Informational Paper 44

Medical Assistance, BadgerCare, SeniorCare, and Related Programs

Wisconsin Legislative Fiscal Bureau
January, 2007

Medical Assistance, BadgerCare, SeniorCare, and Related Programs

Prepared by

Marlia Moore and Rebecca Hotynski

Wisconsin Legislative Fiscal Bureau
One East Main, Suite 301
Madison, WI 53703

TABLE OF CONTENTS

Medical Assistance, BadgerCare, SeniorCare, and Related Programs

Introduction

Title XIX of the federal Social Security Act, enacted in 1965, established the medical assistance (MA) program, an entitlement program that funds health services for certain groups of low-income individuals. This program, which is commonly referred to as "Medicaid" or "Title 19," is jointly financed with state and federal funds and administered by states within federal guidelines pertaining to eligibility, scope of services, provider reimbursement, and administrative operating procedures. The state's MA program pays health care providers for a wide range of services they provide to individuals enrolled in the program.

The program supports the costs of acute and long-term care services to certain groups of individuals -- elderly, blind, disabled, children under the age of 19 and their parents or caretaker relatives, and pregnant women -- who meet specified financial and nonfinancial criteria. MA recipients are entitled to receive covered, medically necessary services furnished by certified providers.

States receive matching payments from the federal government to pay for covered services and program administration. The federal matching rate for program benefits, or federal financial participation (FFP) rate, is based on a formula that compares a state's per capita income to national per capita income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. In federal fiscal year 2006-07 (the period from October 1, 2006 through September 30, 2007), Wisconsin's FFP rate is 57.47%. Most administrative costs are funded on a 50% state / 50% federal basis, although certain types of administrative expenses qualify for greater federal cost-sharing. Federal law does not limit the amount of matching funds states can receive under MA. Consequently, the more funding a state provides to support the program, the more federal funding the state receives to partially support program costs.

Wisconsin's MA program is authorized under Chapter 49 of the state's statutes and administered by the Division of Health Care Financing in the Department of Health and Family Services (DHFS). DHFS administers the program based on state statutes, administrative rules promulgated under HFS 101 to 108 and provisions contained in the state's MA plan. The state's MA plan provides the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) assurances that the program is administered in conformity with federal law and CMS policy. The state plan is amended quarterly to reflect changes in federal and state law and policy. All state plan amendments must be reviewed and approved by CMS.

The state administers several programs under waivers of federal MA law, including BadgerCare, Family Care, SeniorCare, and multiple long-term care home- and community-based waiver programs. These programs operate under broad guidelines specified in federal law and under the terms and conditions of the waiver agreements and the state MA plan approved by CMS. This federal / state relationship permits the state to receive significant federal funding to support these programs, but also limits the state's options regarding program eligibility, services, and recipient cost-sharing. BadgerCare and SeniorCare are budgeted separately from MA, but Family Care capitation payments are budgeted in the same appropriations

that support other MA services and are therefore considered part of the MA budget.

Table 1 summarizes the funding that was budgeted for MA, BadgerCare, and SeniorCare in the 2005-07 biennium, by source. These sources include general purpose revenue (GPR), segregated revenue (SEG) from the MA trust fund, program revenue (PR) from various sources that are discussed in Chapter 5, and federal revenue (FED).

Table 1: Amounts Budgeted for MA, BadgerCare and SeniorCare Benefits, By Source (2005-07 Biennium)

	2005-06	2006-07	2005-07 Biennium	% of Total Program Funding
Medical Assistance*				
GPR	$1,298,566,600	$1,726,097,100	$3,024,663,700	34.5%
FED	2,557,713,200	2,662,548,100	5,220,261,300	59.5
PR	19,312,800	19,203,300	38,516,100	0.4
SEG	384,399,300	110,338,200	494,737,500	5.6
Total	$4,259,991,900	$4,518,186,700	$8,778,178,600	100.0%
BadgerCare				
GPR	$62,439,100	$78,131,000	$140,570,100	34.5%
FED	121,320,300	130,861,100	252,181,400	62.0
PR	6,864,700	7,250,900	14,115,600	3.5
Total	$190,624,100	$216,243,000	$406,867,100	100.0%
SeniorCare				
GPR	$52,090,900	$57,560,700	$109,651,600	36.8%
FED	50,521,300	53,624,100	104,145,400	34.9
PR	40,104,100	44,146,000	84,250,100	28.3
Total	$142,716,300	$155,330,800	$298,047,100	100.0%

*Excludes GPR funding that supports MA payments to counties under the Wisconsin Medicaid cost reporting (WMCR) program.

CHAPTER 1

MEDICAL ASSISTANCE ELIGIBILITY

Federal law requires states to cover certain groups of individuals under their MA programs and permits states, at their option, to extend coverage to other groups of individuals. Elderly, blind and disabled individuals eligible for supplemental security income (SSI) benefits and children for whom foster care or adoption assistance payments are made under Title IV-E of the federal Social Security Act are automatically eligible for MA. Other individuals must meet certain financial and nonfinancial eligibility criteria to be eligible.

Federal law defines two broad categories of individuals who are, or may be, eligible for MA -- categorically needy and medically needy individuals. Categorically needy MA recipients include individuals that federal law requires states to cover under their MA programs and certain other groups that states may, at their option, cover.

Medically needy MA recipients include some groups of individuals and families that have more income and, in some instances, more countable resources than individuals who are eligible for MA under the categorically needy groups. The medically needy group also includes individuals who become eligible for MA as a result of "spend-down." Individuals in this group have the same demographic characteristics as individuals in other medically needy groups, but do not meet the medically needy income limit. Individuals in this group are eligible for MA after they incur medical expenses equal to the amount that their income exceeds the medically needy income limit. The amount these individuals must spend on qualifying medical expenses during a six-month benefit period is called the MA deductible. Once the deductible has been met, these individuals are eligible for MA reimbursement of covered services for the remainder of a six-month benefit period.

In some states, categorically needy recipients receive a broader range of benefits than do medically needy recipients. However, in Wisconsin, medically needy MA recipients receive the same benefits as categorically needy recipients. Therefore, the distinction between medically and categorically needy recipients is less important in Wisconsin than in other states.

Although MA is a means-tested program, some groups of low-income individuals are not eligible for coverage. Generally, only pregnant women, children, and their parents and caretaker relatives, and individuals who are elderly, blind, or disabled may be eligible for MA. Individuals who do not meet these qualifications, such as childless, non-elderly adults who are not disabled, cannot qualify, no matter how little income they have, unless they have certain health conditions, such as tuberculosis, breast, cancer, or cervical cancer. Further, because different income and asset eligibility standards apply to individuals based on their age, pregnancy and disability status, some individuals in a family may qualify for MA coverage, while others in the family may not.

The MA program has numerous eligibility requirements. Certain expenses, such as child care, are deducted from household income as part of the eligibility determination. Additionally, other types of income, such as Wisconsin Works (W-2) payments, kinship care payments, and a portion of child support payments, may not be counted when determining a family's income. The information

provided in this paper is intended to generally describe each eligibility category, rather than to describe all of the criteria the state uses to determine eligibility.

Eligibility for Families with Dependent Children and Pregnant Women

This section describes general eligibility criteria for Wisconsin's MA program for families with dependent children and pregnant women. For many groups, the income eligibility criteria are based on a percentage of the federal poverty level (FPL). Table 2 shows the FPL for 2006, which is based on the number of individuals in a family.

Table 2: 2006 Federal Poverty Level

Family Size	Monthly Income
1	$817
2	1,100
3	1,383
4	1,667
5	1,950
6	2,233

AFDC and AFDC-Related Groups. Families with dependent children are eligible for MA if they meet certain requirements related to the state's former aid to families with dependent children (AFDC) program, based on the requirements of that program that were in effect on July 16, 1996. Families eligible for AFDC and AFDC-related MA meet the same demographic standards for eligibility, but must meet different financial eligibility standards.

Generally, to be eligible for MA under the AFDC criteria, a family would have gross income below a certain level and net income at or below an amount equivalent to the AFDC payment levels in effect on July 16, 1996.

Under the AFDC-related criteria, there is no limit for gross income, but families have to have net income at or below the AFDC assistance standard. The assistance standard is higher than the AFDC payment levels. Table 3 identifies the AFDC payment levels and assistance standards that were in effect on July 16, 1996, for urban counties. The payment levels and assistance standards for rural counties are somewhat less.

Table 3: AFDC Payment Levels and Assistance Standard as of July 16, 1996 for Urban Counties

	Monthly Payment Level		Monthly Assistance Standard	
Family Size	Amount	% of the 2006 FPL	Amount	% of the 2006 FPL
1	$249	30.5%	$311	38.1%
2	440	40.0	550	50.0
3	518	37.4	647	46.8
4	618	37.1	772	46.3
5	708	36.3	886	45.4
6	766	34.3	958	42.9

Because the AFDC and AFDC-related income criteria are based on the payment levels and assistance standards in place at a point in time, this criteria represents a smaller percentage of the federal poverty level every year, since the federal poverty level increases annually, based on inflation.

Another difference between the AFDC and AFDC-related criteria reflects the deductions available under each set of criteria. To determine net income under MA, families are allowed a number of deductions from gross income, including a deduction of $90 per month from earned income for work expenses and a deduction for dependent care costs (up to $175 per month or $200 per month, depending on the age of the dependent). Additionally, under the AFDC criteria, a family's net income reflects a deduction of $30 per month of earned income and one-third of any additional earned income, in addition to the $90 deduction for work expenses. This deduction is not available however, for determining eligibility under the AFDC-related criteria.

In addition, Wisconsin's MA program provides coverage to certain individuals that meet criteria related to the income requirements under the state's AFDC plan. These individuals include:

- Certain individuals in families that do not meet the AFDC assistance standard, but would have met the standard, except for certain circumstances;

- Children residing in licensed foster homes or group foster homes;

- Children for whom adoption assistance agreements are in effect and children adopted under state-established agreements;

- Children residing with relatives for whom kinship care payments are made;

- Children whose parents are eligible for SSI caretaker supplement payments;

- Relative caretakers, if the children are not temporarily absent and the children are considered deprived;

- Certain pregnant women; and

- Certain children residing in medical institutions, nursing facilities, psychiatric facilities or intermediate care facilities for the mentally retarded (ICFs-MR).

As of September, 2006, there were approximately 251,100 individuals enrolled in MA under AFDC and AFDC-related eligibility criteria. Counties redetermine MA eligibility for families with dependent children, pregnant mothers and children every 12 months.

Healthy Start. Beginning in the 1980s, several changes to federal law expanded MA coverage to more groups of low-income pregnant women and children. In Wisconsin, these expansions became known as "Healthy Start." Under the Healthy Start criteria, MA covers pregnant women and children who are less than six years of age in families with countable income that does not exceed 185% of the FPL. Children ages six through 19 years old are eligible if the family's income is no more than 100% of the FPL. Generally, the parents of these children are not eligible for MA.

As of September, 2006, there were approximately 149,100 children and pregnant women enrolled in MA under the Healthy Start criteria.

Spend-Down for Children and Pregnant Women. Individuals eligible for MA under the spend-down provision meet the demographic criteria of other MA-covered groups, but their income exceeds the limits that would otherwise apply. The following groups of low-income women and children are eligible for MA coverage under the spend-down provision:

- Any child under 18 years of age;

- An individual under the age of 21 who resides in an intermediate care facility, a skilled nursing facility or inpatient psychiatric hospital; and

- A pregnant woman (eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls).

Under the spend-down provision, a person can become eligible for MA after incurring medical expenses during a six-month period in an amount that equals the amount his or her income is above the medically needy income limits established by the state. In this way, the spenddown provision offers protection against catastrophic medical costs. As of September 2006, there were approximately 207 individuals in the low-income family group who qualified for MA by meeting the spend-down requirement.

Presumptive Eligibility for Pregnant Women. A period of "presumptive eligibility" is available for pregnant women to ensure they have access to prenatal care. This period begins on the day on

which a qualified provider determines, on the basis of preliminary information, that the household income of the woman meets MA eligibility criteria. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to apply for MA, the last day of the month following the month in which the determination of presumptive eligibility is made, whichever is earlier. As of September, 2006 approximately 4,000 women were eligible for MA under a presumptive eligibility determination.

Even if a woman is initially determined to be eligible for MA as a result of a presumptive eligibility determination and is later found to have been ineligible for MA at the time she received services, the state's MA program pays the provider for services rendered to the woman during the period of presumptive eligibility.

Transitional Eligibility. Federal law requires states to extend MA eligibility for certain individuals and families for specified periods. Families that would have lost eligibility for AFDC because of a change in income they earn from employment can remain eligible for up to twelve months based on certain conditions. Families who would have lost AFDC eligibility because their child or family support payments increase can remain eligible for four months under certain conditions. A pregnant woman remains MA eligible through the month in which the 60th day after her pregnancy falls, regardless of a change in household income. Additionally, an infant can remain eligible for MA for up to one year if the infant's mother was eligible for MA on the date the infant was born. As of September, 2006, approximately 68,800 individuals were enrolled in MA under transitional eligibility criteria.

Eligibility for Elderly, Blind and Disabled Individuals

SSI Recipients. States must provide MA coverage to all individuals who receive federally-funded cash assistance under supplemental security income (SSI). However, states may establish more restrictive eligibility standards than the SSI standard if they were using those standards on January 1, 1972. States that have chosen this option must allow applicants to "spend down" to the state's MA income standard. States that choose to impose more restrictive standards are referred to "section 209(b)" states. Wisconsin is not one of these states.

States may supplement federal SSI payments with state funds. However, the federal requirement to provide MA to SSI recipients only applies to those individuals who qualify for the federal SSI payment and only to those individuals who actually receive an SSI payment. In calendar year 2006, the federal income limit for SSI is $603.00 per month for an individual and $904.00 per month for a couple. (These limits apply after income is adjusted to reflect certain deductions and exemptions.) Except for section 209(b) states, states' MA programs must cover elderly and disabled individuals and couples with incomes below these limits who actually receive an SSI payment. States may provide MA coverage to individuals who receive a state-only supplemental payment and to individuals who are eligible for a SSI payment but do not receive a payment. Wisconsin's MA program covers both of these optional groups. In calendar year 2006, elderly and disabled individuals with countable income below $686.78 per month and couples with countable income below $1,036.05 per month were eligible for MA.

States must also continue MA coverage for several groups of individuals who previously were eligible for SSI. For instance, states must provide MA coverage to certain disabled individuals who have returned to work and have lost eligibility for SSI as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. States must continue to provide MA coverage to such an individual if he or she needs MA coverage to continue employment and the individual’s earnings are not sufficient to

provide the equivalent of SSI, MA and attendant care benefits the individual would qualify for in the absence of earnings.

States must also continue MA coverage for individuals who were once eligible for both SSI and Social Security payments and who are no longer eligible for SSI because of certain cost of living adjustments in their Social Security benefits. Under federal regulations, states are required to disregard the cost of living adjustment when considering MA eligibility. Similar MA continuations have been provided for certain other individuals who become ineligible for SSI due to eligibility for, or increases in, Social Security or veterans' benefits. Finally, states must maintain MA coverage for certain SSI-related groups who received benefits in 1973, including individuals who care for disabled individuals. In September, 2006, approximately 109,300 individuals were enrolled in MA under SSI and SSI-related eligibility criteria.

Low-Income Medicare Beneficiaries. States must provide limited MA coverage for several groups of Medicare beneficiaries: (1) qualified Medicare beneficiaries (QMBs); and (2) specified low-income Medicare beneficiaries (SLMBs and SLMBs+).

QMBs are individuals who are entitled to Medicare hospital insurance benefits (Medicare Part A) whose income does not exceed 100% of the FPL, and whose resources do not exceed twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple). This group includes elderly individuals who are not automatically entitled to Part A coverage, but who are eligible to buy Part A coverage by paying a monthly premium. Working disabled individuals who have exhausted Part A entitlement but who have extended their coverage by paying a monthly premium are not included in this group.

For QMBs, MA reimburses any required Medicare premium, coinsurance and deductibles for both Part A (hospital and nursing home insurance) and Part B (physician and other outpatient services) coverage.

For coinsurance, providers are reimbursed the lesser of: (a) the MA maximum fee, less the Medicare payment; or (b) the Medicare coinsurance. For example, if the Medicare allowable charge is $100, the MA maximum fee is $90, the coinsurance amount is $20, and Medicare actually pays $80, then MA pays $10 ($90 - $80). If, on the other hand, the MA maximum fee is $110, MA pays the $20 coinsurance and not the difference between the maximum fee and the Medicare payment ($110 - $80 = $30).

QMBs pay copayments normally required of other MA beneficiaries. Providers are required to accept the MA payment and the QMB's copayment (if any) as payment in full. As of September, 2006, 3,272 individuals were enrolled in MA under the QMB criteria. States have the option to provide full MA benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a state-established income standard that is no higher than 100% of the FPL. Wisconsin does not use this option.

A more limited MA benefit is provided to SLMBs and SLMBs+. States are required to pay the Medicare Part B premium for individuals who otherwise meet the QMB requirements but have income between 100% and 120% of the FPL (SLMBs) or have income between 120% and 135% of the FPL (SLMBs+). No other premiums, deductibles or copayments are paid for individuals in this group. As of September, 2006, there were 4,200 individuals enrolled in MA under the SLMB and SLMB+ criteria.

Medically Needy. Elderly and disabled individuals with income or assets that exceed the categorically needy standards may be eligible for medically needy coverage under MA. Under federal law, medically needy income and asset standards must be reasonable, based on family size, and uniform for all covered groups.

Wisconsin offers MA coverage to medically

needy individuals, but the income standards for the elderly and disabled are, in most cases, lower than the standards for categorically needy individuals. In calendar year 2006, the medically needy monthly income standard is $591.67 for individuals and couples, while the categorically needy monthly income standard is $686.78 for individuals and $1,036.05 for couples.

The medically needy income standard is tied to the AFDC payment standard and has not increased for individuals since 2000 and for couples since 1997. The categorically needy income standard, however, is tied to the SSI payment level and is increased annually to reflect inflation. Under federal law, states have the option of increasing their AFDC standard by the increase in the consumer price index since July 16, 1996. Since, in Wisconsin, the AFDC payment standard is not increased annually to reflect inflation, while the SSI payment levels are, the difference between these two income eligibility standards increases annually.

In order to qualify for MA benefits under the medically needy income standard, an individual is required to "spend down" to the medically needy income and asset limits by incurring sufficient medical expenses to reduce his or her income to the maximum amount allowed under the state's MA plan. Countable assets may not exceed $2,000 for an individual and $3,000 for a couple in 2006. As of September, 2006, 6,235 elderly and disabled individuals were enrolled in MA under this spend down option.

Because of the high cost of care in nursing homes, many elderly and disabled individuals who require nursing home care use the medically needy option. States may, at their option, exclude nursing home care from coverage under the medically needy program. However, Wisconsin does not exercise this option.

Institutional Resident and Community Waivers Special Income Limit. Under federal law, states may provide MA coverage to residents of institutional facilities and participants in the community-based waiver programs under a special institutional income rule. This rule permits individuals who are not categorically eligible for SSI and have income between 100% and 300% of the maximum monthly federal SSI payment amount ($603 per month in 2006) to be automatically eligible for MA coverage without "spending down" to the medically needy standards. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($1,809 per month in 2006).

MA recipients who qualify for institutional care or care under a community-based waiver program under the special income limit or the medically needy standard must use any income in excess of allowable deductions for the costs of their care. Allowable deductions under the special institutional income rule include: (a) for institutionalized enrollees, $45 per month, and between $783 and $1,809 per month in 2006 for community-based waiver recipients as a personal maintenance allowance; (b) a transfer of income to a spouse that is the lesser of $2,488.50 or $2,200 plus an excess shelter allowance and a transfer of $550 for each dependent family member living in the community; and (c) medical costs not covered by MA.

If a state provides MA benefits to individuals eligible under this special income rule and does not extend coverage to the medically needy, then federal law requires the state to allow individuals to establish a "Miller" or "qualifying income trust" to obtain eligibility for nursing home care. A Miller trust: (a) is comprised of only pension, social security, and certain other income to the individual; and (b) stipulates that the state will receive reimbursement from the trust up to the amounts paid on behalf of the individual under MA when the individual passes away. Miller trusts are excluded for the purposes of determining MA eligibility, but may be counted as an available resource under SSI or other cash assistance rules. Since Wisconsin provides coverage to individuals both under the special income limit and under the

medically needy standard, provisions regarding Miller trusts are not applicable in Wisconsin.

Federal rules also allow states to provide MA coverage to certain individuals who need the level of care provided by an institution and would be eligible for MA benefits if they received care in an institution. For example, states may provide MA benefits to individuals who receive hospice benefits in lieu of institutional services and individuals of any age who are ventilator-dependent. In addition, children with special medical needs who live at home may be eligible for MA benefits under the "Katie Beckett" provision.

The Katie Beckett Provision. Historically, federal MA income and resource guidelines presented eligibility barriers for disabled children who could be provided needed care in their homes. In the past, if a child under the age of 21 was living at home, the income and resources of the child's parents were automatically considered available for medical expenses for the child. However, if a child was institutionalized for longer than a month, the child was no longer considered to be a member of the parent's household and only the child's own financial resources were considered available for medical expenses. The child was then able to qualify for MA.

These restrictions created a situation where children would remain institutionalized even though their medical care could be provided at home. In 1982, federal MA law was modified to incorporate the "Katie Beckett provision" after Katie Beckett, a ventilator-dependent institutionalized child, was unable to receive care in her home, not because of medical reasons but because she would have lost her MA coverage.

This provision permits states to extend MA coverage to disabled children under the age of 18 who: (1) would be eligible for MA if they were in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR); (2) require a level of care typically provided in a hospital, skilled nursing facility or ICF-MR; (3) can appropriately receive care outside of a facility; and (4) can receive care outside of an institution that costs no more than the estimated cost of institutional care. Unlike certain other MA recipients, the families of the children eligible under the Katie Beckett provision are not subject to copayment or deductible requirements.

As of the end of September, 2006, 5,087 children in Wisconsin qualified for MA under the Katie Beckett provision.

MA Purchase Plan. 1999 Wisconsin Act 9 created a new option provided under federal MA law to extend MA coverage to certain working, disabled persons. The goal of this program, known as the "MA purchase plan" (MAPP), is to remove financial disincentives to work. The MA purchase plan provides enrollees the opportunity to earn more income without the risk of losing MA-funded health care coverage. This plan also allows an individual to accumulate savings from earned income in an independence account to increase the rewards from working.

An individual is eligible to participate in the MA purchase plan if: (a) the individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL ($2,041.67 per month for an individual and $2,750 per month for a two-person family in 2006); (b) the individual's countable assets under MA financial eligibility rules do not exceed $15,000; (c) the individual has a disability, under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHFS; and (e) the individual is at least 18 years old. As of September, 2006, 10,351 individuals were enrolled in MA under MAPP.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,225 for an individual in 2006).

The premium consists of two parts, reflecting

different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the sum of: (a) standard living allowance ($706 per month in calendar year 2006); (b) impairment-related work expenses; and (c) out-of-pocket medical and remedial expenses. The part of the premium based on earned income is equal to 3% of earned income, except that if the deductions for unearned income exceed unearned income, any remaining deductions can be applied to earned income before the 3% premium rate is applied.

Other Eligible Groups

Family Planning Services for Certain Women. The family planning waiver project provides MA family planning services to women, ages 15 through 44, who have income at or below 185% of the FPL and are not otherwise eligible for MA or BadgerCare.

Even though the women enrolled in the project are considered MA recipients, they do not receive MA benefits other than family planning services. Services funded under the waiver include office visits, limited laboratory services, sterilization and contraceptive devices, pharmaceutical supplies, transportation services and certain medical services, such as minor gynecologic procedures and treatment of sexually transmitted diseases. These services are available to women only in conjunction with contraceptive management services.

Under the terms of the waiver, a period of presumptive eligibility is available for women to ensure they have access to family planning services. This period begins on the day on which a qualified provider determines, on the basis of preliminary information, that the household income of the woman meets the eligibility criteria under the waiver. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to apply for MA, the last day of the second month following the month in which the determination of presumptive eligibility is made, whichever is earlier.

As of September, 2006, there were approximately 56,400 women enrolled in the waiver.

Women Diagnosed with Breast or Cervical Cancer. Any woman under the age of 65 who: (a) has been screened for breast or cervical cancer under an early detection program authorized under the breast and cervical cancers preventive health grant from the U.S. Centers for Disease Control and Prevention (known as the well woman program in Wisconsin), and effective July 1, 2004, any woman, ages 15 through 44, screened through the family planning waiver; (b) is diagnosed with breast or cervical cancer, or a precancerous condition of the cervix and requires treatment for breast or cervical cancer or precancerous conditions of the breast or cervix; and (c) is not eligible for creditable health care coverage, as defined by federal law, is elligible for MA services.

Eligible women must be referred through either: (a) the well-woman program, which limits eligibility to women ages 44 through 65 with household income that does not exceed 250% of the FPL; or (b) the family planning waiver, which limits its eligibility to women ages 15 through 44, with income that does not exceed 185% of the FPL. Therefore, the age and income requirements for the well-woman program and the family planning waiver program apply to this group of MA recipients. A woman can be determined presumptively eligible for MA under criteria similar to the criteria for determining presumptive eligibility for pregnant women.

The option to cover these women under MA was first available to states under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354).

As of September, 2006, there were approximately 300 women enrolled in MA as a result of a diagnosis of breast or cervical cancer.

People with Tuberculosis. People who have tuberculosis and who meet the income and resource eligibility requirements for SSI are eligible

for some MA-covered services. For these individuals, MA coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services; (e) case management services; (f) services designed to encourage individuals to take their medications; and (g) services that are necessary as a result of side effects of medications prescribed to treat tuberculosis. As of September, 2006, there were 200 individuals enrolled in MA under these criteria.

Table 4 describes, by eligibility group, the different income and asset qualifications an individual must meet to receive benefits under Wisconsin's MA program in the 2006 calendar year. The income and asset limits shown in the table reflect countable income and assets.

Additional Requirements Affecting Eligibility

An individual's eligibility for MA can be affected by factors other than the individual's age, medical condition and financial status, as described in the following section.

Spousal Impoverishment. Spousal impoverishment protections refer to features of the MA program that affect legally married couples where one spouse receives certain long-term care services (the institutionalized spouse) while the other does not reside in a nursing home or medical institution (the community spouse). The protections allow a portion of the couple's income and assets to be retained for the community spouse. The institutionalized spouse can be receiving long-term services either in a nursing home or through a community-based MA waiver program, such as the community options waiver program. The spousal impoverishment protections are the same in both cases.

Asset Limit. When a married person enters a nursing home or a community-based, long-term care program, the county social services or human services department will, upon request, conduct an assessment of the couple's combined total assets. Countable assets include items owned by either spouse but exclude the couple's home, one vehicle, assets related to burial (including insurance, trusts, funds or plots), household furnishings and clothing or other personal items.

The amount of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or request for home- and community-based waiver benefits. Federal law allows states discretion in establishing the asset protection level within maximum and minimum limits ($19,908 to $99,540 in calendar year 2006). Both federal limits are adjusted annually, based on changes in the consumer price index.

Within these federally-established limits, each state may determine the amount of assets that the community spouse may retain. Wisconsin has set its level in the mid-range of these limits. Wisconsin's spousal asset protection level is the greater of: (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum. As required by federal law, the state asset limits may be adjusted on a case-by-case basis by a fair hearing or court order based on the couple's circumstances.

In addition to the assets protected for the community spouse, the institutionalized spouse may retain $2,000 of assets. Any countable assets in excess of these protected amounts must be expended before the institutionalized spouse can become eligible for MA. These assets may be used to pay for long-term care services or for other purposes, such as home repair or improvements, vehicle repair or replacement, clothing or other household expenses.

Table 4: Income Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2006)

FAMILIES, WOMEN AND CHILDREN

CATEGORICALLY NEEDY

AFDC

- People in families with dependent children that would qualify for AFDC, based on the payment levels in effect in July 16, 1996, if AFDC still existed.

Family Size	Maximum Monthly Net Income*	Income as a % of 2006 FPL
1	$249	30.5%
2	440	40.0
3	518	37.4
4	618	37.1
5	708	36.3
6	766	34.3

* Urban counties. A slightly lower standard applies in rural counties.

AFDC-RELATED

- People in families with dependent children whose net income is no greater than the AFDC assistance standard in effect on July 16, 1996.
- Other AFDC-related groups.

Family Size	Maximum Monthly Net Income*	Income as a % of 2006 FPL
1	$311	38.1%
2	550	50.0
3	647	46.8
4	772	46.3
5	886	45.4
6	958	42.9

* Urban counties. A slightly lower standard applies in rural counties.

HEALTHY START

Pregnant Women and Children Under Age Six

- Pregnant women and children up to age six in families with income up to 133% of the FPL.

Family Size	Maximum Monthly Income	Income as a % of 2006 FPL
1	$1,086	133%
2	1,463	133
3	1,840	133
4	2,217	133
5	2,594	133
6	2,970	133

HEALTHY START

Children Ages Six Through Eighteen

- Children between the ages of six and 19 in families with income up to 100% of the FPL.

Family Size	Maximum Monthly Income	Income as a % of 2006 FPL
1	$817	100%
2	1,100	100
3	1,383	100
4	1,667	100
5	1,950	100
6	2,233	100

MEDICALLY NEEDY

AFDC-RELATED

- Children in families that meet AFDC demographic criteria and the income standards below.
- Children and pregnant women in families that meet AFDC demographic criteria and incur medical expenses during a six-month period, resulting in a "spenddown" to the income standards below.

Family Size	Maximum Monthly Income	Income as a % of 2006 FPL
1	$592	72.5%
2	592	53.8
3	689	49.8
4	823	49.4
5	944	48.4
6	1,021	45.7

HEALTHY START

Pregnant Women and Children Under Age Six

- Pregnant women, infants and children up to age six in families that have income above the categorically needy income standard, but no more than 185 % of the FPL.
- Pregnant women, infants and children up to age six in families that have income above 185% of the FPL, but "spend down" to 185% of the FPL.

Family Size	Maximum Monthly Income	Income as a % of 2006 FPL
1	$1,511	185%
2	2,035	185
3	2,559	185
4	3,083	185
5	3,607	185
6	4,131	185

Note: Income levels are those in effect as of January 1, 2006, and federal poverty levels for the 2006 calendar year. The federal poverty level is updated annually in mid-February. There are not asset limits for individuals to qualify under these eligibility categories.

Table 4: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2006) (continued)

ELDERLY, BLIND AND DISABLED INDIVIDUALS AND COUPLES

CATEGORICALLY NEEDY

- People who meet eligibility requirements for the supplemental security income (SSI) program, including: (a) people who are over age 65; (b) people who are totally and permanently disabled; and (c) people who are totally and permanently blind.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2006 FPL
1	$2,000	$687[1]	84%
2	3,000	1,036[2]	94

[1] Assumes that person has actual shelter costs of at least $201.
[2] Assumes that the family has actual shelter costs of at least $301.

MEDICALLY NEEDY

- People who meet the demographic eligibility criteria for the elderly, blind and disabled group who incur medical expenses, resulting in their "spending down" to medically needy asset and income criteria.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2006 FPL
1	$2,000	$592	72%
2	3,000	592	54

COMMUNITY SPOUSE PROTECTED INCOME AND RESOURCES

- A community spouse of an institutionalized MA-eligible person may retain a certain amount of monthly income and assets that do not have to be used towards the care costs for the institutionalized individual. The spousal asset protection level is the greater of (a) $50,000; or (b) 50% of the couple's resource, up to the federal maximum of $99,540. (The federal minimum spousal asset share amount is $19,908.) In each case, the institutionalized spouse may retain $2,000 in assets. In addition to the assets retained by the community spouse, part of the institutional spouse's income may be transferred to the community spouse to provide income for the community spouse and any dependents living with the community spouse (an additional $550 per month for each qualifying dependent).

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2006 FPL
2	See Text	$2,489	226%

MEDICARE BENEFICIARIES

- Individuals entitled to Medicare hospital insurance benefits under Part A.
- MA pays some or all of the following for Medicare Part A and Part B services: (1) Medicare premiums; (2) coinsurance; and (3) deductibles.

Type	Asset Limit Indiv.	Asset Limit Couple	Maximum Monthly Income Indiv.	Maximum Monthly Income Couple	Benefits Paid
QMB	$4,000	$6,000	$817	$1,100	All Medicare premiums, coinsurance and deductibles.
SLMB	$4,000	$6,000	$980	$1,320	Part B premium.
SLMB+	$4,000	$6,000	$1,103	$1,485	Part B premium.

SPECIAL INCOME LIMIT

- Individuals who are not categorically eligible for MA with income between 100 and 300% of the monthly federal SSI payment level and who are residents of institutional facilities or participating in a community-based waiver program.
- Enrollees are allowed to retain $45 per month if institutionalized or between $817 and $1,809 per month if participating in a community-based waiver program in addition to the community spouse income and resource protections described above.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2006 FPL
1	$2,000	$1,809	220%

MA PURCHASE PLAN

- Disabled adults who are working or enrolled in a certified job counseling program with income up to 250% of the FPL and assets below $15,000.
- All services under MA are covered, but a premium is charged for enrollees with income that exceeds 150% of the FPL.

Family Size	Maximum Asset Limit	Monthly Income	Monthly Income as a % of 2006 FPL
1	$15,000	$2,042	250%
2	15,000	2,750	250

Note: Income and asset limits are applied after various exclusions and deductions. The elderly and disabled groups benefit from an earned income exclusion equal to the first $65 plus one-half of earned income over $65, which is not available to families with dependent children.

The following example illustrates how the asset test is currently applied in Wisconsin. A couple's combined countable resources at the beginning of the initial period of continuous institutionalization is $120,000. The spousal share, which is equal to one-half of the couple's countable resources, is $60,000. After a period of time, the institutionalized spouse applies for MA. By the time the institutionalized person applies for MA, the couple's combined countable resources has been reduced to $90,000. Wisconsin's current spousal impoverishment resource standard is $50,000, and the eligibility resource standard is $2,000. In this example, the greater of: (a) the spousal share at the beginning of the initial period of institutionalization ($60,000); (b) the state spousal resource standard would be deducted from the combined countable resources at the time of application, resulting in an unprotected resource amount of $30,000. Since $30,000 exceeds the state's asset limit of $2,000, the institutionalized spouse would not be eligible for MA. However, if, during that same period of institutionalization, the couple's combined resources are reduced to less than $62,000, the institutionalized spouse would meet the MA asset test ($61,999 - $60,000 = $1,999, which is less than the current asset limit of $2,000).

Income. Once the asset test is met, the person receiving long-term care must still meet income limits to qualify for MA. One way that the spousal impoverishment provisions protect the community spouse is that only the income in the institutionalized spouse's name is counted in determining eligibility for MA. Income that is in the name of the community spouse does not have to be used for the cost of care for the institutionalized spouse, nor does it prevent the institutionalized spouse from being eligible for MA-supported long-term care services.

In addition, spousal impoverishment provisions allow part of the institutional spouse's income to be transferred to the community spouse to provide income for the community spouse. Under federal law, the maximum amount that may be transferred to the community spouse is an amount that would raise the community spouse's total income to $2,488.50 per month for calendar year 2006. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index (CPI). Additional income may also be transferred to provide for certain dependent family members living with the community spouse or if ordered by a court.

Under federal law, the minimum amount of income that states must allow to be transferred to the community spouse is an amount that would bring the community spouse's total income up to the sum of: (a) 150% of the FPL; and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the federal minimum amount. Since the FPL is adjusted each year to reflect increases in the cost of living, the federal minimum is increased each year. If the state establishes an income allowance that is below the federal maximum, the state must establish an excess shelter allowance.

Wisconsin establishes its income allowance between the federally-established minimum and maximum amounts. Specifically, Wisconsin's income allowance is the sum of: (a) 200% of the federal poverty level ($2,200 per month in 2006); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the state's standard (shelter costs in excess of $660 per month for calendar year 2006). In addition, Wisconsin currently permits the institutionalized spouse to transfer up to $550 per month for each qualifying dependent family member living with the community spouse.

Previously, under federal law, the transfer of resources from the institutionalized spouse to the community spouse could be accomplished through the allocation of assets or income streams. As previously noted, assets are divided equally, regardless of ownership, but sources of income are

assigned to their respective individuals. Once income is attributed to each of the spouses, the community spouse's monthly income is compared to the minimum monthly maintenance needs allowance. If their income is below that amount, the institutionalized spouse may choose to transfer some of their resources to make up the difference between the community spouses income and the amount of the allowance. This transfer allows more resources to be allocated to the community spouse, requiring MA to pay a larger share of the institutionalized spouse's care costs.

Previously, under federal law, the institutionalized spouse could chose to transfer either assets or a portion of an income stream to the community partner in order to meet or exceed the minimum monthly maintenance needs allowance for the community spouse, ensuring that they retained sufficient resources to meet their needs within the community. States were allowed to choose between two methods under which the appropriate amount of resources to be transferred to the community spouse was determined.

Under the "income first" method, the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet the minimum monthly maintenance needs allowance. Any remaining income is then applied to the institutionalized spouse's cost of care. Under this method, the assets of the institutionalized spouse (including annuities or other income-producing assets) can only be transferred to the community spouse if such a transfer would not cause the community spouse's income to exceed the state-approved monthly maintenance needs allowance. Otherwise, they remain attributed to institutionalized spouse and must be used towards care costs. This option generally requires a couple to deplete a larger share of their assets before becoming eligible for MA. This is the method used by Wisconsin.

Under the "resources first" method, the couple's assets can be allocated to the community spouse to the extent necessary to ensure that the community spouse's total income, including the income generated by annuities or other income-producing assets, meets or exceeds the state-approved monthly maintenance needs allowance. This method generally allows the community spouse to retain a larger amount of assets than the income-first method.

The federal Deficit Reduction Act of 2005 clarifies that transfers of resources from the institutionalized spouse to the community spouse under these circumstances must follow the "income first" method.

In addition to any amount transferred to the community spouse, the institutionalized spouse may retain income as a personal needs allowance. If the person is in a nursing home, the personal needs allowance is $45 per month. If the individual is enrolled in an MA community-based waiver program, the allowance is higher ($783 and $1,809 per month) to support food, shelter and other costs. Any income in excess of the amount transferred to the community spouse, the personal needs allowance, health insurance premiums, court-ordered support, and other allowable income deductions, must be used to pay for long-term care costs.

