Health Services

Medical Assistance -- Eligibility and Benefits

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June, 2023 Joint Committee on Finance Paper #405

Medical Assistance Cost-to-Continue Estimate (Health Services -- Medical Assistance -- Eligibility and Benefits)

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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.

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; (d) enrollment in long-term care programs, such as Family Care and IRIS; 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 43/SB 70.

TABLE 1

Medical Assistance Cost-to-Continue Change to Base, AB 43/SB 70

Fund	2023-24	2024-25	Biennium
GPR	$119,124,000	$261,743,800	$380,867,800
FED	633,051,500	443,601,100	1,076,652,600
PR	46,004,200	-59,598,400	-13,594,200
SEG	281,844,100	-14,270,500	267,573,600
TOTAL	$1,080,023,800	$631,476,000	$1,711,499,800

3. This paper presents a cost-to-continue reestimate for the 2023-25 biennium. The reestimate is generally based on updated data and projections from the Department of Health Services, but makes certain modifications to the Department's assumptions. The revisions to the cost-to-continue estimate assumptions discussed in this paper result in an decrease of $26.7 million to the GPR funding for MA benefits over the biennium, and a total decrease of $14.5 million from all fund all sources over the biennium, relative to the AB 43/SB 70 estimates. Relative to the MA base, GPR funding for MA would increase by $354.2 million GPR over the biennium and by $1,697.0 million from all fund sources. Table 2 shows the funding adjustments made under the resulting cost-to-continue reestimate, expressed both as a change to the appropriation base and a change to the Administration's original estimate. Following the table is a description of the major contributing factors and assumptions for the cost-to-continue reestimate.

TABLE 2

MA Cost-to-Continue Reestimate, By Fund Source

	Change to Base			Change to AB 43/SB 70		
	2023-24	2024-25	Biennium	2023-24	2024-25	Biennium
GPR	$113,687,700	$240,502,500	$354,190,200	-$5,436,300	-$21,241,300	-$26,677,600
FED	618,648,900	326,565,800	945,214,700	-14,402,600	-117,035,300	-131,437,900
PR	82,458,000	38,064,300	120,522,300	36,453,800	97,662,700	134,116,500
SEG	298,691,500	-21,588,100	277,103,400	16,847,400	-7,317,600	9,529,800
Total	$1,113,486,100	$583,544,500	$1,697,030,600	$33,462,300	-$47,931,500	-$14,469,200

Medical Assistance Enrollment

4. Over the past three years, state Medicaid programs have been operating under a "continuous eligibility" policy, meaning that any person who was enrolled in the program as of March 18, 2020, or who later became eligible for coverage, could not be disenrolled even if changes to their household income, age, or household situation would have otherwise made them ineligible for

coverage. This policy, which was a condition of receiving enhanced federal matching rate under the federal Families First Coronavirus Response Act of 2020 (FFCRA), resulted in steady enrollment increases for all states over the past three years. To illustrate this impact on Wisconsin's Medical Assistance program, the following table shows a comparison of enrollment for the full benefit eligibility categories in January of 2020 and April of 2023.

TABLE 3

Enrollment Comparison by Full Benefit Category

Eligibility Category	January 2020	April 2023	Change
Elderly	32,783	40,979	8,196
Disabled	206,204	230,619	24,415
Children	446,325	590,451	144,126
Parents	158,055	251,936	93,881
Childless Adults	151,020	297,014	145,994
Pregnant Women	18,256	37,916	19,660
Foster Care/Subsidized Adoption	20,704	29,065	8,361
Other Full Benefit	988	957	-31
Well Woman MA	488	508	20
Total	1,034,823	1,479,445	444,622

5. The continuous eligibility policy ended on March 31, 2023, meaning that any person enrolling after that date has been subject to standard eligibility and disenrollment policies. For persons enrolled in the program prior to that date, eligibility will be redetermined on a rolling basis under a process that has come to be called "Medicaid unwinding." In preparation for the unwinding, DHS established a twelve-month eligibility redetermination schedule. However, although renewals are initiated mid-month on this 12-month schedule, since the renewal or coverage termination occurs 45 days after the renewal is initiated, the time between the first renewal notices being sent and the final renewals or terminations will extend for a total of about 14 months, from mid-April, 2023, to the end of May, 2024.

6. In general, the redetermination schedule was developed to distribute the workload for county and state eligibility determination staff over the 12-month unwinding period, as well as to maintain an even monthly renewal workload in future years. Although federal policies would have permitted the unwinding period to be completed in a shorter period of time, most states, like Wisconsin, have elected to use a 12-month unwinding timeline, largely due to the same or similar logistical considerations. According to a survey of state Medicaid agencies conducted by the Kaiser Family Foundation, 43 states are using a 12-month schedule.

7. For the purpose of scheduling redeterminations, DHS grouped individuals so that all members of a household will be reviewed at the same time. In addition, for individuals who are enrolled in other programs, such as FoodShare, the eligibility reviews for all programs were scheduled to coincide to reduce the need to undergo repeated application processes. Finally, the Department

considered the length of time since the most recent coverage renewal. In general, about 68,000 to 72,000 households are scheduled for eligibility redetermination in each month.

8. There is considerable uncertainty about what proportion of currently enrolled individuals will be disenrolled during the unwinding period, in large part because there is no precedent for the current situation, or even a comparable period in the program's history. According to the Kaiser Family Foundation survey cited earlier, state estimates of the rate of disenrollment range from 7% to 33% (as a percentage of the total Medicaid population). The U.S. Department of Health and Human Services' (DHHS) Office of Health Policy has estimated that 17.4% of all enrollees would be disenrolled, although this represents a national-level estimate that may not reflect individual states' experiences.

9. The rate of disenrollment will be affected, in part, by the number of individuals who lose eligibility for administrative reasons, rather than for reasons of program eligibility. An administrative disenrollment occurs when coverage is terminated--for a person who would otherwise meet eligibility criteria--due to a failure to correctly complete the application process by the deadline. Although DHHS is encouraging (or, in some cases, requiring) that states adopt measures to limit unintentional disenrollment, the Office of Health Policy estimates that 45% of all disenrollments will be for administrative, rather than eligibility, reasons.

10. Complicating the overall caseload estimates further, the regular process of enrollment and subsequent disenrollment of new enrollees (including due to births, deaths, and moves in and out of the state) will proceed as normal, which could either add to or subtract from the number of individuals who are disenrolled at the time of their unwinding redetermination. This may be affected by changes in economic conditions, particularly the unemployment and underemployment rates.

11. Under the assumptions used for the Administration's cost-to-continue estimate for AB 43/SB 70, total enrollment would decline by 27% from the beginning to the end of the unwinding period. However, the rate of decrease would vary by subgroup, from 46% for childless adults, 36% for parents, 24% for children, and 2% for enrollees in the EBD groups. By the end of the biennium, the Administration projects that the number of children, parents, and pregnant women will be at, or close to, the number who were enrolled in these categories in March of 2020. The number of childless adults is projected to be about 5% higher and the number of elderly and disabled beneficiaries will be 3% higher than in March of 2020, reflecting the net effect of unwinding disenrollment and the underlying enrollment trends.

12. The Administration's assumptions regarding enrollment in EBD Medicaid are based on the assumption that growth in the elderly and disabled enrollee categories will continue at a rate that is similar to recent years, largely mirroring growth rates in the state's elderly population. Since enrollment in EBD categories was not as affected by continuous eligibility policies as for the BadgerCare Plus groups, the unwinding process will not be as significant of a factor in determining EBD enrollment. Enrollment in elderly and disabled adults and children will decline slightly during the first year, before continuing a more typical growth pattern. Although these estimates are, by their nature, somewhat uncertain, the cost-to-continue estimate presented in this paper retains these assumptions for the EBD caseload.

13. The Administration's assumptions regarding BadgerCare Plus enrollment generally reflect the expectation that caseloads will mostly return to the levels that prevailed prior to the implementation of the continuous eligibility policy in early 2020. This would be consistent with an expectation that the economic indicators that are correlated with BadgerCare Plus enrollment, such as the household poverty rate, will not be substantially different during the biennium than they were prior to 2020. However, the enrollment projections used for the reestimate presented in this paper use a slightly lower rate of disenrollment for nonelderly adults during unwinding. This is largely to account for the possibility of coverage extensions granted for certain parents and children under current law transitional medical assistance provisions, as well as for the possibility that a higher proportion of childless adults who are eligible for coverage will remain enrolled during unwinding due to efforts to limit administrative disenrollments. Table 4 shows average monthly enrollment projections by eligibility category for the 2023-25 biennium, as well as actual and projected enrollments for 2021-22 and 2022-23.

TABLE 4

Actual and Projected Monthly Average Enrollment by Group, Cost-to-Continue Reestimate

	Actual	Projected	Estimates	
	2021-22	2022-23	2023-24	2024-25
Elderly, Blind, Disabled MA				
Elderly	84,089	88,015	87,268	87,502
Non-Elderly Disabled Adults	151,437	153,460	153,571	153,755
Disabled Children	34,741	35,893	35,805	35,834
EBD Total	270,266	277,368	276,645	277,092
BadgerCare Plus				
Children	553,511	583,790	581,419	493,102
Parents	224,548	245,079	236,494	184,982
Childless Adults	257,860	286,213	221,016	179,069
Pregnant Women	32,545	36,642	25,962	19,078
BadgerCare Plus Total	1,068,464	1,151,724	1,064,891	876,231
Other Full Benefit				
Foster Care/Subsidized Adoption	25,616	27,533	23,926	21,765
Well Woman	518	540	502	479
Total Full Benefit	1,364,864	1,457,165	1,365,964	1,175,567
Limited Benefit Groups				
Family Planning Only	45,649	49,017	41,434	36,407
Medicare Cost Sharing	16,244	15,589	16,212	16,663
Total Enrollment	1,426,757	1,521,771	1,423,610	1,228,637

Long-Term Care Programs

14. In addition to overall caseload projections, the cost-to-continue estimate takes into consideration enrollment and cost trends 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,

although these programs typically account for around 8% of total MA enrollment, they typically account for around 40% of MA costs, and so trends in these program can have a significant bearing on the cost-to-continue estimate.

15. The reestimate as described in this paper adopts the Department's assumptions regarding enrollment in both Family Care and IRIS. Specifically, DHS estimates that average monthly enrollment in Family Care will be approximately 53,100 in 2022-23 (a 2.8% increase from 2021-22 enrollment), and increase to approximately 54,300 in 2023-24 and 55,600 in 2024-25 (increases of 2.3% and 2.4% over the prior year, respectively). For IRIS, the Department estimates that average monthly enrollment will be approximately 25,100 in 2022-23 (a 6.4% increase from 2021-22 enrollment), and increase to approximately 26,900 in 2023-24 and 28,700 in 2024-25 (increases of 7.2% and 6.7%, respectively). Both of these assumptions appear consistent with recent enrollment trends, when considering the elimination of the waiting list for adults eligible for long-term care services in the spring of 2021.

16. 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 6,530 in 2022-23 to 5,950 by 2023-24 and 5,400 by 2024-25. As such, total fee-for-service patient bed days are anticipated to decline by approximately 9% annually.

17. Prior to the 2021-23 biennium, DHS estimated that 17% of nursing home patient days were attributable to managed care. However, 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. As such, it is estimated that 50.2% of nursing home patient days are attributable to managed care annually in 2023-25. The reestimate as described in this paper adopts the Department's assumptions regarding nursing home utilization in the 2023-25 biennium.

