Representative Nygren
Senator Darling

HEALTH SERVICES -- MEDICAL ASSISTANCE -- GENERAL
HEALTH SERVICES -- DEPARTMENTWIDE

Omnibus Departmentwide and MA -- General

Motion:

Move the following provisions:

MEDICAL ASSISTANCE -- GENERAL

1. *MA Cost-to-Continue [Paper #345].* Adopt Alternative 2 to increase funding in the bill by $138,787,800 (-$10,867,200 GPR, $94,953,900 FED, $36,346,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17 to reflect current estimates of MA benefits costs in the 2015-17 biennium, and the budgeting of drug settlement funds ($21,500,000 PR) in the Medicaid program in 2015-16 to supplant GPR funding.

2. *SeniorCare -- Cost-to-Continue [Paper #346].* Adopt the modification to reduce funding in the bill by $5,097,900 (-$1,028,500 GPR, -$1,660,800 FED, and -$2,408,600 PR) in 2015-16 and by $7,820,600 (-$1,578,400 GPR, -$2,170,500 FED, and -$4,071,700 PR) in 2016-17 to reflect revised FMAP and SeniorCare enrollment reestimates.

3. *SeniorCare -- Required Medicare Part D Application and Enrollment [Paper #347].* Adopt Alternative A2 to delete the Governor's recommendations to require SeniorCare enrollees to apply for and enroll in Medicare Part D. Increase funding in the bill by $32,442,700 ($5,198,000 GPR, $5,198,000 FED, and $22,046,700 PR) in 2015-16 and $64,885,400 ($10,396,000 GPR, $10,396,000 FED, and $44,093,400 PR) in 2016-17 to reflect this change.

4. *Disproportionate Share Hospital Payments [Paper #348].* Adopt Alternative A1, B1, and C1 to approve the Governor's recommendation to require DHS to make disproportionate share hospital payments of $35,910,900 in 2015-16 and $35,842,300 in 2016-17 in accordance with the Governor's proposed formula, with technical modifications. Adopt Alternative C3 to modify the provision to specify that the payments be made annually on an ongoing basis.

5. *Reimbursement Rates for Federally Qualified Health Centers (FQHCs) [Paper #349].* Adopt Alternative 6b to do all the following: (a) require DHS to reimburse FQHCs, for services provided prior to July 1, 2016, under the methodology in effect on January 1, 2015; (b) require DHS to reimburse FQHCs for services provided on or after July 1, 2016, at a payment system based on the Medicaid prospective payment system, with a three-year phase-in for new rates (effective for fiscal years 2016-17, 2017-18, and 2018-19); (c) require DHS to consult with FQHCs as it develops this system; and (d) increase MA benefits funding by $7,245,800 ($2,898,300 GPR and $4,347,500

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FED) in 2015-16, and $8,552,100 ($3,579,100 GPR and $4,973,000 FED) to reflect a one-year delay of the fiscal effect of this item under the administration's methodology.

6. *Independent Assessment Requirement for Personal Care Services [Paper #350].* Adopt Alternative A1 to approve the Governor's recommendation to reduce MA benefits funding to reflect an estimate of personal care expenditure reductions associated with a proposal to require an independent assessment for personal care services. Adopt Alternative B2a to reduce funding by $1,000,000 GPR and $1,000,000 FED in 2015-16 to reflect a delayed starting date for the third-party personal care assessment contract.

7. *Enhanced Dental Services Reimbursement Pilot Program [LFB Paper #351].* Modify the proposed enhanced dental services reimbursement pilot program as follows:

a. Include Marathon County in the pilot program.

b. Specify that the reimbursement rates established for the providers participating in the pilot program shall equal 80% of the median fee for each procedure, as reported in the most recent American Dental Association fee survey for that association's East North Central region, or the provider's usual and customary charge, whichever is less. Specify that if the median fee is not reported for a procedure then the Department shall establish a fee for the procedure that approximates the median usual and customary charge for that procedure for dentists practicing in Wisconsin, but that the reimbursement paid to a provider for the procedure shall not exceed the provider's usual and customary charge for that procedure.