The following example illustrates how the income test is applied in Wisconsin. In 2006, 200% of the FPL for a two-person family was $2,200 per month. If a community spouse has shelter costs of $810 per month, the excess shelter costs equal $150 per month ($810 - $660 = $150). In this case, the maximum monthly income allocation is $2,350 ($2,200 + $150 = $2,350). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,350 per month to determine the spousal income allocation amount ($2,150). If the institutionalized spouse's income is $3,600, the institutionalized spouse’s nursing home liability amount would be $1,405 per month [$3,600 (the institutionalized spouse's income) - $2,150 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,405].

Divestment. State and federal MA law include provisions that are intended to prevent individuals with financial resources from avoiding liability for the cost of care in a medical or nursing facility or other long-term care services, which would unnecessarily result in greater state and federal MA costs. These provisions are intended to prevent individuals from disposing of assets or income for less than market value for the purpose of becoming eligible for MA.

In Wisconsin, divestment occurs when: (a) an individual transfers income, non-exempt assets or other homestead property that belongs to an institutionalized person or his or her spouse for less than the fair market value of the income or asset; or (b) an individual takes an action to avoid receiving income or assets to which he or she is entitled.

In the latter case, actions that would cause income or assets not to be received would include: (a) irrevocably waiving pension income; (b) disclaiming an inheritance; (c) not accepting or accessing injury settlements; (d) diverting tort settlements into a trust or similar device; (e) refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony; and (f) refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate if the value of the abandoned portion is clearly identified and there is certainty that a legal claim action will be successful.

Two recent changes to divestment rules include: (a) limiting individuals' ability to use annuities to become eligible for MA by treating annuities as a countable asset if there is a market in which the annuity could be sold; and (b) ensuring that assets transferred to a community spouse are for the sole benefit of the community spouse. In addition, DHFS changed the treatment of jointly-held assets to prevent MA applicants from reducing their countable assets by adding co-owners to their assets. This change ensures that the value of the asset is allocated equally among elderly, blind, and disabled MA applicants only, rather than among all co-owners.

A divestment transfer can be conducted by: (a) the institutionalized person; (b) his or her spouse; (c) a person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse; or (d) a person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse (relatives, friends, volunteers, and authorized representatives).

Under specified circumstances, resource transfers to certain family members are permitted without adversely affecting their MA eligibility. For example, both homestead and non-homestead property can be transferred to either a spouse or a child of any age who is either blind or permanently, totally disabled. In addition, homestead property can be transferred to: (a) a child under 21 years of age; (b) a sibling who was residing in the home for at least one year immediately before the date the person became institutionalized and has a verified equity interest in the home; and (c) a child of any age who was residing in the person's home for at least two years immediately before the person became institutionalized and who provided care that permitted the person to reside at home.

Divestment penalties also do not apply if the state demonstrates that: (a) the individual intended to dispose of the assets either at fair market value or for other valuable consideration; (b) the assets were transferred exclusively for a purpose other than to qualify for MA; (c) the community spouse divested assets that were part of the community spouse asset share; (d) all of the assets transferred for less than fair market value have been returned to the individual; (e) the division or loss of property occurred as a result of a divorce, separation action, foreclosure, or repossession; or

(f) imposition of a penalty would result in an undue hardship. Undue hardship is currently considered as a serious impairment to the institutionalized person's immediate health.

A person may be denied MA coverage of institutional and community-based waiver services, if that person, his or her spouse, or the person's representative disposes of certain assets for less than fair market value or does not receive assets to which he or she is entitled for the purpose of meeting the MA resource test. Until recently, states were required to review the assets of all long-term care MA applicants for a period of 36 months before the date the applicant applied for MA, or 60 months if the applicant's assets were included as part of a trust. This period is commonly referred to as the "look back" period. If an eligibility worker determined that an individual transferred resources any time during the look back period, a penalty period would be calculated. The penalty period establishes the amount of time that the person would be ineligible for MA-funded long-term care costs. The length of the penalty period is calculated by dividing the amount of the transfer by the monthly private pay rate of nursing homes ($5,339 in 2006), and the penalty period began on the date of the transfer.

For example, under the prior divestment standard, if a person made a transfer of $100,000 two years before applying for MA, the penalty period for the applicant would total 18 months ($100,000/$5,339 per month = 18.7 months, rounded down). Since the penalty period began on the date of the transfer (in this example, 24 months before the person applied for MA), the penalty period would be over by the time that the individual applied for MA. Hence, the applicant would not be penalized for making this transfer.

Under the provisions of the federal Deficit Reduction Act of 2005 (DRA), new policies apply to assets transferred on or after the date of enactment (February 8, 2006). For transfers that occurred before February 8, prior policies still apply. For new transfers, the look back period was extended to five years for all income and assets disposed of by the applicant. Further, the start date of the penalty period was changed to the first day of the month during or after which the assets were transferred for less than fair market value, or the date on which the individual is eligible for MA and would otherwise be receiving institutional-level care, based on an approved application for such care but for the application of the penalty period, whichever is later.

Using the same example previously described and applying the current legal provisions regarding divestment, a person transferring $100,000 two years before applying for MA would still generate a 18-month penalty period. However, now the penalty period begins on the date the person is determined to be eligible for MA and would be receiving care in a nursing home, or services under a home- and community-based waiver program, based on an approved application for such care. Under this example, the state's MA program would not pay for long-term care services for the individual until 18 months after the person applies, and is determined to be eligible for, MA-funded long-term care services. If an individual is already enrolled in MA but is not receiving long-term care services, the penalty period would begin at the time the individual is approved to receive long-term care services.

The DRA also addresses how the state must consider annuities. As a result, applicants and recipients of long-term care services are now required to disclose any annuities they own and whether the annuity is irrevocable or counted as an asset. The DRA further requires individuals to make the state a remainder beneficiary as a condition of eligibility for long-term care services. Further, the purchase of an annuity may be considered a divestment unless one of the following conditions are met: (a) the state is named as the remainder beneficiary in the first position for at least the total amount of MA benefits received; (b) the state is named as a beneficiary in the second

position behind a community spouse, a minor, or a disabled child; or (c) the state is named in the first position if the spouse or the child's representative disposes of any remainder for less than fair market value. As with the changes made to regulations regarding other divestments under DRA, these provisions apply to transactions occurring after February 8, 2006.

Citizenship. In order to be eligible for full MA benefits, a person must be a U.S. citizen or meet criteria for certain classes of aliens (individuals who reside in the U.S., but are not U.S. citizens). For those individuals who entered the U.S. on or after August 22, 1996, and do not fall into an alien class that allows for eligibility (such as refugee, asylee, Native American, or Cuban / Haitian entrant), there is a five-year bar on MA eligibility.

The DRA imposed new documentation requirements for citizenship and identity verification. Beginning on July 1, 2006, MA applicants and individuals renewing their MA coverage are required to provide documentation of their citizenship status and identity. Medicare beneficiaries and most SSI recipients are exempt from the new citizenship documentation requirements.

To fulfill the citizenship and identity documentation requirement, individuals must provide original documents or copies certified by the issuing agency. Acceptable documents include a U.S. passport, a certificate of naturalization, a certificate of U.S. citizenship, a birth certificate or, subject to specified preconditions, a state-issued driver's license or picture identification card or a school-issued picture identification card.

Non-qualified immigrants may be eligible for emergency medical services from the time of the first treatment for the emergency until the condition is no longer an emergency. Non-qualified pregnant immigrants who do not meet requirements for full MA benefits may be eligible for some medical services, including prenatal care, labor, and delivery services under BadgerCare.

Residence. States are required to cover eligible residents, including residents who are absent from the state. This includes coverage of individuals who are placed in out-of-state institutional settings. Federal law prohibits states from establishing a period of residency before an individual can become eligible for MA.

In Wisconsin, an individual is considered a resident if he or she: (a) is physically present in the state; and (b) intends to reside in Wisconsin. State law also specifies that a migrant worker is considered a Wisconsin resident if he or she: (a) is employed primarily in agriculture or in the cannery industry; (b) is authorized to work in the U.S.; (c) is not related by blood or marriage to the employer; and (d) routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

Homelessness. Homeless individuals who meet MA eligibility criteria cannot be denied MA coverage because they have no permanent or fixed address. States are required to provide a means of making eligibility cards available to eligible individuals who are homeless. As an anti-discrimination measure, Wisconsin law prohibits counties from placing the word "homeless" on an individual's MA identification card.

Number of MA Recipients by Group

Table 5 shows the average monthly number of MA recipients for each fiscal year from 1996-97 though 2005-06. Although there are dozens of eligibility categories that DHFS uses to identify MA recipients, these categories have been grouped in this table to show six major groups of MA recipients: (a) elderly recipients; (c) disabled and blind recipients; (c) MA recipients who are enrolled in MA home- and community-based waiver programs, Family Care, and the MA purchase plan; (d) "family MA," which includes families with dependent children, including those who meet the AFDC-related and Healthy Start-related criteria; (e) Medicare recipients who receive limited benefits

under the MA program; and (f) women enrolled in the family planning waiver project. For each category, the table provides information on the average monthly number of recipients, the percentage change from the previous year, and the percentage of the total enrollment each group represents.

Table 5: Average Monthly Number of MA Recipients, by Group (Fiscal Years 1996-97 through 2005-06)

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Elderly Recipients										
Average Number	47,744	46,141	44,626	43,529	42,172	40,640	39,153	37,557	36,235	34,586
% Change from Previous Year	-3.1%	-3.4%	-3.3%	-2.5%	-3.1%	-3.6%	-3.7%	-4.1%	-3.5%	-4.6%
% of Total	10.9%	11.5%	11.3%	10.8%	10.0%	8.8%	7.6%	6.5%	5.8%	5.3%
Disabled / Blind Recipients	01,466	100,557	99,170	97,940	96,209	95,423	96,125	97,938	99,562	100,149
% Change from Previous Year	0.3%	-0.9%	-1.4%	-1.2%	-1.8%	-0.8%	0.7%	1.9%	1.7%	0.6%
% of Total	23.2%	25.1%	25.0%	24.3%	22.8%	20.6%	18.7%	16.9%	15.8%	15.4%
Community-Based Waiver, MAPP, and Family Care Recipients	5,302	6,198	6,923	7,805	10,148	14,963	20,189	23,833	26,796	29,522
% Change	21.0%	16.9%	11.7%	12.7%	30.0%	47.4%	34.9%	18.0%	12.4%	10.2%
% of Total	1.2%	1.5%	1.7%	1.9%	2.4%	3.2%	3.9%	4.1%	4.3%	4.5%
"Family MA" Recipients	270,129	234,471	231,263	238,092	256,978	296,387	336,620	367,928	401,622	414,809
% Change	-11.0%	-13.2%	-1.4%	3.0%	7.9%	15.3%	13.6%	9.3%	9.2%	3.3%
% of Total	61.8%	58.6%	58.3%	59.1%	61.0%	63.9%	65.4%	63.6%	63.8%	63.6%
Medicare Beneficiaries with Limited Benefits	12,240	12,754	14,444	15,630	16,048	16,224	15,639	15,215	15,587	16,690
% Change	7.2%	4.2%	13.2%	8.2%	2.7%	1.1%	-3.6%	-2.7%	2.4%	7.1%
% of Total	2.8%	3.2%	3.6%	3.9%	3.8%	3.5%	3.1%	2.6%	2.5%	2.6%
Family Planning Waiver Recipients With Limited Benefits	0	0	0	0	0	0	7,050	36,379	49,388	56,013
% Change								416.0%	35.8%	13.4%
% of Total								6.3%	7.8%	8.6%
Total	436,881	400,120	396,425	402,995	421,555	463,636	514,777	578,850	629,191	651,768
% Change from Previous Year	-7.0%	-8.4%	-0.9%	1.7%	4.6%	10.0%	11.0%	12.4%	8.7%	3.6%

Source: DHFS MMIS Data -- 481 Reports.

CHAPTER 2

COVERED SERVICES AND PROVIDER REIMBURSEMENT

Mandatory and Optional Services

States are required to provide certain services to MA recipients and may offer, at their option, additional services under their MA programs. The federal mandatory service requirements differ for MA recipients that meet categorically and medically needy eligibility criteria.

For categorically needy recipients, states must cover at least: (a) nursing home services; (b) inpatient and outpatient hospital services; (c) physician services; (d) laboratory and x-ray services; (e) home health services; (f) rural health clinics services; (g) family planning services; (h) early and periodic screening, diagnostic and treatment services (EPSDT, known as HealthCheck in Wisconsin); (i) nurse mid-wife and nurse practitioner services; and (j) pregnancy-related services, including prenatal care coordination and postpartum care.

In addition, states must cover some or all of the premiums, deductibles, and coinsurance that would otherwise be paid by MA recipients that are also eligible for Medicare.

States that provide coverage to medically needy recipients must provide to these individuals, at a minimum: (a) pregnancy-related services, including prenatal care, delivery services, and postpartum care; (b) ambulatory services, as defined in a state's plan, for recipients under age 18 and groups of individuals entitled to institutional services; and (c) home health services to any individual entitled to nursing home care. For those states that cover services in an institution for mental disease (IMD) or an intermediate care facility for the mentally retarded (ICF-MR), states must cover for any medically needy group, either: (a) inpatient and outpatient hospital, rural health clinics, laboratory and x-ray services; nursing home, EPSDT, physician services, nurse mid-wife and nurse practitioner services; or (b) any seven of a variety of services considered mandatory or optional for categorically needy recipients.

In Wisconsin, MA recipients who are eligible under the medically needy eligibility criteria receive the same services as recipients eligible under the categorically needy criteria.

While some services are designated as "optional" under federal law, they may, in fact, be mandatory for certain groups of MA recipients. For example, any service a state is permitted to cover under MA that is necessary to treat an illness or condition identified through an EPSDT screen must be provided to the child who receives the EPSDT screen, regardless of whether the service is otherwise included in the state MA plan. In addition, certain "optional" services, such as drugs and medical equipment and supplies, must be provided to one or more of three groups of MA recipients -- children, pregnant women and nursing home residents. Further, although payment for "transportation services" is considered an optional service under federal regulations, states must assure necessary transportation for recipients to and from providers.

Many states, including Wisconsin, offer some optional services that serve as substitutes for, rather than additions to, services that would otherwise be used by MA recipients. For example, although coverage for rehabilitative services is optional, recipients that use these services could

instead receive similar treatment from hospitals on an outpatient or inpatient basis, which may be more expensive.

Medical Necessity

All services provided under MA must be "medically necessary." A medically necessary service is defined by rule as a service that is required to prevent, identify, or treat a recipient's illness, injury, or disability and meets all of the following standards:

- Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the enrollee's illness, injury or disability;

- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

- Is appropriate with regard to generally accepted standards of medical practice;

- Is not medically contraindicated with regard to the recipient's diagnosis, symptoms, or other medically necessary services the recipient receives;

- Is of proven medical value or usefulness and, consistent with DHFS rules, is not experimental in nature;

- Is not duplicative with respect to other services provided to the recipient;

- Is not solely for the convenience of the recipient, the recipient's family or a provider;

- With respect to prior authorization of a service and other prospective coverage determinations made by DHFS, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

- Is the most appropriate supply or level of service that can be safely and effectively provided to the recipient.

Service Limitations

Subject to federal limitations, states may use several methods to control the amount and type of services recipients receive in order to control costs. Some of these methods are described below.

Limitations on Quantity of Services. Certain services are subject to limits on the number of billable units of service that can be made on behalf of a recipient during a specified time period. For example, an MA recipient may receive one comprehensive, routine physical examination in each calendar year.

Prior Authorization. The state's MA program uses prior authorization to reduce unnecessary care, promote the most effective and appropriate use of available services, and contain program costs. Providers must obtain prior authorization for certain services before they render those services. The state MA program pays providers for services that require prior authorization only if: (a) prior authorization is approved by qualified medical professionals and staff according to criteria established by DHFS; and (b) the service is performed between the dates indicated on the prior authorization request form. Generally, authorizations are valid for up to one year, unless the authorization specifies a more limited period.

Copayments and Cost Sharing. Federal regulations permit states to require MA recipients to share in the cost of receiving certain services. Providers collect these fees (copayments) from MA recipients, and MA payments for services that require copayments are reduced by a corresponding amount. Federal regulations establish maximum copayments for services and exempt some services and groups of MA recipients from copayment requirements altogether.

The federal Deficit Reduction Act (DRA) of 2005 allows states to establish higher copayments and

premiums for certain recipients in families with income that exceeds 100% of the FPL. However, total cost-sharing and premium amounts cannot exceed 5% of family income, as applied on a quarterly or monthly basis. The DRA exempts some groups of MA recipients (including pregnant women, certain children in foster care, and individuals who receive hospice care) and some services (including preventive services and all services to individuals who receive hospice care) from the higher cost-sharing requirements.

The DRA also permits a provider or pharmacist to deny services or access to drugs if a recipient cannot pay the cost sharing amount at the point of service. States can also make premiums enforceable and terminate coverage for failure to pay premiums for 60 days.

Federal Reimbursement Requirements

Federal law provides states considerable flexibility in designing reimbursement methods for health care providers. However, four basic requirements apply to all services. First, with the exception of copayment requirements, providers must accept MA reimbursement levels as full payment of services, thereby prohibiting providers 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, MA payment is secondary to any other health coverage or third-party payment source available to recipients, including Medicare. Fourth, the state's methods and procedures used to determine payments must assure that payments will be "consistent with efficiency, economy and quality of care."

Federal law also contains requirements specific to certain types of services. One requirement limits the amount states may reimburse providers for inpatient hospital and nursing home services. Specifically, aggregate payments for inpatient hospital services (or long-term care facility services provided in hospitals) and nursing facilities may not exceed the amount that would have been paid under Medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "Medicare upper payment limit." These upper payment limits vary based on ownership and facility type. For instance, separate upper payment limits are applied to nursing facilities that are state-owned, non-state publicly owned, and privately owned.

States must use a public process for determining rates that includes: (a) publishing proposed and final rates and the methodologies underlying them; (b) providing a reasonable opportunity for review and response to the proposed rates, methodologies, and justifications; and (c) in the case of hospitals, setting rates that take into account hospitals serving a disproportionate share of low-income patients with special needs.

Table 6 lists the services and benefits that are covered under Wisconsin's MA program, as they are identified in statute.

Nursing Homes

Under the MA program, nursing homes are categorized into three groups: (1) nursing facilities, which consist of skilled nursing facilities (SNF) and intermediate care facilities (ICFs); (2) intermediate care facilities for the mentally retarded (ICFs-MR); and (3) institutions for mental diseases (IMDs).

Nursing facilities are institutions that provide: (a) skilled nursing care and related services for residents who require medical or nursing care; (b) rehabilitation services for injured, disabled, or sick individuals; and (c) on a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities. A facility that primarily provides for the care and treatment of mental diseases does not qualify as a nursing facility.

Table 6: MA-Covered Services and Benefits

- Physicians' services
- Early and periodic screening, diagnosis and treatment of individuals under 21 years of age (HealthCheck)
- Rural health clinic services
- The following federally mandated medical services if prescribed by a physician:
    - Inpatient hospital services, other than services in an institution for mental disease (IMD)
    - Outpatient hospital services
    - Skilled nursing home services other than in an IMD
    - Home health services, or nursing services if a home health agency is unavailable
    - Laboratory and x-ray services
    - Family planning services and supplies
    - Nurse-midwifery services
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under MA that are required for enrollment in a group health plan
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act
- Dental services, dentures
- Optometrists' or opticians' services
- Transportation:
    - By emergency medical vehicle to obtain emergency medical care
    - By specialized medical vehicle to obtain medical care
    - By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Eyeglasses
- The following medical services that are not federally mandated, if prescribed by a physician:
    - Intermediate care facility (ICF) services, other than IMD services
    - Physical and occupational therapy
    - Speech, hearing and language disorder services
    - Medical supplies and equipment
    - Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
      --who are under 21 years of age
      --who are under 22 years of age and received services immediately prior to reaching age 21
      --who are 65 years of age or older
    - Medical day treatment, mental health and substance abuse services, including services provided by a psychiatrist and services provided by a psychiatrist in an individual's home or in the community if the individuals is at least 21 years of age
    - Nursing services, including services performed by a nurse practitioner
    - Legend (prescription) drugs and over-the-counter drugs listed in the Wisconsin's MA drug index
    - Personal care services
    - Substance abuse day treatment services
    - Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
    - Community-based psychosocial services
    - Respiratory care services to individuals who are ventilator-dependent for life support
- Home and community-based services authorized under a waiver
- Case management services for enrollees with certain conditions
- Hospice care
- Podiatry services
- Care coordination for women with high-risk pregnancies
- Prenatal, postpartum and young child care coordination services for certain residents of Milwaukee County
- Care coordination and follow-up of individuals having lead poisoning or lead exposure, including lead inspections
- School medical services
- Mental health crisis intervention services
- Case management services for enrollees with high-cost chronic health conditions or high-cost catastrophic health conditions

Federal law defines an ICF-MR as an institution (or as a distinct part of an institution) that: (a) primarily provides health or rehabilitative services for mentally retarded individuals; and (b) provides active treatment services to individuals who are mentally retarded.

An IMD is defined by federal law as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care for individuals with mental diseases, including medical care, nursing care and related services.

In 2005-06, MA fee-for-service expenditures for nursing home care, excluding care provided at the state centers for the developmentally disabled, totaled $940.1 million (all funds) representing approximately 21% of gross MA expenditures in that year. In 2005, there were 401 licensed nursing homes listed with DHFS, with 39,146 licensed beds. Of these nursing homes, 397 were skilled nursing facilities, two were ICFs, and two were IMDs. On average, 87.9% of licensed nursing home beds were occupied and 63.9% of nursing home residents were supported by MA in 2005.

Nursing facility care is a covered service under MA when the services are provided to an MA-eligible individual in an MA-certified facility and the following conditions are met: (a) a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity is conducted; (b) each assessment is conducted or coordinated by a registered professional nurse; (c) an assessment is conducted within 14 days of admission to a facility, promptly after a significant change in the resident's physical or mental condition, and at least once every 12 months; (d) the results of the assessment are used in developing and revising each resident's plan of care; and (e) the assessments are coordinated with any state-required preadmission screening to avoid duplication of assessments. In addition, nursing facilities may not admit a person who is mentally ill or mentally retarded unless a preadmission screening and annual resident review (PASARR) determines the individual requires the level of services provided by nursing facilities.

Nursing facilities are responsible for conducting PASARR Level I screens to identify whether or not an individual is suspected of having a serious mental illness or a developmental disability. Level II screens are completed under contract with Behavioral Consulting Services and are a more extensive review that must be completed by appropriate medical professionals, such as psychiatrists and physicians. In fiscal year 2005-06, MA paid for 34,310 Level I screens and 6,833 Level II screens.

Federal law specifies that ICF-MR services may be covered under MA if the facility meets certification requirements, provides continuous active treatment to its residents, and has as its primary purpose to provide health or rehabilitation services. In addition, ICFs-MR must meet certain conditions relating to: (1) governing body and management; (2) client protections; (3) facility staffing; (4) active treatment services; (5) client behavior and facility practices; (6) health care services; (7) physical environment; and (8) dietetic services.

In order for an MA recipient to receive services in an IMD, an independent team of health care professionals, including a physician, must certify that ambulatory care resources do not meet the treatment needs of the recipient, proper treatment of the recipient's psychiatric condition requires services provided on an inpatient basis under the direction of a physician, and the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will be needed in reduced amount or will no longer be needed. IMDs must also meet several participation conditions that are specified in federal law.

Federal law prohibits states from covering IMD services under their MA programs for individuals between the ages of 22 to 65. However, Wisconsin

provides GPR funding to support a portion of the costs of care for these individuals.

Federal law also requires that long-term care facilities protect and promote residents' rights, including the right to: (a) exercise one's rights; (b) receive notice both orally and in writing, at the time of admission, of the resident's legal rights during the stay and periodically of the services available and the related charges; (c) protect one's funds; (d) choose a personal attending physician and to be fully informed in advance about care and treatment and any changes in that care and treatment and (unless the resident is judged incompetent) to participate in planning care and treatment; (e) privacy and confidentiality; (f) voice grievances without discrimination or reprisal and prompt efforts by the facility to respond to these grievances; (g) receive information from outside agencies and review nursing home surveys; (h) choose whether or not to perform services for the facility; (i) have privacy in written and telephone communications; (j) have access to and receive visits from outside individuals; (k) retain and use personal property; (l) share a room with a spouse if both are located in the same facility; (m) self-administer drugs if it can be done safely; and (n) refuse the transfer to another room in the same facility under certain circumstances. Federal law also provides residents admission, transfer and discharge rights.

Reimbursement of Nursing Homes Other than State Facilities. Under state law, DHFS is required to reimburse nursing homes for care provided to MA recipients according to a prospective payment system that is updated annually. The payment system must include standards that meet quality and safety standards for providing patient care. In addition, the payment system must reflect all of the following: (a) a prudent buyer approach to payment for services; (b) standards that are based on allowable costs incurred by facilities and information included in facility cost reports; (c) a flat-rate payment for certain allowable direct care and support service costs; (d) consideration of the care needs of residents; (e) standards for capital payments that are based upon the replacement value of the facility; and (f) assurances of an acceptable quality of care for all MA recipients that reside in of these facilities.

Under 2005 Act 25, certain changes were specified to be included in the determination of the nursing home reimbursement formula. Beginning in 2005-06, the formula requirements were expanded to include factors that: (a) incorporate acuity measurements under the most recent resource utilization groupings (RUGs III) resident classification methodology adopted by CMS to determine case-mix adjustment factors; (b) determine the average case-mix index for each MA-supported nursing facility four times each year for residents who are primarily supported by MA on the last day of each calendar quarter; (c) incorporate payment adjustments for dementia, behavioral needs, or other complex medical conditions; and (d) may include incentives for providing high quality levels of care.

The act provided for a period of transition between the use of the previous calculation for reimbursement and the implementation of a new method incorporating the RUG acuity measures. The previous calculation, which relied on facility reported costs associated with various levels of patient care to determine reimbursements, is largely cost based, and as such, requires more extensive auditing to ensure accuracy. The new formula relies on acuity measures which are independently established and regularly updated by health care providers, making the reimbursement calculation more of a price-based formula, based on the diagnosed care needs of each facility's residents. DHFS staff indicates that this transition may lead to a more equitable reimbursement determination for facilities that serve higher-needs individuals, while potentially requiring less in-depth monitoring of cost reporting.

During the transition period, DHFS will use a blended rate that incorporates both the previously used method of calculating reimbursement and the

new method to decrease the impact of any redistribution of reimbursement revenues between facilities.

When DHFS develops each facility's prospective payment rate, both patient levels of care and categories of expenditures are considered. Under MA nursing home reimbursement methods, DHFS consider four cost centers when developing facility-specific nursing home rates. These cost centers include: (1) direct care; (2) support services; (3) property tax and municipal services; and (4) property.

Previously, these cost centers played a greater role in determining the distribution of funding between nursing homes. Facilities could expect to be reimbursed up to their actual expenditure, provided that it did not exceed the targeted cost. From this perspective, high-cost homes were penalized if they exceeded the targeted rates for these cost centers, since their reimbursements would be less than their costs. However, as funding provided for nursing home reimbursement has lagged behind industry cost growth and inflation, the disparity between average actual nursing home costs and targeted rates set for cost centers has increased. DHFS staff estimates that as many as 80% of the state's nursing homes report expenditures that exceed set price targets for the various cost centers. From this perspective, calculating reimbursements based on these targets has become less useful as a means of providing goals for nursing homes to limit expenditures.

Direct Care. Direct care costs are comprised of direct care nursing services and direct care supplies and services. Direct care nursing services include the services of registered nurses, nurse practitioners, licensed practical nurses, nurse's assistants, nurse aide training and training supplies. Direct care supplies and services include personal comfort supplies; medical supplies; over-the-counter drugs; and the non-billable services of a ward clerk, activity person, recreation person, social workers, volunteer coordinator, certain teachers or vocational counselors, religious person, therapy aides, and counselors on resident living.

DHFS is required to establish payment for allowable direct care nursing services and direct care supplies and services. Previously, that rate was required to take into account direct care costs for a sample of all facilities in the state, as adjusted to reflect respective case mixes and regional labor cost variations (for the nursing services component). DHFS may provide special rates and supplements to these standard rates in certain cases such as for the provision of services to individuals who are ventilator dependent, require supplemental skilled care due to complex medical conditions, or require specialized psychiatric rehabilitation services.

DHFS staff has determined the direct care facility rate by calculating and combining the direct care nursing services allowance and the direct care supplies and services allowance. The direct care nursing rate is determined by comparing actual allowable direct care cost information of the facility (adjusted for inflation) to the direct care nursing target. Facilities have been reimbursed for their actual allowable expenses in this category up to the established direct care nursing target. For direct care supplies and services, DHFS establishes a single direct care supplies and services target that is provided to all facilities regardless of actual expenditures. As previously indicated, the new reimbursement formula will combine estimated costs determined under this method with price-based calculations derived from recent RUGS III resident classification methodology adopted by CMS to determine case-mix adjustment factors. Eventually, the emphasis of the calculation is expected to be shifted entirely to the use of the case-mix index; however, DHFS estimates that the transition period could take several years to complete.

DHFS pays a higher rate to qualifying homes for the care of residents requiring supplemental skilled care due to complex medical conditions. For instance, services for individuals with AIDS or

AIDS-related complex (ARC) and individuals who are ventilator-dependent are paid under special per diem rates in lieu of the facility's daily rate. For fiscal year 2005-06, the AIDS/ARC rate was $150 per patient day and the ventilator-dependent rate was $475 per patient day. Facilities may also receive a specialized psychiatric rehabilitative services supplement of $9 per patient day to their daily rate. In order to receive the specialized services supplement, the nursing home must (a) prepare a specialized psychiatric rehabilitative services care plan for each resident receiving the services; and (b) complete and submit a Level II PASARR screen every two years that indicates that nursing home care is appropriate and that these specialized services are necessary.

Support Services. Support services include dietary services, housekeeping, laundry, security services, fuel and utility costs, and administrative and general costs. The support services component of a facility's rate is comprised of the dietary and environmental services allowance, the administrative and general services allowance, and the fuel and utility allowance. A flat rate is established for each of these allowances that is based on support service costs for a sample of all facilities within the state plus an inflation increment per patient day.

Property Taxes, and Municipal Services. For tax-paying facilities, the statutes direct that the payment be made for the amount of the previous calendar year's tax or the amount of municipal service costs, up to a maximum amount. Tax exempt facilities may also receive a per patient day property tax allowance for the costs of certain municipal services, including those services which are financed through the municipalities' property tax and are provided without leveraging a separate service fee for the service.

For 2005-06, the payment to a facility for property taxes or municipal service fees was subject to a maximum payment of the previous year tax or fees plus an inflation adjustment factor of 7% for real estate taxes and municipal fees.

Property. Allowable property-related costs include land improvements, buildings, fixed and movable equipment, and other long-term physical assets. The statutes require that the capital payments be based on a replacement value for the facility, as determined by a commercial estimator that is paid for by the facility.

For 2005-06, DHFS limits the allowed value for most facilities to no more than $55,900 per bed. Facilities that entered into a major phase-down agreement after July 1, 2003, are subject to a limit of $75,900 per bed.

Provider Incentives. The MA program pays certain qualifying nursing homes incentive payments, which are specified in the annual nursing home reimbursement formula. In 2005-06, nursing homes can receive four types of incentives payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 65% or more of MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.30 per patient day to $2.70 per patient day for facilities with more than 50 beds and from $1.30 to $4.20 per patient day for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA/Medicare increases). A separate incentive payment is available for facilities located within the City of Milwaukee that ranges from $1.45 per patient day to $4.60 per patient day.

Second, a nursing facility with a high percentage of MA/Medicare residents (70% or more) can also receive a private room incentive, ranging from $1.00 per patient day if 15% or more of its beds are in private rooms, up to $2.00 per patient day if 90% of more of its beds are in private rooms. The incentive payment increases in proportion to the percentage of licensed beds that are licensed for single occupancy.

Third, an incentive payment is provided to facilities that complete an approved remodeling or

renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy. The incentive payment is made for two years and is equal to 25% of the lesser of the approved projected cost or 25% of the actual cost of the project per year for two years. This incentive was only available for projects submitted for consideration by the Department by September 30, 2003.

Finally, an MA access incentive is provided to nursing facilities at a rate of $3.69 per patient day and to ICFs-MR at a rate of $16.21 per patient day.

Hold Harmless Rate. If the facility's projected expenses are greater than the rates determined for the inflation-adjusted direct care, support services, fuel and utility, property tax, and over-the-counter drug allowance portions of the facility's rate, then the facility is guaranteed that the payment rate for these costs will not be less than the rate that was effective for June 30, 1994. The hold harmless determination does not include the capital allowance, payment for ancillary services and materials, or the special payments to local government-operated facilities.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for the direct care, support services, and property tax components, plus the property allowance, payments for ancillary services and materials, and special allowances for government-operated facilities. Ancillary services and materials are specifically-identified services and materials that could be billed separately to the MA program by an independent provider of the service, such as home health services. The special allowances for government-operated facilities represent supplemental MA payments to facilities that are described in the following paragraphs.

County Supplemental Payments. County- and municipally-operated nursing facilities and Family Care care management organization (CMO) counties with nursing home operating costs that are not fully reimbursed by the MA per diem rate described above are eligible to apply for supplemental MA funding. Under 2003 Wisconsin Act 33, $37.1 million in both 2003-04 and 2004-05 was budgeted to support supplemental payments to these facilities. In addition to these amounts, 2003 Wisconsin Act 100 required DHFS to allocate, in each year of the 2003-05 biennium, any additional revenue the state received above the Act 33 budgeted amounts as a result of nursing home intergovernmental transfer (IGT) claiming to support supplemental MA payments to county and municipal nursing homes. This provision ended after 2004-05.

2005 Wisconsin Act 25 provided $37.1 million annually for DHFS to make these supplemental payments. However, 2005 Wisconsin Act 107 created a permanent mechanism by which additional funding may be available to support these supplemental payments. Specifically, Act 107 requires DHFS, in each year, to distribute all federal MA moneys the state receives as matching funds to operating deficits incurred by county- and municipally-operated nursing homes that were not anticipated and budgeted as revenue in the biennial budget act for the fiscal year in which it is received, to increase supplemental payments to county and municipally-operated nursing homes.

In order to distribute these supplemental funds, DHFS currently determines: (1) the projected overall operating deficits for each county and municipal home (the difference between allowable costs per patient day and MA payments per day); (2) the projected direct care operating deficit (the difference between allowable costs per patient day and MA payments per day); (3) the eligible direct care deficit for each county and municipal home (the lesser of the overall operating deficit and the direct care deficit); and (4) the non-direct care operating deficit (the difference between the projected overall operating deficit and the projected direct care operating deficit.

DHFS then distributes the supplemental funds

by: (1) summing the Medicare gap (the difference between what Medicare would pay for services and what MA would pay for those services) for all facilities; (2) allocating the remaining funds proportionally to the Medicare gap; (3) limiting any individual awards to the facility's eligible direct care deficit per day; and (4) repeating the previous two steps until all of the funds are allocated. If supplemental funding remains after all eligible facilities have been reimbursed for their direct care deficits, the same process is followed to address any non-direct care deficits. In 2005-06, $37.1 million in supplemental payments were made to county-operated facilities and to Family Care CMOs. After accounting for the supplemental payments, counties had unreimbursed expenses of approximately $107.8 million. Appendix I identifies actual supplemental MA payments to county- and municipally-operated nursing homes by county and payments made to Family Care CMOs from 2003-04 through 2005-06.

Reimbursement for State Facilities. MA payments for care provided at the state centers for the developmentally disabled and the Veterans Homes at King and Union Grove are determined by DHFS separately from the methods established for all other nursing facilities. The state centers and the Veterans Home are paid based on their actual and allowable costs plus the MA access incentive, except that payment cannot exceed the Medicare upper limit or the amount appropriated by state law. Interim payment rates are established for these facilities, but a cost reconciliation is done at the end of the state fiscal year to adjust payments to actual costs within the general limitations. For the 2006-07 fiscal year, approximately $108.7 million (all funds) is budgeted to support MA payments to the three state centers and $40.2 million (all funds) to support MA payments to the Veterans Homes at King and Union Grove.

State Supplement for IMD Nursing Homes. Although federal law does not permit states to use federal MA funds to support services for individuals between the ages of 22 and 65 in IMDs, Wisconsin provides state funding for counties to support a portion of the costs of care for this population. The state provides a GPR supplement of $9 per person per day to support the care of individuals who receive specialized mental health services in an institutional setting under the nursing home reimbursement formula. In addition, DHFS distributes $10,583,800 GPR in each fiscal year to assist counties in supporting residents of IMDs and individuals relocated from IMDs to community-based treatment programs. A portion of these funds are available annually to support relocation services for individuals who have a mental illness, are otherwise eligible for MA, and are in need of active treatment but whose needs can be met in the community.

Hospitals

Inpatient Services. In fiscal year 2005-06, fee-for-service payments for inpatient hospital services totaled $357.0 million (all funds), representing approximately 7.9% of total benefits payments for MA, BadgerCare, and related programs in that year.

Federal MA regulations define inpatient hospital services as services that are ordinarily furnished in a hospital for the care and treatment of inpatients and are furnished under the direction of a physician, nurse midwife or dentist. Further, inpatient hospital services must be provided at facilities that:

- Are maintained primarily for the care and treatment of patients with disorders other than mental diseases;

- Are licensed or formally approved as a hospital by the state;

- Except in the case of medical supervision of nurse-midwife services, meet the requirements for participation in the Medicare program; and

- Have in effect a utilization review plan

applicable to all MA patients that meet federally-defined requirements.

Under Wisconsin's MA program, payment for most inpatient hospital services is based on a prospective payment system known as a diagnosis-related group (DRG) system. The DRG system pays hospitals based on a patient's diagnosis and/or the nature of the services furnished in relation to that diagnosis. However, the DRG system allows for certain hospital-specific costs and circumstances to be considered as part of the rate calculation.

The DRG payment system covers most general and specialty hospitals in the state, hospital IMDs and major border states' hospitals.

Under the DRG system, the hospital determines the patient diagnosis and then bills MA for the hospital-specific DRG rate related to that condition and treatment. All inpatient stays are reimbursed under the DRG-based payment method except some AIDS patient care, ventilator patient care, unusual cases and brain injury cases, which may be billed on a per diem rate or as negotiated with DHFS. The DRG includes all covered services except professional services provided at the hospital, including physicians, dentists, anesthesia assistants, pharmacy, specialized medical vehicle transportation and durable medical equipment and supplies for non-hospital use. The certified provider bills these services separately.

