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May 19, 2004

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 996 and Senate Bill 567: MA Payments to Counties and Local Health Departments for Certain Services and Community Aids Funding

Assembly Bill 996 and Senate Bill 567 are identical bills that would make one-time changes to the medical assistance (MA) and community aids programs to reduce a projected shortfall in state funding currently budgeted to support MA benefits in the 2003-05 biennium by an estimated $53.2 million. The shortfall, which is currently estimated to be $277.5 million, would be reduced to an estimated $224.3 million if either of these bills were enacted.

The bill would: (a) authorize the Department of Health and Family Services (DHFS) to make MA payment adjustments to counties and local health departments for certain MA-covered services that would be funded with GPR and federal MA matching funds; (b) reduce community aids funding in calendar years 2004 and 2005 to support the GPR share of the MA payment adjustments to counties and local health departments; (c) increase GPR funding for MA benefits; and (d) repeal several provisions included in 2003 Wisconsin Act 33 (the 2003-05 biennial budget act) that created a new intergovernmental transfer (IGT) program for certain MA-covered services currently provided by local governments as a method of increasing federal support for the state's MA program.

CURRENT LAW

Act 33 Local Government IGT Provisions. Act 33 authorized DHFS to establish an IGT program for certain MA-covered, non-institutional services provided by counties after January, 2003. DHFS would have implemented this provision by amending the MA state plan and increasing MA payment rates to counties that provide these services to reflect more closely the estimated cost counties incur in providing these services.

Based on the rate increases included in the state plan amendment, DHFS would have provided supplemental payments to counties equal to the total value of the rate increases. Counties would have then been required to return both the state and federal share of these payments to DHFS. This IGT revenue (including both the state and federal share of the payment) would have been first deposited to a new program revenue (PR) appropriation, then the federal share of the payment would have been transferred to the segregated (SEG) MA trust fund to support the state's share of MA benefit costs. Counties would not have retained the funding for the rate increases provided under this initiative.

The funding provided in Act 33 for MA benefits was based on the assumption that this IGT initiative would generate $53,783,400 in 2003-04 and $29,596,400 in 2004-05 in additional federal MA funds that would be deposited in the MA trust fund after it was paid back by the counties. The estimated revenue was greater in 2003-04 than in 2004-05 because the 2003-04 estimate was based on payments for rate increases for services provided over an 18-month period (from January, 2003, through June, 2004), whereas the 2004-05 revenue estimate was based on payments for rate increases for services provided over a 12-month period (July 1, 2004 through June 30, 2005).

The new rates paid to counties and local health departments under this initiative were developed using the original rate established for each service or the earliest rate available on DHFS claims systems since January, 1990, for a service, and then inflating those rates forward to the present, based on medical cost inflation. The supplemental payments would have reflected the difference between the current rates paid and what the rates would have been if inflated forward based on medical inflation.

Community Services Deficit Reduction Benefit (CSDRB) Program. Under the CSDRB program, counties and local health departments can claim federal MA matching funds to support their costs of providing certain MA-covered services that are not fully reimbursed under the rates established in the MA maximum fee schedule. Payments under the CSDRB program are made in the calendar year following the year in which the counties and local health departments incurred the costs.

If the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) had approved the IGT proposal included in Act 33, DHFS would have been no longer able to claim federal MA matching funds under the CSDRB program. The rate increases that would have been established under the Act 33 provision would have fully reimbursed local governments for providing these services, and therefore no additional federal funding could have been claimed under the CSDRB program. For this reason, Act 33 budgeted $17 million SEG from the MA trust fund in 2004-05 to make hold harmless payments to counties and local health departments to reflect the elimination of CSDRB program under the initiative. No funding for hold harmless payments was provided in 2003-04 because counties and local health departments would have continued to claim federal matching funds under the CSDRB program in that year for services provided in calendar year 2002.

MA State Plan Amendments. DHFS submits MA state plan amendments periodically to CMS for approval. Amendments are considered automatically approved within 90 days after CMS receives the proposed amendment from a state, unless CMS provides the state with: (a) a written notice of disapproval; or (b) a written notice of additional information it needs to make a final determination. If CMS provides a written notice requesting additional information, the 90-day period for approval begins once the state provides the additional information to CMS.