c. Specify that the enhanced reimbursement procedures do not apply to dental services provided in a federal qualified health center.

d. Require the Department to include in any contract with a health maintenance organization that includes the provision of dental services, a requirement that the health maintenance organization reimburse providers of dental services in accordance with the enhanced reimbursement pilot program for qualifying services provided in one of the pilot counties.

e. Specify that dental services provided on a fee for service basis in a county that is included in the pilot program as of the effective date of the bill shall continue to be provided on a fee for service basis under the pilot program, and that dental services provided on a managed care basis in a county that is included in the pilot program as of the effective date of the bill shall continue to be provided on a managed care basis under the pilot program.

f. Require DHS to work in collaboration with the American Dental Association's Health Policy Institute to prepare an evaluation of the pilot program on a quarterly basis, beginning at the end of the first quarter after the effective date of the pilot program, and require the department to submit the report to the Joint Committee on Finance. Specify the report shall contain, at a minimum, data on key outcomes of interest from the pilot counties and non-pilot counties, both before and after the implementation of the pilot program. The outcomes of interest shall include the following: (a) dental care utilization among children and adults in both dental clinics and emergency rooms; (b) participation by dentists in the Medicaid program; (c) the fiscal impact of the pilot

program, including costs and savings; (d) if feasible, a comparison of the program as administered in a fee-for-service system versus the program as administered under an HMO system; and, (e) if feasible, the impact of the program on oral health outcomes, such as MA recipients' self-reported assessment of oral health and barriers to dental care.

g. Increase funding by $900,000 GPR and $1,400,000 FED in 2016-17 to reflect an estimate of the impact of establishing the dental fees at 80% of the median fee and including Marathon County in the pilot program.

8. *MA Coverage of Residential Based Substance Abuse Treatment Services [Paper #352].* Adopt Alternative 2 to modify the Governor's recommendation to extend MA coverage to residential based substance abuse treatment by specifying that MA reimbursement for treatment services would be provided for dates of service no sooner than July 1, 2016, or the date the U.S. Department of Health and Human Services approves any state plan amendment or federal waiver authorizing these services, whichever is later. Reduce funding in the bill by $2,566,500 (-$1,026,600 GPR and -$1,539,900 FED) in 2015-16.

9. *Include Drugs in Managed Care Contracts [Paper #353].* Adopt the modification to delete the funding reduction in the bill relating to drugs in MA managed care contracts. Provide $692,800 ($289,300 GPR and $403,500 FED) in 2015-16 and $1,532,000 ($640,800 GPR and $891,200 FED) in 2016-17 to reflect the deletion of this item.

10. *BadgerCare Plus Coverage for Childless Adults [Paper #354].* Adopt Alternatives 2a and 2b to approve the Governor's recommendations and require DHS to make the following reports to the Committee: (a) prior to submitting an amendment to the current childless adults waiver agreement, a report that summarizes the provisions and estimates the fiscal effect of that proposed amendment; and (b) if CMS approves an amendment to the current childless adults waiver agreement, and prior to implementing that policy, a report that summarizes the provisions and estimates the fiscal effect of the CMS-approved amendment.

11. *Fraud Prevention -- Advanced Analytics System.* Provide $5,000,000 ($500,000 GPR and $4,500,000 FED) in 2015-16 for the procurement and implementation of an advanced analytics system for the purpose of minimizing provider and beneficiary fraud in the state's medical assistance (MA) program, or for the purposes of verifying the identification of MA and Medicare claimants prior to utilization of services.

12. *Federal Match for Services Provided by Poison Control Centers.* Expand the purposes for which funds may be expended from the federal MA benefits appropriation to include any federal funds the state receives under Title 21 of Social Security Act (the Children's Health Insurance Program) that the state allocates for services provided by the state's poison control center.

13. *Qui Tam Claims.* Move to eliminate private individuals' authority to bring *qui tam* claims against any person who makes a false claim for medical assistance. [Under current law, with regards to the MA program, a *qui tam* claim is a claim initiated by a private individual on behalf of the individual and on behalf of the state against a person who makes a false claim for medical assistance.]