18. It is expected that approximately 19,800 children will be enrolled in the children's long term support (CLTS) waiver program by the end of 2022-23. However, on average, only 89% of CLTS enrollees are estimated to experience monthly program costs, an average of 16,300 per month in 2022-23. The administration's cost-to-continue estimate assumes that enrollment in the program will increase to 21,200 by June, 2024, and 21,700 by June, 2025 (of which 19,600 and 20,500, respectively, will experience monthly program costs).

19. Like in previous biennia, the Department's assumptions include funding sufficient to cover the full cost of CLTS services without maintenance of a waiting list. It is currently projected CLTS will experience average monthly enrollment growth of 150 individuals per month in 2023-24 and 75 individuals per month in 2024-25, and that the share of monthly enrollees with costs in the program will grow from an average of 91% per month in 2023-24 to 93% per month in 2024-25.

Home and Community-Based Services Enhancement Plan

20. A provision of the American Rescue Plan Act included federal incentives for states to improve their home and community-based services programs (HCBS) for elderly and disabled individuals. Under the provision, states received a 10.0 percentage point increase in their standard federal matching percentage for base HCBS expenditures during a 12-month period from April 1, 2021 to March 31, 2022. States are required to spend the state savings resulting from the enhanced federal matching rate to improve HCBS programs over a two-year period, from April 1, 2022, through March 31, 2024 (subsequently extended to March 31, 2025). States were required to submit a plan to the Centers for Medicare and Medicaid Services (CMS) with an expenditure plan for HCBS enhancements. For Wisconsin, the enhanced federal matching percentage resulted in state savings of $405.5 million.

21. Under Wisconsin's expenditure plan, the Department currently estimates that $101.9 million of this savings will be spent for HCBS initiatives in the 2021-23 biennium, leaving $303.6 million for expenditure through March 31, 2025. The Department intends to leave an unexpended surplus in the MA trust fund of $303.6 million at the end of the 2021-23 biennium, in order to carry over the funding needed for the remaining plan expenditures into the 2023-25 biennium. The Administration's cost-to-continue estimate includes the anticipated HCBS plan expenditures in the overall calculation of MA funding needs for 2023-24, which results in the carry-over funds being appropriated as SEG in the program. In addition to this SEG funding increase, the cost-to-continue item includes a FED increase of $191.2 million in 2023-24, to reflect the matching funds for the portion of HCBS plan expenditures that are eligible for federal financial participation. In total, this HCBS plan spending accounts for 29% of the biennial appropriation increase in the cost-to-continue reestimate.

HMO Capitation Rates and Payments

22. The Administration's cost-to-continue estimate assumed 2.0% annual increases to the 2024 and 2025 calendar year capitation rates for BadgerCare Plus and SSI HMOs, which is consistent with capitation estimates developed for prior biennial budgets. The reestimate presented in this paper 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.

23. Although it is assumed that HMO capitation rates will increase by 2.0% annually from 2023 levels, these rates will still be at or below capitation rates paid in 2022, because capitation rates decreased in 2023, from the 2022 rates. For BadgerCare Plus standard (parents and children), HMO monthly capitation rates declined by an average of 3.5%, for childless adults, the rates decreased by an average of 11.6%, and for SSI HMOs, the capitation rates declined by 3.2%. These decreases can be attributed, in large part, to lower average acuity levels (better health and lower service utilization) as enrollment has expanded with the continuous eligibility policy. That is, in comparison with HMO enrollees prior to 2020, the program currently enrolls more individuals with lower health care needs. In addition, enrollees are more likely to have other sources of coverage, such as employer-sponsored plans, which are billed for services instead of MA, further reducing average MA costs. As enrollment decreases during the unwinding period, the average cost can be expected to increase again, as the health care needs of those remaining in the program will be higher, and the likelihood of beneficiaries

have other insurance coverage is lower. This will eventually put upward pressure on capitation rates. However, since the unwinding process will be gradual, and there is some time lag in the data used to set capitation rates, the 2.0% annual growth rate remains a reasonable estimate for these rates for the 2023-25 biennium.

24. Beginning with the 2021 plan year, the Department has included risk corridor payment and recoupment provisions in HMO and long-term care managed care organization (MCO) contracts, in part to account for increased uncertainties regarding service utilization during the COVID-19 pandemic and the enrollment changes brought on by the continuous eligibility policy. Under these risk corridor provisions, HMOs and MCOs are required to make payments back to the program if the sum of their payments for contract services exceeds their total capitation revenues by a certain percentage. Conversely, HMOs and MCOs are entitled to receive an additional payment from the program if they suffer losses (contract payments in excess of capitation revenue) that exceed certain specified percentages. For the 2021 contracts, HMOs and MCOs experienced surplus revenue, in aggregate, and so will be required to make payments back to the program under the risk corridor provisions. These payments, which are expected to occur in the fall of 2023, have not been finalized, but the Department estimates that they will total approximately $182.0 million. The Administration's cost-to-continue estimate reflects the impact of these risk corridor recoupment payments in 2023-24, which reduces the amount needed for HMO and MCO payments in that year by $182.0 million, ($70.0 million GPR and $112.0 million FED).

25. The Administration's cost-to-continue estimate does not include any risk corridor recoupment payments for the 2022 plan year, since it is too early to determine whether the HMOs and MCOs realized surpluses of a sufficient magnitude to trigger payments. Nevertheless, there are at least some preliminary indications that 2022 was profitable for the MA HMOs and MCOs, although possibly not as profitable as 2021. Some of the circumstances that lead to lower 2023 capitation payments--lower average acuity and higher proportion of alternative coverage associated with the expanded enrollment--continued throughout 2022. On the other hand, these favorable conditions may have been somewhat offset by rebounding service utilization, following a year in which COVID-19 restrictions suppressed some types of service usage.

26. On balance, it is reasonable to assume some recoupments for the 2022 plan year, payable in 2024-25. For the purposes of the reestimate presented in this paper, it is assumed that recoupments will be one-third of the estimate for 2021, as a percentage of total capitation payments. These payments would offset HMO and MCO payments by an estimated $69.4 million ($27.3 million GPR and $42.1 million FED).

Fee-For-Service Utilization

27. For servicers delivered on a fee-for-service (FFS) basis, the cost-to-continue estimate typically relies on recent trends in claims data by service category and eligibility group to estimate service utilization for the upcoming biennium. For most FFS categories, the estimate projects costs on a per member-per month basis, and inflates or deflates those amounts based on recent trends. The FFS categories that are estimated in this way and that have the greatest impact on the overall cost-to-continue estimate are typically prescription drugs, inpatient hospital services, and personal care services.

28. The estimate presented in this paper uses updated information from the Department of Health Services for FFS utilization. In general, the reestimate for many categories is lower than the projections used for AB 43/SB 70, due to revised estimates of the baseline expenditures for 2022-23. For the same reason that HMO capitation rates were lowered in 2023, FFS utilization is now projected to be somewhat lower in some of the major service categories in 2022-23 than earlier projections due to a caseload that is, on average, healthier than in the past.

Federal Medicare Premiums and Part D Clawback

29. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for certain enrollees who are dually-eligible for Medicaid and Medicare. The Administration's cost-to-continue estimate was based on projections for these premiums for 2024 and 2025 included in the 2022 annual report of the Medicare Board of Trustees. The number of dually-eligible beneficiaries eligible for Part A premium payments is expected to remain relatively constant throughout the biennium, at approximately 7,200 per month, while the number eligible for Part B premium payments is projected at about 139,000 per month. The reestimate presented in this paper accepts the Administration's estimates of the dually eligible beneficiaries eligible for Part A and Part B premiums, but uses updated premium projections from the 2023 Medicare Trustees report, which are slightly lower than the 2022 projections. Total Part A and Part B premium payments are estimated at $330.3 million ($127.1 GPR and $203.2 million FED) in 2023-24 and $348.6 million ($137.0 million GPR and $211.5 million FED) in 2024-25.

30. 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 in this paper updates the Administration's estimate of dually-eligible enrollees, but updates the estimate using the most recent projections of changes to per capita drug costs included in the 2023 Medicare Trustees report. Total clawback payments are estimated at $357.9 million GPR in 2023-24 and $405.7 million GPR in 2024-25.

Federal Medical Assistance Percentage (FMAP)

31. The FMAP determines the federal matching rate for Medicaid benefit expenditures. The FMAP formula is based on the state's per capita personal income in relation to the national average. Historically, Wisconsin's FMAP has typically ranged between 58% to 62%, although it was increased by 6.2 percentage points during the past three years, under provisions of the federal Families First Coronavirus Response Act (FFCRA). That enhanced rate is now being phased down over the course of calendar year 2023, returning to the standard formula, beginning in 2024. Under the phase-out schedule, states receive a 5.0 point increase in the second quarter of 2023 (April 1 to June 30), a 2.5 point increase in the third quarter, and a 1.5 point increase in the fourth quarter.

32. Table 5 below shows the actual and projected FMAP rates applicable to MA benefit expenditures in each fiscal year from 2022-23 through 2024-25. The rates shown for 2024-25 have

been decreased slightly from the Administration's cost-to-continue estimate, reflecting the most recent projections. As shown in the table, the FMAP is projected to decline from 2022-23 through the end of the biennium, reflecting the phase-out of the enhanced rate received under FFCRA. In addition to the FMAP for regular Medicaid (Title 19 of the federal Social Security Act), the table also shows the higher rate applicable to expenditures for children eligible under the Children's Health Insurance Plan (CHIP or Title 21).

TABLE 5

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)
2022-23		
State	34.06%	23.84%
Federal	65.95	76.16
2023-24		
State	38.48%	26.94%
Federal	61.52	73.06
2024-25		
State	39.31%	27.52%
Federal	60.69	72.48

33. Although the state's FMAP will be lower in the 2023-25 biennium without the enhanced formula, in comparison to the 2021-23 biennium, this does not significantly impact the cost-to-continue adjustment to GPR appropriations. This is because the 2021-23 budget for MA was established with the expectation that the enhanced rate would already have expired by 2022-23. Thus, the current appropriation base for MA reflects the assumption that the FMAP would be 60.32% in that year under the standard formula. In comparison to that rate, the current FMAP projections for the two state fiscal years of the 2023-25 biennium (61.52% and 60.69%) are actually somewhat higher. Consequently, in isolation, the FMAP has a slight negative effect on GPR appropriation adjustments, relative to the GPR appropriation base for the program.

Medical Assistance Trust Fund Revenue

34. The medical assistance trust fund (MATF) is a segregated fund used for the nonfederal share of MA benefits, offsetting an equal amount of GPR. In a typical biennium, most revenues to the trust fund are collected from provider assessments, such as the nursing home bed assessment and the hospital assessment (although, in that case, indirectly through a transfer from the hospital assessment fund). The 2021-23 budget included two changes to MATF revenues that are notable. First, MATF revenues included transfers from the general fund of $174,665,900 in 2021-22 and $527,783,700 in 2022-23. Second, all revenues received by the state under terms of the Master Tobacco Settlement

and deposited in the permanent endowment fund are annually transferred to the MATF. Previously, the MATF received $50,000,000 annually from permanent endowment fund, but the remaining revenues in that fund were deposited in the general fund.

35. The transfers from the general fund and the increase in the transfer from permanent endowment fund result in higher SEG appropriations for MA, and an equivalent reduction in GPR appropriations and available general fund revenues. Because the reduction in GPR appropriations is equal to the reduction general fund revenues, these changes have no net change to the use of general fund resources for the program.

36. The MATF transfer measures were included in the 2021-23 budget act as part of an initiative to reduce statewide GPR expenditures as a means to reduce the state's obligations under a federal maintenance of effort provision for state education spending. Those maintenance of effort provisions no longer apply for the 2023-25 biennium.

