Medical Assistance and Related Programs

(BadgerCare Plus, EBD Medicaid, Family Care, and SeniorCare)

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The state's medical assistance (MA) program provides health care services for people with limited resources, using a combination of state funds and federal matching funds. The Wisconsin Department of Health Services (DHS) administers the MA program under a framework of state and federal laws and policies, and in conformity with the MA state plan and agreements to waive certain federal law provisions ("federal waivers") negotiated between DHS and the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (DHHS).

The MA program pays certified health care providers for primary, preventive, acute, and long-term care services they provide to enrollees. These providers include individual practitioners as well as hospitals, nursing homes, managed care organizations, and local governmental entities such as county human services departments and school districts. MA enrollees are entitled to receive covered, medically necessary services furnished by these providers.

States receive federal matching funds to partially support these covered services. The federal medical assistance percentage (FMAP) is the portion of the total payment supported by these federal matching funds. Each state's FMAP is calculated annually under a formula that compares a three-year average of the state's per capita income to national per capita income. Currently Wisconsin's standard FMAP is approximately 58%, although costs related to certain services and certain enrollees can qualify for higher federal matching rates.

Although Wisconsin's MA program has several components, targeted toward various eligibility groups, it can be viewed in terms of its two primary components: BadgerCare Plus and EBD Medicaid. BadgerCare Plus provides low-income children, their parents, and childless adults with health care services, such as physician services, inpatient and outpatient hospital care services, and vision and dental care. EBD Medicaid provides elderly, blind, and disabled individuals with long-term care services, as well as the same acute care services typically provided to BadgerCare Plus recipients. EBD Medicaid also provides non-traditional long-term care services under home and community-based programs, such as Family Care, as an alternative to nursing home care.

In addition to these two main MA components, the program has several subprograms that provide limited benefits, targeted to certain persons who are not otherwise eligible for EBD Medicaid or BadgerCare Plus. These include: (a) Medicare cost-sharing assistance, for persons who have limited income and assets, but who are not eligible for full Medicaid benefits; (b) the family planning only services program, which provides coverage for contraceptive services and testing and treatment for sexually transmitted diseases; and (c) SeniorCare, which provides prescription drug assistance to persons age 65 and over.

This paper provides information on the operation of the various MA program components, including eligibility standards, covered medical services, and provider reimbursement policies. In addition, the paper covers the fiscal aspects of the MA program, including funding and enrollment data.

List of Common Acronyms

ACA	Patient Protection and Affordable Care Act of 2010
CHIP	Children's Health Insurance Program
CIP	Community Integration Program
CLTS	Children's Long-Term Support Program
CMS	Centers for Medicare and Medicaid Services (Federal)
COP	Community Options Program
DHS	Department of Health Services (State)
DHHS	Department of Health and Human Services (Federal)
DMS	Division of Medicaid Services (State)
DQA	Division of Quality Assurance
EBD	Elderly, Blind and Disabled
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
HMO	Health Maintenance Organization
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IM	Income Maintenance
IMD	Institution for Mental Disease
IRIS	Include, Respect, I Self-Direct
MA	Medical Assistance
MAGI	Modified Adjusted Gross Income
MAPP	Medical Assistance Purchase Plan
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income

CHAPTER 1

EXPENDITURE AND ENROLLMENT TRENDS

This chapter provides information on total MA expenditures and participation in recent years. For enrollment and expenditures information for SeniorCare, which is not included in this section, see Chapter 7.

Total MA expenditures and caseloads have increased significantly over the past decade, due to program eligibility changes and the effects of the economic recession of 2008. Table 1.1 shows total (all funds) MA expenditures and average monthly enrollment for state fiscal years 2006-07 through 2015-16. Because of delays in finalizing 2015-16 financial information at the time of publication, the dollar amounts shown for that year, as well as generally throughout this paper, are budgeted or preliminary amounts, rather than actual expenditures.