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14. *Ambulatory Surgical Center (ASC) Assessment Report.* Require DHS to annually submit a report to the Joint Committee on Finance that contains all of the following information for the prior fiscal year: (a) the total amount of revenue collected from eligible ASCs under the ASC assessment; (b) the amount each eligible ASC paid under the assessment (require DHS to specify the specialty of the center paying the assessment, but allow DHS to withhold the name of the ASC paying the assessment); (c) the total amount of money received by each managed care organization, if money was received, from the assessment; (d) the total amount each managed care organization paid to ASCs; and (e) the total amount of revenue returned to eligible ASCs under the assessment.

In addition, require the Department of Revenue (DOR), upon the request of DHS, to provide to DHS any information in the possession of DOR that is necessary for DHS to complete the report described in this motion.

DEPARTMENTWIDE

1. *Eliminate Long-Term Vacancies [Paper #385].* Adopt Alternative 2 to delete the funding associated with the FED and PR position authority that would be deleted under the Governor's recommendations. Reduce funding by $1,714,000 FED and $152,400 PR annually.

2. *Federal Revenue Reestimates [Paper #386].* Adopt the modification to reduce estimates of federal funding DHS allocates to income maintenance consortia by $6,918,400 FED in 2015-16 and by $7,918,400 FED in 2016-17.

3. *Funding and Position Transfers [Paper #387].* Adopt Alternative 1 to make no change to funding budgeted for supplies and services for the Division of Medicaid Services.

4. *Ambulance Staffing of Paramedics.* Require DHS to allow an ambulance service provider to staff an ambulance at the paramedic level with one paramedic and one emergency medical technician of any level if all the following criteria apply: (a) the ambulance service provider was initially licensed at the paramedic level in 1993; (b) the ambulance service provider is located in a municipality in Dodge and Jefferson Counties; and (c) the ambulance service provider has dispatched an ambulance containing two paramedics, and that ambulance containing two paramedics is occupied providing service.

5. *Surplus Retention Limitations for Providers of Rate-Based Services and Rate-Regulated Services.* Modify contracting requirements for rate-based services and rate-regulated services purchased by the Department of Health Services (DHS), the Department of Children and Families (DCF), the Department of Corrections (DOC), or by county departments of human services, social services, community programs, or developmental disability services for social services under s. 46.036, public assistance and children and family services by under s. 49.34, and corrections under s. 301.08, as detailed below. Specify that these changes would take effect on January 1, 2016, and would first apply to contracts commencing performance after that date.

Specify that a rate-based service is a service, or a group of similar services, provided under one or more contracts between a provider and the purchaser that is reimbursed through a prospectively set rate and that is distinguishable from other services by the purpose for which funds

are provided and by the source of funding. Specify that a rate-regulated service means a rate-based service that is reimbursed through a rate established under s. 49.343.

Rate-based Services by Nonprofit Providers. Require that if the revenue received under a contract for a rate-based service exceeds the allowable costs incurred during the contract period (surplus), then the nonprofit provider of the rate-based service must be permitted to retain that surplus under the contract. Specify that a contract for a rate-based service may limit the provider to retaining no more than 5% of revenue received under the contract, but may not limit the provider from retaining 5% or less. Further, specify that the provider is not guaranteed that there will be a surplus under the contract.

Require that if the aggregate surplus retained by a nonprofit provider of a rate-based service under all contract periods ending in the calendar year for that rate-based service exceeds 5% of the total revenues under such contracts as of December 31, then the provider of the rate-based service must provide written notice of the amount of the excess to all purchasers under those contracts. Specify that the provider must return a purchaser's proportional share of the overall excess if that purchaser provides a written request no later than six months after the date the purchaser receives the written notice of the excess.

Specify that in the case of a rate-based nonprofit provider that is a successor following a merger, acquisition, consolidation, reorganization, sale, or other transfer, in calculating the surplus, the successor provider may offset surpluses generated by a preexisting provider against deficits generated by the preexisting provider. Specify that the net surpluses or deficits are the surpluses or deficits of the successor provider.

