at global, national, and local levels. Subsequently, these social circumstances create societal stratification and are responsible for health inequities among different groups of people based on social and economic class, gender, and ethnicity, which in turn contribute to negative health outcomes including obesity, heart disease, diabetes, and depression.

4. With the increasing recognition of the importance of the social determinants of health, some have advocated a more aggressive approach to using nonmedical social services as a way of improving population health and reducing costs for public healthcare programs, including Medicaid.

5. The total healthcare costs associated with any group, including those covered under medical assistance, is heavily influenced by the particularly high costs associated with a small number of individuals with serious illness or chronic conditions. According to an analysis of national

healthcare expenditure data (the Peterson-Kaiser Health System Tracker), the costliest 5% of individuals account for 50% of all health system costs. In many cases, the high costs associated with these individuals will not be influenced by social interventions, since they are associated with intensive clinical interventions for serious illness or trauma. In some cases, however, the high costs may be mitigated or avoided with "upstream" interventions that target social determinants of health.

6. As evidence of the impact of the potential impact of nonmedical interventions on health costs, a 2016 study, from the Yale School of Public Health found that "states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare and Medicaid spending), had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes." Specifically, the researchers found that between 2000 and 2009, the period covered by their data, states with higher ratios of social to health spending had better health outcomes one and two years later compared to states with lower ratios.

7. Medicaid has long provided some nonmedical services to help address health-related needs. For instance, the program provides transportation services to facilitate access to medical appointments. Likewise, for some persons with serious mental illness or substance use disorder, the program covers psychosocial rehabilitation services, which includes several services that are not traditionally provided as part of clinical treatment, but that nevertheless may contribute to improved health. The proposed community health benefit would seek to expand nonmedical services to other dimensions of social and economic needs.

8. The administration points to a new initiative in North Carolina as a potential model for the proposed community health benefit. In October, 2018, the DHHS Centers for Medicare and Medicaid Services (CMS) approved North Carolina's request for a Medicaid demonstration waiver. Among other provisions, the demonstration waiver included authorization for North Carolina to select two to four regions of the state in which to operate a pilot program of enhanced case management and other services focused on housing instability, food insecurity, transportation insecurity, and interpersonal violence and toxic stress. Overall, the goal of the pilot is to improve health outcomes and lower healthcare costs.

9. North Carolina's approved pilot will operate between November 1, 2019, and October 31, 2024, and serve approximately 25,000 to 50,000 beneficiaries. The pilot regions are to be selected based on the regions having specific target populations of high-need Medicaid beneficiaries within their geographic regions.

10. Examples of services offered under North Carolina's pilot include: tenancy support and sustaining services, housing quality and safety improvement, access to legal assistance, support for a security deposit, and post-hospitalization assistance; food support services such as nutrition counseling and education, funding for nutrition provided through food banks for medical conditions, and meal delivery services; non-emergency health related transportation, such as public transit and private services (taxis, ride-sharing) for accessing the pilot services; and transportation, support resources (including assisting individuals to transition out of traumatic situations), access to legal assistance, and child-parent support.

11. The bill would provide DHS broad authority to determine which specific nonmedical services that contribute to the determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit. The administration indicates that it has not yet determined the specific social determinants to be addressed by this provision. Instead, DHS anticipates working with providers, community members, and other stakeholders to design the benefit and delivery models to effectively address the particular needs of individual communities.

12. DHS indicates that it anticipates implementing the program in multiple pilot locations but that the locations have not yet been selected. DHS further indicates that the anticipated target population would be non-disabled, non-elderly adults and families in Medicaid.

13. The bill would provide \$45,000,000 (\$22,500,000 GPR and \$22,500,000 FED) in 2020-21 to fund the services identified by DHS. This estimate assumes that approximately 12,500 individuals would be served on a monthly basis, at an average cost of \$300 per person per month. However, DHS would not be required to provide these services as a benefit if DHHS does not provide federal financial participation for these services.

14. The funding provided by the bill is based on the assumption that community health benefit services would be eligible for the MA administrative FMAP of 50%, rather than the standard FMAP applicable to Medicaid benefits. However, DHS indicates that if CMS classifies some, or all, of the benefits offered under this provision as benefits, eligible for a higher FMAP, the Department would be able to offer more service options or serve more people without increasing the GPR funding.

15. If the Committee approves the creation of the community health benefit, it could adopt the Governor's recommended funding, with the 50% administrative FMAP assumption, on the grounds that this level of GPR funding would provide sufficient resources to administer the benefit even if CMS does not approve the program activities as a covered benefit eligible for a higher FMAP [Alternative 1].

16. Alternatively, the Committee could approve funding at the same overall level, but based on the presumption that CMS would classify the activities in the Department's waiver as benefits for MA recipients. In this case, the standard FMAP of 59.55% in 2020-21 would apply to these services. Relative to the bill, GPR funding could therefore be reduced by \$4,297,500 GPR and FED funding increased by \$4,297,500 to reflect the higher FMAP for the same total expenditure of \$45,000,000 (but totals of \$18,202,500 GPR and \$26,797,500 FED) [Alternative 2]. However, if the Committee chooses this option and the state does not receive the standard FMAP application to services, less total funding would be available to support community health benefits.

17. As noted above, the administration has not yet determined many elements of the proposed community health benefit, including what types of nonmedical services that would be offered, how the services would be delivered, what types of MA beneficiaries would be targeted, and what region or regions the program would operate in. Without more knowledge of the basic parameters of the proposed benefit, it is difficult to evaluate to what extent it might achieve its stated goals of addressing the social determinants of health. This, in turn, may make it difficult for the Committee to make a decision on whether to provide funding for the benefit.

18. On the one hand, the Committee could determine that the state should explore further the potential benefits for improved health outcomes and lower costs by providing certain targeted nonmedical services through the MA program. But the Committee may feel that more information is needed before agreeing to provide funding for this purpose. As such, another alternative would be to authorize DHS to seek a demonstration waiver to implement a community health benefit, but without providing additional funding for such a benefit. Under this alternative, DHS would fund the benefit within existing resources as the Department deems necessary and appropriate, or request additional funding during the following biennial budget if a waiver is approved and after developing a more detailed program for implementation [Alternative 3].

19. While the state Medicaid program does not currently have a specific community health benefit, there are a number of other state, federal, and local programs available to Wisconsin families and individuals with low income aimed at addressing certain social health determinants. For example FoodShare and the Women, Infants, and Children (WIC) program are intended to address food insecurity; local housing authorities are intended to help people obtain federal Section 8 housing assistance; and the homeless case services to homeless families by grant recipients such as homeless shelters.

Furthermore, the Department has developed policies in the existing contracts with health maintenance organizations (HMOs) that are intended to encourage the HMOs to address social determinants of health as part of an overall care management model. For instance, the HMOs must establish partnerships and maintain effective working relationships with key social service and community-based agencies to ensure the social determinants of health (for example, housing instability, low health literacy, chronic stress, traumatic life events, and other social factors) are identified and addressed.

The Committee may therefore feel that a new benefit is not necessary since state, local, and federal governments already administer and fund programs intended to target the social determinants of health, making this provision redundant. As such, the Committee may wish to delete the provision [Alternative 4].

ALTERNATIVES

1. Approve the Governor's recommendation to provide \$45,000,000 in 2020-21 (\$22,500,000 GPR and \$22,500,000 FED, based on an assumed 50% FMAP applicable to Medicaid administrative costs) to fund a new MA benefit for nonmedical services that contribute to the determinants of health and to require the Department seek federal approval for the benefit.

ALT 1	Change to	
	Base	Bill
GPR	\$22,500,000	\$0
FED	<u>22,500,000</u>	<u>0</u>
Total	\$45,000,000	\$0

2. Modify the Governor's recommendation by reducing funding by \$4,297,500 GPR and

by providing a corresponding FED increase in 2020-21, reflecting the assumption that the proposed benefit would be classified as a Medicaid benefit and, therefore, would be eligible for the state's FMAP applicable for Medicaid benefits.

ALT 2	Change to	
	Base	Bill
GPR	\$18,202,500	- \$4,297,500
FED	<u>26,797,500</u>	<u>4,297,500</u>
Total	\$45,000,000	\$0

3. Approve the Governor's recommendation to create an MA benefit for nonmedical services that contribute to the determinants of health, and to require DHS to seek a waiver to get federal approval for these activities, but delete funding provided for this benefit. Under this alternative, the Department could seek funding in a future biennial budget if federal approval is obtained.

ALT 3	Change to	
	Base	Bill
GPR	\$0	- \$22,500,000
FED	<u>0</u>	<u>- 22,500,000</u>
Total	\$0	- \$45,000,000

4. Take no action.

ALT 4	Change to	
	Base	Bill
GPR	\$0	- \$22,500,000
FED	<u>0</u>	<u>- 22,500,000</u>
Total	\$0	- \$45,000,000

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May, 2019

Joint Committee on Finance

Paper #365

Dental Access Incentives (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 173, #12]

CURRENT LAW

Wisconsin's MA program covers the following categories of dental services when the services are provided by or under the supervision of a dentist: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) palliative emergency services; and (i) general anesthesia, intravenous conscious sedation, nitrous oxide, and nonintravenous conscious sedation. The program also covers various services provided by dental hygienists, including oral screening and preliminary examinations, prophylaxis, pit and fissure sealants, and periodontal maintenance. Some dental services reimbursed under the MA program are provided by federally qualified health centers (FQHCs), which are reimbursed under a prospective payment system intended to approximate the full actual cost of providing services to individuals enrolled in MA. FQHCs primarily serve MA recipients and uninsured individuals. Dental services provided outside an FQHC, such as in a private office setting, are reimbursed by the MA program at the lesser of the provider's usual and customary charge or amounts prescribed under a maximum fee schedule established by the Department of Health Services (DHS).

The 2015-17 budget act established a pilot project which increased the MA reimbursement rate for pediatric dental care and adult emergency dental services provided in Brown, Marathon, Polk, and Racine Counties. The Department implemented the enhanced reimbursement rates in these counties on October 1, 2016.

GOVERNOR

Provide \$18,290,900 (\$7,894,700 GPR and \$10,396,200 FED) in 2019-20 and \$20,528,800 (\$8,789,800 GPR and \$11,739,000 FED) in 2020-21 to reflect the net effect of: (a) providing

enhanced reimbursement rates under the MA program to dental providers who meet certain qualifications; and (b) eliminating the dental reimbursement pilot project.

Dental Access Incentive Payments to Dental Providers. Provide \$28,097,600 (\$11,520,000 GPR and \$16,577,600 FED) in 2019-20 and \$30,335,500 (\$12,437,600 GPR and \$17,897,900 FED) to increase reimbursement rates for dental providers that meet quality of care standards, as established by the Department, and that meet one of the following qualifications: (a) for a non-profit or public provider, 50 percent or more of the individuals served by the provider lack dental insurance or are enrolled in MA; or (b) for a for-profit provider, five percent or more of the individuals served by the provider are enrolled in MA.

Require the Department to increase reimbursement in the following manner, for dental services rendered on or after January 1, 2020 by a provider meeting the above criteria: (a) for a qualified non-profit provider, a 50 percent increase above the rate that would otherwise be paid to that provider; (b) for a qualified for-profit provider, a 30 percent increase above the rate that would otherwise be paid to that provider; and (c) for providers rendering services to individuals enrolled in managed care under the MA program, increase reimbursement on the basis of the rate that would have been paid to the provider had the individual not been enrolled in managed care. Specify that if a provider has more than one service location, the eligibility thresholds described above apply to each location, and payment for each service location would be determined separately.

Elimination of the Dental Reimbursement Pilot Project. Reduce funding by \$9,806,700 (-\$3,625,300 GPR and -\$6,181,400 FED) in 2019-20 and by \$9,806,700 (-\$3,647,800 GPR and -\$6,158,900 FED) in 2020-21 to reflect the effect of repealing the provisions of 2015 Act 55, which created an enhanced dental reimbursement pilot program to increase MA reimbursement rates for pediatric dental care and adult emergency dental services provided in Brown, Marathon, Polk, and Racine counties. This funding reduction is based on the difference between the standard reimbursement rate and the enhanced rate for expenditures in the pilot program counties in 2017-18.

DISCUSSION POINTS

1. The enhanced dental services reimbursement pilot program was created by the 2015-17 budget act out of a concern that low MA reimbursement rates are a significant reason for low rates of participation in MA by dentists. According to the Department's 2016 MA access monitoring plan, only 37% of Wisconsin dentists are certified to participate in the MA program, and of these, only 47% are considered active providers, which is defined as serving more than 25 MA patients per year. This is in contrast to primary care physicians, of whom 85% are certified to participate in the MA program and 72% of those enrolled are considered active providers.