On March 26, 2003, DHFS submitted to CMS a state plan amendment to implement the IGT initiative included in Act 33. CMS officials expressed concern over the use of IGT initiatives to secure additional federal MA matching funds and indicated that the amendment, as proposed, would not be approved due to CMS' current policy not to approve any state plan amendments that include new IGT initiatives. In addition, CMS established a policy that MA payments to local units of government should not exceed that government's documented costs to provide the service. The proposal in Act 33 would have established rates for local governments that were not based on their documented costs. Due to concerns that the original proposed amendment would not be approved, DHFS submitted an alternative proposal to CMS on March 5, 2004. CMS has until June 3, 2004, to approve, disapprove, or request additional information on the revised proposed amendment. Otherwise, it will be automatically approved.

Community Aids. Community aids are state and federal funds that are distributed by DHFS to counties for two broad, statutorily-defined functional areas: (1) social services for individuals and children in need of protection and services; and (2) services for persons with needs relating to mental illness, substance abuse, or developmental disabilities. Although these two broad functional areas are authorized by separate statutory provisions and are frequently administered at the county level by separate agencies, these functions are considered to be related components of a coordinated state/local human services system.

The term "human services" refers to a broad array of services provided to persons in need, including income maintenance payments and assistance with health care costs. Human services supported by community aids funding include: (a) crisis respite child care; (b) community living/support services, such as daily living skills training, respite care, and home-delivered and congregate meals; (c) work-related and day services; (d) community residential services, such as foster home care, adult family home care, shelter care, and community-based residential facilities; (e) community treatment services, including juvenile probation, supervision, reintegration, and aftercare; (f) supported employment; (g) supportive home care services; (h) community prevention, access, and outreach; (i) transportation; and (j) some inpatient and institutional care.

Some of the services that could be funded under community aids, including community treatment services and supportive home care services, may also be covered under MA if the service is provided to an MA enrollee by an MA certified provider. Most counties have at least one agency that is certified to provide some MA-covered services. Counties, acting as agents of the state, may also contract with MA certified providers to provide MA-covered services as part of their responsibility to provide human services. For some of the MA-covered services provided by or

through counties, such as home health or personal care services, the state's share of MA costs are funded with state GPR budgeted for MA. For other services, such as community support and case management services, counties use either community aids or other local revenue to fund the state share of the MA payments.

Community aids funds include appropriations of state GPR and federal funds that are combined and distributed to counties. Table 1 summarizes community aids funding in the 2003-05 biennium.

TABLE 1

Community Aids Funding by Source
2003-04 and 2004-05

Funding Source	2003-04	2004-05
GPR	$177,204,200	$177,206,500
FED		
Title IV-E	$27,837,700	$27,837,700
Title IV-B	3,622,600	3,622,600
Mental Health Block Grant	2,513,400	2,513,400
Substance Abuse Prevention and Treatment	9,735,600	9,735,600
Social Services Block Grant	27,093,800	27,093,900
TANF	13,420,500	13,420,500
Total FED	$84,223,600	$84,223,700
Total Funding	$261,427,800	$261,430,200

DHFS allocates community aids to counties on a calendar year basis under a basic county allocation (BCA) and five separate, categorical allocations. The BCA represents approximately 93% of the funds DHFS allocates to counties under the community aids program and these funds may be spent on any eligible community aids service. The five categorical allocations are: (a) the family support program; (b) the Alzheimer's family and caregiver support program (AFCSP); (c) the federal substance abuse prevention and treatment (SAPT) block grant; (d) the community mental health block grant; and (e) the tribal child care program. Funding provided under the categorical allocations may only be used to support costs associated with that program or type of service. Table 2 shows community aids funding for the BCA and the categorical allocations for calendar years 2004 and 2005.

TABLE 2

Community Aids Funding by Type of Allocation
Calendar Years 2004 and 2005

Allocation	2004	2005
BCA	$241,758,500	$241,758,800
SAPT	9,735,600	9,735,600
Mental Health	2,513,400	2,513,400
AFCSP	1,919,800	1,919,800
Family Support	5,089,800	5,089,800
Tribal Child Care	412,800	412,800
Total	$261,429,900	$261,430,200

Under current law, counties are required to provide matching funds equal to 9.89% of the BCA and the Alzheimer's family and caregiver support allocation. However, most counties provide more county funds than the amount that is required under current law.

SUMMARY OF BILL

The bill would: (a) authorize DHFS to make MA payment adjustments to counties and local health departments for MA-covered services that would be funded with GPR and federal MA matching funds; (b) reduce community aids funding in calendar years 2004 and 2005 to support the GPR share of the MA payment adjustments to counties; (c) increase GPR funding for MA benefits; and (d) repeal certain related provisions included in Act 33.