37. Recognizing that the maintenance of effort provision would only apply for the 2021-23 biennium, the transfer from the general fund to the MATF was made on nonrecurring basis. For the 2023-25 budget, therefore, the SEG and GPR changes that were made in the appropriation base as a part of this transfer provision are reversed. However, the change to the permanent endowment fund was an ongoing change.

38. The 2021-23 budget change to the permanent endowment fund transfer has introduced a source of uncertainty into the MA cost-to-continue estimate that was not there previously. Most sources of MATF revenues are fixed or can be estimated with reasonable certainty. Thus, prior to the permanent endowment fund change, the SEG appropriation from the MATF, which is sum certain, could be established by the budget to match expected revenues. Tobacco settlement payments, however, are not known with as much certainty as the traditional MATF revenues, since they can vary based on tobacco sales, the receipt of disputed payments from prior years, and other factors.

39. To illustrate the uncertainty of tobacco settlement payments, the 2021-23 budget assumed that the amount of proceeds deposited in the MATF would be $97.3 million in 2021-22 and $103.6 million in 2022-23. However, in part because the state received disputed payments from prior years, the total amount received was $126.8 million in 2021-22 and $133.4 million in 2022-23. Furthermore, because the SEG appropriation is set to match MATF revenue estimates set during the budget, the program does not have authority to spend this additional MATF revenue received to offset GPR spending. Previously, since the amount of tobacco proceeds deposited in the MATF was fixed at $50,000,000 annually, the relative shares of SEG and GPR funding in the program could be known with greater certainty.

40. The cost-to-continue reestimate presented in this paper assumes that the state will receive $101,523,900 in 2023-24 and $95,817,200 in 2024-25, which is the same assumption used for the cost-to-continue estimate included in AB 43/SB 70. These estimates are developed by the National Association of Attorneys General.

41. In the event that the state receives tobacco settlement payments in excess of the amounts included in the cost-to-continue estimate (and all else being equal), the MA program will not be able

to spend this amount, and would instead spend more from the GPR appropriation for the program than would otherwise be the case. To reduce this source of uncertainty in the estimate, the Committee could consider returning to the previous policy of transferring $50,000,000 annually from the permanent endowment fund to the MATF annually, and depositing the remainder in the general fund. Relative to the cost-to-continue estimate, this would have no net effect on the general fund balance since it would increase general fund revenues by amounts equal to increases in the GPR appropriation MA ($51,523,900 in 2023-24 and $45,817,200 in 20024-25). The MATF SEG appropriation would be reduced by corresponding amounts. [Alternative B1]

Summary

42. The Medicaid program, in Wisconsin as well as nationally, will be undergoing significant enrollment changes during the 2023-25 biennium, as the program returns to normal operations following the COVID-19 public health emergency. Since the unwinding process is just now beginning, the caseload projections used for the cost-to-continue estimate are subject to a greater degree of uncertainty than is typically the case. Moreover, in addition to the magnitude of the enrollment changes, there is additional uncertainty related to how the unwinding process will change the average costs of those who remain enrolled.

43. 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, the cost-to-continue reestimate presented in this paper the estimate presented in this paper adopts an overall cautious approach that allows for the possibility that MA costs will increase above recent trends. However, the estimate cannot account for all contingencies, including a significant recession, which could result in deficit in the MA GPR appropriation.

44. In addition to adopting the cost-to-continue reestimate, as shown in the table under Part A of the alternatives, the Committee could consider changes to the treatment of permanent endowment fund transfers to the medical assistance trust fund under Part B.

ALTERNATIVES

A. MA Cost-to-Continue Reestimate

Adopt funding changes to the medical assistance appropriation base as shown in the following table.

Medical Assistance Cost-to-Continue Change to Base, Reestimate

Fund	2023-24	2024-25	Biennium
GPR	$113,687,700	$240,502,500	$354,190,200
FED	618,648,900	326,565,800	945,214,700
PR	82,458,000	38,064,300	120,522,300
SEG	298,691,500	-21,588,100	277,103,400
Total	$1,113,486,100	$583,544,500	$1,697,030,600

B. Transfer of Permanent Endowment Fund Revenue to the Medical Assistance Trust Fund

1. Specify that the amount to be transferred from the permanent endowment fund to the medical assistance trust fund shall be $50,000,000 in each fiscal year, and that any other amounts in the permanent endowment fund from tobacco settlement payments shall be transferred to the general fund in each fiscal year. Increase the GPR appropriation for MA benefits by $51,523,900 GPR in 2023-24 and $45,817,200 GPR in 20024-25 and increase estimated general fund revenues by corresponding amounts. Decrease the SEG appropriation from the medical assistance trust fund for MA benefits by $51,523,900 SEG in 2023-24 and $45,817,200 SEG in 20024-25 and decrease estimated trust fund revenues by corresponding amounts.

ALT B1	**Change to Base**	
	Revenue	Funding
GPR	$ 97,341,100	$ 97,341,100
SEG	-97,341,100	-97,341,100
Total	$0	$0

2. Take no action.

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June, 2023 Joint Committee on Finance Paper #406

Postpartum Eligibility Extension
(Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 238, #4]

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 primarily upon household income level. 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.

Once enrolled in BadgerCare Plus, a pregnant woman remains eligible for a period of time following delivery. Currently that postpartum eligibility period extends until the last day of the month that falls 60 days following delivery. Under a provision of 2021 Act 58, DHS is required to submit a request for federal approval of a state Medicaid plan amendment or federal waiver to extend postpartum eligibility for pregnant women until the last day of the month in which the 90th day following the pregnancy falls. Until such a request is approved, or if such a request is denied, the 60-day postpartum eligibility standard remains in effect. The Department submitted a federal waiver request in June of 2022, but the federal Centers for Medicare and Medicaid Services (CMS), which has responsibility for administering the Medicaid program, has not yet acted on the request.

DISCUSSION POINTS

1. During the 2021-23 legislative session, the Committee and Legislature considered proposals to extend postpartum coverage under BadgerCare Plus to 12 months, both as part of biennial budget deliberations and as part of separate legislation introduced in both houses. In the end, the Committee elected to include a one-month extension to the current law 60-day period in the budget act. Since this 90-day period was conditioned upon federal approval of a waiver request, and the

federal government has not yet acted upon the state's waiver application, the 60-day period remains in effect.

2. Since March of 2020, state Medicaid programs have been operating under a "continuous enrollment" policy, as a condition of receiving enhanced federal matching rate provided under Families First Coronavirus Response Act of 2020. This policy requires states to maintain eligibility for any enrolled person, regardless of household income or other changes that would otherwise result in disenrollment. Consequently, MA has, in practice, provided extended postpartum coverage during the 2021-23 biennium, even though the federal government has not approved the state's waiver application for a 90-day postpartum eligibility period. For some women, this policy has provided postpartum coverage exceeding 12 months.

3. The continuous enrollment policy ended as of March 31, 2023, as the result of a change included in the federal 2023 budget appropriations act. This change will result in a resumption of the 60-day postpartum eligibility limit.

4. Upon the expiration of the 60-day postpartum MA eligibility period, a woman may retain coverage in other MA eligibility categories, most often as a parent, if she meets the applicable income and nonfinancial eligibility criteria. For a woman whose household income is above the 100% of FPL income eligibility threshold for non-pregnant adults, MA coverage is terminated and her coverage status then 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.

5. Prior to the changes in enrollment patterns resulting from the continuous enrollment policy, approximately 28% of pregnant women enrolled in BadgerCare Plus had a household income above 100% of the FPL. In both 2018-19 and 2019-20, this share of the pregnant woman enrollment category accounted for a monthly average of approximately 5,300 women.

6. Advocates of a 12-month postpartum Medicaid coverage policy maintain that extended coverage could help reduce the maternal death rate, which has historically been higher in the United States than in other high-income countries. A 12-month policy ensures coverage stability during a time when maternal health problems may arise, while avoiding transitions between insurers and primary care providers. Some postpartum conditions, such as cardiomyopathy (heart muscle disease), aneurisms, kidney failure, and perinatal mood and anxiety disorders, frequently extend beyond a 60-day postpartum coverage period.

7. In addition to the potential benefits of stable medical care, a postpartum extension may help provide greater financial stability for low income families. Because Medicaid coverage does not charge a premium for pregnant women and 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.

8. 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.

9. The federal American Rescue Plan Act of 2021 included a provision that gives states the option to extend coverage to postpartum women for 12 months following delivery. As initially passed, this option was available to states for five years, from April 1, 2022, until March 31, 2027. However, Congress subsequently passed legislation making the 12-month coverage a permanent state option.

10. Since the creation of the 12-month coverage option, 43 states have implemented or are in the process of implementing a 12-month postpartum coverage policy. Wisconsin and Texas are the only two states that passed legislation authorizing a postpartum coverage extension shorter than 12 months (although the Texas Legislature recently adopted a 12-month extension instead). While states can adopt a 12-month postpartum coverage policy with a state Medicaid plan amendment, a coverage period that is less than the full 12 months requires a federal waiver. 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.

11. DHS submitted its federal waiver request in June of 2022, but the federal Centers for Medicare and Medicaid Services has not yet acted on the request. CMS also did not act on the Texas 6-month waiver request before the Texas Legislature adopted a 12-month postpartum extension bill.

12. Given that over one year has elapsed since Wisconsin submitted the waiver application to CMS for a 90-day postpartum period, and that 43 states have already adopted a 12-month postpartum extension, it is possible that CMS may not approve Wisconsin's waiver application. Among other features, federal Medicaid waivers are generally intended to demonstrate new, state-specific policy approaches to the Medicaid program. CMS may determine that a one-month extension to the current 60-day postpartum policy does not offer a sufficiently novel approach to warrant approval.

13. AB 43/SB 70 would implement a 12-month postpartum eligibility extension. The statutory changes in AB 43/SB 70 related to postpartum coverage are identical to two companion bills, AB 114 and SB 110, which were introduced subsequent to the introduction of the Governor's bill.

14. AB 43/SB 70 would provide funding increases of $16,949,900 ($5,674,800 GPR and $11,275,100 FED) in 2023-24 and $17,464,000 ($5,960,500 GPR and $11,503,500 FED) in 2024-25 to reflect the estimated cost of providing one-year postpartum coverage. The Administration estimates that the 12-month postpartum extension, once fully phased in, would increase enrollment of pregnant women by 6,700 in 2023-24 and 4,300 in 2024-25, above the baseline enrollment projection. These funding and enrollment estimates were developed under the assumption that the state would also adopt full Medicaid expansion. Without adopting full expansion, the Administration estimated that the funding needed for a 12-month postpartum extension would be $20,783,800 ($7,997,600 GPR and $12,786,200 FED) in 2023-24 and $21,414,200 ($8,379,400 GPR and $13,034,800 FED) in 2024-25.

15. The following table shows a reestimate of implementing the postpartum extension. This estimate, which is not based on adopting full Medicaid expansion, is similar to the comparable estimate developed by the Administration for 2024-25, but is somewhat lower than the Administration's estimate for 2023-24. The difference is primarily due to the use of different assumptions regarding the number of women who would otherwise lose coverage under the current 60-day policy. It assumes that once fully phased in, a 12-month postpartum policy would increase the monthly average MA enrollment by approximately 5,300.