2. The low rate of participation in MA by dentists is one of the key reasons frequently cited for why utilization of dental services by MA beneficiaries is low. A lack of dentists willing to accept MA patients makes it more difficult for MA enrollees to make appointments for preventive or restorative services. This, in turn, may lead to poor overall oral health. Tooth decay and other oral conditions are often the result of lack of access to dental care and, if untreated, may lead to more

significant problems. Some of these problems reach the point of requiring costly emergency care.

3. Under the enhanced dental services reimbursement pilot program, dental providers rendering services in Brown, Marathon, Polk, and Racine counties are reimbursed for pediatric services and emergency dental procedures for adults using a fee schedule that is roughly double the reimbursement standard fee-for-service rate schedule. The program has been in operation for nearly three years.

4. Outside of the pilot counties, reimbursement rates for dental services were last increased in 2008, when the Legislature approved a 1% increase to the fee schedule for most non-institutional providers. Prior to that time, rates had not been increased since 2002, also a 1% increase. Because increases for dental provider rates have been infrequent and small, payments for dental providers have fallen significantly below dentists' usual and customary charges. According to the American Dental Association, Wisconsin's reimbursement for pediatric dental services is among the lowest in the country, equal to about 32% of dentists' charges on average.

5. The Department contracted with the University of Wisconsin Population Health Institute to conduct an evaluation of the impact of the dental pilot on utilization of dental services in the MA program in the one year before and one year after project initiation in 2016, comparing both pilot and non-pilot counties.

6. The evaluation found evidence of greater provider participation in MA in the year following the start of the pilot program. In the four pilot counties, the number of dental providers certified to participate in MA increased by 33%, while the number of MA-certified dentists increased by 7% in non-pilot counties. Not all certified providers actively serve MA patients, but the evaluation found that the number of providers seeing at least 100 MA patients during the year increased by 55% in pilot counties, compared to just 7% in non-pilot counties.

7. Utilization of any dental services during the year increased by 4.1 percentage points for children living in the pilot counties (from 40.0% to 44.1% of all enrolled children) and by 5.1 percentage points for adults living in the pilot counties (from 24.9% to 30.1% for all enrolled adults). By comparison, utilization of any dental services increased by 2.0 percentage points for children and by 1.4 percentage points for adults in non-pilot counties.

8. While the pilot program appears to have had a clear impact on provider participation, the evaluation authors noted that the impact of the program on utilization of dental services by MA beneficiaries is less clear, due in large part to data limitations. The evaluation team had access only to aggregate claims data, which did not distinguish between provider types. Therefore, the utilization data included visits to FQHCs, even though FQHC reimbursement rates are unaffected by the rate increases in the pilot program. Three of the four pilot counties (Brown, Marathon, and Polk) contain FQHCs that provide dental services that expanded their capacity in recent years. The authors concluded, therefore, that they could not rule out that the increases in utilization was due, at least in part, to increased use of FQHC dental services, rather than to dentists participating in the pilot program.

9. The Department argues that even if the increase in utilization can be attributed solely to

the pilot program, the effects have been relatively modest in comparison to the cost. In 2017-18, MA costs of funding the rate enhancement was \$9.8 million, roughly doubling the cost relative to the standard rate, but the share of all enrolled children living in the pilot counties who received services as the result of the pilot program increased by, at most, just 4.1%.

10. Although the Department notes that a statewide expansion of the program could encourage greater participation and therefore increase utilization of dental services by all MA beneficiaries, it argues that the cost of such increases would be high relative to the impact on utilization. The Department estimates that a statewide expansion of the enhanced dental reimbursement rates would increase MA expenditures by approximately \$57 million (\$20 million GPR and \$37 million FED) on an annualized basis.

11. In further support of the limited impact of reimbursement rate increases, the Department cites a 2013 National Bureau of Economic Research study that found that reimbursement rate increases have a statistically significant, but modest impact on utilization. Using data from various sources, the study estimated that an increase of about 40% in Medicaid reimbursement rates for dental preventive services results in approximately a 1% to 3% increase in utilization of preventive services.

12. Instead of broad-based reimbursement rate increases, the bill would establish a mechanism for targeting additional payments to providers that serve a high proportion of MA patients. Under the proposed access payment program, for-profit dentists with MA patients or uninsured patients composing at least 5% of their total would receive a 30% multiplier on all MA services. Non-profit providers for which MA or uninsured patients make up at least 50% of their patients would receive a 50% multiplier for all MA services.

13. The Department's staff believes that with this targeted access incentive payment approach, providers who already serve MA patients, but are just below the threshold for receiving enhanced payments, would seek to serve more MA patients. In addition, providers who are already meeting the criteria for enhanced payment would also benefit, making a high-MA patient business model more sustainable.

14. The administration's fiscal estimate assumes that all or most non-profits that currently serve MA patients and approximately 42% of certified for-profit dental service providers would qualify for an access incentive payment. Approximately two-thirds of the total funding would go to for-profit providers and one-third would go to non-profit providers.

15. The administration estimates that the proposed access incentive payment would increase MA benefits costs by approximately \$30.3 million by the second year of the biennium, an increase of approximately 33% above the baseline estimate (excluding pilot program payments).

16. The dental access incentive payment would be similar in concept to disproportionate share hospital (DSH) supplement payments the MA program pays to hospitals that serve a higher percentage of MA patients. DSH payments have the effect of increasing the base hospital reimbursement rate, in rough proportion to each hospital's proportion of MA patients. Hospitals that have a greater reliance on MA patient revenue receive a higher payment to help offset the lower base reimbursement provided by MA. The dental access payments would use a simpler two-tier system,

but would have the effect of targeting funds to dental practices that have a higher number of MA patients.

17. Under the bill, the additional costs associated with the dental access incentive provision would be offset by savings associated with repealing the four-county pilot program. The table below shows the administration's estimate of the fiscal effect of both the creation of both provisions.

Administration's Estimate of Fiscal Effect of Dental Initiatives

	2019-20		2020-21		2019-21 Biennium	
	GPR	FED	GPR	FED	GPR	FED
Dental Access Incentive	\$11,520,000	\$16,577,600	\$12,437,600	\$17,897,900	\$23,957,600	\$34,475,500
Repeal Pilot Program	<u>-3,625,300</u>	<u>-6,181,400</u>	<u>-3,647,800</u>	<u>-6,158,900</u>	<u>-7,273,100</u>	<u>-12,340,300</u>
Net Effect	\$7,894,700	\$10,396,200	\$8,789,800	\$11,739,000	\$16,684,500	\$22,135,200

18. The bill's funding for the dental access incentive program is based on two full years of implementation. However, the bill specifies that the access incentive would first apply to services rendered after January 1, 2020, six months into the first year of the biennium. Consequently, if the Committee adopts the provision, funding for MA benefits should be reduced by \$14,048,800 (\$5,760,000 GPR and \$8,288,800 FED) in 2019-20 to reflect a reestimate of the fiscal effect based on six months of incentive payments in that year (Alternative A1).

19. If the Committee approves the move toward a statewide approach to dental access through the proposed access incentive program, it may also decide to approve the repeal of the four-county pilot program (Alternative B1). However, given that the incentive access program would not take effect until January 1, 2020, the Committee may also wish to consider delaying the repeal of the pilot program until that date, to ease the transition for providers in those counties. In this case, the program should be funded for six months in 2019-20, which would increase MA costs by an estimated \$4,903,400 (\$1,812,700 GPR and \$3,090,700 FED) in that year (Alternative B2).

20. Relative to the bill, the net fiscal effect of Alternative A1 (reestimate of dental access incentive) and Alternative B2 (six-month delay in the repeal of the pilot program) would be a funding decrease of \$9,145,400 (-\$3,947,300 GPR and -\$5,198,100 FED) in 2019-20.

21. It is possible that with more time, combined with greater outreach efforts, the pilot program would lead to more substantial increases in utilization. The evaluation report notes that the effects on provider participation and utilization were greater in Brown County, which may be attributed to greater efforts to involve local dentists in education and outreach initiatives in an effort to improve participation and access. The percentage of Brown County children who received any services increased by 7.1% in the year following implementation. The Committee could decide to retain the enhanced dental reimbursement pilot program (take no action on the repeal) to allow more time to evaluate its impact, either in place of or in addition to the incentive access program. Relative to the bill, this would increase MA benefits funding by funding by \$9,806,700 (\$3,625,300 GPR and \$6,181,400 FED) in 2019-20 and by \$9,806,700 (\$3,647,800 GPR and \$6,158,900 FED) in 2020-21 (Alternative B3).

22. As passed by the Legislature, the period of enhanced payments for dental services provided in the four-county area would have ended after the 37th month following implementation. However, due to one of the Governor's partial vetoes in 2015 Act 55, the pilot program has no termination date.

23. 2017 Wisconsin Act 344 created provisions that establish ongoing, biennial reporting requirements for DHS to provide specified information on the pilot project, including: (a) the number of MA recipients who received services; (b) an estimate of the potential reduction in health care costs and emergency department use by MA recipients due to the pilot project; (c) the feasibility of continuing the pilot project in specific areas of the state; (d) program costs; and (e) an analysis of the MA populations who received services, and who may benefit, from the pilot project.

24. Several arguments could be offered to repeal the pilot program. First, as previously indicated, the program has already been evaluated by the University of Wisconsin Population Health Institute. If the pilot program is continued, DHS will incur additional staff and contracting expenses to conduct ongoing evaluations to meet the reporting requirements created in Act 344. Second, the current pilot program provides significantly higher reimbursement rates for pediatric and emergency dental services rendered by providers in four counties, which may be seen as unfair to dental providers in the rest of the state that provide these same services. Finally, although the evaluation showed significant increase in the number of dentists that were certified to serve MA recipients in the pilot counties, the significant cost of providing the enhanced rates did not significantly increase the number of pediatric and emergency services provided to MA recipients in these counties.

ALTERNATIVES

A. Dental Access Incentive Payment

1. Adopt the Governor's recommendation to create a dental access incentive payment program beginning January 1, 2020, but reduce funding in bill by \$14,048,800 (-\$5,760,000 GPR and -\$8,288,800 FED in 2019-20 to reflect a reestimate of cost of the program based on six months of operation in that year, rather than 12 months. The total funding estimate would be \$14,048,800 (\$5,760,000 GPR and -\$8,288,800 FED) in 2019-20 and \$30,335,500 (\$12,437,600 GPR and \$17,897,900 FED) in 2020-21.

ALT A1	Change to	
	Base	Bill
GPR	\$18,197,600	- \$5,760,000
FED	<u>26,186,700</u>	<u>- 8,288,8000</u>
Total	\$44,384,300	- \$14,048,800

2. Take no action.

ALT A2	Change to	
	Base	Bill
GPR	\$0	- \$23,957,600
FED	<u>0</u>	<u>- 34,475,500</u>
Total	\$0	- \$58,433,100

B. Enhanced Dental Reimbursement Pilot Program

1. Approve the Governor's recommendation to reduce MA benefits funding by \$9,806,700 (\$3,625,300 GPR and -\$6,181,400 FED) in 2019-20 and by \$9,806,700 (-\$3,647,800 GPR and -\$6,158,900 FED) in 2020-21, and to repeal the enhanced dental reimbursement pilot program.

ALT B1	Change to	
	Base	Bill
GPR	- \$7,273,100	\$0
FED	<u>- 12,340,300</u>	<u>0</u>
Total	- \$19,613,400	\$0

2. Modify the Governor's recommendation by increasing funding for MA benefits by \$4,903,400 (\$1,812,700 GPR and \$3,090,700 FED) in 2019-20 to reflect a delay in the repeal of the pilot program until January 1, 2020.

