Health Services

Medical Assistance

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June, 2021 Joint Committee on Finance Paper #335

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

[LFB 2021-23 Budget Summary: Page 250, #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 of 2021, approximately 1.33 million individuals were enrolled in full benefit or partial benefit MA programs. Of that total, approximately 1.0 million were enrolled in BadgerCare Plus and 260,000 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.

DISCUSSION POINTS

1. The MA "cost-to-continue" estimate establishes the program's budget for the upcoming biennium under a scenario in which no changes are made to program benefits, eligibility, or provider reimbursement rates. The 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. Table 1 shows the funding change to the appropriation base, by fund source, under the cost-to-continue estimate included in AB 68/SB 111.

TABLE 1

Medical Assistance Cost-to-Continue Change to Base, AB 68/SB 111

Fund	2021-22	2022-23	Biennium
GPR	$163,182,700	$483,193,800	$646,376,500
FED	1,062,244,500	702,068,300	1,764,312,800
PR	203,977,500	242,751,700	446,729,200
SEG	58,166,600	-5,073,300	53,093,300
Total	$1,487,571,300	$1,422,940,500	$2,910,511,800

3. This paper presents a cost-to-continue reestimate for the 2021-23 biennium. This estimate is generally based on updated data and projections from the Department of Health Services, but makes certain modifications to the Department's assumptions. Table 2 shows the funding adjustments made under the current cost-to-continue reestimate, expressed both as a change to the appropriation base and a change to the administration's original estimate.

TABLE 2

MA Cost-to-Continue Reestimate, By Fund Source

	Change to Base			Change to Bill		
	2021-22	2022-23	Biennium	2021-22	2022-23	Biennium
GPR	$120,307,000	$397,244,700	$517,551,700	-$42,875,700	-$85,949,100	-$128,824,800
FED	987,447,400	652,366,400	1,639,813,800	-74,797,100	-49,701,900	-124,499,000
PR	192,843,400	214,277,400	407,120,700	-11,134,100	-28,474,300	-39,608,500
SEG	61,393,500	-5,314,600	56,078,900	3,226,900	-241,300	2,985,600
Total	$1,361,991,300	$1,258,573,900	$2,620,565,100	-$125,580,000	-$164,366,600	-$289,946,700

4. The following sections of this paper provide a discussion of the significant assumptions underlying the cost-to-continue estimate.

Federal Matching Rate

5. The federal medical assistance percentage (FMAP) determines the respective share of Medicaid program costs that will be covered with federal and state funds. The FMAP is determined under a formula based on the state's per capita personal income over the previous three years in relation to the nationwide per capita income. Over the past several years, the FMAP has generally been between 58% and 60%, meaning that the state's share of costs has been between 42% and 40%. However, a provision of the federal Families First Coronavirus Response Act (FFCRA), which was passed in March of 2020, provides a temporary 6.2 percentage point increase to the state's FMAP,

applicable for any quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. Thus, in federal fiscal year 2020-21, while the standard FMAP would have been 59.4%, the enhanced FMAP under FFCRA is 65.6%, reducing the state's share from 40.6% to 34.4%. This increase also affects the applicable matching percentage for the Children's Health Insurance Program (CHIP), since the Medicaid FMAP is the basis for the CHIP formula. In federal fiscal year 2020-21, the enhanced CHIP FMAP is 75.9%, up 4.3 percentage points from the standard CHIP FMAP of 71.6%.

6. A key assumption for the cost-to-continue estimate, as it relates to the state's FMAP, is the duration of the federal public health emergency, since this will determine how many additional quarters the FFCRA enhanced FMAP will be in effect. CMS has told states to expect the public health emergency will remain until at least the rest of calendar year 2021. Based on this notice, the administration's cost-to-continue estimate assumed that the enhanced FMAP will expire at the end of calendar year 2021, meaning that the standard FMAP would be applicable in the final six months of state fiscal year 2021-22 and all of 2022-23. While it is possible that the public health emergency will be extended further, there would be considerable risk in making this assumption for the purposes of establishing the GPR budget for MA. Thus, the estimate presented in this paper adopts the same assumption as the administration's estimate for the expiration of the enhanced FMAP.

7. Table 3 shows the FMAP projections, along with the corresponding state share percentage, used for the cost-to-continue estimate. For the purposes of this table, both the Medicaid and CHIP rates are shown on a state fiscal year basis, which are blended rates for the corresponding federal fiscal years. For both 2020-21 and 2021-22, these rates reflected the effect of enhanced FMAP provided under the FFCRA.

TABLE 3

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

State Fiscal Year	Title 19 (Most MA Services)	Title 21 (Children's Health Insurance Plan)
2020-21		
State	34.44%	21.23%
Federal	65.56	78.77
2021-22		
State	37.15%	26.00%
Federal	62.85	74.00
2022-23		
State	39.68%	27.77%
Federal	60.32	72.23

8. For the purposes of the reestimate presented in this paper, the federal share percentage for 2022-23 has been increased by 0.38 percentage points, relative to the administration's budget

assumption. This increase to the FMAP is based on the most recent estimates developed by the Federal Funds Information for States (FFIS), using new population data from the 2020 U.S. Census and personal income data from the Bureau of Economic Analysis (BEA). FFIS notes that the 2022-23 FMAP is subject to revision, as the impacts of COVID-19 relief legislation on state personal income are not fully incorporated into BEA's figures. The final FMAP for that year will be released in the fall.

MA Program Enrollment

9. The total funding increases under this cost-to-continue estimate, $1,362.0 million in 2021-22 and $1,258.6 million in 2022-23 (all funds basis), are significantly higher than in recent biennia. By comparison, the cost-to-continue increase for the 2021-23 budget was $208.2 million in 2019-20 and $633.9 million in 2020-21. The primary reason for the larger adjustment is higher program enrollment due to the effects of the COVID -19 pandemic. Enrollment in full benefit MA eligibility categories is now expected to be approximately 25% higher at the end of the 2019-21 biennium than the projections used to set the Act 9 appropriations. Thus, a significant portion of the 2021-23 cost-to-continue estimate are adjustments to the appropriation base to reflect a higher enrollment baseline.

10. While program enrollment has perhaps the greatest impact on the cost-to-continue estimate, it is also the component subject to the greatest uncertainty. Since some of the conditions currently affecting the program are unique, past enrollment patterns may not be a reliable guide for projecting future enrollment.

11. Enrollment in MA, and in particular BadgerCare Plus, typically increases in response to the job and income losses caused by economic recession, and the contraction caused by the COVID-19 pandemic was particularly rapid. Nationally, the inflation adjusted GDP declined year-over-year by 9.0% in the second quarter of 2020, the largest recorded decrease in at least 70 years. There was a net loss of 18.2 million jobs in the first few months of pandemic, representing over 15% of pre-pandemic employment. These job losses resulted in loss of household income and employ-sponsored health care coverage, leading many to enroll in medical assistance coverage.

12. In addition to the direct impact of job losses on MA enrollment, the program has also been affected by enrollment and eligibility provisions of federal COVID-19 legislation. As a condition of receiving the enhanced FMAP during the COVID-19 public health emergency, states are generally not permitted to disenroll any person who was enrolled at the time of the passage of the Act or who subsequently enrolls in the program. Similar with the enhanced FMAP, this so called "continuous enrollment" requirement lasts for the duration of the public health emergency, in this case until the end of the month that the federal declaration expires.

13. One feature of the enrollment patterns in MA during normal periods is the regular movement on and off of the program, as some individuals lose eligibility and others are newly enrolled. This enrollment "churn" occurs in part because MA eligibility is based on monthly income, rather than annual income levels, so individuals whose income varies throughout the year may move above and below the eligibility threshold. This churning pattern has changed with the continuous enrollment provision since individual who may become eligible during a period of low income will

not be disenrolled if they begin to earn more. The continuous enrollment provision, which was intended to provide a stable source of coverage for low income individuals during the pandemic, means that enrollment can only grow over time, even as the economy improves.

14. To illustrate the enrollment patterns for different eligibility groups during the 2019-21 biennium, Table 4 compares monthly enrollment for major eligibility categories in July of 2019 with enrollment in April of 2020, along with the percentage change.

TABLE 4

MA Enrollment Comparison by Major Eligibility Category

Category	July, 2019	April, 2021*	Pct. Change
EBD	239,852	260,829	8.7%
BC+ Children	453,449	529,484	16.8
Parents	160,163	209,626	30.9
Childless Adults	149,587	235,699	57.6
Pregnant Women	19,931	28,268	41.8
Foster Children	20,890	24,063	15.2

* Due to the potential for retroactive adjustments, the enrollment figures for April, 2021 are subject to change slightly.

15. Although enrollment can only grow while the continuous enrollment period is in effect, the rate of growth has slowed over time. This suggests that there are fewer individuals among those not already enrolled who are experiencing circumstances that lead to new enrollment, including job or income losses, or health issues that lead them to seek coverage (for those who were already eligible but not enrolled). To illustrate with an example, childless adult enrollment grew by an average of 9,800 per month during the final quarter of 2019-20 (April to June of 2020), but has grown by an average of about 3,500 per month recently.

16. Because the regular process of eligibility redetermination has been suspended since March of 2020, the Department is not able to determine the precise share of those currently enrolled that would not meet eligibility requirements if not for the continuous enrollment provision. Upon completion of the continuous enrollment period, Wisconsin income maintenance agencies will begin the process of redetermining eligibility of all individuals currently enrolled. While CMS has provided some guidance for states, it is generally expected that these procedures will be changed or further refined as the end of the public health emergency draws to a close. One of the key issues to be determined is the length of time states will have to complete the eligibility review for all individuals enrolled. Based on current guidance, this period is expected to last at least six months, but could be extended to one year for the purpose of balancing the renewal caseload going forward.

17. Going forward into the 2021-23 biennium, the key factors that will determine the caseload can be summarized as follows: (a) the rate that enrollment continues to grow during the remainder of the continuous enrollment period; (b) the share of those enrolled upon the termination

of the continuous enrollment period who are determined to be no longer eligible; (c) the length of time needed to complete redetermination; and (d) the underlying trends and balance between individuals who become eligible and individuals who lose eligibility.

18. Regarding disenrollment, the administration's estimate assumes that the share of the caseload that will lose eligibility will vary, depending upon the characteristics of the group. For instance, for childless adults, which is the category that has seen the most growth and is typically subject to a high degree of enrollment churn, it is assumed that one-quarter of the caseload at the conclusion of the public health emergency will eventually be disenrolled. Parents and children are subject to less churn, and so the percentage of the caseload subject to disenrollment is assumed to be lower, at about 19% and 12%, respectively. Because the EBD Medicaid eligibility groups have relatively little churn and so have not been as affected by the continuous enrollment provision, the administration assumes that only about 5% will be subject to disenrollment.

19. The administration assumes that the eligibility redetermination process will occur over a 12-month period, spanning calendar year 2022. However, the rate of disenrollment is expected to be higher in the first few months after the conclusion of the public health emergency, reflecting an assumption that the redetermination process will prioritize individuals who are most likely to be found ineligible for continued coverage.

20. Along with this disenrollment, the administration's estimate makes assumptions regarding the normal process of enrollment and disenrollment for individuals who become newly eligible and those, due to a change in income or other circumstance, are no longer eligible. The administration's caseload estimate makes different assumptions about the net effect of these underlying trends depending on the eligibility group and timing. During the first six months of the biennium, the continuous enrollment provisions will remain in effect, and so the caseload growth is generally expected to be similar to recent growth rates. Beginning in calendar year 2022, the underlying caseload trends will differ by broad program category. For elderly, blind, and disabled groups, the growth rates are assumed to be 2.5% annually for elderly enrollees, 1.5% annually for disabled adults, and 1.0% for disabled children. These rates were generally based on prior trends, although are slightly higher than the growth rates that prevailed in the years prior to the pandemic. For BadgerCare Plus groups, the administration assumed that the underlying growth rates would match the patterns seen in the years following the Great Recession. While that recession had the greatest impact on employment and earnings in 2008 and 2009, the Department notes that the caseload continued to grow throughout 2010 and into the first months of 2011. Thus, the underlying growth rate is estimated at 5.7% in 2021-22, matching the calendar year 2010 growth rate, and 2.0% in 2022-23, matching the growth rate in 2011.

21. The effect of the disenrollment process that will occur upon the expiration of the public health emergency is expected to outweigh the underlying caseload growth rate. Thus, the total caseload is projected to decline throughout 2022, before growing again, at a slower rate, in the final six months of the biennium (the first six months of 2023).

22. The estimate presented in this paper generally accepts the administration's updated projections and assumptions, but with two modifications that have the effect of slightly lowering caseload estimates. First, the growth rates used for BadgerCare Plus groups for the remainder of the

continuous enrollment period are reduced slightly, to more closely match the lower rate of growth seen in recent months for those categories. Second, instead of assuming that the underlying growth rate for BadgerCare categories will be the same as caseload growth seen 2010 and 2011, the reestimate assumes a slightly slower underlying grow rate. This revision is warranted primarily because the current economic forecasts project a more rapid recovery than was the case following the 2009 recession. The major relevant indicators, such as unemployment rate and employment-to-population ratio are already closer to pre-pandemic levels than was the case in 2010 and 2011, following the 2009 recession.

23. The attachment to this paper shows the average monthly caseload estimates used for the cost-to-continue reestimate, for the major eligibility groups. To illustrate how enrollment changes over time, these averages are shown for each calendar quarter, beginning in the first quarter of 2021 and continuing through the second quarter of 2023 (the end of the 2021-23 biennium). The annualized rate of change is also shown for each quarter.

Enrollment and Utilization Projections for Long Term Care Programs and Services

24. In addition to overall caseload projections, the cost-to-continue estimate takes into consideration enrollment in MA's long term care programs, such as Family Care and IRIS, as well as nursing home utilization by individuals not enrolled in Family Care. Collectively, these programs typically account for around 40% of MA costs, and so trends in these program can have a significant bearing on the cost-to-continue budget.

25. DHS estimates that average monthly enrollment in Family Care will be approximately 51,100 in 2020-21 (a 0.5% increase from 2019-20 enrollment), and increase to approximately 52,400 in 2021-22 and 53,700 in 2022-23 (increases of 2.7% and 2.5% over the prior year, respectively). For IRIS, the Department estimates that average monthly enrollment will be approximately 22,000 in 2020-21 (a 10.1% increase from 2019-20 enrollment), and increase to approximately 23,900 in 2021-22 and 25,800 in 2022-23 (increases of 8.5% and 7.9% over the prior year, respectively). The percentage increases anticipated for both Family Care and IRIS are lower than actual increases in previous years potentially due to the gradual elimination of the waiting list for elderly, blind, and disabled adults to receive long-term care services. The waiting list, as it pertains to adults seeking home and community based long-term care services, was eliminated in the spring of 2021. The re-estimate as described in this paper adopts the Department's assumptions regarding enrollment in both Family Care and IRIS.

26. The Department indicates the Medicaid program has experienced a long-term trend of declining nursing home utilization, driven by two underlying factors: (1) a reduction in the total number of individuals using nursing home services over time and (2) a decrease in the average length of a nursing home stay. Specifically, DHS projects that the monthly average census of Medicaid fee-for-service nursing home residents will decline from around 8,400 in 2020-21 to 7,800 by 2021-22 and 7,100 by 2022-23. As such, total fee-for-service patient bed days are anticipated to decline by 8.2% in 2020-21, 8.1% in 2021-22, and 8.2% in 2022-23.

27. While DHS has historically estimated that 17% of nursing home patient days are attributable to managed care that trend has been updated, based on the decrease in fee-for-service

patient days and the increase in long-term managed care enrollment, resulting in an associated increase in nursing home services utilization under managed care. DHS indicates that in 2019-20, it is estimated that 38% of nursing home patient days were attributable to managed care. This percentage is expected to increase to approximately 43% in 2020-21, 49% in 2021-22, and 55% in 2022-23. The reestimate as described in this paper adopts the Department's assumptions regarding nursing home utilization in the 2021-23 biennium.

28. As of May, 2021, there are 12,928 children enrolled in the children's long term support (CLTS) waiver program. The administration's cost-to-continue estimate assumes that enrollment in the program will increase to 13,822 by June, 2022, and 14,542 by June, 2023. Both the 2017-19 and 2019-21 budgets included funding to eliminate waiting lists for the program. However, since funding for the program has continued to be budgeted as a sum certain allocation within the larger MA budget, and the number of children eligible to receive CLTS services has continued to grow, there are still children on the waiting list for CLTS services. The Department's cost-to-continue estimate provides sufficient funding to eliminate the waiting list for CLTS services as it exists in May, 2021. However, as with previous budgets, if the number of children applying, and found eligible, for CLTS services continues to increase, there could still be children on the waiting list at the end of the 2021-23 biennium. In order to eliminate this possibility the Governor's recommendation included a statutory provision to require DHS to ensure that any child who is eligible, and applies, for the CLTS waiver program receives services under the CLTS waiver program. [This statutory change is discussed in a separate budget paper].

Fee-for-Service Utilization and Managed Care Capitation Rates

29. Typically the cost-to-continue estimate relies on recent trends in claims data by service category and eligibility group to estimate service utilization for the upcoming biennium. However, the Department believes that recent claims data are not a reliable basis for making estimates for the 2021-23 biennium. The COVID-19 pandemic likely affected the use of many medical services during the past year in various ways, meaning that these data are unlikely to be representative of utilization moving forward. Moreover, the composition of the caseload in recent months likely differs from the expected future caseload in ways that affect the average type and quantity of services used. For this reason, the administration has relied on utilization data from 2019, prior to the disruptions resulting from COVID-19 pandemic, as the basis for utilization estimates. Given the lack of more recent reliable data, this approach likely represents the best approximation of future utilization and the estimate presented in this paper uses the same average cost data as the Department's updated estimate.

30. The administration's cost-to-continue 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.

31. Normally, MCO monthly capitation rates are based, in large part, on service utilization data from prior years. However, the projections for MA HMO capitation rates for the next few years, particularly for acute care services, will be subject to the same uncertainties as fee-for-service utilization projections, due to the COVID-19-related disruptions occurring during the past year.

Likewise, the average medical need of the expanded caseload in 2020 and 2021 may differ from what the needs the caseload in a typical year. To account for uncertainties, the Department established a risk corridor provision in the 2021 HMO contract. Under this provision, the state will pay a portion of an HMO's costs that exceed the expected costs by at least 2.0% and HMOs will pay back a portion of their gains if costs are below expectations by at least 2.0%.

Federal Medicare Premiums and Part D Clawback

32. 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 is based on projections for these premiums included in the most recent report of the Medicare Trustee. Growth in the number of dually eligible assumes growth in these costs based on recent trends. Since no more recent projections are available, the reestimate presented in this paper does not change the administration's estimates.

33. 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. The reestimate is based on the most recent projections of clawback formula adjustments from FFIS, as well as estimates of changes to per capita drug costs included in the Medicare Trustee's report.

Summary

34. 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.

35. While there is typically some degree of uncertainty in MA budget estimates, the 2021-23 budget period presents particular challenges because the factors that drive program enrollment and health care utilization are difficult to predict in the wake of the COVID-19 pandemic. The estimate presented here largely rests on the assumption that economic conditions will improve as the country emerges from the economic recession caused by COVID-19, although with some lingering effects on low income and medically needy households.