MA Payment Adjustments to Counties. The bill would authorize DHFS, effective January 1, 2003, to make, from the community aids GPR appropriation, the state share of MA payment adjustments to county departments or local health departments for the following services: (a) early and periodic screening, diagnostic, and treatment; (b) home health; (c) family planning; (d) physical, occupational, and speech therapy; (e) mental health and substance abuse day treatment and outpatient services; (f) nursing services; (f) personal care; (h) community support program; (i) community-based psychosocial services; (j) respiratory care for ventilator-dependent individuals; (k) case management; (l) prenatal care and child care coordination; and (m) mental health crisis intervention. This provision would be repealed effective January 1, 2006.

The bill would specify that total MA payment adjustments and other MA payments for services could not exceed applicable limits under federal law that require that payments for services are: (a) as much as necessary to safeguard against unnecessary utilization; (b) consistent with

efficiency, economy, and quality of care; and (c) sufficient to enlist enough providers to ensure adequate access to services.

Additional MA Payments from the Community Aids Appropriation. The bill would authorize DHFS to make payments to local health departments from the community aids GPR appropriation in 2004-05 that would not exceed, on an annualized basis, CSDRB payments to those local health departments for services provided in 2002. In 2002, two cities, Madison and Beloit, received CSDRB payments for MA covered services totaling approximately $71,100. The bill would authorize supplemental payments to these health departments to hold them harmless due to the elimination of CSDRB. Because cities do not receive community aids funding, payments to these local health departments would not be offset by corresponding community aids reductions. The bill would provide $71,100 GPR in 2004-05 to fund these payments from the community aids appropriation.

Beginning January 1, 2003, the bill would authorize DHFS to make, from the community aids appropriation, the state's share of MA payments for home health and personal care services and respiratory care services for individuals who are dependent on ventilators. Such payments could be made to any MA-certified provider for such services, not just those services provided by counties or local health departments. This provision would be repealed effective January 1, 2006.

This provision is intended to provide flexibility so that base MA benefits could be funded from the community aids appropriation if the amount of additional federal funding exceeds the amount anticipated under the bill. This would happen if counties provided more services than anticipated, or counties' costs increase more than anticipated, resulting in larger MA payment adjustments to those counties. As a result, community aids would be reduced further to fund the state's share of the larger MA payment adjustments. The remaining GPR available from the additional community aids reduction would be used to fund base MA costs from the community aids appropriation.

Community Aids. The bill would authorize DHFS to decrease a county's community aids allocation by the GPR share of any amount a county receives as MA payment adjustments. No county's community aids decrease could exceed the GPR share of that county's BCA. This provision would also be repealed effective January 1, 2006.

Under the bill, the county match requirement to the BCA would be specified in a schedule established annually by DHFS. The county's required match for the Alzheimer's family and caregiver support program would remain at 9.89% of the county's distribution. These provisions would be repealed on January 1, 2006, and the match requirement would return to current law.

Appropriation Changes. The bill would decrease the community aids GPR appropriation by $53,204,600 in 2004-05 and increase the MA GPR appropriation by a corresponding amount. In addition, the bill would require DHFS, in submitting its 2005-07 biennial budget request, to submit information concerning the GPR community aids and MA benefits appropriation as though the

changes included in the bill had not been made. This provision is intended to ensure that the community aids and MA appropriation changes would be one-time changes, effective only in 2004-05, and would not affect ongoing base funding for these programs.

CSDRB Hold Harmless Payments. The bill would delete Act 33 provisions that would have authorized DHFS to make CSDRB hold harmless payments from the MA trust fund for services beginning in January, 2003, and would delete $17.0 million SEG in 2004-05 that was budgeted for such payments. Instead, under this bill, counties would be held harmless from elimination of CSDRB for calendar years 2003 through 2005, since funding for MA payment adjustments would include sufficient funding to hold counties harmless from both the reduction in community aids and the elimination of the CSDRB program. However, the bill would restore DHFS' authority to make CSDRB payments from the MA trust fund for calendar year 2006, since MA payment adjustments would no longer be available beginning January 1, 2006, and federal funding under CSDRB would not be available until after calendar year 2006.

Federal Approval of the MA State Plan Amendment. The bill would specify that if the state plan amendment authorizing the revised payment methodology for services provided by counties or local health departments is not approved in writing by CMS by July 1, 2005, or is disapproved by CMS on any date, the entire bill is void and the Secretary of the Department of Administration would be required to notify the Revisor of Statutes concerning the lack of approval or disapproval.