Estimated Cost of 12-Month Postpartum Extension for Pregnant Women

Fund Source	2023-24	2024-25
GPR	$5,000,000	$8,400,000
FED	8,000,000	12,900,000
Total	$13,000,000	$21,300,000

16. The Committee could determine that since the federal option for a 12-month postpartum period is now permanent, and that most other states have already adopted the extension, Wisconsin could also now adopt the policy, with funding increases as shown in the table above. [Alternative 1]

17. Although CMS may or may not approve of the state's 90-day postpartum eligibility waiver, the Committee may determine that continuing to wait for CMS to review the waiver application is preferable to adopting the full 12-month policy, in which case no change to state statute of funding would be needed. [Alternative 2]

ALTERNATIVES

1. Provide $13,000,000 ($5,000,000 GPR and $8,000,000 FED) in 2023-24 and $21,300,000 ($8,400,000 GPR and $12,900,000 FED) in 2024-25 to support the cost of implementing a 12-month postpartum eligibility extension under the MA program. Adopt statutory changes included in AB 43/SB 70 to adopt the 12-month postpartum extension.

ALT 1	Change to Base
GPR	$13,400,000
FED	20,900,000
Total	$34,300,000

2. Take no action.

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June, 2023 Joint Committee on Finance Paper #407

Medical Assistance Provider Reimbursement Rates (Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 242, #7; Page 244, #9 and #10; Page 245, #11, #12, and #13]

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. 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 health maintenance organizations (HMOs) that are paid monthly capitation payments.

For most services, fee-for-service reimbursement is made in accordance with a maximum fee schedule established by the state, which specifies reimbursement rates for each specific covered procedure. HMOs negotiate reimbursement with providers in their networks, but HMO rates are generally similar to the FFS rates set in the schedule.

Federal law gives states flexibility in designing MA reimbursement methods, subject to four basic requirements. First, with the exception of copayments when required, 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

1. Assembly Bill 43 and Senate Bill 70 would provide funding to increase provider reimbursement rates for hospitals, primary care providers, emergency department physicians, outpatient mental health and substance use disorder treatment providers, child and adolescent day treatment providers, and autism treatment providers. Each of these is discussed in the following sections.

2. The 2021-23 biennial budget increased reimbursement rates for a number of different services, as shown below. All increases in this table took effect January 1, 2022, unless otherwise noted. The estimated costs shown are included in the base funding for MA in 2023-24 and beyond.

Rate Increases Included in the 2021-23 Biennial Budget

		Annual Ongoing Cost ($ in Millions)		
Provider Type	Description	GPR	FED	Total
Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID)	Estimated to be a 12% rate increase effective July 1, 2021, and an additional 12% rate increase effective July 1, 2022	$67.6	$102.8	$170.4
Outpatient Mental Health	15% increase to outpatient mental health and substance abuse services rates	5.3	7.9	13.2
Child Day Treatment Providers	20% increase to child and adolescent day treatment rates	1.1	1.6	2.7
Opioid Treatment Providers	5% increase to opioid treatment provider rates	0.6	1.0	1.6
Primary Care Providers	$5 per visit increase to reimbursement when providing medication-assisted treatment (MAT)	0.4	0.5	0.9
Dentists	40% increase to dental services rates	12.3	18.6	30.9
Applied Behavioral Analysis (ABA) Providers	15% increase to a selected adaptive behavioral treatment rate	3.9	5.8	9.7
Emergency Physicians	15% increase to emergency department physician services rates	1.7	2.7	4.4
Speech-Language Pathologists	Increase speech-language pathology rates to 75% of the 2021 Medicare rate, a 34% increase in aggregate	0.8	1.1	1.9
Audiologists	Increase audiology rates to 75% of the 2021 Medicare rate, a 35% increase in aggregate	0.8	1.1	1.9
Ambulance Services	Increase selected ambulance rates to 80% of the 2021 Medicare urban rate	4.5	6.7	11.2
Chiropractors	Increase spinal manipulation rates to 70% of the 2021 Medicare rate	1.1	1.7	2.8
Physical Therapists	5% increase to physical therapy rates	0.6	0.9	1.5
Home Health	Rates for selected nursing care services in home health agencies that are licensed under Wis. Stat. § 50.49 were increased by 7.95 %	1	1.5	2.5
Personal care	Hourly rate increased from $19.16 to $20.80 on January 1, 2022, and to $23.44 on January 1, 2023.	14.1	24.3	38.4

3. Outside of the biennial budget process, DHS can modify reimbursement rates administratively. State statutes require that DHS submit any such rate increases with an estimated all-funds annual fiscal effect of $7,500,000 or greater to the Committee for passive review. Since enactment of the 2021-23 biennial budget, DHS has made several administrative reimbursement rate changes, most with an estimated all-funds annual cost of under $1.0 million. DHS made three rate changes with larger effects in this period: (a) a 16% increase to selected ambulance service rates effective February, 2022, with an estimated annual cost of $6.9 million from all funds ($2.6 million GPR); (b) an additional 10% increase to ambulance service rates effective February, 2023, with an estimated annual cost of $6.6 million from all funds ($2.6 million GPR); and (c) an 8.7% increase to behavioral treatment rates used primarily for applied behavioral analysis (ABA) therapy administered to children with autism, with an estimated all-funds cost of $5.7 million ($2.1 million GPR) per year.

4. A primary goal of most rate increases is to improve access to certain medical services. However, access can be constrained by a variety of factors, including the availability of medical professionals with necessary credentials and the viability of potential business models in a given location, such as a rural area. Because reimbursement under MA is generally lower than reimbursement paid by private insurance plans, providers often limit the share of their total service capacity they make available to MA patients. If providers have excess capacity and may have appointment slots go unfilled, they are more likely to accept MA patients even at rates much lower than commercial insurance; conversely, if provider capacity is insufficient to meet demand, providers have an incentive to prioritize patients with private insurance even if MA reimbursement is only slightly lower than commercial rates. For these reasons, in some cases a moderate MA rate increase may increase access to services while in other cases even a large rate increase may have limited impact.

5. The funding provided under AB 43/SB 70 for rate increases reflects a two-year increase in federal matching rates the state would have qualified for by adopting full Medicaid expansion. The Committee removed full Medicaid expansion from further consideration under Motion #10. Hence, the FED and GPR shares of costs presented in this paper differ from those under the bill.

6. In general, rate increases require some time to implement. DHS renews contracts with health maintenance organizations on a calendar year basis, so implementing increases effective January 1 reduces administrative burden. For these reasons, and consistent with practice in prior budgets, rate increases described in this paper are assumed to take effect January 1, 2024, unless otherwise noted. As a result, the fiscal effect in 2023-24 will be half of that in 2024-25; the 2024-25 amount represents a full year of the increased rates and the estimated ongoing cost.

Hospitals—Base Reimbursement

7. AB 43/SB 70 would provide $22,716,300 (all funds) in 2023-24 and $45,432,500 (all funds) in 2024-25 to increase base inpatient and outpatient hospital rates. The Administration's proposal is contingent on the adoption of full Medicaid expansion.

8. Reimbursement for hospital inpatient and outpatient care provided to MA recipients generally consists of a base rate payment plus supplemental payments. For acute care hospitals, base reimbursement for each inpatient stay is determined by the patient's diagnosis, regardless of the

specific procedures performed or length of stay. Long-term care, rehabilitation, and psychiatric hospitals receive a per-diem base reimbursement. Base reimbursement for outpatient care is based on the service provided. A variety of supplemental payments are made in addition to these base reimbursements, the largest being 'access' payments and disproportionate share hospital (DSH) payments. Access payments are made to acute care hospitals, critical access hospitals (smaller rural acute care hospitals), and rehabilitation hospitals for each visit at flat rates that depend only on the hospital type and whether the visit was an inpatient stay or for outpatient services. DSH payments are made in proportion to the base reimbursement for each inpatient stay and depend on what share of a hospital's total patient-days serve MA patients. Only hospitals for which MA patients comprise at least 6% of total patient days receive DSH payments. The table below shows estimated total base reimbursement and supplemental reimbursement, including access and DSH payments, paid to each category of hospital in 2022

Estimated Total Inpatient and Outpatient Hospital Reimbursement under MA in 2022 ($ in Millions)

Hospital Category	Number in Wisconsin	Total Base Reimbursement	Total Supplemental Reimbursement	Grand Total
Acute Care	84	$1,154.8	$816.7	$1,971.5
Critical Access	58	187.5	23.1	210.6
Long-Term Acute	3	19.4	0.8	20.3
Psychiatric	17	89.1	1.1	90.2
Rehabilitation	8	8.7	2.2	10.9
Total	170	$1,459.5	$843.9	$2,303.4

9. For an inpatient stay at an acute care hospital, the process to determine MA base reimbursement begins with a statewide base rate, currently $6,979 per inpatient stay. This rate is converted to a hospital-specific base rate by making adjustments for a series of factors, including a wage index applicable to the hospital's geographic location and the hospital's direct graduate medical education costs. This base rate is then scaled up or down to determine reimbursement for the particular "diagnosis-related group" (DRG) of services delivered. The same scaling factors ("DRG weights") are used for all hospitals, and generally correspond to the relative amount of resources treating the given diagnosis is expected to require. For example, a diagnosis that typically consumes 50% more hospital resources than the weighted average of all inpatient stays will be assigned a weight of 1.5. If actual costs of a particular inpatient stay exceed the reimbursement determined under the DRG formula plus a specified threshold amount (currently, $46,587), MA makes an "outlier payment" in proportion to the excess cost. The product of the hospital's unique base rate times the appropriate DRG weight, plus an outlier payment if applicable, is the base MA reimbursement for that stay.

10. Outpatient reimbursement is calculated in a similar manner, although based on the service or group of related services provided rather than the patient's diagnosis. The statewide base rate for an outpatient visit is currently $94.82. A slight hospital-specific adjustment is made to this rate for direct graduate medical education costs, but it is not adjusted for other hospital-specific factors such as wage differentials and capital costs. There is no mechanism for outlier payments for outpatient care.

11. Critical access hospitals (CAHs) are reimbursed for both inpatient and outpatient care using a similar methodology to that used for non-CAH hospitals. However, instead of using statewide DRG and outpatient base rates, DHS calculates payment rates for each CAH to approximate the actual cost incurred by the hospital in the prior year. Additionally, outlier payments are determined using a much lower threshold ($300) and payment of 100% of excess costs beyond that point instead of only 80% or 95% as for non-CAH hospitals.

12. Rehabilitation, long-term care, and psychiatric hospitals are reimbursed for inpatient services on a per diem basis. The per diem rate is set for each hospital and adjusted annually to approximate 85.08% of the average daily cost. Costs are calculated using prior year cost reports and inflated to the current year using an inflation forecast.

13. The table below compares total MA reimbursement (including base reimbursement and supplements) to reported costs estimated by DHS to be attributable to MA patients for each type of hospital. The non-federal share of access payments, in addition to other MA expenditures, are funded from an assessment collected from all hospitals; the amount of the assessment is included in the estimated costs shown, and the access payments are included in the total reimbursement.

Comparison of 2022 MA Hospital Reimbursement to Estimated Costs ($ in Millions)

Hospital Category	Total MA Reimbursement	Estimated Costs for MA Covered Services	Share of Costs Reimbursed Under MA
Acute Care	$1,971.5	$2,432.3	81%
Critical Access	210.6	194.7	108
Long-Term Acute	20.3	23.3	87
Psychiatric	90.2	101.6	89
Rehabilitation	10.9	11.5	95
Total	$2,303.4	$2,763.3	83%

14. MA base hospital reimbursement rates are adjusted each year through established rate-setting processes. Critical access, rehabilitation, long-term care, and psychiatric hospital rates are adjusted based on reported costs. The statewide base rates for inpatient stays at acute care hospitals and for outpatient care are adjusted based on inflation, state budgetary constraints, and other factors. The 2023 base rates were determined by applying a 3.3% increase to the 2022 rates, based on a federal measure of hospital market inflation.