The methodology of calculating DRG rates and the adjustments are described in the MA inpatient hospital state plan prepared by DHFS. This plan is updated annually to reflect changes to the program.

DHFS includes a number of adjustments to a hospital's DRG rate to reflect differences in costs among hospitals. These DRG-based adjustments are described below.

Disproportionate Share Hospitals. An adjustment may be made to a hospital's DRG base rate if the hospital provides a disproportionate share of services to MA and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital has an MA utilization rate of at least one percent and meets at least one of the following: (1) the hospital's MA utilization rate, as measured by the percent of inpatient days attributable to MA patients is at least one standard deviation above the mean MA utilization rate for hospitals receiving MA payment; or (2) the hospital has a "low-income utilization rate" of more than 25%.

In order for a hospital to receive its disproportionate share adjustment, it must have at least two obstetricians who have staff privileges and who have agreed to participate in the MA program. In order to meet this requirement, hospitals may designate any physician with staff privileges to perform obstetrical care. If a hospital serves patients who are predominantly under age 18, or if the hospital did not offer nonemergency obstetrical care as of December 31, 1987, it need not comply with the obstetrical requirement.

In fiscal year 2005-06, 27 hospitals qualified for disproportionate share rate adjustments, the cost of which totaled approximately $42.9 million (all funds). In addition, two types of supplemental payments -- payments to hospitals in Milwaukee County under the general assistance medical program and to essential access city hospitals -- that are described later in this section, are considered disproportionate share payments.

Rural Hospital Adjustment. A rural hospital may qualify for an adjustment to its hospital-specific DRG base rate if it meets all of the following conditions:

- The hospital is located in Wisconsin, is not located in a CMS-defined metropolitan statistical area (MSA), and the MA program's rural area wage index is used in the calculation of its hospital-specific DRG base rate;

- As of January 1, 1991, Medicare classified

the hospital in a rural wage area;

- The hospital is not classified as a "rural referral center" under Medicare;

- The hospital did not exceed the median for urban hospitals in Wisconsin for each of the following operating statistics: (a) total discharges, excluding newborns; (b) the Medicare case mix index; and (c) the Wisconsin MA case mix index.

- The combined Medicare and MA utilization rate was equal to or greater than 50%.

In 2005-06, the MA program paid approximately $900,000 (all funds) for rural hospital DRG adjustments.

Direct Medical Education Payments. Adjustments for direct graduate medical education (GME) costs are added to certain hospitals' base DRG rates to partially reimburse these hospitals for costs directly related to operating a medical education program. Direct GME costs are those costs associated with payment of salaries and fringe benefits for residents and interns. Hospitals located in Wisconsin are eligible for this payment. The GME adjustment varies by hospital, since the calculation is dependent on case mix and utilization.

Under provisions in 2003 Wisconsin Act 33, funding for direct GME adjustments was reduced on a one-time basis in 2003-04. For a six-month period no GME adjustments were included in the rates, and after that six-month period GME was restored to previous levels. In 2005-06, the cost of making direct GME adjustments totaled $11.9 million (all funds).

Capital Reimbursement. Allowable capital costs are added to a hospital's base DRG rate. Hospitals in Wisconsin and in bordering states are eligible for this reimbursement. Allowable costs are determined based on the inpatient costs attributable to MA recipients compared with total inpatient revenues.

Outlier Payments. Since the DRG payment is an average payment, it does not fully reimburse hospitals for extraordinarily costly inpatient stays. Outlier payments provide a measure of relief from the financial liability presented by extremely high cost cases. These payments are based on an individual stay, in addition to the DRG payment. The MA program makes two types of outlier payments, one based on cost, the other based on length of stay. If a hospital's claim meets criteria for both a cost outlier and a length of stay outlier, the method that gives the greater amount of payment to the hospital is used. DHFS may evaluate the necessity of resources and the length of stay for all outlier cases before it makes an outlier payment. In 2005-06 MA paid hospitals approximately $58.1 million (all funds) in outlier payments for inpatient services.

Other Payment Systems. Not all hospitals in Wisconsin are paid for inpatient services using the DRG system. Inpatient hospital services provided at the two state-operated IMDs (Mendota Mental Health Institute and Winnebago Mental Health Institute) are initially paid on a per diem basis. At the end of each state hospital's fiscal year, DHFS determines the costs for services these hospitals provided to MA recipients in that year. DHFS makes a final reimbursement settlement to each hospital to reflect the hospital's actual costs of providing services to MA recipients. However, each hospital's total MA reimbursement cannot exceed the hospital's charges.

DHFS reimburses three privately-operated rehabilitation hospitals, Sacred Heart Rehabilitation Hospital in the City of Milwaukee, Lakeview Rehabilitation Hospital in the Village of Waterford, and Bethesda Lutheran Hospital in St. Paul, Minnesota, on a per diem basis to reflect the special nature of the patient mix at these facilities, which usually require long lengths of stay. Mendota Mental Health Center in Madison and Winnebago Mental Health Center in Winnebago County are initially paid on a per diem basis, prior to their receiving full MA cost reimbursement.

Critical Access Hospitals. DHFS reimburses hospitals that are certified as critical access hospitals (CAHs) for their reasonable costs for both inpatient and outpatient services. A CAH is a rural hospital that: (a) has no more than 25 beds used for acute inpatient care and "swing beds," which are beds used for skilled nursing facility-level care (b) provides inpatient care for no more than an average annual stay of 96 hours per patient; and (c) provides emergency care 24 hours per day. A hospital is considered a rural hospital for purposes of CAH designation if it is: (a) located outside of a metropolitan statistical area, or is in a rural area of an urban county; (b) located more than a 35 mile drive from another hospital or certified by DHFS as a necessary provider of health care services to residents in the area; (c) is designated as a CAH under Medicare; and (d) is not designated as an urban hospital for purposes of reimbursement under either Medicare or MA. CAHs may establish psychiatric and rehabilitation district part units with up to 10 beds, which are excluded from the 25 total bed count limit.

Initially, DHFS pays CAHs interim rates as CAHs submit claims throughout the year. Once DHFS receives a final cost report for the fiscal year, DHFS makes a final payment adjustment to each CAH to ensure that each CAH is paid its reasonable costs. CAHs are not eligible for supplemental payments or other payment adjustments, since their reimbursement is limited to its reasonable costs. In 2005-06, there were 56 hospitals in Wisconsin that were certified as CAHs. These hospitals received reimbursements of approximately $19.3 million (all funds) in that year for both inpatient and outpatient services.

Payments to Hospitals Outside of Wisconsin. Hospitals outside of Wisconsin that provide inpatient services to Wisconsin MA recipients may be reimbursed for the services they provide. The method DHFS uses to calculate these payments depends on whether the hospital is granted "border status" by Wisconsin's MA program. A hospital can be granted border status if it can demonstrate that it is common practice for MA recipients in a particular area of Wisconsin to go for medical services to the provider's locality in the neighboring state.

To be considered a major border status hospital, the hospital must have had 75 or more Wisconsin MA recipient discharges or at least $350,000 in inpatient charges for services provided to Wisconsin MA recipients for the preceding two years. These hospitals are reimbursed under the same payment methodology as in-state hospitals, and are eligible to receive DSH DRG adjustments.

Minor border status hospitals do not meet the criteria for a major border status hospital. These hospitals are reimbursed under a DRG payment methodology, but their payment is based on a standard DRG base rate without adjustments for hospital-specific differences. However, these hospitals can request an administrative adjustment to their payment that would consider such differences.

Out-of-state hospitals that are not granted major or minor border status may also be reimbursed for services provided to Wisconsin MA recipients under the same methodology as minor border status hospitals. However, payments for all non-emergency services provided by hospitals without border status designation require prior authorization.

Outpatient Services. The MA program initially pays hospitals an interim rate for outpatient services they provide throughout the year. At the end of a hospital's fiscal year, DHFS makes a retrospective final settlement payment to each hospital, based on the hospital's audited cost report. The final settlement identifies a hospital's allowable outpatient costs and is limited to the lesser of the following:

- Customary outpatient charges in the final settlement year; or

• The sum of the outpatient visit rate effective for the final settlement year multiplied by the number of MA outpatient visits for the period, multiplied by the number of MA outpatient visits for the period; or

• The sum of the interim clinical diagnostic laboratory reimbursement plus the lower of cost or charges for other services.

The outpatient rate per visit is based on a hospital's outpatient cost per visit, as documented in an audited cost report, which is inflated to the current fiscal year and adjusted to reflect the amount of funding available and other limits on outpatient hospital payments. In 2005-06, MA and BadgerCare fee-for-service payments to hospitals for outpatient services totaled approximately $85.8 million (all funds).

Supplemental Hospital Payments. In addition to reimbursement for billed services, some hospitals may receive supplemental payments. Supplemental payments are available to hospitals to recognize the unique circumstances of a hospital that adds to its costs. Federal law limits the amount the state can pay for hospital supplements in two ways. First, no hospital can receive funding (both reimbursements and supplements) for more than its total charges. Second, the total funding spent on hospital services (both reimbursements and supplements) cannot exceed the total amount of funding that would have been paid by Medicare for comparable services. This is referred to as the Medicare upper limit. Additional information on supplemental payments, including the eligibility criteria, and a description of how the payments are calculated, is available in the MA inpatient hospital state plan, which is updated annually by DHFS.

Essential Access City Hospitals. DHFS pays up to $4,748,000 (all funds) annually to hospitals that meet a statutory definition of an essential access city hospital (EACH). An EACH is an acute care general hospital with medical and surgical, neonatal intensive care, emergency and obstetrical services, located in the inner City of Milwaukee, as defined by certain zip codes. An EACH must have 30% or more of its total inpatient days attributable to MA patients, including MA patients enrolled in an HMO and at least 30% of its MA inpatient stays must be for MA recipients who reside in the inner City of Milwaukee. In addition, the state plan specifies that a hospital qualifies for an EACH supplement if the hospital met these criteria during the year July 1, 1995 through June 30, 1996. Since the creation of this supplemental payment in 1991, the only hospital that has met the criteria for this supplemental payment is Aurora Sinai Medical Center.

General Relief/Inter-Governmental Transfer Payments. DHFS makes supplemental MA payments hospitals that have at least: (a) 13% of their annual operating costs attributable to MA recipients and low-income individuals covered by a county administered general assistance medical program (GAMP), of which at least two percent is attributable to services provided to GAMP participants; or (b) $5.0 million of its annual operating expenses attributable to services provided to MA recipients and GAMP participants, of which at least $3.5 million must be attributable to GAMP participants. In addition, the hospital must have an MA inpatient utilization rate of at least one percent, a contract with Milwaukee County to serve individuals covered by GAMP, and at least two obstetricians with staff privileges that have agreed to provide obstetrical care to MA recipients, unless the hospital predominately serves patients under age 18 or the hospital did not provide non-emergency obstetrical care as of December 21, 1987.

In 2005-06, seven hospitals in Milwaukee County received a total of $32.7 million ($7.0 million GPR, $18.9 million FED, and $6.8 million PR). The PR source of funding for these payments is an intergovernmental transfer (IGT) payment Milwaukee County makes to DHFS, which uses it to partially support the state share of the general relief supplemental payments.

Pediatric Inpatient Supplement. DHFS makes supplemental payments to acute care hospitals in Wisconsin that provide a significant amount of services to individuals under the age of 18. In order to qualify for the supplement, a hospital must: (a) be an acute care hospital located in Wisconsin; and (b) have inpatient days for stays in the hospital's acute and intensive care pediatric units that exceed 12,000 days in the second calendar year preceding the hospital's fiscal year. For 2005-06, this calculation is based on a hospital's inpatient days in the hospital's fiscal year that ends in calendar year 2003. Days for neonatal intensive care units are not included in this determination.

The pediatric supplement is limited to $2.0 million annually. In 2005-06, Children's Hospital of Wisconsin received approximately $1.7 million and University of Wisconsin Hospital received approximately $273,200 as a pediatric inpatient supplemental payment.

Managed Care Supplement. Hospitals participating in the state's MA managed care initiative are eligible to receive supplemental payments of up to $250,000 annually. To be eligible, a hospital must qualify for a DRG disproportionate share adjustment, have more than 9.0% of its patient days for newborns, be located in a county other than Milwaukee County, participate in MA managed care for that year, and be a major provider of managed care services to MA recipients in that county. In 2005-06 no hospitals qualified for this supplement.

Other Services

Physicians' and Clinic Services. Generally, physicians' services include any medically necessary diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided to a recipient. These services may be provided in the physician's office, hospital, nursing home, recipient's residence or elsewhere, and must be performed by, or under the direct, on-site supervision of a physician.

Physicians must obtain prior authorization before they perform selected surgeries or provide injections related to infertility treatment. In addition, medical services that are considered by DHFS to be obsolete, unnecessary or ineffective are not covered. Among these services are acupuncture, artificial insemination, cosmetic services, the provision of personal comfort items, and vitamin C injections. Further, MA does not cover services that are considered to be experimental in nature. A service is considered experimental if DHFS has determined that the procedure or service is not generally recognized by the professional medical community as effective or proven treatment for the condition for which it is being used.

Physicians' services are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by DHFS. The maximum fee schedule reflects higher rates paid for certain types of services provided to MA recipients in health professional shortage areas (HPSAs). HPSA-enhanced payment rates for primary care services other than obstetric and gynecological procedures, are equal to 120% of the rates paid for the same services in non-HPSA areas of the state. Obstetric and gynecological services provided to adult MA recipients are paid at a rate equal to 150% of the rates paid for the same services provided in non-HPSA areas of the state. Primary care and emergency medical providers are eligible for HPSA-enhanced reimbursement if the provider is located in a zip code identified as a HPSA or the recipient lives in a zip code identified as a HPSA. Certain pediatric office visits and emergency department visits may also be eligible for the HPSA bonus, if they meet the other requirements. HealthCheck services, described below, are not eligible for the enhanced HPSA reimbursement.

Early and Periodic Screening, Diagnostic and Treatment Services (HealthCheck). This service, which in Wisconsin is commonly referred to as "HealthCheck," provides comprehensive screenings to MA recipients under the age of 21. HealthCheck screening examinations are distinguished

from other preventive health services covered under MA because they include a significant health education component, a schedule for periodic examinations, detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the patient is appropriately referred for care.

Each comprehensive HealthCheck screen includes the following components: (1) a comprehensive health and developmental history (including preventive health education); (2) a comprehensive unclothed physical examination; (3) an age-appropriate vision screen; (4) an age-appropriate hearing screen; (5) oral assessment and evaluation services plus direct referral to a dentist for children beginning at three years of age; (6) appropriate immunizations; and (7) appropriate laboratory tests.

Federal law requires states to provide MA coverage for health, diagnostic and treatment services that are medically necessary to correct or ameliorate physical and mental illnesses and conditions discovered as part of an EPSDT screen. Any federally-reimbursable MA service must be provided, even if the service is not otherwise covered under a state's MA program. Such services resulting from a HealthCheck referral are subject to the applicable prior authorization requirements.

Rural Health Clinic Services. Rural health clinics (RHCs) are Medicare-certified outpatient health clinics located in rural areas with a shortage of personal health services or primary medical care professionals, as determined by the U.S. Department of Health and Human Services. Each RHC is operated under the medical direction of a physician and is staffed by at least one nurse practitioner or physician assistant. A physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner may furnish services. RHC services are primary care services provided by RHC-approved professionals that meet all applicable MA eligibility requirements. For clinics affiliated with hospitals having 50 or fewer beds, MA calculates a visit rate using the clinic's reasonable costs with a 30% ceiling limit on overhead expenses, or their prospective payment rate (whichever is higher). For other clinics, the MA payment is limited to the Medicare per visit rate for rural health clinic services. For the most recent audited year of 2005, the Medicare per visit rate is $70.78. In 2005-06, there were 61 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. As required by federal law, DHFS reimburses FQHCs for 100% of their reasonable cost of providing services to MA recipients. This reimbursement requirement recognizes that FQHCs serve a disproportionate share of the state's MA, Medicare, and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 28 FQHCs operating in Wisconsin, including 18 centers operating under federal grants from the U.S. Public Health Service**,** nine Native American tribal clinics, and one health center that meets the operating requirements of federally-funded community health centers but does not receive federal operating grants (a "look-alike" FQHC). In 2005-06, DHFS expended approximately $55.0 million to reimburse FQHCs for the services they provided to MA recipients.

Indian Health Service. Some MA services are provided to Native Americans through Indian Health Services (IHS) and tribe-owned facilities. MA state plans must provide that an IHS facility, meeting state requirements for MA participation, be accepted as an MA provider on the same basis as any other qualified provider. Under federal law, a facility operated by IHS or in an IHS-owned or leased facility operated by a tribe or tribal organization is eligible for 100% federal MA reimbursement. If the MA services are provided

through a tribe-owned or operated facility, federal funding is available at the state's usual matching rate.

Home Health Services. "Home health services" refer to several types of medically necessary services that are prescribed by physicians and provided to MA recipients in their place of residence. Home health agencies that provide these services must be licensed to provide home health services under Medicare, and be licensed by DHFS. All home health services must be provided in accordance with orders from the client's physician in a written plan of care. A physician must periodically review the plan according to specified guidelines or when the client's medical condition changes.

Home Health Skilled Nursing Services. A recipient is eligible for home health skilled nursing services if he or she: (a) requires less than eight hours of direct, skilled nursing services in a 24-hour period, according to a plan of care; (b) does not reside in a hospital or nursing facility; and (c) requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence. These services are provided exclusively by registered nurses (RNs) and licensed practical nurses (LPNs).

In determining whether or not a service requires the skills of a registered nurse or licensed practical nurse, the complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice are considered.

*Private-Duty Nursing Services***.** A recipient is eligible for private duty nursing services if he or she: (a) requires eight or more hours of direct skilled nursing services in a 24-hour period, according to a plan of care; (b) does not reside in a hospital or nursing facility; and (c) has a written plan of care specifying the medical necessity for these services. Only LPNs and RNs can provide these services. All providers must receive prior authorization before providing these services to MA recipients.

Under the private duty nursing benefits, RNs and LPNs may provide certain services to ventilator-dependent recipients, such as tracheostomy care, oxygen therapy, and operation of ventilators. A recipient must have been hospitalized for at least 30 consecutive days for a respiratory condition and must be dependent on ventilator for at least six hours per day and be served in their home to qualify for this benefit. These respiratory care services require prior authorization.

Wisconsin's MA program pays for home health skilled nursing services and private duty nursing services provided by nurses in independent practice only when no home health agency is willing and able to provide care to the recipient.

Home Health Therapy Services. Wisconsin's MA program covers medically necessary skilled physical therapy, occupational therapy, and speech and language pathology services provided by home health agencies. The physical therapists, occupational therapists, and speech-language pathologists that provide these services may be: (a) employed by the home health agency; (b) employed by an agency under contract with the home health agency; or (c) independent providers under contract with the home health agency. A therapy evaluation must be completed before a therapy plan of care is provided for the recipient.

Home Health Aide Services. These services are provided to maintain an individual's health or to facilitate treatment of his or her medical conditions. These services must include at least one medically necessary, nurse-delegated task per visit, which can be safely performed by a home health aide but could not be safely delegated to a personal care worker. Examples of these tasks include simple dressing changes and taking vital signs.

Personal Care Services. Personal care services are medically oriented activities related to assisting recipients with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services may

only be provided under the written orders of a physician. Covered personal care services include assistance with specific activities of daily living (such as eating, dressing, and bathing), meal preparation, and accompanying an individual to obtain medical diagnosis and treatment.

Home health agencies, certain county agencies, and independent living centers that receive state and federal funding can be certified to provide personal care services. Prior authorization is required: (a) for any recipient to receive more than 250 hours of personal care services in a calendar year; and (b) for all personal care hours provided to a recipient that is also receiving private-duty nursing or respiratory care services.

Laboratory and X-Ray Services. Professional and technical diagnostic services covered under Wisconsin's MA program include: (a) laboratory services provided by a certified physician or under a physician's supervision; (b) laboratory services prescribed by a physician and provided by an independent certified laboratory; and (c) x-ray services prescribed by a physician and provided by, or under the general supervision of, a certified physician. MA payment for laboratory and x-ray services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS. However, federal law prohibits MA payments from exceeding the Medicare allowable fees.

Family Planning Services and Supplies. MA recipients may receive family planning services that are prescribed by a physician. These services include physical examinations and health histories, office visits, laboratory services, counseling services, the provision of contraceptives and supplies, and prescribing medication for specific treatments. Unlike most services covered under Wisconsin's MA program, the costs of most family planning services are supported on a 90% FED / 10% GPR basis. MA payment for these services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS.

Nurse Midwifery Services. Services provided by a certified nurse-midwife include the care of mothers and their babies. An MA recipient may receive these services for up to six weeks after the birth of her baby. Nurse midwives are paid the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS. The rates in the fee schedule are 90% of the rates that would be paid to a physician had the physician performed the same service.

Dental Services. Wisconsin's MA program covers basic dental services within the following categories of service: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) orthodontics; and (i) adjunctive general services. Limitations apply to the frequency and type of covered dental services. For example, examinations and teeth cleanings are limited to twice per year for children through the age of 12. For clients 13 years of age and older, cleanings and examinations are limited to once per year. A tooth extraction is only covered in cases of a medical emergency or when it is necessary for orthodontia. Orthodontic services are provided only to children up to age 20 with cases of severe malocclusion and only after the orthodontist receives prior authorization. MA payment for dental services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS.

Vision Care Services. Vision care services provided by optometrists and ophthalmologists include services related to the dispensing and repair of eyeglasses, as well as evaluation and diagnostic services. Opticians may be reimbursed for services relating to the supply, dispensing and repair of eyeglasses. Eyeglass frames, lenses and replacement parts must be provided by dispensing opticians, optometrists and ophthalmologists in accordance with the Department's vision care

volume purchase plan, unless prior authorization is provided to purchase these materials from an alternative source. Certain types of services are not covered, including spare eyeglasses, tinted lenses, sunglasses and services or items provided principally for convenience or cosmetic reasons. Providers are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

Transportation. Under Wisconsin's MA program, three modes of transportation services may be provided to MA recipients: (a) ambulance; (b) specialized medical vehicle (SMV); and (c) public common carrier or private motor vehicle. Both SMV and common carrier transportation are commonly referred to as "non-emergency transportation."

Ambulance transportation services may be covered if a recipient requires emergency transportation, usually to a hospital. An ambulance may also be used to transport a recipient to specific destinations on a non-emergency basis if the recipient has a significant medical condition or need for medical monitoring that cannot be provided by a common carrier, private motor vehicle, or SMV. For example, an individual on a life-support system or an infant in an isolette (incubator) may be transported by ambulance.

SMVs may be used to transport indefinitely disabled or blind recipients who are unable to take public common carrier or private motor vehicle transportation if the purpose of the trip is to receive covered MA services. An "indefinite disability" is defined by DHFS as a physical or mental impairment that includes an inability to move without personal assistance or mechanical aids, such as a wheelchair, walker or crutches or a mental impairment that prohibits the recipient from using common carrier transportation reliably or safely. Recipients who are temporarily confined to a wheelchair or otherwise incapacitated may also use SMV transportation. All recipients that use SMV services must be certified by a physician, physician's assistant, nurse midwife, or nurse practitioner as unable to use common carrier or other transportation safely.

Ambulance and SMV providers are paid a base rate and other applicable rates, such as mileage (both for miles traveled with a client and without a client) and waiting time. A provider may not be reimbursed more than the provider's usual and customary charges.

Counties, through contracts with common carriers and private motor vehicles, provide transportation services for MA recipients who are able to walk. Such services may be provided by buses, trains, taxis, human service vehicles, private motor vehicles, and in some instances, airplanes. In providing these services, counties must use the least expensive means the individual is capable of using and that is reasonably available at the time the service is required. These services are covered only after a county department of human services approves the service. Unlike other services, common carrier transportation services are reimbursed as an administrative expense and therefore, are eligible for 50% federal matching funds, rather than 58% available for other services.

Chiropractors' Services. Wisconsin's MA program covers manual manipulations of the spine to treat a subluxation (a partial dislocation of the normal functioning of a bone or joint). Covered services may also include x-rays and spinal supports, office visits, diagnostic analysis, and chiropractic adjustments. Prior authorization is required for more than 20 manual manipulations per spell of illness. Chiropractors are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

Physical and Occupational Therapy. Therapies prescribed by a physician that are provided by certified physical and occupational therapists, or by a certified physical or occupational therapy assistant under the supervision of a certified physical or occupational therapist, are covered under Wiscon-

sin's MA program. Prior authorization is required for therapy services that exceed 35 treatment days per spell of illness, except if the therapy is provided to a hospital inpatient or an individual who receives the service through a home health agency.

Therapy providers are reimbursed for evaluations, modalities and procedures at the lesser of their usual and customary charges or amounts prescribed under DHFS' fee schedule.

Speech and Language Pathology Services. Wisconsin's MA program covers medically necessary diagnostic, screening, preventive or corrective speech and language pathology services prescribed by a physician and provided by a certified speech-language pathologist or under the direct, immediate, on-premises supervision of a certified speech-language pathologist. Covered services, which are specified by rule, include evaluation procedures and speech treatments. Prior authorization is required for all services that exceed of 35 treatment days per spell of illness, except if the therapy is provided to a hospital inpatient or an individual who receives the service through a home health agency.

Providers are paid the lesser of their usual and customary charges or amounts prescribed under DHFS' fee schedule.

Medical Supplies and Equipment. Wisconsin's MA program covers certain disposable medical supplies and durable medical equipment (DME) when a physician prescribes them and when certified providers supply them.

Medical supplies are disposable, consumable, expendable or nondurable medically necessary supplies that have a very limited life expectancy. Examples include catheters, syringes and continence supplies. Payment for medical supplies ordered for a patient in a hospital or nursing home is considered part of the institution's base cost and is, therefore, not billed directly by the provider.

DME includes medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment, and prostheses. A physician, podiatrist, nurse practitioner, or chiropractor must prescribe all DME services, including purchases, rental, and repairs. The item must be necessary and reasonable for treating an illness or injury, or for improving the function of a malformed body part. Most DME services, including the purchase of wheelchairs, wheelchair accessories and hospital beds, require prior authorization. In cases where DHFS determines that a piece of equipment will only be needed on a short-term basis, equipment is rented, rather than purchased, for the client. Payment for medical supplies and DME is based on the lesser of the provider's usual and customary charges or the amounts in DHFS' fee schedule.

Mental Health and Substance Abuse Services. Wisconsin's MA program provides outpatient and day treatment mental health and substance abuse services if these services are prescribed by a physician and other conditions are met.

Providers must obtain prior authorization to provide mental health and substance abuse outpatient services if MA payments for services exceed $500 or after 15 hours of services are provided to a recipient in a calendar year.

All substance abuse day treatment services require prior authorization and are only reimbursed for up to five hours per day. Mental health day treatment services are reimbursed for up to five hours per day or 120 hours per month and require prior authorization after 90 hours are provided in a calendar year.

Nurse Practitioner Services. Wisconsin's MA program covers nursing services within the scope of practice and delegated medical acts and services provided under protocols, collaborative agreements, or written or verbal orders from a physician. Such services include medically necessary diagnostic, preventive, therapeutic, rehabilitative

or palliative services provided in a medical setting, the recipient's home, or elsewhere. Nurse practitioners and clinical nurse specialists, like physicians, are paid the lesser of their usual and customary charges or amounts prescribed under DHFS' fee schedule.

Legend (Prescription) Drugs and Over-the-Counter Drugs. Drugs and drug products covered under the state's MA program include legend (prescription) and non-legend (over-the-counter) drugs and supplies listed in the Wisconsin MA drug index, which are prescribed by a licensed physician, dentist, podiatrist, optometrist, or when a physician delegates prescription of drugs to a nurse practitioner or physician assistant.

Federal Rebate Requirement. Under federal law, state MA programs offering prescription drug coverage must cover drugs from manufacturers that have entered into rebate agreements with the U.S. Department of Health and Human Services. Federal matching funds are not available for drugs purchased from other manufacturers, except for: (a) certain drugs that the state determines are essential to the health of MA recipients and the use of which the state subjects to prior authorization; and (b) vaccines.

Reimbursement Rate. DHFS reimburses pharmacists and physicians licensed to practice medicine and surgery for all covered prescription drugs at the lesser of: (a) the usual and customary charge; or (b) the estimated acquisition cost (EAC) plus a dispensing fee. The EAC for brand name and not readily-available generic drugs is equivalent to the average wholesale price (AWP), as reported by pharmaceutical manufacturers, less a discount. In 2005-06, the amount of the discount is 13%. The EAC for readily-available generic drugs is determined based on the maximum allowable cost (MAC) list, which is developed by DHFS.

Utilization Review and Cost-Saving Measures. Federal law requires drug use review programs to assure that prescriptions are appropriate, medically necessary, and unlikely to produce adverse effects. The drug use review must be both prospective and retrospective. The prospective part of this review, conducted by the pharmacist at the point of sale or distribution, must include a screening for drug interactions and incorrect dosage and a processing system to identify patterns of fraud, abuse, or inappropriate care. Retrospective reviews involve a review of claims data to identify unusual patterns of prescribing activity among recipients or providers, which may require an intervention by DHFS if the prescribing activity is deemed inappropriate.

Wisconsin's MA program uses "automatic generic substitution" to ensure that MA recipients receive the generic version of a drug when appropriate. Under this policy, the MA program automatically reimburses a pharmacy for the generic equivalent of a drug when such a drug is available, even if a brand-name drug is prescribed by a physician. The MA program will only reimburse a pharmacy for a brand name drug when a generic equivalent is available if the pharmacy receives prior authorization. The pharmacy must obtain information from the prescriber indicating why the brand name drug is medically necessary and submit this information to DHFS with its request for prior authorization.

The MA program covers certain over-the-counter medications to substitute for more expensive medications that may only be available with a prescription. Reimbursement for over-the-counter drugs is limited to the amount paid for nonprescription generic drugs, except for insulin, ophthalmic lubricants, and contraceptive supplies, which may be a brand name drug. MA recipients must have a prescription for payment of any nonprescription drug. Coverage of over-the-counter drugs is limited to antacids, analgesics, insulins, contraceptives, cough preparations, ophthalmic lubricants, and iron supplements for pregnant women.

Pharmaceutical care services are incentive-

based payments where pharmacies may receive an enhanced dispensing fee if they provide services that achieve a positive patient outcome, such as increasing patient compliance or preventing potential adverse drug reactions.

Preferred Drug List and Supplemental Rebates. 2003 Wisconsin Act 33 authorized DHFS to implement several measures to reduce the cost of drugs under the MA, BadgerCare and SeniorCare programs, including: (a) establishing a preferred drug list (PDL); (b) entering into agreements with prescription drug manufacturers so that manufacturers would provide supplemental rebates for drugs purchased under these programs; (c) utilization management and fraud and abuse controls; and (d) any other activity to reduce costs of, or expenditures for, prescription drugs, while maintaining high quality in prescription drug therapies.

In July, 2004, EDS, the state's MA fiscal agent, contracted with Provider Synergies to assist DHFS in implementing the PDL, negotiate supplemental rebates with manufacturers, and staff and advise the Department's Medicaid Pharmacy Prior Authorization Advisory Committee.

As of December 2006, DHFS had implemented a PDL for 57 classes of drugs. The Department's decisions regarding the list of preferred medications are based on a review of the relative clinical effectiveness and cost of products within these therapeutic classes. Appendix II identifies the preferred drug list, as of December, 2006.

In addition to the therapeutic classes for which a preferred drug list has been or will be developed, the MA program currently requires prior authorization for certain drugs in drug categories to determine their medical necessity. All drugs that are listed on the preferred drug list as non-preferred drugs currently require prior authorization.

Medicare Prescription Drug Benefit and MA Recipients. Beginning January 1, 2006, Medicare beneficiaries may obtain outpatient prescription drug coverage under a new Medicare benefit authorized in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108 – 173). This new benefit is commonly referred to as "Medicare Part D." Medicare beneficiaries who also have full MA benefits are referred to as "dual eligibles." These individuals are automatically enrolled in Medicare Part D, and state MA programs no longer cover their prescription drug benefits. Chapter 9 of this paper provides information on the Medicare Part D benefit.

Community Support Program (CSP) Services. Community support programs (CSPs) provide chronically mentally ill individuals with treatment, rehabilitation, and support services. These services are provided in the community, rather than in institutions or clinics. Covered services include: (a) assessment and treatment planning; (b) treatment services, including psychotherapy, symptom management, medication management, crisis intervention and psychiatric and psychological evaluations; (c) psychological rehabilitation services, including employment-related services, social and recreational skill training, assistance and supervision of activities of daily living and other support services; and (d) case management services.

Counties or agencies under contract with counties that meet requirements established by rule may provide CSP services. Counties are responsible for providing the state matching funds for CSP services. Consequently, MA payment for CSP services is equal to the federal share of the lesser of the maximum allowable fee, as established by DHFS, or the billed amount.

Community-Based Psychosocial Services. Beginning in 2004-05, community-based psychosocial services, sometimes referred to as comprehensive community services (CCS), is available to MA recipients with mental health or substance abuse conditions, as a county-funded service. Counties must elect to provide the service and provide the state's share of the costs of the benefit. In order to receive these services, recipients must have im-

pairment in major areas of community living, as evidenced by the need for ongoing and comprehensive services of either high-intensity or low-intensity nature. Services can include medical and remedial services and supportive activities intended to provide for a maximum reduction of the effects of the individual's mental health or substance abuse condition and restoration to the best possible level of functioning, and to facilitate the individual's recovery. An MA recipient must have a physician's prescription to receive these services. All services must be consistent with needs identified through a comprehensive assessment. The assessment is completed by a recovery team made up of the individual, a licensed mental health professional, the individual's family, and others as appropriate.

Case Management Services. Case management services help individuals access services covered by MA and services provided under other programs. Case management providers are required to perform a written comprehensive assessment of a person's abilities, deficits and needs. Following the assessment, providers develop a case plan to address the needs of the client.

Case management services may be provided for an individual who: (a) has a developmental disability; (b) has a chronic mental illness; (c) has Alzheimer's disease; (d) is alcohol or drug dependent; (e) is physically disabled; (f) is a child with a severe emotional disturbance; (g) is age 65 or over; (h) is a member of a family that has a child at risk of physical, mental or emotional dysfunction; (i) is infected with HIV; (j) is infected with tuberculosis; (k) is a child eligible for the birth-to-three program; (l) is a child with asthma; or (m) is a women the age of 45 through 64 and who is not residing in a nursing home.

Case management services must be provided by qualified private, nonprofit agencies or qualified public agencies. Payment for case management services is based on a uniform, contracted hourly rate. The MA program pays the federal share of this rate and case management agencies must provide the state MA match by using funding provided through other programs, such as the local tax levy, community aids, community options program, family support program or Alzheimer's caregiver support funds.

In addition, DHFS administers a targeted case management program that assigns high-cost MA recipients to case managers contracted by DHFS to coordinate medical care and monitor services to ensure that these clients receive the most efficient and cost-effective treatment alternatives. In order to qualify for case management services under this program, an individual must have MA costs that exceed $25,000 annually and not be eligible for case management services under other programs. In addition, recipients are required to receive services through a contracted facility, which currently is Children's Hospital in Milwaukee. The only difference between this service and other case management services funded under MA is that GPR budgeted in the MA benefits appropriation is used to fund the state's share of costs for this benefit, whereas case management agencies must provide the state's share of costs for other case management services.

Hospice Care. Hospice services are services that are necessary for the mitigation and management of terminal illness and related conditions. These services are divided into two categories -- core services and other services. Core services include nursing care by, or under the supervision of, a registered nurse, administrative and supervisory physician services, medical social services provided by a social worker under the direction of a physician, and counseling services. Other services include services contracted by a hospice in order to meet certain staffing needs, such as physical therapy, occupational therapy and speech pathology.

Hospices are reimbursed for the care of clients based on one of the following types of care: (a) routine home care, with a per diem rate for less

than eight hours of care per day; (b) continuous home care, with an hourly rate for between eight and 24 hours of care per day; (c) inpatient respite care in a hospital or nursing facility; (d) general inpatient care in a hospital or nursing facility; or (e) nursing home room and board. The MA rates paid for the types of care are the per diem or hourly amounts allowed by CMS. All MA hospice providers must also be certified under Medicare.

Podiatry Services. Podiatry services include medically necessary services for the diagnosis and treatment of the feet and ankles that are provided by a certified podiatrist. Covered services include office, home and nursing home visits, mycotic procedures, surgery, casting, strapping, taping, physical medicine, laboratory, x-ray, drugs and injections. Routine foot care is covered only if the individual has certain conditions and is under the active care of a physician. Podiatrists are paid at the lesser of the provider's usual and customary charge or the maximum allowable fee established by DHFS.

Prenatal Care Coordination Services. Prenatal care coordination services help women and, when appropriate, their families gain access to, coordinate, assess and follow-up on necessary medical, social, educational, and other services related to a pregnancy. These services are available to women who are at a high risk for adverse pregnancy outcomes, as determined through the use of a risk assessment tool developed by DHFS. Covered services include the administration of risk assessments, care planning, ongoing care coordination and monitoring, health education, and nutrition counseling.

Similar services, such as child care coordination services, are available to MA-eligible children through age six in Milwaukee County. The MA payment for prenatal care and child care coordination services is the lesser of the provider's usual and customary charges or the maximum allowable fee established by DHFS.

Care Coordination and Follow-up for Individuals with Lead Poisoning or Lead Exposure. MA covers care coordination and follow-up services for children with lead poisoning or lead exposure. Home inspections are covered after a child is shown to have lead poisoning (a blood lead level equal to or greater than 10 micrograms per deciliter). All environmental inspections are subject to prior authorization.

School Medical Services. MA school medical services are MA-eligible services provided to MA-eligible students by school districts, cooperative educational service agencies (CESAs), the Educational Services Program for the Deaf and Hard of Hearing, and the Wisconsin Center for the Blind and Visually Impaired. The services that can be reimbursed as school medical services include: (a) speech, language, hearing and audiological services; (b) occupational and physical therapy services; (c) nursing services; (d) psychological counseling and social work services; (e) developmental testing and assessments; and (f) transportation, if provided on a day the student receives other school medical services.

Schools provide the state's match for school-based health services. Of the federal matching funds received for school-based services, 60% is distributed to school providers and 40% is credited to the state's general fund.

The Centers for Medicare and Medicaid Services required DHFS to make changes to the MA state plan, approved in October, 2006, regarding school medical services. The changes require more documentation by school districts and modify what can be claimed as a school medical service. For example, school districts are now required to conduct semi-annual time studies, fill out uniform cost reports, and can no longer claim durable medical equipment as an expense in this area.