Specify that the provider must use the retained surplus for any allowable costs specified in 2 CFR Part 200 or in other applicable federal law or regulations. Specify that the purchaser may not interfere with the provider's use of the retained surplus for such purposes. Repeal current law which requires the retained surplus to be used for deficits in previous or future contract periods or to address programmatic needs of clients served by the rate-based service that generated the surplus.

Specify that a provider may accumulate funds from more than one contract period for a rate-based service. Repeal current law which provides for a maximum retention of 10% of all revenue received under all current contracts for the same rate-based service. Further, repeal the current law requirement that a provider return the excess over that 10% cumulative maximum to the purchasers in proportion to a purchaser's share of the surplus and to use any excess which is not returned to reduce the provider's unit rate in the next contracting period. Further, repeal current law which requires providers to apply 50% of accumulated reserves to reducing the unit rate in the next contracting period if the provider has held for four consecutive contracting periods an accumulated reserve that is equal to or greater than 10% of the revenue received under all current contracts for the rate-based service.

Rate-Based Services by For-Profit Providers. Specify that in calculating the profits allowed under a contract for a rate-based service, a proprietary agency that is a successor provider following a merger, acquisition, consolidation, reorganization, sale, or other transfer may offset surpluses

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generated by a preexisting provider against deficits generated by such a provider. Specify that the net surpluses or deficits are the surpluses or deficits of the successor provider.

Rate-Regulated Services by Nonprofit Providers . Require if on December 31 of any year the aggregate revenues received by a provider under all contracts for all rate-regulated services with contract periods ending in that calendar year (combined revenues) exceed the allowable costs related to the provision of those rate-regulated services, then the provider of the rate-regulated service shall be permitted to retain the surplus of combined revenues. Specify that a contract for a rate-regulated service may limit the provider to retaining no more than 5% of the combined revenues, but may not limit the provider from retaining 5% or less. Further, specify that the provider is not guaranteed that there will be a surplus of combined revenues.

Specify that the provider of a rate-regulated service must use the retained surplus of combined revenues for any allowable costs specified in 2 CFR Part 200 or in other applicable federal law or regulations. Specify that purchasers may not interfere with the provider's use of the retained surplus of combined revenues for such purposes.

Require that if on December 31 of any year the total amount of surplus combined revenues retained by a provider exceeds 5% of the total revenue received under all of the provider's contracts for rate-regulated services, then the provider of the rate-regulated services must provide written notice of the amount of the excess to all purchasers under those contracts. Specify that the provider must return a purchaser's proportional share of the overall excess if that purchaser provides a written request no later than six months after the date the purchaser receives the written notice of the excess. Authorize DCF (but not DHS or DOC) to grant an exception to the requirement to return the excess surplus upon a request by the provider.

Specify that in calculating the surplus of combined revenues generated by two or more affiliated providers of rate-regulated services, the providers may offset surpluses generated by affiliated providers against deficits generated by such providers, but not below zero. If there is a net surplus of combined revenues over allowable costs, then that net surplus must be proportionally allocated among the affiliated providers that generated a surplus. Specify that an affiliated provider is a provider that has control of, is subject to the control of, or is under common control with another provider. Specify that control is the possession of the power, directly or indirectly, to direct or cause the direction of the management and policies of a provider through the ownership of more than 50% of the voting rights of the provider, by contract, or otherwise.

Specify that in the case of a rate-regulated provider that is a successor following a merger, acquisition, consolidation, reorganization, sale, or other transfer, in calculating the surplus of combined revenues, the successor provider may offset surpluses generated by a preexisting provider against deficits generated by the preexisting provider. Specify that the net surpluses or deficits are the surpluses or deficits of the successor provider.