Table 1.1: MA Expenditures and Participation

	Expenditures ($ in Millions)	Average Monthly Enrollment
2006-07	$4,703.2	765,500
2007-08	4,950.7	801,100
2008-09	5,944.9	894,500
2009-10	6,696.1	1,042,500
2010-11	7,181.7	1,098,000
2011-12	6,597.2	1,112,700
2012-13	7,187.7	1,106,800
2013-14	8,070.1	1,103,100
2014-15	8,526.2	1,130,100
2015-16	9,197.1*	1,129,200

* Budgeted amount.

Expenditure Trends

Table 1.2 provides information on benefit expenditures under the state's MA program, by fund source, from state fiscal year 2011-12 through 2015-16. The four main funding sources are the following: (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG), which are primarily generated by assessments on medical providers; and (d) program revenues (PR), such as rebates from drug manufacturers and premiums paid by certain participants. Chapter 2 describes these funding sources in more detail.

Table 1.2 shows how the relative contributions made by the funding sources have changed in recent years, including several noteworthy shifts.

First, though not shown in Table 1.2, FED funding for the program decreased significantly in 2011-12 from the previous year due to the end of temporary additional federal funding under the American Recovery and Reinvestment Act of 2009. The additional funding was provided through an increase in the percentage of program costs covered by the federal government (the federal medical assistance percentage, or FMAP). The decline in total program expenditures in 2011-12 was primarily due to a shift of approximately $430 million of payments from 2011-12 to 2010-11 to take advantage of those higher federal matching rates.

Second, the PR amounts shown in Table 1.2 increased significantly in 2013-14, due to changes in how the state accounts for PR. Until fiscal year 2013-14, the expenditure amounts shown do not include drug manufacturer rebates and certain other PR funding sources, such as participant premiums paid by certain MA recipients. These

Table 1.2: MA Benefit Expenditures by Fund Source

	2011-12	2012-13	2013-14	2014-15	2015-16*
GPR	$1,863,950,600	$2,072,332,900	$2,298,313,300	$2,533,537,500	$2,747,405,300
FED	3,979,299,400	4,359,848,500	4,607,116,100	4,772,162,300	5,125,303,000
PR	112,650,600	124,301,200	547,366,700	627,515,400	617,943,400
SEG	641,254,500	631,246,000	617,347,000	593,026,500	706,486,900
Total	**$6,597,155,100**	**$7,187,728,600**	**$8,070,143,100**	**$8,526,241,700**	**$9,197,138,600**

*Budgeted amounts.

revenues were previously treated as offsets to state and federal MA benefit costs, and proportionately reduced the amount of GPR and FED needed to fund the program. However, based on recommendations from the Legislative Audit Bureau, 2013 Act 20 (the 2013-15 budget act) created several new appropriations that are directly funded from these PR sources. As a result, the inclusion of these PR amounts more accurately shows the program's total expenditures.

MA recipients receive program benefits either on a fee-for-service basis, where the state pays providers directly for services, or through managed care organizations (MCOs) and health maintenance organizations (HMOs) that receive monthly capitation payments for each participant they serve. Table 1.3 shows total net MA benefit expenditures in 2015-16 broken out as follows: (a) total capitation payments made to MCOs and HMOs; and (b) the 12 service categories that account for the largest share of fee-for-service expenditures. These two payment systems are described in further detail in Chapter 9.

The expenditure totals shown in Table 1.3 for the fee-for-service categories reflect only those services provided on that basis, and do not include the portion of the capitation payments attributable to the cost of services for participants in managed care. For example, in 2015-16, the state paid approximately $170.0 million (all funds) for physician and clinic services delivered on a fee-for-service basis. HMO enrollees also receive physician and clinic services, but reimbursement for those services is part of the monthly capitation rates paid to those enrollees' HMOs. One major exception is prescription drugs (approximately $996 million in 2015-16), which are reimbursed completely through fee-for-service.

Program Participation

After a period of rapid growth beginning in 2008, total MA enrollment has plateaued in recent years, due to a mix of economic factors and program eligibility changes. Table 1.4 provides average monthly enrollment, by eligibility category, from 2012-13 through 2015-16. Because enrollment rolls can be adjusted later under a process for retroactive eligibility (described in Chapter 4), the figures in the table, particularly in 2015-16, should be viewed as preliminary.