Act 33 Provisions. The bill would repeal several provisions enacted in Act 33 that are related to the creation of a PR appropriation that, under Act 33, would have been used to receive funding from counties under the original IGT proposal.

FISCAL EFFECT

The bill would make statutory changes to replace the IGT proposal enacted in Act 33 with enabling legislation that is consistent with the proposed state plan amendment that was submitted to CMS for approval on March 5, 2004. As previously indicated, CMS has until June 3, 2004, to approve, disapprove, or request additional information on the revised state plan amendment. Otherwise, the state plan amendment is automatically approved.

The revised amendment addresses concerns raised by CMS officials that the original proposed amendment would not be approved under new CMS policies that: (a) no state plan amendments that include new IGT initiatives would be approved; and (b) no state plan amendments would be approved if states pay local governments more than the local governments' documented costs. CMS has indicated that the rate methodology used in the original proposed amendment was not an appropriate basis for calculating rates and could result in payments to counties that exceeded their documented costs. The new payments would be based on the difference between the current MA rates and counties' documented costs. In an email dated April 6, 2004, CMS indicated that it

would approve the revised proposal if the state passed enabling legislation. However, this communication does not indicate CMS' formal approval of the revised proposal.

The bill would decrease GPR funding for community aids by $103,458,800 in 2004-05. The GPR available from this reduction would be used in 2004-05 to: (a) fund the state share of MA payment adjustments made to counties ($50,183,100 GPR and $70,275,700 FED); (b) fund payments to local health departments that would otherwise lose funding if the CSDRB is eliminated ($71,100 GPR); and (c) support base MA costs that were originally budgeted as SEG in Act 33 ($53,204,600 GPR). Only the portion of the GPR that would be used to support base MA costs would be transferred to the current MA appropriation. The remainder of the GPR would remain in the current community aids appropriation, but DHFS would be authorized to use GPR in that appropriation to support the new MA payments.

In addition, the bill would decrease SEG funding budgeted in the MA trust fund by $17,000,000 in 2004-05 that was budgeted in Act 33 for CSDRB hold harmless payments to counties and local public health departments. These MA payment adjustments are intended to replace both reduced funding for community aids and the elimination of CSDRB hold harmless payments.

Table 3 illustrates these funding changes.

TABLE 3

2004-05 Fiscal Effect on Counties, Local Health Departments, and State MA Benefits

	GPR	FED	SEG	Total
Payments to Counties				
Community Aids	-$103,458,800	$0	$0	-$103,458,800
CSDRB Hold Harmless Payments	0	0	-17,000,000	-17,000,000
New MA Payment Adjustments	50,183,100	70,275,700	0	120,458,800
Subtotal	-$53,275,700	$70,275,700	-$17,000,000	$0
Payments to Local Health Departments				
CSDRB Hold Harmless Payments	$71,100	$0	$0	$71,100
MA Benefits Appropriation	$53,204,600	$0	$0	$53,204,600
Total Change to Current Law	$0	$70,275,700	-$17,000,000	$53,275,700

Effect on Projected MA Shortfall. In a January 15, 2004, letter to members of the Legislature, this office indicated that, if the state is unable to secure any additional federal matching funds for certain initiatives, approximately $401 million of state funds would be needed to fully

fund the MA program in the 2003-05 biennium. This figure represents a combination of: (a) unsupported segregated revenues from the MA trust fund budgeted in Act 33 to support MA program costs ($310.6 million); and (b) projected increases in MA program costs compared to the Act 33 estimates ($90.4 million). On February 26, 2004, the Governor signed 2003 Wisconsin Act 129, which increased segregated revenue to the MA trust fund by $123.5 million in 2003-04 to support MA costs budgeted in Act 33. Act 129 reduced the projected shortfall in the MA program from $401 million to $277.5 million.

If this bill is enacted and the state receives final approval from CMS of its MA state plan amendment, the projected shortfall would be reduced by an estimated $53.2 million in 2004-05 as a result of the GPR that would be provided to fund MA base benefits in 2004-05 under this initiative. Therefore, the projected shortfall would be approximately $224.3 million ($277.5 million - $53.2 million = $224.3 million).