MA Funding of Abortion Services. Under Wisconsin's MA program, abortions may be

covered if one of the following conditions apply:

- If, in the opinion of the physician, the abortion is directly and medically necessary to save the recipient's life;

- If the recipient is a victim of sexual assault or incest and the crime was reported to law enforcement authorities prior to the abortion; or

- A medical condition exists prior to the abortion, for which the physician determines the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the recipient.

When an abortion meets the state and federal requirements for MA payment, MA would cover office visits and all other medically necessary related services. MA covers treatment for complications arising from an abortion, regardless of whether the abortion itself is a covered service. MA does not cover services incidental to a noncovered abortion.

CHAPTER 3

MANAGED CARE FOR LOW-INCOME FAMILIES AND CERTAIN OTHER GROUPS OF MA RECIPIENTS

Wisconsin's MA program uses managed care to provide health care services to certain MA populations to improve the quality of services they receive and to control program costs.

Health maintenance organizations (HMOs) are health care plans that provide comprehensive health services to enrolled members for a fixed, periodic payment ("capitation rate"). If enrollees require more services, or more costly services than the HMO can support with the capitation rates they receive, the HMO may incur a financial loss. If enrollees use the estimated number of services, or fewer or less costly services than the HMO can support with the capitation rates, the HMO may realize a profit. In this way, the HMOs, rather than the state, assume the financial risks associated with enrollees' use of most MA services by the covered population. The delivery of MA services through HMOs may encourage the use of preventive services and improve continuity and quality of care provided to MA and BadgerCare recipients. As a condition of serving low-income families enrolled in MA, HMOs must agree to also serve families enrolled in BadgerCare.

As of October, 2006, 13 HMOs were providing health care services to 359,719 individuals enrolled in MA and BadgerCare. Table 7 lists the participating HMOs and their enrollment as of October, 2006.

Table 7: HMOs with MA and BadgerCare Enrollees (October, 2006)

HMO	Enrollment
Abri Health Plan	6,895
Compcare	25,646
Dean Health Plan	8,743
Group Health Cooperative of Eau Claire	15,700
Group Health Cooperative of South Central WI	3,756
Health Tradition Health Plan	5,594
Managed Health Services	107,223
MercyCare Health Plan	9,320
Network Health Plan	52,106
Security Health Plan	22,435
United Healthcare of WI	94,708
Unity Health Plan	3,477
Children's Community Health Plan	4,116
Total	359,719

Enrollment. HMOs do not serve MA and BadgerCare recipients in all areas of the state. Under federal law, unless a state obtains a waiver to amend the state plan, it cannot require an MA recipient to enroll in an HMO unless the recipient has a choice of at least two HMOs. If only one HMO offers services in an area, the recipient has the option to enroll in the HMO or receive services on a fee-for-service basis. In areas where no HMOs offer services, all MA and BadgerCare recipients receive services on a fee-for-service basis. In areas of the state classified as "rural," a state may require MA recipients to enroll in a managed care plan if there is only one plan available, provided that the recipient has a choice of at least two physicians and the enrollee is permitted to obtain services from another provider in the following circumstances: (a) the service or type of provider necessary to meet the individual's care needs are not offered through the managed care network; (b) for up to 60 days, if the recipient's main provider of services is not a member of the provider network and will not

join the network; or (c) the state determines that services are required outside of the provider network. Twenty-five Wisconsin counties are classified as "rural" under the federal definition.

On June 1, 2005, CMS approved a state plan amendment which permits DHFS to require certain MA recipients to enroll in an HMO, even if only one HMO is participating in the program in the county. DHFS intends to begin implementing this mandatory enrollment requirement in some areas beginning in January, 2007. Since HMOs typically limit the number of MA and BadgerCare recipients they serve, some MA recipients in counties with a single participating HMO may continue to receive services on a fee-for-service basis. The state plan amendment also specifies certain conditions under which a recipient is exempt from mandatory HMO enrollment.

Appendix III provides information, by county, on the enrollment status of this population, as of October, 2006.

In order to serve families in MA and BadgerCare, an HMO must be licensed by the Wisconsin Office of the Commissioner of Insurance and must meet MA standards for quality assurance, cultural competency, enrollment capacity, and coordination of care.

Services. MA and BadgerCare recipients that are enrolled in HMOs are entitled to receive, as needed, all services that are available to MA recipients who are not enrolled in HMOs. HMOs have the option of covering dental and chiropractic services. In 2006, HMOs serving Milwaukee, Waukesha, Racine, and Kenosha Counties chose to cover dental services for enrollees in those counties. Of the 13 HMOs, four chose to cover chiropractic services. Recipients enrolled in HMOs that do not cover dental and chiropractic services may obtain these services from MA-certified providers on a fee-for-services basis.

While HMOs are responsible for providing family planning services, an enrollee may obtain these services from a primary physician of choice, whether or not that provider participates in the enrollee's HMO. If the enrollee chooses a primary care physician outside of the HMO, those services are reimbursed on a fee-for-service basis.

In Wisconsin, state law exempts HMO enrollees from any cost-sharing requirements for services provided to MA and BadgerCare recipients by an HMO. However, federal regulations allow states to authorize HMOs to require enrollees to share in the cost of the services they receive as long as these cost-sharing requirements meet the same requirements that apply to cost-sharing under fee-for-service.

Payments. DHFS establishes capitation payments for 14 different regions of the state. Each HMO receives a base rate for each enrollee. If the HMO elects to cover dental and/or chiropractic care, the base rate is increased to reflect these additional costs. These rates are then adjusted based on an enrollee's age and gender.

Table 8 identifies aggregated capitation rates the state paid to HMOs for serving MA and BadgerCare recipients in each of these 14 regions for calendar year 2006. The combined rate identified in the table represents the total amount an HMO would be paid per enrollee if the HMO elected to cover dental and chiropractic care.

Federal regulations include requirements states must meet in setting capitation payments. Capitation payments must be actuarially sound, which means that they must: (a) be established in accordance with generally accepted actuarial principles and practices; (b) be appropriate for the population to be covered and the services provided; and (c) have been certified as meeting these requirements by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. Capitation payments that do not

Table 8: Aggregated Monthly HMO Rates for MA and BadgerCare Enrollees (December, 2006)

County or Region	Base Capitation Rate	Dental	Chiropractic	Combined Rate
AFDC/Healthy Start Children				
Region 1 (Duluth / Superior)	$155.06	$6.47	$1.10	$162.63
Region 2 (Wausau / Rhinelander)	150.92	5.91	1.26	158.09
Region 3 (Green Bay)	152.79	5.83	0.93	159.55
Region 4 (Twin Cities)	164.30	5.33	2.19	171.82
Region 5 (Marshfield / Steven Pt)	149.04	7.42	1.57	158.03
Region 6 (Appleton / Oshkosh)	137.74	6.12	1.07	144.93
Region 7 (La Crosse)	134.68	5.77	1.32	141.77
Region 8 (Madison / South Central)	145.81	6.16	0.94	152.91
Region 9 (Southeast)	139.07	5.42	0.55	145.04
Region 10 (Milwaukee County)	148.18	5.40	0.10	153.68
Region 11 (Dane County)	134.26	5.35	0.66	140.27
Region 12 (Eau Claire)	138.18	4.71	2.69	145.58
Region 13 (Kenosha)	165.66	6.01	0.39	172.06
Region 14 (Waukesha)	151.93	4.15	0.55	156.63
Healthy Start Pregnant Women				
Region 1 (Duluth / Superior)	$634.85	$2.83	$1.93	$639.61
Region 2 (Wausau / Rhinelander)	594.31	2.06	2.89	599.26
Region 3 (Green Bay)	595.93	2.23	1.38	599.54
Region 4 (Twin Cities)	684.66	3.02	3.00	690.68
Region 5 (Marshfield / Steven Pt)	619.73	3.27	3.57	626.57
Region 6 (Appleton / Oshkosh)	585.20	3.63	2.16	590.99
Region 7 (La Crosse)	592.64	2.26	2.31	597.21
Region 8 (Madison / South Central)	655.46	3.15	2.18	660.79
Region 9 (Southeast)	608.58	2.58	1.38	612.54
Region 10 (Milwaukee County)	745.26	4.55	0.29	750.10
Region 11 (Dane County)	665.43	3.12	1.29	669.84
Region 12 (Eau Claire)	715.82	1.95	3.79	721.56
Region 13 (Kenosha)	672.97	5.29	0.67	678.93
Region 14 (Waukesha)	624.01	2.25	0.88	627.14
BadgerCare				
Region 1 (Duluth / Superior)	$165.20	$8.68	$2.05	$175.93
Region 2 (Wausau / Rhinelander)	162.22	6.43	3.29	171.94
Region 3 (Green Bay)	163.51	7.38	2.26	173.15
Region 4 (Twin Cities)	168.14	6.93	3.82	178.89
Region 5 (Marshfield / Steven Pt)	148.98	9.07	3.72	161.77
Region 6 (Appleton / Oshkosh)	152.08	9.01	2.26	163.35
Region 7 (La Crosse)	125.89	6.81	2.64	135.34
Region 8 (Madison / South Central)	170.16	8.49	2.64	181.29
Region 9 (Southeast)	162.01	7.37	1.63	171.01
Region 10 (Milwaukee County)	152.83	9.00	0.34	162.17
Region 11 (Dane County)	151.80	5.52	1.78	159.10
Region 12 (Eau Claire)	146.10	5.95	3.10	155.15
Region 13 (Kenosha)	174.77	10.22	1.35	186.34
Region 14 (Waukesha)	168.05	6.68	1.45	176.18

meet these requirements may not be funded with federal MA matching funds.

Most services provided by HMOs are covered under their capitation payment, although a few services are reimbursed outside of the capitation payment, including certain neonatal intensive care unit (NICU) costs, costs incurred for qualifying individuals with HIV or AIDS, and ventilator-assisted patients.

Accessibility. Federal regulations require that states ensure, through contracts with HMOs, that each HMO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. Under the terms of the contracts between DHFS and participating HMOs, each HMO is required to provide medical care to its enrollees that are as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to MA recipients not enrolled in an HMO within the area served by the HMO. The contracts also require that each HMO have an MA-certified primary care provider within a 20-mile distance from any enrollee residing in the HMO service area. Additionally, HMOs must have a mental health or substance abuse provider, and a dental provider (if the HMO provides dental services) within a 35-mile distance from any enrollee residing in the HMO service area or no further than the distance for MA recipients not enrolled in an HMO, giving consideration to whether the providers are accepting new patients and where full or part-time coverage is available.

Quality. Federal regulations require states to have a written strategy for assessing and improving the quality of managed care services provided by all HMOs and must periodically review the effectiveness of that strategy and update it as necessary. Among the items that must be included in this strategy are arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each HMO contract. Further, states must require, through contracts with HMOs, that each HMO have an ongoing quality assessment and performance improvement program for services furnished to enrollees. These projects must focus on clinical and nonclinical areas and involve performance measurement, interventions to achieve quality improvement, evaluation of the effectiveness of interventions, and activities for increasing or sustaining improvement. HMOs must report to states on the status and results of these projects. States must annually review the impact and effectiveness of these projects.

Some of the activities DHFS uses to improve the quality of care MA and BadgerCare recipients served by HMOs are described below. The first three activities are required under federal regulations. The remaining activities are not required under federal regulations, but were included in DHFS' Strategic Plan Assessment for 2002-2004.

External Quality Review Organization and Quality of Care Audits. DHFS contracts with an external quality review organization, MetaStar, to meet some of the federal requirements, including providing detailed analysis of HMO-submitted performance improvement projects. In addition, MetaStar conducts targeted quality-of-care audits. These audits have included reviews of enrollees' use of emergency department services for asthma, diabetes, and pregnancy, services for certain chronic conditions, primary care office visits, prenatal care for high-risk conditions, HealthCheck examinations, and medical records reviews. DHFS uses this information to work with HMOs to improve care in those areas where concerns are identified.

Quality Assessment and Performance Improvement Projects. Under the current contracts, each HMO must conduct quality assessment and performance improvement projects in at least two priority areas. Each HMO can select from a list of clinical and non-clinical priority areas developed by DHFS, or it can request approval to study a different priority area. The clinical priority areas listed in the contracts include: (a) prenatal services; (b) identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; (c) evaluating the need for specialty services; (d) availability of comprehensive, ongoing nutrition education, counseling, and assessments; (e) smoking cessation; (f) enrollees with special health care needs; (g) outpatient management of asthma; (h) the provision of family planning

services; (i) early postpartum discharge of mothers and infants; (j) sexually-transmitted disease screening and treatment; (k) high-volume / high risk services selected by the HMO; (l) prevention and care of acute and chronic conditions; (m) coordination and continuity of care; and (n) obesity.

Non-clinical priority areas include: (a) grievances, appeals, and complaints; (b) access to, and availability of services; (c) enrollee satisfaction with HMO customer services; and (d) satisfaction with services for enrollees with special health care needs or cultural competency of the HMO and its providers.

Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS). DHFS tracks quality improvement through MEDDIC-MS, a set of standardized criteria for the uniform measurement of health care services provided to MA and BadgerCare recipients who are enrolled in managed care. The system uses validated encounter data, reported by HMOs, to measure HMOs' performance against several quality standards, including inpatient hospital services and emergency room use by asthma patients, blood lead toxicity screenings for children, preventive dental services, diabetes care, childhood immunization, mammography screenings, and maternity care. Using these data, in August 2006, DHFS released reports comparing HMO performance in aggregate, and by HMO. With limited exceptions, these data do not compare performance among the HMOs with providers serving MA and BadgerCare recipients under fee-for-service, since the population served under fee-for-service is not comparable to the population served in managed care.

Targeted Interventions and Care Analysis Projects. Targeted interventions and care analysis projects are intended to improve the care HMOs provide to individuals with certain chronic conditions. Targeted interventions involve reviewing HMO encounter data and fee-for-service claims data to identify MA recipients that meet certain criteria for a specific condition and that are not receiving optimal care or should be scheduled to receive certain care under current treatment guidelines for their conditions. DHFS sends enrollee-specific reports to each HMO that identify which enrollees are receiving less than optimal care or are scheduled to receive certain care. HMOs can use this information to target appropriate care to these individuals. Care analysis projects involve using HMO encounter data and fee-for-service claims data to identify each HMO's performance in caring for enrollees with selected health concerns. Each HMO receives a specific report on its performance, which can be compared against other HMOs' performances.

Consumer Satisfaction Survey. DHFS conducts a survey of HMO enrollees using a standardized survey, CAHPS (consumer assessment of health plans), with some state-specific modifications. This survey measures enrollees' assessment of the quality of care provided by HMOs. In May, 2005, DHFS published a report on the results of the survey, which indicates at least 80% of enrollees were satisfied with their care, based on seven key indicators. HMOs performance was highest in the "getting needed care" and "helpful clinic office staff" indicators. Lowest performance was indicated for "quality of HMO" and "HMO customer service" indicators.

Disease Management. While not required to under the terms of the contracts, 11 HMOs indicated in a November, 2003, survey that they operated disease management programs and one HMO indicated that it plans to offer disease management in the future. All 11 HMOs that operated disease management programs indicated that they had a program for diabetes management and nine reported that they had an asthma management program. Other services and diseases that HMOs indicated that they targeted included obstetrical care, coronary artery disease, chronic obstructive pulmonary disease, hypertension, pre-diabetes, nutrition / obesity, smoking cessation, and

mental health. The survey results did not include comprehensive data on the effectiveness of these programs. Because disease management programs are not specified by DHFS, they do not conduct formal oversight of disease management activities implemented by health plans. The November, 2003, survey is the most recent information available regarding these activities.

HealthCheck Screenings. The state's contracts with HMOs provide a financial incentive for HMOs to conduct HealthCheck screenings. Each HMO must report to DHFS the number of HealthCheck screens that it provides for MA- and BadgerCare-eligible children enrolled in the HMO. If an HMO fails to screen at least 80% of the number of expected screens, as calculated according to the contract, DHFS penalizes the HMO by recouping MA payments from the HMO. For calendar year 2003, the most recent year for which information is available, the state recouped approximately $1.5 million from HMOs that failed to meet the 80% standard. The mean HealthCheck screening rate for calendar year 2003 was 67.5%.

HMO Report Cards. DHFS uses information from the MEDDIC-MS system and from the CAHPS survey to publish HMO report cards. These report cards are designed to be consumer-friendly representations of each HMO's performance that can be used by MA and BadgerCare recipients when they select an HMO. The report cards rate the HMOs as "above average," "average," or "below average" on five clinical performance indicators (HealthCheck, shots, lead screens, Pap tests, and mental health/drug abuse evaluations) and four non-clinical performance indicators.

Promotion of Accreditation Programs. DHFS encourages HMOs to actively pursue accreditation by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other accrediting bodies approved by DHFS by reducing certain administrative requirements if an HMO is accredited by one of these organizations. Accreditation by these private organizations means that HMOs have been evaluated and meet minimum standards for quality of care. HMOs that are accredited by the NCQA participate in the national Health Plan and Employer Data and Information Set (HEDIS) survey, which measures HMOs' performance on quality indicators.

Other Managed Care Programs

Children Come First and Wraparound Milwaukee. The Children Come First (CCF) and Wraparound Milwaukee programs provide community-based mental health and substance abuse services to eligible children with severe emotional disorders (SED). These programs serve as an alternative to inpatient psychiatric care and provide a comprehensive level of services that includes a care coordinator and individualized services. To be eligible for services, a child must have a severe emotional disturbance and be in an out-of-home placement or at risk of admission to a psychiatric hospital or placement in a residential care center or a juvenile corrections facility. Children residing in a nursing facility, psychiatric hospital or psychiatric unit of a general hospital at the time of enrollment are not eligible. All necessary mental health and substance abuse services are funded on a capitated basis with MA and county matching funds. Reimbursement for all other medical services provided to MA-eligible children enrolled in the programs is provided on a fee-for-service basis.

Children enrolled in these programs are generally under the jurisdiction of the juvenile court under one or more of the following types of court orders: (a) a delinquency petition; (b) a children in need of protection and services (CHIPS) petition; or (c) a juvenile in need of protection and services (JIPS) petition.

Under CCF, DHFS contracts with Dane County, which in turn, contracts with Community Partnerships, Inc., a limited service health organization, to arrange services for program

clients. In 2005-06, the total capitation rate was approximately $3,280 per child per month, of which, approximately $1,570 was paid by MA and the remainder was paid by Dane County. The amount paid by MA reflects an estimate of the amount MA would have paid for services to these children if, instead, they received services under the MA fee-for-service system. As of September, 2006, 153 children were enrolled in CCF.

Milwaukee County's Children and Adolescent Treatment Center operates the Wraparound Milwaukee program. In 2005-06 MA paid a monthly capitation rate of $1,588 to support the cost of MA services to children participating in the program. Milwaukee County and the DHFS Bureau of Milwaukee Child Welfare contribute funds to pay for those costs not covered by MA or for costs of children not eligible for MA. As of November, 2006, 480 children were enrolled in the Wraparound Milwaukee program.

Allied Services for Healthy Foster Children. 1999 Wisconsin Act 9 required DHFS to request a waiver from the Secretary of the U.S. Department of Health and Human Services, by January 1, 2001, that would allow DHFS to require children in foster care who live in Milwaukee County to enroll in a managed care plan as a condition of receiving benefits under MA. In October, 2004, DHFS received the necessary waiver from CMS. DHFS plans to enroll children on a mandatory basis, although parental consent or court approval will likely be necessary to enroll a child in a managed care organization (MCO). Unlike the Children Come First and Wraparound Milwaukee projects, which provide behavioral health services to a select group of children, this project will involve providing comprehensive health care, including physical and behavioral health services, to children in out-of-home care in Milwaukee County.

DHFS has letters of intent from four HMOs that currently serve MA and BadgerCare enrollees to begin enrolling these children in HMOs in January, 2007. DHFS will pay HMOs capitation rates ranging from $240 to $520 per month to provide services to these children

SSI Managed Care. Under federal rules, states may require MA recipients to enroll in managed care plans, subject to certain limitations and exceptions. For example, states may not require the following groups to be enrolled in managed care plans: (a) dually-eligible MA recipients (MA recipients who are also eligible for Medicare); (b) most Indians who are members of federally recognized tribes; and (c) certain groups of children who are under the age of 19, including children who are eligible for SSI, and children who are in foster care or other out-of-home placement.

The Department intends to require MA recipients who meet all of the following criteria to enroll in managed care programs: (a) are age 19 or older; (b) are eligible for MA under SSI or SSI-related criteria due to a disability; (c) are not living in an institution or a nursing home; and (d) are not participating in a home- or community-based waiver program. Individuals who will be permitted, but not required, to enroll in HMOs include individuals who are dually eligible for MA and Medicare, and individuals participating in the MA purchase plan (MAPP). Currently, DHFS is expanding the program on a county-by-county basis with the cooperation of local government and participating HMOs. The requirement to enroll varies by county-operated program.

As of October, 2006, Milwaukee, Waukesha, Racine, Kenosha, and Dane Counties were offering SSI managed care options. The Department expects six additional counties to implement the program in early 2007, with as many as 23 additional counties to begin participating before the end of 2007. As of October, 2006, 19,931 individuals were enrolled in the SSI managed care program, another 2,744 had opted out, and 1,014 were exempted from being required to participate. Approximately 2,000 individuals were estimated to be engaged in the enrollment process at that time, including those who had received notification of eligibility but had

not yet completed enrollment, and those within the window for opting-out, as described below.

Currently, the Milwaukee area counties and Dane County have employed different approaches to implementing SSI managed care in their areas. Milwaukee HMO contracts include all MA covered benefits except community support programs, comprehensive community services, targeted case management, and crisis intervention. Milwaukee-area counties also require MA-only eligible persons to select an HMO within two months of notification, or be automatically assigned to one of the five HMOs. Individuals must remain with their HMO of choice (or the HMO to which they were assigned) for a two-month trial. Individuals may return to fee-for-service MA or change HMOs within the first four months.

The Dane County model includes all MA covered benefits except day treatment, which is provided on a fee-for-service basis. Dane County includes community support programs and targeted case management, but does not currently enroll persons diagnosed with mental retardation. Only one HMO option is available, and enrollment is voluntary unless MA-only eligible individuals fail to make an active choice between fee-for-service and managed care during their six-week enrollment period. If they do not make a choice, the individual is automatically enrolled in the managed care program. After enrollment, individuals have 90 days to opt out of the program. At the end of the 90 days, individuals who have not opted out are required to remain with the HMO for nine months, at which time they again have the option to opt for fee for service. Dually-eligible individuals may join or leave the managed care program at any time.

Under both programs, enrollees receive a complete assessment of medical and social needs, a care plan for medical and social services, assistance from a health care coordinator, and transportation to and from appointments and covered services. In addition, enrollees do not pay copayments for services and prescription drugs they receive through their HMOs.

Contracts with participating HMOs contain several requirements related to the continuity of care. First, the HMO is required to cover medications already in use by the enrollee until such a time as they are prescribed a different drug. Second, the HMO must authorize and cover services with the enrollees' current providers for the first 60 days of enrollment, or until the first of the month following the completion of the individual's assessment and care plan. Third, the HMO must honor fee-for-service prior authorizations at the level approved for 60 days or until the month following the HMO's completion of the assessment and care plan.

CHAPTER 4

COMMUNITY-BASED LONG-TERM CARE PROGRAMS

Introduction

Individuals who meet the functional and financial eligibility criteria to qualify for MA benefits may receive either community-based or institutional long-term care services. During the past two decades, the state significantly increased funding for community-based long-term care programs, including several managed care programs and the MA home- and community-based waiver programs, to provide MA recipients more choices in the long-term care services they receive.

The Family Care, I-Care, SSI managed care programs, the program for all-inclusive care for the elderly (PACE), and Wisconsin partnership program (WPP) provide community-based long-term care using a managed care model. These programs provide comprehensive health care and other supportive services to maintain people in the community under a capitated, risk-based payment system, at a limited number of sites throughout the state.

Under the MA home- and community-based waiver programs, participants have access to services that are not available to all MA recipients. These services are intended to enable MA recipients to remain in their homes or live in other non-institutional settings. While all MA recipients are entitled to receive MA card services, including nursing home care, if they require these services, the amount of funding budgeted for community-based waiver services determines how many people will receive waiver services. Consequently, there are waiting lists for services under these programs, and, for some individuals, nursing home care remains the only long-term care option immediately available to them.

In 2005-06, the state spent over $2.3 billion (all funds) to provide long-term care services to Wisconsin residents, including approximately $1.0 billion (45%) on institutional care, and almost $1.3 billion (55%) on community-based long-term care services and Family Care capitation payments, as shown in Table 9.

Table 9: All Funds Expenditures for Selected Long-Term Care Services (Fiscal Year 2005-06)

Program / Service	Amount
MA Waiver Services, excluding COP-W	$430,654,900
COP and COP-W Services	143,768,200
Family Care Capitation Payments*	233,758,200
I-Care / SSI Managed Care Payments	126,277,200
PACE / WPP Payments	99,399,300
MA Fee-for-Service Home Care Services	243,165,900
Total**	$1,277,023,700
Total Institutional Care ***	$1,054,456,000
All Long-Term Care	$2,331,479,700

*Includes capitation payments for non-MA enrollees and nursing home care funded by CMOs.
**Excludes encumbrances.
***MA payments to all nursing homes, including the State Centers for the Developmentally Disabled and the Veterans Homes.

Long-Term Care Managed Care Programs

Family Care

The Family Care program is a comprehensive long-term care program that was created to improve the quality of long-term care services indi-

viduals receive, provide individuals with more choices and greater access to services, and to be a cost-effective system for delivering long-term care services. The program, which provides comprehensive services to elderly, physically disabled, and developmentally disabled individuals, operates under four federal waivers. Approximately $233.8 million was expended on the Family Care program in 2005-06 for capitated payments to care management organizations (CMOs). Funding provided to support aging and disability resource centers (ADRCs) is budgeted by calendar year, and is expected to total approximately $9.7 million for 2006.

The Family Care program consists of two major components. First, ADRCs provide information, assessments, eligibility determinations and other preliminary services. Second, CMOs manage and provide the Family Care benefit for every person enrolled in the program under a capitated, risk-based payment system. The Family Care benefit provides a comprehensive and flexible range of long-term care services, including the types of services currently available under the community options program (COP), the MA community-based waiver programs, and the MA fee-for-service program. Examples of services CMOs must provide include supportive living services, supported employment services, adult day care, respite care, supportive home care, residential services, nursing home services, personal care services, home health services, and therapy services. Funding for acute care services, such as hospital and physician services, are not part of the monthly capitation rate CMOs receive. These costs are billed to MA on a fee-for-services basis.

Family Care enrollees may participate in the "self-directed supports" option, which is available through each of the CMOs. Under the self-directed supports option, participants have greater control over how services are received and who provides these services. For instance, participants work with an interdisciplinary team to determine when and where work will be performed and may employ family members and friends to provide services. When an individual chooses to self-direct certain services, the associated funding is carved out of the capitation rate and managed by either a "fiscal intermediary" or "co-employment agency."

As of November, 2006, 16 counties were independently operating ADRCs (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, Trempealeau, Brown, Barron, Green, Wood, Manitowoc, Sheboygan, and Forest), while six counties operated two additional ADRCs collaboratively (Calumet/Outagamie/ Waupaca and Green Lake/Marquette/Waushara). At that time, five counties were operating CMOs (Fond du Lac, La Crosse, Milwaukee, Portage and Richland). Four of the CMOs (Fond du Lac, La Crosse, Portage, and Richland) provide services to individuals who are elderly, developmentally disabled, and physically disabled. The Milwaukee County CMO serves only the elderly population. Additional counties engaged in the planning process anticipate operating CMOs beginning in early to mid-2007.

2005 Wisconsin Act 386 repealed the "pilot" status of the Family Care program, and authorized the expansion of Family Care services to areas of the state that encompass up to 50% of the state's population. The approval of the Joint Committee on Finance under a 14-day passive review process is now required before DHFS can approve any expansion of the Family Care program to areas where, in the aggregate, more than 29% but less than 50% of the population that is eligible for the Family Care benefit reside. In order to expand the program beyond where 50% of the population that is eligible reside, the approval of the full Legislature is required. These same review provisions were extended to apply to any expansion of similar managed care programs for long term care services.

Act 386 also expanded requirements directing DHFS to conduct ongoing evaluations of the long-term care system, including the review of client

access to services, client choice of living and service options, quality of care, and cost effectiveness. These provisions also apply to other managed care programs for long-term care services.

In order to be eligible for the Family Care benefit, enrollees must meet both functional and financial eligibility criteria.

Functional Eligibility. All Family Care enrollees must be at least 18 years of age or older, reside in the Family Care county, and have as their primary disability something other than mental illness or substance abuse.

An individual meets the functional eligibility criteria if one of the following applies:

a. The person's functional capacity is at the comprehensive level, which is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance or supervision.

b. The person's functional capacity is at the intermediate level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others; or

c. The person is not functionally eligible under either a. or b. above, but submits an application for the Family Care benefit within 36 months after the date on which this benefit first became available in his or her county of residence, and has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by DHFS, funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county.

Financial Eligibility. Financial eligibility criteria are met if an individual either: (a) qualifies for MA; or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rules.

The deductions and allowances for non-MA Family Care are more generous than under MA so that individuals who are not eligible for MA may still be eligible for Family Care. For example, Family Care allows a deduction for countable assets of either $9,000 (for nursing home, CBRF, or adult family home residents), or $12,000 (for individuals who reside in their own home or in residential care apartment complexes (RCACs), compared to the $2,000 or $3,000 exclusion under MA. In addition, Family Care provides a monthly deduction for earned income that is equal to the first $200 of earned income plus two-thirds of earned income in excess of $200, whereas MA allows a deduction of $65 plus one-half of earned income in excess of $65. Family Care also allows a slightly higher personal needs allowance of $65 per month for individuals in nursing homes, CBRFs, and adult family homes, compared to $45 per month allowed for other MA nursing home residents. The personal needs allowance for individuals in their own home or in an RCAC is a minimum of $783 and a maximum of $1,809 per month in 2006 (the same as for MA waiver participants).

The Family Care benefit is not an entitlement for non-MA eligible persons and the provision of services is limited by program funding. Services provided to non-MA eligible participants are supported entirely by GPR funds. Beginning May 1, 2003, DHFS instructed CMOs to no longer enroll

most non-MA eligible applicants until further notice. As of October, 2006, 123 (1.2%) of the 9,900 Family Care enrollees were not eligible for MA.

All enrollees are required to share in program costs. If an enrollee is MA-eligible, the cost-share is identical to that required under MA community waiver cost-share rules. Family Care enrollees who are not MA-eligible have a cost-share based on the alternative financial eligibility test, which requires the person to contribute to the cost of care any countable income and assets in excess of non-MA Family Care exclusions.

Aging and Disability Resource Centers. ADRCs provide "one-stop shopping" for information, assessments, eligibility determinations and other preliminary services relating to long-term care. In addition to assisting potential long-term care users, physicians, hospital discharge planners or other professionals who work with elderly or disabled individuals can use the information services ADRCs provide.

ADRCs must provide the following services:

- Information, referral services, and assistance at convenient hours;
- A determination of functional eligibility for the Family Care benefit;
- Prevention and early intervention services;
- Benefits counseling;
- Long-term care options counseling;
- Timely referrals to the county economic support unit, which is responsible for determining financial eligibility and cost sharing for individuals interested in enrolling in a CMO;
- Assistance in enrolling in a CMO, if desired;
- Equitable assignment of waiting list priorities for the non-MA eligible Family Care population;
- Assessment of risk for individuals on a waiting list and development of an interim plan of care;
- Transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system;
- Access to SSI, MA and FoodShare; and
- Assurance of prompt responses to emergency calls, 24 hours a day.

ADRCs must provide all of their services, including conducting functional screen, eligibility determinations and individual counseling, free-of-charge.

Funding

The two entities that provide direct services under Family Care -- ADRCs and CMOs -- are reimbursed under two different mechanisms.

ADRCs. The ADRC contract assigns responsibilities to each ADRC. The contract allows each ADRC to be reimbursed for its costs in carrying out these required functions, subject to an upper reimbursement limit. If actual costs exceed this limit, the ADRC is responsible for those costs. Thus, the ADRC assumes some financial risk in carrying out its functions. As an incentive to test new methods to improve long-term care, ADRCs can also apply for "prevention grants" to test programs aimed at preventing conditions, such as improper nutrition, that contribute to a decline in functional ability. Table 10 lists the maximum (all funds) contract amounts for the ADRCs for calendar year 2007, as well as any prevention grants awarded for that calendar year. In calendar

year 2006, the costs of operating ADRCs is estimated to total approximately $9.7 million.

Table 10: ADRC Contract Amounts (Calendar Year 2007)

County	Contract Amount	Prevention Grants
Fond du Lac	$915,200	$0
Jackson	324,900	103,500
Kenosha	1,348,000	76,200
La Crosse	1,072,600	53,700
Marathon	1,731,000	0
Milwaukee	4,667,200	132,300
Portage	666,000	150,000
Richland	379,800	0
Trempealeau	360,100	0
Barron	352,000	109,800
Brown	1,748,700	62,600
Calumet	1,938,900	165,800
Forest	208,100	97,300
Green	258,600	66,100
Waushara	455,200	71,500
Manitowoc	624,500	163,900
Sheboygan	852,500	0
Racine	1,563,600	0
Total	$19,466,900	$1,252,700

CMOs. CMOs receive a monthly capitation rate for each enrollee that corresponds to the enrollee's level of functional eligibility. Two different capitation rates are paid to each CMO, including: (1) a comprehensive rate, for enrollees that meet a nursing home level of care standard; and (2) an intermediate rate, for enrollees with a lower level of care need. The capitation rates differ by county to reflect differences in the historical costs of serving long-term care clients in each county.

The calendar year 2007 rates at the comprehensive level vary from a low of $2,089 per month in La Crosse County to a high of $2,490 per month in Portage County. The intermediate rate is the same for all five CMOs -- $712 per month.

In 2005-06, payments to CMOs totaled approximately $233.8 million, including $2.4 million to support non-MA eligible individuals. Table 11 summarizes the capitation rates, enrollment and MA cost estimates by county for 2006-07.

Table 11: CMO Capitation Rates, Enrollments and Budgeted Expenditures

County	Comprehensive Rates CY 2007	October, 2006 Enrollment	2006-07 Budget (All Funds)
Fond du Lac	$2,231	966	$25,516,100
La Crosse	2,089	1,717	41,856,200
Portage	2,490	889	26,825,300
Milwaukee	2,117	5,979	155,469,700
Richland	2,204	346	9,343,200
Total		9,897	$259,010,500

Administration. DHFS has a number of duties in administering the Family Care program, including: (a) developing and implementing the monthly per person rate structure to support the costs of the Family Care benefit; (b) maintaining continuous quality assurance and quality improvements; (c) requiring, by contract, that ADRCs and CMOs establish procedures under which an individual who applies for or receives the Family Care benefit may register a complaint or grievance and procedures for resolving complaints and grievances; and (d) developing criteria to assign priority equitably on any waiting lists for persons who are eligible for the Family Care benefit but who do not qualify for MA.

For any county or tribe participating in the Family Care program, the county board of supervisors, the county administrator, or the tribe must appoint a local long-term care council (LTCC) to fulfill the following duties:

a. Develop the initial plan for the structure of the ADRC and the CMO, including recommendations to the county board (or other governing board or tribe) and to DHFS;

b. Under criteria prescribed by DHFS in

consultation with the state Council on Long-Term Care, evaluate the performance of the CMO and determine whether additional CMOs are needed in the area and, if so, recommend this to DHFS;

c. Advise DHFS regarding applications for initial certification or certification renewal of CMOs, including providing recommendations for organizations applying for certification or recertification, and assist DHFS in reviewing and evaluating the applications;

d. Receive information about and monitor complaints from individuals served by the CMOs concerning whether the numbers of providers of long-term care services used by the CMOs are sufficient to ensure convenient and desirable consumer choice and provide recommendations to DHFS;

e. Review initial plans and existing provider networks of any CMO to assist the CMO in developing a network of service providers that includes a sufficient number of accessible, convenient and desirable services;

f. Advise CMOs about whether to offer optional acute and primary health care services and, if so, how these benefits should be offered;

g. Review the utilization of various types of long-term care services by CMOs;

h. Monitor the pattern of enrollments and disenrollments in the CMOs;

i. Identify gaps in services, living arrangements and community resources and develop strategies to build local capacity to serve older individuals and individuals with physical or developmental disabilities;

j. Perform long-range planning on policy for older individuals and individuals with physical or developmental disabilities;

k. Annually review interagency agreements between the ADRC and CMOs and make recommendations, as appropriate, on the interaction between the resource center and CMOs to assure coordination among them;

l. Annually review the number and types of complaints and grievances about the long-term care system by individuals who receive or may receive care under the system, to determine if a need exists for system changes, and recommend system or other changes, if appropriate;

m. Identify potential new sources of community resources and funding for needed services for the elderly and disabled;

n. Support long-term care system improvements to the elderly and disabled; and

o. Annually report to DHFS concerning significant achievements and problems in the local long-term care system.

State law requires that more than half of the members of the council be persons who are elderly or who have physical or developmental disabilities (or their immediate family members or representatives). The remaining members should include providers of long-term care services, county residents with the ability and interest in long-term care, and members of the county board of supervisors or other elected officials.

In December, 2003, APS Health Care, Inc. completed an independent evaluation of the access to, quality, and cost effectiveness of the Family Care program in calendar year 2002. The following conclusions were identified in the report:

Access. (1) The long-term care functional screen is an accurate and reliable instrument for assessing eligibility; (2) the use of independent, third-party "enrollment consultants" to ensure individuals fully understand the Family Care program and eligibility for other long-term services is valuable;

(3) a major accomplishment of the program was elimination of wait lists in the CMO counties by the end of calendar year 2002; (4) access monitoring activities need to be strengthened; (5) CMOs appear to meet requirements for health services availability, accessibility, adequacy, and access performance standards; (6) the number of providers participating in the MA program may have increased; (7) reliance on emergency room utilization did not significantly change over time; (8) the frequency of visits to physicians and hospital lengths of stay decreased; and (9) DHFS must continue developing strategies to better track and understand reasons for disenrollments.

Quality. (1) All five CMOs demonstrated a "member-centered" orientation with strengths in care management; (2) four of the five CMOs were able to resolve all outstanding issues within three reviews of their member-centered assessment and plan reviews, grievance; (3) appeal data does not fully reflect the total complaints that were made; (4) CMOs have considerable flexibility in meeting quality standards that have resulted in both creative efforts and problems with record keeping and data utilization; (5) members consistently report high levels of self-determination and choice and health and safety outcomes and supports; (6) the more time an individual spent in Family Care resulted in a greater presence of indicators of outcomes and supports being present; and (7) the program has the potential to reduce costs by improving health care and health outcomes.