15. The Wisconsin Hospital Association (WHA) reports that the average operating margin (the difference between income and expenses, expressed as a percent of income) for Wisconsin hospitals in 2021 was 15.5%, with total income $4.0 billion above total expenses and losses. This is the highest average margin reported in the past decade, significantly higher than a previous peak of 11% reached in 2014. Although final figures for 2022 are not yet available, WHA reports that, in aggregate, Wisconsin hospitals' margins for the year are expected to be significantly lower.

16. Profitability varies widely between facilities in the state. In 2021, 21 hospitals (out of 152 in the state) reported negative margins. In prior years the median margin has been consistently below the average, indicating that the majority of hospitals have margins below the average while a small number have margins significantly higher than the average. For example, in 2019 the average margin was 9% but the median was 5%, indicating that half of hospitals had margins lower than 5% and half had margins higher than 5%. A similar relationship held in prior years. Sustaining negative operating margins for several years may cause hospitals to close or reduce their capabilities.

17. MA reimbursement is only one of many factors contributing to the overall fiscal health of hospitals, but is perhaps the one over which state budgetary policy has the greatest impact. MA patients accounted for approximately 15% of total patient charges for all hospitals in 2021. By comparison, Medicare, which reimburses for hospital services under policies established by the federal government, accounted for 46% of patient charges.

18. 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.

19. Including all supplements, MA reimbursed hospitals at approximately 90% of the rates paid by Medicare in 2021, although a direct comparison is difficult given the significant differences in the enrolled populations and mix of procedures between the two programs.

20. 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.

21. The additional funding provided under AB 43/SB 70 to increase hospital base reimbursement would bring average reimbursement across all hospital types from 83.4% of estimated 2022 costs to 85.0%. DHS indicates that this increased reimbursement would be included in the annual rate-setting process to determine how it would be allocated among different types of hospitals and different services, such as inpatient and outpatient care.

22. To increase hospital base reimbursement, the Committee could provide the amount of funding proposed in the bill (Alternative A1) or a higher or lower amount. For example, providing an all-funds increase of $20 million per year would bring average reimbursement to 84.1% of estimated 2022 costs (Alternative A2).

Hospitals—Graduate Medical Education (GME) Supplement

23. AB 43/SB 70 would provide $1,875,000 (all funds) annually to increase grants paid to hospitals to fund the creation of new accredited graduate medical training programs and the addition of positions to existing programs in hospitals serving a rural or underserved community. These grants are separate from the GME adjustments discussed above to the hospital-specific DRG and outpatient rates, which are made for existing GME positions. The current GME grants are included in the

supplemental reimbursement identified above.

24. Under current law, residency positions funded under the grant program must be in a specialty such as family medicine, pediatrics, psychiatry, general surgery, or internal medicine. In 2021-22, DHS distributed a total of $1.2 million in all funds ($0.4 million GPR) to six hospitals to establish new residency programs. By statute, these grants are limited to a term of three years, and hospitals in the City of Milwaukee are ineligible for these funds. Under the program to expand existing residency programs, payments are subject to per-hospital and per-position limits. By state statute, DHS may not distribute more than $225,000 GPR to a particular hospital and may not distribute more than $75,000 GPR to fund a given position per year. These grants do qualify for federal matching funds, so with matching funds at the state's typical matching rate, the per-hospital limit is approximately $575,000 and the per-position limit is approximately $190,000. In 2021-22, DHS distributed $1.6 million in all funds (approximately $0.5 million GPR) in grants through this program to seven hospitals.

25. The federal Health Resources and Services Administration (HRSA) designates health professional shortage areas (HPSAs) where they determine that a geographic area, or a specific population such as low-income residents within a geographic area, has insufficient primary care, mental health, or dental care providers to deliver an adequate level of services for the population living in that area. As of June, 2023, there are primary care or mental health provider shortages in all or part of 50 Wisconsin counties, including many in rural areas. This includes primary care shortages in rural areas of 33 counties, partially-rural areas of nine counties, and non-rural areas of 4 counties; and mental health shortages in rural areas of 34 counties, partially-rural areas of three counties, and non-rural areas of six counties. In total across all shortage areas in the state, HRSA estimates that an additional 56 mental health professionals and 130 primary care providers are needed to provide an adequate level of services.

26. As of April, 2023, DHS had awarded grants to eight hospitals to expand existing residency programs in 2022-23, providing support for total of 21 residency positions. Based on this and prior years' grants and the potential for an increased number of grants that would be possible if the increase proposed in AB 43/SB 70 is approved, DHS estimates that approximately 25 positions would be supported annually in 2023-24 and 2024-25.

27. Under current practice, DHS limits grants for residency program expansions to lower per-hospital and per-position limits than established in statute. Currently, grants are limited to $75,000 in all funds (approximately $29,500 GPR) per position. The Department indicates that the funding provided in AB 43/SB 70 reflects the cost to increase this limit to $150,000 in all funds ($59,000 GPR).

28. However, current expenditures under the limits used by DHS are significantly below the amount appropriated in the base budget. The appropriation that funds these grant programs was last modified under the 2019-21 biennial budget. That act combined two separate appropriations—one providing $2,500,000 GPR per year for grants to establish new residency programs and another providing $813,000 GPR per year for grants to expand existing residency programs—to create the current appropriation with base funding of $3,313,000. The GPR amounts awarded in 2021-22 ($0.4 million for new residency programs and $0.5 million for expansions of existing programs) used only

$0.9 million of this appropriation authority. Under-spending in recent years has contributed to the accumulation of a closing balance of $6.0 million at the end of 2021-22 in this continuing appropriation, although some balance carried forward each year is necessary to support future obligations under multi-year grants.

29. In light of current under-spending, additional appropriation authority is not necessary to support the Administration's intent to increase grants for residency program expansions to $150,000 in all funds ($59,000 GPR) per position.

30. AB 43/SB 70 also modified the statutory per-hospital and per-position limits. However, DHS indicates that these modifications are not necessary to meet the Administration's intent to establish a per-position limit of $150,000 in all funds ($59,000 GPR) since this is still below the current statutory limit of $180,500 in all funds ($75,000 GPR).

31. In addition to these changes to the grant program supporting expansions of existing residency programs, AB 43/SB 70 would expand support for the creation of new residency programs by extending the maximum term of grant support from three years to five years. The Committee could extend the maximum term or maintain the current limit independently of any changes to the grants for existing residency programs. The expansion is included under both alternatives described below.

32. No appropriation or statutory changes are necessary to meet the Administration's intent to increase grants for expansions of existing residency program to $150,000 in all funds ($59,000 GPR) per position. To enable the expansion of the grant program supporting the establishment of new residency programs, the Committee could adopt the extension of the maximum term to five years. [Alternative B1]

33. To further increase financial support for training of health professionals, the Committee could determine that expenditures under the GME grant programs should be increased above the current base appropriation level. For example, the Committee could provide $1,875,000 ($721,500 GPR and $1,153,500 FED) in 2023-24 and $1,875,000 ($733,700 GPR and $1,141,300 FED) in 2024-25, the same all-funds amounts budgeted under AB 43/SB 70. This would increase the GPR appropriation to $4,046,700 in 2024-25, which could be allocated between grants to establish new residency programs, increased per-position grants to expand existing residency programs, and potentially an increased number of expansion grants above the 25 anticipated under lower payment levels. [Alternative B2]

Primary Care Providers

34. AB 43/SB 70 would provide $63,053,700 (all funds) in 2023-24 and $126,107,400 (all funds) in 2024-25 to support reimbursement rate increases for primary care medical services.

35. Primary care predominantly consists of office visits with family or general practitioners. These may be prompted by a specific medical concern, such as an illness or symptom, or be regularly-scheduled preventative check-ups. Regular check-ups with primary care providers are particularly recommended for infants and children. Primary care can offer preventive health guidance, treat common ailments, provide early interventions that prevent conditions from worsening and requiring

more intensive care, and refer patients to more specialized providers as necessary.

36. As noted above, there are shortages of primary care professionals in 46 Wisconsin counties. As of September 30, 2022, an estimated 27% of Wisconsin's population lived in an area designated by HRSA as having a shortage of primary care providers. In those areas, the available primary care capacity met only 59% of the estimated need on average, indicating significant limitations on accessing primary care.

37. As shown in the table under Discussion Point 2, the 2021-23 budget provided a $5 increase to reimbursement for primary care visits that involve the provision of medication-assisted treatment for substance use disorders. This supplement was intended to increase access to opioid use disorder treatment, but does not provide a large overall change to primary care reimbursement. The most recent prior change to reimbursement for primary care providers, effective January of 2021, modified procedure definitions to allow providers to bill for total time spent on a visit, including time reviewing medical records and collaborating with other providers, instead of only direct face-to-face time with the patient. DHS estimated this change could increase total reimbursement by approximately 20%. Reimbursement rates for primary care services were last modified effective January, 2020, when a 6% increase was applied.

38. Currently, MA reimburses primary care providers for patient evaluation and management (E&M) in a problem-focused office visit, in response to a referral from another provider seeking consultation, and in a preventative or well-patient check-up. Reimbursement rates differ based on several factors, including the provider's credentials and the duration or complexity of the visit. Primary care providers can also be reimbursed for other services they provide, such as vaccine administration, but this makes up a small portion of overall reimbursement for primary care.

39. Medicare does not use all of the same primary care procedure codes reimbursed by MA, making a direct comparison of rates difficult. However, the most-commonly used MA rates for problem-focused office visits, accounting for a majority of total primary care reimbursement, are on average 43% of the current Medicare rates.

40. Both MA and Medicare establish different rates for different provider types. For example, when primary care is delivered by a physician assistant MA provides 90% of the reimbursement paid for the same service delivered by a physician (MD). Medicare reimburses physician assistants at 85% of the rates paid to MDs. The comparisons presented here are for the rates paid to MDs under MA and Medicare, which account for the majority services delivered. The funding amounts presented, including under AB 43/SB 70 and the other alternatives, reflect the cost to increase all MA rates such that the relationships between rates paid to different providers are preserved. For example, if the Committee provides funding to increase the MA rates paid to MDs to a specified percentage of the Medicare rates paid to MDs, that alternative would also include funding to increase rates paid to physician assistants to 90% of the new MD rates, and similarly for other provider types.

41. To increase MA reimbursement rates for patient evaluation and management services (the main services delivered by primary care providers) to 80% of Medicare rates, as under AB 43/SB 70, the Committee could provide $126,107,400 ($49,572,800 GPR and $76,534,600 FED) in 2024-

25 and half that amount in 2023-24 to reflect a January 1, 2024, effective date. [Alternative C1]

42. Alternatively, the Committee could provide any greater or lesser amount of funding to increase primary care reimbursement. For example, providing $70,551,800 ($27,733,900 GPR and $42,817,900 FED) in 2024-25 and half that amount in 2023-24 to reflect a January 1, 2024, effective date would be sufficient to increase MA patient evaluation and management rates to 65% of Medicare rates. [Alternative C2]

Emergency Department Physicians

43. AB 43/SB 70 would provide $10,825,200 (all funds) in 2023-24 and $21,650,200 (all funds) in 2024-25 to increase the reimbursement rates for services delivered by physicians in hospital emergency departments.

44. When MA members receive care in a hospital, MA provides reimbursement both to the hospital, for the cost of operating the facility and providing services such as nursing (as discussed above), and also 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.