As a means-tested benefit program, MA enrollment in general, and BadgerCare Plus enrollment in particular, is sensitive to economic conditions and the level of access to employer-sponsored health insurance in Wisconsin. Consequently, the economic impact of the 2008 financial crisis and recession led to large increases in BadgerCare Plus enrollment in the following years. As the economy has recovered, enrollment growth has slowed, with enrollment totaling approximately 1.1 million over the last several years.

In addition to economic factors, enrollment

Table 1.3: Managed Care Capitation Payments and Fee-For-Service Expenditures, Fiscal Year 2015-16

	Expenditures ($ in Millions)	% of Total
Managed Care Capitation Payments		
BadgerCare Plus Health Maintenance Organization (HMO) Payments*	$1,836.6	20.9%
Family Care Managed Care Organization (MCO) Payments	1,463.3	16.7
SSI Managed Care HMO Payments*	254.3	2.9
PACE/Partnership MCO Payments	153.5	1.8
Other	52.0	0.6
Total	**$3,759.7**	**42.9%**
Twelve Largest Fee-For-Service Expenditure Categories		
Prescription Drugs	$996.0	11.3%
Inpatient and Outpatient Hospitals*	799.8	9.1
Nursing Homes	713.3	8.1
Long-Term Care Waiver Programs	585.8	6.7
MA Home Care (including Home Health, Personal Care, and Hospice)	353.2	4.0
Medicare Premiums and Cost-Sharing	292.7	3.3
Clawback Payments to Federal Government (100% GPR)	190.3	2.2
Federal Funds Claimed on Certain County-Supported Services	175.7	2.0
Physicians/Clinics	170.0	1.9
Federally Qualified Health Centers	148.8	1.7
State Centers for Persons with Developmental Disabilities	120.1	1.4
Nonemergency Medical Transportation	74.8	0.9
Total	**$4,620.5**	**52.7%**
All Other Fee-for-Service Expenditures	$395.8	4.5%
Total Benefit Expenditures**	**$8,776.1**	**100.0%**

*Includes hospital access payments and other supplemental payments.

** Data reflect gross expenditures, prior to receipt of prescription drug rebates, premiums, and other offsets. Total does not equal expenditure total in Table 1.2 due to differences in the accounting system used to track expenditures by category.

also depends on policy decisions to expand or reduce coverage levels. The most recent major change to program eligibility occurred under 2013 Act 28 (the 2013-15 biennial budget act), and affected eligibility for adults without dependent children ("childless adults") and parents and caretaker relatives. That act and subsequent legislation provided full BadgerCare Plus coverage to childless adults in households with incomes up to 100% of the federal poverty level (FPL), beginning on April 1, 2014. Previously, a childless adult could only receive MA coverage if he or she had been enrolled in the former BadgerCare Plus "Core Plan" before enrollment in that program closed. Over the course of the first year after this change, the number of enrolled childless adults increased steadily, reaching approximately 160,000 in early 2015. Since then, the number of childless adult enrollees has declined somewhat, reaching approximately 144,000 at the end of 2016.

The same legislation reduced income eligibility levels for parents and caretaker relatives to 100% of the FPL, from its previous level of 200%, effective April 1, 2014. This resulted in approximately 45,000 parents and caretakers with household income over 100% of the FPL losing access to BadgerCare Plus coverage immediately following this eligibility change.

Table 1.4: Average Monthly Enrollment in MA and MA-Related Programs, by State Fiscal Year

	2012-13	2013-14	2014-15	2015-16
BadgerCare Plus				
Children	479,433	478,747	470,110	469,576
Parents and Caretakers	251,450	229,212	179,146	176,612
Pregnant Women	20,698	21,160	21,189	21,032
Childless Adults	20,333	39,046	144,488	150,339
Total BadgerCare Plus	**771,914**	**768,165**	**814,933**	**817,559**
% Change		-0.5%	6.1%	0.3%
Elderly, Blind and Disabled (EBD)				
Elderly (Disabled and Non-Disabled)	59,853	60,605	61,621	61,632
Disabled Non-Elderly Adults	130,423	133,244	135,832	136,357
Disabled Children	30,897	31,319	31,689	32,002
Total EBD	**221,173**	**225,168**	**229,142**	**229,991**
% Change		1.8%	1.8%	0.4%
Other Full Benefit Groups				
Foster Children	17,651	16,742	17,738	18,345
Well Woman MA	971	946	798	705
Total Full Benefit MA	1,011,709	1,011,021	1,062,611	1,066,600
% Change		-0.1%	5.1%	0.4%
Limited Benefit Groups				
Family Planning Only Services	72,784	69,798	45,515	40,693
Limited Benefit Medicare Beneficiaries	20,347	21,463	21,980	21,941
Basic Plan*	1,619	818	0	0
Total MA Enrollment	**1,106,459**	**1,103,100**	**1,130,107**	**1,129,233**
% Change		-0.3%	2.4%	-0.1%