CONCLUSION

The following table presents the funding changes to the 2020-21 appropriations under the cost-to-continue estimate.

MA Costs-to-Continue Reestimate

	Change to Base		
	2021-22	2022-23	Biennium
GPR	$120,307,000	$397,244,700	$517,551,700
FED	987,447,400	652,366,400	1,639,813,800
PR	192,843,400	214,277,400	407,120,700
SEG	61,393,500	-5,314,600	56,078,900
Total	$1,361,991,300	$1,258,573,900	$2,620,565,100

Prepared by: Jon Dyck
Attachment

ATTACHMENT

Actual and Projected Monthly Average Enrollment by Calendar Quarter for Major Full Benefit MA Groups

	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2201 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2
EBD Medicaid	248,094	249,948	254,359	257,992	260,964	*264,576*	*267,557*	*270,310*	*267,619*	*264,881*	*262,767*	*262,102*	*262,866*	*264,215*
Children	452,791	473,757	493,723	509,986	522,881	*532,180*	*540,081*	*547,323*	*533,099*	*520,297*	*507,451*	*499,702*	*498,442*	*499,887*
Parents	160,018	174,803	187,258	197,164	205,337	*211,640*	*216,757*	*221,289*	*211,585*	*202,339*	*193,592*	*188,296*	*187,058*	*187,519*
Childless Adult	154,174	176,998	196,640	214,615	229,220	*238,583*	*246,262*	*253,144*	*238,020*	*223,236*	*209,672*	*201,524*	*199,465*	*199,957*
Pregnant Women	19,169	20,844	23,581	25,491	27,152	*28,579*	*29,701*	*30,718*	*27,918*	*25,096*	*22,687*	*21,288*	*20,905*	*20,949*
Foster Children	20,763	21,161	22,038	22,873	23,518	*24,287*	*24,886*	*25,416*	*25,258*	*25,000*	*24,769*	*24,656*	*24,675*	*24,748*

Annualized Percentage Change by Calendar Quarter, Actual and Projected

	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2201 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2
EBD Medicaid	2.6%	3.0%	7.2%	5.8%	4.7%	*5.7%*	*4.6%*	*4.2%*	*-3.9%*	*-4.0%*	*-3.2%*	*-1.0%*	*1.2%*	*2.1%*
Children	0.3%	19.8%	18.0%	13.8%	10.5%	*7.3%*	*6.1%*	*5.5%*	*-10.0%*	*-9.3%*	*-9.5%*	*-6.0%*	*-1.0%*	*1.2%*
Parents	-0.2%	42.4%	31.7%	22.9%	17.6%	*12.9%*	*10.0%*	*8.6%*	*-16.4%*	*-16.4%*	*-16.2%*	*-10.5%*	*-2.6%*	*1.0%*
Childless Adults	8.8%	73.7%	52.3%	41.9%	30.1%	*17.4%*	*13.5%*	*11.7%*	*-21.8%*	*-22.6%*	*-22.2%*	*-14.7%*	*-4.0%*	*1.0%*
Pregnant Women	-4.2%	39.8%	63.8%	36.5%	28.7%	*22.7%*	*16.6%*	*14.4%*	*-31.8%*	*-34.7%*	*-33.2%*	*-22.5%*	*-7.0%*	*0.8%*
Foster Children	-0.1%	7.9%	17.6%	16.0%	11.8%	*13.7%*	*10.2%*	*8.8%*	*-2.5%*	*-4.0%*	*-3.6%*	*-1.8%*	*0.3%*	*1.2%*

Note: Beginning in the second quarter of 2021, the enrollment figures and annualized percentage changes reflect the projections used for the cost-to-continue estimate. These figures are italicized.

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June, 2021 Joint Committee on Finance Paper #336

Nursing Home Reimbursement (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 256, #4]

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.

In 2019-20, the average MA payment rate to nursing homes was $191.11 per day, excluding the state centers and the veterans homes. Of that amount, patient liability accounted for $36.47 (19.1%) and MA payment accounted for $154.64 (80.9%). Rate increases discussed in this paper do not apply to the patient liability portion of the MA payment rate.

In 2020 and 2021, nursing homes incurred significant costs in providing care for individuals with COVID-19. During this period, many nursing homes faced increased costs relating to staffing and personal protective equipment. In addition, nursing homes saw declining occupancy rates, in part due to hospitals performing less elective procedures earlier in the pandemic (resulting in fewer discharges to skilled nursing facilities) and in part due to guidelines surrounding restricted nursing home admissions when a suspected or confirmed case of COVID-19 was identified in a facility.

Recent federal legislation has provided financial assistance to states, and directly to nursing homes and other health care providers, to fund costs related to the COVID-19 pandemic. The attachment to this paper provides a brief summary of some of the main sources of federally-funded financial assistance the state's nursing homes have received to support these costs. However, this

paper addresses ongoing, MA-supported reimbursement to nursing homes in the 2021-23 biennium.

DISCUSSION POINTS

1. There are two broad categories of nursing homes in Wisconsin. The first type 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. 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.

2. As of February, 2021, there were 363 licensed nursing homes, with a total of 28,297 licensed nursing home beds, in Wisconsin. Of these, 341 facilities, or approximately 94% of all facilities, were Medicaid certified providers. In addition, there were four ICFs-IID (excluding the three state centers) in Wisconsin, with a total of 94 licensed ICF-IID beds. All ICFs-IID in Wisconsin are certified to participate in the Medicaid program.

3. According to the Department of Health Services (DHS) during the seven-year period from 2007-08 through 2014-15, an average of three nursing homes closed per year in Wisconsin. However, DHS indicates that since 2015-16 annual closures accelerated, as 47 nursing homes closed from 2015-16 through 2019-20. The number of licensed nursing home beds in the state decreased by 5,250 from 2015-16 through 2019-20.

4. The Medicaid program has experienced a long-term trend of declining nursing home utilization, which is largely due to two underlying factors: (1) a reduction in the total number of individuals using nursing home services over time and (2) a decrease in the average length of a nursing home stay. DHS projects that the monthly average census of Medicaid nursing home residents that receive services on a fee-for-service basis (not through managed care) will decrease from approximately 12,580 in 2015-16 to 7,130 by 2022-23.

5. DHS indicates that since 2012, the nursing home industry has experienced significant restructuring in terms of payer mix. In 2012, 45 facilities received Medicaid reimbursement for 80% or more of total resident days, with those facilities accounting for 17% of total Medicaid resident days that year. In 2018, however, only six facilities received Medicaid reimbursement for 80% or more of total resident days, with those facilities accounting for only 2% of total Medicaid resident days.

6. Medicaid payments to certified facilities are funded as part of the total Medicaid benefits budget. However, due to the decline in nursing home bed days and a decrease in overall occupancy rates of nursing homes, when rate increases have been provided as a percentage of base funding, the nursing home industry has typically received less than the amounts budgeted for rate increases as actual utilization has decreased at greater rates than budget projections.

7. To address the gap between the budgeted amount and the expended amount, 2019 Act 9 (the 2019-21 biennial budget act) provided nursing homes with a sum certain GPR increase, as well as the corresponding federal matching percentage (FMAP) in each year of the biennium. Specifically, 2019 Act 9 provided $15.0 million GPR in 2019-20 and $15.0 million GPR in 2020-21, to increase Medicaid payments to nursing homes, equivalent to a fee-for-service rate increase of approximately 5.9%, as well as a 1.0% cost-to-continue funding adjustment relating to resident acuity.

8. 2019 Act 9 also contained a session law provision that directed DHS to use the additional reimbursement funding to support staff in those facilities who provide direct care. As such, the Department applied 58.7% to the direct care nursing cost center, 10.0% to the direct care other supplies and services cost center, and 31.2% to the support services cost center. ("Cost centers" are components of the total MA reimbursement nursing homes receive.)

9. Direct care nursing services include the services of registered nurses, nurse practitioners, licensed practical nurses, resident living staff, feeding staff, nurse's assistants, nurse aide training, and training supplies. The direct care other supplies and services cost center includes: personal comfort supplies; medical supplies; over-the-counter drugs; and the non-billable services of a ward clerk, activity person, recreation person, social workers, volunteer coordinator, certain teachers or vocational counselors, religious persons, therapy aides, and counselors on resident living. The support services cost center includes dietary services, maintenance, transportation, housekeeping, laundry, security services, fuel and utility costs, and administrative and general costs.

10. However, despite the rate increase provided in 2019 Act 9, the average Medicaid fee-for-service nursing home daily rates do not fully fund the daily nursing home service costs for Medicaid recipients.

11. Assembly Bill 68/SB 111 would provide $78,288,100 ($29,084,000 GPR and $49,204,100 FED) in 2021-22 and $163,689,900 ($65,574,200 GPR and $98,115,700 FED) in 2022-23 to increase MA reimbursement for nursing home services, including services provided on a fee-for-service basis, through managed care, and hospice room and board services. The administration estimates that this funding would increase the average Medicaid fee-for-service nursing home daily rate by 11.5% in 2021-22 and an additional 11.7% in 2022-23. DHS indicates that this increase would make nursing home reimbursement rates more consistent with current per diem reimbursement rates for psychiatric, long-term acute care, and rehabilitation hospitals, for which MA covers approximately 86% of total costs [Alternative 1].

12. Alternatively, the Committee could consider several alternatives to the reimbursement proposal contained in AB 68/SB 111, as shown in the following table.

Nursing Home Rate Increase Alternatives
2021-23

	2021-22			2022-23		
	GPR	FED	Total	GPR	FED	Total
Alt. 2 (3%/3%)	$7,618,700	$12,889,900	$20,508,600	$16,182,700	$24,602,900	$40,785,600
Alt. 3 (5%/5%)	12,697,800	21,483,200	34,181,000	27,236,900	41,408,800	68,645,700
Alt. 4 (15%/15%)	38,093,400	64,449,500	102,542,900	85,696,600	130,286,300	215,982,900

13. The percentage increases in the table are calculated based on an increase in each year of the upcoming biennium. For example, if the Committee selected Alternative 2, those amounts are based on a 3% increase on July 1, 2021, and an additional 3% increase on July 1, 2022. However, funding amounts included in the table are based on current estimates of (declining) patient bed days. If actual patient bed days decrease more than the current projections, the total cost of reimbursement payments may be less than the amounts budgeted. Conversely, if actual patient bed days exceed current estimates, the total cost of reimbursement payments may be more than the amounts budgeted.

14. In addition to nursing homes admitting fee-for-service Medicaid residents, Family Care and PACE/Partnership managed care organizations also contract for nursing home services, and hospice providers contract with nursing homes for room and board services. As such, fee-for-service nursing home rate increases also increase Medicaid managed long-term care and hospice costs.

15. Historically, DHS has estimated that 17% of nursing home patient days are attributable to managed care and an additional 4% to hospice care. However, based on the decrease in fee-for-service patient days and the increase in long-term managed care enrollment, resulting in an associated increase in nursing home services utilization under managed care, these estimated percentages have been updated. In 2019-20, 38% of nursing home patient days were paid by managed care organizations, rather than on a fee-for-service basis. DHS expects this percentage to increase to approximately 43% in 2020-21, 49% in 2021-22, and 55% in 2022-23.

16. As to hospice care, previous estimates of the percentage of nursing home patient days attributable to these services should be updated. Specifically, DHS estimates that for 2021-22 and 2022-23, 9.3% of nursing home patient days will be attributable to hospice care. For Medicaid enrollees receiving hospice services while in a nursing home, per diem rates for hospice nursing home room and board are reimbursed to the hospice provider at a rate equal to 95% of the nursing home rate, net of resident cost-share. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

17. For these reasons, any funding increase provided by the Committee under Alternative 1, 2, 3, or 4 would be applied to nursing home services provided on a managed care and fee-for-service basis, as well as hospice days.

18. Additionally, each of the four alternatives presented in this paper and the corresponding funding estimates are based on the assumption that average rates paid to the four non-State Center ICFs-IID in the state would be increased by the same percentage as the one selected by the Committee

for skilled nursing facilities. However, due to the much more limited number of ICF-IID beds in the state it is estimated that less than 2% of the biennial all funds estimates provided will fund an increase in the ICF-IID rate.

19. Policies adopted under the federal Families First Coronavirus Response Act (FFCRA) provide a temporary 6.2 percentage point increase to the state's federal matching rate (FMAP), applicable for any quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. Based on communication from the federal Department of Health and Human Services, the 6.2 percentage point increase under provisions of FFCRA is expected to be in effect for the first six months of the 2021-23 biennium. For this reason, the alternatives presented in the previous table assume an FMAP of 62.85% in 2021-22 and 60.32% for 2022-23.

20. In addition, the Committee may wish to include a non-statutory provision to require that the rate increase, or a portion of the rate increase, selected under Alternative 1, 2, 3, or 4 be allocated to support staff in those facilities who perform direct care in light of the ongoing staffing shortages in the facilities [Alternative 5].

21. Specifically, a 2020 survey of long-term care providers found that of the long-term care providers surveyed nursing homes were experiencing registered nurse and licensed practical nurse vacancy rates of nearly 22%. Additionally, across assisted living facilities and nursing homes, nearly 50% of respondents indicated that they were unable to compete with non-healthcare employers; more than one in three providers reported not getting a single application for available caregiver positions; 70% said there were no qualified applicants for caregiver openings; and one in two said they could not increase wages because of inadequate Medicaid and Family Care reimbursement.

22. On the other hand, the Committee may wish to allow the Department to determine where best to allocate the additional funding without a recommendation from the Committee. Historically, DHS has worked with providers in identifying the greatest areas of needed funding as part of the state's development of its nursing home reimbursement methodology it submits annually to the Centers for Medicare and Medicaid Services (CMS). As such, the Committee would select the desired rate increase from Alternative 1, 2, 3, or 4, with no additional session law provision directing the allocation of the increase.

23. Finally, the Committee may choose to take no action on this item [Alternative 6].

ALTERNATIVES

1. Provide $78,288,100 ($29,084,000 GPR and $49,204,100 FED) in 2021-22 and $163,689,900 ($65,574,200 GPR and $98,115,700 FED) in 2022-23 to increase MA reimbursement rates paid to nursing homes by 11.5% on July 1, 2021, and by an additional 11.7% on July 1, 2022.

ALT 1	Change to Base
GPR	$94,658,200
FED	147,319,800
Total	$241,978,000

2. Provide $20,508,600 ($7,618,700 GPR and $12,889,900 FED) in 2021-22 and $40,785,600 ($16,182,700 GPR and $24,602,900 FED) in 2022-23 to increase to increase MA reimbursement rates paid to nursing homes by 3% on July 1, 2021, and by an additional 3% on July 1, 2022.

ALT 2	Change to Base
GPR	$23,801,400
FED	37,492,800
Total	$61,294,200

3. Provide $34,181,000 ($12,697,800 GPR and $21,483,200 FED) in 2021-22 and $68,645,700 ($27,236,900 GPR and $41,408,800 FED) in 2022-23 to increase to increase MA reimbursement rates paid to nursing homes by 5% on July 1, 2021, and by an additional 5% on July 1, 2022.

ALT 3	Change to Base
GPR	$39,934,700
FED	62,892,000
Total	$102,826,700

4. Provide $102,542,900 ($38,093,400 GPR and $64,449,500 FED) in 2021-22 and $215,98,900 ($85,696,600 GPR and $130,286,300 FED) in 2022-23 to increase to increase MA reimbursement rates paid to nursing homes by 15% on July 1, 2021, and by an additional 15% on July 1, 2022.

ALT 4	Change to Base
GPR	$123,790,000
FED	194,735,800
Total	$318,525,800

5. Direct the Department to increase the Medical Assistance rates paid for direct care to skilled nursing facilities and ICFs-IID by the amount selected in Alternative 1, 2, 3, or 4, or a portion of such amount, to support staff in those facilities who perform direct care.

6. Take no action.

Prepared by: Alexandra Bentzen
Attachment

ATTACHMENT

Federal Legislation to Support Nursing Homes' One-time COVID-Related Costs

During the COVID-19 pandemic, nursing homes have been eligible for various sources of federal funding. Most significantly, of the $1.99 billion provided to Wisconsin through the Coronavirus Aid, Relief, and Economic Security (CARES) Act Coronavirus Relief Fund (CRF) nursing homes received approximately $105.6 million in direct payments from DHS. These payments were distributed through the CARES Act Provider Payment (CAPP) program and the skilled nursing facility post-acute care admission incentive program. Additionally, nursing homes received testing support and personal protective equipment funded through the CRF.

Under the CAPP program, specific health care provider types could apply for funds to offset COVID-19-specific losses and expenses they incurred between March and August, 2020. Funding under this program was distributed in two main rounds. Round 1 was intended to cover the period from March through May, with any potential payments offset by other CARES Act payments including loans from the payroll protection program. Round 2 was intended to cover the period from June through August, and was not offset by other CARES Act payments received by providers. Between the two rounds, a total of $75.6 million was paid to nursing homes under this program.

The second DHS direct payment program targeted at nursing homes was the post-acute care admission incentive program. This program offered a $2,900 payment for every admission a nursing home received directly from a hospital, covering admissions between the last two weeks of October and until all funds were expended or through December 30, 2020, whichever was earlier. DHS indicated that the intent of the program was to increase the number of staffed nursing home beds that can accept hospital discharges. In total $30 million was paid to nursing homes under this program, which was the total amount set aside for this program.

Beyond payments directly from the state, some nursing homes may have, applied and, been eligible for payments directly from the federal government. Examples of such funding include the CARES Act provider relief fund payments directly from the U.S. Department of Health and Human Services and payroll protection program loans from the federal Small Business Administration.

The federal CARES Act provider relief fund payments were distributed in a number of issuances, some general and some targeted to specific provider types. It is not known how much of the funding distributed under the general distribution rounds went to nursing homes. However, of the approximately $7.4 billion targeted to nursing homes, facilities in Wisconsin received $135,336,850. Additionally, nursing homes were eligible to receive funding through the Nursing Home Quality Incentive program. Under this provision, approximately $1.9 billion was provided to reward nursing homes that created and maintained safe environments for their residents. Of this amount, Wisconsin nursing homes received a total of $57,288,048.

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June, 2021 | Joint Committee on Finance | Paper #337

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

[LFB 2021-23 Budget Summary: Page 257, #6]

CURRENT LAW

Long-Term Care Programs. In order to receive long-term care services under the state's medical assistance (MA) program, an individual must be at least 65 years old, or be an adult with a developmental or physical disability, and meet both financial and non-financial eligibility criteria.

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.

Family Care 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: 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.

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. 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 the acuity of people served by each MCO.

Direct Care Workforce Funding Initiative. In federal regulations issued by the Centers for Medicare and Medicaid Services (CMS), CMS specified that MA capitation rates must be "actuarially sound." In its commentary on the regulations, CMS reasoned that in order to meet this requirement, MA capitation rates must cover all reasonable, appropriate, and attainable costs of providing services under the contract, including associated administrative costs.

CMS requires states and their actuaries develop MA capitation rates in a manner that complies with federal law, regulations, and policy. The CMS guidance addresses special contract provisions, such as incentive and withhold arrangements between the state and the MCOs, and delivery systems MCOs may use in contracts with their provider networks. However, CMS guidance restricts states' ability to fund "pass through" payments as part of MCOs' capitation payment. 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. 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.