2005-07 Biennium. The purpose of this bill is to secure additional federal MA matching funds that could be used to reduce state GPR spending for community aids and instead use these GPR savings to fund MA base costs. The original proposal included in Act 33 would have established the IGT initiative as an ongoing source of additional federal revenue, subject to federal approval. However, under the bill, the additional federal funding would only be available for MA costs through calendar year 2005. If this proposal were modified so that it would provide the additional revenue on an ongoing basis, it is estimated that it would provide approximately $11 million GPR on an ongoing basis, beginning in 2005-06, to support MA base costs.

In addition, the bill would affect funding budgeted for community aids through all of calendar year 2005 and community aids allocations for the second half of 2005 would typically be budgeted in 2005-06. Therefore, it is expected that the 2005-07 biennial budget bill would include the following funding changes to reflect the availability of the additional federal funding in the second half of 2005: (a) community aids funding would be reduced by approximately $7.0 million GPR in 2005-06; (b) funding would be budgeted for MA payment adjustments paid in 2005-06 (approximately $10.0 million GPR and $14.1 million FED); and (c) funding would be provided on a one-time basis to restore CSDRB hold harmless payments for counties and local health departments in 2006-07 (approximately $17.1 million SEG).

The administration indicates that the current proposal was developed as a one-time, rather than ongoing, source of funding for the MA program in response to a request made by county representatives. Directors of county human service departments and members of the Wisconsin Counties Association did not want the state to permanently reduce the amount of funding specifically earmarked for community aids-eligible activities, even though total payments to counties (the combination of increased MA payments and reduced community aids allocations) would not change if the bill were enacted.

Estimate of Additional Federal Funding. The funding included in the bill is based on the administration's estimate that payment adjustments for non-institutional services provided by

counties under the bill would total approximately $48.2 million annually during calendar years 2003 through 2005.

This estimate is based on actual 2002-03 MA claims for non-institutional services provided by counties, which totaled approximately $87.1 million. The estimate then applied the MA payment to cost percentage (approximately 65%) for county costs submitted for calendar year 2002 to arrive at the estimated $48.2 million in annual payment adjustments. Therefore, under this estimate, it is assumed that total payments to counties for non-institutional services covered under the bill would total approximately $135.3 million annually. It is expected that payment adjustments to counties in 2004-05 would total approximately $120.5 million for costs incurred from January 2003 through June, 2005 ($48.2 million x 2.5 calendar years = $120.5 million).

This estimate is based on several assumptions. First, it assumes that DHFS would require all counties that submit claims for MA payment to submit documented cost data on a calendar year basis. Currently, not all counties that submit claims for MA payment participate in CSDRB and therefore do not submit cost data for MA claims on an annual basis. Therefore, some counties would incur additional administrative costs of submitting cost data for MA claims under this bill. It is expected that the documentation requirements would be substantially similar to the documentation requirements under CSDRB. Therefore, those counties already participating in CSDRB would not likely experience a significant increase in administrative costs.

Second, the estimate assumes that counties would continue to provide the same amount of services as they provided during 2002-03. Further, it assumes that the difference between current MA payments and counties' actual costs would not change from the difference determined based on 2002 costs.

Effect on Community Aids. Under the bill, funding for community aids would be decreased by $103,458,800 GPR in 2004-05 and by $7,020,700 GPR in 2005-06. Because community aids is allocated on a calendar year basis, the BCA would be reduced by $55,275,300 GPR in both 2004 and 2005. Therefore, the total BCA (all funds) to counties in 2004 would be $186,483,200 and $186,483,500 in 2005.

The bill would direct DHFS, as part of the 2005-07 biennial budget submission, to submit information concerning the GPR community aids appropriation as though the funding reduction in the bill had not been made. Therefore, the decrease in community aids funding would be a one-time decrease. When the funding is restored to the base amount, on January 1, 2006, the restored funds would be subject to statutory provisions that require community aids funding to be used to support community aids-eligible services.

Community aids GPR funds, along with county match and overmatch funds, are currently used to meet federal match and maintenance-of-effort requirements for federal grants, including the substance abuse prevention and treatment block grant, the community mental health block grant, MA waiver programs, and funding available under Titles IV-B and IV-E of the Social Security Act. In addition, counties may use community aids or county funds for MA fee for service benefits,

including case management, crisis intervention, and services they provide under the community support program (CSP). After adjusting for the approximately $26.0 million in match funds needed for county matched, MA benefits, DHFS has determined that there is sufficient GPR and county funds to support the match and maintenance-of-effort requirements for the other federal funds.

The amount of MA payment adjustments each county receives would be based on actual claims submitted by counties for MA-covered services provided in calendar year 2003, 2004, and 2005. Each county's community aids BCA would be reduced by a corresponding amount in 2004 and 2005. While total funding to counties would not change under this bill, the source of these payments to counties would change.

