



WISCONSIN DEPARTMENT *of* HEALTH SERVICES

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DHS Presentation at WCHSA Fall Conference
December 1, 2017

Wisconsin's Medicaid Program

- Medicaid Program: Key Facts
- Medicaid Budget Compared to Overall State Budget
- Enrollment/Service Expenditures
- How Provider Rates Are Set
- New Developments

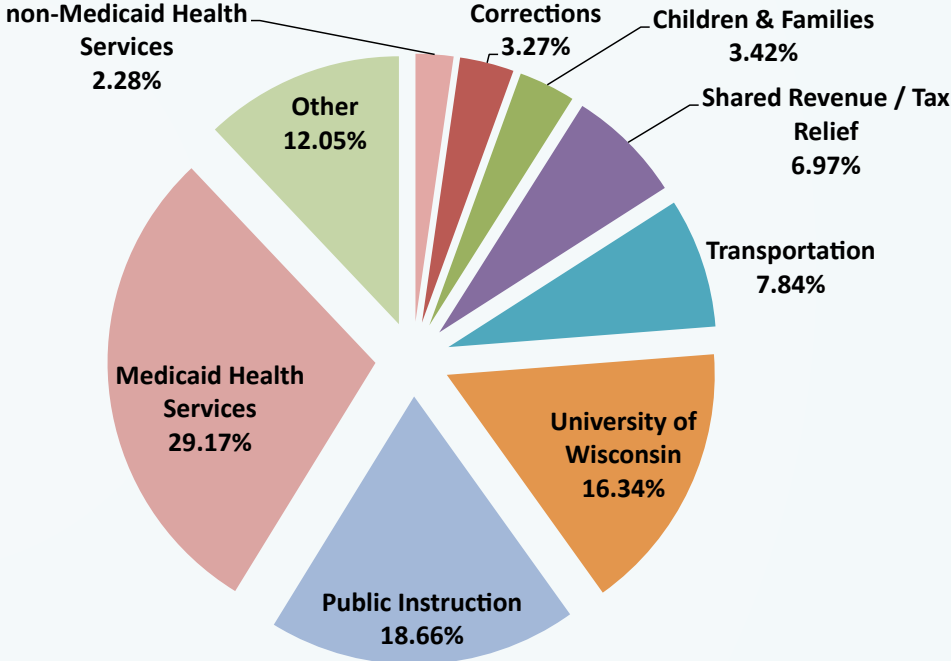
Medicaid Program: Key Facts

2017-19 Budgeted Level (Two Years)		
GPR	\$6.1B	30.5%
Segregated Revenues (<i>Provider taxes, other revenues</i>)	\$1.2B	5.8%
Program Revenue (<i>drug rebates, other third party revenues</i>)	\$1.9B	9.8%
Federal Funds	<u>\$10.8B</u>	53.9%
Total All Funds	\$20.0B	100.0%