*Limited benefit plan for certain childless adults, eliminated in April 2014.

Cost Per Eligibility Category

Table 1.5 shows the total annual and average per person costs for each of the major eligibility categories in the MA program for 2015-16. These figures represent only costs that can be reliably allocated to individuals in the program. Therefore, certain program costs, such as hospital access payments paid through HMOs and certain payments to counties for providing MA services, are not reflected in the totals. For this reason, Table 1.5 provides a relative comparison of the total and per member costs associated with different MA groups, and should be viewed as approximate costs for the various groups.

As the table shows, individuals eligible under the EBD categories have the highest average cost and highest program costs. Children enrolled in BadgerCare Plus, the largest MA group by enrollment, have relatively low average costs compared to other full-benefit MA enrollees.

Table 1.5: 2015-16 Total and Average Benefit Cost by Eligibility Group

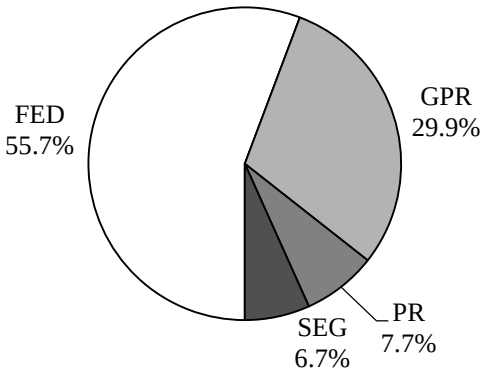
	Annual Cost	Average Per Member Cost
Elderly, Blind, and Disabled		
Elderly	$1,757,725,700	$28,520
Non-Elderly Adults	2,817,118,800	20,660
Disabled Children	471,741,500	14,741
EBD Total	$5,046,586,000	21,943
BadgerCare Plus		
Children	$827,188,700	$1,762
Parents	729,085,200	4,128
Pregnant Women	226,298,700	10,760
Childless Adults	856,873,500	5,700
BadgerCare Plus Total	$2,639,446,100	3,228
Other Groups		
Foster Children	$113,089,400	$6,165
Well Woman	10,435,200	14,803
Family Planning Only Waiver	17,011,600	418
Medicare Savings Programs for Dual Eligibles	34,977,400	1,594

CHAPTER 2

FUNDING SOURCES

This chapter provides additional information about revenues that fund MA benefits costs. The four main sources of funding are : (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG) generated by specific assessments or programs; and (d) program revenues (PR), such as rebates from drug manufacturers and premiums paid by certain participants. Figure 2.1 shows the proportion of the total MA budget supported by each of these funding categories in state fiscal year 2015-16.

Figure 2.1: Percentage of Total MA Spending, by Fund Source, 2015-16



General Purpose Revenue (GPR)

In Wisconsin, as in other states, the non-federal share of MA benefits costs is funded primarily by revenues deposited to the state's general fund (general purpose revenue).

In the 2015-17 biennium, MA benefits accounted for approximately 17.2% of the total state general fund budget. Funding for MA benefits is the second-largest GPR commitment in Wisconsin's budget, surpassed only by aids to elementary and secondary school districts.

In addition to GPR, other non-GPR sources fund the non-federal share of MA expenditures. Those sources also generate federal matching funds and are described later in this chapter.