ALT B2	Change to	
	Base	Bill
GPR	- \$5,460,400	\$1,812,700
FED	<u>- 9,249,600</u>	<u>3,090,700</u>
Total	- \$14,710,000	\$4,903,400

3. Take no action.

ALT B3	Change to	
	Base	Bill
GPR	\$0	\$7,273,100
FED	<u>0</u>	<u>12,340,300</u>
Total	\$0	\$19,613,400

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May, 2019

Joint Committee on Finance

Paper #366

SeniorCare Cost-to-Continue Estimate (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 174, #14]

CURRENT LAW

Wisconsin's SeniorCare program provides assistance to help eligible seniors purchase prescription medication. State residents who are age 65 or older, who are not eligible for full Medicaid benefits, and who meet income requirements are eligible for benefits under the program. SeniorCare participants must pay a \$30 annual enrollment fee, which supports costs the Department of Health Services (DHS) incurs to administer the program. Once an individual is enrolled, his or her receipt of benefits depends upon meeting deductible and copayment requirements. The deductible, if any, is based on the annual income level of the enrollee, as follows: (a) no deductible for persons with an annual income below 160% of the federal poverty level (FPL); (b) \$500 deductible for persons with an annual income between 160% of the FPL and 200% of the FPL; and (c) \$850 deductible for persons with an annual income between 200% of the FPL and 240% of the FPL.

Persons with incomes above 240% of the FPL may enroll in the program, but will not be eligible for benefits unless the program's spend down rules are met. "Spend down" means that the person incurs expenses for prescription drugs within a year that equals the difference between his or her annual income and 240% of the FPL. Upon meeting that threshold, persons in the spend-down category must then meet an \$850 deductible. After satisfying the applicable deductible, all enrollees make copayments of \$5 for generic medications and \$15 for brand name medications, while the program pays all other medication costs.

SeniorCare benefits are funded with a combination of state general purpose revenue (GPR), federal Medicaid matching funds (FED) and program revenue (PR) from rebates received from drug manufacturers that participate in the program. Base funding for program benefit expenditures is \$117,307,400 (\$20,927,400 GPR, \$21,067,700 FED, and \$75,312,300 PR).

GOVERNOR

Provide \$6,699,800 (-\$1,310,200 GPR, -\$1,139,600 FED, and \$9,149,600 PR) in 2019-20 and \$18,661,700 (\$2,679,700 GPR, \$2,389,400 FED, and \$13,592,600 PR) in 2020-21 to fund projected increases in the cost of benefits under the SeniorCare program in the 2019-21 biennium.

MODIFICATION

Reduce funding by \$11,592,400 (-\$3,125,800 GPR, -\$5,758,100 FED, and -\$2,708,500 PR) in 2019-20 and \$12,658,000 (-\$3,517,000 GPR, -\$6,123,600 FED, and -\$3,017,400 PR) in 2020-21 to reflect a reestimate of SeniorCare benefit costs.

Explanation: The administration's cost-to-continue estimate, which is the same as the estimate included in the Department of Health Services' agency budget request, was based on program enrollment and cost data available in September of 2018, at the time of the request submittal. Since that time, SeniorCare enrollment in the two lowest income tiers has declined, continuing a long-term trend. The reestimate reflects updated data on actual enrollment and adjusts the caseload, cost, and rebate, projections for the 2019-21 biennium to more closely match recent patterns. In addition, the reestimate updates the projected federal matching rate for federal fiscal year 2020-21.

	Change to	
	Base	Bill
GPR	- \$5,273,300	- \$6,642,800
FED	- 10,631,900	- 11,881,700
PR	<u>17,016,200</u>	<u>- 5,725,900</u>
Total	\$1,111,000	- \$24,250,400

Prepared by: Jon Dyck



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May, 2019

Joint Committee on Finance

Paper #367

Post-Partum Eligibility (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 175, #15]

CURRENT LAW

In Wisconsin, most adults with household income up to 100% of the federal poverty level (FPL) are eligible for health care coverage under BadgerCare Plus. However, pregnant women may have household income of up to 306% of the FPL and still qualify for BadgerCare Plus. In determining the household's family size (for the purpose of determining the household's income as a percentage of the FPL), the number of children the woman is expecting is included. For example, a pregnant woman who is expecting one child and who resides with her husband is considered to be in a three-person household. In 2019, 306% of the FPL for a three-person family is \$65,270.

Under federal law, all pregnant women who are enrolled in the medical assistance (MA) program remain eligible for MA coverage through the end of the month in which their 60-day postpartum period ends. For example, if a woman's child is born on April 7, the woman remains enrolled in MA through June 30.

When the woman's period of extended eligibility following delivery ends, the woman's eligibility for MA coverage is redetermined. The woman may remain enrolled in the program if she continues to meet all MA eligibility requirements, including the income limit that applies to nonpregnant, non-disabled adults (100% of the FPL). In 2019, 100% of the FPL is \$21,330 per year for a three-member family. However, if her countable household income exceeds 100% of the FPL, she will be disenrolled from the program.

As required by federal law, a newborn child is automatically eligible for MA (BadgerCare Plus) coverage from the date he or she is born through the end of the month in which the child turns one year old if the natural mother was eligible for MA (or MA-supported emergency services) when the baby was born.

GOVERNOR

Increase funding for MA benefits by \$22,880,000 (\$9,609,600 GPR and \$13,270,400 FED) in 2020-21 to reflect an estimate of the cost of extending MA coverage for post-partum women for an additional 10-month period, so that a woman would remain eligible for MA coverage until the last day of the month in which the 365th day after the last day of the pregnancy falls. Require DHS to seek approval from the federal Department of Health and Human Services to implement this change in program eligibility.

DISCUSSION POINTS

1. The Governor's recommendation is intended to ensure that post-partum women continue to have uninterrupted health care coverage, with no or nominal cost, for at least one year following delivery.

2. Women who are no longer eligible for MA following the current two-month post-partum period may have access to other health care coverage, including by: (a) purchasing an individual health plan offered on the benefit exchange (termination of MA coverage is a qualifying event that enables these women to enroll in a plan mid-year, outside of the normal enrollment period); or (b) obtaining coverage offered by an employer, which may include a spouse's employer-sponsored plan. However, due to the cost of premiums, deductibles, and copayments, some women in low-income households do not enroll in these plans, or if they do, may choose not to access services due to cost-sharing requirements. It is not known how many, or what percentage of post-partum women who were formerly enrolled in MA no longer have health care coverage following the two-month period of extended eligibility.

3. Disruptions in health care coverage can adversely affect the continuity and quality of health care services these women receive. Women experience disruptions in health care coverage before and after delivery because of changes in their employment and income status. For example, a woman who previously did not qualify for BadgerCare Plus may qualify for a limited period, then be disenrolled following the two-month post-partum period. Similarly, a woman may discontinue her employer-sponsored coverage if she decides to leave her job and remain at home to care for her child.

4. A recent study, summarized in the April, 2017 edition of Health Affairs, provides some information on health care coverage of women before and after childbirth, based on national survey data covering the period between 2005 and 2013. The study yielded information on the monthly insurance status of pregnant women, beginning three months prior to conception (as estimated by delivery dates), through six months following delivery. The insurance status of each woman in the study was coded in one of three categories: (a) MA or coverage under the children's health insurance program (CHIP); (b) private or other insurance coverage; and (c) no insurance.

5. The study found that leading up to delivery, the proportion of pregnant women who were uninsured decreased, while the proportion of pregnant women with Medicaid or CHIP coverage increased. This is not surprising, since all states have enacted higher maximum income standards for pregnant women than for other low-income populations as part of their MA programs. This is largely

due to the federal requirement that states provide pregnancy-related medical services to all women with family income under 138% of the FPL. However, the researchers found that, *after* delivery, the uninsurance rate for these women rose rapidly, nearly returning to the pre-pregnancy rate (23 percent six months after delivery, compared to 25 percent in the tenth month before delivery.)

6. The study also found that 41% of women who had MA or CHIP coverage at the time of delivery had the same type of insurance coverage continuously for the six-month period following delivery, compared with 64% of women who had private coverage at the time of delivery.

7. The study found that the number of uninsured months following delivery was much higher among women covered by MA or CHIP at the time of delivery than for women with private insurance coverage, with 55 percent of the MA or CHIP women having at least one uninsured month, and 25 percent of these women having two or more months of being without insurance over the six-month period following delivery.

8. Finally, the study identified several risk factors that are associated with lapses in health insurance coverage among these women after childbirth, including: (a) having an income of between 100% to 185% of poverty; (b) not speaking English at home; (c) being unmarried; and (d) having MA or CHIP coverage at the time of delivery.

9. In May, 2018, the American College of Obstetricians and Gynecologists' (ACOG's) Presidential Task Force on Redefining the Postpartum Visit published several recommendations, which stressed the need for ongoing post-partum care, rather than a single postpartum visit. The ACOG recommendations cited an estimate that 40% of all postpartum women, including women with and without health care coverage, do not attend a postpartum visit. The ACOG recommendations are summarized as an attachment to this paper.

10. Maintaining MA coverage for postpartum women for one year may reduce pregnancy-related mortality. The Centers for Disease Control and Prevention (CDC) administers a pregnancy mortality surveillance system that collects information on pregnancy-related deaths, which are deaths that occur during pregnancy or within one year of the pregnancy from any cause related to, or aggravated by, the pregnancy. The system produces a pregnancy-related mortality ratio, which is an estimate of the number of pregnancy-related deaths for every 100,000 live births. This ratio is often used as an indicator to measure the nation's health. Since the system was implemented, the CDC reports that, nationally, the pregnancy-related mortality ratio has increased from 7.2 deaths per 100,000 births in 1987 to 18.0 deaths per 100,000 births in 2014 (the most recent year for which information is available). Possible causes of the rising pregnancy related mortality rates in the United States include pre-existing conditions, medical errors, and unequal access to care.

11. The CDC notes that considerable racial disparities in pregnancy-related mortality exist. For example, during the 2011-14 period, the pregnancy related mortality ratios were:

- 12.4 deaths per 100,000 live births for white women;
- 40.0 deaths per 100,000 live births for black women; and
- 17.8 deaths per 100,000 live births for women of other races.

12. Based on information from codes DHS uses to categorize different groups of MA enrollees, the administration estimates that, annually, of approximately 18,800 pregnant women who are enrolled in MA, approximately 6,500 women lose MA eligibility after the two-month post-partum period ends. The rest reside in households with income less than 100% of the FPL, so they remain eligible for MA coverage. DHS does not maintain information on the number of women who are disenrolled from MA each month because they reside in households with income that exceeds 100% of the FPL so it is not known if or when the women who are initially eligible for MA at the end of their post-partum coverage lose coverage.

13. The administration estimates that the average per member per month cost of providing post-partum MA coverage for these women is \$352, based on historical costs of providing services to pregnant women, and making adjustments for costs that the MA program does not incur following delivery, such as maternity "kick" payments (supplemental payments the MA program provides to HMOs to cover costs of maternity care, which are excluded from capitation payments). The enrollment and average cost estimates used by the administration appear reasonable.

14. Based on these estimates, the administration calculated the 2020-21 annualized increase in MA costs by multiplying the estimated number of women by the average cost per woman and the number of additional months per year that coverage would be extended (\$352 per woman per month x 10 months x 6,500 women = \$22,880,000). The administration then applied a 58% FMAP rate to obtain the GPR and FED funding amounts (\$9,609,600 GPR and \$13,270,400 FED). Based on the current estimates of FMAPs in the 2020-21 (59.55%), the cost of the Governor's proposal is reestimated to be \$9,225,000 GPR and \$13,625,000 FED in 2020-21. Consequently, GPR funding in the bill could be reduced by \$354,600 GPR in 2020-21 and FED funding could be increased by a corresponding amount to reflect a reestimate of the FMAP available to support the cost of this item [Alternative 1].

15. An alternative methodology could be used to estimate the costs of the proposal, based on a phase-in of these costs. If a waiver were approved and effective July 1, 2020, as assumed by the administration, in July, 2020 the first group of women who would otherwise lose MA coverage would instead retain that coverage in July (one-twelfth of the estimated 6,500 women (542) who would otherwise lose MA eligibility). In August, 2020, a second group of 542 women would retain coverage, while coverage would continue for the first group. This monthly cost increase would continue until April, 2021, when the costs of the extension would be fully phased in. Based on this methodology, funding in the bill could be reduced by \$8,530,500 (-\$3,778,000 GPR and -\$4,752,500 FED) in 2020-21. Under this option, the bill would need to be modified so that the period of extended eligibility would first apply to women who would no longer be eligible for MA coverage as of June 30, 2020, or the effective date of the approved waiver, whichever date is later [Alternative 2].

Since the annualized GPR cost of this option (\$9,330,600) would not be fully funded in 2020-21, this alternative, while reducing costs in 2020-21, would increase estimates of GPR commitments in the next budget by approximately \$3.5 million in both 2021-22 and 2022-23.

16. To date, no other state has sought and received federal approval of a waiver enabling the state to extend the post-partum eligibility period for all pregnant women with MA coverage at the time of delivery.

