Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

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.

Prepared by: Carl Plant