Federal Matching Funds (FED)

Federal matching funds are the largest funding source for Wisconsin's MA program. The federal government provides a match to state spending based on the state's federal medical assistance percentage, or FMAP. The FMAP indicates the percentage of MA costs for which the federal government is responsible. Historically, Wisconsin's standard FMAP has generally ranged between 58% and 62%, meaning that federal matching funds have typically supported approximately sixty cents of each dollar of MA benefit costs.

Each state's FMAP is adjusted annually based on a formula in federal law that compares the state's per capita income to national per capita income. Federal statutes set the minimum allowable FMAP at 50%, and the maximum allowable FMAP at 83%. In federal fiscal year 2016-17 (the period from October 1, 2016, through September 30, 2017), thirteen states received the minimum federal FMAP of 50%, and Mississippi received the highest FMAP of 74.63%.

Wisconsin's standard FMAP for federal fiscal year 2016-17 is 58.51%. Higher FMAPs apply for certain enrollees and certain services. Most notably, the federal Children's Health Insurance Program (CHIP) provides enhanced federal funding for services for certain children, generally those in households with income above 150% of the FPL (the CHIP threshold varies by the age of the child). The enhanced FMAP is calculated to reduce the state's share (under the standard FMAP) by 30%. In addition, the federal Patient Protection and Affordable Care Act (ACA) provided for an additional 23 percentage point increase to the enhanced FMAP, beginning in federal fiscal year 2015-16 and ending in federal fiscal year 2018-19. With that increase, the state's FMAP for services provided to these children was raised to 93.76% in federal fiscal year 2015-16 and to 93.96% in federal fiscal year 2016-17.

Although Wisconsin's FMAP does not generally fluctuate significantly from year to year, small changes in the percentage can have a large effect on the state's MA budget due to the size of the program. Table 2.1 provides the standard FMAP, and the FMAP for CHIP expenditures, that Wisconsin received from federal fiscal year 2011-12 through 2016-17.

Table 2.1: Wisconsin's Federal Medical Assistance Percentages

FFY	Standard FMAP	FMAP for CHIP
2011-12	60.53%	72.37%
2012-13	59.74	71.82
2013-14	59.06	71.34
2014-15	58.27	70.79
2015-16	58.23	93.76
2016-17	58.51	93.96

Federal legislation has, on occasion, temporarily increased states' FMAPs during economic downturns. The most recent temporary increase occurred as the result of the federal American Recovery and Reinvestment Act of 2009 (ARRA), which increased Wisconsin's FMAP between October 1, 2008 and June 30, 2011 (including a six-month extension passed subsequent to ARRA). That ARRA-enhanced FMAP, which was recalculated quarterly based on the state's unemployment rate, generally ranged between 65% and 70% in federal fiscal years 2009-10 and 2010-11. Over the time period, this enhanced FMAP generated approximately $1.3 billion in additional FED funding for the state, which reduced the amount of state funding that otherwise would have been needed to support MA enrollment increases that occurred during and after the recession of 2008. On July 1, 2011, Wisconsin returned to the standard formula-based FMAP of approximately 60%.

Finally, in addition to the enhanced CHIP FMAP, several other categories of service or services for particular eligibility groups qualify for federal matching funds in excess of the standard FMAP. These include expenditures for family planning services (90% federal matching rate), treatment services for certain women with breast or cervical cancer (the enhanced CHIP FMAP, not including the 23 percentage point increase under the ACA), and services provided through an Indian Health Service facility (100% federal matching rate).

Segregated Funds (SEG)

In addition to GPR, Wisconsin funds the state share of MA benefits with segregated (SEG) funds generated from several sources. These revenues offset GPR spending on the program.

In general, SEG revenues are collected separately from the state's general fund tax collections, are credited to statutorily-established funds, and may only be used for the statutory purpose of those funds. The primary SEG funding sources for Medicaid are provider assessments (also known as provider taxes), certified public expenditure (CPE) programs, and inter-