In 2017 Act 59, DHS was directed to develop and implement an allowable payment mechanism to provide additional funding to certain providers, separate from the capitation rates. The result of that law was the creation of the direct care workforce funding supplement to address concerns regarding direct care staff recruitment and retention.

Funding provided for the direct care workforce funding supplement is separate from funding provided as part of the MA base reestimate, to ensure that DHS establishes and pays actuarially sound capitation payments to long-term care MCOs.

DISCUSSION POINTS

1. 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. For 2019-21, the definition of direct care worker was expanded to include supported employment service providers.

2. Additionally, a direct care worker provides one or more of the following services through direct interaction with enrollees: (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.

3. DHS calculates the amount of funding available to each direct care provider by dividing the amount for each payment by the total MCO payments to direct care providers, 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 from the MCO it contracts with. The result is the payment amount to each provider.

4. However, since participation is voluntary, some providers may decline the funding. Payment amounts fluctuate based on the available pool of funding for each payment. Redistribution payment amounts are significantly less than other payment amounts since this funding pool is limited to ineligible and declined funding from the original payment pool. For 2019-21, eligible providers received four rounds of payments (two in calendar year 2020 and two in calendar year 2021), as well as two rounds of redistributive funding composed of unspent funds from calendar year 2018 and 2019.

5. 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 covered time period. Providers then pay their direct care workers using the entire direct care workforce funding received from the MCOs.

6. Starting with payments in 2020, providers have six months to distribute each payment to workers and may claim expenditures made in the prior 12 months as appropriate uses of the direct care workforce funding.

7. 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. Some allowable COVID-19 direct care workforce expenses include, but are not limited to, additional paid time off, hazard pay, increased overtime, and increased weekend and night differentials. Other uses of the funding are not allowed.

8. Providers may choose which direct care workers receive the funding, as long as the direct care worker has provided services to a Family Care or Partnership participant in Wisconsin. Any direct care worker, as previously defined, that provided services to a Family Care or Partnership participant in Wisconsin may receive the funding.

9. According to data for calendar year 2018, the most recent year for which DHS has

finalized survey data, more than a third of Family Care direct care workforce supplemental funding has been allocated to increase compensation for direct care workers. An additional fifteen percent of funds were allocated to taxes and benefits for the workforce, with the remaining half allocated to bonuses associated with recruitment, retention, and performance.

10. MCOs are contractually obligated to participate in the program, while participation is optional for providers. DHS indicates that MCOs are supportive of the funding generally, but indicate the existing payment process is administratively burdensome. Providers have been very supportive of the program, with 89% of responding providers indicating some or significant positive impact from the direct care workforce payments, and 71% of responding providers attributing one or more instances of staff retention to the direct care workforce supplement.

11. The Department calculates the payments for MCOs to issue to providers and MCOs subsequently provide proof of the checks issued under the program. Based on that reporting, the Department indicates that 96% of all checks and 98% of all funding that DHS directed MCOs to pay were issued to providers. The remaining payments were not issued for a variety of reasons, with the largest category being that MCOs are waiting for providers to return the signed provider agreements or the agreement was never returned.

12. Table 1 shows the funding that was provided as part of 2017 Act 59 (the 2017-19 biennial budget act), and the funding increase provided in 2019 Act 9 (the 2019-21 biennial budget act). Actual payments under the provision vary from the funding in Table 1 due to changes in the state's federal matching rate (FMAP) between the time of the budget and the time of implementation.

TABLE 1

Direct Care Reimbursement

	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
2017 Act 59 Budgeted Funding	$12,500,000	$17,773,700	$30,273,700	$12,500,000	$17,958,100	$30,458,100
2019 Act 9 Budgeted Increase	12,000,000	17,527,600	29,527,600	15,000,000	22,082,800	37,082,800
Total	$24,500,000	$35,301,300	$59,801,300	$27,500,000	$40,040,900	$67,540,900

13. Despite funding for this initiative in both 2017 Act 59 and 2019 Act 9, a 2020 survey of long-term care providers found that direct care staff recruitment and retention is an ongoing issue. Specifically, the report notes: an increase in caregiver vacancies from 19% in 2018 to 23.5% in 2020; caregiver vacancy rates in excess of 30% for adult family homes; and one in three providers limiting admissions due to caregiver vacancies. This survey included skilled nursing facilities, which have not been eligible for funding under the direct care workforce funding supplement. However, recent budgets have included separate reimbursement rate increases for direct care performed in skilled nursing facilities to address similar concerns for those providers.

14. In recognition of the ongoing worker shortage and the positive feedback and high

participation from providers, the Committee could provide additional funding for the Department to increase the funding distributed to providers under the supplement. The Department indicates its intent is to administer any additional funding provided under this provision in a substantially similar manner to funding previously provided and distributed through the direct care workforce funding supplement. Table 2 presents a number of alternatives available to the Committee in choosing how much additional funding to provide for the direct care workforce funding initiative.

TABLE 2

Family Care Direct Care Reimbursement

	2021-22			2022-23		
	GPR	FED	Total	GPR	FED	Total
Alternative 1	$10,000,000	$16,917,900	$26,917,900	$10,000,000	$15,201,600	$25,201,600
Alternative 2	15,000,000	25,376,900	40,376,900	15,000,000	22,802,400	37,802,400
Alternative 3	20,000,000	33,835,800	53,835,800	20,000,000	30,403,200	50,403,200

15. Policies adopted under the federal Families First Coronavirus Response Act (FFCRA) provide a temporary 6.2 percentage point increase to the state's federal matching rate, applicable for any quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. Based on communication from the federal Department of Health and Human Services, the 6.2 percentage point increase under provisions of FFCRA is expected to be in effect for the first six months of the 2021-23 biennium. For this reason, the alternatives presented in Table 2 assume an FMAP of 62.85% in 2021-22 and 60.32% for 2022-23.

16. The American Rescue Plan Act (ARPA), increased the federal matching rate for Medicaid home and community based services (HCBS) spending by 10 percentage points from April 1, 2021, through March 31, 2022, provided that states maintain state spending levels as of April 1, 2021. If CMS determines that the direct care workforce funding initiative as implemented in Wisconsin is an allowable activity on which the state can claim the enhanced FMAP, additional federal matching funds, beyond those shown in Table 2, could be available to the state.

17. ARPA specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. States have until March 31, 2024, to spend the enhanced funds. CMS guidance regarding the ARPA provision, released on May 13, 2021, confirms that the enhanced funds must be used for activities "beyond what is available under the [state's] Medicaid program as of April 1, 2021." States are not allowed to use the additional federal funds to supplant existing state funds.

18. Alternatively, the Committee may determine that, it is not necessary to increase the amount of base funding that would be provided to fund the direct care supplement in the 2021-23 biennium, for which the GPR amounts are shown in Table 1 [Alternative 4].

ALTERNATIVES

1. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 1	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

2. As in AB 68/SB 111, provide $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,802,400 ($15,000,000 GPR and $22,802,400 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 2	Change to Base
GPR	$30,000,000
FED	48,179,300
Total	$78,179,300

3. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 3	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

4. Take no action.

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June, 2021 Joint Committee on Finance Paper #338

Personal Care Reimbursement (Health Services - Medical Assistance)

[LFB 2021-23 Budget Summary: Page 258, #7]

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.

The MA program covers personal care services only if all of the following apply: (a) they are medically necessary; (b) these are authorized through an independent assessment; (c) they are authorized by a doctor certified to participate in the state's MA program; (d) they are detailed in the beneficiary's plan of care; and (e) the services are 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.

Personal care services can be paid either on a fee-for-service basis as a state plan benefit or through one of the state's long-term care programs. For Family Care participants needing personal care services, such services are part of the enrollees care plan and thus paid by the managed care organization. Under the current contracts, Family Care MCOs are required to pay the MA fee-for-service rate or less for state plan services, unless the MCO determines, on an individualized basis, that the MCO is unable to acquire the service at the fee-for-service rate. For IRIS (the state's alternative to managed care), participants needing personal care services can do so either through MA-certified providers, in which case the agency receives the fee-for-service rate, or by self-directing their personal care services. If the participant chooses to self-direct his or her personal

care services, he or she can hire, train, and oversee their own personal care workers.

As of January 1, 2020, the MA rate for personal care services is $4.79 per 15 minute increment billed, or $19.16 an hour.

DISCUSSION POINTS

1. Often, personal care workers are employed by a personal care agency. There are currently 313 personal care agencies certified by the DHS Division of Quality Assurance, of which 280 have also completed Medicaid certification. The hourly Medicaid personal care reimbursement rate of $19.16 is paid to personal care agencies to fund all of their costs associated with providing care for Medicaid participants, including wages and benefits for personal care workers; the agencies' other direct care costs, such as nursing staff, supervisors, and travel costs; and indirect costs, such as office operations and insurance costs.

2. According to survey results from 300 direct support professionals released by the Wisconsin Personal Services Association (WPSA), Wisconsin Long Term Care Workforce Alliance, Survival Coalition of Wisconsin Disability Organizations, and InControl Wisconsin in November, 2020, the median direct care worker wage is $12.73 per hour. That same survey showed that more than half of respondents work a second job in order to support themselves or their families, and nearly 75% of respondents said they would stay in their direct care position if there were consistent bonuses or pay increases.

3. According to the Governor's Task Force on Caregiving "the diminishing provider network in rural areas is evidenced by the fact that 24 of Wisconsin’s 72 counties have five or fewer personal care provider agencies." If agencies continue to close, consumers in rural locations could be left with fewer options for receiving care that allows them to live at home. Further, a WPSA April, 2021, workforce survey of more than 120 personal care agencies found that 95% of responding personal care agencies turned away a client in the past year because no personal care worker was available.

4. In order to prevent the closure of additional personal care agencies, to increase retention and recruitment of personal care workers, and to ensure personal care services are accessible to individuals across the state, the Committee could choose to increase the reimbursement rates provided to personal care agencies. Medicaid reimbursement rates are particularly important for personal care agencies, many of whom rely on Medicaid as their primary revenue source. In a WPSA membership poll, of the 62 responding agencies, 40 agencies (64.5%) said that 90-100% of their revenue is from Medicaid, and an additional 13 agencies (21%) said that 80-90% of their total revenue is from Medicaid.

5. Assembly Bill 68/Senate Bill 111 would provide $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,443,800 ($15,000,000 GPR and $22,443,800 FED) in 2022-23 to increase MA personal care reimbursement rates and require DHS to increase MA rates paid for direct care to agencies that provide personal care by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments, in 2021-22, and by a budgeted sum of

$15,000,000, as the state share of payments, and the matching federal share of payments, in 2022-23, to support staff in those agencies who perform direct care.

6. The following table provides the funding amounts necessary to increase the reimbursement rate for personal care by 3%, 5%, and 10% in each year of the 2021-23 biennium.

Personal Care Rate Increase Alternatives
2021-23, By Funding and Hourly Rate

	2021-22				2022-23			
	GPR	FED	Total	Hourly Rate*	GPR	FED	Total	Hourly Rate**
Alt. 1 (3%/3%)	$2,844,200	$4,245,000	$7,089,200	$19.73	$8,867,100	$13,479,400	$22,346,500	$20.32
Alt. 2 (5%/5%)	4,740,300	7,075,000	11,815,300	20.12	14,875,100	22,612,600	37,487,700	21.13
Alt. 3 (10%/10%)	9,480,500	14,149,900	23,630,400	21.08	30,233,400	45,959,600	76,193,000	23.19

* As of January 1, 2022
** As of January 1, 2023

7. The amounts in the table above are based on the assumption that the increase be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services.

8. Further, the estimated amounts assume that the rate increase would take effect January 1, 2022, and January 1, 2023. This is because managed care rates and contracts are set each calendar year, which means a January 1 implementation date allows for the rate increases to be incorporated into the Department's annual Family Care contracts without requiring retroactive adjustments. Additionally, the Department has previously indicated that retroactive adjustments for self-directed personal care provided to IRIS participants is very difficult.

9. The American Rescue Plan Act (ARPA), increased the federal matching rate for Medicaid home and community based services (HCBS) spending by 10 percentage points from April 1, 2021 through March 31, 2022, provided that states maintain state spending levels as of April 1, 2021. If CMS determines that personal care services as provided in Wisconsin are an allowable activity on which the state can claim the enhanced FMAP, additional federal matching funds, beyond those shown in the previous table, could be available to the state.

10. ARPA specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. States have until March 31, 2024 to spend the enhanced funds. CMS guidance regarding the ARPA provision, released on May 13, 2021, confirms that the enhanced funds must be used for activities "beyond what is available under the [state's] Medicaid program as of April 1, 2021." States are not allowed to use the additional federal funds to supplant existing state funds.

11. As in AB 68/SB 111, the Committee may wish to include a session law provision to require that the rate increase selected under Alternative 1, 2, or 3 is directed to support staff in the personal care agencies who perform direct care [Alternative 4].

12. Finally, in light of competing budget priorities, the Committee may choose to take no action on this item [Alternative 5].

ALTERNATIVES

1. Provide $7,089,200 ($2,844,200 GPR and $4,245,000 FED) in 2021-22 and $22,346,500 ($8,867,100 GPR and $13,479,400 FED) in 2022-23 to increase hourly rates paid for personal care services to $19.73 on January 1, 2022, and to $20.32 on January 1, 2023.

ALT 1	Change to Base
GPR	$11,711,300
FED	17,724,400
Total	$29,435,700

2. Provide $11,815,300 ($4,740,300 GPR and $7,075,000 FED) in 2021-22 and $37,487,700 ($14,875,100 GPR and $22,612,600 FED) in 2022-23 to increase hourly rates paid for personal care services to $20.12 on January 1, 2022, and to $21.13 on January 1, 2023.

ALT 2	Change to Base
GPR	$19,615,400
FED	29,687,600
Total	$49,303,000

3. Provide $23,603,400 ($9,480,500 GPR and $14,149,900 FED) in 2021-22 and $76,193,000 ($30,233,400 GPR and $45,959,600 FED) in 2022-23 to increase hourly rates paid for personal care services to $21.08 on January 1, 2022, and to $23.19 on January 1, 2023.

ALT 3	Change to Base
GPR	$39,713,900
FED	60,109,500
Total	$99,823,400

4. Direct the Department to increase the Medical Assistance rates paid for direct care to agencies that provide personal care services by the percentage selected in Alternative 1, 2, or 3 to support staff in those agencies who perform direct care.

5. Take no action.

Prepared by: Alexandra Bentzen

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June, 2021 Joint Committee on Finance Paper #339

Disproportionate Share Hospital Payments (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 260, #10]

CURRENT LAW

Wisconsin's medical assistance (MA) program reimburses hospitals for services they provide to MA recipients through several mechanisms that vary depending upon the type of hospital. Specialty hospitals, including psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals, receive a hospital-specific daily rate, tied to a percentage of their average costs. General medical/surgical (GMS) hospitals receive a base payment for services provided, but may also receive supplemental payments. Base payments for GMS hospitals 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. Base payments also depend on whether a GMS hospital qualifies as a critical access hospital, meaning it has fewer than 25 beds and is typically located in a rural area or far from other general hospitals.

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.

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. For each qualifying hospital, the DSH payment is calculated using an add-on percentage, multiplied by the hospital's base inpatient payment for services provided on a fee-for-service (FFS) basis. The add-on percentage is determined by the share of a hospital's patient days that are attributable to MA, such that those hospitals with a higher proportion of MA patients generally

have a higher add-on percentage. However, the maximum payment that a hospital may receive in a year is subject to a cap, which results in some hospitals receiving an add-on percentage that is lower than it would otherwise be based on MA inpatient utilization alone.

By statute, DHS is required to allocate $27,500,000 GPR annually for DSH payments, although the 2019-21 biennial budget act, as modified by partial veto, temporarily increased the state share of payments. Under the corresponding state plan approved by the federal Medicaid authority, the state share of DSH payments during 2019-21 was set at $47,500,000 each year. Since this increase applies only during the 2019-21 biennium, the state allocation will return to $27,500,000 in 2021-22 and thereafter.

The state receives federal matching funds on the state funds allocation, so the total amount of DSH payments is determined by the applicable federal matching rate. In the 2019-21 biennium, in addition to the increase in the state share of payments, the total amount distributed was also affected by a temporary 6.2 percentage point increase to the state's federal matching rate under provisions of the federal Families First Coronavirus Response Act of 2020. This increase, which first applied in January of 2020 and will remain in effect through at least the end of the 2019-21 biennium, has the effect of increasing total payments since the state share remains fixed. With the combination of the temporary increase to the amount of state funds allocated for payments and the COVID-19-related increase to the federal contribution rate, total DSH payments (state and federal funds) increased from $67.7 million in 2018-19 to $127.5 million in 2019-20 and $132.7 million in 2020-21.

The maximum DSH payment that any one hospital may receive is capped. By statute, the DSH cap is set at $4.6 million, but to account for the temporary increase in the state funds allocation the cap was temporarily increased to $7.95 million by the 2019-21 budget act. However, the Department adjusted this cap to $8.67 million in 2019-20 and to $9.02 million in 2020-21 to account for the higher total payment resulting from the temporary increase to the federal matching rate.

DISCUSSION POINTS

1. Because the increase in the state share of DSH payments provided by the 2019-21 budget was temporary, the $20,000,000 GPR provided for this portion of the payment is not included in the GPR appropriation base for the 2021-23 biennium. Therefore, maintaining the same level of state funding for DSH payments in the 2021-23 biennium would require an increase to the base. Assembly Bill 68/Senate Bill 111, conditioned on the adoption of full Medicaid expansion, would provide $20,000,000 GPR annually to maintain the total state funding allocation at $47,500,000, and would establish this amount as the ongoing, annual statutory allocation. The federal matching funds associated with this GPR increase would be estimated at $33,835,800 FED in 2021-22 and $29,925,100 FED in 2022-23. The bill would establish the maximum DSH payment at $7,950,000.

2. Hospital payments, including both base payments and supplements, account for one of the largest expenditures categories in MA. Through the combination of base reimbursements and supplements, MA paid approximately $2.0 billion on an all funds basis for hospital services in 2019-20, excluding the state mental health institutions. Base rate reimbursements made up approximately

59% of this total, access payments accounted for 33%, DSH payments contributed 6%, and other supplements made up the remaining 2%.

3. MA reimbursement impacts the overall fiscal health of hospitals, which varies widely between facilities in the state. The Wisconsin Hospital Association reports that the median operating margin (the difference between income and expenses, expressed as a percent of income) for hospitals in 2019 was 5%, although 40 hospitals (out of 152 in the state) reported negative margins and some reported significantly higher margins, in excess of 10%. In 2012 the median operating margin was also approximately 5%, although it grew to a peak of almost 8% in 2015 before declining back to the current level.

4. Sustaining negative operating margins for several years may cause hospitals to close or reduce their capabilities. Data compiled by the University of North Carolina Cecil G. Sheps Center shows that 180 rural hospitals have closed nationwide since 2005, and that the rate of closures is increasing, although only one has closed in Wisconsin (Franciscan Skemp Medical Center in Arcadia). A nationwide study published in *Health Affairs* in June, 2020, reports that median profit margins for non-profit critical access hospitals improved from 2.5% in 2011 to 3.2% in 2017, while median profit margins for non-CAH non-profit hospitals decreased from 3.0% to 2.6%. Profit margins decreased for for-profit hospitals as well over the study period.