45. Under current rates, MA reimburses emergency room patient evaluation at rates ranging between $22 and $43 per visit, depending on the complexity of the case, and reimburses critical care at $89 per hour. Patient evaluation accounts for the majority of overall reimbursement.

46. 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.

47. Nationwide, based on recent growth in medical residencies for emergency physicians, reductions in emergency department visits, and reports from newly-trained emergency physicians of more limited employment options, the American College of Emergency Physicians (a leading industry group) and published academic research forecast that the supply of emergency physicians in 2030 will exceed demand.

48. The availability of emergency physicians may vary significantly between urban and rural areas. Even with nationwide trends of increasing availability, emergency departments in rural areas may face challenges in attracting physicians.

49. As shown in the table under Discussion Point 2, professional reimbursement rates for emergency department patient evaluations were increased by 15% under the 2021-23 biennial budget, taking effect January, 2022. The most recent prior change to this rate was a 1% increase that took effect July 1, 2008.

50. Medicare rates for emergency department patient evaluations vary with the complexity of the case to a greater degree than current MA rates do, with the result that the MA rate for the least

complex cases is higher than (approximately double) the Medicare rate but the MA rate for the most complex cases is lower than (approximately one quarter) the Medicare rate. Higher complexity cases make up the majority of claims; on average current MA rates are 30% of Medicare rates. The rate increase included in AB 43/SB 70, and the other alternatives presented here, compare rates to different target percentages of Medicare, but assume that rates already above the target level would not be reduced.

51. As described above, DHS establishes different rates for different provider types, including a 10% reduction for services delivered by physician assistants. In the case of emergency department care, MA rates also include several other adjustments. A 20% increase applies for services delivered in federally-defined health professional shortage areas (HPSAs), and special rates apply when the patient is under age 18 that range from 13% to 247% higher than the base rates depending on the specific procedure. In aggregate, these adjustments mean that average MA professional reimbursement for emergency room visits is about 30% higher than the unadjusted MA rates. Medicare also applies various modifiers to their rates, including some that are similar to these.

52. DHS indicates that the increase included in AB 43/SB 70 was intended to bring base MA rates to 50% of base Medicare rates, and then to apply the same adjustments that apply to current MA rates such as the 10% reduction for physician assistant services. (This would be the same approach as described above for primary care providers.) However, the Department's estimate compared current MA rates for physician assistants to base (MD) Medicare rates, determining that a larger increase than necessary was required. The amount provided under AB 43/SB 70 would be sufficient to increase base MA rates for emergency department patient evaluations to 56% of base Medicare rates, including the cost to apply the same adjustments to the base rates as are currently in effect. [Alternative D1]

53. To increase MA reimbursement for emergency department patient evaluations to 50% of Medicare rates (comparing base MD rates to base MD rates and then applying the same MA adjustments to the base rates as are currently in effect), the Committee could provide $19,326,400 ($7,597,200 GPR and $11,729,200 FED) in 2024-25 and half that amount in 2023-24 to reflect a January 1, 2024, effective date. [Alternative D2]

54. Alternatively, the Committee could determine that current reimbursement rates are sufficient (Alternative D4) or provide a greater or lesser reimbursement increase. For example, Alternative D3 would provide $10,237,300 ($4,024,300 GPR and $6,213,000 FED) in 2024-25 and half that amount in 2023-24 to increase MA reimbursement for emergency department patient evaluations to 40% of Medicare rates.

Outpatient Mental Health and Day Treatment Providers

55. AB 43/SB 70 would provide $5,666,700 (all funds) in 2023-24 and $11,333,400 (all funds) in 2024-25 to increase reimbursement for outpatient mental health and substance use disorder (SUD) services and child and adolescent day treatment.

56. Outpatient mental health and SUD services include psychological testing, diagnosis, psychotherapy, and counseling, for individuals, groups, and families. The most commonly billed

codes under MA, accounting for approximately 60% of total spending, are the 45 minute and 60 minute individual psychotherapy sessions.

57. Child and adolescent day treatment provides more intensive mental health care in a nonresidential setting for children that meet or substantially meet the criteria to be designated as severely emotionally disturbed. Day treatment 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. Day treatment services are intended for children 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.

58. In addition to the positive health outcomes, these mental health services can support effective functioning in the workplace or school. If people are unable to access the treatment they need, their condition may deteriorate, which could include the inability to maintain employment or attend school, worsening patterns of substance use, or the need for more intensive mental or physical health services, at greater expense to the state.

59. As noted above, there are shortages of mental health professionals in 43 Wisconsin counties. As of September 30, 2022, an estimated 48% of Wisconsin's population lived in an area designated by HRSA as having a shortage of mental health providers. In those areas, the available mental health capacity met only 39% of the estimated need on average, indicating broad and severe limitations on accessing mental health care.

60. Reimbursement rates for certain substance use disorder services were increased administratively, effective February, 2023, to align the rates under this benefit with current MA rates for other comparable services. DHS estimates that this change will increase annual expenditures by $0.8 million on an all-funds basis; in aggregate, it increased the affected substance-use–specific rates by 14%.

61. As shown in the table under Discussion Point 2, reimbursement rates for all outpatient mental health and SUD services were increased by 15% under the 2021-23 biennial budget, taking effect January, 2022. Also effective January, 2022, a 5% increase was applied to these and other rates for home and community-based services using supplementary federal funding provided under the American Rescue Plan Act (ARPA), bringing the total increase to 21% over 2021 rates. The most recent prior increase took effect in January, 2018; that change simplified rate tiers and structures as well as increasing reimbursement and, on aggregate, resulted in an increase in total payments estimated at 28%.

62. Also shown in the table under point 2, the reimbursement rate for child and adolescent day treatment was increased by 20% under the 2021-23 biennial budget, taking effect January, 2022. All day treatment services are reimbursed together under one hourly rate, which was increased from $32.53 to $39.04. The most recent prior change to this rate was a 1% increase that took effect July 1, 2008.

63. Medicare generally reimburses for SUD treatment using psychotherapy procedure codes, while Wisconsin's MA program uses a set of codes specific to substance abuse counseling services, meaning that it is not straightforward to compare reimbursement between the two programs for outpatient mental health and SUD services. Nevertheless, some comparisons can be made for the most common psychotherapy procedures billed by psychologists and clinical social workers. MA rates for individual psychotherapy treatment are currently slightly higher than Medicare rates (104%). Some other MA rates in this benefit are slightly lower, however; the MA reimbursement for a psychiatric diagnostic evaluation, for example, is currently 91% of the Medicare rate. Partly because Medicare is limited to the elderly, it does not cover services comparable to child and adolescent day treatment.

64. The Committee could provide $11,333,400 ($4,455,200 GPR and $6,878,200 FED) in 2024-25 and half that amount in 2023-24 to reflect a January 1, 2024, effective date to provide the same all-funds amount to increase reimbursement for outpatient mental health and SUD services and child and adolescent day treatment as provided under AB 43/SB 70. This would reflect a 10% increase in aggregate, although DHS would have flexibility in implementation to determine the amount of increase for each specific service in these categories. [Alternative E1]

65. Given the recent rate increases and comparability to Medicare rates, the Committee may decide that an additional increase is not warranted at this time (Alternative E3). Alternatively, the Committee could provide a larger or smaller increase. For example, the Committee could provide $5,686,200 ($2,235,300 GPR and $3,450,900 FED) in 2024-25 and half that amount in 2023-24 to reflect a January 1, 2024, effective date to increase reimbursement for outpatient mental health and SUD services and child and adolescent day treatment by 5% in aggregate. [Alternative E2]

Applied Behavior Analysis (ABA) Providers

66. AB 43/SB 70 would provide $4,075,200 (all funds) in 2023-24 and $8,150,400 (all funds) in 2024-25 to support an increase to reimbursement rates for autism treatment services, known as adaptive behavioral treatment, or applied behavior analysis (ABA).

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

68. MA covers both comprehensive and focused treatment for individuals with autism spectrum disorders. Comprehensive treatment, also known as intensive behavioral intervention (IBI), is an early intervention treatment approach designed to alter multiple aspects of childhood development and behavior, typically involving higher weekly hours and longer duration. Focused treatment is dedicated to altering specific behaviors or developmental differences, typically involving fewer weekly hours and shorter duration. Prior authorization is required for these services.

69. There is some controversy regarding the ABA treatment approach, with some adults

who underwent ABA treatment when they were younger reporting that the treatment had positive impacts while others describe the rigid and repetitive patterns of rewards and punishment that constitute the treatment as traumatic and doing more harm than good in terms of their long-term mental health, including by reinforcing stigmatization of people with autism and teaching them to hide the fact that they are on the autism spectrum. Former practitioners have described the treatment as abusive. A mental health professional with autism invited to speak at a Legislative Council symposium series on the topic in 2020 identified that ABA therapy has disproportionately negative impacts on mental health outcomes and that children with autism would be better served by social and cultural supports, and services such as speech and occupational therapy. These services can help children understand autism, develop skills that help them function as opposed to skills focused on appearing neurotypical, and provide tools to cope with issues such as sensory overload.

70. Nevertheless, ABA treatment providers report that demand for services from parents of children with autism exceeds the current availability of treatment. They report that, as of August 2020, there were 1,300 children on waitlists for treatment statewide, and that families covered by MA must typically wait six months or longer to begin treatment.

71. Most ABA treatment consists of a treatment provider following an established, patient-specific protocol to train patients to modify their behavior. This can be performed by a provider with any level of behavioral treatment credential, with licensed behavioral treatment supervisors having the highest level, treatment therapists an intermediate level, and treatment technicians having minimal enrollment requirements. As needed, the treatment protocol can be modified by a licensed supervisor or treatment therapist, often working alongside a treatment technician to instruct them in the modified protocol. MA currently reimburses treatment by an established protocol at $47.64 per hour, with higher rates for focused (not comprehensive) treatment when delivered by treatment therapist or licensed supervisor. The current MA rate for treatment with protocol modification is $91.72 per hour. Other rates apply for assessments, group therapy, and family ABA treatment guidance.

72. In the 2021-23 biennial budget, the Governor proposed a 25% increase to adaptive behavioral treatment rates. The Legislature provided a 15% increase to the rate for treatment without protocol modification, effective January 1, 2022. Administratively, DHS increased the other adaptive behavioral treatment rates by 15%, also effective January 1, 2022, to achieve a 15% increase across the board. Subsequently, effective December, 2022, DHS expanded reimbursement by allowing coverage of group adaptive behavioral treatment. Effective February, 2023, DHS provided a further 8.7% increase to all adaptive behavioral treatment rates, achieving the cumulative increase of 25% originally proposed in the Governor's budget.

73. When a treatment technician participates in treatment with protocol modification, some private insurers, and Medicaid programs in other states including Minnesota and Michigan, provide separate reimbursement for the supervisor or therapist leading the treatment and for the technician ("concurrent billing"). Other insurers, including MA, establish one rate for the service, with the understanding that more than one staff person may participate in many cases.

74. The Administration indicates that the increase provided under AB 43/SB 70 was intended to increase the reimbursement rate for treatment with protocol modification to $120.52 per hour, which the Administration indicates would better account for the time spent by treatment

technicians participating in this service alongside supervisors. However, the Administration's estimate does not take into account the increase provided effective February, 2023, which included this rate. Because this rate has already been partially increased, a lower amount of funding is required to meet the Administration's intent.