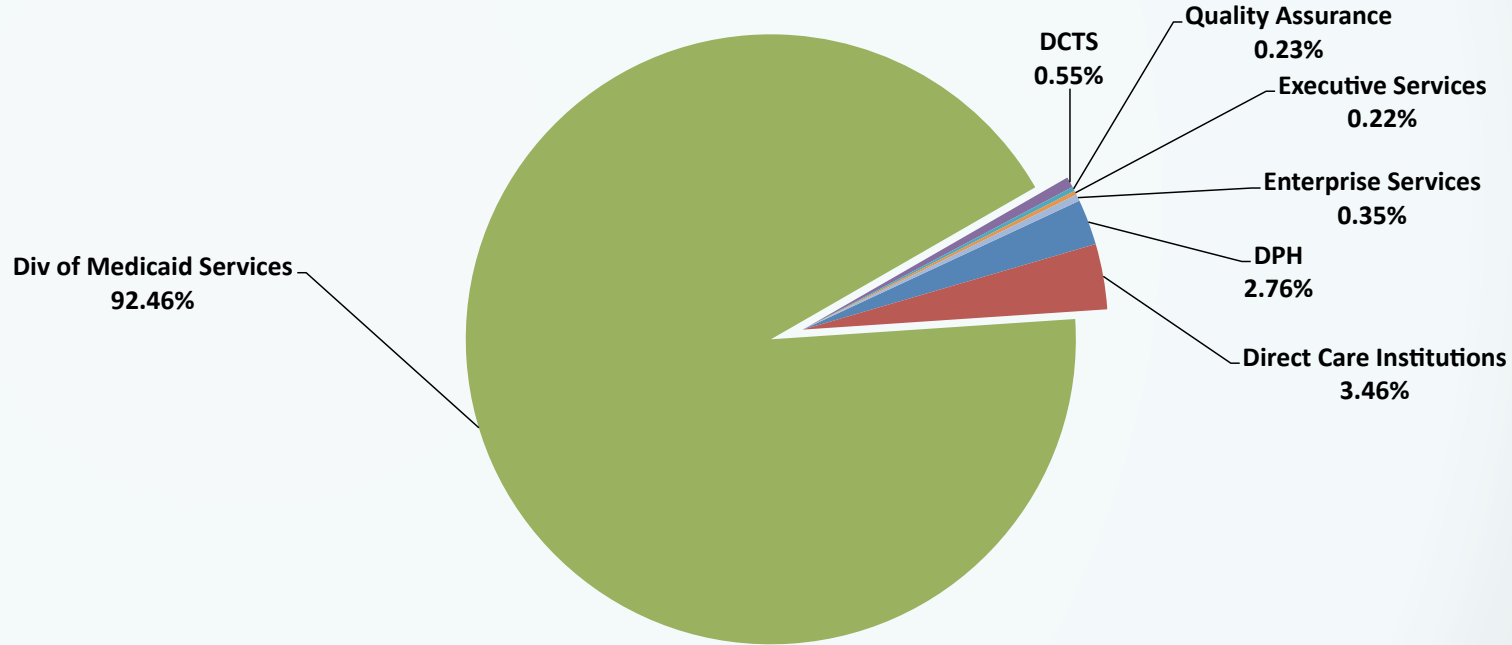
Medicaid Program: Key Facts

- Enrollees (October 2017): 1,184,715
- Providers: 73,000+
- Average Fee for Service Paid Claims Per Year: 27.9 million
- Average Annual HMO Service Encounters: 12.9 million
- Prior Authorization Requests Per Month: 19,741

2017-19 Biennial Budget by State Agency (All Funding Sources)



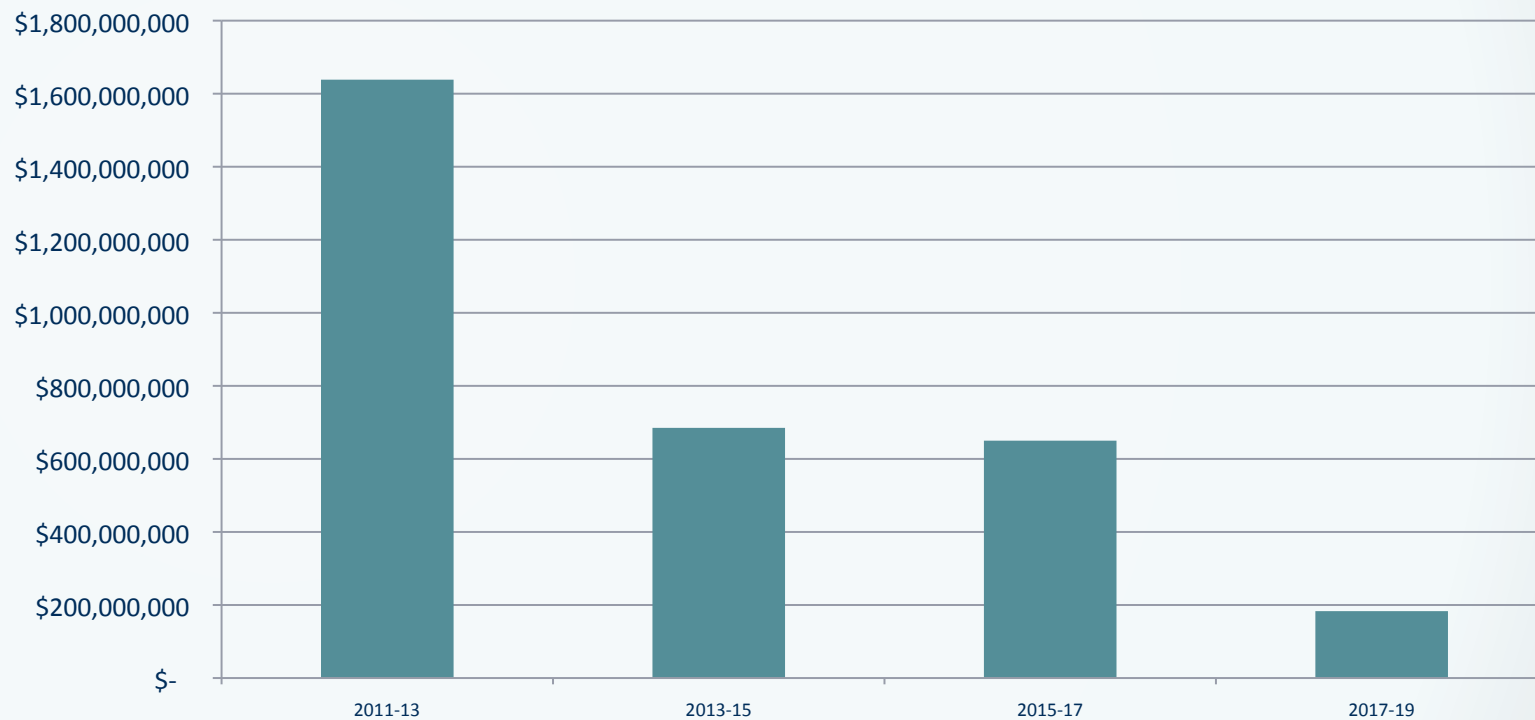
DHS 2017-19 Biennial Budget by Division (Total Budget = \$23.9B All Funds)