5. The COVID-19 pandemic and response have also impacted hospital's finances. The Epic Health Research Network documented a 30% drop in hospital admissions nationwide in March and April of 2020, with patient volume returning to approximately normal by July. A second, smaller, dip brought admissions down to 15% below pre-pandemic levels in January and February of 2021. One factor contributing to this trend, the postponement of elective and non-emergent procedures, had particularly large impact on hospital revenues, since these are typically profitable. COVID-19 precautions also necessitated that hospitals make changes to procedures, facilities, and supplies such as personal protective equipment. The Wisconsin Hospital Association estimates that COVID-19 resulted in approximately $2.5 billion in losses for hospitals in the state. The pandemic has affected different hospitals differently, and the Kaiser Family Foundation reports some share of hospitals nationwide have remained profitable.

6. Several state and federal programs have provided funding to hospitals intended to offset these losses. The federal provider relief fund, created by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and expanded by subsequent legislation, has provided $1.99 billion to 5,429 healthcare providers in Wisconsin as of May, 2021, including hospitals. Wisconsin businesses have also received $14.26 billion in forgivable loans under the paycheck protection program; nationally, healthcare providers received approximately 13% of these loan funds, per the Kaiser Family Foundation. The Wisconsin Hospital Association estimates that hospitals will receive a total of $1.2 billion in federal COVID-19 aid from these and other sources.

7. At the state level, the administration allocated $44 million to hospitals out of the approximately $2.0 billion received by the state under the federal coronavirus relief fund (CRF) program. This comprised $4 million allocated to the Medical College of Wisconsin and the remaining $40 million distributed to other hospitals in proportion to their share of combined inpatient and outpatient Medicaid revenue compared to other facilities around the state, offset by certain other relief

payments. Distribution of these relief payments by the state began in mid-July, 2020.

8. Several different points of comparison offer useful measures of the adequacy of MA hospital payments. These benchmarks include the rates paid by Medicare, the actual costs incurred by hospitals to provide care to MA patients, and the rates paid by commercial insurers. MA payments are lower than each of these.

9. Including all supplements, MA reimbursed hospitals at approximately 90% to 95% of the rates paid by Medicare in 2019, although a direct comparison is difficult given the significant differences in the enrolled populations and mix of procedures between the two programs. Nationwide, this relationship is reversed, with Medicaid programs paying on average slightly more than Medicare (about 103%) in 2019, per the American Hospital Association.

10. 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.

11. 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.

12. 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, the Wisconsin Hospital Association estimates that MA hospital payments cover approximately 66% of hospital costs attributable to MA patients (including a proportionate share of capital and fixed costs). 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.

13. 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 publicly-funded programs, such as Medicaid and Medicare, tend to have lower reimbursement rates than private insurance, putting 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 reduce this imbalance.

14. The Department adjusts hospital base reimbursement rates annually based on a hospital inflation index. The cost of these rate increases, along with anticipated changes in hospital service utilization, are reflected in the MA cost-to-continue reestimate. Increases to the DSH payment have been provided as separate budgetary decisions, outside of this base reimbursement rate adjustment. The following table shows funding provided by DSH payments since 2013-14, when the current

program was first established.

Disproportionate Share Hospital Payments by Fiscal Year and Fund Source
($ in Millions)

Fiscal Year	GPR	FED	Total
2013-14	$15.0	$21.9	$36.9
2014-15	15.0	21.9	36.9
2015-16	15.0	21.0	36.0
2016-17	15.0	21.5	36.5
2017-18	27.5	39.3	66.8
2018-19	27.5	40.2	67.7
2019-20	47.5	80.0	127.5
2020-21	47.5	85.2	132.7

15. Because the GPR portion of the DSH payments is fixed by statute (or nonstatutory provision), the total amount of the payment varies with changes in the federal matching rate. With the temporary increase in the matching rate provided under federal COVID-19 relief legislation, total DSH payments were higher in the 2019-21 biennium than they otherwise would have been, by approximately $10.5 million in 2019-20 and $14.6 million in 2020-21.

16. Because the enhanced federal matching rate is expected to continue through at least the end of calendar year 2021, the total DSH payment in 2021-22 will also be higher than it would be with the standard matching percentage. With a return to the state's standard matching rate, and with a state share set at $47.5 million per year (as proposed by the Governor), total DSH payments would be approximately $118 million to $120 million per year.

17. While hospitals have benefited from a higher DSH payment due to the enhanced federal matching rate, most hospitals have likely experienced an increase in the proportion of their patients who are enrolled in MA, as opposed to commercial insurance, during the COVID-19 pandemic. Total enrollment in full benefit MA eligibility groups has increased by approximately 250,000 since the beginning of the 2019-21 biennium, which is equivalent to just over 4% of the state's population. The shift from commercial insurance to MA coverage likely has affected hospital revenues.

18. Of the 152 hospitals in Wisconsin, 89 qualified for DSH payments in 2020-21 and 63 hospitals, with an MA inpatient percentage below 6.0%, did not qualify. For the hospitals that did qualify, the MA inpatient percentage varies widely. For 58 of the qualifying hospitals, MA patients accounted for less than 16% of total inpatient days, 33 hospitals had an MA percentage between 16% and 36%, and for three hospitals in Milwaukee County MA patients accounted for between 52% and 55% of patient days (Ascension St. Joseph's, Aurora Sinai Medical Center, and Children's Hospital of Wisconsin). The table below shows the distribution of hospitals by their MA share of inpatient days, and the total DSH payments made to the hospitals in each interval.

Distribution of 2020-21 DSH Payments by Share of MA Inpatient Days

MA Share of Inpatient Days	Number of Hospitals	Total DSH Payments
0.0% to 5.9%	63	$0
6.0% to 11.9%	36	11,168,200
12.0% to 17.9%	30	46,728,800
18.0% to 23.9%	11	26,975,100
24.0% to 29.9%	3	7,018,800
30.0% to 36.0%	4	14,212,300
Over 50%	3	26,594,800

19. Upon introduction of the bill, the administration indicated that the GPR increase that would be provided for DSH payments would be an allocation of GPR savings associated with adopting the full Medicaid expansion, and the statutory increase was made contingent upon implementation of full 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 the DSH increase is no longer warranted (Alternative 5).

20. The Committee could make the DSH increase permanent, as in AB 68/SB 111, but without making the increase contingent on the state adopting full Medicaid expansion (Alternative 1). As under AB 68/SB 111, this alternative would establish in statute the level of GPR funding for DSH payments ($47,500,000 per year) and payment cap ($7,950,000) that are currently in effect on a temporary basis. The FED funding amount in Alternative 1 has been adjusted to reflect updated forecasts of the federal matching rate. To account for the fact that total DSH payments may be affected by the temporary increase to the federal matching rate, the Department could be authorized to make a proportional adjustment to the payment cap.

21. Alternatively, the Committee could provide a smaller increase. Alternative 3 illustrates the cost of increasing permanent DSH levels by only half of the temporary amount currently in effect, setting the GPR share at $37,500,000 and adjusting the maximum payment proportionately, to $6,280,000. With standard federal matching rate, total DSH payments would be approximately $94.0 million per year.

22. Alternative 2 and 4 provide the same level of funding as Alternatives 1 and 3, respectively, but on a temporary basis for the 2021-23 biennium only.

ALTERNATIVES

1. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to permanently establish the GPR share of DSH payments at $47,500,000. Set the maximum payment at $7,950,000, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 1	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

2. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to temporarily maintain the GPR share of DSH payments at $47,500,000 for the 2021-23 biennium only. Set the maximum payment at $7,950,000 for the biennium, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 2	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

3. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to permanently establish the GPR share of DSH payments at $37,500,000. Set the maximum payment at $6,280,000, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 3	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

4. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to temporarily establish the GPR share of DSH payments at $37,500,000 for the 2021-23 biennium. Set the maximum payment at $6,280,000 for the biennium, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 4	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

5. Take no action. This would return the GPR share of DSH payments to $27,500,000 and the maximum payment to $4,600,000.

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June, 2021 Joint Committee on Finance Paper #340

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

[LFB 2021-23 Budget Summary: Page 262, #12]

CURRENT LAW

BadgerCare Plus is a subcomponent of the medical assistance (MA) program that provides medical coverage for adults and children. Eligibility is determined based on household income. For most non-elderly adults, the income eligibility threshold is 100% of the federal poverty level (FPL), but for pregnant women, the income eligibility threshold is 306% of the FPL. The income that is considered the poverty level varies by household size. For the purpose of determining household size of a pregnant woman, the number of children that the woman is expecting are counted. So, for instance, a pregnant woman who is expecting one child and lives with one other adult and no other children is counted as having a household size of three. In 2021, 100% of the FPL for a three-person household equates to an annual income of $21,960 and 306% of the FPL for a three-person household equates to an annual income of $67,108.

To be eligible for BadgerCare Plus, an individual must meet certain nonfinancial criteria in addition to meeting the income criteria. Generally, the individual must be a resident of Wisconsin and be a U.S. Citizen or a qualifying immigrant. For the purposes of this provision a qualifying immigrant includes a person who was lawfully admitted at least five years prior to enrollment and has maintained residency in the U.S. during that time. However, this five-year waiting period for immigrants does not apply to pregnant women, meaning any pregnant woman who is a U.S. citizen or who is lawfully admitted immigrant is eligible for coverage. [Although not relevant to the pregnant woman eligibility category, there are certain other exceptions to the five-year waiting period, including for refugee status, victims of trafficking, and Cuban or Haitian immigrants.]

Once enrolled, a pregnant woman remains eligible until the last day of the month that falls 60 days following delivery. At that time, the woman will lose MA eligibility unless she qualifies for MA under another category, such as a parent.

The BadgerCare Plus prenatal program provides limited benefits to pregnant women who do not meet the criteria for full benefits under the BadgerCare Plus pregnant woman eligibility category. This includes pregnant prison or jail inmates and pregnant immigrants without legal presence in the United States. The prenatal program covers only certain services, including prenatal care, prescription drugs, and labor and delivery services. Prenatal program coverage is provide under provisions of the federal Children's Health Insurance Program (CHIP), and it is the unborn baby, rather than the mother, who is considered the recipient of health benefits. For this reason, unlike the full benefit BadgerCare Plus coverage for pregnant women, the prenatal program does not provide an extended period of coverage for the woman after the child is born.

DISCUSSION POINTS

1. Upon the expiration of the 60-day postpartum MA eligibility period, women may retain coverage in other eligibility categories, most often as a parent, if they meet the applicable income and nonfinancial eligibility criteria. In Wisconsin, a pregnant woman who is a U.S. citizen or a qualifying immigrant and who has a household income below 100% of the FPL can continue to be enrolled after the 60-day postpartum period expires.

2. Some women leave a job or reduce the number of hours worked for a period of time after giving birth. In these cases, a woman who had a household income above 100% of the FPL prior to the birth may continue to be eligible for MA coverage as a parent if the reduction in income places her household below that threshold.

3. For a woman whose household income remains above the 100% of FPL income eligibility threshold for non-pregnant adults, MA eligibility will end following the 60-day postpartum period. In these cases, her coverage status generally falls into one of three categories: (a) she may have employer-sponsored coverage, either through her employer or her spouse or partner's employer; (b) she may purchase an individual market policy often with the help of federal premium tax credits; or (c) she may become uninsured.

4. These three outcomes would also apply to women, of any household income level, who are immigrants within the five-year waiting period for Medicaid coverage. While these women are eligible for MA coverage during pregnancy and during the 60-day postpartum period, they are not eligible (with limited exceptions) for coverage under federal Medicaid law.

5. The Congressional Budget Office (CBO) estimates that of women who lose Medicaid coverage following the 60-day postpartum period (those not already under the income threshold for adults), 45% become uninsured, 30% move to employer-sponsored or individual market coverage, and 30% of women will transition to a non-pregnant adult Medicaid category due to a decrease in household income following the birth. Because these are nationwide estimates, these percentages may not reflect postpartum outcomes in Wisconsin. [It is unclear why CBO's percentage estimates add to more than 100%, but it may be due to some overlap in these categories or the nature of these estimates as rough approximations.]

6. A woman who loses all coverage or who switches to other coverage after the 60-day

postpartum period may experience an interruption in care. This would be the case for a woman who becomes uninsured, but may also be the case with a switch to employer-sponsored plan or individual market plan. These insurance policies often have higher deductible, coinsurance, and copayment requirements than Medicaid coverage, and so may cause a woman to stop going to postpartum appointments to save money.

7. In recent years, several health care professional associations, advocacy groups, and health researchers have called for a change to federal Medicaid policy to extend postpartum eligibility from 60 days to 12 months following delivery. As an example, the Equitable Maternal Health Coalition (EMHC), representing several groups recently issued a recommendation for 12 months of postpartum Medicaid coverage. The organizations in this coalition are the American College of Obstetricians and Gynecologists, the Association of Maternal and Child Health Programs, the March of Dimes, and the Society for Maternal-Fetal Medicine.

8. In making the case for extended postpartum care, the EMHC points out that maternal mortality is higher in the United States than in other highly developed countries, and is the only such country where the mortality rate has been increasing. The mortality rate went from 10.3 deaths per 100,000 births in 1991 to 17.4 deaths per 100,000 births in 2018. The rates of maternal death and serious health complications are particularly high for women for certain racial and ethnic minorities. For instance, black and American Indian mortality rates are 2.5 to 3.0 times greater than for non-Hispanic white women.

9. Of particular concern for the discussion of extending postpartum coverage are conditions and adverse health events that occur later in the postpartum period. The EMHC notes that 30% of maternal deaths (excluding suicide and drug overdose) occur between 43 days and 365 days following delivery. In addition, it is estimated that one in seven women experience perinatal mood and anxiety disorders, which frequently extend beyond Medicaid's 60-day postpartum coverage period.

10. In its most recent report to Congress (March, 2021), the Medicaid and CHIP Payment and Access Commission (MACPAC), also recommended a 12-month postpartum coverage period. The MACPAC report identifies various postpartum health conditions, such as cardiomyopathy (heart muscle disease), aneurisms, and kidney failure, which are some of the leading cause of postpartum maternal death and serious illness. In addition, the report notes that some preexisting chronic conditions, such as diabetes and hypertension may become worse with pregnancy and following delivery. Finally, the stresses associated with caring for an infant can lead to or worsen various health conditions, including anxiety, depression, and substance abuse.

11. The advocates of this policy argue that a longer period of postpartum coverage ensures coverage stability during a time when health problems may arise, while avoiding transitions between insurers and primary care providers. In addition, because Medicaid coverage generally has lower cost sharing requirements than employer-sponsored or individual market insurance, the coverage extension can relieve some of the financial stress on a family during the infant's first year.

12. A 12-month postpartum coverage policy would match the current law treatment of infants born to a mother who is enrolled in Medicaid. The child, regardless of other family circumstances, is automatically eligible for MA coverage for the first year after birth. Establishing a

similar 12-month policy for the mother would allow both mother and child to have a stable source of coverage for the same period of time.

13. Assembly Bill 68 and Senate Bill 111 would establish a 12-month postpartum coverage period for the medical assistance program. This extension proposal has two components. First, it would apply to women enrolled in the BadgerCare Plus pregnant women eligibility category, providing a 10 month extension to the current postpartum period. Second, it would offer full benefits postpartum coverage for women whose pregnancy-related care is covered under the prenatal program, which currently does not provide any postpartum coverage.

14. AB 68/SB 111 would require the Department to request federal approval for the postpartum coverage extension for BadgerCare Plus pregnant women, but to initiate the coverage extension regardless of the federal decision. The administration's fiscal estimate assumes that the state would request and receive approval of a federal waiver for the BadgerCare Plus coverage extension, meaning that the state would be eligible to receive federal matching funds for the associated costs. However, the administration assumed that the state would not receive federal approval for the postpartum coverage for the prenatal program enrollees, meaning that the full cost would be a state responsibility.

15. In developing the budget proposal, the administration estimated that providing 12-month postpartum coverage would increase the average monthly enrollment in the BadgerCare Plus pregnant woman enrollment category by 6,200, once the policy is fully phased in. The monthly average number of women whose pregnancy was covered under the prenatal program and who would gain postpartum coverage under the proposal is estimated at 1,900.

16. The federal American Rescue Plan Act of 2021 (ARPA) includes a provision that gives states the option to extend coverage to post-partum women for 12 months following delivery. This option begins April 1, 2022, and would be available to states for five years, until March 31, 2027. With the creation of the postpartum extension under ARPA, the state could adopt this coverage with a state Medicaid plan amendment and receive federal matching funds under Medicaid. Establishing a coverage extension under a plan amendment, instead of a federal waiver, allows for more streamlined approval process, avoiding the need to develop and submit a waiver application, propose an experimental purpose for the coverage, an evaluation design, and demonstrate that the state is in compliance with federal budget neutrality rules.

17. The ARPA provision would not apply to the proposed postpartum coverage for women whose care is covered under the prenatal program. Consequently, the full cost of this part of the proposal would remain a state responsibility.

18. The following table presents a reestimate of the cost of implementing a 12-month postpartum coverage period, for women enrolled in BadgerCare Plus (pregnant women eligibility category) and for women enrolled under the prenatal program. For the purposes of this estimate, it is assumed that coverage extension would first apply on April 1, 2022, corresponding to the date that federal optional coverage would begin.

Estimated Cost of Postpartum Extension for Women Covered through BadgerCare Plus and Prenatal Program

Extension for Pregnant Women Enrollees (Alternative A1)

	2021-22	2022-23
GPR	$500,000	$8,260,000
FED	750,000	12,390,000
Total	$1,250,000	$20,650,000

Postpartum Coverage for Prenatal Program Enrollees (Alternative A2)

	2021-22	2022-23
GPR	$260,000	$4,570,000

19. These estimates were developed using data on the number of women whose MA pregnancy coverage expired and who were no longer enrolled following the current postpartum period. Once fully phased in, it is estimated that the postpartum provision would increase the monthly average enrollment by 6,750 for women enrolled as pregnant women and would increase enrollment by 1,650 for women whose coverage is provided through the prenatal program.

20. Because the full impact on the caseload would not occur until approximately 10 months after implementation, the fiscal estimates shown above do not reflect the full annualized fiscal effect. Once fully phased in, the annual cost of the postpartum coverage would be approximately $25 million ($10 million GPR and $15 million FED) for women enrolled in the pregnant women category and approximately $6 million GPR for women enrolled through the prenatal program.

21. The ARPA provision was passed under Congressional budget reconciliation procedures, which limits federal spending outside a budget window. This is likely the reason that the postpartum provision included an expiration date in 2027. The coverage option could be extended or the sunset eliminated in the future, although this would require a separate act of Congress. If the Committee adopts the postpartum coverage extension, the statute should specify whether the state continue coverage continues regardless of whether a federal waiver is approved, at 100% state cost (Alternative B1), or whether the coverage should only be provided contingent on federal approval (Alternative B2).

ALTERNATIVES

A. 12- Month Postpartum Coverage

Adopt one or more of the following alternatives:

1. Provide $1,250,000 ($500,000 GPR and $750,000 FED) in 2021-22 and $20,650,000

($8,260,000 GPR and $12,390,000 FED) in 2022-23 to reflect the estimated cost of extending benefits, for women enrolled in MA as pregnant women, until the last day of the month in which the 365th day after the last day of the pregnancy falls. Specify that this coverage extension first applies to women whose coverage would otherwise expire on March 31, 2022.