17. Others would argue that there is no need to extend MA eligibility for postpartum women beyond the current two-month period. The current two-month period enables women to schedule a post-partum visit with their obstetrician-gynecologist, or primary care provider and to address any birth-related health conditions. Further, other programs, including the Family Foundations home visiting program, state and local health programs supported by the federal maternal and child health block grant and the state women's health block grant, are currently available to serve the health needs of post-partum women. Finally, it is not certain that the state would be successful in obtaining a waiver to implement the proposal. For these reasons, the Committee could delete the Governor's proposal from the bill [Alternative 3].

ALTERNATIVES

1. Adopt the Governor's recommendations, but reduce GPR funding by \$354,600 and increase FED funding by \$354,600 to reflect a reestimate of the FMAP available to support the cost of this item.

ALT 1	Change to	
	Base	Bill
GPR	\$9,255,000	- \$354,600
FED	<u>13,625,000</u>	<u>354,600</u>
Total	\$22,880,000	\$0

2. Modify the bill by reducing funding by \$8,530,500 (-\$3,778,000 GPR and -\$4,752,500 FED) in 2020-21. Specify that that the period of extended eligibility would first apply to women who would no longer be eligible for MA coverage as of June 30, 2020, or the effective date of the approved waiver, whichever date is later.

ALT 2	Change to	
	Base	Bill
GPR	\$5,831,600	- \$3,778,000
FED	<u>8,517,900</u>	<u>- 4,752,500</u>
Total	\$14,349,500	- \$8,530,500

3. Take no action.

ALT 3	Change to	
	Base	Bill
GPR	\$0	- \$9,609,600
FED	<u>0</u>	<u>- 13,270,400</u>
Total	\$0	- \$22,880,000

Prepared by: Charles Morgan
Attachment

ATTACHMENT

American College of Obstetricians and Gynecologists (ACOG) Recommendations

- To optimize the health of women and infants, post-partum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.
- Anticipatory guidance should begin during pregnancy and development of a postpartum care plan that addresses the transition to parenthood and well-women care.
- Prenatal discussions should include the woman's reproductive life plans, including a desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.
- All women should ideally have contact with a maternal care provider within the first three weeks postpartum. This initial assessment should be followed up with ongoing care as needed concluding with a comprehensive postpartum visit no later than 12 weeks after birth.
- The timing of the comprehensive postpartum visit should be individualized and woman centered.
- The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.
- Women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with higher lifetime risk of maternal cardio metabolic disease.
- Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders should be counseled regarding the importance of timely follow-up with their obstetrician-gynecologists or primary care providers for ongoing coordination of care.
- For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician-gynecologist or other obstetric care provider.
- Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process, rather than an isolated visit.



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May, 2019

Joint Committee on Finance

Paper #368

Family Care Direct Care Funding (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 179, #23]

CURRENT LAW

MA Long-Term Care Programs. There are two statewide programs that provide eligible elderly and disabled adult Medicaid recipients comprehensive long-term care services that are not otherwise available as MA card services. Under the state's self-directed fee-for-service program, IRIS (Include, Respect, I Self-Direct), individuals direct their long-term care supports and services through management of a designated budget amount. Under Family Care, managed care organizations (MCOs) receive monthly capitated payments from the Department of Health Services (DHS) to pay for long-term care services, based on individualized care plans that are designed to meet the needs of each enrollee.

Alternatively, adults in some counties have access to two additional, fully-integrated managed care programs, the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership (Partnership) program.

In order to receive MA funded long-term care in Wisconsin an individual must be over the age of 65, or an adult with a developmental or physical disability, in addition to meeting both financial and non-financial eligibility criteria. As of January 1, 2019, there were 48,797 people enrolled in Family Care, 3,524 people enrolled in Partnership, and 570 people enrolled in PACE.

An individual must enroll in an MCO to receive the Family Care benefit. Enrollees have access to a broad range of services, including home and community based services, and nursing home services. In addition to long-term care services, card services that may be provided through the MCO include, but are not limited to: care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit.

In some counties, individuals may enroll in an MCO to receive PACE or Partnership

services. Partnership differs from Family Care in that the program is fully-integrated and therefore provides primary and acute health care, as well as long-term care services to elderly individuals and individuals with disabilities. PACE is also a fully-integrated program. However, PACE requires that eligible individuals be 55 or older in order to enroll in the program. Table 1 shows the counties in which PACE and Partnership are available.

TABLE 1

Counties Offering Partnership and PACE

<u>Partnership Counties</u>		<u>PACE Counties</u>
Calumet	Ozaukee	Milwaukee
Columbia	Racine	Racine
Dane	Sauk	Waukesha
Dodge	Washington	
Kenosha	Waukesha	
Milwaukee	Waupaca	
Outagamie		

DHS makes capitation payments to MCOs, which are funded from a combination of GPR, federal MA matching funds, and county contributions. Capitation rates are set on a calendar year basis. Two different capitation rates are paid to each Family Care MCO: a nursing home rate, for enrollees that meet the nursing home level of care standard, and a non-nursing home rate, for enrollees that need a lower level of care.

A nursing home level of care is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance, or supervision. A non-nursing home level of care is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and he or she is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

In 2019, the monthly capitation rates for Family Care enrollees requiring a nursing home level of care ranged from \$2,537.12 to \$4,284.72 and from \$478.46 to \$538.57 for enrollees requiring a non-nursing home level of care. PACE and Partnership MCOs only serve individuals who need a nursing home level of care. In 2019, the monthly capitation rates for PACE and Partnership enrollees ranged from \$2,931.68 to \$5,643.21.

The capitation payments DHS makes to MCOs represent the average cost calculated across all members of each respective MCO in each geographic service area. These average costs reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. Capitation rates differ by MCO to reflect differences in acuity of people served by each MCO.

Direct Care Supplements to Capitation Payments. 2017 Wisconsin Act 59 provided \$60,731,800 (\$25,000,000 GPR and \$35,731,800 FED) to increase the payments DHS made to MCOs in the 2017-19 biennium in an effort to address the direct care workforce shortage. This funding was budgeted and administered as supplements, separate from the MA capitation payments MCOs received. As a condition of receiving the supplements, DHS required MCOs to pass additional funding on to providers, who in turn passed the funding on to certain direct care workers in the form of wage increases, bonuses, and additional paid time off, and to fund employer payroll tax increases that result from increasing direct care workers' wages.

As in past budgets, Act 59 provided, as part of the MA base reestimate, funding increases to ensure that DHS could establish and pay actuarially sound capitation payments to long-term care MCOs in the 2017-19 biennium.

GOVERNOR

Increase funding for Medicaid benefits by \$14,763,800 (\$6,000,000 GPR and \$8,763,800 FED) in 2019-20 and \$14,760,100 (\$6,000,000 GPR and \$8,760,100 FED) in 2020-21 to increase the supplemental payments DHS makes to MCOs in recognition of the workforce challenges facing the state.

The following table shows the total funding that would be budgeted for the direct care funding supplements in the bill, including: (a) the funding that would be provided under the MA cost-to-continue item; and (b) this item.

**Family Care Direct Care Reimbursement
Governor's Bill**

	2019-20			2020-21		
	<u>GPR</u>	<u>FED</u>	<u>Total</u>	<u>GPR</u>	<u>FED</u>	<u>Total</u>
2017-19 Increase (Part of MA Cost-to-Continue)	\$12,500,000	\$18,257,900	\$30,757,900	\$12,500,000	\$18,257,900	\$30,757,900
2019-21 Increase	<u>6,000,000</u>	<u>8,763,800</u>	<u>14,763,800</u>	<u>6,000,000</u>	<u>8,760,100</u>	<u>14,760,100</u>
Total	\$18,500,000	\$27,021,700	\$45,521,700	\$18,500,000	\$27,018,000	\$45,518,000

Under the bill, approximately \$2,207 million (\$837 million GPR, \$60 million PR, and \$1,310 million FED) in 2019-20 and \$2,323 million (\$880 million GPR, \$59 million PR, and \$1,383 million FED) in 2020-21 would be budgeted for managed long-term care services through the Family Care, PACE, and Partnership programs. Of this total, approximately \$30.8 million (\$12.5 million GPR and \$18.3 million FED) would be budgeted annually for DHS to make supplemental direct care payments to MCOs (excluding the funding increase discussed in this item).

DISCUSSION POINTS

1. In April, 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued final regulations relating to MA-funded managed care. CMS specified that capitation rates must be actuarially sound and in its commentary on the regulations, CMS reasoned that in order for capitation rates to be actuarially sound, as required by federal law, the rates must cover all reasonable, appropriate and attainable costs of providing services under the contract, including associated administrative costs. Consequently, CMS concluded that additional supplemental payments to providers that are not directly related to service delivery are not permissible.

2. Under these regulations, CMS does not allow for a direct care wage pass through. This means that modifications to the rate methodology used to establish capitation payments cannot be constructed to ensure that annual payments to a specific category of providers increase by a defined amount of funding. However, with prior approval from CMS, DHS can provide a uniform dollar or percentage increase for network providers that provide a particular service or services.

3. In response to concerns regarding workforce availability and reimbursement rates for direct care work, Act 59 included \$60,731,800 (\$25,000,000 GPR and \$35,731,800 FED) in addition to the funding provided for capitation payments. Act 59 required DHS to work with the MCOs and CMS to develop an allowable payment mechanism, using the additional funding, to increase the direct care and services portion of the capitation rates in recognition of the direct caregiver workforce challenges facing the state.

4. As such, DHS worked with the MCOs, providers, associations, and advocates between December, 2017, and February, 2018, to develop the direct care workforce funding supplement. The proposal was subsequently approved by CMS.

5. For purposes of administering the supplement, a direct care worker is defined as an employee who contracts with, or is an employee of, an entity that contracts with an MCO to provide: (a) adult day care services; (b) daily living skills training; (c) habilitation services; (d) residential care (adult family homes of 1 or 2 beds, adult family homes of 3 or 4 beds, community-based residential facilities, residential care apartment complexes); (e) respite services provided outside of a nursing home; or (f) supportive home care.

6. Additionally, a direct care worker provides one or more of the following services through direct interaction with members: (a) assisting with activities of daily living or instrumental activities of daily living; (b) administering medications; (c) providing personal care or treatments; (d) conducting activity programming; or (e) providing services such as food service, housekeeping, or transportation.

7. DHS calculates the amount of funding available by determining the specific quarterly amount each provider is eligible to receive. The quarterly amount is calculated by dividing the total funds into four quarterly amounts, one for each quarter of calendar year 2018. Next, DHS divides the amount for each quarter by the total MCO payments to direct care providers for the quarter, in order to determine the percentage increase all direct care providers will receive. Finally, DHS multiplies the percentage increase by the payments each provider received during that quarter from the MCO it

contracts with. The result is the payment amount to each provider.

8. Once DHS has calculated the amount each provider should receive, DHS pays the MCO the determined amount. The MCOs are then contractually obligated to pay providers the entire direct care workforce payment received from DHS. Subsequently, providers receive payment from each MCO contracted with during the quarter. Providers then pay their direct care workers using the entire direct care workforce funding received from MCOs.

9. Providers may use this funding to: provide wage increases, bonuses, and additional paid time off to direct care workers. Additionally, providers may pay for employer payroll tax increases that result from increasing workers' wages. Other uses of the funding are not allowed.

10. Funding is provided to the MCOs and subsequently to providers as outlined in Table 2. The final payment does not cover a set range of service dates but rather is a final payment to redistribute any funds MCOs return to DHS because providers chose not to participate.

TABLE 2

Family Care Direct Care Workforce Funding Initiative Distribution Schedule

<u>Quarterly Payment</u>	<u>Made to MCO</u>	<u>Dates of Service</u>	<u>Deadline for MCOs to Pay Providers</u>
Quarter 1	June 29, 2018	January 1–March 31, 2018	August 15, 2018
Quarter 2	September 28, 2018	April 1–June 30, 2018	October 31, 2018
Quarter 3	December 21, 2018	July 1–September 30, 2018	February 15, 2019
Quarter 4	June 28, 2019	October 1–December 31, 2018	July 31, 2019
Final	December 20, 2019		January 31, 2020

11. Providers may choose which direct care workers receive the funding, as long as the direct care worker has provided services to a Family Care and Family Care Partnership member in Wisconsin. Any direct care worker that provided services to a Family Care and Family Care Partnership member in Wisconsin may receive the funding.