Table 2.2: Medical Assistance Trust Fund Revenues, Expenditures, and Balances

	Actual 2014-15	Preliminary 2015-16
Beginning Balance	$0	$9,623,700
Revenues		
Provider Assessments		
Hospital Assessment*	$133,244,900	$156,103,400
Nursing Home/ICF-ID Bed Assessment**	74,065,900	73,673,800
Ambulatory Surgical Center Assessment**	16,620,000	16,616,500
Critical Access Hospital Assessment*	2,081,100	1,697,700
Subtotal	$226,011,900	$248,091,400
Federal MA Funds Deposited to MA Trust Fund		
Nursing Home Certified Public Expenditure Program	$27,393,700	$34,409,000
Intergovernmental Transfer From UW System	9,944,400	12,987,100
HealthCheck-Eligible Services - Residential Care Centers	7,600,000	0
Hospital Certified Public Expenditure Program	0	4,353,500
Subtotal	$44,938,100	$51,749,600
Other		
Transfer from Permanent Endowment Fund	$50,000,000	$50,000,000
Interest Earnings	-10,600	7,900
Total Revenue	$320,939,400	$359,472,600
Expenditures	$311,315,700	$369,096,300
Ending Balance	$9,623,700	$0

*Deposited in separate trust fund and then transferred to MATF.
**Deposited directly in MATF.

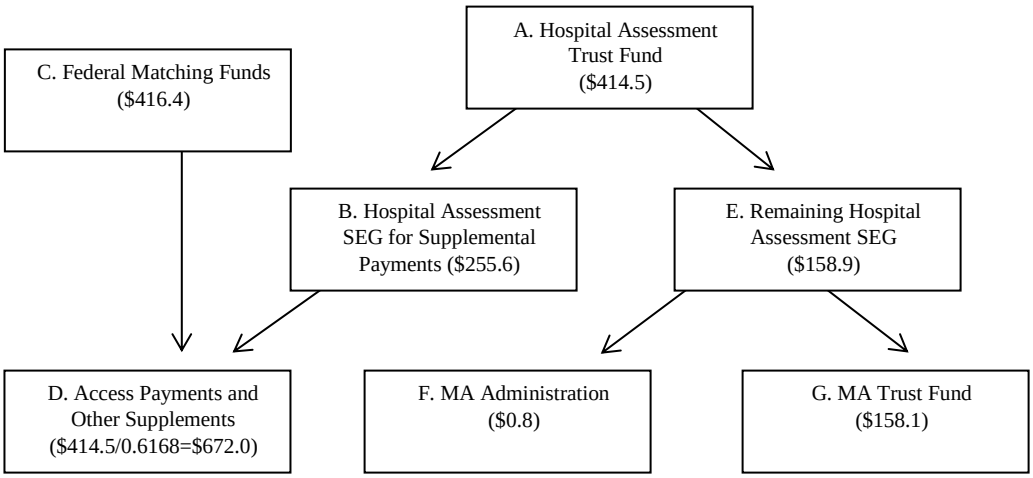
governmental transfers (IGTs).

The principal segregated fund that supports the MA program is the medical assistance trust fund (MATF). Table 2.2 shows actual MATF revenues and expenditures for state fiscal year 2014-15 and preliminary figures for 2015-16. Revenues to the fund are described below.

Hospital Assessment. 2009 Wisconsin Act 2 authorized DHS to collect an assessment from most hospitals in the state, excluding several types of hospitals such as critical access hospitals and institutions for mental disease. The purpose of the assessment is to return a portion of the assessment, combined with associated federal matching funds, to hospitals through MA supplemental payments, while also using the remaining SEG revenue to supplement GPR funding for the MA program as a whole.

Figure 2.2 shows how the assessment is allocated between hospital supplemental payments and other MA benefits. The total annual amount of the assessment is established in statute at $414,507,300, with each hospital's assessment based on a uniform percentage of that hospital's gross patient revenues. In 2015-16, the assessment equaled approximately 1.13% of each hospital's gross patient revenues. Revenues collected from the assessment are deposited to a separate fund, the hospital assessment trust fund (shown in box "A" in the Figure 2.2).

Figure 2.2: Allocation of Hospital Assessment Revenue ($ in Millions)*



*The dollar amounts shown for the hospital assessment (box "A") and the hospital payments (box "D") reflect the statutorily required collections and payments. While the amounts shown in other boxes are generally illustrative of the annual allocations, the actual amounts will vary from year to year depending upon the applicable FMAP and the timing of hospital payments.