ALT A1	Change to Base
GPR	$8,760,000
FED	13,140,000
Total	$21,900,000

2. Provide $260,000 GPR in 2021-22 and $4,570,000 GPR in 2022-23 to reflect the estimated cost of providing full benefits MA coverage for women covered under the MA prenatal program, until the last day of the month in which the 365th day after the last day of the pregnancy falls. Specify that this coverage extension first applies to women whose pregnancy ends after April 1, 2022.

ALT A2	Change to Base
GPR	$4,830,000

3. Take no action.

B. Federal Approval and Coverage Option

If Alternative A1 is adopted, Require DHS to request federal approval of a state Medicaid plan amendment or federal waiver to extend postpartum eligibility for pregnant women enrolled in BadgerCare Plus. In addition, adopt one of the following provisions:

1. Request the Department to extend postpartum coverage regardless of whether federal approval is granted.

2. Specify that the Department may only extend postpartum coverage under BadgerCare Plus if the federal government approves a state plan amendment or waiver providing for such coverage.

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June, 2021 Joint Committee on Finance Paper #341

MA Reimbursement -- Outpatient Mental/Substance Abuse/ Child- Adolescent Day Treatment, Autism, and Emergency Services (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 263, #13, Page 267, #22 and #23]

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 payments are often referred to as "provider reimbursement," although in most cases the MA program pays a pre-established fee, rather than an amount equal to the provider's usual and customary charges or the provider's cost of providing the service. Providers receive reimbursement either on a fee-for-service (FFS) basis, where the MA program makes payments directly to providers, or under a managed care model, where providers are reimbursed by managed care organizations (HMO) that are paid monthly capitation payments.

Federal law gives states flexibility in designing MA reimbursement methods, subject to four basic requirements. First, with the exception of copayment requirements, providers must accept program reimbursement as full payment for services, thereby prohibiting them from billing recipients for additional payment. Second, payment rates must be sufficient to attract enough providers to ensure that the availability of health care services to MA recipients is no less than the availability of these services for the general population. Third, with limited exceptions, MA payment is secondary to any other coverage or third-party payment source available to recipients, including Medicare. Fourth, the state's procedures relating to the utilization of, and the payment for, care and services must be adequate to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care.

DISCUSSION POINTS

Outpatient Mental Health and Substance Abuse Services

1. Assembly Bill 68 and Senate Bill 111 would provide funding to increase provider reimbursement rates for outpatient mental health and substance abuse treatment services and for child-adolescent day treatment. As proposed, rates would be increased by 40% from current levels, but this increase would be phased in, with a 20% increase taking effect on January 1, 2022, and the remaining rate increase taking effect on January 1, 2023. The following table shows the estimated funding required for each component.

Outpatient Mental Health and Substance Abuse Services

	2021-22	2022-23
GPR	$3,535,000	$10,605,000
FED	5,302,500	15,907,400
Total	$8,837,500	$26,512,400

Child-Adolescent Day Treatment Services

	2021-22	2022-23
GPR	$534,200	$1,602,700
FED	801,400	2,404,100
Total	$1,335,600	$4,006,800

2. The administration proposed increases for these services to increase access to behavioral health services under medical assistance, particularly for youth, citing a need for suicide prevention and treatment.

3. Outpatient mental health and substance abuse services encompass approximately 65 billing codes, generally related to psychological testing, diagnosis, psychotherapy, and counseling, for individuals, groups, and families. The most commonly billed codes under MA, accounting for over 50% of total spending, are the 45 minute and 60 minute individual psychotherapy sessions.

4. The reimbursement rates for outpatient mental health and substance abuse services were last changed in January of 2018. In addition to increasing payments for each billing code, the reimbursement schedule for these services was simplified, generally to reduce the number of rate tiers that correspond to different professional degrees. Because of this change to the rate structure, the percentage increase varied by code and by professional level, but on aggregate, the changes resulted in an increase in total payments of approximately 28%.

5. One benchmark sometimes used for Medicaid reimbursement rates are the rates paid for

the same services by Medicare. These comparisons are not always straightforward, since the two programs can have different coverage and reimbursement policies for the same type of services. As a pertinent example, Wisconsin's MA program uses a set of codes specific to substance abuse counseling services, but Medicare generally reimburses for substance abuse treatment using psychotherapy codes.

6. Nevertheless, some comparisons can be made for the most common psychotherapy codes. For psychologists and clinical social workers, reimbursement rates are approximately 84% of the equivalent Medicare rate. At this ratio, psychotherapy rates are higher, in comparison to Medicare, than for many other professional medical services. If the Committee decides to provide the reimbursement rate increases as proposed in AB 68/SB 111 (Alternative A1), the resulting rates would be above Medicare rates for the outpatient mental health services for which there are comparable billing codes.

7. Although psychiatrists do not commonly bill using the psychotherapy codes, the MA rate and the Medicare rate for these providers are approximately equal. Psychiatrists commonly bill for services using medical evaluation and management (office visit) codes, rather than psychotherapy. The evaluation and management codes would not be changed under the administration's proposal. However, the Department implemented a 33% increase to reimbursement rates for psychiatry office visit and inpatient services codes, effective January 1, 2020.

8. Given that mental health and substance abuse services, unlike many MA professional services, were last increased in recent years, the Committee may decide that an additional increase is not warranted at this time (Alternative A3). Alternatively, the Committee could provide a smaller increase. As noted, it is not always possible to use Medicare as a benchmark because of differences in reimbursement policies. Nevertheless, a 15% increase for the outpatient services would generally bring the MA reimbursement rates for outpatient behavioral health services that are below Medicare close to the Medicare reimbursement rate. A 15% rate increase, taking effect January 1, 2022, would increase MA expenditures by an estimated $6,628,100 ($2,651,200 GPR and $3,976,900 FED) in 2021-22 and $13,256,200 ($5,302,500 GPR and $7,953,700 FED) in 2022-23 (Alternative A2).

Child-Adolescent Day Treatment Services

9. Day treatment for mental health conditions is a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy or other therapies, skill development, substance abuse counseling, and follow-up services to alleviate problems related to mental illness or emotional disturbances related to a diagnosed mental illness. Mental health day treatment for children is provided if the need for services is identified as the result of a HealthCheck examination (the state's federally-required early and periodic screening, diagnosis, intervention, and treatment program), and if prescribed by a physician. In addition, the child must meet or substantially meet the criteria to be designated as severely emotionally disturbed. Day treatment services are intended for persons who have a demonstrated need for structure and intensity of treatment that is not available in outpatient treatment, but who have the ability to function in a semi-controlled, medically supervised environment.

10. The current reimbursement for child-adolescent day treatment is $32.53 per hour. AB

68/SB 111 would provide funding to increase the rate by 20%, to $39.04, on January 1, 2022, and then by 40% (relative to the current rate), to $45.54 on January 1, 2023.

11. Unlike the reimbursement rate for outpatient behavioral health services, the reimbursement rate for child-adolescent day services has not been increased in recent years. The last change was a 1% increase, taking effect July 1, 2008.

12. Although day treatment is just one example of many MA non-institutional services for which a reimbursement rate increase has not been provided since 2008, the Committee may determine that an increase for this particular service is warranted to support these intensive services for youth who are severely emotionally disturbed (Alternative B1). The Committee could decide, however, to provide a smaller increase. A one-time 20% increase to the rate would increase MA expenditures by an estimated $1,335,600 ($534,200 GPR and $801,400 FED) in 2021-22 and $2,671,200 ($1,068,500 GPR and $1,602,700 FED) in 2022-23 (Alternative B2).

Autism Services

13. Autism treatment services are intended to teach children with autism spectrum disorder the skills that children would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to improve a child's social, behavioral, and communicative skills in order to demonstrate measurable outcomes in these areas and overall developmental benefits in both home and community settings. The intent is for the child to make clinically significant improvements and have fewer needs in the future as a result of the service.

14. Wisconsin's MA program provides autism treatment services as part of the behavioral treatment benefit, which includes both comprehensive and focused treatment for individuals with autism spectrum disorders. Comprehensive treatment is an early intervention treatment approach designed to address multiple aspects of development and behavior. Services are generally provided for at least 20 hours per week, and typically provided for one or more years. Focused treatment is dedicated to addressing specific behaviors or developmental deficits, typically involving fewer weekly hours and shorter duration. Prior authorization is required for all behavioral treatment services. Treatment is often initiated at age three or four, although many older children receive treatment services as well.

15. The primary goal of behavioral treatment is to prepare members and their families for successful long-term participation in normative settings and activities at home, in school, and in the community. Providers that develop plans of care must indicate specific, measurable goals that build toward this outcome. Comprehensive treatment must be administered face-to-face with the child, and may be provided in the child's home or the provider's office.

16. Assembly Bill 68/Senate Bill 111 would increase reimbursement for behavioral health assessments and adaptive treatment services provided to MA recipients with autism or other diagnosis or conditions associated with similar behaviors by 25%, effective January 1, 2022. The bill would provide $7,539,400 ($3,015,800 GPR and $4,523,600 FED) in 2021-22 and $15,078,700 ($6,031,500 GPR and $9,047,200 FED) in 2022-23 to fund reimbursement increases. However, the funding in the bill does not fully account for the utilization increase the administration projected. In order to meet

the administration's intent, the estimated cost of providing a 25% rate increase for these services is $12,565,700 ($5,026,300 GPR and $7,539,400 FED) in 2021-22 and $25,131,200 ($10,052,500 GPR and $15,078,700 FED) in 2022-23.

17. The following table provides information on MA payments and units of services in 2019-20 for the five procedures that would be provided rate increases under the bill. The average payment amount in the last column reflects 15 minutes of service, the unit of service providers bill Medicaid. Consequently, the average hourly rate equals four times the amount shown.

Autism Treatment Services
State Fiscal Year 2019-20 Reimbursement

Service	Provider	Total Payments	# of Claims	Avg. Payment Per Unit of Service
Assessments				
Behavior Identification Modification	Physician or Other Qualified Health Care Professional	$1,299,753	65,218	$19.93
Supporting Assessment	Technician under the Direction of Physician or Qualified Health Care Professional	419,861	99,032	4.24
Behavioral Treatment				
Adoptive Behavioral Treatment	Technician under the Direction of Physician or Health Care Professional	32,245,332	3,321,218	9.71
Adaptive Behavioral Treatment, with Protocol Modification	Physician or Other Health Care Professional	14,269,212	825,718	17.28
Family Adaptive Behavior Treatment Guidance	Physician or Other Health Care Professional	2,012,734	93,198	21.60
Total		$50,246,891	4,404,384	

18. Wisconsin's MA program reimburses comprehensive behavioral treatment services under the federal early and periodic screening, diagnostic, and treatment (EPSDT) benefit, which requires that state MA programs provide comprehensive services to correct and ameliorate health conditions of MA eligible children. As an EPSDT benefit, MA-supported behavioral treatment services are only provided to children and youths under 21 years of age.

19. In September, 2020, the Wisconsin Legislative Council hosted the Symposia Series on Early Access to Autism Treatment, which included a review of current state MA policies and a discussion of options for enhancing access to early diagnosis of autism and promoting treatment. Participants reviewed the results of an August, 2020, survey conducted by the Wisconsin Autism Providers Association, which showed that:

- 24 of the 43 evaluation providers indicated that they had over 1,100 children who were currently waiting for evaluations, and that several providers had waits in excess of nine months.

- Over 3,000 children were enrolled in treatment, but 56% of treatment providers reported

that at least 15% of planned treatment hours were undelivered due to insufficient staff capacity.

- Fewer than half of current children receiving services had MA as a primary provider, and 23% of providers only accepted commercial insurance clients.

- Approximately 1,300 children were on waitlists for treatment services, and 43% of providers reported a waitlist of six months or longer for MA clients,

20. The providers identified that MA-eligible children had difficulty accessing services due to staff shortages at all levels, and high staff turnover rates, resulting in significant costs to providers to recruit and train new staff. Increasing MA reimbursement rates for behavioral treatment services was proposed as one way of increasing access for these services.

21. Reimbursement rates for direct treatment were last increased in 2018, when DHS increased these rates by 33%.

22. The administration's estimate of the cost of increasing behavioral treatment services by 25%, as proposed in AB 68/SB 111, assumes that utilization of these services would increase by 20%. However, it is difficult to predict the extent to which increasing MA reimbursement for these services will increase utilization of behavioral health treatment services.

23. Several rate options are presented for the Committee's consideration, including: (a) the rate increases provided AB 68/SB 111, as corrected to reflect the utilization increase assumed by the administration (Alternative C1); (b) a 15% rate increase, effective January 1, 2022 (Alternative C2); and (c) a 10% rate increase, effective January 1, 2022 (Alternative C3).

Emergency Physician Reimbursement

24. When MA members receive care in a hospital, MA provides reimbursement both to the hospital, for the cost of maintaining and operating the facility, and to the medical professionals that deliver specific services to the patient during their hospital stay. In the case of an emergency room visit, professional reimbursement primarily includes critical care and evaluation of the patient.

25. Under current rates, MA reimburses emergency room patient evaluation at rates ranging between $20 and $38, depending on the complexity of the case, and reimburses critical care at $89 per hour. In aggregate, these rates are approximately 37% of the rates paid by Medicare, although this percentage varies for specific services.

26. The most recent significant change in MA reimbursement rates for emergency room physician services was a 1% increase that took effect in July 1, 2008, as part of a general rate increase provided for many types of services in the 2007-09 biennial budget. A 6% rate increase for some other patient evaluation and management services that took effect January 1, 2020, did not include emergency room visits.

27. Under federal law, emergency rooms must provide care to stabilize any patient, without regard to ability to pay or type of insurance coverage. This is in contrast to most other healthcare providers, who typically consider MA reimbursement levels before deciding whether to enroll as an

MA provider and how many MA patients to accept.

28. AB 68/SB 111 would provide $5,218,500 ($1,983,000 GPR and $3,235,500 FED) in 2021-22 and 2022-23 in one-time funding to temporarily increase reimbursement rates for hospital emergency room physician services in calendar year 2022. In an April 23, 2021, letter to the Co-Chairs of the Committee, the administration indicated their intent to make the increase permanent instead, requesting an additional $5,218,500 ($1,983,000 GPR and $3,235,500 FED) in 2022-23. Alternative D1 reflects this revised proposal. These funding amounts reflect the cost to increase reimbursement for these services to 50% of the rates paid by Medicare, and would provide a 36% increase over current reimbursement.

29. Alternatively, the Committee could determine that current reimbursement rates are sufficient (Alternative D3) or provide a different level of reimbursement increase. Alternative D2 would provide a permanent 15% increase to current rates.

ALTERNATIVES

A. Outpatient Mental Health and Substance Abuse Services

1. Provide $8,837,500 ($3,535,000 GPR and $5,302,500 FED) in 2021-22 and $26,512,400 ($10,605,000 GPR and $15,907,400 FED) in 2022-23 for a 40% increase to reimbursement rates for outpatient mental health and substance abuse services, starting with a 20% increase on January 1, 2022, and the remaining increase starting on January 1, 2023.

ALT A1	Change to Base
GPR	$14,140,000
FED	21,209,900
Total	$35,349,900

2. Provide $6,628,100 ($2,651,200 GPR and $3,976,900 FED) in 2021-22 and $13,256,200 ($5,302,500 GPR and $7,953,700 FED) in 2022-23 for a 15% increase to the reimbursement rates for outpatient mental health and substance abuse services starting on January 1, 2022.

ALT A2	Change to Base
GPR	$7,953,700
FED	11,930,600
Total	$19,884,300

3. Take no action.

B. Child-Adolescent Day Services

1. Provide $1,335,600 ($534,200 GPR and $801,400 FED) in 2021-22 and $4,006,800 ($1,602,700 GPR and $2,404,100 FED) in 2022-23 for a 40% increase to the reimbursement rate for child-adolescent day services, starting with a 20% increase on January 1, 2022, and the remaining increase starting on January 1, 2023.

ALT B1	Change to Base
GPR	$2,136,900
FED	3,205,500
Total	$5,342,400

2. Provide $1,335,600 ($534,200 GPR and $801,400 FED) in 2021-22 and $2,671,200 ($1,068,500 GPR and $1,602,700 FED) in 2022-23 for a one-time 20% increase to the reimbursement rate for child-adolescent day services.

ALT B2	Change to Base
GPR	$1,602,700
FED	2,404,100
Total	$4,006,800

3. Take no action.

C. Autism Services

1. Provide $12,565,700 ($5,026,300 GPR and $7,539,400 FED) in 2021-22 and $25,131,200 ($10,052,500 GPR and $15,078,700 FED) in 2022-23 to increase rates for behavioral treatment services by 25%, effective January 1, 2022.

ALT C1	Change to Base
GPR	$15,078,800
FED	22,618,100
Total	$37,696,900

2. Provide $7,539,500 ($3,015,800 GPR and $4,523,700 FED) in 2021-22 and $15,078,800 ($6,031,500 GPR and $9,047,300 FED) in 2022-23 to increase rates for behavioral treatment services by 15%, effective January 1, 2022.

ALT C2	Change to Base
GPR	$9,047,300
FED	13,570,800
Total	$22,618,100

3. Provide $5,026,300 ($2,010,500 GPR and $3,015,800 FED) in 2021-22 and $10,052,500 ($4,021,000 GPR and $6,031,500 FED) in 2022-23 to increase rates for behavioral treatment services by 10%, effective January 1, 2022.

ALT C3	Change to Base
GPR	$6,031,500
FED	9,047,300
Total	$15,078,800

4. Take no action.

D. Emergency Physician Reimbursement

1. Provide $5,218,500 ($1,983,000 GPR and $3,235,500 FED) in 2021-22 and $10,437,000 ($3,966,000 GPR and $6,471,000 FED) in 2022-23 to increase reimbursement for emergency physician services on a permanent basis, effective January 1, 2022.

ALT D1	Change to Base
GPR	$5,949,000
FED	9,706,500
Total	$15,655,500

2. Provide $2,205,000 ($837,900 GPR and $1,367,100 FED) in 2021-22 and $4,410,000 ($1,675,800 GPR and $2,734,200 FED) in 2022-23 to increase reimbursement for emergency physician services on a permanent basis, effective January 1, 2022.

ALT D2	Change to Base
GPR	$2,513,700
FED	4,101,300
Total	$6,615,000

3. Take no action.

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June, 2021 Joint Committee on Finance Paper #342

Coverage of Room and Board Costs during Residential Substance Use Disorder Treatment (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 264, #15]

CURRENT LAW

The Medical Assistance (MA) program currently provides coverage for residential treatment for substance abuse when medically necessary, as determined by the acuity of the patient's substance use disorder and the stability and supports available to them outside of a residential facility. Facilities that provide residential treatment must be licensed by the Department of Health Services (DHS) as either a transitional residential treatment service or a medically-monitored treatment service. A transitional residential treatment service is defined as a clinically-supervised, peer-supported, therapeutic environment with clinical involvement providing substance abuse treatment in the form of counseling for three to 11 hours per week. A medically-monitored treatment service is defined as a 24-hour service providing observation, monitoring, and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week.