12. Preliminary feedback received by DHS shows that during the second funding quarter, 52% of providers spent the additional funding on staff bonuses, 34% provided their staff with wage increases, 9% provided employee time off, and 5% spent the funds on employer payroll taxes resulting from direct care workforce payments.

13. Results of the second quarter direct care workforce funding provider survey indicate that overall, 41% of participating providers believe the direct care workforce funds have had a significant positive impact on their ability to recruit and retain workers and another 44% believe the funds have had some positive impact. 63% of participating providers reported that they could point to one or more instances in which the funding had a direct impact on their ability to recruit and retain direct care staff.

14. The main concern expressed to DHS is about the time-limited nature of the funds, which makes it difficult for MCOs and providers to commit to providing ongoing funding and wage increases that may be unfunded in future years. Since the amounts paid out for the 2017-19 initiative are not incorporated into the calculations for capitation payments in future years, funding is only available if the supplemental funding remains in the MA cost-to-continue item.

15. The Governor's budget bill would continue the funding provided for the initiative in 2017-19 and provide an additional \$14,763,800 (\$6,000,000 GPR and \$8,763,800 FED) in 2019-20 and \$14,760,100 (\$6,000,000 GPR and \$8,760,100 FED) in 2020-21.

16. DHS indicates that if funding for the direct care supplement is approved, the Department would distribute the allocated funds for 2019-21 in a substantially similar manner to the way it distributed the supplemental funding in the 2017-19 biennium. However, DHS would seek feedback from MCOs and providers before finalizing the payment mechanism.

17. A 2018 survey of long-term care providers found that: more than 50% of providers indicated they were unable to compete with other employers; 54% had no applicants for vacant caregiver positions; 83% indicated that there were no qualified applicants for caregiver openings; and 25% denied admissions to their facilities due to the lack of caregivers. This survey included skilled nursing facilities, which were not eligible for funding under the Act 59 supplemental funds, and would not be eligible for the 2019-21 funding if those funds are distributed according to the same criteria. However, the Governor's budget bill includes a separate reimbursement rate increase for direct care performed in skilled nursing facilities.

18. In response to the ongoing workforce shortage and the initial positive feedback from providers who indicate that the funding provided in the 2017-19 budget had a positive impact on their ability to recruit and retain workers, the Committee could approve the Governor's recommendation to increase funding for the direct care supplement [Alternative 1]. Based on the GPR funding increase in the bill and revised estimates of the federal medical assistance percentage (FMAP) applicable for 2020-21, it is estimated that an additional \$73,000 FED would be available to fund the direct care supplement in 2020-21. These additional federal matching funds have been incorporated into the alternatives before the Committee.

19. On the other hand, in light of the positive feedback provided by providers and the ongoing workforce shortage, the Committee could determine that the funding increase in the bill is insufficient. Consequently, the Committee could increase the GPR funding that would be provided for the supplement in the bill by \$3,000,000 GPR annually. Under this alternative, total funding would be \$22,145,700 (\$9,000,000 GPR and \$13,145,700 FED) in 2019-20 and \$22,249,700 (\$9,000,000 GPR and \$13,249,700 FED) in 2020-21 [Alternative 2]. Alternatively, the Committee could double the GPR funding that would be budgeted in the bill by providing \$29,527,600 (\$12,000,000 GPR and \$17,527,600 FED) in 2019-20 and \$29,666,300 (\$12,000,000 GPR and \$17,666,300 FED) in 2020-21 [Alternative 3].

20. Alternatively, the Committee may determine that, based on other GPR priorities, it is not necessary to increase the amount of base funding that would be provided to fund the direct care supplement in the 2019-21 biennium. Consequently, the funding increase in the bill could be deleted

(-\$30,757,900 in 2019-20 and -\$30,752,000 in 2020-21) [Alternative 4].

ALTERNATIVES

1. Approve the Governor's recommendation, as modified to provide an additional \$73,000 FED in 2020-21 to reflect a reestimate of federal matching funds to support the direct care supplement.

ALT 1	Change to	
	Base	Bill
GPR	\$12,000,000	\$0
FED	<u>17,596,900</u>	<u>73,000</u>
Total	\$29,596,900	\$73,000

2. Increase funding in the bill by \$7,381,900 (\$3,000,000 GPR and \$4,381,900 FED) in 2019-20 and by \$7,489,600 (\$3,000,000 GPR and \$4,489,600 FED) in 2020-21 to support the direct care supplement.

ALT 2	Change to	
	Base	Bill
GPR	\$18,000,000	\$6,000,000
FED	<u>26,395,400</u>	<u>8,871,500</u>
Total	\$44,395,400	\$14,871,500

3. Increase funding in the bill by \$14,763,800 (\$6,000,000 GPR and \$8,763,800 FED) in 2019-20 and \$14,906,200 (\$6,000,000 GPR and \$8,906,200 FED) in 2020-21 to double the funding that would be provided in the bill.

ALT 3	Change to	
	Base	Bill
GPR	\$24,000,000	\$12,000,000
FED	<u>35,193,900</u>	<u>17,670,000</u>
Total	\$59,193,900	\$29,670,000

4. Take no action.

ALT 4	Change to	
	Base	Bill
GPR	\$0	- \$12,000,000
FED	<u>0</u>	<u>- 17,523,900</u>
Total	\$0	- \$29,523,900

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May, 2019

Joint Committee on Finance

Paper #369

Nursing Home Reimbursement (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 179, #24]

CURRENT LAW

The Department of Health Services (DHS) reimburses nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) for services they provide to individuals who are eligible for medical assistance (MA) according to a prospective payment system that DHS updates annually. Each facility's reimbursement rate is based on five "cost centers" that reflect several factors, such as resident acuity (a measure of residents' functional abilities), and the wage rates paid within each facility's designated geographic region (labor region adjustments). MA certified facilities are provided funding under this payment system from amounts budgeted within the total MA benefits budget.

GOVERNOR

Provide \$8,676,200 (\$3,525,900 GPR and \$5,150,300 FED) in 2019-20 and \$17,757,800 (\$7,216,600 GPR and \$10,541,200 FED) in 2020-21 to increase the MA reimbursement rates paid to nursing homes and ICFs-IID.

In session law, require DHS to increase the MA rates paid for direct care to nursing facilities and ICFs-IID with a 1 percent annual rate increase related to an increase in acuity of patients in these facilities and an additional 1.5 percent annual rate increase to support staff in those facilities who perform direct care, for a total increase of 2.5 percent in 2019-20 and an additional increase of 2.5 percent in 2020-21.

Funding for the 1% annual rate increase, to offset the cost of rising resident acuity, is budgeted as part of the Medicaid cost-to-continue.

DISCUSSION POINTS

1. There are two broad categories of nursing homes in Wisconsin. The first are skilled nursing facilities (SNFs), which are institutions that provide rehabilitation services for injured, disabled, or sick individuals, as well as skilled nursing and health-related care and services to individuals who, because of their mental or physical condition, require services that can be made available to them only through residential care. SNFs primarily serve older adults and people with physical disabilities.

2. The second type of facilities are intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), which are defined in federal law as institutions, or a distinct part of an institution, that primarily provide health or rehabilitative services and active treatment services to individuals with intellectual disabilities.

3. Table 1 shows the number of MA-certified nursing homes and beds by ownership type, as of October, 2018.

TABLE 1

MA-Certified Nursing and ICF-IID Facilities (October, 2018)

<u>Facility Type</u>	<u>Number of Facilities</u>	<u>Number of Beds</u>
Skilled Nursing		
For-Profit	209	17,910
Non-Profit	106	8,375
Government	<u>50</u>	<u>4,960</u>
Total	365	31,245
ICF-IID		
For-Profit	1	8
Government	<u>6</u>	<u>527</u>
Total	7	535

4. Funding for nursing home services generally fall into three categories: private pay, Medicare, and MA. Approximately 65% of SNF patient days are covered by Medicaid, 20% are private-pay, while Medicare covers the remaining 15% of patient days. Private pay and Medicare usually pay higher reimbursement rates and help to offset the costs of providing services to MA residents. Unlike SNFs, which serve individuals on Medicare and have a significant number of private-pay residents, over 99% of ICF-IID patient days are funded by Medicaid.

5. DHS considers five "cost centers" when developing facility-specific SNF rates, including: (a) direct care; (b) support services; (c) property tax and municipal services; (d) property; and (e) provider incentives. Each facility's rate reflects several factors, such as the SNF's resident acuity and labor region adjustments. These factors, among others, may affect a SNF's costs of providing direct care services.

6. SNFs are provided funding under this payment system from amounts budgeted within

the total MA benefits budget to support MA reimbursement payments to nursing homes. Over 98% of Wisconsin Medicaid nursing home patient days fall into the SNF category.

7. There are a variety of factors currently impacting the SNF industry in Wisconsin. These factors include expanding community based long-term care options, resident acuity, the health of the larger economy, and Medicaid reimbursement rates.

8. First, across all insurance types, there has been a trend towards care recipients favoring services in home and community based settings, as well as smaller more homelike assisted living facilities. As a result, the number of SNF patient days and SNFs have decreased.

9. The number of MA fee-for-service patient days has continually decreased. As Table 2 shows, it is anticipated that the current trend will continue. SNF days are estimated to decrease by approximately 5% annually.

TABLE 2
Projected MA Fee-For-Service SNF Patient Days*

<u>Fiscal Year</u>	<u>Days</u>
2017-18	3,983,150**
2018-19	3,784,498
2019-20	3,605,596
2020-21	3,416,495

*Does not include hospice (nursing home room and board), Veterans Home, or ICF-IID (state and non-state) days.

**Actual, not projected days.

10. Table 3 shows the number of SNFs that have closed in each year between 2007-08 and 2017-18.

TABLE 3
Annual Number of SNF Closures

<u>Fiscal Year</u>	<u>Number of SNF Closures</u>
2007-08	3
2008-09	5
2009-10	3
2010-11	1
2011-12	2
2012-13	2
2013-14	4
2014-15	2
2015-16	6
2016-17	8
2017-18	<u>7</u>
Total	43

11. As shown in Table 3, a total of 43 Wisconsin SNFs have closed since 2007-08, with almost half of all facility closures during this 10-year period occurring over the past three fiscal years.

12. There are currently no MA-certified SNFs in Vilas or Menominee counties and only one MA-certified nursing home in each of Adams, Bayfield, Buffalo, Burnett, Florence, Forest, Lafayette, Langlade, Marquette, Pepin, and Waushara counties. SNF closures are especially problematic for higher needs residents and in more rural parts of the state as residents may need to be relocated far away from their communities.

13. SNF closures in smaller communities may be contributing to residents selecting inappropriate care settings in an effort to stay close family and friends, within their communities. For example residents in need of the 24-hour per day nursing services provided in a SNF may choose to live in an assisted living facility where nursing services are only available for a couple of hours each day if they can remain close to family, friends, and spouses who reside in the community.

14. Second, people receiving services in the community for as long as possible may be contributing to the increase in SNF resident acuity, as may the increase in the number of people who are living longer. According to the Council of State Governments, people age 85 and older represented about 15% of all Americans age 65 and over in 2016, by 2050 they will represent more than 20%.

15. The Congressional Budget Office reports that on average approximately one third of people over age 65 report having at least one functional limitation, compared to two thirds of people over age 85. Functional limitations are defined as physical problems that limit a person's ability to perform routine daily activities, such as eating, bathing, dressing, paying bills, and preparing meals.

16. Separate from the funding discussed in this paper, the MA cost-to-continue includes a 1% increase in the nursing home rate, for both SNFs and ICFs-IID, in 2019-20, to reflect an increase in resident acuity, and an additional 1% increase in 2020-21.

17. The third factor impacting the nursing home industry is the health of the overall economy, especially as it pertains to unemployment. According to the Bureau of Labor Statistics, Wisconsin's unemployment rates has been at or below 4% since June, 2016. As a result many facilities have difficulty recruiting and retaining staff.

18. In 2018, Wisconsin's two nursing home associations, LeadingAge Wisconsin and Wisconsin Health Care Association, along with the Wisconsin Assisted Living Association, and the Disability Service Provider Network released data from their most recent provider survey showing that one in five caregiver positions remain vacant (up from one in seven in 2016) and 20% of the state's long-term care providers report that they have denied admissions in the past year due to insufficient staffing (up from 18% in 2016). These findings include assisted living facilities for whom Medicaid funds less than 20% of patient days.

19. The final factor significantly impacting the nursing home industry as a whole is reimbursement rates. Decreasing occupancy rates and increasing resident acuity means that nursing homes have become more sensitive to adjustments to their daily reimbursement rates. Additionally, 55% of providers participating in the aforementioned provider survey said reimbursement rates do not allow for wage increases for their staff.