75. The Committee could provide $6,491,500 ($2,551,800 GPR and $3,939,700 FED) in 2024-25, and half that amount in 2023-24 to reflect a January 1, 2024, effective date, to increase reimbursement for adaptive behavioral treatment. This amount reflects the cost to increase the reimbursement rate for treatment with protocol modification by 31% to $120.52 per hour, as intended under AB 43/SB 70. [Alternative F1]

76. In light of the negative outcomes of ABA treatment experienced by some and the recent administrative rate increases, the Committee could take no action on adaptive behavioral treatment rates (Alternative F3). The Committee could also provide a greater or lesser increase. For example, providing $3,101,500 ($1,219,200 GPR and $1,882,300 FED) in 2024-25 and half that amount in 2023-24 would be sufficient to provide a 15% increase to the rate for treatment with protocol modification, bringing it to $105.48. [Alternative F2]

ALTERNATIVES

A. Hospitals—Base Reimbursement

1. Provide $22,716,300 ($8,741,200 GPR and $13,975,100 FED) in 2023-24 and $45,432,500 ($17,859,500 GPR and $27,573,000 FED) in 2024-25 to increase base MA reimbursement for hospital services effective January 1, 2024.

ALT A1	Change to Base
GPR	$26,600,700
FED	41,548,100
Total	$68,148,800

2. Provide $10,000,000 ($3,848,000 GPR and $6,152,000 FED) in 2023-24 and $20,000,000 ($7,862,000 GPR and $12,138,000 FED) in 2024-25 to increase base MA reimbursement for hospital services effective January 1, 2024.

ALT A2	Change to Base
GPR	$11,710,000
FED	18,290,000
Total	$30,000,000

3. Take no action on base MA reimbursement for hospital services.

B. Hospitals—Graduate Medical Education (GME) Supplement

1. Increase a statutory limit on the term of grants provided to support the establishment of new residency programs from three years to five years.

2. Provide $1,875,000 ($721,500 GPR and $1,153,500 FED) in 2023-24 and $1,875,000 ($733,700 GPR and $1,141,300 FED) in 2024-25 to increase funding for grants to establish new and expand existing residency programs. Increase a statutory limit on the term of grants provided to support the establishment of new residency programs from three years to five years.

ALT B2	Change to Base
GPR	$1,455,200
FED	2,294,800
Total	$3,750,000

3. Take no action on graduate medical education residency program grants.

C. Primary Care Providers

1. Provide $63,053,700 ($24,263,100 GPR and $38,790,600 FED) in 2023-24 and $126,107,400 ($49,572,800 GPR and $76,534,600 FED) in 2024-25 to increase MA patient evaluation and management reimbursement rates to 80% of Medicare rates.

ALT C1	Change to Base
GPR	$73,835,900
FED	115,325,200
Total	$189,161,100

2. Provide $35,275,900 ($13,574,200 GPR and $21,701,700 FED) in 2023-24 and $70,551,800 ($27,733,900 GPR and $42,817,900 FED) in 2024-25 to increase MA patient evaluation and management reimbursement rates to 65% of Medicare rates.

ALT C2	Change to Base
GPR	$41,308,100
FED	64,519,600
Total	$105,827,700

3. Take no action on reimbursement for primary care services.

D. Emergency Department Physicians

1. Provide $10,825,200 ($4,165,500 GPR and $6,659,700 FED) in 2023-24 and

$21,650,200 ($8,510,700 GPR and $13,139,500 FED) in 2024-25 to increase MA reimbursement for emergency department patient evaluations to 56% of Medicare rates.

ALT D1	Change to Base
GPR	$12,676,200
FED	19,799,200
Total	$32,475,400

2. Provide $9,663,200 ($3,718,400 GPR and $5,944,800 FED) in 2023-24 and $19,326,400 ($7,597,200 GPR and $11,729,200 FED) in 2024-25 to increase MA reimbursement for emergency department patient evaluations to 50% of Medicare rates.

ALT D2	Change to Base
GPR	$11,315,600
FED	17,674,000
Total	$28,989,600

3. Provide $5,118,700 ($1,969,700 GPR and $3,149,000 FED) in 2023-24 and $10,237,300 ($4,024,300 GPR and $6,213,000 FED) in 2024-25 to increase MA reimbursement for emergency department patient evaluations to 40% of Medicare rates.

ALT D3	Change to Base
GPR	$5,994,000
FED	9,362,000
Total	$15,356,000

4. Take no action on professional reimbursement under MA for emergency department physicians.

E. Outpatient Mental Health and Day Treatment Providers

1. Provide $5,666,700 ($2,180,500 GPR and $3,486,200 FED) in 2023-24 and $11,333,400 ($4,455,200 GPR and $6,878,200 FED) in 2024-25 to increase MA reimbursement of mental health and SUD services and child and adolescent day treatment by 10% in aggregate.

ALT E1	Change to Base
GPR	$6,635,700
FED	10,364,400
Total	$17,000,100

2. Provide $2,843,100 ($1,094,000 GPR and $1,749,100 FED) in 2023-24 and $5,686,200 ($2,235,300 GPR and $3,450,900 FED) in 2024-25 to increase MA reimbursement of mental health

and SUD services and child and adolescent day treatment by 5% in aggregate.

ALT E2	Change to Base
GPR	$3,329,300
FED	5,200,000
Total	$8,529,300

3. Take no action on MA reimbursement of mental health and SUD services and child and adolescent day treatment.

F. Applied Behavior Analysis (ABA) Providers

4. Provide $3,245,700 ($1,249,000 GPR and $1,996,700 FED) in 2023-24 and $6,491,500 ($2,551,800 GPR and $3,939,700 FED) in 2024-25 to increase MA reimbursement for adaptive behavioral treatment.

ALT F1	Change to Base
GPR	$3,800,800
FED	5,936,400
Total	$9,737,200

5. Provide $1,550,700 ($596,700 GPR and $954,000 FED) in 2023-24 and $3,101,500 ($1,219,200 GPR and $1,882,300 FED) in 2024-25 to increase MA reimbursement for adaptive behavioral treatment.

ALT F2	Change to Base
GPR	$1,815,900
FED	2,836,300
Total	$4,652,200

6. Take no action on MA reimbursement for ABA providers.

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Community Support Program
(Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 246, #15]

CURRENT LAW

The Community Support Program (CSP) is a set of psychosocial rehabilitation services covered under the Medical Assistance program (MA) and administered by counties, multi-county partnerships, and Native American tribes and bands. Under current law, the state does not provide GPR funding for these services; the Department of Health Services (DHS) claims federal Medicaid matching funds (61% of costs in 2024-25) for county and tribal expenditures and provides the majority of this revenue to counties and tribes, but the remaining costs are borne by the counties and tribes.

CSP is intended to serve people with severe mental health conditions that affect day-to-day functioning, and typically serves people with schizophrenia, bipolar disorder, schizoaffective disorder, or recurrent major depression. Approximately 4,000 people receive CSP services per year. Specific treatment services include individual, family, and group psychotherapy, medications, and crisis intervention. Services are delivered using a treatment team approach, with each individual having a case manager who maintains a clinical treatment relationship with the client on a continuing basis.

To be eligible for CSP services, a patient must be likely to require repeated acute treatment or prolonged periods of institutional care. CSP provides non-institutional services that can prevent the need for admissions into a more restrictive setting.

Comprehensive Community Services (CCS) is a similar county-administered psychosocial rehabilitation MA benefit that is intended to serve patients with lower-intensity or shorter-term needs than are addressed by CSP, but greater needs than can be met by counseling and

psychotherapy alone. CCS can provide medication management, peer support, skills development and employment-related training, mental health education, psychotherapy, and substance use disorder treatment. Unlike for CSP, the state reimburses counties for the full allowable cost of CCS services, including both the federal matching funds and state funds for the nonfederal share.

DISCUSSION POINTS

1. Assembly Bill 43 and Senate Bill 70 would provide $19,239,100 GPR in 2023-24 and $21,516,500 GPR in 2024-25 to provide reimbursement payments to counties for CSP services for both the federal and nonfederal share of the payment, instead of only the federal share.

2. Counties report that CSP services are effective at reducing the need for extended hospitalizations or other institutional care, and provide support to county residents with acute needs. CSP interventions are based on the assertive community treatment model, which has demonstrated positive outcomes in numerous evaluations since it was developed by Wisconsin researchers in the 1970s and is now endorsed by national mental health provider organizations, nonprofits, and government agencies.

3. Based on expenditures in recent years, DHS estimates that CSP expenditures statewide will total $49.6 million in 2022-23, consisting of $19.2 million in county funding and $30.4 million in federal funds.

4. CSP services are currently offered in 66 counties, all except Florence, Fond du Lac, Portage, Richland, Taylor, and Wood. The Wisconsin County Human Service Association indicates that smaller rural counties face financial constraints that make it difficult for them to make the initial investment necessary to establish CSPs, although not all of the counties without a CSP are rural. Aside from financial constraints, some counties may also choose not to prioritize providing these services.

5. Transferring responsibility for the nonfederal share of CSP costs from counties to the state would remove the financial barrier to counties providing these services. This would increase the likelihood that these services would be available in the remaining counties, achieving consistency across the state in the care provided to residents with severe mental health needs.

6. Reducing or eliminating the county share of costs could also support the expansion of CSP services in counties where they are currently available, but limited due to constraints placed on the program by the county. For example, counties may be able to reduce waitlists, expand the range of services offered, or expand the geographic reach of services to improve access in under-served areas of a county.

7. In other cases, increased funding may improve the quality of CSP services. Counties may be able to better adhere to evidence-based methods and the assertive community treatment model. Such program modifications have the potential to improve outcomes for people already receiving CSP services and new participants.

8. More broadly, transferring the nonfederal share of expenditures from counties to the

state would provide financial support to counties, many of which face difficulty meeting costs within existing revenues. CSP funding could support human services and mental health budgets in particular, by making revenue sources currently dedicated to CSP available to support other costs. The state allocates funding to each county under the Community Aids program to support health and human services, including an allocation designated specifically for community mental health services. These allocations generally remain fixed from year to year, while many counties report significant growth in costs and challenges in recruiting staff. Providing state funding for CSP could enable counties to redirect community aids funding to meet rising costs in other areas.

9. In addition to changing caseloads, expansions in CSP services are expected to increase program expenditures. The cost estimates described in this paper assume 5% growth from 2022-23 to 2023-24 and a further 10% growth from 2023-24 to 2024-25, as counties respond to the new funding available. There is potential for continued growth beyond this biennium, as occurred when the state assumed the nonfederal share of costs for the CCS program in 2014-15.

10. Some of the growth in CSP expenditures that would occur under the proposal may be attributable to a shift in services from one service category to another, rather than a net increase in overall program services. That is, individuals who could be eligible for CSP services, but who are not receiving them because of constraints on program access, are likely to need treatment in some form. So, for instance, a person in this situation may be receiving day treatment or require hospitalization, which are services for which the state is already responsible for the nonfederal share. In this case, a shift of services to CSP due to the state assuming the nonfederal share of the cost would not increase the state's cost. However, while some degree of shift in services is possible, the magnitude of this effect is unknown, and so is not included in the estimate.

11. The funding provided under AB 43/SB 70 reflects a two-year increase in federal matching rates the state would have qualified for by adopting full Medicaid expansion. The Committee removed full Medicaid expansion from further consideration under Motion #10. Hence, the nonfederal share of CSP expenses in this biennium would be higher.