Under the bill, the GPR funding for the MA payment adjustments would be budgeted in the GPR appropriation for community aids, but the statutory authority for the appropriation would be expanded to include authority to make MA payments. Even though GPR for MA payments would be budgeted in the same appropriation as GPR budgeted for community aids, the MA payments would not be subject to statutory requirements regarding the use of community aids funds. Rather, as specified under federal law, these payments are reimbursement for services rendered and states are prohibited from placing restrictions on how providers, including local government providers, use MA payments.

Table 4 illustrates funding, by source, that would be provided to counties under the bill.

TABLE 4

Funding to Counties Under the Bill
($ in Millions)

Calendar Year	Community Aids BCA	MA Payment Adjustments	MA CSDRB Payments	CSDRB Hold Harmless Payments	Total Funding
2003	$242.1	$0.0	$16.0	$0.0	$258.1
2004	186.5	72.3	0.0	0.0	258.8
2005	186.5	72.3 *	0.0	0.0	258.8
2006	241.8	0.0	0.0	17.0	258.8
2007	241.8	0.0	17.0	0.0	258.8

*Of this amount, it is possible that counties would receive $24.1 million in late December, 2004, rather than in January, 2005.

Additional Provisions. The bill contains other provisions that have fiscal consequences, which are described below.

Base Funding for MA and Community Aids. The bill directs DHFS, in submitting its 2005-07 biennial budget request to DOA, to submit base funding information for MA and community aids as though the 2004-05 appropriation changes made in the bill had not occurred. This provision would, in effect, restore funding for community aids and MA prior to any other changes in the 2005-07 biennial budget bill. The result would be a decrease in funding for MA of $53,204,600 GPR in each year of the 2005-07 biennium compared to the amount that would be provided in 2004-05 under the bill, and corresponding increases in funding for community aids, compared to the 2004-05 funding level that would be established under the bill.

Restoration of CSDRB Hold Harmless Payments. The bill would eliminate funding and statutory provisions related to the CSDRB hold harmless payments through December, 2005, then restores the statutory provisions, beginning in January, 2006, and then delete the provisions again, beginning in January 2007.

This one-time restoration of CSDRB hold harmless payments is necessary to continue to hold counties harmless from the elimination of the CSDRB program under this bill. Under the bill, community aids funding would be restored beginning in calendar year 2006, and therefore, MA payment adjustments would not be available beginning in that calendar year. Federal claiming under CSDRB would not be possible again until later in calendar year 2007 for costs incurred in calendar year 2006. Therefore, it is expected that the 2005-07 biennial budget bill would provide approximately $17 million in 2006-07 to hold counties harmless for the elimination of CSDRB in 2006.

Status of Other Act 33 Initiatives that Affect the Projected MA Deficit. Act 33 included two other provisions that were intended to reduce state GPR costs to fund MA base benefits by increasing federal MA matching funds. The January, 2004, projected MA shortfall of approximately $401 million assumed that neither of these provisions would be approved. The current status of these initiatives is described below.

One initiative reduced shared revenue funding by $10 million annually and required that $20.5 million annually lapse from the school aids appropriation. Under the provisions included in Act 33, these reductions were to be offset by the availability of supplemental MA payments for ambulance services provided by local governments and school-based health services provided by school districts. The amount of the supplemental payments to local governments and school districts calculation would have been determined on a payment methodology that is similar to the payment methodology originally proposed for county services in Act 33.

To date, this proposal has not been approved by CMS, although CMS' indication that it would approve the revised proposal for local governments non-institutional costs would also apply to the Act 33 provision that would provide MA payment adjustments for ambulance services provided by local government. DHFS has "stopped the clock" on the proposed state plan amendment for payment adjustments for school-based health services, pending resolution of the other state plan amendment.

The other proposal included in Act 33 that would have increased federal MA matching funds available to support MA base costs would have established an IGT initiative for counties' costs for long-term care costs under the community integration program (CIP) waivers. As proposed in the Governor's biennial budget recommendations, it was expected that this initiative could have increased federal MA matching funds by $434 million.

DHFS never submitted a formal state plan amendment to implement the IGT initiative for community-based long-term care costs. A concept paper was submitted to CMS, but CMS' current policy to not approve any state plan amendments that include IGT components makes it unlikely that CMS would approve the original proposal included in the Governor's biennial budget recommendations.

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