20. In the 2017-19 biennial budget, nursing home reimbursement rates were increased by 2% in each year of the biennium for SNFs, 1% in each year of the biennium for ICFs-IID, and an additional \$5 million all funds was provided in each year of the biennium targeted towards the behavioral and cognitive impairment (BEHCI) incentive.

21. However, DHS indicates that if wage growth for direct care workers continues at 2.5% per year, which was the average annual growth in certified nursing assistant (CNA) wages from 2013-2017, an annual 1.5% increase in the nursing home rate would be required to reimburse facilities for costs associated with wage growth in the 2019-21 biennium.

22. The Governor's budget contains a non-statutory requirement that the 1.5% reimbursement rate increase in each year of the 2019-21 biennium be put towards supporting staff who perform direct care in these facilities. The Department indicates that under this requirement funding for nursing homes could be applied to both the direct care and support services cost centers and that stakeholder input would be solicited throughout the rate development process to determine the final allocation.

23. DHS indicates that direct care wage and fringe costs represent about 60% of all SNF expenses. Generally, the direct care cost center is divided into two main categories. The first is "direct care - nursing," which includes: wages, fringe benefits, and purchased service expenses for registered nurses, nurse practitioners, licensed practical nurses, qualified intellectual disabilities personnel, certified nursing assistants, feeding assistants, nurse aide training and nurse aide training supplies.

24. The other category in the direct care cost center is "direct care - other supplies and services," which includes expenses for: ward clerks, non-billable physician time, non-billable lab, radiology, pharmacy, physical therapy, occupational therapy, speech therapy, dental, psychiatric and respiratory services, active treatment, volunteer coordinators, social service personnel, recreation personnel, religious services and other special care personnel, as well as their supplies, including purchased laundry-diapers and underpads, catheter and irrigation supplies, and other medical supplies. This category also includes certain over-the-counter drugs ordered by a physician. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident or which are not billable separately to MA, per administrative code.

25. The support services cost center, as it pertains to direct care, includes expenses for: dietary, maintenance, housekeeping, laundry, security, and transportation. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, and license fees.

26. For the reasons discussed in this paper, the Committee may wish to approve the Governor's recommendation to provide a 1.5% increase to nursing home rates in 2019-20 and an additional 1.5% in 2020-21. If the Committee wishes to adopt the Governor's proposed reimbursement rate increases, funding in the bill should be reduced by \$39,000 (-\$15,900 GPR and -\$23,100 FED) in 2019-20 and increased by \$154,700 (\$29,200 GPR and \$125,500 FED) in 2020-21, to reflect more current utilization rates and a more recent federal matching percentage (FMAP) [Alternative 1].

27. Alternatively, the Committee may determine that, in light of the numerous factors currently impacting the nursing home industry and the fact that almost as many SNFs have closed in the last three fiscal years as in the seven before that, the Governor's funding increase is insufficient to address the financial challenges facing the nursing home industry.

28. As such, the Committee could provide a 3% increase to nursing home rates in 2019-20 and an additional 3% in 2020-21. This would result in a total cost of approximately \$17,274,400 (\$7,020,000 GPR and \$10,254,400 FED) in 2019-20 and \$36,091,700 (\$14,599,500 GPR and \$21,492,200 FED) in 2020-21. Under this option, funding in the bill would be increased by \$8,598,200 (\$3,494,100 GPR and \$5,104,100 FED) in 2019-20 and by \$18,333,900 (\$7,382,900 GPR and \$10,951,000 FED) in 2020-21 [Alternative 2].

ALTERNATIVES

1. Approve the Governor's recommendation as reestimated to reflect more current utilization trends and an updated federal matching percentage for 2020-21.

ALT 1	Change to	
	Base	Bill
GPR	\$10,755,800	\$13,300
FED	<u>15,793,900</u>	<u>102,400</u>
Total	\$26,549,700	\$115,700

2. Modify the Governor's recommendation and provide a 3% increase to nursing home rates in 2019-20 and an additional 3% in 2020-21. Under this option, funding in the bill would be increased by \$8,598,200 (\$3,494,100 GPR and \$5,104,100 FED) in 2019-20 and by \$18,333,900 (\$7,382,900 GPR and \$10,951,000 FED) in 2020-21.

ALT 2	Change to	
	Base	Bill
GPR	\$21,619,500	\$10,877,000
FED	<u>31,746,600</u>	<u>16,055,100</u>
Total	\$53,366,100	\$26,932,100

3. Take no action.

ALT 3	Change to	
	Base	Bill
GPR	\$0	- \$10,742,500
FED	<u>0</u>	<u>- 15,691,500</u>
Total	\$0	- \$26,434,000

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May, 2019

Joint Committee on Finance

Paper #370

Personal Care Reimbursement Rate (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 180, #25]

CURRENT LAW

Under the state's medical assistance (MA) program, personal care services are defined as medically-oriented activities that assist MA beneficiaries with activities of daily living that are necessary to maintain the individual in his or her place of residence in the community. Personal care services can include a range of services provided to persons with disabilities and chronic conditions that enable them to accomplish activities of daily living, such as eating, bathing, and dressing, as well as other activities that permit an individual to live independently, including meal preparation, light housework, and shopping for food and clothing.

Personal care services may be paid as a state plan benefit for all MA enrollees, when such services are: (a) medically necessary; (b) authorized through a needs assessment; (c) authorized by a doctor; (d) detailed in the beneficiary's plan of care; and (e) provided by a personal care provider certified to participate in the MA program. MA recipients in nursing homes, hospitals, and community-based residential facilities with more than 20 beds are not eligible for personal care services.

GOVERNOR

Increase funding for MA benefits by \$3,330,300 (\$1,352,100 GPR and \$1,978,200 FED) in 2019-20 and \$13,421,400 (\$5,449,100 GPR and \$7,972,300 FED) in 2020-21 to increase the reimbursement rates paid to personal care agencies to support staff in those agencies who perform direct care.

In session law, require DHS to increase the MA rates paid to agencies that provide personal care services by 1.5 percent annually to support staff in those agencies who perform direct care.

DISCUSSION POINTS

1. Personal care services are budgeted within the total MA benefits budget to support MA reimbursement payments to personal care providers. Most personal care services paid by MA are paid at the fee-for-service rate.

2. The MA fee-for-service reimbursement rate for personal care services was last increased as part of the 2017-19 biennial budget act, which increased the hourly rate for personal care services by 2% in each year of the biennium. This resulted in an increase in the personal care rate from \$16.08 per hour to the current rate of \$16.73 per hour.

3. The Governor's budget would provide a 1.5% increase in the reimbursement rate on January 1, 2020, and an additional 1.5% on July 1, 2020. Under the bill, the hourly rate would increase from \$16.73 to \$16.98 on January 1, 2020, and to \$17.24 on July 1, 2020.

4. The personal care reimbursement rate is paid to personal care agencies to fund all of the agencies' costs associated with providing care, including: (a) wages and benefits for personal care workers; (b) the agencies' other direct care costs, such as nursing staff, supervisors, and travel costs; and (c) indirect costs, such as office operations and insurance costs. The Wisconsin Personal Services Association (WPSA), an industry group representing personal care agencies, estimates that personal care workers employed by its member agencies currently earn less than \$11 per hour.

5. Further, WPSA found that 84% of the personal care agencies surveyed as part of its 2018 member survey downsized in the past year and that one out of two agencies are considering no longer providing MA personal care services. 83% of the members surveyed found it difficult to fill job openings and one out of three agencies were experiencing turnover rates above 50%.

6. In 2016, Survival Coalition surveyed over 500 long-term care recipients and their families and found that 85% of long-term care recipients do not have enough direct care workers to work all of their shifts. 43% of those surveyed noted that they could not find a worker seven or more times a month. Approximately 20% of the people surveyed said they were considering moving out of their apartment or other community living arrangement due to their difficulties receiving needed direct care services.

7. Based on the current worker shortage in the industry, the Committee may wish to adopt the Governor's recommendation to increase reimbursement rates. The bill would require that the additional funding provided to personal care agencies be spent to support staff in those agencies who perform direct care. One way that the additional funding could be used to support direct care staff would be for agencies to increase compensation to their workers, thereby improving their chances of attracting new employees, while also retaining existing employees.

8. By using the most recent claims and enrollment data, it is estimated that the cost of increasing the personal care reimbursement rate by 1.5% on January 1, 2020, and an additional 1.5% on July 1, 2020, would increase MA benefits costs by approximately \$3,125,100 (\$1,272,100 GPR and \$1,853,000 FED) in 2019-20 and \$12,997,500 (\$5,273,600 GPR and \$7,723,900 FED) in 2020-21. If the Committee wishes to adopt the Governor's proposed reimbursement rate increases, funding

in the bill could be reduced by \$205,200 (-\$80,000 GPR and -\$125,200 FED) in 2019-20 and by \$423,900 (-\$175,500 GPR and -\$248,400 FED) in 2020-21 [Alternative 1].

9. If personal care agencies passed all of the Governor's recommended increase on to their workers in the form of higher wages, wages in the industry would rise only slightly. The same would be true for other forms of support provided to direct care workers since the Governor's recommendation would result in a July 1, 2020, rate that is \$0.51 higher than the current hourly rate. As such, the Committee could modify the Governor's recommendation and instead increase the reimbursement rate by 3% on January 1, 2020, and an additional 3% on July 1, 2020. Under this alternative, the hourly rate would increase from the current rate of \$16.73 to \$17.23 on January 1, 2020, and to \$17.75 on July 1, 2020.

10. A 3% rate increase would result in a total cost of approximately \$6,250,100 (\$2,544,000 GPR and \$3,706,000 FED) in 2019-20 and \$26,182,500 (\$10,623,600 GPR and \$15,558,900 FED) in 2020-21. Under this option, funding in the bill would be increased by \$2,919,800 (\$1,191,900 GPR and \$1,727,900 FED) in 2019-20 and by \$12,761,100 (\$5,174,500 GPR and \$7,586,600 FED) in 2020-21 [Alternative 2].

ALTERNATIVES

1. Adopt the Governor's recommendation to increase the MA reimbursement rate for personal care services by 1.5% on January 1, 2020, and an additional 1.5% on July 1, 2020. Reduce funding in the bill by \$205,200 (-\$80,000 GPR and -\$125,200 FED) in 2019-20 and by \$423,900 (-\$175,500 GPR and -\$248,400 FED) in 2020-21 to reflect a reestimate of the costs of Governor's proposal.

ALT 1	Change to	
	Base	Bill
GPR	\$6,545,700	- \$255,500
FED	<u>9,576,900</u>	<u>- 373,600</u>
Total	\$16,122,600	- \$629,100

2. Modify the Governor's recommendation by increasing the reimbursement rate by 3% on January 1, 2020, and an additional 3% on July 1, 2020. Increase funding in the bill by \$2,919,800 (\$1,191,900 GPR and \$1,727,900 FED) in 2019-20 and by \$12,761,100 (\$5,174,500 GPR and \$7,586,600 FED) in 2020-21.

ALT 2	Change to	
	Base	Bill
GPR	\$13,167,600	\$6,366,400
FED	<u>19,265,000</u>	<u>9,314,500</u>
Total	\$32,432,600	\$15,680,900

3. Take no action.

ALT 3	Change to	
	Base	Bill
GPR	\$0	- \$6,801,200
FED	<u>0</u>	<u>- 9,950,500</u>
Total	\$0	- \$16,751,700

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May, 2019

Joint Committee on Finance

Paper #371

Children's Long-Term Care Services (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 180, #26 and Page 192, #3]

CURRENT LAW

Statewide Application, Intake, and Screening for Children's Long-Term Care Services.

There are three state programs that provide long-term care services for children of any age: the children's long-term support (CLTS) waiver program, Katie Beckett Medicaid, and the children's community options program (CCOP).

Children's Long-Term Support. The CLTS program provides Medicaid-funded home and community-based supports and services to children with significant physical and developmental disabilities and severe emotional disturbance. All children who receive CLTS waiver services are eligible for Medicaid state plan services (generally, primary and acute care services). CLTS funds supplemental services that are not covered under the state's Medicaid (or MA) plan. As of February 28, 2019, there were 8,963 children enrolled in the program. The average monthly cost per child of these MA-funded supplemental support services is currently approximately \$1,140.