12. To reduce the financial burden on counties and make CSP services available more consistently statewide, the Committee could provide $21,710,600 GPR in 2023-24 and $24,235,200 GPR in 2024-25 to assume the full nonfederal share of CSP costs. Under this alternative, counties would be reimbursed for 100% of the costs of CSP services; CSP services would no longer be included in the current cost reporting and partial reconciliation process used for other county-based services. This reflects the same policy as proposed under AB 43/SB 70, although the GPR funding amounts have been increased to reflect the removal of full Medicaid expansion. [Alternative A1]

13. The Committee could also determine that the nonfederal share of CSP services should remain a county responsibility. [Alternative A2]

14. If the Committee determines that the proposal to have the state assume the nonfederal share of the cost of CSP would have the benefit of establishing more uniform access to program services across the state, but has concerns about the overall cost, an alternative approach would be to adopt Alternative A1, but offset a portion of the cost by reducing GPR payments to counties under the mental health component of the community aids program.

15. Currently, DHS makes community aid payments to the counties under the community mental health component of the program totaling $24,348,700 GPR. The mental health component of the community aids grant was established by the 2015-17 budget, through the consolidation of several other grant programs used to support community-based mental health services. Among those grants were programs intended to support counties' costs for CSP and other psychosocial rehabilitation programs. However, the mental health component of the community aids program is a fixed payment to each county, and not tied to the level of service currently provided by the county. Consequently, unlike the CSP program change under Alternative A1, the program does not create incentives to attain a level of county service, or to serve specific policy goals.

16. The Committee could offset all or a portion of the estimated cost of Alternative A1 by eliminating the community mental health component of the community aids program or reducing the payment by some amount. For instance, the Committee could reduce the payment by $10,000,000, beginning in 2024 (community aids payments are made on a calendar year basis). While this would be a 41% reduction in this county aid payment, the counties in aggregate would still realize a net financial benefit from the combination of Alternatives A1 and B1 since their cost of CSP services would decrease by an estimated $21.7 million. [Alternative B1]

17. Eliminating the full community mental health component of the community aids program would reduce GPR costs by an amount that is approximately equal to the estimated cost of the CSP proposal in 2024-25. [Alternative B2]

18. The net cost of adopting Alternatives A1 and B1 together would be $30,945,800 GPR over the biennium ($16,710,600 GPR in 2023-24 and $14,235,200 GPR in 2024-25). Adopting Alternatives A1 and B2 together would have approximately no net cost in 2024-25. However, because the community aids reduction would take effect January 1, 2024, it only offsets a portion of the costs in fiscal year 2023-24. Therefore, the net cost of adopting Alternatives A1 and B2 together would be $9,422,800 GPR over the biennium ($9,536,300 GPR in 2023-24 and -$113,500 GPR in 2024-25).

ALTERNATIVES

A. Nonfederal Share of the Community Support Program

1. Provide $21,710,600 GPR in 2023-24 and $24,235,200 GPR in 2024-25 to assume the full nonfederal share of CSP costs. Require DHS to provide reimbursement payments to counties for CSP services for both the federal and nonfederal share of the payment, instead of, under current law, only the federal share. Delete CSP services from a list of county services for which counties may submit a cost report to DHS for a partial cost reconciliation payment.

ALT A1	Change to Base
GPR	$45,945,800

2. Take no action.

B. Community Mental Health Component of the Community Aids Program

1. Reduce the amount that DHS distributes under the community mental health component of the community aids program by $10,000,000, from $24,348,700 to $14,348,700, beginning in 2024. Reduce the community aids appropriation by $5,000,000 GPR in 2023-24 and $10,000,000 GPR in 2024-25 to reflect this reduction.

ALT B1	Change to Base
GPR	-$15,000,000

2. Eliminate the community mental health component of the community aids program, beginning in 2024. Reduce the community aids appropriation by $12,174,300 GPR in 2023-24 and 24,348,700 GPR in 2024-25 to reflect this reduction.

ALT B2	Change to Base
GPR	-$36,523,000

3. Take no action.

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June, 2023 Joint Committee on Finance Paper #409

Residential Substance Use Disorder Treatment Room and Board Funding (Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 247, #16]

CURRENT LAW

The Medical Assistance (MA) program currently provides coverage of residential substance use disorder (SUD) treatment for individuals who need a 24-hour, structured environment that is removed from their normal social routine. However, mirroring restrictions on federal matching funds, MA only covers treatment costs, not room and board costs incurred during treatment.

MA currently covers residential SUD treatment 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 24-hour residential setting supervised by a physician or prescriber knowledgeable in addiction and providing each patient at least six hours of treatment services per week. Treatment services can include evaluations, medication management, counseling, therapies, supportive services, and other services. A medically-monitored treatment service is defined as a 24-hour clinical residential setting with a qualified medical director, providing at least 20 hours per week of treatment services to each patient, including services for higher-acuity substance use disorders and co-occurring mental health disorders.

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. An IMD is a larger facility, with over 16 beds, that is primarily engaged in the diagnosis and treatment of mental disorders, including substance use disorders; federal law otherwise restricts Medicaid coverage to mental or behavioral health facilities with 16 beds or fewer, or to a general hospital.

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. Beginning in January, 2022, DHS has provided grants to counties and Native American tribes and bands to support some of these costs. These grants have been funded by payments received under settlements of opioid-related litigation, including $2.5 million from the settlement with pharmaceutical consultant McKinsey and Company and $2.5 million from the national settlement with distributors Cardinal, McKesson, and AmerisourceBergen and manufacturer Janssen Pharmaceuticals.

DISCUSSION POINTS

1. Assembly Bill 43 and Senate Bill 70 would provide $8,309,500 GPR annually to support the cost of coverage of room and board for MA enrollees receiving residential substance use disorder treatment. 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 American Society of Addiction Medicine standards that are used to identify need for this care indicate 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.

3. 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.

4. 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. Of recent MA admissions, 75% 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 require an average of three weeks of care, while low-intensity patients typically receive five weeks of care before they can be discharged, although some episodes of care have lasted as long as thirteen weeks. 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.

5. During 2021-22 there was an average caseload of 336 MA enrollees receiving residential SUD treatment at any given time. Based on an estimated average stay of four weeks, this would correspond to about 4,400 MA patients served per year.

6. Indicative of the prevalence of severe SUD in the state, MA paid 8,358 claims for inpatient hospital treatment for alcohol and other drug abuse and dependence in 2021-22, including stabilization and detoxification. While some enrollees received inpatient hospital treatment more than once in the year, approximately 5,700 members required these services at least once. Alcohol abuse and dependence accounted for slightly over half of these patients, opioid abuse and dependence for one quarter, and other substance use disorders for the remaining quarter.

7. Based on 2019 data, approximately 25% of patients receiving inpatient hospital treatment for SUD are readmitted for a second time within a calendar year, and approximately 10% require inpatient SUD 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 hospital treatment.

8. 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 more likely to remain sober after one year compared to those who received lower levels of treatment.

9. 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." The Wisconsin Department of Corrections contracts for approximately 150 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 approximately $6 million.

10. 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.

11. DHS reports that many residential treatment providers are reluctant to accept MA patients without a consistent source of funding for room and board. Providers have expressed that doing so would be unsustainable financially. The facilities that accept MA patients may have waitlists,

and 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.

12. Prior to the grant funding supported by opioid settlement funds, counties were 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. Because access to room and board funding is dependent upon individual county policies and funding, there can be considerable variation in access to residential SUD treatment within the state.

13. 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.

14. 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.

15. The variety of ways that other states and local governments choose to fund residential SUD treatment limits the ability to make direct comparisons of Wisconsin's 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.

16. 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.

17. 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 for room and board costs would be $63 per day, the average rate currently paid by county programs. A 10% increase in utilization over the 2021-22 average would give an average caseload of 370, for a total annual cost of $8.5 million GPR.

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 Administration estimates that reductions in the usage of more expensive services would offset the treatment costs for the increased usage of residential SUD treatment and 25% of the room and board costs of the expanded population. This would reduce the new room and board costs to $8.3 million.

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. As noted earlier, the Department is providing grants for room and board costs using opioid settlement funds, although this may not be a reliable source of funding on an ongoing basis. Payments from the settlements with pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and with Jansen Pharmaceuticals were much higher in the first year than in subsequent years, going from $31.0 million in 2022-23 to $8.0 million in 2023-24. Consequently, not all opioid mitigation services that were supported initially with these funds will be funded on an ongoing basis. In addition, since settlement funds must be used specifically for opioid mitigation strategies, there may be some question of whether this is an appropriate ongoing source for residential SUD treatment room and board if a substantial proportion of clients are receiving treatment for alcohol use disorder or non-opioid addictions.

21. To provide state funding for room and board costs of residential SUD treatment as an MA benefit, the Committee could provide $8,309,500 GPR annually as proposed under AB 43/SB 70. Coverage would be estimated to take effect July 1, 2023. [Alternative 1]

22. To provide time for DHS to implement reimbursement rates and policies, and in consideration of the opioid settlement funding available for a portion of these costs in the short term, the Committee could provide a lesser amount of funding with the expectation that the effective date of coverage of room and board costs as an MA benefit would be delayed. For example, coverage could begin in July of 2024. [Alternative 2]

23. The Committee may determine that room and board costs should continue to be a county responsibility and take no action. 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. [Alternative 3]

ALTERNATIVES

1. Provide $8,309,500 annually in the GPR appropriation for Medical Assistance to support the room and board costs of MA enrollees receiving residential substance use disorder treatment. Specify that room and board costs for residential substance use disorder treatment is a reimbursable service category under MA. Coverage would be estimated to take effect July 1, 2023.

ALT 1	Change to Base
GPR	$16,619,000

2. Provide $8,309,500 in 2024-25 in the GPR appropriation for Medical Assistance to support the room and board costs of MA enrollees receiving residential substance use disorder treatment. Specify that room and board costs for residential substance use disorder treatment is a reimbursable service category under MA. Specify that these provisions would take effect July 1, 2024.

ALT 2	Change to Base
GPR	$8,309,500

3. Take no action.

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June, 2023 | Joint Committee on Finance | Paper #410

SeniorCare Reestimate
(Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 256, #30]

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 $133,343,400 ($17,971,900 GPR, $17,738,300 FED, and $97,633,200 PR) per year.

MODIFICATION

Provide $5,489,500 ($6,605,100 GPR, $1,828,800 FED, and -$2,944,400 PR) in 2023-24 and $16,958,800 ($5,477,800 GPR, $4,167,200 FED, and $7,313,800 PR) to reflect a reestimate of SeniorCare benefit costs.

Explanation: The estimate included in Assembly Bill 43 and Senate Bill 70 was based on program enrollment and costs through December, 2022. It also reflected a temporary five percentage point increase to the federal matching rate that would have applied in conjunction with full Medicaid expansion as proposed under the bill. Full Medicaid expansion was removed by the Committee under Motion #10, and this reestimate accounts for the resulting increase in GPR costs and decrease in the federal share. In addition, this reestimate reflects updated enrollment, per-member costs, and rebate rates through April, 2022. Enrollment is slightly higher than projected under AB 43/SB 70, but per-member costs are lower, creating a net reduction in total funding. The share of costs covered by rebates (PR) is slightly lower than previously projected, increasing GPR and FED costs. Relative to the funding provided under AB 43/SB 70, this reestimate reduces funding by $2,002,300 ($6,229,900 GPR, -$1,797,400 FED, and -$6,434,800 PR) in 2023-24 and reduces funding by $2,310,200 ($3,542,800 GPR, -$981,600 FED, and -$4,871,400 PR) in 2024-25.

	Change to Base
GPR	$12,082,900
FED	5,996,000
PR	4,369,400
Total	$22,448,300

Prepared by: Carl Plant

HEALTH SERVICES

Medical Assistance -- Eligibility and Benefits

LFB Summary Items for Which No Issue Paper Has Been Prepared

Item #	Title
25	Coverage of Acupuncture Services
31	Wisconsin Chronic Disease Program Reestimate