The MA program is required to make supplemental hospital payments in accordance with a formula under which the total assessment ($414.5 million) is divided by a statutorily-set factor (0.6168). The resulting payment of approximately $672.0 million is shown in box "D" in Figure 2.2. (Hospital supplemental payments, including hospital access payments, which account for approximately 98% of this total, are described in Chapter 9.) In order to make these payments, the program uses an amount of SEG funds from the hospital assessment fund that, when added to the associated federal matching funds, equals $672.0 million (shown in boxes "B" and "C" in Figure 2.2). The amounts shown in the Figure 2.2 are for illustrative purposes. The actual amounts vary year to year depending upon the FMAP and the timing of payments. Since a portion of payments are paid for hospital services provided to MA participants who are eligible under CHIP, the applicable FMAP will be a blend of standard and enhanced matching rates. The amount of supplemental payment expenditures will also vary since some payments are made in a different fiscal year than the date of service accounting for the accrual of the supplemental payment.

The remaining SEG in the hospital assessment trust fund, after making the required supplemental payments, is used to offset state GPR needed to fund the program. In Figure 2.2, box "E" shows the remaining SEG after supplements are paid. Of this amount, 0.5% is transferred to an appropriation for MA administrative costs (box "F"), while the rest is deposited in the MA trust fund (box "G") and used for MA benefits.

In 2015-16, the transfer from the hospital trust fund to the MA trust fund was $156.1 million.

Nursing Home and ICF-IID Bed Assessment. The state established a provider assessment on nursing home beds beginning in state fiscal year 1991-92. Nursing homes pay $170 per month per licensed bed, regardless of whether the bed is occupied. Nursing homes operated by the

Department of Veterans Affairs are exempt from paying the nursing home bed assessment.

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 amount. However, the current method DHS uses to reimburse nursing homes for the care they provide to MA recipients includes a supplemental payment that is intended to offset, in the aggregate, the total estimated costs nursing homes incur to pay the nursing home assessment.

In addition, the state collects a bed assessment on all beds in intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) in the state. This assessment is $910 per licensed bed per month.

All revenues generated from the nursing home and ICF-IID bed assessment are deposited in the MATF. In 2015-16, those revenues were estimated at $73.7 million. The state has used SEG revenues from the nursing home bed assessment and associated federal matching funds, in part, to fund rate increases for nursing homes and to replace GPR funding for general MA benefits.

Ambulatory Surgical Center Assessment. Federal regulations define an ambulatory surgical center (ASC) as any distinct entity that operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization, with the expected duration of services not exceeding 24 hours following an admission. State law authorizes the Wisconsin Department of Revenue (DOR) to collect an assessment on the gross patient revenues of ASCs located in Wisconsin consistent with federal regulations, which generally limit those provider assessments to 6.0% of the applicable patient revenues.

In 2015-16, as well as annually in previous years dating back to 2010-11, DOR has collected and transferred to the MATF approximately $16.6 million in ASC assessment revenues. Those assessment revenues, along with federal matching dollars, are used to fund ASC access payments, budgeted at $20.0 million annually (the actual amount paid varies slightly depending upon the volume of services provided). Of the $20 million budgeted for payments, approximately $7.9 million is provided from the ASC assessment revenues deposited in the MA trust fund and $12.1 million is from federal matching funds. The balance of the ASC assessment revenues not used for that purpose (approximately $8.7 million) is used to support other MA benefit expenditures.

Critical Access Hospital Assessment. State law and federal law define a critical access hospital (CAH) as a hospital with no more than 25 beds used exclusively for acute inpatient care, located outside of a metropolitan statistical area (or located in a rural area of an urban county) or located more than a 35-mile drive from another hospital. In addition, a hospital that does not meet the distance criteria, but was designated by the state, prior to January 1, 2006, as a "necessary provider" of health care services to residents in the area is eligible for CAH status. There are currently 58 CAHs in Wisconsin.

The CAH assessment works similarly to the larger hospital assessment, except that the CAH assessment is based on gross *inpatient* revenues rather than total gross *patient* revenues. The assessment rate is equal to the calculated rate for the larger hospital assessment, rather than being based on a statutorily-set dollar amount. Assessment revenue is deposited in the critical access hospital fund.