Supports and services covered by CLTS include: communication aids; adaptive aids; support and service coordination; foster care and treatment foster care; counseling and therapeutic services; daily living skills training; day services; financial management; consumer education and training; home modifications; intensive in-home treatment; housing start-up and counseling; care, support, and supervision in an adult family home; consumer and family directed supports; nursing services; respite care; personal emergency response system; specialized medical and therapeutic supplies; specialized transportation; supported employment; and supportive home care.

Katie Beckett. Katie Beckett is a special fee-for-service Medicaid eligibility category that enables certain children, under the age of 19, with long-term developmental and physical disabilities, mental illness, and complex medical needs, to live at home with their families and receive Medicaid state plan services. In order to qualify for services under the Katie Beckett program, a child must require the level of care typically provided in a hospital or nursing facility,

and must not incur a cost at home to the Medicaid program that exceeds the cost Medicaid would pay if the child was in an institution.

Children enrolled in Medicaid under the Katie Beckett eligibility criteria would not otherwise qualify for BadgerCare Plus or other elderly, blind or disabled (EBD) eligibility standards, since they may reside in households that exceed Medicaid's general income limit. As with the CLTS program, only the child's income, not the family's income, is counted in determining whether the child meets the program's financial eligibility criteria. Children can be enrolled in Katie Beckett even if they have health care coverage under their parents' private insurance plan. However, MA is always the payer of last resort.

The program is intended to enable disabled children to continue to remain with their families while they receive MA-supported services that would otherwise be available to them in nursing homes and hospitals. As of January, 2019, there were 6,616 children enrolled in Medicaid through Katie Beckett at an estimated average monthly cost of \$1,053 per member per month.

Children's Community Option Program. CCOP is a GPR-funded, county-administered program serving children with disabilities under age 22 who live in an eligible community setting and who are functionally eligible for the CLTS program, as determined by the children's long-term care functional screen. Although children served by CCOP must be functionally eligible for CLTS, they do not have to be enrolled in Medicaid to receive service coordination and assistance under the program.

CCOP has a base budget of \$11.2 million and provides a flexible source of funding for counties to assist local families in caring for their children with disabilities at home. Counties can use CCOP funding: (a) as local match for services under the CLTS waiver program; (b) to purchase goods and services for children who are ineligible for Medicaid, but who are functionally eligible for services under CCOP; (c) to purchase goods and services for Medicaid-eligible children who are not enrolled in CLTS because their long-term care needs can be met with one-time or intermittent services under CCOP; (d) for interim services for children on the CLTS waiting list; and (e) to purchase non-waiver allowable goods and services needed by CLTS enrollees.

In 2018, counties used CCOP funding to provide allowable goods and services to 2,735 children. This unduplicated count is limited to children with CCOP claims; it does not include CLTS encounters for which the non-federal share of costs are reimbursed by funds from county CCOP allocations. Considering only CCOP claims, the average monthly cost per enrollee in 2018 was approximately \$322 per month. However, since CCOP funds can cover one-time, intermittent, or ongoing service needs the actual costs used to calculate a monthly average vary significantly, based on each individual's identified service needs. As such, average CCOP monthly costs per enrollee should not be compared to average monthly enrollee costs for other long-term care programs.

Beyond completion of the children's long-term care functional screen tool, the application, intake, and eligibility process for the three programs varies by program and by the applicant's county of residence.

CLTS Program Waiting List. Under the CLTS program, counties must currently serve eligible children on a first-come, first-serve basis with the funding allocations they receive from DHS. Since children who qualify for the program are not currently entitled to receive waiver services, the state has established a waiting list for children who are not yet enrolled in the program. Children who are waiting to receive CLTS waiver services qualify for MA state plan services, which include physician, hospital, home health, and personal care services.

Currently, funding for the program is budgeted as sum certain amounts from appropriations that support other MA benefits costs. The Department of Health Services (DHS) provides counties with annual funding allocations to support CLTS waiver services.

The 2017-19 biennial budget act increased funding for the CLTS program by \$14,162,200 (\$5,847,600 GPR and \$8,314,600 FED) in 2017-18 and \$25,389,700 (\$10,420,000 GPR and \$14,969,700 FED) in 2018-19. This additional funding, in combination with program funding adjustments provided under the MA cost-to-continue item, was intended to enable the state to eliminate waiting lists for the CLTS program by the end of 2017-18. However, since the program continued to be budgeted as a sum certain allocation within the MA budget, and counties continued to receive new applications for children who qualified for services, the waiting list continued to grow in the 2017-19 biennium. As of February 28, 2019, 1,047 children were on the waiting list for CLTS services.

GOVERNOR

Statewide Application, Intake, and Screening for Children's Long-Term Care Services. Provide \$2,090,300 (\$687,800 GPR and \$1,402,500 FED) in 2019-20 and \$2,439,100 (\$874,600 GPR and \$1,564,500 FED) in 2020-21 to implement a statewide contract for children's long-term care intake, application, and screening functions. The contract would include administration of all Katie Beckett MA screens and all initial screens for the CLTS waiver program and the children's community options program.

As part of the contract, funding would be provided for: (a) five children's services navigators to help direct families to available community resources, programs, and services; (b) two children's disability resource specialists to assist families with complex or multisystem concerns experienced when seeking support for their children with disabilities; and (c) two children's disability ombudsmen to provide advocacy services for children with long-term support needs.

CLTS Program Waiting List. Create a statutory provision that would require DHS to ensure that any child who is eligible, and applies, for the CLTS waiver program receives services under the CLTS waiver program.

DISCUSSION POINTS

Statewide Application, Intake, and Screening for Children's Long-Term Care Services

1. The bill would fund several changes to the administration of children's long-term care

services. The programs impacted by these changes include CLTS, Katie Beckett, and CCOP.

2. Although financial and other program eligibility requirements differ between the three programs, under current policy every child must complete an initial screen using the children's long-term care functional screen tool to determine the child's functional eligibility for services. Beyond completion of the children's long-term care functional screen tool, which may be administered by one of 52 separate entities (51 county waiver agencies and CompassWisconsin: Threshold), the application, intake, and eligibility process for the three programs varies by program and by the applicant's county of residence.

3. In an effort to simplify the intake process, CompassWisconsin: Threshold was started as a pilot program to provide a unified point for intake, application, and eligibility determination for Katie Beckett, CLTS, and CCOP. However, the pilot was never expanded statewide and currently serves only families in Adams, Columbia, Dane, Green, Jackson, Jefferson, Kenosha, La Crosse, Lafayette, Marquette, Monroe, Ozaukee, Racine, Rock, Walworth, Washington and Waukesha counties.

4. Table 1 summarizes the current eligibility process for CLTS, CCOP, and Katie Beckett.

TABLE 1

Overview of Intake, Application, and Eligibility for Children's Long-Term Care Programs

<u>Program</u>	<u>Intake</u>	<u>Initial Assessment and Screen</u>	<u>Disability Determination</u>	<u>Renewal and Change of Condition Screen</u>	<u>Eligibility Determination</u>
CLTS	County Waiver Agency or CompassWisconsin: Threshold Consultant	County Waiver Agency or CompassWisconsin: Threshold Consultant or Katie Beckett Consultant if the family first applied for Katie Beckett, in a non-CompassWisconsin: Threshold County	N/A	County Waiver Agency	County Waiver Agency
CCOP	County Waiver Agency or CompassWisconsin: Threshold Consultant	County Waiver Agency or CompassWisconsin: Threshold Consultant or Katie Beckett Consultant if the family first applied for Katie Beckett, in a non-CompassWisconsin: Threshold County	N/A	N/A	County Waiver Agency
Katie Beckett	Katie Beckett Consultant or CompassWisconsin: Threshold Consultant	Katie Beckett Consultant or CompassWisconsin: Threshold Consultant	DHS Disability Determination Bureau	Katie Beckett Consultant or CompassWisconsin: Threshold Consultant or County Waiver Agency if child has Katie Beckett and CLTS	DHS Bureau of Children's Services Katie Beckett Eligibility Team

5. Medicaid enrollment and cost data from September, 2017, suggest that approximately 50% of children receiving CLTS services are also enrolled in Katie Beckett. For these families the multiple entry points and contacts become especially burdensome.

6. Currently, the state has a contract with Luxvida for Katie Beckett and CompassWisconsin: Threshold. However, Luxvida does not intend to continue providing these services at the end of its contract on June 30, 2019. As such, the DHS intends to establish a single point-of-entry system for children's long-term care programs, operated by a consolidated, children's long-term care intake and screening team administered by the state through a vendor contract.

7. In addition to creating a simpler intake and eligibility experience for applicants, a 2016 DHS analysis of long-term care functional screens performed for adult long-term care services found that managed care organizations with specialized units for administering the adult long-term care functional screen were the most accurate and efficient type of administering entity, when compared to screeners located at county agencies.

8. For these reasons the Committee could approve the Governor's recommendation to fund a contract for consolidated intake, application, and screening for children's long-term care services in Wisconsin [Alternative A1]. Consistent with the administration's errata, if the Committee approves any of the alternatives A1, B1, C1, or D1, funding would be provided in the appropriation that funds MA contracts, rather than MA benefits.

9. DHS estimates that a statewide consolidated intake, application, and screening team would administer approximately 7,700 children's long-term care functional screens per year in the 2019-21 biennium, including approximately 5,400 initial screens for CLTS and CCOP and 2,300 screens for the Katie Beckett program (including 700 initial screens, 1,500 recertification screens, and 100 screens due to a child's change in condition). Currently, about half of all monthly Katie Beckett renewals require updated functional screens, as determined by the child's diagnosis and other factors.

10. DHS currently estimates that a statewide intake, application, and screening team would require 23 regional certified screeners. However, the actual number of screeners a contractor would employ may depend on the responses DHS receives through the procurement process. In addition, the Department's cost estimate indicates a need for a team supervisor, a program and policy analyst, and a program coordinator.

11. Costs associated with the contract would generally be eligible for federal MA administration matching funds, equal to 50% of eligible project costs. However, DHS recently received approval to claim 75% enhanced federal reimbursement for eligibility activities directly related to completion of the children's long-term care functional screen. Table 2 below shows DHS estimates of the costs associated with the statewide intake, application, and screening contract.

TABLE 2**Estimated Intake, Application, and Screening Contract Costs**

	2019-20			2020-21		
	GPR	FED	All Funds	GPR	FED	All Funds
New Contract Cost						
Human Services Supervisor	\$66,900	\$66,900	\$133,800	\$65,600	\$65,700	\$131,300
23 Screeners	755,500	1,551,400	2,306,900	736,700	1,512,700	2,249,400
Program Coordinator	42,800	42,800	85,600	41,500	41,600	83,200
Program and Policy Analyst	56,600	56,600	113,200	55,300	55,300	110,600
Screeener Travel Costs	75,000	154,100	229,100	75,000	154,100	229,100
25% Administrative Add On	<u>249,100</u>	<u>467,900</u>	<u>717,000</u>	<u>243,500</u>	<u>457,300</u>	<u>700,800</u>
Subtotal	\$1,245,900	\$2,339,700	\$3,585,600	\$1,217,700	\$2,286,700	\$3,504,400
Offsets						
Luxvida Contract	-\$359,800	-\$738,700	-\$1,098,500	-\$359,800	-\$738,700	-\$1,098,500
CLTS Administrative Savings	<u>-441,400</u>	<u>-441,500</u>	<u>-882,900</u>	<u>-441,400</u>	<u>-441,500</u>	<u>-882,900</u>
Total Cost	\$444,700	\$1,159,500	\$1,604,200	\$416,500	\$1,106,500	\$1,523,000

12. Since procurement for a new statewide intake, application, and screening contractor cannot begin until the passage of the biennial budget act, DHS would need to seek an interim sole-source contract or in some other manner ensure services between the end date of the Luxvida contract and the new statewide contractor team being operational. For this reason, funding in Table 2 provides funding for a full 12 months in 2019-20.

13. Funding in Table 2 includes a 25% administrative "add on." DHS indicates that the additional administrative funding for payroll costs would help ensure that DHS can procure a fiscally sound contract that includes sufficient funding for a smaller-scale contractor to operate the contract.

14. However, as shown in Table 2, funding for this contract would be partially offset by the savings from not renewing the existing Luxvida contract. Additionally, county waiver agencies would also see their workload decrease as the new contract would administer all initial functional screens for CLTS and CCOP, including the approximately 4,145 screens per year currently conducted by the county agencies. To capture this reduction, DHS would reduce its current limit on total CLTS administrative expenditures from 7% to 6.2% effective July 1, 2019.