Cost Effectiveness. In order to evaluate the cost-effectiveness of the Family Care program, APS reviewed service utilization and expenditure data: (a) for Family Care participants before and after they enrolled; (b) for Family Care participants and compared data to similar groups of MA recipients that did not participate in Family Care; and (c) at the county level and at the individual level.

The evaluation reached the following conclusions: (1) the rate setting and capitated payment system methodology is sound; (2) total long-term care costs for members in the non-Milwaukee CMO counties increased less than for the statewide comparison group; (3) spending and utilization rates for home health care visits increased; (4) costs for inpatient hospital and physician office visits decreased for Family Care members but increased for the comparison group over the study period; (5) prescription drug costs increased more for Family Care members than for the comparison group; (6) geographic differences account for a substantial amount of the changes over time observed in spending and utilization rates by members; (7) members in the non-Milwaukee CMO counties saw significant decreases for personal care and residential care services; (8) members saw post-enrollment cost and utilization reductions in ICF-MR days; and (9) Family Care has the potential to generate savings through improved member health care and health outcomes.

Independent Care Program and SSI Managed Care

Since 1994, the independent care (I-Care) program has provided coordinated medical and social services for SSI-related MA enrollees ages 18 and older in Milwaukee County. Under the program, care coordinators assess the medical, behavioral health and social needs of recipients and develop case plans with enrollees and their providers. The SSI managed care initiative (described in Chapter 3) has since expanded to serve Southeast Wisconsin (Kenosha, Racine, and Waukesha counties), and Dane County. Individuals enrolled in I-Care and SSI managed care programs receive certain benefits that are not available to MA recipients who receive services on a fee-for-service basis, including ongoing care coordination services, exemption from co-payments, more convenient access to transportation, and access to certain non-standard services.

In 2006, the MA program paid SSI managed care providers under a 32-cell rate structure for Medicaid-only and Medicare-eligible individuals who receive SSI cash payments and for those who

do not receive cash payments. The rates reflect risk-adjusted rates for enrollee age and gender. The age and gender adjusted rates are based on a four-cell rate structure that is sensitive to cost variances based on an enrollee's eligibility group and Medicare status. The SSI managed care program also enrolls SSI eligible individuals who qualify for Medicaid benefits under the Medicaid Purchase Plan (MAPP). A single rate cell structure has been established for Medicaid-only and other Medicare-eligible MAPP enrollees because the limited number of participants does not allow for the calculation of credible age and gender adjusted rate cells.

In 2006, the MA program paid the regionally determined capitation rates shown in Table 12. As of November, 2006, there were a combined total of 19,900 individuals enrolled in the SSI managed care program within the three regions. Approximately $227.5 million (all funds) is budgeted to support SSI managed care capitation payments in 2006-07.

Table 12: SSI Managed Care Monthly Capitation Rates by Region and Enrollee Group (CY 2006)

	Milwaukee County	Dane County	Southeast Wisconsin
MA Only Eligibles, Cash Payment	$862.31	$541.41	$772.44
Medicare Eligibles, Cash Payment	235.47	122.70	161.54
MA Only Eligibles, No Cash Payment	1,535.79	712.23	1,096.70
Medicare Eligibles, No Cash Payment	272.93	135.56	169.14
MA Only MAPP Enrollees, Cash Payment	1,105.48	1,025.45	1,112.03
Medicare eligible MAPP Enrollees, Cash Payment	154.96	184.81	137.90

PACE/Wisconsin Partnership Program

The program for all-inclusive care for the elderly (PACE) and the Wisconsin partnership program (WPP) are managed care programs that provide both acute health and long-term care services to elderly and disabled individuals who are eligible for nursing home care. The programs provide a comprehensive system of health care and other supportive services to maintain people in the community. These voluntary programs are available to people that are eligible for both MA and Medicare.

There are two primary differences between PACE and WPP. First, PACE requires enrollees to attend a day health center on a regular basis in order to receive many services. In contrast, WPP focuses on providing comprehensive services in the participants' homes while offering voluntary enrollment in adult day care. Second, PACE requires that the client's primary physician be a physician who is a member of the PACE organization, while WPP attempts to retain the client's current primary physician by recruiting that physician to the WPP organization. PACE programs serve only elderly individuals, while the WPP also serves individuals with physical disabilities.

There is currently one PACE site (Community Care Health Plan (CCHP) in Milwaukee) and five WPP sites (CCHP in Milwaukee County, CCHP in Racine County, ElderCare Health Plan in Dane County, Health Plan for Community Living in Dane County, and Partnership Health Plan in Dunn, Chippewa, and Eau Claire Counties.)

The MA capitation rates DHFS pays to provide services vary by site. In 2006, these capitation rates ranged from $2,814 for elderly persons at ElderCare in Dane County to $5,913 for persons with developmental disabilities at the Community Living Alliance in Dane County. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services. The MA capitation rate reflects an estimated 5% savings from the average fee-for-service equivalent for nursing home care. Table 13 lists the range of

capitation rates, enrollment, and actual expenditures for each of the PACE / WPP sites.

Table 13: PACE/WPP Capitation Rates, Enrollments and Expenditures (All Funds)

Site	Calendar Year 2006 Rates	Nov. 2006 Enrollment	2005-06* Expenditures
CCHP	$2,898 to $4,293	950	$34,666,100
Elder Care	$2,814 to $4,039	619	19,202,200
HPCL	$4,030 to $5,913	332	16,465,700
PHP	$2,844 to $5,582	1,029	29,970,300
Total		2,930	$100,304,300

Home- and Community-Based Waiver Services

CMS may waive certain requirements of federal MA law to permit states to develop innovative methods of delivering or paying for MA services. In Wisconsin, CMS has approved waivers to enable the state to deliver services to certain MA populations through HMOs and to provide home- and community-based services as an alternative to institutional care.

Under the community-based waiver provisions of federal MA law, states may offer medical and support services to certain groups of MA recipients. Community-based waiver services provide a cost-effective alternative to institutional care that may not otherwise be available to MA recipients. Medical support and social services generally excluded from MA coverage can be offered to waiver participants, including supportive home care services, home modifications, adaptive aids, specialized transportation services, adult day care, and supportive services in community-based residential facilities, as well as any other services requested by the state and approved by CMS. Appendix IV to this paper provides a list of waiver services available under CIP IA, CIP IB, BIW, CLTS, COP-W and CIP-II.

Applicants for these programs are evaluated to determine the level of care they require, including whether they require care in a nursing facility or ICF-MR. Individuals who meet the level of care requirements must be informed of the availability of the MA-waiver services, but cannot be required to participate in MA-waiver programs. MA waiver participants may be either relocated or diverted from institutions.

Unlike MA card services and nursing home care, which are entitlements to all individuals who qualify for such services, the amount of MA community-based waiver services available to qualifying individuals is limited by state and county budgets. As a result, eligible individuals can be, and often are, placed on waiting lists for these programs. Table 14 presents information on the number of individuals on waiting lists for COP and MA waiver services in each year from 1996 through 2005. Of the 11,583 individuals on waiting lists as of December 31, 2005, 634 (5.5%) were residing in an institution, 7,930 (68.5%) were receiving no public long-term care funding, and 3,019 (26%) were

Table 14: Number of Individuals on County COP and MA Waiver Program Waiting Lists*

Year	Number
1996	8,834
1997	8,270
1998	9,189
1999	10,829
2000	11,353
2001	9,478**
2002	9,330
2003	10,143
2004	12,969
2005	11,583

*As of December 31 of each year.
**The Family Care benefit became available in 2001 resulting in significant waiting list reductions.

receiving some public long-term care funding but not COP or waiver funding.

In order to obtain a federal MA home- and community-based services waiver from CMS, a state must demonstrate that the projected average per capita cost for individuals receiving services under a waiver do not exceed the costs which would have been incurred for the same group of individuals had the waiver not been granted. A state may exclude individuals from the waiver for whom the cost of waiver services is likely to exceed the cost of institutionalization. States must also provide assurances that safeguards are in place to protect the health and welfare of waiver participants.

A state's waiver application is required to specify a limit on the number of individuals who will participate in the waiver; however the limit is often set well above the projected number of individuals to be served. Furthermore, CMS usually increases the limit at a state's request. Waivers are granted for an initial period of three years, while waiver renewals are usually authorized for five-year periods.

Under seven federal MA home- and community-based waivers, Wisconsin operates seven programs that are intended to reduce the number of individuals who would receive long-term care services in nursing homes or institutions. Individuals who are elderly and physically disabled are served under one federal waiver that encompasses two state programs – the community options waiver program (COP-W) and the community integration (CIP II) program. The community integration programs CIP IA and CIP IB are authorized under one federal waiver, while the brain injury waiver (BIW) operates under a single, separate waiver. The children's long-term support (CLTS) and intensive in-home autism programs are authorized under three separate federal waivers. The Department is also working with CMS to secure a new waiver to implement a community opportunities recovery program (COR), targeting services to adults who have co-occurring mental and physical health conditions.

DHFS allocates the funding budgeted for each waiver program to counties on a calendar year basis. The state-supported COP and COP-waiver allocations are based on the prior calendar year's awards. These base allocations are adjusted only when there is a change in the total amount of funding appropriated by the Legislature for these programs. Under CIP II, allocations are based on the number of slots designated for a county and the daily rate. The allocations for the other MA waivers are based on the most recent caseload information and the actual county costs per day in calendar year 2005, inflated to 2007. Counties may obtain federal MA matching funds for eligible services supported by county funds. Appendix V lists 2007 county allocations of GPR funding budgeted for MA waiver services and services funded under COP.

In order to participate in the MA waiver programs, individuals must meet both financial and non-financial eligibility criteria.

*Non-Financial Criteria***.** In addition to the MA financial eligibility criteria, individuals must meet nursing home level of care requirements in order to qualify for the state's MA waiver programs. The services available under the MA waiver programs are intended to substitute for nursing home care and thus, are only available to individuals who require that level of care.

*Financial Criteria***.** Several provisions of MA law relating to eligibility for institutional care are also applicable to the MA home- and community-based waiver programs. For instance, states may provide nursing home and MA waiver services to individuals with income between 100% to 300% of the applicable 2006 SSI payment level (up to $1,809 per month in 2006). The same spousal impoverishment protections apply to spouses that receive services in a nursing home or under the MA home- and community-based waiver programs. However, in-

dividuals who qualify under the special income limit and receive services in the community may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance than individuals who reside in nursing homes. In 2006, under the MA waiver programs, the personal needs allowance ranges from $783 to $1,809 per month, whereas nursing home residents may retain $45 per month. The personal needs allowance is larger, in part, because room and board costs are not an allowable benefit under the MA waiver programs, and participants must use their personal needs allowance to support this cost.

Community Integration Program -- CIP IA. The community integration program IA provides community-based services to individuals who previously resided at one of the three state centers for the developmentally disabled (Northern Center in Chippewa Falls, Central Center in Madison and Southern Center near Union Grove). State law requires that a center must not fill a bed that has been left vacant because of a relocation under CIP IA.

The county in which the person relocates receives the CIP IA slot to finance the services in the community. If the CIP IA participant dies, the county retains the CIP IA slot to fund community services to other individuals with developmental disabilities.

For the 2006-07 fiscal year, DHFS provides counties a maximum average per day allowance of $125 for each person relocated from the centers before July 1, 1995, $153 for relocations that occurred between July 1, 1995 and June 30, 1997, $225 for individuals placed between July 1, 2002 and June 30, 2003, and $325 for persons placed on or after July 1, 2003. For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed with federal matching funds for approximately 58% of the excess costs, as long as overall expenditures for theses services are below the maximum permitted under the waiver. In 2005-06, approximately $94.5 million was expended to support CIP IA services, including approximately $7.4 million of county funds.

The average cost of serving residents at the three state centers was $526.50 per day in 2005, compared to $259.73 per day for individuals enrolled in CIP IA when MA card services expenditures are included.

Community Integration Program -- CIP IB. The community integration program IB provides community-based services for individuals who are relocated or diverted from ICFs-MR other than the state centers for the developmentally disabled. A CIP IB slot can be created in three ways: (1) the Legislature can provide funding to support additional CIP IB slots that do not require the closing of an ICF-MR bed; (2) a slot may be created following the closure of an ICF-MR bed; or (3) counties can create slots by funding the required state MA match for these slots.

The allocation of new CIP IB slots depends on how they are created. DHFS allocates new, state-funded slots that do not result from a bed closure to counties based on need. DHFS usually provides slots created by bed closings to the county in which the facility is located.

In 2006-07, the maximum average per day allowance for state reimbursement under CIP IB is $49.67, although DHFS pays a higher rate for placements from facilities that close or have on file a Department-approved plan for significant downsizing. The state claims federal matching funds for county costs that exceed the state payment rates up to a maximum of the average cost of care in an ICF-MR (approximately $176.89 per day). As of May, 2006 there were 3,432 state-funded and 7,385 locally-supported individuals participating in CIP IB. In addition to these state-matched slots, Wisconsin claims federal funding for individuals for whom counties elect to provide the state match with county funds. In 2005-06, approximately $337.9 million was expended to support CIP IB services, including $108 million of

county funds.

Relocation Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-MR. In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services in ICFs-MR and nursing homes, other than the state centers for the developmentally disabled. The change was intended to increase access to community-based, long-term care services for individuals with developmental disabilities by allowing counties access to funding which had been previously designated solely for institutional care, and to instead use those funds to support noninstitutional services for these individuals (referred to as "the money follows the person"), as long as total program costs for institutional and community services could be managed within the same allowable funding limit. Act 33 also provided funding for phase-down payments to ICFs-MR that agreed to reduce the number of their licensed beds.

As of January 1, 2005, 1,412 individuals with developmental disabilities resided in ICFs-MR and nursing homes in Wisconsin, other than the state centers. This population is considered to be the target population for the community relocation initiative. As of September, 2006, 434 of these individuals had relocated from institutions to alternative community-based residential settings.

The average cost of serving individuals with developmental disabilities in ICFs-MR other than the state centers was $176.89 per day in 2005. By comparison, the average actual cost to serve a person under CIP IB was $121.20 per day, when costs for MA card services are included. During calendar year 2005, 1,314 individuals were participating in CIP IA, and 10,566 in CIP IB.

CIP IA and CIP IB participants may participate in the self-determination project. The project was created in 1998 under a three-year Robert Wood Johnson Foundation grant to expand consumer choice and control for individuals with developmental disabilities in three Wisconsin counties (La Crosse, Winnebago, and Dane Counties). Under the initiative, participants are part of a person-centered team that is responsible for identifying the care needs of the individual and how those needs will be met by: (a) identifying the enrollee's goals and establishing a method to attain those goals; (b) adhering to the constraints of a care budget established for the individual; (c) strengthening social supports and using community resources; and (d) establishing processes and supports to meet the needs identified in a consumer-directed service plan. The project allows participants to have greater choice in determining what services will be provided and who will provide those services, while technical functions, such as payroll-related duties are designated to fiscal intermediaries. As of July 1, 2006, 56 CIP IA and 970 CIP IB enrollees were participating in this option.

Community Integration Program -- CIP II. CIP II participants are individuals who are either over the age of 65 years or physically disabled who are relocated or diverted from nursing homes. CIP II funding is based on actual and anticipated nursing home bed closures. The Legislature may create new CIP II slots without the requirement that a nursing home bed be closed. However, under state statutes, the number of MA recipients who receive CIP II services at any time may not exceed the number of MA beds that are closed.

For 2006-07, the maximum daily reimbursement rate available to counties serving CIP II clients is $41.86. However, 2003 Wisconsin Act 33 authorized DHFS to provide counties enhanced reimbursement for CIP II services provided to individuals who are relocated to the community after July 24, 2003, if the nursing home bed that was occupied by the individual is delicensed upon relocation. Similar to other MA waiver programs, counties can receive federal matching funds for costs in excess of this maximum. Since the costs of care for

individual service plans vary, counties are expected to support a combination of high cost and low cost participants.

The authority of the Department to relocate MA-eligible individuals from nursing homes to the community and provide services under CIP II was expanded somewhat under 2005 Act 25. That act authorized DHFS to pay counties an enhanced rate (up to the actual cost of the plan) for services provided to individuals relocated to the community, provided that the number of individuals relocated under the provision did not exceed the number of nursing home beds that are delicensed as part of plans submitted by nursing homes and approved by DHFS. Further, the aggregate cost of serving these individuals in the community is required to be less than the estimated cost of serving those individuals in a nursing home. Participation in the relocation initiative remains voluntary. If an individual relocated under this initiative receives services for at least 180 days before leaving the program, the county would retain the funding allocated to provide services to the individual under CIP II, and would be allowed to use these funds to provide services to eligible individuals who may be on the county's waiting list for services, but not yet residing in a nursing home.

Under 2005 Act 355, DHFS is authorized to pay an enhanced rate for CIP II services provided to up to 150 individuals who meet the MA level of care requirements for nursing home care, but who are diverted from imminent entry into nursing homes on or after July 27, 2005. The act requires DHFS to develop criteria for determining when individuals meet this standard, and directs the Department to include considerations for the immanent loss of current living arrangements and the risk of a long-term nursing home stay. The act also allows DHFS to submit a request to the Joint Committee on Finance under a passive review process to increase the number of persons served above 150, should it become likely that the number of individuals eligible to benefit from this provision may exceed the statutory cap. As of December, 2006, DHFS has not requested an expansion of the program.

In 2005-06, approximately $59.4 million was expended to support CIP II services, including $1.9 million of county funds. At the end of calendar year 2005, 3,083 individuals were receiving MA services under CIP II. DHFS usually distributes new CIP II slots to the county in which the facility with the closed bed is located.

Brain Injury Waiver (BIW). Individuals who are substantially handicapped by a brain injury and receive, or are eligible for, post-acute rehabilitation institutional care may receive community services under this special waiver program. Currently, the maximum reimbursement rate is $180 per day. The brain injury waiver (BIW) does not require a nursing home bed closing for creation of a new slot. Instead, the number of available slots is established as part of the state budget. Because of the limited number of slots, any new or available BIW slots are reserved for MA enrollees who receive care in certified units for brain injury rehabilitation and who will be relocating to the community. In addition, counties may not retain a BIW slot if an enrollee dies.

Before DHFS implemented this program, brain-injured individuals would typically have to be institutionalized because the other MA waiver programs for which these individuals are eligible do not provide sufficient funding to meet the needs of this group. Further, people who suffer a brain injury after they are 21 years old are not considered developmentally disabled and therefore are not eligible for services provided under CIP IA or CIP IB.

In calendar year 2005, the program served 334 individuals. In 2005-06, approximately $20.3 million was expended for BIW services, including $2.4 million of county funds.

Children's Long-Term Support (CLTS) Program. 2003 Wisconsin Act 33 provided funding to support a new MA waiver program, operating

under three MA home- and community-based waivers, that provides children with long-term care needs MA services and a single entry point for eligibility determinations in each county. These waivers include: (a) the children's developmental disability waiver for children who meet the ICF-MR level of care; (b) the children's mental health waiver for children who meet the psychiatric hospital or severe emotional disturbance level of care; and (c) the children with physical disabilities waiver for children with hospital, intensive skilled nursing, skilled nursing, and intermediate care facility levels of care.

The CLTS program seeks to improve access to services, choice, coordination of care, quality, and financing of long-term care services for children with physical, sensory, and developmental disabilities, and severe emotional disturbance.

2003 Wisconsin Act 33 provided $821,800 in 2004-05 to support waiver services to individuals participating in the CLTS program. These waiver slots have been allocated to several counties across the state. Counties are also permitted to create waiver slots by supplying the local match to obtain federal matching funds to support these services. As of July 1, 2006, there were 95 state-matched and 515 locally-matched CLTS slots.

In order to be eligible to participate in the CLTS waiver, children must meet functional and financial eligibility criteria that are similar to the family support program and the Katie Beckett eligibility criteria. The functional criteria require a child to have a severe physical, emotional or mental impairment which is diagnosed medically, behaviorally or psychologically and which is characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services and which has resulted, or is likely to result in, a substantial functional limitation in at least two of the five following functions of daily living: (a) learning; (b) mobility; (c) receptive and expressive language skills; (d) self-direction; and (e) self-care.

The financial eligibility criteria require that, in 2006, the child's income may not exceed $1,809 per month and countable assets may not exceed $2,000. Children who have income and/or assets that exceed these limits may become eligible for MA by "spending down" to the CLTS income and asset criteria.

Although, the income of the parents of the child is not considered for determining eligibility for MA, families may be required to contribute to the cost of services. Fees are assessed for families at or above 330% of the poverty level, beginning at one percent of the service costs and increasing up to a maximum of 41% of service costs for families with incomes over 2000% of the federal poverty level. County support, service coordination, and administrative costs are excluded for purposes of calculating the fee. Families may request a fee recalculation if experiencing a dramatic change in income, and my either deduct a disability allowance of either the standard $3,300 from their adjusted gross income or may deduct their actual allowable medical deduction reported on their income taxes from the previous calendar year.

The services provided under the CLTS waiver are similar to those available under other MA home- and community-based waivers. Some of the services that are necessary for adults, such as home-delivered meals, housing counseling, and adult day care, adult family home, residential care apartment complex, and community-based residential facility services, are not available to children under the waivers. Similarly, the CLTS waiver supports services that are not available under the other waivers, including intensive in-home autism services and specialized medical and therapeutic supplies. DHFS paid counties an average daily rate of $48.42 to provide waiver services in 2006. In addition to receiving waiver services, CLTS enrollees have access to all MA-covered card services. As with other MA waiver programs, DHFS allocates funding to counties on a calendar year basis based on each county's estimated expenditures.

Children may continue receiving services under the waiver until they reach the age of 21 (as long as they continue to be eligible for MA). At that time, they must receive services under another waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 21 years of age, although counties can prevent a disruption in services by placing children that receive services under CLTS on a waiting list for an adult waiver slot.

Intensive In-Home Autism Services. 2003 Wisconsin Act 33 also created an intensive in-home autism benefit operating under two of the three children's long-term care waivers (the children's developmental disability waiver and the children's mental health waiver). Intensive, in-home autism services are defined as one-on-one behavioral modification therapy services for children with autism disorder, Asperger's disorder, or pervasive developmental disorder. These services are intended to teach autistic children the skills that children would typically learn by imitating others around them, such as social interaction and language skills.

Until January 1, 2004, in-home autism services were provided as a fee-for-service benefit under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. However, in June of 2000, the U.S. Department of Health and Human Services (HHS) notified the state that in-home autism services offered under the EPSDT benefit would no longer be eligible for federal MA matching funds. HHS later indicated that the appropriate method for claiming federal financial participation for intensive in-home autism services is through a section 1915 (c) home- and community-based waiver. As a result, the administration developed a proposal to recreate the benefit as a service available under the CLTS waivers.

The state began providing intensive in-home autism services under the CLTS waivers on January 1, 2004. When the in-home autism benefit became available under the waivers, the responsibility for administering the in-home autism benefit was transferred from the state to counties. As a result, counties became responsible for conducting assessments, establishing individual service plans (ISPs), and performing quality assurance activities for each enrollee.

In order to qualify for intensive in-home autism services, a child must have a verified diagnosis of an autism spectrum disorder. The vast majority of children eligible to receive autism services are eligible for MA under the Katie Beckett provision, while a small number of eligible individuals qualify for MA as supplemental security income (SSI) recipients.

Services may be provided at either the intensive or ongoing level. Children are eligible for in-home autism services at the intensive level for up to three years as long as they begin receiving services by the time they are eight years old. Services are available at the ongoing level until the individual reaches 16 years of age. As of November, 2006, 697 children were receiving intensive in-home autism services, while 880 children were receiving ongoing autism services.

Participants at the intensive level may receive 20 to 35 hours per week of intensive in-home autism services plus one hour per week of case management services, while participants at the post-intensive level are limited by the services identified in the ISP and the funding that is available. An ISP is developed for each participant to identify the type of care and number of hours of service that each individual requires.

Funding is provided to counties to support intensive in-home autism services based on an established weekly rate and the number of hours specified in each participant's individual service plan. In addition, counties are reimbursed for the cost of case management, and are permitted to claim up to 7% of direct service and case management costs to support administrative expenses. At the post-intensive level, counties receive $30.60 per partici-

pant per day to support all benefit and administrative costs.

Community Opportunities Recovery Waiver. Under 2005 Act 25, DHFS was directed to seek a waiver from CMS to provide services under a new home and community-based program for persons with a dual diagnosis of mental health and physical health conditions. The community opportunities recovery waiver (COR) is anticipated to serve MA recipients who have a serious mental illness and who meet nursing home level of care requirements, allowing them to receive services in the community. As of December, 2006, CMS had not yet approved the waiver request.

Community Options Waiver Program. The community options waiver program (COP-W) provides services to elderly and physically disabled individuals who would otherwise receive care in a nursing facility.

Unlike other community-waiver programs, under COP-W, counties are allocated a given amount of funding, rather than a number of slots or placements. Thus, a county can serve more or fewer clients, depending on the average cost per client. However, counties are subject to the federally imposed waiver-requirement that the average cost of care statewide under COP-W does not exceed the average cost of care in nursing homes. DHFS limits the average expenditure per COP-W client to $41.86 per day, which is the same limit as under CIP II.

The average cost of care for participants in the COP-W and CIP II programs was $73.33 per day in calendar year 2005, while the average cost for MA nursing home recipients was $120.42 per day. This comparison includes not only direct costs, but other costs such as MA card costs for hospital care and other services and SSI costs. In calendar year 2005, 8,499 individuals received services under COP-W. Approximately $89.9 million was expended to support COP-W services in calendar year 2005, including $1.1 million in county funds.

Community Options Program (Non-Waiver)

The non-waiver community options program is a 100% GPR-supported program that counties use to supplement funding for services provided under the MA waiver programs and to support services that are not covered under the waivers and services for individuals who are not eligible for MA. Counties also use this funding as the local match to create new MA waiver slots or to draw down federal matching funds on costs that exceed the waiver daily rate. This funding may also be used to support non-MA allowable expenditures, such as room and board costs or certain medical supplies and care provided by a spouse or parent of a minor. There are two groups of individuals that are eligible for COP services that are not eligible for MA waiver services -- individuals with early stages of Alzheimer's disease who do not require a skilled nursing facility level of care and individuals with chronic mental illness.

Eligibility. Similar to MA card services and the MA waiver programs, individuals who apply for COP funded services must meet both nonfinancial and financial eligibility requirements.

Non-Financial Eligibility. In order for a person to receive services supported by COP, a person must meet at least one of five nonfinancial eligibility criteria. Specifically, the person must:

1. Require a level of care reimbursable in nursing homes under MA;

2. Meet requirements for participants in Wisconsin's program that assists counties for the cost of care for: (a) individuals who lost MA eligibility prior to July 1, 1989, because the nursing home in which they resided was determined to be institution for mental disease (IMD); and (b) individuals who replace those individuals;

3. Be a current resident of a nursing home

who is eligible for MA and who is identified as a person for whom community care is appropriate;

4. Have a chronic mental illness and be likely to require long-term care or repeated hospitalization without long-term, community support services; or

5. Be diagnosed as having Alzheimer's disease or a related illness and meets certain level of care requirements.

An individual must be a resident of Wisconsin for at least six months before he or she is eligible for COP services.

Counties may not use COP funds to support waiver allowable services to certain individuals who are eligible for MA waiver services. Specifically, counties may not use COP funds to provide waiver-allowable services to any person: (1) for whom MA waiver services are available; (2) for whom MA waiver services would require less total expenditure of state funds than would comparable services funded under COP; or (3) who is eligible for and offered MA waiver services, but chooses not to participate in the MA waiver program. These provisions are intended to maximize the total amount of federal MA funding available to the state for community-based long-term care.

Financial Eligibility. An individual who meets the financial eligibility criteria for MA nursing home care or one of the MA waiver programs also meets the financial eligibility criteria under COP. In addition, COP provides an alternative financial eligibility test that allows a person who is likely to become medically indigent within six months by spending excess assets for medical or remedial care to be financially eligible under COP.

The formula used by DHFS to implement this six-month spend down provision compares the sum of the individual's assets, after certain exclusions, and the individual's projected income over the next six months, after certain exclusions, with the average cost of nursing home care for six months. If the sum of assets and income is less than the cost of nursing home care, the individual is financially eligible for COP services. In 2006, DHFS used $32,034 as the average cost of nursing home care for a six-month period ($5,339 per month).

Many of the asset and income exclusions used for the COP six-month spend down test are similar to exclusions used for MA. However, some differences affect both the eligibility determination and the enrollee's cost-sharing responsibility. Under COP:

a. An individual does not have to deplete his or her assets immediately. Instead, one-sixth of the value of assets above the exclusion level is added to available resources for computing the participant's cost share.

b. Participants not in substitute care may exclude an additional $3,000 in assets.

c. The monthly income that may be excluded for general living expenses also includes any special non-medical expenses specified in the county's cost-sharing plan. Allowances for non-medical expenses by counties varies; some counties do not allow any deductions, while other counties allow deductions for property taxes, insurance payments, high shelter costs and other items.

Although COP is not part of MA, MA spousal impoverishment and the divestment provisions apply. The divestment provisions may be waived if: (a) the transferred resource has no current value; or (b) the county determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred resource in the calculation of the amount of cost-sharing required.

Services. In general, counties use COP funds to supplement funding for MA waiver clients in three

areas: (1) to provide pre-relocation funding; (2) to purchase services that cannot be funded under the waivers and to provide services to individuals who are not eligible for the waivers; and (3) to supplement funding provided under the MA waiver programs.

For instance, COP funds may be used to develop assessments and case plans for applicants for MA waiver services or to initiate services while a future waiver client is still residing in an institution, for a period of up to 90 days. For example, counties may use COP funds to pay the security deposit on an apartment, to install a telephone, to purchase furnishings or to make housing modifications before a person's moves to the apartment.

Counties may also use COP funds to provide services that cannot be funded under the MA waiver programs, including room or board expenses, certain medical supplies and care provided by a spouse or parent of a minor.

Finally, counties may use COP funding to supplement MA waiver funding in those instances where the total amount provided under the waiver, together with other available sources of funding, is insufficient to support the costs of providing community-based services.

Counties' use of COP funding is subject to the following restrictions:

1. No state funds may be used to purchase land or construct buildings;

2. No state funds may be used to provide services for an individual who resides in an institution (other than for acute or recuperative stays of 30 days or less), unless a variance is granted by the county long-term support planning committee or DHFS; and

3. No state funds may be used for care provided in a CBRF facility that is larger than 20 beds unless a variance is granted by DHFS or the CBRF consists entirely of independent apartments.

Of the $61.9 million GPR expended for COP services in calendar year 2005, counties expended $8.7 million to provide services not covered under the MA waiver programs, $13.0 million for individuals not eligible for the MA waiver program, $34.1 million to support locally-matched CIP IB slots and waiver costs in excess of the state maximum reimbursement rate for MA waiver programs, and $6.1 million to support assessments, case plans, and other expenditures.

Program Restrictions

Significant Numbers Requirement. State law requires counties to provide noninstitutional community alternatives for a "significant number" of people in each of the COP client groups. This requirement was enacted in response to concerns that some client groups were underserved by COP, particularly people with developmental disabilities and chronic mental illness. DHFS is required to determine what constitutes a "significant number" of people for each county.

DHFS requires counties to allocate COP funds to serve a minimum number of clients in the following eligible groups: (a) elderly, 57%; (b) developmentally disabled, 14%; (c) physically disabled, 6.6%; and (d) chronically mentally ill, 6.6%. People with substance abuse problems are also a target population under COP, but counties are not required to allocate COP funds for this population. DHFS may grant variances to the "significant numbers" requirement on a county-by-county basis.

Table 15 presents statewide information on the number of people served in each COP client group on December 31, 2005, and compares the percentage of individuals served in each client group to the "significant numbers" percentages. For purposes of compliance with the "significant numbers" requirement, clients served with COP and COP-W funds are counted on December 31st of each year. To provide counties with the flexibility to exceed the "significant numbers" percentages, the total of the percentages is less than 100%.

Table 15: Total Number of Person Served with COP and COP-W Funds by Disability Group (December 31, 2005)

	Number	Actual Percent	"Significant Numbers" Percentages
Elderly*	5,498	50.4%	57.0%
Developmentally disabled	2,453	22.5	14.0
Physically disabled	2,208	20.3	6.6
Seriously mentally ill	735	6.7	6.6
Chemically dependent and others	7	0.1	0.0
Total	10,901	100.0%	84.2%

*All individuals over 65, regardless of primary disability, are counted as elderly.

CHAPTER 5

FUNDING SOURCES

Federal law permits states to use several funding sources, other than state tax revenue, to support the states' share of MA benefits costs. These funding sources include:

- Broad-based health care related taxes, including assessments, licensing and certification fees, which states may levy on classes of health care services or on providers of these services, including nursing facilities, hospitals, physician services and other health care services.

- Certain provider-related donations that are made directly or indirectly to the state or local government by a health care provider or a similar entity.

- Intergovernmental transfers of funds made to the state by local subdivisions within the state.

- Revenues contributed by local governments.

However, federal law places some restrictions on states' use of these funding sources. For example:

- Provider assessments must be broad-based and applied uniformly to classes of providers;

- Donations or voluntary contributions from a provider must not have a direct or indirect relationship with MA payments to that provider, that class of providers, or a related entity;

- There are prohibitions on state hold-harmless provisions that allow providers to receive back in MA payments most or all of what they pay under the provider tax; and

- No more than 25% of the allowable share of state funds may be collected from a provider assessment.

Under federal law, public funds may be considered as the state's share in claiming federal MA matching funds, if the funds: (a) are appropriated directly to the agency administering MA; or (b) are transferred from other public agencies (including tribes) to the state MA agency and are under the MA agency's administrative control and the public funds are not federal funds the state uses to match other federal funds. In addition, state and federal funds must be allocated across the state to ensure that individuals in similar circumstances are treated similarly throughout the state and that a lack of funds from local sources does not result in lowering the amount, duration, scope, or quality of services or level of administration, under the state plan.

Wisconsin uses several of these funding sources, in addition to GPR, to support the state's share of MA costs. This chapter briefly describes these sources.

Provider Assessments. Wisconsin has established provider assessments on nursing homes and hospitals to fund a portion of the state's share of MA costs.

Nursing Homes. The state established a provider assessment on nursing home beds in 1991-92. The nursing home assessment is an amount per licensed nursing home bed and applies to all

nursing home beds, including those in the state centers for the developmentally disabled, the state veterans homes, and beds occupied by Medicare beneficiaries. In 2006-07, the monthly assessment per bed is $75 for nursing facilities and $445 for ICFs-MR.

The revenues generated from the nursing home assessment are deposited, in part, in the medical assistance trust fund (MATF). In 2005-06, the nursing home bed assessment generated approximately $44.5 million -- $30.7 million of which was deposited in the MATF and $13.8 million of which was deposited in the general fund.

Although federal rules prohibit states from implementing any hold- harmless provisions that would directly tie MA reimbursement levels to the amount of the tax paid by any individual provider, most nursing homes benefit from the assessment because the state has used assessment revenue and the federal matching funds, in part, to fund rate increases for nursing homes. Non-MA residents may benefit to some degree if higher MA provider rates result in less cost-shifting to private-pay patients. Nursing homes with few or no MA-funded residents do not benefit significantly from higher MA provider rates. However, many nursing homes have a large number of residents supported by MA. As of December 31, 2005, only 18 of the 401 licensed nursing homes in the state were not certified to serve MA-funded residents. On December 31, 2005, approximately 64% of Wisconsin nursing home residents used MA as their primary source of payment for services. For private-pay residents, a nursing home may elect to include the assessment in their bill, either in the overall rate or as a separate, billable amount.

Hospitals. Current law requires DHFS to assess hospitals a total of $1.5 million annually. All revenue from the assessment is credited to a program revenue appropriation to support a portion of MA benefits costs. The amount each hospital pays in each year is proportional to the hospital's share of total gross private pay revenues all hospitals received in the previous fiscal year.

Licensing and Certification Revenues. DHFS currently collects revenue to support its regulation function by charging facilities a flat certification fee or a fixed amount per licensed bed that varies by the type of facility. For instance, nursing homes are required to pay $6 per licensed bed annually, while other inpatient health care facilities, such as hospitals, pay $18 per licensed bed. Licensing and support service revenues currently support health facility plan and rule development activities, facility accreditation, capital construction and remodeling plan reviews, technical assistance, and associated licensing and support costs. Facility accreditation, technical assistance, and licensing and support costs are eligible for federal matching funds under MA. In 2005-06, approximately $237,700 in licensing and certification revenues were used support MA-allowable costs, generating $328,200 in federal matching funds.

Nursing Home Intergovernmental Transfer Program. Wisconsin claimed federal MA funds under the nursing home intergovernmental transfer (IGT) program from 1985-86 through 2004-05. Under the program, the state claimed federal MA funds based on the difference between what the state actually paid to nursing homes and what the state would have paid to these nursing homes under Medicare payment principals. Beginning in 2001-02, the net federal revenue the state received under the IGT program was deposited to the MATF, which DHFS used to support a portion of the state's share of MA benefits costs.

Table 16 identifies the amount of federal MA matching funds the state received each year under the nursing home IGT program from 1992-93 through 2004-05.

The state's nursing home IGT revenues decreased dramatically in 2003-04 after the Health Care Financing Administration (now CMS) issued a regulation relating to the upper payment limit (UPL) that narrowed the Medicare UPL provision

that states used to maximize the receipt of federal MA reimbursement. The new rule established an additional Medicare UPL test that is applied separately to non-state, public nursing facilities that prohibits the use of any difference between the federal UPL and the actual payments to private facilities to claim excess funds in order to support higher payments to county and municipal facilities. Previously, the UPL test was applied in aggregate to each group of nursing homes so that the test was applied to privately owned (profit and nonprofit) nursing homes and county- and municipally-owned nursing homes as a group.

Table 16: Nursing Home IGT Revenues ($ in Millions)

Fiscal Year	Amount
1992-93	$18.6
1993-94	42.5
1994-95	67.5
1995-96	63.2
1996-97	118.5
1997-98	94.1
1998-99	95.4
1999-00	105.0
2000-01	372.8
2001-02	351.7
2002-03	322.5
2003-04	52.8
2004-05	50.9

Transitional provisions included under this rule permitted states to gradually comply with these new requirements over several years. Wisconsin, Nebraska and Pennsylvania were permitted to phase-out the excess payments made in 1999-00 by increments of 15% each year, beginning in 2003-04 and continuing until the excess payments are completely phased-out by 2009-10. In addition, the transitional provisions allowed Wisconsin to claim higher IGT revenues through 2002-03.