Rate-Regulated Services by For-Profit Providers. Specify that in calculating the profits allowed under a contract for a rate-regulated service, a proprietary agency may combine the aggregate revenues received by the provider from all purchasers of all rate-regulated services

provided by the provider. Further, specify that a proprietary agency may offset surpluses generated by affiliated providers against deficits generated by such providers, but not below zero. If there is a net surplus of combined revenues over allowable costs, then that net surplus must be proportionally allocated among the affiliated providers that generated a surplus.

Note:

The attachments summarizes the fiscal effect of the motion, by item.

[Change to Bill: $22,122,200 GPR, $37,324,700 FED, $139,058,900 PR and $41,539,700 SEG]

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Fiscal Effect Of Omnibus Motion
Health Services Medical Assistance -- General and Departmentwide

Item #/Title	2015-16 GPR	2015-16 FED	2015-16 PR	2015-16 SEG	2015-16 Total	2016-17 GPR	2016-17 FED	2016-17 PR	2016-17 SEG	2016-17 Total
Medical Assistance -- General										
1 MA Cost-to-Continue	-$10,867,200	$94,953,900	$36,346,200	$18,354,900	$138,787,800	$13,211,400	-$65,102,400	$43,357,700	$23,184,800	$14,651,500
2 SeniorCare Cost-to-Continue	-1,028,500	-1,660,800	-2,408,600	0	-5,097,900	-1,578,400	-2,170,500	-4,071,700	0	-7,820,600
3 SeniorCare -- Required Medicare Part D Application and Enrollment	5,198,000	5,198,000	22,046,700	0	32,442,700	10,396,000	10,396,000	44,093,400	0	64,885,400
4 Disproportionate Share Hospital Payments	0	0	0	0	0	0	0	0	0	0
5 Reimbursement Rates for Federally Qualified Health Centers	2,898,300	4,347,500	0	0	7,245,800	3,579,100	4,973,000	0	0	8,552,100
6 Independent Assessment Requirement for Personal Care Services	-1,000,000	-1,000,000	0	0	-2,000,000	0	0	0	0	0
7 Enhanced Dental Services Reimbursement Pilot Program	0	0	0	0	0	900,000	1,400,000	0	0	2,300,000
8 MA Coverage of Residential Based Substance Abuse Treatment Services	-1,026,600	-1,539,900	0	0	-2,566,500	0	0	0	0	0
9 Include Drugs in Managed Care Contracts	289,300	403,500	0	0	692,800	640,800	891,200	0	0	1,532,000
10 BadgerCare Plus Coverage for Childless Adults	0	0	0	0	0	0	0	0	0	0
11 Fraud Prevention -- Advanced Analytics System	500,000	4,500,000	0	0	5,000,000	0	0	0	0	0
12 Federal Match for Services Provided by Poison Control Centers	0	0	0	0	0	0	0	0	0	0
13 Qui Tam Claims	0	0	0	0	0	0	0	0	0	0
14 ASC Assessment Report	0	0	0	0	0	0	0	0	0	0
Subtotal, MA -- General	-$5,036,700	$105,202,200	$55,984,300	$18,354,900	$174,504,700	$27,148,900	-$49,612,700	$83,379,400	$23,184,800	$84,100,400
Departmentwide										
1 Eliminate Long-Term Vacancies	$0	-$1,714,000	-$152,400	$0	-$1,866,400	$0	-$1,714,000	-$152,400	$0	-$1,866,400
2 Federal Revenue Reestimates	0	-6,918,400	0	0	-6,918,400	0	-7,918,400	0	0	-7,918,400
3 Funding and Position Transfers	0	0	0	0	0	0	0	0	0	0
4 Ambulance Staffing of Paramedics	0	0	0	0	0	0	0	0	0	0
5 Surplus Retention Limitations of Rate-Based Services	0	0	0	0	0	0	0	0	0	0
Subtotal, Departmentwide	$0	-$8,632,400	-$152,400	$0	-$8,784,800	$0	-$9,632,400	-$152,400	$0	-$9,784,800
Total, MA -- General and Departmentwide	-$5,036,700	$96,569,800	$55,831,900	$18,354,900	$165,719,900	$27,148,900	-$59,245,100	$83,227,000	$23,184,800	$74,315,600

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