15. Counties would continue to conduct change of condition and annual renewal screens for CCOP and CLTS. Local administration of the renewal screen makes sense for these children because the CLTS support and service coordinator has monthly contact with the family. Children enrolled in CCOP also have an assigned county support and service coordinator.

16. Beyond providing a single entry-point for children's long-term care, the bill would fund a number of services currently available only to adults in the state's long-term care programs. Specifically, the bill includes funding for DHS to contract for two children's disability ombudsmen and a children's services navigator program, which would consist of five children's service navigators and two children's services resource specialists.

17. Currently, the state provides ombudsman services to adult Family Care, Partnership, and IRIS enrollees ages 18 to 59 through a contract with Disability Rights Wisconsin. Long-term care recipients ages 60 and older receive ombudsman services from the Board on Aging and Long-Term Care. However, there is currently no dedicated ombudsman program for children under the age of 18. For this reason the Committee may wish to approve the Governor's recommendation to include funding for this purpose in the contract [Alternative D1].

18. Finally, the bill includes funding to contract for a children's services navigator program, which would consist of five children's service navigators and two children's services resource specialists. The five children's services navigators would help direct the families towards the various available resources for their children with long-term support needs. The two children's services resource specialists would assist with more complex, or multi-system concerns families may experience when seeking support for their children with disabilities, including navigation and coordination of services through children's mental health programs, special education programs, vocational rehabilitation, or child welfare programs.

19. The children's services navigator program is modeled on the disability benefit specialist (DBS) program located in the state's aging and disability resource centers. The DBS program assists adults with disabilities between the ages of 18 and 59 with accessing Social Security, Medicaid, Medicare, health insurance, and other public and private benefits. For adults ages 60 and older, elder benefit specialists provide similar services. To ensure parity between the children and adult services available in the state the Committee may wish to approve the Governor's recommendation to contract for a children's services navigator program [Alternatives B1 and C1].

20. For both the children's services navigator program and the children's disability ombudsman services, the administrations estimates of number of positions needed is based on comparing children's caseload to adult caseloads and the number of positions available to provide services to the adult population. Funding for the children's disability ombudsman services and the children's services navigator program is shown in Table 3.

TABLE 3

Children's Ombudsman and Navigator Program Contract Costs

Position Type	2019-20			2020-21		
	GPR	FED	All Funds	GPR	FED	All Funds
5 Children's Services Navigators	\$132,200	\$132,200	\$264,400	\$249,000	\$248,800	\$497,800
2 Children's Resource Specialists	58,000	57,900	115,900	115,900	109,700	219,300
2 Children's Ombudsmen	<u>52,900</u>	<u>52,900</u>	<u>105,800</u>	<u>99,500</u>	<u>99,500</u>	<u>199,000</u>
Total	\$243,100	\$243,000	\$486,100	\$458,100	\$458,000	\$916,100

21. The funding amounts shown in Table 3 are based on the assumption that the children's ombudsman positions and the children's services navigator program would start providing services on January 1, 2020.

22. Like the funding for the intake, application, and screening contract, the funding shown in Table 3 includes a 25% increase over staffing costs for other administrative costs, including startup costs, that the contractor may incur in executing the contract and providing children's ombudsman and navigator services.

23. The Wisconsin Children's Long-Term Support Council notes that by connecting more children and families to existing "standard" resources, the need for more specialized and expensive services may be reduced in the future. As such, the Committee could approve the Governor's recommendation as it pertains to the intake, application, and screening procedure, as well as the children's ombudsman and children's navigator program [Alternatives A1, B1, C1, and D1].

24. However, the Committee may be concerned that the more complex the contract becomes, the harder it will be to find a vendor who can fulfill all the necessary requirements. For example, in both 2011 and 2014, Luxvida was the only vendor to submit a proposal for the Katie Beckett and CompassWisconsin: Threshold contract. For this reason the Committee could include some, of the elements in the Governor's budget recommendations [Alternatives A2, B2, C2, and D2].

CLTS Program Waiting List

25. In order to receive CLTS services, children must meet both financial and functional eligibility criteria. The functional criteria require a child to have a physical disability, developmental disability, or severe emotional disturbance, which is diagnosed medically, behaviorally, or psychologically. The impairment must be characterized by the need for individually planned and coordinated supports, treatment, or other services that permit the child to remain living in a home or community-based setting. CLTS services are available to children from birth through age 21 statewide. However, children generally transition to Family Care or IRIS upon turning 18.

26. In order to qualify for CLTS services, a child's monthly income may not exceed \$2,199 per month. When determining financial eligibility for CLTS services the child's family's income is disregarded. However, families with income greater than or equal to 330% of the federal poverty level (\$70,389 for a family of three in 2019) are required to pay a percentage of program costs on a sliding scale based on income.

27. As previously mentioned, funding for the program is currently budgeted as sum certain amounts from appropriations that support other MA benefits costs. As such, when demand for program services exceeds funding, children will be placed on a waiting list until funding becomes available. This occurs, for example, when a child receiving CLTS services "ages out" of the program and receives Family Care or IRIS services instead.

28. As shown in Table 4, in 2019-21, base funding for the program is approximately \$81.4 million (\$33.2 million GPR and \$48.2 million FED). In addition to the amounts in Table 4, counties will contribute approximately \$6.1 million annually to fund program services from state and local sources, which, like the GPR funding, is eligible for federal MA matching funds (approximately \$8.8 million). The county contribution is a maintenance of effort requirement enacted as part of the 2017-19 biennial budget.

29. The bill would require DHS to ensure that any child who is eligible, and applies, for CLTS waiver program receives services under the CLTS waiver program. The administration estimates that, including administrative costs, average monthly costs per child enrolled in CLTS is approximately \$1,140. Table 4 shows the amount the administration estimates would be necessary to provide services to 9,910 children on a monthly basis by June, 2021.

TABLE 4

CLTS Costs and Enrollment in Governor's Bill

	2019-20			2020-21		
	<u>GPR</u>	<u>FED</u>	<u>All Funds</u>	<u>GPR</u>	<u>FED</u>	<u>All Funds</u>
Base	\$33,192,500	\$48,195,400	\$81,387,900	\$33,192,500	\$48,195,400	\$81,387,900
Cost-to-Continue	<u>14,547,500</u>	<u>21,245,100</u>	<u>35,792,600</u>	<u>15,601,400</u>	<u>22,781,000</u>	<u>38,382,400</u>
Total	\$47,740,000	\$69,440,500	\$117,180,500	\$48,793,900	\$70,976,400	\$119,770,300
Estimated Enrollment as of June 30			9,780			9,910

30. However, as of February 28, 2019, there were 8,963 children enrolled in the program and 1,047 were on the statewide waiting list for services. The administration contends that the statutory change requiring DHS to ensure that eligible children who apply for CLTS services receive services would create a guarantee whereby funding for the CLTS program is no longer based on an available number of "slots," but rather is funded within the larger MA budget in the same manner that adult long-term care services and other MA card services are funded.

31. As such, DHS would no longer be permitted to create waiting lists for CLTS services. However, eligible children could still wait for certain eligible services for example based on provider availability, which is outside the county or Department's control.

32. In order to fulfill the commitment to ending the waiting list for CLTS services, and to ensure that children in the state have the same access to long-term support services as adults currently have under the Family Care and IRIS programs for whom waiting lists for waiver services have been eliminated, the Committee could approve the Governor's recommendation [Alternative E1].

33. Following the introduction of the budget bill, several groups sought clarification regarding the statutory provision in the bill. The Committee could modify the provision to more clearly indicate the administration's intent by adding a provision that specifically prohibits DHS and counties from establishing waiting lists for enrollment in the CLTS program [Alternative E2].

34. On the other hand, continuing to provide sum certain funding for CLTS services within the MA benefits appropriations maintains a measure of fiscal control on MA spending for waiver services. However, as it is difficult to accurately predict the number of children that would qualify for CLTS services, it is possible that, by maintaining current law, there may be future waiting lists for the program, notwithstanding the funding increases that would be provided in the bill [Alternative E3].

ALTERNATIVES

A. Intake, Application, and Screening

1. Approve the Governor's recommendation to provide \$1,604,200 (\$444,700 GPR and \$1,159,500 FED) in 2019-20 and \$1,523,000 (\$416,500 GPR and \$1,106,500 FED) in 2020-21 to fund intake, application and screening costs. Reduce funding in the bill for MA benefits by these amounts and increase funding for MA contracts cost by corresponding amounts.

ALT A1	Change to	
	Base	Bill
GPR	\$861,200	\$0
FED	<u>2,266,000</u>	<u>0</u>
Total	\$3,127,200	\$0

2. Take no action.

ALT A2	Change to	
	Base	Bill
GPR	\$0	- \$861,200
FED	<u>0</u>	<u>- 2,266,000</u>
Total	\$0	- \$3,127,200

B. Children's Services Navigators

1. Approve the Governor's recommendation to provide \$264,400 (\$132,200 GPR and \$132,200 FED) in 2019-20 and \$497,800 (\$249,000 GPR and \$248,800 FED) in 2020-21. Reduce funding in the bill for MA benefits by these amounts and increase funding for MA contracts cost by corresponding amounts.

ALT B1	Change to	
	Base	Bill
GPR	\$381,200	\$0
FED	<u>381,000</u>	<u>0</u>
Total	\$762,200	\$0

2. Take no action.

ALT B2	Change to	
	Base	Bill
GPR	\$0	- \$381,200
FED	<u>0</u>	<u>- 381,200</u>
Total	\$0	- \$762,200

C. Children's Resource Specialists

1. Approve the Governor's recommendation to provide \$115,900 (\$58,000 GPR and \$57,900 FED) in 2019-20 and \$219,300 (\$109,600 GPR and \$109,700 FED) in 2020-21. Reduce funding in the bill for MA benefits by these amounts and increase funding for MA contracts cost by corresponding amounts.

ALT C1	Change to	
	Base	Bill
GPR	\$167,600	\$0
FED	<u>167,600</u>	<u>0</u>
Total	\$335,200	\$0

2. Take no action.

ALT C2	Change to	
	Base	Bill
GPR	\$0	- \$167,600
FED	<u>0</u>	<u>- 167,600</u>
Total	\$0	- \$335,200

D. Children's Ombudsman Positions

1. Approve the Governor's recommendation to provide \$105,800 (\$52,900 GPR and \$52,900 FED) in 2019-20 and \$199,000 (\$99,500 GPR and \$99,500 FED). Reduce funding in the bill for MA benefits by these amounts and increase funding for MA contracts cost by corresponding amounts.

ALT D1	Change to	
	Base	Bill
GPR	\$152,400	\$0
FED	<u>152,400</u>	<u>0</u>
Total	\$304,800	\$0

2. Take no action.

ALT D2	Change to	
	Base	Bill
GPR	\$0	- \$152,400
FED	<u>0</u>	<u>- 152,400</u>
Total	\$0	- \$304,800

E. CLTS Program Waiting List

1. Approve the Governor's recommendation to include a statutory requirement that requires DHS to ensure that any child who is eligible, and applies for the CLTS waiver program receives services under the CLTS waiver program.
2. Approve the Governor's recommended statutory provision. In addition, prohibit DHS and the counties from establishing waiting lists for enrollment in the CLTS program.
3. Take no action.

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HEALTH SERVICES

Medical Assistance

LFB Summary Items for Which No Issue Paper Has Been Prepared

<u>Item #</u>	<u>Title</u>
1	Overview of Medical Assistance Funding and Enrollment
17	Telehealth Expansion
18	Dental Services for Individuals with Disabilities
19	Behavioral Health Technology -- Incentive Payments
20	Substance Abuse Hub-and-Spoke Treatment Model
21	Doula Services
22	MA Reimbursement for Clinical Consultations
27	Long-Term Care Services -- Statutory Revisions to Reflect Current Programs and Federal Requirements

LFB Summary Item Addressed in a Previous Paper

<u>Item #</u>	<u>Title</u>
13	Blood-Lead Testing -- HMO Incentives (Paper #394)

LFB Summary Items Removed From Budget Consideration

<u>Item #</u>	<u>Title</u>
3	Full Medicaid Expansion
16	Prescription Drug Copayments
28	Childless Adult Demonstration
29	Repeal Health Savings Account Program
30	MA Eligibility -- Cooperation with Child Support and Establishing Paternity
31	Joint Committee on Finance Review and Approval of Certain MA Program Changes
32	Joint Committee on Finance Review Process for Federal Waivers, Pilot Programs, and Demonstration Projects