MA provides residential substance use disorder (SUD) treatment under two separate circumstances. Some MA beneficiaries have been able to access residential treatment since May 1, 2017, as part of the comprehensive community services (CCS) benefit. CCS gives counties the option to offer a variety of psychosocial rehabilitation and support services as MA benefits. Beginning February 1, 2021, a new benefit expanded the range of eligible providers and covered MA recipients who are not enrolled in a county CCS program. Specifically, this new benefit takes advantage of a federal waiver that allows substance abuse services to be provided as an MA benefit for non-elderly adults in an institution for mental disease (IMD), in addition to previously-eligible facilities. IMDs are larger facilities, with over 16 beds; federal law otherwise restricts Medicaid coverage to facilities with 16 beds or fewer.

Federal law excludes residential room and board costs from eligibility for federal matching funds, except in the case of inpatient hospital care. Consequently, under current policy, MA provides coverage only for the treatment costs of residential SUD care. MA patients must pay their own room and board costs, unless a county program or charitable organization provides funding.

DISCUSSION POINTS

1. Assembly Bill 68 and Senate Bill 111 would provide $3,274,600 GPR annually to fund coverage of room and board costs for MA enrollees receiving residential SUD treatment (Alternative 1). DHS has not yet established a reimbursement policy, but indicates that it would likely include a maximum daily rate and take into consideration the MA member's ability to contribute to the room and board costs. Because federal Medicaid funds cannot be used for residential facility room and board costs, this MA benefit, unlike most MA costs, would be funded entirely with GPR.

2. Patients require residential SUD treatment when they have severe or complex substance use disorders, often with co-occurring conditions such as psychiatric disorders or unstable housing. The department indicates that these patients are at high risk of immediate relapse, continued use, harm to themselves or others, and in some cases death, unless they receive residential SUD treatment. Patients experiencing physiological withdrawal symptoms or other acute medical conditions require monitored detoxification treatment in an inpatient hospital setting before they can be safely discharged to a residential SUD treatment facility.

3. Residential SUD treatment provides individual, family, and group counseling and therapy, medication management, nursing services, case management, peer support, and recovery coaching, for a total of at least twenty hours per week for high-intensity patients and six hours per week for low-intensity or transitional patients. Approximately 85% of recent MA admissions have been for high-intensity patients. In addition to direct treatment services, the safe and stable living environment gives patients the opportunity to stabilize and develop recovery skills. High-intensity patients typically require two to six weeks of care, while low intensity patients typically receive four to thirteen weeks of care before they can be discharged. Discharge decisions are based on clinical evaluation of a patient and their particular circumstances, and MA coverage policy allows members to receive care as long as is medically necessary.

4. The administration estimates that, with the newly-expanded coverage of residential SUD treatment and the proposed coverage of room and board, MA could provide residential treatment for approximately of 240 patients at a time across the state. Based on an average stay of four weeks, this bed capacity could provide treatment for approximately 3,000 MA members per year.

5. Indicative of the prevalence of severe SUD in the state, approximately 5,000 MA members received inpatient hospital detoxification treatment in 2019. Alcohol abuse and dependence accounted for approximately half of these patients, opioid abuse and dependence for one quarter, and other substance use disorders for the remaining quarter. Approximately 25% of patients were readmitted into an inpatient hospital for detoxification treatment for a second time within the calendar year, and approximately 10% required detoxification treatment three or more times in the year. DHS indicates that improved access to residential SUD treatment, especially after a patient has already received inpatient detoxification treatment, could improve patients' recovery and decrease the likelihood of relapse and the need for inpatient detoxification.

6. A systematic research review supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and published by *Psychiatric Services* in March, 2014, finds evidence that residential SUD treatment can reduce alcohol and drug relapse, reduce crime rates, reduce suicide rates, improve quality of life, and improve social and community functioning. However, results varied between treatment populations, specific interventions, and study methodologies. A study published in the *Journal of Addictive Diseases* in October, 2008, found that, among patients recommended for residential treatment, those who received it were 1.7 times as likely to remain sober after one year compared to those who received lower levels of treatment.

7. In a 2020 report produced with grant funding from the U.S. Department of Justice, the National Alliance on Mental Illness finds that, "without an effective mental health system, communities have relied on the criminal justice system to provide mental health care and as a result, every year over 2 million people with mental illness are booked into America's jails and prisons." In 2019-20, the Wisconsin Department of Corrections contracted for 176 beds in residential SUD treatment facilities across the state to provide SUD treatment for probationers, parolees, offenders on extended supervision, or intensive sanctions inmates, at an annual cost of $6.2 million GPR and $0.8 million PR.

8. DHS reports that many residential treatment providers are reluctant to accept MA patients given the current lack of a consistent source of funding for room and board. Providers have expressed that doing so would be unsustainable financially.

9. The facilities that accept MA patients frequently have waitlists, typically around two weeks in length. County officials indicate that this delay poses a significant barrier for some patients; severe substance used disorders often prevent patients from remaining ready and committed to receiving care for the duration of the waiting period.

10. Currently, counties are the most common source of room and board funding for MA patients to receive residential SUD treatment. Many counties provide some funding for this purpose, supported by local tax levy or grant funding, but they typically do not guarantee funding to all MA patients who meet the MA conditions of eligibility for residential SUD treatment. Instead, most counties place a variety of additional restrictions and conditions on which patients may receive county funding, and may implement waiting lists.

11. When county funding for room and board is unavailable, few MA members with substance use disorders have the resources to pay these costs themselves. This does happen in occasional cases, however, most often with financial support from family and friends.

12. As well as removing a financial barrier, counties indicate that state funding for room and board would streamline patients' access to residential SUD treatment; currently, people rely on county human services departments for placement, but the availability of state room and board reimbursement would allow patients to seek care directly, opening more avenues to connect patients with treatment providers and removing administrative barriers. This would build on the recent benefit expansion's potential for broadening access.

13. Research published in *Psychiatric Services* in May, 2019, reports that "the high

prevalence of homelessness among individuals with a substance use disorder, frequent and repeated use of emergency department services, extended boarding in emergency rooms, and frequent readmission to the hospital all indicate unmet need for residential services." The researchers identify insufficient access among Medicaid members in particular.

14. The variety of ways that states and local government could chose to fund residential SUD treatment limits the ability to make direct comparisons of Wisconsin policy to other states. For instance, a state may not provide funding for room and board costs directly, but may nevertheless support this cost indirectly, through general aid to local government human services agencies. Based on available data for neighboring states, however, Iowa and Michigan do not provide direct state funding for room and board costs of treatment but Minnesota does.

15. Providing MA coverage for room and board costs could impact the MA budget in three distinct ways: the room and board reimbursement itself would represent a new GPR cost, the improvement in access would likely lead to increased utilization and hence increased GPR and FED reimbursement costs, and the increase in residential SUD treatment would likely reduce the need for certain other services, such as emergency room care and inpatient detoxification treatment, reducing GPR and FED reimbursement costs.

16. The additional cost resulting from the reimbursement itself is the most straight-forward component to estimate, although it could vary depending on the final reimbursement amount and the total utilization of residential SUD treatment. The administration estimates that reimbursement would be $50 per day, approximately equal to the current rate paid by Minnesota's MA program and the room and board costs paid by the Department of Corrections for placement of state inmates in county jails. The administration also estimates that, on average, 240 MA members will be receiving residential SUD treatment on any given day, for a total annual cost of $4.3 million GPR. This estimate of daily MA utilization corresponds to 23% of the state's total treatment bed capacity.

17. The administration's funding estimate assumes that the gross cost of room and board payments would be offset by savings in other MA services. In 2019, MA paid $3,700 on average for inpatient detoxification treatment, on an all-funds basis. As noted above, approximately 25% of patients were readmitted for inpatient detoxification treatment two or more times within the year, a population that likely has an unmet need for residential SUD treatment. Members of this group received detoxification treatment an average of two additional times in the year, for an additional cost of $7,400 after their first treatment. These amounts do not include other costs associated with substance abuse disorder, such as hospital emergency room visits, although the Department does not have a way to reliably track those costs. By comparison, residential SUD treatment is expected to cost approximately $6,000 to $6,500, excluding room and board. Consequently, a case where residential treatment prevents readmissions for detoxification treatment would result in a modest net reduction in MA benefits expenditures.

18. Several other factors influence the overall fiscal effect of increasing access to residential SUD treatment, with various degrees of uncertainty, including what percentage of members receiving residential treatment would otherwise have required detoxification treatment or other MA services, how many additional readmissions could be prevented beyond the first year analyzed here, and to what degree the need for other services, such as emergency room care, could be prevented. The

funding provided in AB 68/SB 111 is based on the Department's assumptions regarding offsetting savings, accounting for about 25% of the gross room and board costs.

19. In counties that currently provide some room and board funding, county officials report one motivation for doing so is to prevent the need for admissions into residential assisted living facilities, the state mental health institutes, or other intensive care. Counties are generally responsible for the costs for such treatment, or at least the non-federal share of certain MA-funded services, meaning that improved access to residential SUD treatment for MA beneficiaries could have a positive fiscal impact on counties as well. Counties would also likely reduce expenditures of county funds for room and board costs. County officials indicate that these savings would likely be reinvested in behavioral health services to meet a rising need for crisis services, to continue to provide treatment to uninsured residents, and to improve preventative interventions.

20. Since the Department has not yet established policies for reimbursement of room and board costs, it is reasonable to assume that reimbursement for these costs, if approved, would not begin for some period of time after the passage of the budget. Assuming that the implementation process takes approximately six months, the funding could be adjusted accordingly, to provide $1,637,300 GPR in 2021-22 and $3,274,600 GPR in 2022-23 (Alternative 2).

21. The Committee may determine that room and board costs should continue to be a county responsibility (Alternative 3). In this case, counties would continue to determine the amount of funding allocated for this purpose, weighing the costs and benefits alongside other county priorities.

ALTERNATIVES

1. Provide $3,274,600 GPR annually to provide coverage for room and board costs of MA enrollees receiving residential treatment for substance use disorders and include room and board for residential substance use disorder treatment as a covered service under MA, with coverage estimated to begin effective July 1, 2021

ALT 1	Change to Base
GPR	$6,549,200

2. Provide $1,637,300 GPR in 2021-22 and $3,274,600 GPR in 2022-23 to provide coverage for room and board costs of MA enrollees receiving residential treatment for substance use disorders and include room and board for residential substance use disorder treatment as a covered service under MA, with coverage estimated to begin effective January 1, 2022.

ALT 1	Change to Base
GPR	$4,911,900

3. Take no action.

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June, 2021 Joint Committee on Finance Paper #343

Doula Services, Community Health Worker Services, and Community Health Benefit (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 265, #17 and #18, and page 266, #19]

CURRENT LAW

Federal law establishes certain services that states are required to fund under their MA programs, as well as other services that states may fund, at their option. These federally-defined services are commonly referred to as state plan services, since states indicate in plans submitted to the Centers for Medicare and Medicaid Services (CMS) 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, physical therapy, and prescription drugs. Some optional services allow latitude for states and CMS to deliver social or supportive services that go beyond those that are typically included in traditional health insurance plans. This includes "other diagnostic, screening, preventive and rehabilitative services" and "other practitioner services."

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 matching funds to support these services. Wisconsin has several active waivers, including for the provision of many long-term care services.

DISCUSSION POINTS

1. This paper discusses three proposals to establish new MA benefit categories: (a): services provided by doulas, who are trained to provide support before, during, and after childbirth; (b); services provided by community health workers, who are trained to help connect members of their own community to needed services impacting health; and (c) services to address medical and non-medical determinants of health, including housing supports, access to healthy foods, and chronic

disease management.

2. Although Wisconsin does not currently cover these services under MA, it does cover certain related services. The MA prenatal care coordination benefit provides health education and connections to medical, social, and other services for pregnant women with a high risk for adverse pregnancy outcomes, although this benefit does not typically offer the sustained direct support throughout the pregnancy and delivery that doulas provide. The prenatal care coordination benefit provides reimbursement for services provided by public health educators, however, which are similar to community health workers in that neither role requires a formal medical credential and both provide outreach aimed at preventing adverse health outcomes. Peer support specialists play a similar role for people with substance abuse disorders or mental illness, providing supportive services that do not require a professional medical or counseling license. MA reimburses peer support specialists through the county-option comprehensive community services benefit, which provides rehabilitation services to people with severe substance abuse or mental health conditions.

3. All three proposals discussed in this paper are similar in the sense that they are non-clinical services for individuals who may face social or economic conditions that contribute to poor health outcomes. In addition, all three services may already be provided outside of MA, through a variety of programs discussed below, including local public health programs, county social services, or nonprofit organizations. Providing these services through MA would likely expand their reach and would allow the state to access federal Medicaid matching funds to cover a portion of the cost. Under the state's standard matching rate, federal funds cover approximately 60% of the cost of Medicaid state plan or waiver services. The remainder of this paper provides a more detailed description of the three proposed new MA benefit categories.

Doula Services

4. Assembly Bill 68 and Senate Bill 111 would provide $1,015,200 ($406,700 GPR and $608,500 FED) in 2022-23 to reimburse certified doulas for childbirth education and support services, including emotional and physical support, provided during pregnancy, labor, birth, and the postpartum period (Alternative A1). Coverage would be estimated to begin July 1, 2022.

5. The administration's fiscal estimate for doula coverage is based on reimbursement policies and data from Minnesota's doula benefit. Minnesota reimburses doulas $47 per visit for up to six visits, plus $488 for attending the birth. It is assumed that 6% of pregnant women enrolled in BadgerCare Plus, approximately 1,300 per year, would access doula services, at a cost of $770 each.

6. Doula certification typically requires attending workshops and trainings, completing coursework and examinations, and receiving positive reviews from medical professionals and new parents after attending several birthings. Training curricula cover health during pregnancy, labor, and the postpartum period, medical resources, strategies for effective physical and emotional support, breastfeeding, postpartum depression, cultural competence, and other topics.

7. Doulas can fill gaps in the current healthcare system to improve outcomes in communities that are currently underserved. In particular, the administration promotes doula services as one strategy to address racial disparities in adverse maternal and child outcomes. Black women

experience 1.75 times greater risk than White women of significant complications from labor or delivery, and five times the risk of dying in childbirth or from complications, based on DHS data. DHS and Centers for Disease Control and Prevention (CDC) data also indicate that Wisconsin's Black infant mortality rate, 14.6 deaths per 1,000 live births, is among the highest of any state in the nation, 30% above the nationwide average of 10.5 deaths per 1,000 live births to Black parents and approximately three times the rate for White infants in Wisconsin.

8. People giving birth in rural areas also face disparities in care. Analysis published by the National Conference of State Legislators (NCSL) in 2021 finds "maternity care deserts" in many rural areas, where people face transportation barriers and shortages of obstetricians and other prenatal care providers. Research published by CDC and the Minnesota Department of Health in 2013 found that these rural access barriers correlated with higher risk factors, such as smoking while pregnant, and worse birth outcomes, including increased rates of preterm births. These reports recommended increasing access to doulas to improve rural maternity care, and Minnesota added Medicaid coverage for doula services in 2013.

9. The same NCSL analysis cites research demonstrating that continuous support from doulas during childbirth can decrease the use of pain relief medication during labor, decrease incidence of cesarean deliveries, decrease the length of labor, and prevent negative childbirth experiences.

10. By providing relatively low-cost preventative and supportive care, advocates for doula coverage argue that doulas can reduce the need for higher-cost procedures, creating savings as well as better health outcomes. A systematic review published by the Cochrane Library in 2017 found that, across 27 different studies of the impacts of doula care, on average doula services achieved a 25% reduction in caesarean births. Vaginal births not only have better health outcomes, they also cost Medicaid programs approximately $4,500 less per birth, according to 2013 analysis by Truven Health Analytics. Currently, approximately one out of three Medicaid births is caesarean. Doulas may also create savings by helping to prevent more serious birth complications. The Truven analysis estimates that healthcare costs for a low birthweight or preterm birth, for example, average $55,000.

11. Research published in the *Wisconsin Medical Journal* in 2013 found that, based on birth costs and outcomes in Wisconsin in 2010, doulas could be expected to save on average $420 per delivery they attend (2010 dollars). Depending upon utilization patterns and actual reimbursement costs, any savings resulting from avoiding adverse maternal and child outcomes could at least partially offset the cost of providing care.

12. Several states have begun providing doula services as a Medicaid benefit, including Minnesota and Oregon. Indiana provides doula services to Medicaid-eligible residents using Title V maternal and child health block grant funding, instead of as a Medicaid benefit. Some managed care organizations have begun providing doula services as well, such as one in Nebraska serving pregnant youth in foster care.

13. The Department indicates that some MA health maintenance organizations may employ doulas as part of performance improvement projects related to birth outcomes. However, because doula service is not an MA benefit category, the cost of these services is not included in the HMO

capitation rates, but is instead considered an HMO administrative expense. Consequently, utilization of doulas by HMOs is limited. If doula service is added as a MA benefit category, then these provider payments could be included in the HMO rate development process or could be reimbursed separately, outside the HMO contract.

14. AB 68/SB 111 would require DHS to seek federal approval, through a state Medicaid plan amendment or federal waiver, of the doula benefit. The Department would implement the benefit only if the federal government approves a plan amendment or waiver.

15. Although doula coverage would add a service that is currently unavailable under MA, there are existing MA initiatives that are intended to address adverse maternal and child outcomes. In 2011, for instance, MA established an obstetric medical home initiative to provide intensive prenatal and postpartum care coordination for women determined to be at high risk for adverse outcomes. This program is only available in certain parts of the state, in southeast Wisconsin counties and in Dane and Rock counties. MA also has a prenatal care coordination benefit for pregnant women who are at high risk for adverse pregnancy outcomes. The services include outreach, assessment, care plan development, care coordination and monitoring, and health education and nutritional counseling. If the doula coverage proposal is approved (Alternative A1), doulas may be incorporated in these program benefit categories or may be covered as a separate service. If the doula proposal is not approved (Alternative A2), DHS would continue to administer these programs for women who are considered to be at high risk for adverse pregnancy outcomes.

Community Health Workers

16. AB 68/SB 111 would provide $14,232,000 ($5,701,600 GPR and $8,530,400 FED) in 2022-23 to fund coverage of community health worker services under MA (Alternative B1). Coverage would be estimated to begin July 1, 2022.

17. A community health worker (CHW) is a member of a particular community working to help improve the health of their own community by bridging the gaps between community members and health services, promoting services that address their particular needs, and providing culturally competent, accessible care. They respond to both medical and non-medical drivers of health, including access to healthy food, chronic health conditions, and housing security. They typically do not require specific medical credentials, but rather are trained to provide services such as outreach, case management, and chronic disease management coaching. CHWs can make use of their community connections and common experiences to understand patients' unique needs and preferences, tailoring care to be more effective.

18. As in the case of doulas, the administration proposes to provide CHW coverage as a means to address the social and economic conditions affecting some MA beneficiaries and that are associated with disparate health outcomes between groups. State death records show that White residents live on average 15 years longer than Black residents in Wisconsin. Native American residents are approximately three times as likely to die by suicide as Black residents, and lesbian, gay, and bisexual youth attempt suicide at seven times the rate of heterosexual youth. Black men face four times the risk of dying by stroke as White men do, and the disparity for women is a factor of seven; these are the third-largest disparities in heart disease mortality by state in the country, per CDC data.

19. A growing number of policymakers and organizations across the country utilize CHWs, and several programs rely on them in Wisconsin. In recent years, DHS has provided approximately $960,000 per year from a CDC grant for diabetes prevention and control to organizations that use CHWs for that purpose. The largest recipients of this funding are two programs that implement the evidence-based Pathways Community HUB model of CHW services: Great Rivers HUB operated by the Great Rivers United Way in western Wisconsin, and UniteWI serving Milwaukee. These CHW programs engage in activities beyond diabetes management as well, using funding from health systems, private donors, and other organizations, to pursue the full range of services CHWs can offer.