Medicaid's Impact on Overall State Budget

- Medicaid comprises about 30% of total state budget (18% of GPR budget)
- In recent budget cycles, the Medicaid cost to continue has consumed all or most of GPR revenue growth
- DHS has been striving to minimize cost growth in the program while maintaining eligibility, benefits, and access to services

GPR Cost-to-Continue Increase for Medicaid in Recent Biennial Budgets



GPR Increases to Medicaid v. Other Programs in Recent Biennial Budgets

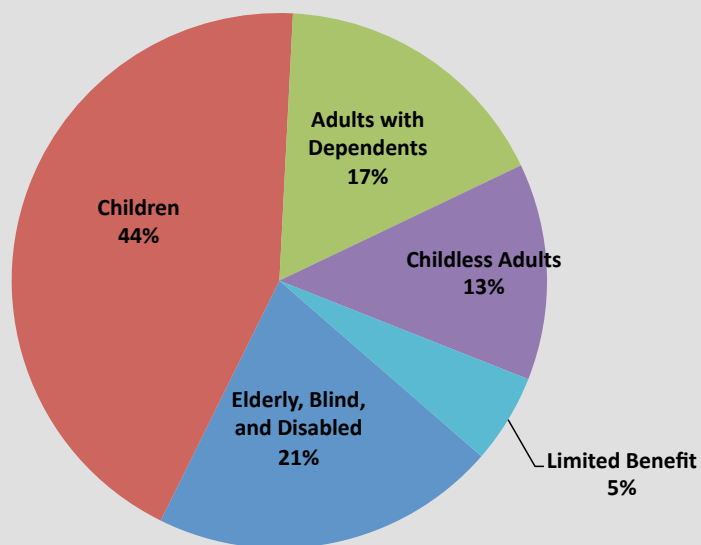
	2011-13	2013-15	2015-17	2017-19
Medicaid	\$1,638M	\$685M	\$650M	\$183M
Other State Programs	(\$942M)	\$261M	\$448M	\$1.112M
Total GPR Increase	\$696M	\$946M	\$1,098M	\$1.295M
<i>% for Medicaid</i>	<i>235%</i>	<i>72%</i>	<i>59%</i>	<i>14%</i>

Estimating the Medicaid Budget

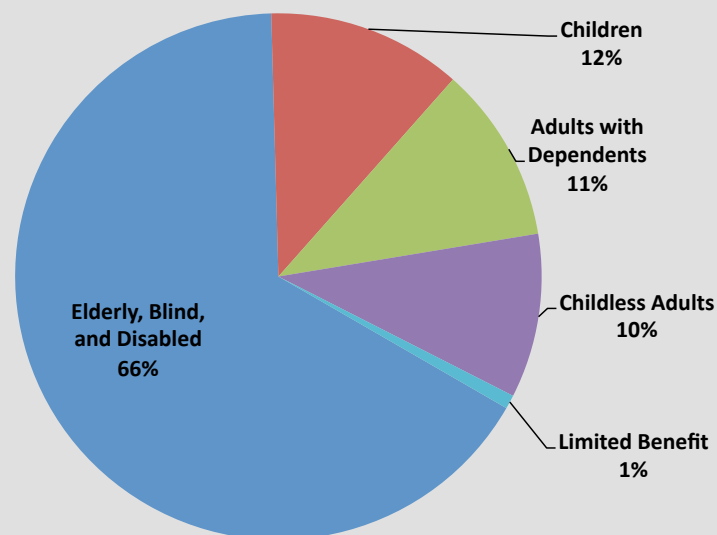
- Costs
 - Enrollment
 - Cost per enrollee by service
 - Per member HMO rates
- Revenue
 - Federal Matching Rate
 - Drug Rebate Revenues
 - Third Party Collections
 - Provider Tax Revenue