Certified Public Expenditure Program. After CMS imposed restrictions on the amounts that states could claim under IGT and began phasing out payments, DHFS determined that larger reimbursement claims could be made using the operating losses incurred by nursing homes. In 2005, DHFS requested CMS' approval to create a "certified public expenditure program," under which the state would receive federal MA matching funds based on unreimbursed costs counties and private facilities incur to provide nursing home care to MA recipients. As of January 1, 2007, CMS had not yet approved Wisconsin's request. However, CMS has approved similar programs in other states, and is expected to approve Wisconsin's application before the end of the 2005-07 biennium.

MA Trust Fund. The MATF was created by 2001 Act 16 as a separate, nonlapsible trust fund to which all federal matching funds based on nursing home and local government intergovernmental transfer were deposited. In the years following its creation, the Legislature has designated revenue from other sources, including transfers from the general fund and a portion of the revenues collected from the nursing home bed assessment, for deposit to the MATF. As in previous biennium, segregated revenues budgeted in the 2005-07 biennium from the MATF supports a portion of the state's share of MA benefits costs.

Local Government Revenue. Local government revenue used to fund the state's share of MA costs can come from state aid programs, including community aids, the community options program (COP) and shared revenue, as well as from local taxes.

Counties provide the largest share of local government revenue, but school districts also contribute a portion of the state's share of MA benefits costs. Table 17 identifies the estimated amount of local government revenue used to fund MA benefits costs in 2005-06.

MA Waivers. Counties retain federal MA matching funds the state claims for costs counties incur in providing home- and community-based

Table 17: Estimated Local Funds Used to Match Federal MA Funds (Fiscal Year 2005-06)

	Local	FED	Total
Waiver Services	$92,786,400	$127,190,900	$219,977,300
Non-Institutional Services			
Community Support Program	19,232,600	26,363,900	45,596,500
Case Management Services	14,855,000	20,363,200	35,218,200
Crisis Intervention Services	10,924,500	14,975,200	25,899,700
Other	9,200	12,600	21,800
School-Based Services	27,236,900	37,336,100	64,573,000
Milwaukee County IGT GAMP Payment	6,799,400	9,320,600	16,120,000
Total	$171,844,000	$235,562,500	$407,406,500

waiver services that exceed their state allocations In calendar year 2005, counties and tribes contributed approximately $102 million under the MA waiver programs, generating approximately $152.2 million in federal matching funds. As of May, 2006, there were 7,385 CIP IB locally-supported slots.

Non-Institutional Services Provided by Counties. There are several non-institutional services for which counties, rather than the state, provide the state match. Counties, at their option, may elect to provide these services and, by doing so, agree to provide the state's share of funding. DHFS forwards to counties the federal MA matching funds DHFS claims for MA-eligible services. These services include community support program services, case management services, and crisis intervention services.

Community Services Deficit Reduction Benefit. Prior to 2004-05, counties and municipalities that provided MA services could claim federal MA matching funds, through the community services deficit reduction benefit (CSDRB) 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. Services eligible for federal MA matching funds under this benefit included: (a) EPSDT; (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; (g) 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 services.

Under provisions of 2003 Wisconsin Act 33, DHFS suspended CSDRB payments to counties in fiscal years 2004-05 through 2006-07 because DHFS instead made supplemental MA payments to counties for these services under the Wisconsin Medicaid cost reporting program (WIMCR) program. Under provisions of 2005 Wisconsin Act 25, the CSDRB program was eliminated.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide the state's match for school-based health services. Of the federal matching funds received for school-based services, 60% is distributed to school providers and 40% is credited to the state's general fund.

Milwaukee County General Assistance Medical Program IGT. In 2005-06, Milwaukee County provided $6,799,400 to DHFS through an IGT to support the state's share of payments to hospitals in Milwaukee County as reimbursement for services provided by the hospitals and originally paid under Milwaukee County's general assistance medical program (GAMP). These hospitals then reimburse Milwaukee County for any payments under GAMP.

Tribal Gaming Revenue. DHFS is budgeted $825,000 annually from revenue the state receives from tribes from gaming proceeds, to fund the state's share of MA payments to tribal FQHCs.

Table 18 identifies the non-GPR funding sources the state uses to fund the state's share of MA benefits costs in the 2005-07 biennium.

Table 18: Non-GPR Sources of the State's Share of MA Benefits Costs (2005-07 Biennium)

	2005-06 Estimate	2006-07 Estimate
Provider Assessments		
Nursing Home Assessment*	$44,603,000	$41,882,300
Hospital Assessment	1,500,000	1,500,000
Local Government Revenues		
County Nursing Home CPE**	0	90,000,000
Other	171,844,000	174,378,100
Tribal Gaming Revenue	825,000	825,000
Total	$218,772,000	$308,585,400

*Includes $13.8 million in 2005-06 and in 2006-07 from the nursing home bed assessment that is deposited to the state's general fund.

**The 2006-07 figure includes estimates of claims for services provided in 2005-06 ($47 million) and 2006-07 ($43 million).

Donations. Finally, it is permissible for the state to accept and use certain donations as a match for federal funding under MA. Under federal law, the following provider-related donations may be used as the state match to claim federal funding: (a) bona fide provider-related donations, which are donations made to the state or local government that have no direct or indirect relationship to MA payments to the health care providers or related entities; and (b) donations made by health care facilities to support the direct costs of governmental employees who are located at these facilities and who determine individuals' eligibility for MA and conduct outreach activities. There are no limitations on the amount of bona fide provider-related donations that may be used as the state match under MA; however, donations for outstationed eligibility workers is limited to 10% of the state's MA administrative costs. The state does not currently receive regular revenues in the form of donations for the purposes of supporting MA payments.

CHAPTER 6

ADMINISTRATION

State law assigns DHFS numerous responsibilities relating to the administration of the MA program. These duties, which are listed under s. 49.45 of the statutes, include fiscal management, general supervision, eligibility determinations, fraud investigations and recovery of improper payments, claims processing, provider certification and regulation, rule development, and reporting requirements. In addition, DHFS must ensure that the state's MA program complies with the state's MA plan and federal law and policy. DHFS meets these responsibilities, in part, by contracting with outside entities and working with counties and tribal governing bodies.

Under state law, counties and tribal governing bodies are responsible for: (a) determining MA eligibility and informing recipients of their rights and duties; (b) recovering incorrect payments; (c) authorizing payments for certain mental health benefits; (d) determining medical support liability; (e) reporting health insurance information; and (f) administering the MA home- and community-based waiver programs.

MA Contracts. DHFS contracts with private firms to provide several administrative services, including processing claims, reviewing prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Most of these services are provided under a contract with the current MA fiscal agent, Electronic Data Systems, Inc. (EDS). In 2005-06, DHFS expended approximately $162.8 million ($63.2 million GPR and PR and $99.6 million FED) to support contracted services for the MA, BadgerCare, FoodShare, chronic disease, and supplemental security income (SSI) caretaker supplement programs. Table 19 summarizes these contracting costs in 2005-06, by funding source.

Table 19: MA, BadgerCare, SeniorCare, and Related Programs Administrative Contract Costs (Fiscal Year 2005-06)

	GPR/PR	FED	Total
Fiscal Agent Services	$15,473,200	$29,629,900	$45,103,100
Peer Review Organizations	303,800	834,900	1,138,700
HMO Enrollment Assistance	1,295,900	1,295,900	2,591,800
CARES	16,903,500	17,140,200	31,043,700
Other DHFS Contracts	4,238,600	4,734,000	8,972,600
Income Maintenance -- Eligibility Determinations*	25,834,300	45,962,600	71,796,900
Total	$63,163,100	$99,597,500	$162,760,600

*Estimated

Most administrative costs are eligible for 50% federal cost-sharing. However, some administrative costs are matched at a higher rate. For instance, Medicaid management information systems (MMIS) functions, and services provided by MetaStar and by certain state employed medical professionals are eligible for 75% cost-sharing.

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the state's MA program and several related programs. In 2005-06, DHFS paid EDS approximately $45.1 million for services EDS provided for these programs. Of this amount, approximately $21.2 million (47%) supported claims processing services. DHFS first entered into an agreement with EDS to provide fiscal agent services in 1991.

Under the current fiscal agent contract, EDS provides a variety of services, including: processing claims, distributing MA eligibility

cards, reviewing prior authorization requests, reviewing prior authorization requests, managing pharmacy point-of-sale systems, collecting BadgerCare premiums, coordinating benefits, and maintaining MMIS.

Peer Review Organizations. Under federal law, states are required to develop a utilization review plan and provisions for the external review of certain facilities. In order to meet these requirements, DHFS contracts with MetaStar and other entities to provide certain services and operates the provider compliance audit program within the DHFS Bureau of Health Care Program Integrity.

In 1981, DHFS first entered into an agreement with MetaStar to provide several surveillance and utilization control activities for the state's MA program. Under the current contract, MetaStar conducts managed care and medical record quality reviews, hospital audits, best practices seminars, performance improvement projects, encounter validity audits, and other peer reviews. In 2005-06, DHFS paid MetaStar approximately $1.1 million to provide these services. Because MetaStar operates as an external quality review organization (EQRO), 75% of these costs are funded with federal matching funds.

HMO Enrollment Contract. DHFS currently contracts with Automated Health Systems, Inc. to provide outreach and enrollment counseling services to AFDC, Healthy Start, and BadgerCare recipients that enroll in HMO plans. These services are provided through a call center located in Milwaukee County. In 2005-06, DHFS expended approximately $2.6 million to support services provided under the HMO enrollment contract.

CARES. In 1991, DHFS entered into a contract with Deloitte to develop the client assistance for reemployment and economic support system (CARES). DHFS continues to contract with Deloitte to maintain the system. CARES is described in greater detail later in this paper.

Other Contracts and Interagency Agreements. DHFS enters into a number of contracts and agreements with organizations to perform several other functions, including: (a) developing and supporting the nursing home reimbursement model; (b) conducting disability determinations for certain MA applicants; (c) supporting the Department of Administration's Division of Hearings and Appeals; and (d) providing ombudsman services to individuals in long-term care facilities.

Each state is required to establish methods for identifying and investigating cases of potential fraud and abuse. These cases include providers billing for services not covered under MA or billing for services that were not provided. Federal funding supports approximately 75% of the costs of supporting Wisconsin's MA fraud control units (MFCUs), which are located in the Department of Justice. The MFCUs also investigate and prosecute cases of abuse and neglect in health care facilities.

Provider Certification and Regulation. States must determine which providers may participate in the MA program. Federal law specifies the standards and certification procedures for institutional providers, such as hospitals and nursing homes, but does not specify requirements for assisted living facilities. For certain other kinds of providers, such as physicians and pharmacies, states generally follow their own laws on licensure and monitoring.

Both Medicare and MA use state certification agencies to determine institutional providers' compliance with program standards. For hospital certification, both Medicare and MA rely on the findings of the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) for determining whether an institution meets most program requirements. In Wisconsin, JCAHCO surveys most hospitals and DHFS survey activity is limited to: (a) a sample to validate the reviews by JCAHCO; (b) investigation of violations of program requirements; and (c) initial surveys of those hospitals that are not surveyed by the JCAHCO.

For Wisconsin nursing homes and assisted living facilities, the Bureau of Quality Assurance in DHFS performs regular surveys that serve as the basis for Medicare and MA certification and state licensure. Under federal law, DHFS is required to survey each nursing home at least once every 15 months and survey all nursing homes, on average, every 12 months. Federal law does not specify how frequently assisted living facilities must be surveyed, and Wisconsin's administrative code only specifies survey frequency requirements for residential care apartment complexes (RCACs) -- not for community-based residential facilities or adult family homes. State law requires DHFS to survey RCACs at least once every three years.

DHFS may impose both state and federal citations and state forfeitures and federal civil monetary penalties for violations of state and federal law. However, DHFS is not required to impose an assessment for each citation that is issued. In addition, DHFS may reduce the amount of monetary penalties under certain circumstances.

A conditional license may also be issued to nursing homes, for up to one year, when deficiencies continue to exist that directly threaten patient health, welfare and safety. When a conditional license is issued, a written plan of correction is developed and a time schedule for correction of the deficiencies is established. DHFS is also permitted to place a monitor or request the appointment of a receiver for a facility in certain circumstances in order to ensure that adequate care is being provided. When a facility is placed under receivership, DHFS assumes the operation of the facility until residents can be relocated to another institutional facility or to the community.

Alternate Eligibility Determination Sites. States are required to "outstation" eligibility workers in disproportionate share hospitals and federally qualified health centers to give individuals the opportunity to apply for MA at the sites where they receive health care. DHFS has notified and provided training to employees at these facilities so that employees can initiate the application process (the application must still be reviewed by county income maintenance workers). Also, DHFS has expanded "outstationing" by establishing sites in local community centers, health clinics, and schools.

Income Maintenance Administration

Income maintenance (IM) refers to the eligibility determination and management functions associated with several federal and state programs. Under state law, county human and social service departments are required to enter into annual contracts with DHFS for the reasonable cost to perform eligibility functions for MA, BadgerCare, and FoodShare. DHFS also contracts with tribes for these functions. In addition, DHFS contracts with counties and tribes for the administration of other programs, including the supplemental security income (SSI) caretaker supplement, Family Care, and funeral and cemetery aids. Administering agencies are responsible for processing applications, determining eligibility and payment levels, periodically making eligibility redeterminations, and maintaining accurate case files regarding recipients of public assistance.

IM Administrative Funding. In calendar year 2007, DHFS allocated approximately $51.5 million (all funds) to counties and tribes to support costs of processing applications, reviews, changes and other tasks related to eligibility determination for MA, Food Share, BadgerCare, and the SSI caretaker supplement program. This allocation is referred to as the base income maintenance administrative allocation (IMAA).

DHFS allocates IM funding to counties on a calendar year basis and to tribes on a federal fiscal year basis. Funding for other IM functions, including funeral and cemetery aids, MA transportation, and public assistance fraud programs (both pro-

gram integrity and investigations) are provided as separate allocations and amendments to the IM contract. County and tribal IMAA allocation amounts for calendar year 2005, 2006, and 2007 are listed in Appendix VI.

Wisconsin Act 25 provided both one-time and ongoing funding to increase IMAA contracts. First, Act 25 provided $954,500 SEG in 2005-06 and 2006-07 from the utility public benefits fund to support a one-time increase in IMAA contracts in calendar year 2006. Second, Act 25 provided ongoing funding of: (a) $315,000 (all funds) in 2005-06, and $630,000 (all funds) in 2006-07 to support IM agencies' costs of conducting second-party reviews; and (b) $75,000 (all funds) annually to support IM agencies' costs of conducting additional verification activities.

Each program is required, under federal law, to support its proportional share of income maintenance program costs. Since 2003, CMS has required that DHFS use a random moment sampling methodology to determine each program's proportional share of the IM costs. Each program supports its share with GPR, federal funds, local funds, or some combination of these sources.

Local Agency Contribution. County and tribes are not required to provide local funding for IM activities. However, many counties and tribes use other funds, in addition to their state allocations, to support these activities. This funding is called local non-reimbursable expenditures. In 2005, three counties and four tribes did not expend local funds for IM activities, but 49 counties supported more than 15% of the total costs of the county's IM program with other funds. In 2005, counties and tribes expended approximately $91.8 million to conduct IM activities, which included $25.8 million GPR, $46.0 million in federal funds, and $20.0 million in local funds. The federal funding amount includes federal funding that is matched to both the state GPR and local funds. In 2005, the local funding accounted for about 21.8% of the total expenditures in that year.

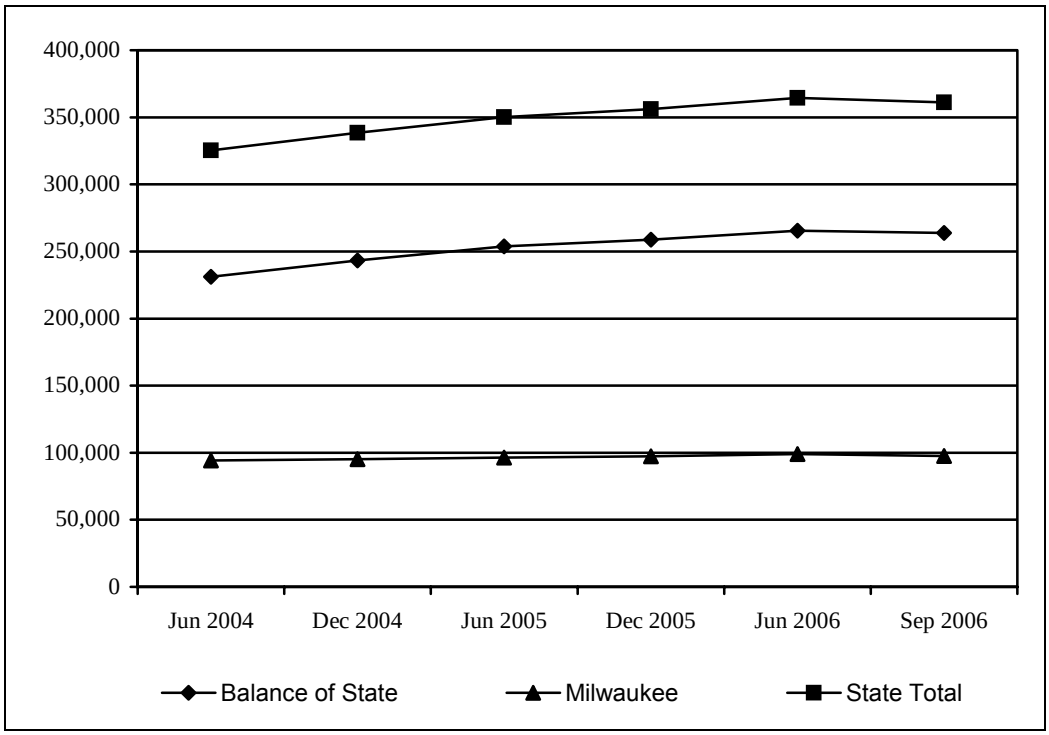
Appendix VII lists non-reimbursable expenditures by counties and tribes for IM activities in 2004 and 2005, and the amount each entity provided.

CARES. The statewide automated client assistance for reemployment and economic support (CARES) eligibility system provides the basis for an integrated application and review process for IM programs. DHFS and the Department of Workforce Development (DWD) jointly administer CARES, since both departments have programs that are supported with CARES. There are approximately 5,000 public and private users of CARES throughout the state, supporting the FoodShare, MA, child care, and Wisconsin Works (W-2) programs. CARES is a mainframe system that was first implemented in January, 1994, and has been maintained and changed as additional programs were added or program needs changed. With the transfer of the FoodShare program from DWD to DHFS in July, 2002, DHFS assumed responsibility for the primary programs supported by CARES. The state contracts with Deloitte, which is responsible for programming and maintaining the daily operations of the system. DHFS purchases services from DWD to connect and support IM workers and other CARES users.

CARES costs are allocated across the programs that are supported by the system, in both DHFS and DWD. The total cost of CARES incurred in 2005-06 was $39.9 million, of which DHFS' share was $35.3 million. The federal funding is available from several sources, including MA, FoodShare, child care, and temporary assistance for needy families (TANF) funding.

IM Caseload and Workload. IM caseloads have increased during each of the last several years. As Figure 1 shows, the increase in caseloads statewide has largely been due to increases in caseloads in non-Milwaukee counties. The caseload numbers shown in the figure includes unduplicated cases for child care, FoodShare, MA, and W2. MA cases comprise the largest number of total cases. In

Figure 1: Unduplicated IM Caseload -- June, 2004, through September, 2006



September, 2006, there were approximately 361,200 unduplicated IM cases statewide, including 97,500 cases in Milwaukee County and 263,700 cases in the rest of the state.

Workload Reduction Efforts. As the numbers of cases have increased, DHFS and IM agencies have implemented systems and policy changes that have reduced the workload for IM agencies. Workload is determined by looking at the caseload and the case mix in each agency and statewide. Funding in 2003 Wisconsin Act 33 for IM contracts was reduced primarily to reflect expected changes in workload for local IM workers. In addition, funding was reduced with the expectation that some counties would establish change reporting centers. IM caseworkers handle applications for programs, perform regular case reviews, and input changes in clients' information into CARES. Dane, Eau Claire, Waukesha, Milwaukee, La Crosse, Kenosha, Outagamie, Racine, and Washington Counties have centralized change reporting centers, in which a specialized unit of workers handles changes submitted by all recipients. These updates frequently reflect changes in income, household status, or assets. Using these centers allows IM caseworkers to focus on initial application cases and case reviews. It also potentially reduces the number of case errors because the clients' information is entered in a more timely and efficient manner.

The largest workload reduction effort in the 2003-05 biennium was the development and implementation of the CARES worker web system. This is a web-based user interface that replaced the CARES mainframe user interface. While the database remains the same, workers use the system in a way that is more intuitive, especially to newer workers. DHFS expects that this project will reduce the amount of training required of new workers, reduce ongoing workload, allow additional web-based projects in the future, and enable workers more direct access to on-line policy and procedure materials.

Coordination of Benefits

Federal law requires states to take all reasonable measures to ascertain the legal liability of other resources to pay for care and services furnished to MA recipients, and to establish procedures for paying claims where other resources are available. DHFS refers to this activity as coordination of benefits (COB). COB seeks payment from any individual, entity or program that is, or may be, able to pay all or part of the expenditures for MA services furnished by the state. Wisconsin law requires the use of other health insurance benefits, such as Medicare, commercial health insurance and settlements resulting from subrogation (injury, medical malpractice, product liability) to defray the costs incurred by MA. Any COB savings generated by states are shared with the federal government in the same proportion as each state's MA benefits expenditures.

Examples of other resources for COB include: (1) commercial health insurance companies through employment-related or privately-purchased health insurance; (2) liability insurance companies for subrogation; (3) an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more MA recipients; (4) health plans administered by employers; (5) service benefit plans; (6) worker's compensation carriers; (7) an absent parent or other entity providing medical child support; and (7) estates.

The identification of COB resources is a shared responsibility of county income maintenance agencies, county child support agencies, district offices of the Social Security Administration, the state's MA fiscal agent, and the state's health care systems and operations unit in the DHFS Division of Health Care Financing. Once a state has identified that a health or liability insurance company is responsible for an MA recipient's medical costs, the state must assure that these resources are used. Consequently, providers are instructed to bill the responsible party, if health insurance or Medicare is indicated on a recipient's MA card, before billing MA.

DHFS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available, by requiring the service provider to obtain reimbursement from other liable sources. A second method is "postpayment recovery," where the state initially pays provider claims, then attempts to recover payments from liable sources. Finally, under "provider-based billing," the state initially uses MA funds to pay provider claims. It then identifies retroactive health insurance coverage that requires documentation (for example, a physician's plan of care, prescriptions or discharge notes), and a bill is produced for the provider to use to bill the health insurer. The provider has 120 days to collect payment from the insurer and refund the MA payment. If the provider does not refund the MA payment within 120 days, the MA payment is automatically recouped from the provider through a claims adjustment.

Table 20 summarizes all coordination of benefits savings the MA program achieved in 2004-05 and funds received through estate recovery.

Estate Recovery Program

DHFS uses estate recovery to offset MA program costs. Under the estate recovery program, MA recipients share in the cost of their health care, after death, through payments from their estates. The estate recovery program allows the state to recover MA payments for nursing home care, inpatient hospital care, and certain home health services. In addition, the state may recover MA payments for home- and community-based waiver services and Family Care services, as well as related inpatient hospital and prescription drug services provided to individuals who are age 55 years and over. State law requires the state to file claims against the estate of a MA recipient to recover certain costs, except in cases that would

Table 20: Coordination of Benefits and Estate Recovery Payments (Fiscal Year 2004-05)

Category	Cost Avoidance	Postpayment Recoveries	Claims Adjustments
Medicare	$827,411,400		
Other Health Insurance	348,522,400*	$9,946,200	
Subrogation		2,566,200	
Provider-Based Bills		395,200	$9,632,500
Medical Support Liability		18,325,700	
Estate Recovery		17,423,400	
Miscellaneous		32,604,100	
Total	$1,175,933,800	$81,260,800	$9,632,500
Grand Total			$1,266,827,100

*Includes claims returned because: (a) insurance carrier payments equaled or exceeded the MA rate, (b) other carrier coverage appears on file, (c) use of other carrier denial is invalid, or (d) other coverage is suspected. This amount does not include claims paid in full by carrier and never billed to MA.

cause undue hardship.

The estate recovery program attempts to recover MA costs by: (a) placing liens against a home; (b) placing claims against a recipient's estate; (c) affidavits; and (d) voluntary recoveries. DHFS may place liens on the home of an MA recipient who is in a nursing home or hospital facility if the individual is not expected to be discharged from the nursing home or hospital, is required to contribute to the cost of care, and if certain family members do not reside in the home. These family members include the MA recipient's spouse, the recipient's child who is under 21, blind, or disabled, or the recipient's sibling who has an equity interest in the home and who has lived in the home continuously beginning at least 12 months before the recipient was admitted to the nursing home.

Before placing a lien, DHFS must notify the recipient in writing that DHFS intends to obtain a lien and that the recipient has a right to a hearing on whether the conditions for placing a lien have been satisfied.

In addition to placing liens, DHFS can place claims against a recipient's estate. A claim on the estate may not be paid if a spouse or a child who is under the age of 21, blind, or disabled, survives the recipient. Individuals may apply for a waiver of the claim if any of three hardships exist: (1) the waiver applicant would become eligible for certain state assistance programs if the estate claim is pursued; (2) the real property is part of the waiver applicant's business and the claim would result in the loss of his or her means of livelihood; or (3) the waiver applicant is receiving general relief or veterans benefits under the economic assistance subsistence grant.

Property considered to be the home of the MA recipient that is being transferred by an affidavit is subject to a lien if the state's claim cannot be satisfied through available liquid assets. However, the lien may not be enforced as long as a spouse or child who is under the age of 21, blind, or disabled exists. DHFS may also send an affidavit to an heir who claims or transfers certain funds to recover any funds remaining after burial and estate administration costs have been paid.

MA recipients who are age 55 or older may also reduce a potential claim against their estates or prepay a MA deductible by making voluntary payments to the estate recovery program. Except in the case of a prepayment of a MA deductible, voluntary payments may not exceed the amount paid by MA to date.

County and tribal governing body participation in the estate recovery program is limited to the collection and transmittal of information to DHFS relating to homestead property, legal descriptions of property, and notices of death. Each county or tribe receives 5% of collections made under the estate recovery program. The federal government also receives a portion of the proceeds equal to its share of the recipient's health care expenditures.

In addition to placing liens, certain transfers of assets may trigger a review by the Department. When a probate case is filed relating to an MA recipient's estate, DHFS may review the action and

file a claim for care-related costs to be recovered under the estate recovery program. Currently, Wisconsin Circuit Court records are available online through the consolidated court automation program (CCAP), allowing the Department to monitor when an estate is in probate through the online records.

However, under 2005 Wisconsin Act 206, a new mechanism for the non-probate transfer of real property at the death of the property owner was created. Under the act, an interest in real property that is solely owned, owned by spouses as survivorship marital property, or owned by two or more persons as joint tenants may be transferred without probate to a designated transfer-on-death (TOD) beneficiary on the death of the sole owner or the last to die of multiple owners. Since the TOD beneficiary has no interest in the property while the owner is alive, the provision does not violate Federal MA divestment rules. However, as the real estate transfer bypasses probate (because it is not subject to probate administration), DHFS is not able to file a claim or collect against these assets, thus impacting the State's ability to recover these assets previously owned by the MA recipient.

CHAPTER 7

BADGERCARE

Introduction

1997 Wisconsin Act 27 established BadgerCare, a program that funds health services for individuals in low-income families with dependent children who are not eligible for MA . Individuals and families began enrolling in the program in July, 1999. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery, and administration. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available from two federal programs -- the state children's health insurance program (SCHIP) and MA. Consequently, BadgerCare operates under federal requirements applicable to both programs. Further, Wisconsin received approval of a waiver of certain federal requirements under MA in order to implement BadgerCare. This waiver approval was granted based on a plan submitted and approved by CMS. BadgerCare operates under the parameters established in that approved plan. The current waiver agreement is scheduled to terminate on March 31, 2007.

Eligibility. Eligibility for BadgerCare is based on both financial and nonfinancial criteria.

Individuals in families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before family members are no longer eligible for the program. Table 21 identifies the initial income eligibility levels for BadgerCare and the ongoing income eligibility limits based on the 2006 FPL. Similar to most MA recipients (except those who qualify for MA based on age or disability) BadgerCare recipients do not need to meet an asset test to be enrolled in the program.

Table 21: BadgerCare Eligibility -- Maximum Countable Monthly Income (Based on 2006 FPL)

Family Size	Initial Eligibility 185% of FPL	Ongoing Eligibility 200% of FPL
1	$1,511	$1,633
2	2,035	2,200
3	2,559	2,767
4	3,083	3,333
5	3,608	3,900
6	4,131	4,467

As with MA, certain kinds of expenses are deducted from household income and certain types of income are not included when determining countable income. For example, the following expenses and income are subtracted from a family's gross income, before taxes, to determine countable family income: (a) $90 per month for work-related expenses for each person in the family that works; (b) child care costs, up to $200 per month per child under age two and up to $175 per month per child age two and above; (c) for self-employed individuals and farmers, all deductions from gross income allowed under federal tax law except depreciation.

Families with incomes above 150% of the FPL must pay a monthly premium to be covered under BadgerCare. This premium is equivalent to

approximately 5% of the family's income. Table 22 provides a schedule of the minimum and maximum premiums a family would be required to pay based a range of countable income, using the 2006 FPL. Families in BadgerCare pay these premiums through direct payment by check or money order, electronic funds transfer, or wage withholding. These premium payments, together with revenue DHFS received from drug companies as manufacturer rebates, are program revenues that partially support program benefits.

Table 22: BadgerCare Premium Schedule (Based on 2006 FPL)

Family Size	Monthly Income		Monthly Premium	
	Minimum	Maximum	Minimum	Maximum
1	$1,225	$1,633	$50	$75
2	1,650	2,200	75	100
3	2,075	2,767	100	125
4	2,500	3,333	125	150
5	2,925	3,900	125	175
6	3,350	4,467	150	200

The income eligibility criteria for BadgerCare are similar to the criteria for MA Healthy Start. Healthy Start covers pregnant women and children under age six in families with income not exceeding 185% of the FPL. However, Healthy Start does not cover men and non-pregnant women with income that exceeds the AFDC-related MA eligibility criteria, nor does it cover children six and older in families with income above 100% of the FPL. Those individuals not covered through the Healthy Start program may be eligible for BadgerCare.

A family that meets the financial and non-financial criteria for MA is eligible for MA, regardless of whether the family has access to health insurance. Because MA is a payer of last resort, if a person has access to other health insurance, MA only pays for services that are not covered from other sources. In contrast, a family that otherwise meets the financial and non-financial eligibility criteria for BadgerCare cannot qualify for BadgerCare if the family has insurance or access to a group health insurance plan for which an employer subsidizes at least 80% of the monthly premium cost. In addition, individuals who had health care coverage any time during the three months before they apply for BadgerCare are ineligible. DHFS may waive these provisions for good cause. Good cause includes but is not limited to: non-voluntarily loss of employment, changing jobs to an employer that doesn't offer insurance, and employer discontinuation of insurance.

When a person applies for BadgerCare, all of his or her family members are first reviewed to determine whether they may be eligible for MA. If one or more of the family members are found to be eligible for MA, those individuals are enrolled in MA. The remaining family members are reviewed for BadgerCare eligibility.

Based on provisions included in 2003 Wisconsin Act 33, effective May 10, 2004, as a condition of eligibility, each member of a family who is employed is required to verify from his or her employer: (a) his or her earnings; (b) whether his or her employer provides health care coverage for which the family is eligible; and (c) the amount that the employer pays, if any, toward the cost of that coverage, excluding any deductibles or copayments required under the coverage. Before May 10, 2004, DHFS received some insurance information in a post-eligibility process conducted by the fiscal agent. Earnings were not verified unless the information provided by the applicant or recipient was considered questionable.

Prenatal Care and Delivery Services for Non-Qualified Immigrants and Inmates of Public Institutions. Provisions in 2005 Wisconsin Act 25 allowed Wisconsin to implement a SCHIP option to provide prenatal care and delivery services to non-qualified immigrants and inmates of public institutions. Under this program, called the BadgerCare prenatal program, coverage is limited to prenatal care, labor and delivery only for the

unborn child of a woman who is a non-qualified immigrant or is an inmate. The pregnant woman must verify her pregnancy and meet all other eligibility criteria for BadgerCare.

Prior to the implementation of the BadgerCare prenatal program, non-qualified immigrants could be eligible for MA-funded emergency services which include labor and delivery services and any emergency care that is needed thirty days before and sixty days after delivery. These MA-funded services remain available for women when their BadgerCare prenatal eligibility ends at delivery. Previously, inmates of public institutions could not be eligible for any type of MA coverage.

With this change, the state receives federal matching funds at the enhanced BadgerCare federal matching rate of approximately 70% for both prenatal care and delivery services for these individuals.

Services. BadgerCare recipients are eligible to receive all of the services that are available to MA recipients. Approximately 65% of BadgerCare recipients are enrolled in HMOs. Average capitation costs for BadgerCare clients are generally higher than AFDC-related and Healthy Start MA capitation costs. As with MA capitation rates, the actual amount paid to an HMO for an enrollee is based on the enrollee's age, gender, and area of residence.

Funding. In the 2005-07 biennium, BadgerCare is funded with GPR, federal funding available under MA and SCHIP, and premiums paid by some recipients. Table 23 identifies expenditures for services to BadgerCare recipients, by fund source, from 1999-00 through 2005-06.

Federal MA matching funds support approximately 58% of the costs of services for adults in families with income at or below 100% of the FPL. SCHIP funding supports approximately 70% of the costs of services for children and all other adults enrolled in BadgerCare. It is estimated that federal SCHIP and MA funds will support approximately 61% of total BadgerCare benefits costs in 2006-07.

Table 23: BadgerCare Expenditures -- $ in thousands (Fiscal Years 1999-00 through 2005-06)

	GPR	PR	FED	Total
1999-00	$21,920.3	$758.2	$35,697.6	$58,376.1
2000-01	46,164.6	1,410.6	81,449.4	129,024.6
2001-02	43,774.6	4,447.7	92,371.7	140,594.0
2002-03	60,814.9	4,113.5	124,538.4	189,466.8
2003-04	64,767.3	6,145.3	134,732.1	205,644.7
2004-05	58,877.6	6,986.4	122,702.1	188,566.1
2005-06	62,297.5	6,943.0	125,176.9	194,417.4

Funding for BadgerCare is limited to the amounts appropriated for the program. Current law requires that if the amount of funding appropriated for BadgerCare is insufficient to fund BadgerCare costs based on projected enrollment levels, DHFS must lower the maximum income eligibility for BadgerCare to a level no greater than necessary to ensure the amounts appropriated are sufficient to cover projected costs. This provision in state law is commonly referred to as the "enrollment trigger." DHFS cannot implement the enrollment trigger unless the Joint Committee on Finance approves a plan to implement it under a 14-day passive approval process.

Under the terms of the initially approved BadgerCare waiver, DHFS was required to notify CMS of its intent to implement the enrollment trigger at least 90 days before the enrollment trigger took effect. However, if the enrollment trigger were enacted, under the terms of the amended waiver approved in January, 2001, the waiver would be terminated and the costs for services to adults with income above 100% of the FPL would be reimbursed under MA, rather than SCHIP, as provided under the original waiver.

As an alternative to reducing the maximum income eligibility for the program, the Joint Committee on Finance may transfer appropriated moneys from other state agencies' GPR appropriations to supplement funding for BadgerCare benefits if the

Committee finds that the transfer will eliminate unnecessary duplication of functions, result in more efficient and effective methods for performing programs, or more effectively carry out legislative intent, and that legislative intent will not be changed by the transfer. To date, the Committee has not authorized DHFS to reduce program eligibility as the means to address a projected shortfall in benefits funding.

Enrollment. As of September, 2006, 94,034 people were enrolled in BadgerCare, including 65,346 adults and 28,688 children. Approximately 84% of BadgerCare recipients were in families that had countable income less than 150% of the FPL and, therefore, these families did not pay monthly premiums. Table 24 identifies enrollment in BadgerCare as of September, 2006, by income.

Table 25 shows the number of BadgerCare recipients at the end of each quarter, beginning in September, 1999 through September, 2006. As shown in the table, enrollment in BadgerCare grew rapidly in its first year, then steadily for the next several years. Beginning in 2003, enrollment growth began to slow, and in June 2004 enrollment began decreasing. The decrease was likely due to provisions in 2003 Act 33 that: (a) increased the monthly premiums paid by families with income above 150% of the FPL, from 3% to 5% of the family's income, effective January 1, 2004; and (b) required applicants to verify information on income and employer health insurance. Since September, 2005, there has been a slight increase in enrollment.

Table 24: BadgerCare Enrollment (September, 2006)

Income Range Based On the % of FPL	Adults	Children	Total	% of Total
No More than 100%	29,133	n/a*	29,133	31.0%
Greater than 100% but No More than 150%	28,040	21,975	50,015	53.0
Greater than 150% but No More than 185%	7,113	5,676	12,789	14.0
Greater than 185% but No More than 200%	1,060	1,037	2,097	2.0
Total	65,346	28,688	94,034	100.0%

* Children with income below 100% of the FPL are eligible for MA and therefore, are not eligible for BadgerCare.

Table 25: BadgerCare Enrollment by Quarter (September, 1999 through September, 2006)

Quarter Ending	Children	Adults	Total	Change from Previous Quarter
1999				
September	6,298	16,853	23,151	N.A.
December	12,851	32,003	44,854	93.7%
2000				
March	16,207	41,073	57,280	27.7
June	18,182	46,965	65,147	13.7
September	20,371	50,627	70,998	9.0
December	22,636	51,885	74,521	5.0
2001				
March	23,708	53,982	77,690	4.3
June	23,576	57,283	80,859	4.1
September	25,538	60,875	86,413	6.9
December	27,753	61,832	89,585	3.7
2002				
March	29,373	62,927	92,300	3.0
June	30,962	66,233	97,195	5.3
September	32,261	66,936	99,197	2.1
December	34,445	68,988	103,433	4.3
2003				
March	35,546	71,108	106,654	3.1
June	35,785	73,373	109,158	2.3
September	36,648	75,113	111,761	2.4
December	37,839	76,383	114,222	2.2
2004				
March	37,356	76,881	114,237	0.0
June	34,957	73,677	108,634	-4.9
September	31,588	65,543	97,131	-10.6
December	30,302	62,728	93,030	-4.2
2005				
March	29,350	61,755	91,105	-2.1
June	28,006	60,719	88,725	-2.6
September	28,944	61,487	90,431	1.9
December	29,489	61,767	91,256	0.9
2006				
March	28,574	64,808	93,382	2.3
June	29,150	64,337	93,487	0.1
September	28,688	65,346	94,034	0.6

CHAPTER 8

SENIORCARE

Introduction

SeniorCare was created as part of 2001 Wisconsin Act 16 to provide assistance to Wisconsin residents who are 65 years of age or older with the purchase of prescription drugs. DHFS began paying program benefits in September 1, 2002.