20. The Pathways Community HUB model is a well-researched system for using CHWs to identify the barriers healthcare services face in reaching particular communities, select proven pathways to connect community members with the care they need, and coordinate that care. The model includes training for CHWs; technology to help CHWs identify and track community members' needs, progress, and outcomes such as the results of referrals to other services; strategies for building a network with human service and clinical organizations in the community; and an accountable payment model based on outcomes.

21. The Great Rivers HUB began in 2017 as a partnership with Gundersen Health System, Mayo Clinic Health System-Franciscan Healthcare, and the Medical College of Wisconsin. It serves La Crosse County, with plans to expand into Monroe and Trempealeau counties. The program's eight CHWs focus on frequent emergency room patients (providing guidance toward other points of care and services to meet their underlying needs), pregnant women experiencing homelessness, families with elementary school children who frequently miss school, and patients with heart disease or diabetes. As one indicator of the program's performance, a local health system saw a decrease of 150 emergency room visits in a year, and an increase in primary care utilization, among 70 members served by the hub.

22. UniteWI implements the Pathways model in the Milwaukee area. Their CHWs specialize in coordinating prenatal care, managing chronic conditions including diabetes and hypertension, connecting residents to asthma care, navigating benefits, and providing healthy food to those experiencing food insecurity.

23. Many other organizations in Wisconsin employ CHWs or offer similar services, including non-profit organizations and health systems. The Bureau of Labor Statistics estimates 350 CHWs work across the state. The Wisconsin Community Health Worker Network facilitates coordination among organizations employing CHWs, supports training new CHWs, and helps link CHWs with health systems, public health departments, and community-serving organizations.

24. Several published studies support the view that CHWs can be an effective way to improve the health of their communities. One study, published in April, 2014, by *JAMA Internal Medicine*, found that CHWs positively impact measures of overall health, including decreasing hospital admissions and increasing access to primary care. They also demonstrate results in studies focused on specific conditions, including decreasing high blood pressure (see *Preventative Medicine*, July, 2003), reducing diabetics' hemoglobin values (see *Journal of General Internal Medicine,* July, 2015), and reducing hospital readmissions for patients living with chronic diseases by 60% (*JAMA Internal Medicine*, above).

25. North Carolina provides CHW services as a Medicaid benefit under a waiver, and Minnesota and Indiana cover CHW services when delegated by a licensed medical professional. Other states offer or are developing CHW benefits as well, as part of ongoing shifts away from paying for volume of care and toward paying for quality and health outcomes.

26. The federal Centers for Medicare and Medicaid Services commissioned a study of 72 innovative payment and service delivery models that had received federal support, including several using CHWs. The analysis found the CHW strategy to be the most cost effective, and the only component among those studied that yielded consistent net savings, in this case, $552 per beneficiary per year. Savings are generated through better management of chronic diseases, reduced emergency room utilization, reduced readmissions after hospital care, and other preventative interventions, although results varied between specific implementations.

27. While this and other research can be used to demonstrate positive health outcomes associated with the use of CHWs and, in some cases, net savings for medical services, the research may not be a reliable indicator of the outcomes that Wisconsin MA would see with the implementation of a CHW benefit under MA. It is possible that the research evaluations differ in a variety of ways from how the benefit would be implemented in Wisconsin. For instance, if the evaluation involves a service that is narrowly targeted to only the individuals who are most likely to benefit, while the criteria for the MA benefit were not as restrictive, the average impact across all individuals served may differ. As with all MA benefits, the Department would need to develop criteria for determining for which individuals and in what circumstances the CHW benefit would be available.

28. The administration's fiscal estimate for the CHW benefit does not assume any offsetting savings for other MA medical services. Instead, AB 68/SB 111 would increase MA funding based on the assumption that the equivalent of 200 full time CHWs would be reimbursement for providing services to MA beneficiaries per year. The actual cost would depend upon several factors that are presently unknown, such as the standards and policies that would be established by the Department for eligibility and quantity of services allowed.

29. The Department indicates that at least some CHW activities would be allowable under existing federal Medicaid authority. For instance, the list of Medicaid eligible services includes preventive services recommended by a physician or other practitioner and performed under the direction of that practitioner. Consequently, the Department believes that a CHW benefit meeting federal standards could be implemented with an amendment to the state's Medicaid plan. Any more expansive scope of CHW services would likely require the state to obtain a federal waiver. AB 68/SB 111 would require the Department to seek federal approval of the CHW benefit, but coverage would be contingent upon federal approval. The Committee could adopt the CHW benefit with the same condition (Alternative B1).

30. The Committee could decide that existing local public health, health system, and non-profit initiatives to support the use of community health workers are adequate and it is not necessary to create a new MA benefit for this service (Alternative B2).

Community Health Benefit

31. AB 68/SB 111 would provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $24,500,000 ($10,014,000 GPR and $14,486,000 FED) in 2022-23 for a new community health benefit under MA, which would provide reimbursement for nonmedical services that contribute to determinants of health (Alternative C1). The bill would require the Department to identify the specific services that would be covered and request any necessary federal waiver or other approval, and coverage would be contingent on federal approval. Coverage would be estimated to begin January 1, 2023.

32. The administration's funding estimate for the community health benefit assumes that approximately 12,500 individuals would be served on a monthly basis, at an average cost of $300 per person per month, for an annual total of $45.0 million. Based on the assumption that the benefit would begin in January of 2023, AB 68/SB 111 would provide $22,500,000 ($9,014,000 GPR and $13,486,000 FED) in fiscal year 2022-23 in the MA benefits appropriations. In addition to MA benefits, this item also would include $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $2,000,000 ($1,000,000 GPR and $1,000,000 FED) in 2022-23 for costs to implement and administer the benefit. These costs include contracts for development of policies related to benefit services, preparation and submittal of a federal waiver, and development of an assessment tool for determining eligibility.

33. Increasingly, public health experts have proposed that a wide variety of social and economic factors, beyond the quality and accessibility of medical services, have a significant impact on a person's health. Nonmedical determinants of health, as identified in the state health plan, *Healthiest Wisconsin 2020,* include a person's behaviors and habits, social and economic conditions they experience, and their physical environment. The attachment to this paper illustrates this model in more detail.

34. The proposed MA benefit would provide services that aim to improve health by addressing one or more of these nonmedical factors that influence health. Depending on final determinations by DHS and CMS, such services could include nutritional mentoring, housing referrals, stress management, wellness and family support, violence intervention, and more. The benefit would focus on identifying members' needs, providing referrals to available resources such as nonprofit organizations, and coordinating services.

35. The Department indicates that this benefit would complement and extend the CHW benefit discussed above by expanding the range of services with which CHWs can connect their clients. Depending on the barriers and medical needs experienced by a particular beneficiary, the service would seek to improve health outcomes by connecting them with a particular nonmedical service.

36. Advocates of this approach point to research on the links between health and access to employment, education, income, housing, and social support. As an example, a study published by the *Journal of the American Medical Association* in May, 2009, documented that an intervention providing housing supports to adults experiencing both homelessness and chronic health conditions reduced hospitalizations by 29% and emergency room visits by 24% among the population served.

In addition, a study published in *Health Affairs* in April, 2018, found that an intervention providing home-delivered, medically tailored meals to certain vulnerable low-income seniors had positive impacts on health, including reducing emergency room visits by 44%.

37. The Department cites the North Carolina Healthy Opportunities Pilot Program as a potential model for a Wisconsin community health benefit. North Carolina received approval of a federal waiver in 2018 that allows the state to initiate four demonstration projects to evaluate the impacts of Medicaid-funded benefits for nonmedical services to address four domains: housing, interpersonal violence/toxic stress, food, and transportation. As an example, in the housing domain the demonstration program will pay for navigation services to help individuals find suitable housing, but, for some beneficiaries, will also directly support housing stability by paying a security deposit and the first month of rent. In the food domain, the program could pay for healthy food boxes or medically tailored meals.

38. While the North Carolina demonstration is one potential model, the Department notes that Wisconsin's program would likely differ, due to differences in the state's existing Medicaid programs. The Department anticipates, for instance, that the benefit would generally not directly fund the cost of services, such as rental payments, but would instead focus on identifying individual needs and connecting individuals to existing public and nonprofit services. As included in AB 68/SB 111, the benefit would be defined as "services that contribute to determinants of health" and would direct the Department to identify the specific services.

39. The proposed community health benefit would be intended to use nonmedical services as a means to address social determinants of health as a means of improving health and reducing utilization of medical services. The Department currently has, or is in the process of implementing, a number of MA initiatives that have a similar intent. A few examples are described below:

- The Department's contract with MA health maintenance organizations (HMOs) includes various care management policies designed to address social conditions that affect health. For instance, for members enrolled on the basis of Supplemental Security Income (SSI) eligibility, the HMOs are required to provide intensive care coordination with attention to social determinants. As a part of this service, HMOs must maintain partnerships with social service organizations that address housing instability, health literacy, and traumatic life experiences.

- HMOs are also required to develop and implement performance improvement projects to improve the health of enrolled members. These projects take a variety of approaches, but typically focus on a specific clinical measure or health disparity and develop strategies to improve outcomes. HMOs may choose to utilize measures that would not otherwise be covered MA benefits. HMOs receive incentive payments for meeting target measures.

- The Department is implementing a hospital-based intensive care coordination pilot program for individuals with a history of frequent emergency room visits. Participating hospitals will receive a $250 payment for each participant, plus a portion of any estimated savings associated with a reduction in hospital services resulting from the program. Under the program, the hospital is expected to assist participants in connecting with health and social service resources, including housing and transportation.

• Under provisions of 2019 Act 76, DHS is required to submit a federal waiver or state plan amendment to provide intensive case management services to assist members who are experiencing homelessness. DHS is currently in the process of developing a federal application for this service.

40. While these initiatives are generally intended to address social determinants of health, the proposed community health benefit may provide authority for more comprehensive services or for other target groups that are currently unserved. However, since the specific services that would be covered and other details regarding of the benefit have not yet been determined, it is unknown what additional services would be provided that are not already available.

41. Given the proposed community health benefit would require a larger funding increase than the other MA benefit changes, and that many of the details relating to specific services and eligibility have not yet been developed, the Committee may determine that creating a more limited pilot program would be preferable to creating a statewide program at this time. In this case, one element of the community health benefit waiver could be to specify that the Department must limit services to pilot program areas and cap enrollment. For instance, to establish a pilot program limited to 3,125 individuals at a time (one-quarter of the estimated number of individuals used for the budget estimate) would require funding of $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $7,625,000 ($3,253,500 GPR and $4,371,500 FED) in 2022-23 (Alternative C2).

42. If the Committee provides funding and adopts a community health benefit, as proposed in AB 68/SB 111, the Department would develop a proposal for federal approval. Under current law, any federal waiver or other approval would need approval of the Committee prior to being submitted to the federal government. If a community health benefit is not approved (Alternative C3), the Department would not have funding and authority for the benefit, but could continue to use other measures, including the initiatives mentioned above, to address social determinants of health of MA enrollees.

ALTERNATIVES

A. Doula Service

1. Provide $1,015,200 ($406,700 GPR and $608,500 FED) in 2022-23 to fund MA coverage of doula services, with coverage estimated to begin July 1, 2022. Require DHS to apply for any necessary waivers of federal Medicaid law and submit any necessary state plan amendments to provide coverage of doula services under MA. Require DHS to reimburse certified doulas for childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, if federal approval is granted. Define a certified doula as an individual who has received certification from a doula certifying organization recognized by DHS.

ALT A1	Change to Base
GPR	$406,700
FED	608,500
Total	$1,015,200

2. Take no action.

B. Community Health Workers

1. Provide $14,232,000 ($5,701,600 GPR and $8,530,400 FED) in 2022-23 to fund coverage of community health worker services under MA, with coverage estimated to begin July 1, 2022. Requite DHS to submit to the federal Medicaid authority any necessary state plan amendments or requests for waiver to cover community health worker services under MA, but limit coverage under this benefit to those services receiving federal approval. Define a community health worker as a frontline public health worker who is a trusted member of or has a close understanding of the community served, enabling the worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and who builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

ALT B1	Change to Base
GPR	$5,701,600
FED	8,530,400
Total	$14,232,000

2. Take no action.

C. Community Health Benefit

1. Provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $24,500,000 ($10,014,000 GPR and $14,486,000 FED) in 2022-23 to fund a new MA benefit, subject to federal approval, for nonmedical services that contribute to determinants of health. Coverage would be estimated to begin January 1, 2023. Direct the Department to determine which specific nonmedical services that contribute to 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 does not provide federal matching funds for these services.

ALT C1	Change to Base
GPR	$10,514,000
FED	14,986,000
Total	$25,500,000

2. Provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $7,625,000 ($3,253,500 GPR and $4,371,500 FED) in 2022-23 to establish a community health benefit under MA on a pilot basis, with enrollment limited to 3,125. Include the other statutory changes from Alternative C1.

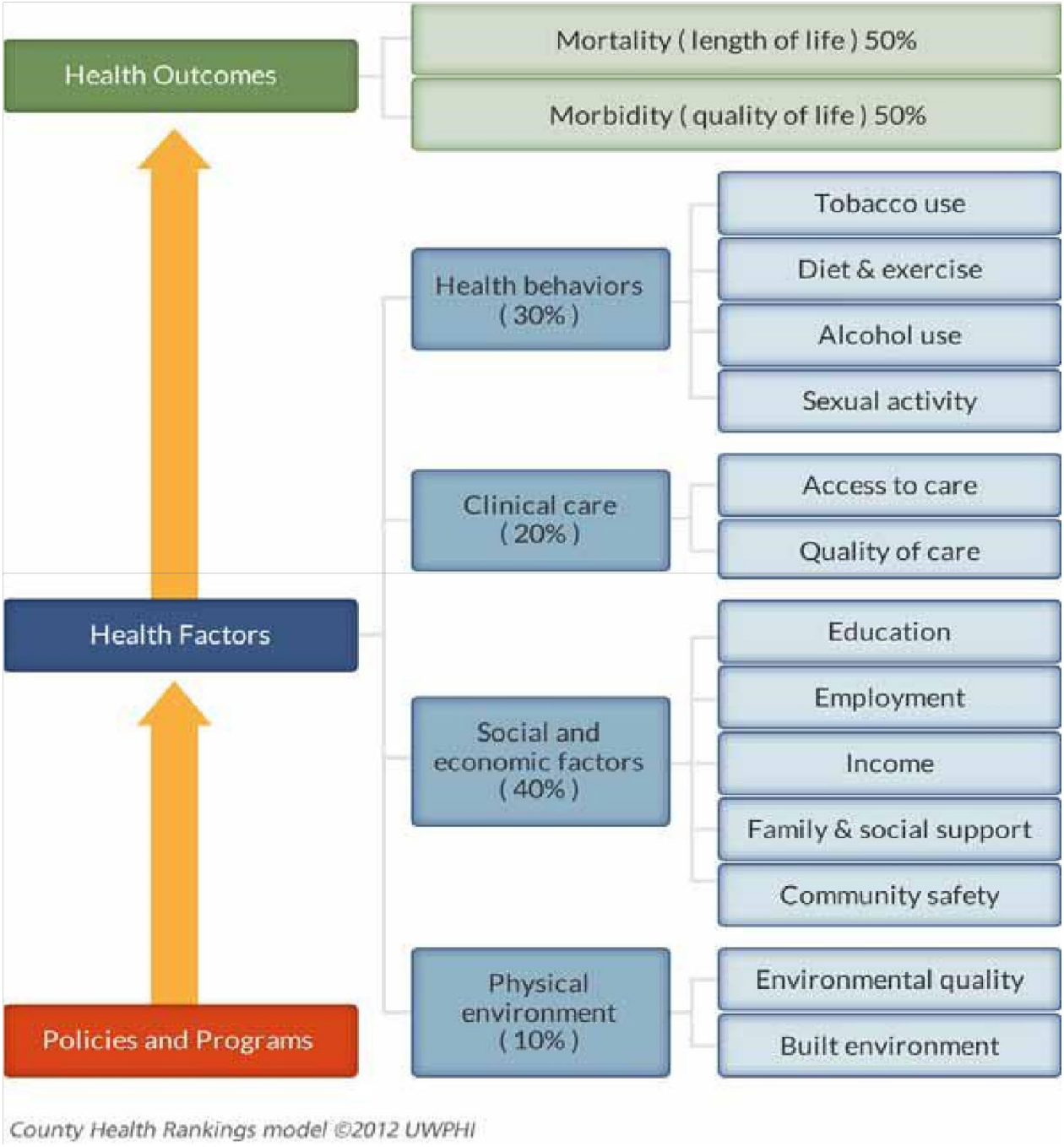
ALT C2	Change to Base
GPR	$3,753,500
FED	4,871,500
Total	$8,625,000

3. Take no action.

Prepared by: Carl Plant
Attachment

ATTACHMENT

Model of the Determinants of Health



Source: University of Wisconsin School of Medicine and Public Health, *Mobilizing Action Toward Community Health, County Health Rankings.* Accessible at http://www.countyhealthrankings.org/about-project/background.

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June, 2021 Joint Committee on Finance Paper #344

MA Dental Access Incentive Payments (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 267, #21]

CURRENT LAW

The Medical Assistance (MA) program provides coverage for a comprehensive range of dental services for children and adults. This includes the following groups of services: (a) diagnostic, including radiographs; (b) preventative; (c) restorative, including fillings and crowns; (d) endodontic, including root canals; (e) periodontic, including gums disease treatments; (f) orthodontic; (g) prosthodontic, including fixed and removable dentures; (h) surgical; and (i) adjunctive, including numbing, sedation, and palliative care. These services can be provided by or under the supervision of licensed dentists and, with certain restrictions, dental hygienists.

MA provides reimbursement for most dental care on a fee-for-service basis, using a rate schedule established by the Department of Health Services (DHS). In several counties in southeastern Wisconsin, dental reimbursement is instead provided by health maintenance organizations (HMOs) under contract to serve MA patients. In four counties (Brown, Marathon, Polk, and Racine), MA provides enhanced reimbursement under a pilot program established by the 2015-17 biennial budget act. In these counties, all dental services provided to patients under 21 years of age and emergency dental services provided to adults are reimbursed at higher rates established in a separate fee schedule.

Dental benefits can be provided in a variety of settings, including private practices, hospital emergency rooms, and low-cost clinics. For-profit dental practices accounted for 46% of MA dental services expenditures in 2019-20, non-profit clinics accounted for 8%, and hospitals for 4%. The MA program expended the remaining 42% of dental expenditures in 2019-20 on dental care provided in federally qualified health centers (FQHCs), which receive reimbursement under a different methodology. FQHCs, a type of non-profit clinic meeting specific federal requirements and providing care to underserved populations and areas, receive MA reimbursement per patient

encounter at rates designed to reflect their actual costs of care.

The MA program expended a total of $154.2 million on dental benefits in 2019-20.