Wisconsin Medicaid in SFY 17

Caseload by Eligibility Groups



Costs by Eligibility Groups



Eligibility Group	Caseload		GPR Costs		All Funds PMPM
	Count (avg. monthly)	% of total	Amount (SFY 17)	% of total	
Elderly, Blind, and Disabled	234,166	21%	\$1,952.1 M	66%	\$1,737
Children	486,792	43%	\$352.9 M	12%	\$151
Adults with Dependents	191,430	17%	\$319.9 M	11%	\$348
Childless Adults	146,397	13%	\$297.5 M	10%	\$423
Limited Benefit	60,381	5%	\$25.0 M	1%	\$86
Totals	1,119,165	100%	\$2947.3 M	100%	\$549

Medicaid Benefits Expenditures by Major Category

FY 17 Expenditures (All Funds)

Category	Amount	% of Total
Family Care and IRIS	\$2,197M	26.3%
BadgerCare Plus and SSI HMOs	\$2,144M	25.7%
Nursing Homes, Waivers, Long Term Care Card Services	\$1,297M	15.5%
Prescription Drugs	\$1,062M	12.7%
Drug Rebates	(\$705M)	(8.4%)
Fee for Service Hospital	\$856M	10.2%
Other Fee for Service Providers + Other Payments	\$663M	7.9%
Part D Clawback Payments	\$215M	2.6%
Medicare Premiums /Cost Share for Dual Eligibles	\$316M	3.8%
Community Mental Health	\$145M	1.7%
Federally Qualified Health Centers	\$164M	2.0%
Total	\$8,354M	100%

Medicaid Payments to Counties: FY 16

	GPR	FED	Total
Adult Legacy Waivers	\$ 67,872,802	\$ 101,809,204	\$ 169,682,006
Children's Long Term Supports	\$ 27,720,447	\$ 41,580,670	\$ 69,301,117
Children's Wraparound HMOs	\$ 11,643,580	\$ 17,465,370	\$ 29,108,949
Mental Health/Substance Abuse	\$ 20,076,370	\$ 83,973,019	\$ 104,049,390
Nursing Facility	\$ 61,164,577	\$ 90,032,666	\$ 151,197,242
Hospital	\$ 6,411,089	\$ 9,616,633	\$ 16,027,722
Personal Care	\$ 10,845,419	\$ 16,268,129	\$ 27,113,548
Other Services	\$ 6,786,833	\$ 26,150,833	\$ 32,937,666
Total	\$ 212,521,117	\$ 386,896,523	\$ 599,417,641

How Provider Rates Are Set

- BadgerCare Plus/SSI Managed Care Rates
 - Per member, per month rate set through an actuarial process
 - Collect prior year “encounter data” – amounts paid by HMOs to providers by service
 - Project forward this cost data to the upcoming year, to reflect:
 - Utilization trends,
 - Medicaid benefits/eligibility changes,
 - Any fee-for-service rate increases for individual provider types
 - Add amount for administration (including care coordination)

How Provider Rates Are Set

- Fee for Service Hospitals –
 - Reimbursed for each discharge based on type of procedure the patient was admitted for, based on:
 - Medicare Severity Diagnosis Related Groupers (DRGs) for inpatient stays
 - Enhanced Ambulatory Patient Groupers (EAPGs) for outpatient visits
 - Apply trend factors to DRG/EAPG rates each year
 - Hospitals also receive “access payments”
 - Flat fee add-on to the usual rate
 - Non-federal share of access payments funded with provider tax levied on hospitals

How Provider Rates Are Set

- Fee for Service Nursing Homes – Set via rate formula based on total funding appropriated by Legislature in the budget process
- Other Fee for Service Providers – Generally speaking, set by Legislature through the biennial budget process

How Provider Rates Are Set

- Examples of Other Special Cases:
 - CCS – Full cost reimbursement based on county cost reports
 - Federally Qualified Health Centers – Perspective rates set based on prior year costs.

Medicaid: New Developments

- Children's Long Term Supports
- Behavioral Health Outpatient Rate Increase
- SSI Managed Care Enrollment – New Enrollment Model
- Medicaid and FoodShare Program Drug Screening and Testing
- Psychosocial Rehabilitation Rule
- Crisis Stabilization Facility for Youth