Eligibility and Application. Any Wisconsin resident who is 65 years of age or older and pays a $30 annual enrollment fee is eligible for SeniorCare, except for: (a) individuals eligible for full benefit MA; (b) individuals who are not U.S. citizens and whose immigration status would make them ineligible for MA; and (c) inmates of public institutions. Individuals who have other prescription drug coverage are eligible to participate in SeniorCare, although SeniorCare only pays for that portion of the eligible costs that are not payable from other sources.

Each applicant becomes eligible for SeniorCare on the first day of the month after the date DHFS receives a completed application and determines that the person is eligible. Once they are enrolled in the program, SeniorCare recipients must re-enroll and pay the enrollment fee every 12 months to remain eligible for SeniorCare benefits. As of September, 2006, 108,064 individuals were enrolled in SeniorCare.

Applications and Eligibility Determinations. DHFS processes applications through a centralized application processing operation. Individuals can apply for SeniorCare by contacting their local office on aging, senior center, or aging resource center. Individuals may obtain an application from the DHFS website or by calling a toll-free number to have an application mailed to them. In addition, many pharmacies have copies of the SeniorCare brochure developed by DHFS that includes information on how and where to apply.

Once DHFS receives a completed and signed application, it must determine the applicant's eligibility as soon as possible, but no later than 30 days from the date it receives an application that contains, at a minimum, the name, address, and signature of the applicant. DHFS must notify an applicant in writing if there is a delay in processing the application due to a delay in securing necessary information for determining eligibility.

An applicant who is notified that he or she is eligible for SeniorCare and has not received any SeniorCare benefits may request to withdraw their SeniorCare application and receive a refund of the enrollment fee up to 10 days following the issuance of an eligibility notice, or 30 days from the date the application was filed, whichever is later.

Right to Appeal. Any individual whose application for SeniorCare is denied or is not acted upon promptly, or who believes that the benefits or services they receive have not been properly determined, may file an appeal of that decision or lack of a decision within 45 days from the effective date of the action. A request for a hearing on an appeal must be made, in writing, to the Department of Administration's Division of Hearings and Appeals.

Cost-Sharing Requirements. All SeniorCare recipients partially contribute towards the costs of the program.

Types of Cost-Sharing Requirements. In addition to paying the enrollment fee, which is required

of all recipients as a condition of eligibility, recipients share in the cost of the program by paying copayments and meeting deductible and spenddown requirements.

Each SeniorCare recipient receives a SeniorCare card, which he or she must present to a pharmacy when they purchase prescription drugs. By using this card, DHFS electronically tracks each recipient's prescription drug purchases and lets the pharmacy know how much to charge the recipient at the time of purchase.

Copayments. Recipients pay a copayment for each drug they purchase under SeniorCare for which SeniorCare reimburses the pharmacy for the cost of the drug purchased. The copayment is $5 for each generic drug and $15 for each brand-name drug. The state's payment to the pharmacy is reduced by the amount of the copayment.

Deductible. Some SeniorCare recipients pay a $500 or $850 annual deductible, depending on their income, before SeniorCare pays for drugs they purchase. Recipients receive a discount for drugs they purchase during the deductible period. This discount equals the difference between the retail price of the drug and the rate at which SeniorCare reimburses pharmacies. It is estimated that, on average, this rate equals 21% of the retail price, or usual and customary rate, of drugs purchased, although the actual discount per drug varies significantly. The amount of the discount is absorbed by the pharmacy. SeniorCare does not reimburse the pharmacy for the value of this discount. Once a recipient meets the deductible requirement, the recipient is only responsible for making the required copayments.

Spenddown. Individuals and married couples with income above 240% of the FPL are required to meet a spenddown requirement. The amount of the spenddown requirement is equal to the amount that the individual's or couple's household income exceeds 240% of the FPL.

Pharmacies may not charge SeniorCare recipients more than the retail price of the drug during the spenddown period. If a pharmacy accepts a discount available from a separate program for the purchase of a drug that counts towards recipient's spenddown requirement, only the amount the recipient actually pays for the drug counts towards the spenddown requirement.

Once a recipient meets a spenddown requirement, he or she must meet an $850 deductible before SeniorCare pays for drugs. For married couples with both spouses participating in the program, the spenddown requirement is a joint requirement -- purchases of prescription drugs for both spouses count towards the spenddown requirement. Once the joint spenddown requirement is met, then each spouse must meet the annual deductible and copayment requirements.

Participation Levels. DHFS has established four "participation levels" for SeniorCare recipients, which are based on the amount of cost-sharing required of enrollees.

Level 1 -- Copayment. Individuals with income at or below 160% of the FPL are enrolled in SeniorCare at Level 1. There is no deductible or spenddown requirement for these individuals. These individuals pay copayments for each drug they purchase under the program.

Level 2a -- $500 Deductible. Individuals with income above 160% of the FPL but no more than 200% of the FPL are enrolled in SeniorCare at Level 2a. These individuals pay a $500 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 2b - $850 Deductible. Individuals with income above 200% of the FPL but no more than 240% of the FPL are enrolled in SeniorCare at Level 2b. These individuals pay the $850 annual deductible before SeniorCare pays for drugs on their be-

half. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 3 -- Spenddown. Individuals with income above 240% of the FPL are enrolled in SeniorCare at Level 3. These individuals are first responsible for the spenddown requirement and then the $850 annual deductible requirement. Once both of these requirements have been met, they pay copayments for each drug they purchase.

Table 26 identifies the number of individuals enrolled in SeniorCare, by participation level, as of September, 2006.

Table 26: SeniorCare Enrollment by Participation Level (September, 2006)

Level 1 (≤ 160% FPL)	51,115
Level 2a (> 160% to ≤ 200% FPL)	25,220
Level 2b (> 200% to ≤ 240% FPL)	15,433
Level 3 (> 240% FPL)	16,296
Total	108,064

Table 27 identifies the various annual income levels that determine SeniorCare participation, based on the 2006 FPL.

Table 27: SeniorCare Annual Income Levels (Based on the 2006 FPL)

% of the FPL	One Person	Two People
160%	$15,680	$21,120
200%	19,600	26,400
240%	23,520	31,680

The amount each recipient saves by participating in SeniorCare depends on the participation level in which the individual is enrolled and the individual's total drug costs. On average, Level 1 recipients save the most and Level 3 recipients save the least, due to the different cost-sharing requirements that apply at different levels. Table 28 identifies the average savings per recipient by participant level, based on allowed costs in 2005-06. Average savings is defined as the difference between the amount a recipient would have paid if they were required to pay the pharmacy's usual and customary charge for drugs covered under the program and what the recipient actually paid in copayments, deductible and spenddown requirements.

Table 28: Average Recipient Savings (Fiscal Year 2005-06)

Level 1	$1,751
Level 2a	1,621
Level 2b	1,401
Level 3	755
All Levels	$1,629

Definition of Household Income. Current law authorizes DHFS to define "household income" for the purpose of making eligibility determinations. By rule, DHFS defines annual household income as a prospective estimate of annual gross income for all persons in the household whose income and need is included in determining eligibility for SeniorCare. This includes the applicant and the applicant's spouse, if the spouse resides with the applicant. The spouse's income is not included if the spouse is an SSI recipient or the spouses are living together in a nursing home.

"Income" includes gross earned and unearned income, including social security income, and is based on projected income for the 12 calendar months beginning with the month in which the SeniorCare application is filed. Self-employment income is determined by deducting estimated business expenses, losses and depreciation from gross self-employment income. Income from sources that are exempt under federal law from consideration in determining MA eligibility is also exempt from consideration for SeniorCare.

Reimbursement to Pharmacies. As a condition of participating in MA, pharmacies must participate in SeniorCare. DHFS reimburses pharmacies for purchases made by SeniorCare recipients only

when the recipient is responsible for copayments. DHFS does not reimburse pharmacies for drugs purchased during a recipient's deductible or spenddown phase.

The amount of the reimbursement equals the lesser of: (a) the pharmacy's usual and customary charge; or (b) the SeniorCare reimbursement rate, which equals the MA rate for the same drug, plus 5% of that rate, plus a dispensing fee. The amount the state pays to the pharmacy is reduced to reflect any required copayments. Pharmacies cannot charge recipients the difference between the retail price of a drug purchased under SeniorCare and the SeniorCare reimbursement rate, unless the recipient is meeting a spenddown requirement.

It is estimated that the SeniorCare reimbursement rate currently equals, on average, approximately 79% of a pharmacy's usual and customary charge. A provider's usual and customary charge represents the amount the provider customarily charges to individuals and other parties for the same product. This amount is typically referred to as the retail price of the product, and usually does not include discounts that providers give to certain purchasers. If an individual has other prescription drug coverage, payment to the pharmacy totals the amount not covered by the other coverage, up to the amount payable under SeniorCare.

DHFS is required to monitor pharmacies' compliance with providing discounted rates to SeniorCare recipients for drugs purchased under the program and to submit an annual report to the Legislature concerning compliance. The report must include information on any pharmacies or pharmacists that discontinue participating in the MA program and the reasons they no longer participate.

Covered Drugs and Limitations. Drugs covered under SeniorCare include prescription drugs that are covered under MA that are produced by manufacturers that have entered into rebate agreement with DHFS. The only over-the-counter medication covered under SeniorCare is insulin.

The list of drugs covered for a SeniorCare recipient depends on whether the recipient is in a family with income less than 200% of the FPL and therefore is part of the state's demonstration waiver, which is discussed later in this section. For those recipients, the drugs covered are identical to the drugs covered under MA. For those that do not participate in the waiver, the list of covered drugs only includes drugs produced by manufacturers that have signed a separate rebate agreement with the state. Most manufacturers that participate in the MA rebate program have signed rebate agreements for the non-waiver SeniorCare population. Consequently the lists of covered drugs for waiver and non-waiver SeniorCare recipients are nearly identical.

DHFS may use the same utilization and cost control procedures under SeniorCare that it uses under MA, such as prior authorization, generic substitution and maximum days supply. Further, pharmacies can receive payments for the same pharmaceutical care services they provide under the MA program.

Prior Authorization. DHFS requires a pharmacy to receive prior authorization for certain drugs, or uses of certain drugs, before it reimburses the pharmacy for the drug under SeniorCare. Most drugs purchased under SeniorCare do not require prior authorization. However, DHFS requires prior authorization for certain stimulants, certain nutritional supplements, and certain drugs that have been demonstrated to entail substantial cost and utilization problems under MA.

In most cases, pharmacists submit requests for prior authorization electronically and receive responses in real time. However, in some cases, pharmacists may be required to submit a paper prior authorization request, particularly where documentation of the medical necessity of the prescription is required for approval.

Generic Substitution. SeniorCare automatically reimburses a pharmacy for the generic equivalent

of a drug whenever a generic equivalent of a drug is available. SeniorCare only reimburses pharmacies for brand name drugs when generic equivalents are available if the pharmacies receive prior authorization. Pharmacies must obtain information from prescribers indicating why the brand name drug is medically necessary and submit this information to DHFS with the requests for prior authorization.

Maximum Days Supply. Pharmacies may only fill most prescriptions in the quantity prescribed, not to exceed a 34-day supply, including refills. In a few cases, pharmacies may dispense up to a 100-day supply of a prescription.

Pharmaceutical Care Services. Pharmaceutical care services are services pharmacists provide that are beyond the standard activity of dispensing and counseling for a prescription drug. The purpose of these services is to maximize the effectiveness of medications for the patient through intervention by the pharmacist. To receive payment for pharmaceutical care services, a pharmacist must meet all basic requirements of federal and state laws for dispensing a drug, plus complete specified activities that result in a positive outcome for both the program and the recipient. Positive outcomes include increased patient compliance or preventing potential adverse drug reactions.

SeniorCare pays pharmacists that provide pharmaceutical care services to SeniorCare recipients for these services only while a SeniorCare recipient is responsible for copayments. For recipients that are meeting the deductible or spenddown requirements, the pharmacist must ask the recipient's permission to bill for pharmaceutical care services, since these costs would be paid by the recipient and would count towards the recipient's deductible or spenddown requirement.

Manufacturer Rebates. Only drugs that are produced by manufacturers that have entered into rebate agreements with the state are covered under SeniorCare. These agreements are modeled on the rebate agreements specified in federal law for MA. Under the terms of the waiver, only drugs purchased during a recipient's copayment period are eligible for rebates from the drug's manufacturer. Manufacturers do not make rebate payments for drugs SeniorCare recipients purchase during their spenddown and deductible periods.

Under the terms of the waiver, drugs purchased at the copayment level by SeniorCare recipients in the waiver are automatically eligible for the same rebates pharmaceutical manufacturers pay under MA. The state has separate rebate agreements with manufacturers that cover drugs purchased by SeniorCare recipients that are not in the waiver. The amount of the rebate paid by a manufacturer that has signed a separate SeniorCare agreement is the same amount as the MA rebate.

Most pharmaceutical manufacturers that participate in the MA rebate program have signed a separate SeniorCare rebate agreement. It is estimated that payments for drugs produced by manufacturers that have signed the SeniorCare rebate agreement represent over 98% of costs for drugs covered for the waiver recipients, based on an analysis of claims paid since the inception of the program. Drugs produced by manufacturers that did not sign a separate SeniorCare rebate agreement are not covered for those recipients not included in the waiver.

Revenue received from pharmaceutical manufacturers is deposited in a program revenue appropriation and is budgeted to offset GPR and federal MA funds proportionately. In 2005-06, DHFS received approximately $50.6 million in revenue from rebates paid by pharmaceutical manufacturers for drugs purchased under the program.

Funding. SeniorCare benefits are funded with GPR, federal MA matching funds and program revenue from rebates paid by pharmaceutical manufacturers whose drugs are covered under the program. Rebates paid by pharmaceutical manufacturers for recipients with income up to 200% of

the FPL offset both GPR and federal revenue proportionately.

In addition to funding budgeted directly for SeniorCare, state costs for drugs purchased under SeniorCare are partially offset by cost-sharing by recipients, reimbursements to pharmacies that are discounted from pharmacies' retail prices, and payments from third parties that are also liable for prescription drug costs for SeniorCare recipients, including private health insurance policies that cover prescription drugs.

GPR funding for program benefits is budgeted in a sum certain appropriation. Under current law, if DHFS completely expends GPR funding budgeted for the program, it must continue to accept applications and determine eligibility for program participation and to notify applicants that program benefits are conditioned on the availability of funding. For any time period in which funding for the program is completely expended: (a) DHFS is not required to pay pharmacies for any drugs purchased by recipients; (b) pharmacies are not prohibited from charging SeniorCare recipients more than the SeniorCare payment rate; and (c) manufacturers, whose drugs are covered under the program, are not required to pay rebates for drugs purchased by recipients.

In March, 2002, DHFS submitted an application to federal Department of Health and Human Services (DHHS) seeking approval to waive certain provisions of federal MA law so that SeniorCare could operate as a demonstration project under Section 1115 of the Social Security Act. On July 1, 2002, DHFS received the necessary waiver approvals to operate a portion of SeniorCare as a five-year demonstration project. Under current federal law, the waiver can be renewed at the end of the five years.

Under the terms of the waiver, DHFS receives federal MA matching funds to support the costs of benefits for SeniorCare recipients with household income at or below 200% of the FPL. Costs for SeniorCare recipients with income above 200% of the FPL are not part of the demonstration project.

All federal MA laws apply to the SeniorCare demonstration project, unless specifically waived by the DHHS Secretary. Approval of the waiver was subject to the state's acceptance of certain terms and conditions. The terms and conditions include various requirements for reporting to DHHS on the project, terms for ending the demonstration project, and various other requirements. Two of the terms and conditions particularly affect SeniorCare and MA funding.

First, the terms and conditions require that the state can only collect rebate revenue from pharmaceutical manufacturers for drug purchases for which a SeniorCare payment has been made. Therefore, rebate revenue is not payable for drugs purchased during recipients' spenddown or deductible periods.

Second, the terms and conditions require that the cost of operating the demonstration project will not exceed 100% of the cost to provide MA services to the elderly without the waiver, over the five years for which the project is approved. This is known as a budget neutrality requirement and is typically required for Section 1115 waiver demonstration projects. To ensure the project is budget neutral, as a condition of the waiver, DHFS has agreed to limit the total amount of expenditures for the SeniorCare waiver population and the MA elderly population. Under this cap, total MA expenditures for the elderly population, including those in the SeniorCare demonstration project, is limited to approximately $8.4 billion over the five years during which the demonstration project is in effect.

DHFS anticipates that the budget neutrality requirement will be met because individuals enrolled in SeniorCare will remain healthier and thereby delay or avoid enrollment in MA. If total expenditures for the elderly exceed the cap, federal matching funds for costs for the elderly would be limited.

Table 29 identifies benefits expenditures for SeniorCare, by source, in 2002-03 through 2005-06.

Table 29: SeniorCare Benefits Expenditures, by Source (Fiscal Years 2002-03 through 2005-06)

	2002-03	2003-04	2004-05	2005-06
GPR	$25,424,500	$38,211,000	$45,383,400	$44,364,400
FED	26,892,600	41,548,200	45,062,900	45,700,200
PR*	6,807,500	31,178,100	39,351,300	50,639,800
Total	$59,124,600	$110,937,300	$129,797,600	$140,704,400

*Manufacturer rebates.

Administration. DHFS contracts with Electronic Data Systems (EDS), the state's MA fiscal agent, to perform application and claims processing functions, customer service and other administrative tasks. Because SeniorCare operates under an MA waiver, public workers employed by DHFS must determine eligibility for SeniorCare. Private workers employed by EDS support the eligibility determination process by scanning applications, following up with applicants to address discrepancies on applications or invalid applications, and performing other customer service functions.

DHFS uses the client assistance for reemployment and economic support (CARES) information system to support eligibility determination functions. This is the same system used to determine eligibility for MA, FoodShare, Wisconsin Works and several other support programs administered by DHFS and the Department of Workforce Development. Claims processing functions are handled by the Medicaid management information system (MMIS), which is the same system that processes MA claims.

SeniorCare administrative costs are funded from a combination of program revenue available from the $30 enrollment fee, GPR and federal MA matching funds. In 2005-06, DHFS received approximately $3.3 million in enrollment fee revenue. In addition, $3.8 million was budgeted in 2005-06 to fund SeniorCare administrative costs, including costs of DHFS staff, CARES and MMIS, costs to operate the central application processing operation at EDS, outreach activities, and customer service functions.

SeniorCare and the Medicare Drug Benefit. Beginning January 1, 2006, Medicare beneficiaries may obtain coverage for outpatient prescription drugs under a Medicare benefit authorized in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108 – 173). This benefit is commonly referred to as "Medicare Part D." The legislation significantly affected how states fund drug coverage for individuals enrolled in both MA and Medicare. However, the act did not directly address the issue of drug coverage for individuals participating in MA waiver programs, such as the SeniorCare waiver.

Beginning on January 1, 2006, MA recipients eligible for full MA benefits that are also eligible for Medicare ("full benefit dual eligibles") began receiving prescription drug benefits under Medicare Part D. Federal MA matching funds are no longer provided to support prescription drug coverage to these individuals, except that federal MA matching funds continue to support MA coverage of drugs that are excluded from coverage under the Medicare benefit, such as over-the-counter drugs and sedative drugs.

However, SeniorCare recipients participating in the waiver are not full benefit dual eligibles, since they only receive drug coverage under the waiver, not all MA services. The act did not address the issue of whether federal MA matching funds would be available for drug coverage for these individuals once the Medicare drug benefit became available.

The act indicated that state pharmacy assistance programs, which are programs entirely funded with state funds, can provide wraparound

coverage for the Medicare benefit, meaning that the state can cover those drugs not covered under the Medicare benefit, and/or contribute towards an individual's cost-sharing requirements under the Medicare benefit.

Because the act allowed states to administer their own pharmacy assistance programs to provide wraparound coverage, but did not address the issue of programs that receive federal funding, it was unknown whether the SeniorCare program would continue to receive federal funding after the January 1, 2006, effective date of the Medicare Part D benefit. The state received notice from CMS that it would allow the SeniorCare waiver to continue to operate with no changes until June, 2007, when the waiver expires. However, DHFS and CMS will need to negotiate a new waiver in order to continue the current SeniorCare program after that date.

CHAPTER 9

MEDICARE PART D

Introduction

Beginning January 1, 2006, Medicare beneficiaries may obtain outpatient prescription drug coverage under a Medicare benefit authorized in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108 – 173). This benefit, commonly referred to as "Medicare Part D," is provided by private entities, both standalone prescription drug plans (PDPs) and comprehensive managed care plans ("Medicare Advantage prescription drug plans," or (MA-PD plans). These private entities assume part of the financial risk associated with offering the new Part D benefit.

Eligibility. Medicare provides health care coverage for nearly all individuals over the age of 65, regardless of income, some people under age 65 with disabilities, and people with end-stage renal disease. Anyone who is entitled to Medicare Part A (hospital insurance) or enrolled in Medicare Part B (supplementary medical insurance) may enroll in Medicare Part D. The beneficiary must live in the service area of the PDP or MA-PD plan to enroll. Income and asset tests determine the level of coverage the individual receives. An individual's countable assets include only his or her liquid assets and real estate holdings, other than his or her home or residential farm.

Enrollment. The Medicare drug benefit is voluntary. The program has an "opt-in" rule, which means that, with limited exceptions, beneficiaries need to apply for the benefit by filling out an enrollment form for an approved plan (either a PDP or MA-PD plan). Initial open enrollment for Medicare Part D began November 15, 2005, and ended on May 15, 2006. If an individual enrolled by December 31, 2005, his or her coverage began with the start of the program on January 1, 2006. Enrollment during the rest of the open enrollment period was effective the first day of the month following enrollment. After a beneficiary chooses a PDP or MA-PD, he or she remains enrolled for a twelve-month period.

Beginning in calendar year 2006, the annual open enrollment period is November 15 through December 31, with enrollment effective January 1 of the following year. During each open enrollment period, the beneficiary may choose to change plans for the following year. Beneficiaries who chose not to sign up at the first opportunity may pay more for their coverage if they waited to enter the program after the open enrollment period that ended May 15, 2006. This penalty may apply to individuals who are eligible for Medicare Part D but have no "creditable coverage" for a continuous period of 63 days or more after their initial enrollment period. (Creditable coverage is coverage determined to be actuarially equal to, or better than, standard Part D coverage, and includes many retiree drug plans.) CMS recently clarified that the penalty will be a premium increase of one percent of the base beneficiary premium for 2007 for each full calendar month that the beneficiary was eligible for Part D but not enrolled in a plan.

Most individuals who are enrolled in both Medicare and MA are not penalized for their failure to select a plan, as described above, since they either receive assistance in enrolling in a Medicare Part D plan, or, if they have not selected a plan by a specified date, are automatically enrolled in a plan.

Cost-Sharing. A Medicare Part D beneficiary's contribution to the cost of their drugs depends on his or her income. Annually, CMS is required to

adjust copayment, coinsurance, deductibles, and coverage limits to reflect changes in the consumer price index. The 2007 cost sharing requirements, by eligibility group, are described below.

Dual Eligibles. Medicare beneficiaries who also have full MA benefits are referred to as "dual eligibles." These individuals are automatically enrolled in Medicare Part D, and state MA programs no longer cover their prescription drug benefits. These individuals receive a "low income subsidy," and pay:

- No premiums;
- No deductibles;
- Copayments as follows:

a. Nursing home residents -- no copayments.

b. Individuals with income less than 100% of the FPL -- $1 per generic drug or preferred multi-source drug and $3.10 per brand-name drug.

c. Individuals with income between 100% and 135% of the FPL -- $2.15 per generic drug or $5.35 per brand-name drug. However, these individuals are not required to pay any copayments once their out-of-pocket prescription drug expenses exceed $3,850.

Low-Income Recipients (Non-MA) with Income Below 135% of the FPL. Individuals who are not dual eligibles that have income below 135% of the FPL and that meet an asset test ($6,000 for singles and $9,000 for couples) pay:

- No premium;
- No deductible; and
- Copayments of $2.15 per generic drug and $5.35 per brand-name drug. However, these individuals are not required to pay any copayments once their out-of-pocket expenses for prescription drugs exceed $3,850.

Low-Income Recipients (Non-MA) with Income Between 135% and 150% of the FPL. Individuals with income between 135% and 150% of the FPL and that meet an asset test ($10,000 for singles and $20,000 for couples) receive a "partial low income subsidy" and pay:

- Premiums based on a sliding scale -- the full premium is paid for individuals with income at 150% of the FPL, which is phased down to no premium subsidy for individuals with income at 135% of the FPL;
- A $53 deductible;
- 15% coinsurance up to $5,451 in total drug spending ($3,850 in out-of-pocket drug spending); and
- Copayments of $2.15 per generic and $5.35 per brand-name drug after the individual spends $3,850 out -of -pocket on their prescription drugs.

Standard Benefit (Enrollees with Income that Exceeds 150% of the FPL). Individuals with income above 150% of the FPL, regardless of their assets, are eligible for the standard Part D benefit. These individuals pay:

- An estimated premium of $27.35 per month ($328.20 per year);
- A $265 deductible;
- 25% coinsurance after the deductible is met (25% of total drug costs between $250 and $2,400); and
- 100% coinsurance for drug costs between $2,400 and $5,451. This $3,051 gap in coverage is commonly referred to as the "donut hole."
- After the $3,850 out-of-pocket limit is reached (the $265 deductible amount, $534 in coinsurance for drug costs between $265 and $2,400

and $3,051 in coinsurance for drug costs between $2,400 and $5,451), recipients pay $2.15 for generic drugs and $5.35 for brand-name drugs, or a coinsurance of 5%, whichever is greater.

Pharmacy Participation and Drug Coverage. Each plan employs a network of pharmacies from which plan participants may purchase drugs. Each plan has a formulary, which must include at least two or more drugs within each therapeutic category and class of covered Part D drugs. In addition to this required coverage, PDPs and MA-PD plans may separately offer enhanced coverage for an additional premium. Medicare drug plans may change formularies at any time, but they are required to notify participants of formulary changes in a timely manner.

Funding. The Part D benefit is supported primarily through contributions from the federal general fund and premium payments from enrollees. However, since premiums are intended to represent approximately 26% of the cost of standard coverage, the primary funding source for the benefit is the federal general fund.

State MA programs also contribute to the cost of providing the Part D benefit, in recognition that state MA programs no longer reimburse pharmacies for drugs purchased by dual eligibles. The amount of this payment is based on a declining percentage of the 2003 calendar year non-federal share of prescription drug costs under state MA programs paid for dual eligibles, inflated to the current year. The percentage began at 90% in calendar 2006 and decreases to 75% over the next 10 years. This payment is often referred to as the "clawback" payment. DHFS estimates that the MA program will pay CMS approximately $145.8 million GPR as a "clawback" payment in 2006-07.

As of June, 2006, there were approximately 182,100 Wisconsin residents enrolled in PDPs, 67,300 Wisconsin residents enrolled in Medicare Advantage plans that provide Part D benefits, and 112,600 Wisconsin residents who were dual eligibles.

In 2007, there are 54 PDPs and 15 Medicare Advantage plans that provide Medicare Part D benefits to Wisconsin residents. The monthly premiums for the PDPs range from $14.80 to $80.30.

CHAPTER 10

TRENDS IN PROGRAM FUNDING AND PARTICIPATION

Table 30 provides annual information on MA, BadgerCare, SeniorCare, and Family Care benefits expenditures, by source, for 1999-00 through 2005-06. The table summarizes information contained in the Department of Administration's annual fiscal reports.

Table 31 provides more detailed cost and caseload information for each of several groups of MA recipients, including: (a) elderly recipients; (b) disabled and blind recipients; (c) "family MA" recipients, which is a group that includes individuals in low-income families with dependent children, children in out-of-home care that are eligible for MA, and children for whom subsidized adoption payments are made; (d) MA recipients who are

Table 30: MA, BadgerCare, Family Care, and Senior Care Benefit Expenditures (Fiscal Years 1999-00 through 2005-06)

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
MA							
GPR*	$967,454,700	$978,742,100	$1,044,015,800	$989,853,600	$615,430,900	$1,512,168,000	$1,195,791,700
FED	1,831,257,300	1,886,906,700	2,039,698,000	2,294,867,500**	2,498,741,500	2,452,099,600	2,424,570,900
PR	15,258,000	15,166,400	18,338,000	16,914,000	19,458,800	20,376,500	19,911,800
SEG	0	639,574,100	204,918,300	361,522,700	829,952,700	97,654,700	359,935,500
Subtotal	$2,813,970,000	$3,520,389,300	$3,306,970,100	$3,663,157,800	$3,963,583,900	$4,082,298,800	$4,000,209,900
BadgerCare							
GPR	$21,920,300	$46,164,600	$43,774,600	$60,814,900	$64,767,300	$58,877,600	$62,297,500
FED	35,697,600	81,449,400	92,371,700	124,538,400	134,732,100	122,702,100	125,176,900
PR	758,200	1,410,600	4,447,700	4,113,500	6,145,300	6,986,400	6,943,000
Subtotal	$58,376,100	$129,024,600	$140,594,000	$189,466,800	$205,644,700	$188,566,100	$194,417,400
SeniorCare							
GPR	$0	$0	$0	$25,424,500	$38,211,000	$45,383,400	$44,364,400
FED	0	0	0	0**	41,548,200	45,062,900	45,700,200
PR	0	0	0	6,807,500	31,178,100	39,351,300	50,639,800
Subtotal	$0	$0	$0	$32,232,000	$110,937,300	$129,797,600	$140,704,400
Family Care							
GPR ***	$2,874,500	$14,255,100	$25,783,300	$48,026,000	$72,647,500	$70,522,600	$96,949,300
FED	4,099,100	32,470,900	57,937,600	87,895,200	120,269,300	98,387,900	133,142,300
Subtotal	$6,973,600	$46,726,000	$83,720,900	$135,921,200	$192,916,800	$168,910,500	$230,091,600
Total Expenditures							
GPR	$992,249,500	$1,039,161,800	$1,113,573,700	$1,124,119,000	$791,056,700	$1,686,951,600	$1,399,402,900
FED	1,871,054,000	2,000,827,000	2,190,007,300	2,507,301,100	2,795,291,100	2,718,252,500	2,728,590,300
PR	16,016,200	16,577,000	22,785,700	27,835,000	56,782,200	66,714,200	77,494,600
SEG	0	639,574,100	204,918,300	361,522,700	829,952,700	97,654,700	359,935,500
Total	$2,879,319,700	$3,696,139,900	$3,531,285,000	$4,020,777,800	$4,473,082,700	$4,569,573,000	$4,565,423,300

*Excludes encumbrances incurred under COP-W and MA supplemental payments to counties under the Wisconsin Medicaid cost reporting program (WMCR).

**In 2002-03, $26,892,600 FED budgeted in the MA benefits appropriation supported SeniorCare benefits.

*** Excludes expenditures from an appropriation to the Division of Disability and Elder Services that previously supported a variety of Family Care-related costs, including some costs of providing services to MA-eligible Family Care participants.

enrolled in community-based waiver programs, the MA purchase plan and Family Care; (e) women enrolled in the family planning waiver program; and (f) other MA recipients that receive limited MA benefits, including certain low-income Medicare recipients.

The table identifies, for each group and year, the total MA benefits expenditures attributed to the group, these expenditures as a percent of the total MA expenditures (for all groups), the average monthly number of recipients who were in each eligibility category, the caseload average as a percent of the total average monthly number of MA recipients, and the average benefits costs for each group of recipients. The expenditure amounts listed in this table differ from those in Table 30 because Table 30 identifies total MA, BadgerCare, and SeniorCare expenditures as recorded in the state's accounting system (WISMART), whereas the information in Table 31 includes MA and Family Care benefits expenditures, but excludes expenditures not attributable to a specific claim. For example, services provided under the home- and community-based waiver programs account for more than half of the difference between the 2005-06 MA and Family Care total ($4.23 billion) in Table 30 and the MA and Family Care total shown in Table 31 ($3.71 billion).

The information provided in Table 31 for fiscal year 2005-06 is shown graphically in Figures 2 and 3. Although MA recipients in low-income families, women enrolled in the family planning waiver program and other MA recipients with limited benefits represented approximately 74.8% of all MA recipients in 2005-06, they accounted for only 29.3% of all MA expenditures. In contrast, elderly MA recipients, who represented 5.3% of all recipients, accounted for 23.8% of all expenditures. Disabled MA recipients represented only 15.4% of the total number of recipients, but accounted for 33.2% of all expenditures in 2005-2006.

Expenditures by Type of Service

Figure 4 provides information on MA funding, by major service category, for the 2005-06 year. The figure shows that spending for institutional services, including services provided by nursing homes and the state centers for the developmentally disabled, accounted for 23.1% of total spending in 2005-06. In contrast, community-based long-term care services accounted for 17.4% of total spending and managed care payments, including payments made under long-term care programs such as Family Care CMOs, PACE, WPP, and I-Care, accounted for 23.5% of total expenditures. Acute care spending represented 31.5% of gross expenditures.

Figure 5 shows MA fee-for-service spending in 2005-06 for the five largest acute care services categories. Inpatient hospital and drug expenditures represented 22.7 and 32.1%, respectively, of fee-for-service acute care expenditures.

Table 33 provides a summary of 2005-06 MA and BadgerCare benefits expenditures, by service category. Table 34 shows how the composition of expenditures has changed from 2001-02 to 2005-06. The service categories identified in Table 33 have been collapsed in Table 34 to highlight historical trends in major service areas. Tables 33 and 34 do not represent a complete picture of MA expenditures, since certain expenditures, such as supplemental payments to nursing homes, and various offsets to program expenditures, are not included. Unlike Table 32, Tables 33 and 34 include expenditures for services provided under the home- and community-based waiver programs.

Table 34 indicates several trends over the five-year period. First, total payments for institutional, long-term care services have decreased slowly, at an average annual rate of 1.3%, while payments for community-based long-term care services have increased at a much higher rate, an average annual rate of 10.7%. Second, total MA payments to managed care providers has increased by more than twice the rate of increase for total MA payments (14.7% and 5.6% , respectively).

Table 31: MA and Family Care Expenditures and Recipients, by Eligibility Group (Fiscal Years 1999-00 through 2005-06)

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Elderly							
Total Expenditures	$850,265,700	$864,315,000	$898,158,700	$913,216,200	$929,262,200	$934,625,800	$882,730,000
Percent of Total	35.4%	33.5%	30.9%	28.4%	26.9%	26.1%	23.8%
Average No. of Recipients	43,500	42,200	40,600	39,200	37,600	36,200	34,600
Percent of Total	10.8%	10.0%	8.8%	7.6%	6.5%	5.8%	5.3%
Average Cost / Recipient	$19,546	$20,481	$22,122	$23,296	$24,714	$25,818	$25,512
Disabled/Blind							
Total Expenditures	$979,387,300	$1,020,403,900	$1,089,553,000	$1,166,751,300	$1,230,171,200	$1,279,512,500	$1,230,736,400
Percent of Total	40.8%	39.5%	37.5%	36.3%	35.6%	35.7%	33.2%
Average No. of Recipients	97,900	96,200	95,400	96,100	97,900	99,600	100,100
Percent of Total	24.3%	22.8%	20.6%	18.7%	16.9%	15.8%	15.4%
Average Cost / Recipient	$10,004	$10,607	$11,421	$12,141	$12,566	$12,847	$12,295
Family MA							
Total Expenditures	$437,150,200	$495,840,800	$597,976,800	$696,925,600	$774,794,000	$813,714,200	$967,554,400
Percent of Total	18.2%	19.2%	20.6%	21.7%	22.4%	22.7%	26.1%
Average No. of Recipients	238,100	257,000	296,400	336,600	367,900	401,600	414,800
Percent of Total	59.1%	61.0%	63.9%	65.4%	63.6%	63.8%	63.6%
Average Cost / Recipient	$1,836	$1,929	$2,017	$2,070	$2,106	$2,026	$2,333
Community-Based Waiver, MAPP, and Family Care Enrollees							
Total Expenditures	$91,319,600	$152,057,500	$264,810,700	$364,333,100	$432,883,500	$448,736,900	$510,859,900
Percent of Total	3.8%	5.9%	9.1%	11.3%	12.5%	12.5%	13.8%
Average No. of Recipients	7,800	10,100	15,000	20,200	23,800	26,800	29,500
Percent of Total	1.9%	2.4%	3.2%	3.9%	4.1%	4.3%	4.5%
Average Cost / Recipient	$11,708	$15,055	$17,654	$18,036	$18,188	$16,744	$17,317
Family Planning Waiver							
Total Expenditures				$1,777,300	$8,650,600	$12,301,600	$16,566,200
Percent of Total				0.1%	0.3%	0.3%	0.4%
Average No. of Recipients				7,100	36,400	49,400	56,000
Percent of Total				1.4%	6.3%	7.9%	8.6%
Average Cost / Recipient				$250	$238	$249	$296
Other Eligible Groups--Limited Benefits							
Total Expenditures	$41,485,000	$48,108,300	$55,008,700	$68,674,300	$84,446,100	$93,585,200	$103,259,000
Percent of Total	1.7%	1.9%	1.9%	2.1%	2.4%	2.6%	2.8%
Average No. of Recipients	15,600	16,000	16,200	15,600	15,200	15,600	16,700
Percent of Total	3.9%	3.8%	3.5%	3.0%	2.6%	2.5%	2.6%
Average Cost / Recipient	$2,659	$3,007	$3,396	$4,402	$5,556	$5,999	$6,183
Total Expenditures	$2,399,607,800	$2,580,725,500	$2,905,507,900	$3,211,677,800	$3,460,207,600	$3,582,476,200	$3,711,705,900
Total Average No. of Recipients	402,900	421,500	463,600	514,800	578,800	629,200	651,700

NOTE: Data includes only expenditures made through the EDS-Federal, automated MA payment system. Certain MA expenditures that are not attributable to a specific claim or that relate to a waiver program, such as supplemental payments made to nursing homes and services provided under the home and community-based waiver programs, are not included in these totals.