DISCUSSION POINTS

1. Assembly Bill 68 and Senate Bill 111 would provide $11,949,700 ($4,779,900 GPR and $7,169,800 FED) in 2021-22 and $23,899,300 ($9,559,700 GPR and $14,339,600 FED) in 2022-23 to increase reimbursement rates for dental providers that meet care quality standards and thresholds for the number of MA or uninsured patients they serve as a percentage of their total patient census. Specifically, the bill would increase rates by 50% for qualified non-profit providers for whom 50% or more of the patients they serve are uninsured or enrolled in MA, and increase rates by 30% for qualified for-profit providers for whom 5% or more of the patients they serve are enrolled in MA.

2. The Department estimates that non-profit facilities accounting for 65% of MA dental claims paid to non-profits, currently meet the threshold of serving at least 50% uninsured or MA-enrolled patients, while facilities accounting for 97% percent of claims paid to for-profit providers currently meet the threshold of serving at least 5% MA-enrolled patients. Based on these estimates of the share of qualifying providers in each group, the Department estimates that the 50% rate increase provided by AB 68/SB 111 for qualifying non-profit providers would have an annual cost of $7.6 million on an all-funds basis, and that the 30% rate increase for qualifying for-profit providers would have an annual cost of $16.3 million on an all-funds basis. The cost estimates for fiscal year 2021-22 reflect the anticipated implementation of this rate increase effective January 1, 2022 (Alternative A1).

3. Neighboring states' Medicaid programs provide reference points to evaluate the adequacy of MA rates in Wisconsin, although differences in economic factors, level of coverage for adults, and other variations between states make direct comparisons difficult. DHS reports that Wisconsin's dental reimbursement rates are 7% above rates in Iowa, 55% above Illinois, and 37% above Michigan, but 11% below reimbursement rates in Minnesota.

4. The rates paid by commercial insurance in Wisconsin can vary between insurers and between different regions and specific dental providers. Although negotiated rates are generally kept confidential between providers and insurance companies, commercial rates are commonly reported to be multiple times higher than the rates paid by MA.

5. With certain exceptions, MA reimbursement rates for dentists have remained fixed since 2008, when rates were increased by 1%. One exception is the pilot program discussed above, and another is a 200% increase provided in the 2017-19 biennial budget for facilities that provide at least 90% of their dental services to people with cognitive and physical disabilities.

6. In a 2020 report, the University of Wisconsin's Institute for Research on Poverty (UW IRP) finds significant shortages throughout the state in the capacity of the dental workforce to provide care to MA enrollees. The federal Health Resources and Services Administration (HRSA) designates dental health professional shortage areas (HPSAs) for grant-making purposes and analysis of healthcare access. Dental HPSAs include specific facilities, populations, and geographic areas where

the ratio of dentists to the population they serve is fewer than one to 5,000, or one to 4,000 for populations with unusually high needs. HRSA has identified 113 current dental HPSAs in Wisconsin. Of the state's 72 counties, 36 are wholly designated as HPSAs, including most counties in the north, northwest, and western parts of the state. Most of the remaining counties contain smaller regions or facilities designated as HPSAs. Overall, 21% of Wisconsin's population has insufficient access to dental professionals, as defined by HPSA designation.

7. Beyond a general shortage of dentists in the state, several factors may impact dentists' willingness to serve MA patients. The higher rates paid by commercial insurers may cause dentists to prioritize patients with commercial insurance, leaving insufficient capacity for MA patients. In addition, since accepting MA patients requires the dental practice to become certified for Medicaid, the enrollment process itself may discourage provider from participation, particularly if the dentist would only serve a relatively small number of MA patients. Finally, the Wisconsin Oral Health Coalition argues in their *Oral Health Roadmap* that the lack of diversity among the dental workforce may limit their effectiveness in reaching underserved communities.

8. The Department's latest MA access monitoring report (2016) reports that 17% of Wisconsin dentists actively serve MA patients, defined as serving more than 25 per year. A total of 37% of licensed dentists are enrolled as MA providers. For comparison, 61% of primary care providers actively serve MA patients, and a total of 85% are enrolled as MA providers.

9. Of Wisconsin children enrolled in MA, 42% received any dental services in 2018, the 43rd lowest utilization by state in the country, per data from federal utilization reports. The UW IRP report referenced above found that 21% of adults enrolled in MA received any dental service in the two-year period ending September, 2018. The Department's 2018 *Healthy Smiles Healthy Growth* survey of Wisconsin third-grade students found that 18% had untreated dental decay, and 5% had an urgent condition causing pain or infection.

10. The Department indicates that MA members in northern counties received an above average level of dental services compared to all MA enrollees, while members in southeastern counties received fewer services. FQHCs provide a significantly larger share of dental services in northern counties than in southeastern counties, which DHS argues contributes to the difference in service access. While this suggests that FQHCs are effective safety-net providers of dental care, they may also be acting as the default provider for many MA patients. Given the higher reimbursement paid to FQHCs, the Department suggests that reliance on them to provide dental care may be a more expensive alternative than providing care in dental offices.

11. The UW IRP report referenced above evaluated whether the increased reimbursement provided under the dental pilot program resulted in increased access to care for MA members. The pilot program reimburses dentists in the four pilot counties for pediatric dentistry and adult emergency dental services at rates on average 2.0 to 2.5 times the statewide MA rates. However, analysis in the report of claims and access data from the two years before and two years after the implementation of the pilot found that it did not consistently or reliably expand access to dental care for MA members. Variable underlying trends and other policy changes in the study period limited the ability to detect small changes in access resulting from the pilot rate increase.

12. The report notes a significant increase in the number of MA members served and total dental services delivered in Brown County, but not in the other three pilot counties. Three months after the implementation of the pilot program, the nonprofit Brown County Oral Health Partnership (BCOHP) received a donation from insurer Delta Dental to open a new clinic and expand services. The report credits this increase in grant funding, well-organized efforts led by BCOHP to increase dentist participation in MA, and the enhanced rates under the pilot program for reinforcing each other and together achieving the observed increase in the level of MA dental care provided. BCOHP primarily serves uninsured or MA-enrolled children, including in schools (using mobile and semi-permanent clinics), in area hospitals, and in several dedicated clinic locations.

13. To explain the weak and inconsistent link between increased reimbursement and increased participation in the MA program by dentists, the report describes the two possible ways to increase provider participation as either to expand the total capacity of dental providers or to re-allocate existing dental visit slots from commercially-insured patients to MA members. The report describes increasing total workforce capacity as "a challenge given existing provider shortages in areas throughout the state," and states that a significant re-allocation of visit slots remains unlikely as long as MA rates (even with the pilot enhancements) "remain substantially lower than commercial insurance payments."

14. The Department cites a number of studies that, consistent with the IRP evaluation of the dental pilot program, find that broad increases to dental reimbursement rates increases produce relatively small gains in dental service access. Given these findings, the administration argues that the targeted increase for providers that meet specified MA patient percentages, as proposed in AB 68/SB 111, may be more effective. The Department's estimate of the cost of the access incentive initiative includes an assumption that the payments would increase the volume of dental services delivered by 5%.

15. The Department argues that one of the reasons for taking the access payment approach is to create incentives for providers to increase their MA patient percentage, for those who currently fall below the applicable thresholds. In addition, this approach recognizes that providers that are already serving a higher percentage of MA patients may experience lower revenues overall than providers that serve relatively few MA patients.

16. While the administration's proposal takes the approach of targeting an increase to providers that meet certain MA access thresholds, some may prefer to treat all provider types the same, regardless of their status as a for-profit or non-profit provider, or the percentage of MA patients that they serve. Alternatives B1, B2, and B3 would increase all MA dental reimbursement rates by 50%, 30%, and 10%, respectively. These alternatives would have no impact on reimbursement paid under the FQHC encounter reimbursement system or the pilot program.

ALTERNATIVES

A. Access Incentive

1. Provide $11,949,700 ($4,779,900 GPR and $7,169,800 FED) in 2021-22 and

$23,899,300 ($9,559,700 GPR and $14,339,600 FED) in 2022-23 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, 2022: (a) for a qualified non-profit or public 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, an increase to 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. Specify that any provider receiving reimbursement through the enhanced dental reimbursement pilot program created by 2015 Act 55 is not eligible for increased reimbursement under this new program.

ALT A1	Change to Base
GPR	$14,339,600
FED	21,509,400
Total	$35,849,000

2. Take no action.

B. Uniform Rate Increase

1. Provide $19,291,000 ($7,716,500 GPR and $11,574,500 FED) in 2021-22 and $38,582,300 ($15,432,900 GPR and $23,149,400 FED) in 2022-23 to increase MA dental reimbursement rates by 50%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

ALT B1	Change to Base
GPR	$23,149,400
FED	34,723,900
Total	$57,873,300

2. Provide $11,574,600 ($4,629,900 GPR and $6,944,700 FED) in 2021-22 and $23,149,300 ($9,259,700 GPR and $13,889,600 FED) in 2022-23 to increase MA dental reimbursement rates by 30%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

ALT B2	Change to Base
GPR	$13,889,600
FED	20,834,300
Total	$34,723,900

3. Provide $3,858,200 ($1,543,300 GPR and $2,314,900 FED) in 2021-22 and $7,716,300 ($3,086,500 GPR and $4,629,800 FED) in 2022-23 to increase MA dental reimbursement rates by 10%, effective January 1, 2022. Do not apply this increase to reimbursement rates paid under the enhanced dental reimbursement pilot program created by 2015 Act 55.

ALT B3	Change to Base
GPR	$4,629,800
FED	6,944,700
Total	$11,574,500

4. Take no action.

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June, 2021 Joint Committee on Finance Paper #345

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

[LFB 2021-23 Budget Summary: Page 269, #28]

CURRENT LAW

Wisconsin's SeniorCare program assists eligible seniors with prescription medication costs. 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 someone is enrolled, their 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 applies for people with an annual income below 160% of the federal poverty level (FPL); (b) a $500 deductible applies for people with an annual income between 160% and 200% of the FPL; and (c) a $850 deductible applies for people with an annual income between 200% and 240% of the FPL.

People with incomes above 240% of the FPL may enroll in the program, but will not be eligible for benefits until they 'spend down' their income below the 240% threshold. This means that enrollees must incur expenses for prescription drugs within a year that equal the difference between their annual income and 240% of the FPL. After meeting that requirement, people in the spend-down category must still meet the $850 deductible.

After satisfying any applicable deductible and spend-down, all enrollees make copayments of $5 for generic medications and $15 for brand name medications, while the SeniorCare 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 $123,311,100 ($20,090,100 GPR, $17,333,500 FED, and $85,887,500 PR) per year.

MODIFICATION

Increase funding by $2,758,900 (-$2,783,900 GPR, $228,100 FED, and $5,314,700 PR) in 2021-22 and increase funding by $10,032,300 (-$2,118,200 GPR, $404,800 FED, and $11,745,700 PR) in 2022-23 to reflect a reestimate of SeniorCare benefit costs.

Explanation: The estimate included in Assembly Bill 68 and Senate Bill 111 was based on program enrollment and costs through June, 2020. This reestimate reflects updated enrollment through May, 2021, which includes somewhat larger growth than predicted, particularly in the lower-income enrollment categories. This reestimate also includes reduced enrollment growth forecasts for 2022-23, in anticipation of a return to prior trends as economic activity returns to normal. Finally, this reestimate updates the projected federal matching rate for 2022-23.

	Change to Base
GPR	- $4,902,100
FED	632,900
PR	17,060,400
Total	$12,791,200

Prepared by: Carl Plant

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June, 2021 Joint Committee on Finance Paper #346

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

[LFB 2021-23 Budget Summary: Page 270, #29]

CURRENT LAW

The children's long-term support (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. Currently, funding for the program is budgeted as sum certain amounts from appropriations that support other MA benefits costs. As of May, 2021, there were 12,928 children enrolled in the program. The average monthly cost per child for these MA-funded supplemental support services is estimated to be $1,038.29 for 2020-21.

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.

In addition to state and federal MA funding, expenditures for the CLTS program are offset by program revenue as the result of a county maintenance of effort requirement enacted as part of the 2017-19 biennial budget act (2017 Act 59). Under this provision county waiver agencies (CWAs) are required to cooperate with DHS to determine an equitable, locally controlled funding

contribution mechanism to CLTS. Typically the maintenance of effort amount has been based on county contributions for the program in calendar year 2016, and has not fluctuated annually. It is estimated that the county contribution will total $6 million PR in each year of the 2021-23 biennium, amounts that serve as the state's share for the purpose of claiming federal MA matching funds. However, DHS reserves the right, in consultation with CWAs, to adjust the methodology in the future to meet changing program needs.

Children who qualify for the program are not entitled to receive waiver services. Historically, counties kept their own waiting lists for children who were not yet enrolled in the program. However, beginning in calendar year 2021, as required by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Services (DHS) has transitioned to full statewide management of the CLTS enrollment process, and counties are now required to place CLTS eligible children on the statewide waiting list. DHS then determines the timing of when an eligible child may be enrolled into the CLTS program, following the order on the statewide waiting list, in compliance with the federal 'first-come, first-served' requirement. All children approved to begin the CLTS enrollment process receive an appropriate CLTS service plan, which is fully funded by state Medicaid funding and related federal match, after application of county CLTS maintenance of effort requirements. Counties may not enroll any new CLTS participant except for children approved by DHS to begin the CLTS enrollment process or children who meet specified crisis need criteria.

The 2017-19 and 2019-21 biennial budget acts increased GPR funding for the CLTS program. This additional funding was intended to enable the state to serve all children on the waiting list for the CLTS program. 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 has still not been eliminated as of May, 2021.

DISCUSSION POINTS

1. 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, as well as a level of care need that is typically provided in an institutional setting such as a hospital, a nursing home, or an institution for people with developmental disabilities. Additionally, children must be able to receive safe and appropriate care at home or in another eligible community based setting; and be able to receive safe and appropriate care at home or in the community that does not have a cost to the Wisconsin Medicaid program that exceeds the cost Medicaid would pay if the child were in an institution. CLTS services are available to children from birth through age 21 statewide. However, children generally transition to Family Care or IRIS upon turning 18.

2. To qualify for CLTS services, a child's monthly income may not exceed $2,382 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 ($72,468 for a family of three in 2021) are required to pay a percentage of program costs on a sliding scale based on income.

3. 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 long-term care services under the Family Care or IRIS programs instead.

4. Based on available data, DHS Division of Medicaid Services (DMS) projects that CLTS enrollment may eventually have approximately 15,000 enrollees per month, at which time the program will reach a steady-state, in which children may be enrolled with no wait time upon being determined eligible. However, this estimate does not reflect the total number of children in Wisconsin who may potentially be eligible for CLTS services. As such this number is subject to change depending on numerous factors including the number of families of children with disabilities who do not: (a) seek services through DHS programs, (b) qualify under Medicaid eligibility standards, and (c) enroll in the program despite the child being found eligible.

5. To reach this anticipated steady-state, DMS anticipates the need to continue increasing the monthly count of CLTS enrollees throughout the 2021-23 biennium by an estimated 100 children per month in 2021-22 and 60 children per month in 2022-23. Using this assumption, 14,542 children will be enrolled in the program on a monthly basis by June, 2023, with average monthly enrollment in the program totaling 13,272 in 2021-22 and 14,212 in 2022-23.

6. However DHS analysis of CLTS program utilization and cost data found that many CLTS enrollees do not incur costs each month. DHS notes that in calendar year 2019, on average, only 95% of total program enrollees incurred costs on a monthly basis. This proportion was higher prior to the waiting list elimination initiative, when the percentage of enrollees with program costs was closer to 97%. This difference suggests that program costs could experience an additional increase during the waiting list elimination period as service provision stabilizes for a larger proportion of enrollees. The previous estimates assume that 95% of all CLTS enrollees will have program costs for the first three months of 2021-22, 96% during the subsequent three months, and 97% of all CLTS enrollees will have program costs beginning in January, 2022, and continuing for the remainder of the biennium. As such, only 14,106 of the 14,542 children enrolled in the program by June, 2023, are estimated to have costs in that month.

7. The average monthly cost per child enrolled in CLTS is estimated to be $1,063.62 in each year of the 2021-23 biennium, which is lower than the average monthly cost of $1,140 per enrollee budgeted for 2019-21 in 2019 Act 9. The Department indicates that the lower average monthly cost per enrollee is largely attributable to a difference in average costs for new enrollees (children enrolled in 2017-18 or later) versus ongoing enrollees (children enrolled prior to 2017-18). DHS suggests that two main factors may explain this difference. First, the Department notes that part of the cost differential is likely attributable to differing average acuity levels among new and continuing enrollees, with new enrollees requiring less intensive services overall, in comparison to ongoing enrollees. Second, DHS states that CLTS encounter data suggests new enrollee costs often vary widely in the first months of service, stabilizing as the initial year of service progresses.

8. Based on the aforementioned assumptions, it is estimated that an additional $27,145,000 ($10,084,000 GPR and $17,061,000 FED) in 2021-22 and $40,019,600 ($15,878,800 GPR and

$24,140,800 FED) in 2022-23, above the amount budgeted for the program in 2020-21 in Act 9, will be required to support program costs in the 2021-23 biennium. Funding for this provision has been included as part of the MA cost-to-continue, consistent with previous legislative and gubernatorial intent to fund the elimination of the waiting list.

9. If there was no net increase in children enrolled in the program in the 2021-23 biennium (based on a policy where a child on the waiting list could only enroll in the program if a child exits the program) it is estimated that an additional $19,126,300 ($7,105,200 GPR and $12,021,100 FED) in 2021-22 and $20,334,600 ($8,068,200 GPR and $12,266,400 FED) in 2022-23, above the amount budgeted for the program in 2020-21 in Act 9 would be required to support program costs in the 2021-23 biennium.

10. As of May, 2021, there is a total of 13,991 children currently enrolled or waiting to enroll in the program. As such, the estimate shown in the table above to fund costs associated with 14,542 children by June, 2023, would eliminate the waiting list as it currently exists. Both 2017 Act 59 and 2019 Act 9 also provided enough sum certain funding for the program to eliminate the waiting list, as it existed at that point in time. However, of those 13,991 children, 1,063 children are still waiting for CLTS services, either on the waiting list or otherwise waiting to complete the enrollment process. As in prior biennia, if additional children are added to the waiting list, funding budgeted as part of the MA cost-to-continue could be insufficient to eliminate the waiting list in the 2021-23 biennium.

11. Assembly Bill 68/Senate Bill 111 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 indicates that the statutory change would create a guarantee, whereby funding for the CLTS program is no longer based on an available number of "slots" or sum certain funding, 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.

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

13. In order to fulfill the commitment to ending the waiting list for CLTS services, as commenced by the Legislature and the Governor in 2017 Act 59, 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 statutory change to the program in AB 68/SB 111 [Alternative 1].

14. 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 CLTS 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 under the MA cost-to-continue item [Alternative 2].

ALTERNATIVES

1. Require DHS to ensure that any child who is eligible, and applies, for CLTS waiver program receives services under the CLTS waiver program.

2. Take no action.

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Health Services -- Medical Assistance

LFB Summary Items for Which No Issue Papers Have Been Prepared

Item #	Title
8	Acute Care Hospital Access Payments
9	Critical Access Hospital Access Payments
11	Pediatric Hospital Supplemental Payments
14	Medication-Assisted Treatment Reimbursement
16	Psychosocial Services
24	Coverage of Acupuncture Services
25	Speech-Language Pathologist Reimbursement
26	Audiology Reimbursement
27	Tribal Care Coordination Agreements