Source: DHFS Medicaid Data Warehouse

FIGURE 2

Average Monthly MA and Family Care Recipients by Major Eligibility Group
Fiscal Year 2005-06

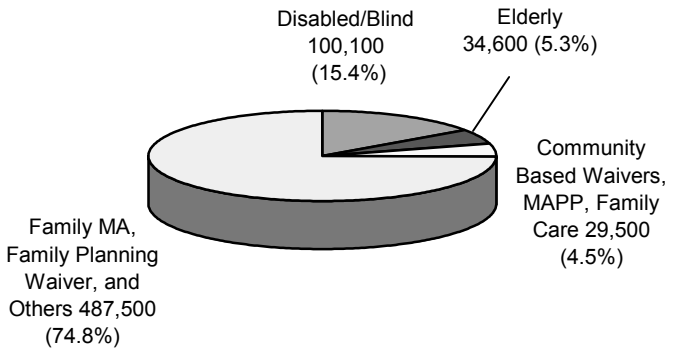


FIGURE 3

Total MA and Family Care Expenditures by Major Eligibility Group
Fiscal Year 2005-06
($ in Millions)

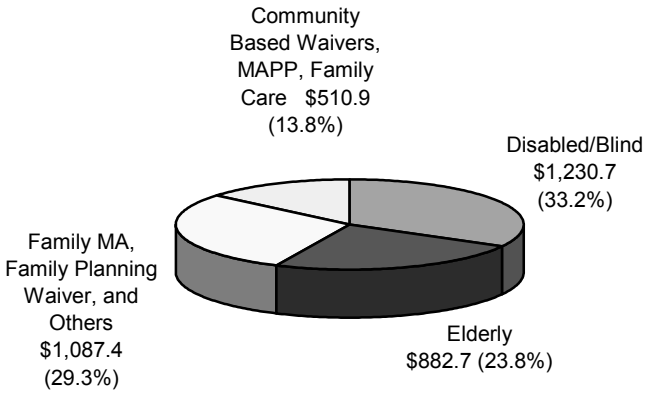
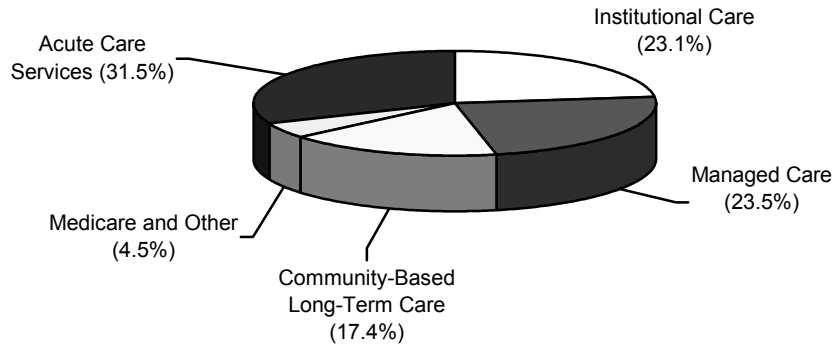


FIGURE 4

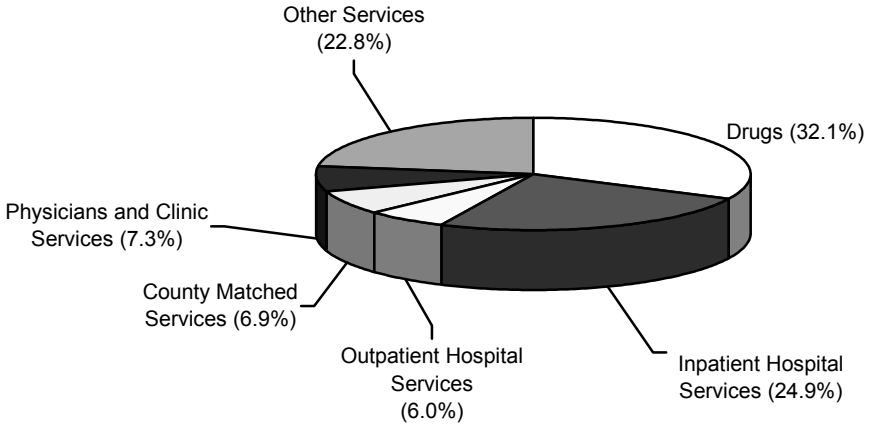
Selected Services as a Percent of Gross MA, BadgerCare, SeniorCare, and Family Care Benefit Expenditures
Fiscal Year 2005-06



Source: DHFS 703 Report

FIGURE 5

Fee-for-Service Expenditures for Acute Care Services
Fiscal Year 2005-06



Source: DHFS 703 Report

Table 32: MA, BadgerCare, SeniorCare and Family Care Benefit Expenditures, by Service Category (Fiscal Year 2005-06)

Long-Term Care Services		
Institutional Services		
Nursing Homes - SNF	$845,841,400	18.6%
Nursing Homes - ICF	32,742,100	0.7
Nursing Homes - ICFs-MR	61,555,500	1.4
State Centers	111,497,900	2.5
Subtotal	$1,051,636,900	23.1%
Community-Based Services		
CIP IA	$87,050,100	1.9%
CIP IB	230,011,200	5.1
COP-Waiver*	96,029,600	2.1
CIP II	57,461,500	1.3
CSLA	0	0.0
Brain Injury	17,908,800	0.4
Autism / Children's Long-Term Care	38,223,400	0.8
Personal Care	176,128,800	3.9
Respiratory Care Services	21,631,100	0.5
Home Health	19,009,100	0.4
Private Duty Nursing	22,168,800	0.5
Hospice	23,531,900	0.5
Subtotal	$789,154,300	17.4%
Total Long-Term Care Services	$1,840,791,200	40.5%
Acute Care Services		
Institutional Fee-for-Service Providers		
Inpatient Hospital	$357,014,200	7.9%
Outpatient Hospital	77,515,600	1.7
Outpatient Hospital-Psychiatric	8,311,800	0.2
Subtotal	$442,841,600	9.7%
Non-Institutional Fee-for-Service Providers		
Drugs	$459,607,300	10.1%
Physicians and Clinics	104,931,900	2.3
County Matched Services	98,229,000	2.2
DME / DMS	38,231,700	0.8
Outpatient Mental Health	29,514,500	0.6
FQHCs	55,000,000	1.2
Laboratory and X-Ray	27,545,200	0.6
School Based Services	23,849,400	0.5
Other Care	9,715,400	0.2
Dental	23,987,400	0.5
SMV Transportation	19,408,000	0.4
Healthcheck	38,834,500	0.9
Therapies	16,292,400	0.4
Ambulance	13,464,000	0.3
Family Planning	10,070,100	0.2
Rural Health Clinics	6,108,500	0.1
Vision	4,229,900	0.1
Chiropractic	4,376,000	0.1
Prenatal Care Coordination	5,295,800	0.1
Subtotal	$988,691,000	21.7%
Total Acute Care Services	$1,431,532,600	31.5%
Managed Care		
Capitation Payments**	$1,059,517,900	23.3%
Supplemental Payments	8,522,900	0.2
Subtotal	$1,068,040,800	23.5%
Other Provider Payments		
Medicare Buy-in Premiums	$108,004,400	2.4%
Medicare Crossovers - Part B	51,467,200	1.1
Medicare Crossovers - Part A	46,431,900	1.0
Subtotal	$205,903,500	4.5%
Total Provider Payments***	$4,546,268,100	100.0%

*Includes an estimate of the GPR expended outside of the MA benefits appropriations to support COP-W.

**Includes payments to HMOs for low-income families and payments to Family Care CMOs, PACE / WPP, and I-Care.

***Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs / CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disorders.

Source: DHFS 703 Report

Table 33: MA BadgerCare, Family Care, and SeniorCare Expenditures by Major Service Category (Fiscal Years 2001-02 through 2005-06)

Service Type	Expenditures					Percent Change Over Previous Year				Ave. Annual Percentage Change
	2001-02	2002-03	2003-04	2004-05	2005-06*	2002-03	2003-04	2004-05	2005-06	
Long-Term Care Services										
Institutional Services										
Nursing Homes	$980,578,234	$990,587,000	$972,247,700	$963,849,500	$940,139,000	1.02%	-1.85%	-0.86%	-2.46%	-1.0%
State Centers	126,885,782	123,875,900	143,044,200	117,714,800	111,497,900	-2.37	15.47	-17.71	-5.28	-2.5
Subtotal	$1,107,464,016	$1,114,462,900	1,115,291,900	$1,081,564,300	$1,051,636,900	0.63%	0.07%	-3.02%	-2.77%	-1.3%
Community-Based Services										
MA Waivers*	$356,107,385	$409,893,911	$443,314,100	$493,729,887	$526,684,600	15.10%	8.15%	11.37%	6.67%	10.3%
Personal Care	104,476,414	113,096,200	123,322,000	176,594,200	176,128,800	8.25	9.04	43.20	-0.26	15.1
Private Duty Nursing	15,203,712	17,622,900	17,688,300	19,534,300	22,168,800	15.91	0.37	10.44	13.49	10.1
Other Home Care	52,628,811	52,016,600	52,507,500	64,996,200	64,172,100	-1.16	0.94	23.78	-1.27	5.6
Subtotal	$528,416,322	$592,629,611	$636,831,900	$754,854,587	$789,154,300	12.15%	7.46%	18.53%	4.54%	10.7%
Total Long-Term Care Services	$1,635,880,338	$1,707,092,511	$1,752,123,800	$1,836,418,887	$1,840,791,200	4.35%	2.64%	4.81%	0.24%	3.0%
Acute Care Services										
Institutional Fee-for-Service										
Inpatient Hospital	$333,197,922	$332,029,100	$337,963,100	$388,597,400	$357,014,200	-0.35%	1.79%	14.98%	-8.13%	2.1%
Outpatient Hospital	69,602,446	75,647,100	91,584,400	103,666,900	85,827,400	8.68	21.07	13.19	-17.21	6.4
Subtotal	$402,800,368	$407,676,200	$429,547,500	$492,264,300	$442,841,600	1.21%	5.36%	14.60%	-10.04%	2.8%
Non-Institutional Fee-for-Service										
Physicians and Clinics	$78,703,489	$85,194,600	$116,851,100	$133,234,300	$104,931,900	8.25%	37.16%	14.02%	-21.24%	9.5%
OP Mental Health	47,813,309	57,185,400	36,829,300	33,149,700	29,514,500	19.60	-35.60	-9.99	-10.97	-9.2
Drugs	432,476,039	494,714,400	700,548,000	772,045,400	459,607,300	14.39	41.61	10.21	-40.47	6.4
DME/DMS	37,766,734	37,233,600	36,379,200	38,614,100	38,231,700	-1.41	-2.29	6.14	-0.99	0.4
SMV Transport and Ambulance	26,280,228	25,942,600	36,464,500	39,797,700	32,872,000	-1.28	40.56	9.14	-17.40	7.8
Dental	23,717,260	21,032,100	27,921,200	30,049,200	23,987,400	-11.32	32.76	7.62	-20.17	2.2
Other Care	183,639,866	193,066,300	244,227,800	345,634,400	299,546,200	5.13	26.50	41.52	-13.33	15.0
Subtotal	$830,396,925	$914,369,000	$1,199,221,100	$1,392,524,800	$988,691,000	10.11%	31.15%	16.12%	-29.00%	7.1%
Total Acute Care Services	$1,233,197,293	$1,322,045,200	$1,628,768,600	$1,884,789,100	$1,431,532,600	7.20%	23.20%	15.72%	-24.05%	5.5%
Managed Care Payments**	$681,842,381	$657,888,600	$1,013,586,400	$873,694,600	$1,068,040,800	-3.51%	54.07%	-13.80%	22.24%	14.7%
Medicare Premiums and Payments	$149,951,400	$162,216,700	$164,455,300	$182,197,300	$205,903,500	8.18%	1.38%	10.79%	13.01%	8.3%
Total Provider Payments***	$3,700,871,412	$3,849,243,011	$4,558,934,100	$4,777,099,887	$4,546,268,100	4.01%	18.44%	4.79%	-4.83%	5.6%

*Includes an estimate of the GPR expended outside of the MA benefits appropriations to support COP-W and excludes encumbrances

**Includes payments to HMOs for low-income families and payments to Family Care CMOs, PACE/WPP, and I-Care

***Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs/CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disturbances.

APPENDIX I

Allocation of Supplemental MA Payments to County- and Municipally-Operated Nursing Homes

County	2003-04	2004-05	2005-06
Barron	$0	$35,639	$225,257
Brown	1,159,618	1,584,938	962,382
Calumet	338,918	496,508	456,671
Clark	1,602,784	1,787,467	1,120,334
Columbia	944,514	760,766	566,934
Dane	915,877	1,108,725	700,298
Dodge	2,267,534	2,734,072	1,563,848
Dunn	1,418,132	1,276,169	895,958
Fond du Lac	1,458,460	1,723,733	1,139,941
Grant	533,468	1,281,742	827,053
Green	974,966	984,850	699,604
Iowa	590,888	370,286	290,820
Jackson	997,124	884,744	543,457
Jefferson	1,015,589	1,282,639	723,478
Kenosha	1,137,460	1,159,677	651,378
Kewaunee	84,873	67,173	261,032
La Crosse	2,768,550	3,006,042	2,117,188
Lafayette	687,182	619,180	416,067
Lincoln	1,191,191	877,628	1,032,199
Manitowoc	1,107,916	1,422,574	890,083
Marathon	2,363,553	2,675,897	1,824,701
Milwaukee	1,218,707	1,219,772	1,144,149
Monroe	878,946	821,846	538,753
Outagamie	1,506,765	1,980,000	1,259,592
Ozaukee	1,506,765	1,548,583	998,739
Pierce	89,529	162,035	154,381
Polk	842,016	854,788	549,689
Portage	844,949	836,565	492,949
Racine	1,551,082	1,885,074	1,210,116
Richland	667,515	713,451	488,345
Rock	1,429,499	1,941,618	1,145,300
Rusk	686,908	772,113	537,860
Sauk	982,352	1,033,120	677,396
Shawano	556,289	365,965	618,474
Sheboygan	3,896,457	4,066,825	2,461,374
St. Croix	706,752	746,024	552,553
Trempealeau	855,227	1,023,548	865,164
Vernon	613,127	620,841	600,448
Walworth	1,835,734	2,202,321	1,102,493
Washington	1,684,032	1,665,383	1,077,785
Waupaca	607,836	763,275	446,113
Winnebago	1,765,279	2,159,490	1,411,333
Wood	1,144,846	1,250,062	858,311
Subtotal	$49,429,209	$54,773,148	$37,100,000
Family Care Awards	670,791	0	0
Total payments	$50,100,000	$54,773,148	$37,100,000

APPENDIX II

Classes of Drugs Comprising Wisconsin's Preferred Drug List as of December, 2006

ACE Inhibitors
ACE Inhibitors/CCB Combinations
Acne Agents
Alzheimer's Agents
Analgesics, Narcotics

Androgenic Agents
Angiotensin Receptor Blockers
Anticoagulants, Injectables
Anticonvulsants
Antidepressants, Other

Antidepressants, SSRI
Antiemetics, Oral
Antifungals, Oral
Antifungals, Topical
Antihistamines, Nonsedating

Antimigraine, Triptans
Antiparkinson's Agents
Antipsychotics, Atypical
Antivirals, Influenza
Antivirals, Other

Agents for BPH
Beta Blockers
Bladder Relaxant Preparations
Bone Resorption Suppression
Bronchodilators, Anticholinergic

Bronchodilators, Beta Agonists
Calcium Channel Blocking Agents
Cephalosporin and Related Agents
Cytokine and CAM Antagonists
Erythropoiesis Stimulating Proteins

Fluoroquinolones
Glucocorticoids, Inhaled
Growth Hormone
Hepatitis C Agents
Hypoglycemics, Adjunct Therapy

Hypoglycemics, Insulins
Hypoglycemics, Meglitinides
Hypoglycemics, Thiazolidinediones
Intranasal Rhinitis Agents
Leukotriene Modifiers

Lipotropics, Other
Lipotropics, Statins
Macrolides/Ketolides
Multiple Sclerosis Agents
NSAIDs

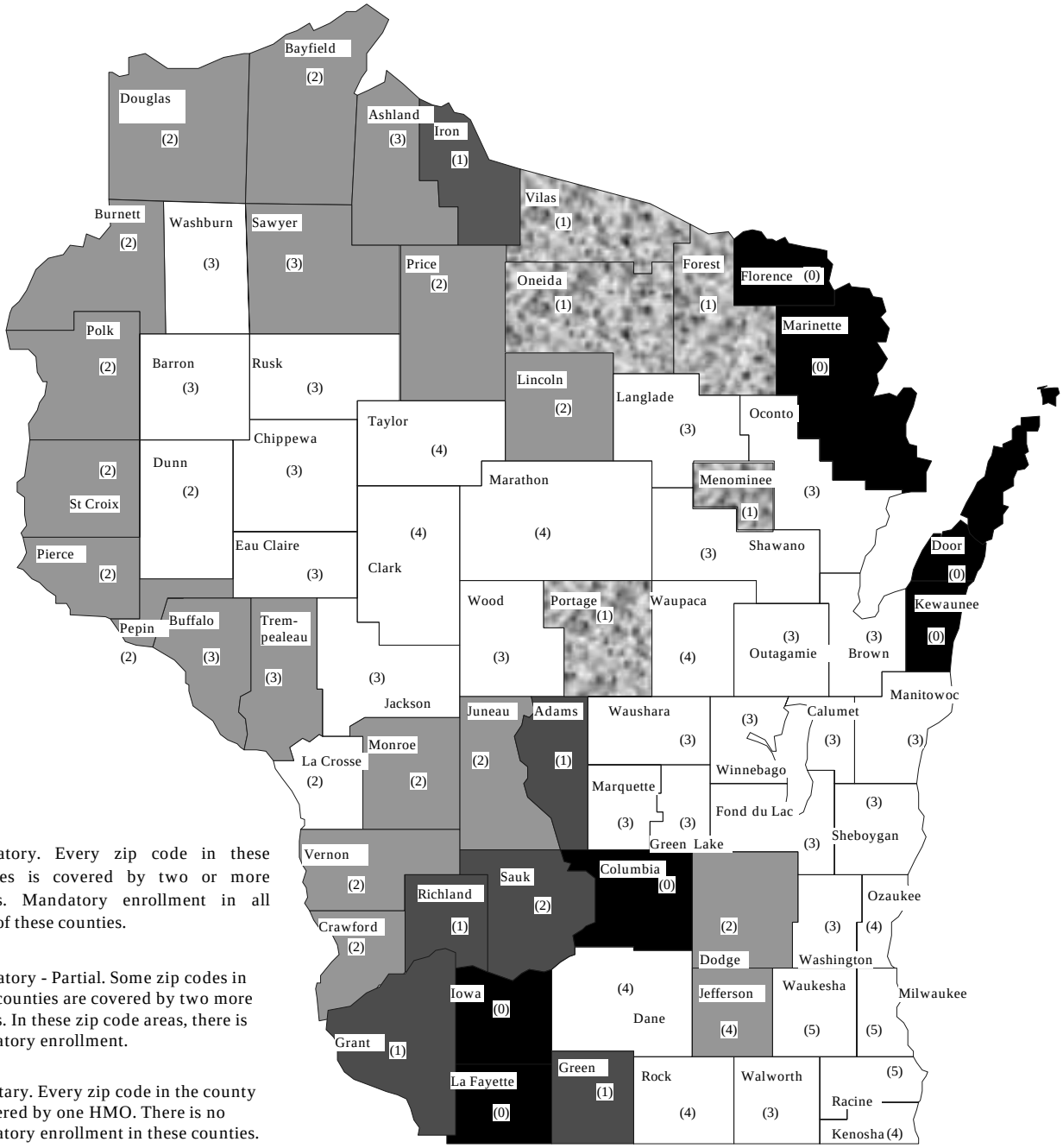
Ophthalmics, Allergic Conjunctivitis
Ophthalmics, Antibiotics
Ophthalmics, Glaucoma Agents
Otics, Antibiotics
Phosphate Binders

Platelet Aggregation Inhibitors
Proton Pump Inhibitors
Sedative Hypnotics
Stimulants and Related Agents
Topical Immunomodulators

Ulcerative Colitis

APPENDIX III

HMO Enrollment Status for MA and BadgerCare Recipients
As of October, 2006



Mandatory. Every zip code in these counties is covered by two or more HMOs. Mandatory enrollment in all areas of these counties.

Mandatory - Partial. Some zip codes in these counties are covered by two more HMOs. In these zip code areas, there is mandatory enrollment.

Voluntary. Every zip code in the county is covered by one HMO. There is no mandatory enrollment in these counties.

Voluntary - Fee-For-Service. Some zip codes in these counties are covered by one HMO, the rest are not covered by an HMO. Consequently, there is no mandatory enrollment in these counties.

Fee-For-Service. No HMOs participate in these counties.

APPENDIX IV

Medical Assistance Waiver Services*

CIP IA, CIP IB, BIW, CLTS, CIP II and COP Waivers

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Adaptive aids include devices, controls or appliances which enable individuals to increase their ability to perform activities of daily living independently.	Yes	Yes	Yes	Yes
Adult day care provides social or health-supportive services for part of a day in a group setting.	Yes	No	No	Yes
Adult family home is a residence in which care and maintenance above the level of room and board, but not including nursing care, are provided to no more than four residents by a person whose lives in the home.	Yes	Yes	No	Yes
Case management includes the planning and coordination of an individual's program plan, along with advocacy and defense services, outreach, and referral.	Yes	Yes	Yes	Yes
Children's foster care includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs (including personal care provision beyond those age activities expected for a child, skilled tasks, monitoring of complex medical needs, and comprehensive behavioral intervention plans).	Yes	Yes	Yes	No
Communication aids/interpreter services are devices or services to assist individuals with hearing, speech or vision.	Yes	Yes	Yes	Yes
Community-based residential facility is a residence for five or more unrelated adults that provides care, treatment or services above the level of room and board.	Yes	Yes	No	Yes
Consumer directed supports are services that provide support, care and assistance to an individual with a disability, prevent the person's institutionalization and allow the person to live an inclusive life. Consume-directed supports are designed to build, strengthen or maintain informal networks of community support for the person.	Yes	No	Yes	No
Consumer and family directed supports are designed to assist children and their families to build, strengthen, and maintain informal networks of community supports. Specific supports may include adaptive and communication aids, consumer education, counseling, daily living skills training, day services, foster care, home modification, respite care, supportive home care, and supported employment.	No	No	Yes	No
Consumer training and education help a person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.	Yes	No	Yes	No
Counseling and therapeutic services provide treatment oriented services for a personal, social, behavioral, mental or alcohol or drug abuse disorder.	Yes	Yes	Yes	Yes

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Daily living skills training include services intended to improve a client's or caretaker's ability to perform routine daily living tasks and utilize community resources.	Yes	Yes	Yes	Yes
Day services include activities to enhance social development.	Yes	Yes	Yes	Yes
Financial management services include the services of a fiscal intermediary for those receiving consumer-directed services to ensure that appropriate compensation is paid to providers of services, and provision of assistance managing personal funds for those unable to manage their money themselves.	Yes	Yes	Yes	Yes
Home modifications include changes to ensure accessibility and safety of the individual's home (such as ramps, lofts, door widening and other physical alterations).	Yes	Yes	Yes	Yes
Home delivered meals is the provision of meals to individuals at risk of institutional care due to inadequate nutrition. Individuals who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician. Home delivered meals cannot meet the full daily nutritional needs of an individual.	No	No	No	Yes
Housing counseling provides assistance in acquiring housing in the community, where ownership or rental of housing is separate from service provision.	Yes	No	No	No
Housing start up provides assistance in establishing housing arrangements in the community after relocation from an institution, including security deposits, furnishings, and household equipment.	Yes	No	No	No
Intensive in-home autism services are one-on-one behavioral modification therapy services for children **with** autism disorder, Asperger's disorder, or pervasive developmental disorder.	No	No	Yes	No
Nursing services are medically necessary skilled nursing services that cannot be provided safely and effectively without the skills of an advance practice nurse, a registered nurse or a licensed practical nurse under the supervision of a registered nurse. Nursing services may include, but are not limited to, periodic assessments of a participant's medical condition and monitoring when the evaluation requires a skilled nurse and the monitoring of a participant with a history of non-compliance with medical needs. Nursing services that are covered as an MA card service are not eligible under the waiver program.	No	No	No	Yes
Personal emergency response systems (PERS) are community-based electronic communications devices activated by the consumer in the event of a physical, emotional or environmental emergency.	Yes	Yes	Yes	Yes
Prevocational services include teaching and activities related to concepts to prepare an individual for paid or unpaid employment such as work directions and routines, **mobility** training, interpersonal skills development and transportation to and from work.	Yes	Yes	No	No

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Residential care complex is a residence for five or more adults that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, and individual bathroom, sleeping and living areas, and that provides not more than 28 hours per week of supportive, personal and nursing services.	No	No	No	Yes
Respite care services provide temporary relief to the primary caregiver.	Yes	Yes	Yes	Yes
Supported employment services include individualized assessments, job development and placement, on-the-job training, performance monitoring, and related support and training to enhance employment.	Yes	Yes	Yes	No
Supportive home care are services to maintain individuals in independent or supervised living situations.	Yes	Yes	Yes	Yes
Specialized medical and therapeutic supplies are items and devices that are necessary to maintain the child's health, manage a medical or physical condition, or improve functioning or enhance independence.	Yes	Yes	Yes	Yes
Specialized transportation are services to improve access to needed community services and the ability to perform tasks independently.	Yes	Yes	Yes	Yes

*Services vary from one waiver to another in terms of scope, frequency, duration and other limitations.

Note: CIP IA and CIP IB funds services for individuals who are relocated from the state centers for the developmentally disabled (CIP IA) and individuals who are relocated or diverted from other intermediate care facilities for the mentally retarded (CIP IB). The brain injury waiver (BIW) program funds services to individuals with brain injuries who require post acute rehabilitation institutional care. The children's long-term care (CLTC) waiver program provides services to children with developmental disabilities, physical disabilities, and who meet the psychiatric hospital or severe emotional disturbance level of care. The community options waiver program (COP-W) and the community integration program (CIP II) provide community based services for elderly and physically disabled individuals.

APPENDIX V

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2007

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Adams	$278,678	$175,698	$59,650	$83,846	$69,411	$110,553
Ashland	347,137	337,468	167,734	0	102,776	280,730
Barron	462,486	310,856	132,590	83,846	589,932	508,823
Bayfield	277,400	195,778	137,452	83,846	180,399	128,099
Brown	2,529,142	1,887,441	699,510	111,795	5,277,983	1,240,305
Buffalo	239,093	153,225	88,832	27,949	155,637	252,315
Burnett	244,298	159,089	66,579	27,949	23,137	86,796
Calumet	267,468	164,557	69,583	55,898	161,959	126,313
Chippewa	658,367	362,145	347,744	83,846	465,394	968,580
Clark	482,730	336,932	179,956	0	524,901	390,041
Columbia	705,610	503,265	151,765	111,795	374,863	293,307
Crawford	265,287	153,872	243,860	0	192,808	168,780
Dane	5,140,635	3,013,000	2,274,586	447,180	2,668,851	2,175,968
Dodge	621,875	366,202	163,261	223,590	739,210	304,642
Door	228,463	120,233	70,200	55,898	159,754	117,851
Douglas	864,519	457,022	964,899	55,898	597,515	428,859
Dunn	396,048	274,437	165,666	0	466,787	455,565
Eau Claire	948,351	637,856	104,252	27,949	543,792	1,684,380
Florence	85,954	49,195	0	0	88,705	19,409
Fond du Lac	564,513	0	0	0	0	0
Forest-Oneida-Vilas	0	0	0	139,744	1,191,045	547,020
Forest	187,158	90,850	71,496	0	0	0
Grant-Iowa	225,589	120,294	56,355	83,846	375,188	402,618
Grant	616,661	327,871	518,427	0	0	0
Green	395,084	195,426	453,224	83,846	98,813	238,496
Green Lake	145,926	104,762	36,356	0	77,123	273,588
Iron	131,960	88,768	39,394	0	99,617	0
Jackson	270,647	198,471	411,370	0	208,232	174,680
Jefferson	595,577	344,248	770,888	279,488	1,893,513	341,441
Juneau	287,882	210,631	166,429	83,846	228,371	296,412
Kenosha	1,694,698	1,512,670	706,709	139,744	778,763	894,050
Kewaunee	231,660	227,733	68,857	27,949	142,761	220,640
LaCrosse	478,315	0	0	0	0	0
Lafayette	217,792	151,413	64,996	0	46,274	47,979
Langlade	322,268	135,408	120,144	0	0	0
Lincoln 51.437 Board	247,683	201,927	157,704	83,846	306,831	425,908
Lincoln-Langlade-Marathon	0	0	123,493	111,795	1,136,079	955,227
Manitowoc	803,362	558,597	1,091,943	83,846	1,400,175	463,639
Marathon	1,144,784	1,139,769	133,340	0	38,163	0
Marinette	484,285	340,181	272,302	111,795	350,156	214,429

APPENDIX V (continued)

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2007

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Marquette	$157,544	$161,802	$168,003	$0	$112,927	$100,305
Menominee	156,328	100,104	38,998	0	30,849	0
Milwaukee	8,527,073	3,066,288	2,078,249	922,310	7,535,136	5,150,960
Monroe	430,595	231,934	381,269	83,846	346,652	403,625
Oconto	337,492	180,025	72,943	111,795	206,104	228,869
Oneida	397,107	154,640	495,109	0	0	0
Outagamie	1,300,259	980,940	374,021	111,795	1,168,096	1,108,366
Ozaukee	483,913	368,593	332,627	55,898	333,628	430,256
Pepin	146,266	64,513	136,493	0	176,576	86,796
Pierce	390,181	171,638	110,494	55,898	578,119	334,764
Polk	452,745	302,216	97,495	55,898	121,911	506,649
Portage	210,952	0	0	0	61,698	38,818
Price	271,976	229,552	154,679	0	217,712	235,236
Racine	2,379,729	982,332	792,868	111,795	598,973	1,368,403
Richland	123,310	0	0	0	0	0
Rock	2,005,994	1,169,290	2,049,159	139,744	1,804,578	741,730
Rusk	201,816	222,714	154,814	83,846	118,431	214,895
St. Croix	426,064	297,906	477,058	223,590	293,068	544,380
Sauk	458,501	367,709	604,157	186,453	524,591	214,585
Sawyer	238,601	148,249	84,495	55,898	91,641	241,912
Shawano	391,547	498,567	160,908	27,949	195,657	431,032
Sheboygan	1,237,477	685,880	1,097,504	139,744	1,484,759	557,578
Taylor	216,717	164,802	66,750	55,898	225,388	338,180
Trempealeau	543,480	410,797	155,920	0	177,871	381,811
Vernon	210,429	233,987	49,208	27,949	232,542	170,953
Vilas	263,319	231,440	244,511	0	0	0
Walworth	685,394	563,369	665,863	111,795	322,520	340,043
Washburn	260,389	248,602	116,073	0	200,649	77,636
Washington	664,063	433,432	390,973	195,641	472,818	580,403
Waukesha	3,570,467	1,918,697	713,957	363,334	1,023,661	1,313,593
Waupaca	606,889	359,328	438,934	55,898	791,050	201,697
Waushara	233,782	328,017	397,926	0	74,091	82,915
Winnebago	1,702,672	1,090,279	975,729	167,693	998,916	980,777
Wood	777,848	541,282	638,947	83,846	1,019,303	704,154
Total	$54,550,304	$32,516,214	$26,067,680	$6,139,543	$43,294,833	$33,348,764

APPENDIX VI

Income Maintenance Administrative Allocations*
2005 through 2007

County	2005	2006	2007
Adams	$246,873	$251,150	$250,809
Ashland	325,027	325,694	325,201
Barron	569,599	567,901	566,891
Bayfield	181,638	183,769	183,524
Brown	1,477,701	1,492,860	1,489,779
Buffalo	166,530	162,962	162,778
Burnett	209,038	208,219	207,939
Calumet	200,268	202,563	202,244
Chippewa	561,451	558,450	557,548
Clark	310,436	312,076	311,553
Columbia	363,742	365,303	364,669
Crawford	206,219	201,772	201,482
Dane	2,404,898	2,438,292	2,432,527
Dodge	568,554	558,407	557,476
Door	220,984	216,487	216,092
Douglas	563,193	568,914	567,945
Dunn	360,491	363,334	362,452
Eau Claire	848,265	851,873	850,038
Florence	160,644	161,856	161,727
Fond du Lac	862,405	802,569	801,507
Forest	163,651	162,522	162,371
Grant	421,361	417,356	416,699
Green	279,072	276,047	275,668
Green Lake	171,288	171,243	170,990
Iowa	172,889	172,967	172,721
Iron	161,606	162,246	162,087
Jackson	241,069	230,879	230,531
Jefferson	508,817	511,883	510,832
Juneau	263,598	262,216	261,716
Kenosha	1,489,787	1,497,546	1,494,115
Kewaunee	160,844	163,225	162,991
La Crosse	1,129,989	1,008,845	1,007,082
Lafayette	165,654	162,892	162,699
Langlade	286,004	284,395	284,008
Lincoln	274,268	278,445	278,064
Manitowoc	609,230	606,270	605,314
Marathon	932,962	939,630	937,745
Marinette	455,376	449,834	449,084
Marquette	162,011	163,313	163,097
Milwaukee	16,292,011	16,083,320	16,058,198
Monroe	405,738	404,789	404,189
Oconto	280,242	283,400	282,868
Oneida	407,478	399,886	399,316
Outagamie	741,641	729,804	728,285
Ozaukee	266,875	268,801	268,275

County	2005	2006	2007
Pepin	$161,840	$161,984	$161,842
Pierce	210,120	209,881	209,421
Polk	381,558	382,525	381,855
Portage	615,363	559,352	558,229
Price	258,934	262,505	262,167
Racine	1,690,696	1,710,760	1,707,440
Richland	240,379	220,097	219,814
Rock	1,538,157	1,554,569	1,551,782
Rusk	245,259	238,512	238,242
St. Croix	349,453	351,673	350,897
Sauk	448,655	448,945	448,199
Sawyer	276,759	274,472	274,078
Shawano	353,934	355,970	355,514
Sheboygan	725,611	729,652	728,184
Taylor	243,519	244,295	243,947
Trempealeau	315,401	309,920	309,509
Vernon	281,191	277,686	277,323
Vilas	174,560	175,560	175,320
Walworth	591,541	592,245	590,910
Washburn	223,228	225,617	225,291
Washington	540,464	547,734	546,753
Waukesha	1,234,216	1,231,185	1,229,210
Waupaca	558,707	539,235	538,485
Waushara	233,414	236,160	235,834
Winnebago	1,033,731	1,033,424	1,031,654
Wood	714,904	720,991	719,701
Menominee	160,644	161,992	161,872
County Totals	$51,053,655	$50,643,146	$50,556,599
Tribes			
Bad River	$160,644	$161,500	$161,357
Lac du Flambeau	160,644	161,958	161,815
Oneida Tribe	160,644	162,389	162,225
Potawatomi Tribe	97,600	98,203	98,083
Red Cliff	160,644	161,509	161,366
Sokaogon	97,600	98,205	98,085
Stockbridge Munsee	97,600	98,151	98,031
Tribal Totals	$935,376	$941,915	$940,962
Statewide Totals	$51,989,031	$51,585,061	$51,497,561

*These allocations do not include additional funds DHFS provides to counties for other IM functions.

APPENDIX VII

Local Overmatch Expenditures for Income Maintenance Activities 2004 and 2005

County	2004	2005
Adams	$79,316	$44,036
Ashland	7,388	2,412
Barron	81,399	112,069
Bayfield	43,971	103,401
Brown	762,027	949,968
Buffalo	21,324	43,975
Burnett	50,730	56,189
Calumet	36,391	50,968
Chippewa	29,638	63,273
Clark	29,544	0
Columbia	167,094	190,882
Crawford	81,588	112,349
Dane	1,661,823	1,913,400
Dodge	193,847	224,936
Door	59,921	70,616
Douglas	51,640	83,652
Dunn	126,824	188,250
Eau Claire	290,260	263,776
Florence	0	0
Fond du Lac	521,989	633,752
Forest	11,552	8,115
Grant	12,485	47,158
Green	16,559	31,434
Green Lake	19,007	30,320
Iowa	84,420	153,320
Iron	30,956	53,015
Jackson	73,961	117,258
Jefferson	239,507	195,334
Juneau	70,313	73,993
Kenosha	2,677,358	3,014,042
Kewaunee	0	15,883
La Crosse	29,858	4,043
Lafayette	28,138	58,236
Langlade	19,853	41,548
Lincoln	44,254	98,280
Manitowoc	102,987	196,743
Marathon	240,310	378,501
Marinette	250,321	227,856
Marquette	0	6,205
Milwaukee	2,347,453	3,460,488
Monroe	71,670	118,274
Oconto	117,817	137,174
Oneida	0	23,878
Outagamie	565,186	725,251
Ozaukee	137,062	186,466
Pepin	$16,886	$0
Pierce	98,003	112,868
Polk	82,656	157,144
Portage	162,027	283,698
Price	68,089	84,237
Racine	501,843	742,444
Richland	32,169	33,906
Rock	314,456	443,744
Rusk	14,163	24,037
Rock	314,456	443,744
Rusk	14,163	24,037
St Croix	188,693	227,319
Sauk	22,953	77,960
Sawyer	9,147	15,625
Shawano	142,248	117,755
Sheboygan	97,537	201,764
Taylor	49,217	69,984
Trempealeau	32,014	36,897
Vernon	78,385	79,145
Vilas	22,720	43,106
Walworth	206,244	254,924
Washburn	48,115	66,814
Washington	219,535	285,107
Waukesha	913,903	1,029,935
Waupaca	188,200	221,986
Waushara	100,597	110,047
Winnebago	322,533	480,182
Wood	110,164	242,926
Menominee	4,718	1,269
County Totals	$15,534,956	$19,955,542
Tribes		
Bad River	$3,488	$0
Lac du Flambeau	0	0
Oneida Tribe	0	0
Potawatomi Tribe	0	0
Red Cliff	0	2,056
Sokaogon	1,252	414
Stockbridge Munsee	0	1,127
Tribal Totals	$4,740	$3,597
Statewide Totals	$15,539,696	$19,959,139