In 2015-16, the CAH assessment generated revenues of $7.6 million for the CAH fund. As with the larger hospital assessment, a portion of the collected revenues, along with associated federal matching funds, is used to make additional payments to those hospitals. Also like the other assessment, the amount of these payments is determined by dividing the amount collected by

0.6168 ($12.3 million in 2015-16). A portion of the remaining SEG funds ($1.0 million in 2015-16) is appropriated to the University of Wisconsin for rural residency and physician loan programs, while the rest ($1.7 million in 2015-16) is transferred to the MA trust fund to support MA benefit expenditures.

Nursing Home Certified Public Expenditure Program. Under a certified public expenditure (CPE) program, a state claims federal matching funds for Medicaid-eligible expenditures made by public entities other than the state. In Wisconsin, DHS administers a CPE program under which the state receives federal matching funds based on unreimbursed costs county and local government facilities incur to provide nursing home care to MA recipients. All federal revenue the state collects under this nursing home CPE program is deposited to the MATF. In 2015-16, those revenues were estimated at $34.4 million.

For federal matching funds generated by the nursing home CPE, DHS must distribute any funds that the state receives in a fiscal year that are in excess of the amount set in the biennial budget. DHS currently distributes these funds, when available, as additional supplemental payments to nursing homes owned and operated by local governments. However, no excess CPE payment was made in 2015-16, as actual collections fell below the budgeted amount.

UW Intergovernmental Transfer Program. Under an intergovernmental transfer (IGT) program, the state Medicaid agency can claim federal matching funds on moneys transferred from another governmental entity with taxing authority or a state university teaching hospital.

Wisconsin currently has an IGT related to services provided by the University of Wisconsin Medical Foundation (UWMF). Under the program, MA makes a supplemental payment to UWMF, in addition to the standard MA reimbursement rate, for services provided by UW physicians to MA beneficiaries. The nonfederal share of the supplement is paid by UWMF, through a transfer made to a DHS program revenue appropriation. The UW System also makes a transfer, limited by statute to $30,338,500 annually, from its general program operations program revenue appropriation to the MA trust fund, which can then be used to fund other MA benefit costs.

In 2015-16, the UW physician supplemental payment was $22.7 million and the transfer to the MATF was $13.0 million.

HealthCheck Services Provided by RCCs. In fiscal year 2004-05, the state began claiming federal MA matching funds for MA-eligible services provided to children in residential care centers (RCCs) under the state's early and periodic screening, diagnosis, and treatment services (EPSDT) benefit (known as "HealthCheck" in Wisconsin). These federal funds were credited to the MATF. Counties paid for the non-federal share of these costs through a combination of community aids, youth aids, and local tax revenues. The federal government has since prohibited the state from claiming federal funds for these expenditures. In 2014-15, the last year the state received funds for those expenditures, $7.6 million in federal matching funds associated with these costs was deposited into the MATF.

UW Hospital Certified Public Expenditure Program. Under a separate CPE program, DHS submits claims for federal matching funds in an amount equal to the deficit the University of Wisconsin Hospital incurs to provide services to MA recipients. In 2015-16, DHS claimed $4.3 million in CPE matching funds.

Transfer from Permanent Endowment Fund. The permanent endowment fund is a nonlapsible trust fund that received the proceeds of the sale of the state's rights to receive tobacco settlement payments. State law requires a $50 million annual transfer from the permanent en-

dowment fund to the MATF. Additional information on that fund is provided in the Legislative Fiscal Bureau's informational paper entitled, "Tobacco Settlement and Securitization and Repurchase Transactions."

Other Assets Transferred to the MATF. The Legislature has, on occasion, authorized the transfer of assets from other state funds to the MATF to support MA benefits expenditures. These have included transfers from the state's general fund and, in the 2007-09 biennium, from the injured patients and families compensation fund (IPFCF). The Wisconsin Supreme Court subsequently found the transfer from the IPFCF to be an unconstitutional taking of property without just compensation and ordered the state to repay a total of $233,747,100 to the IPFCF.

Program Revenues (PR)

MA is also supported with program revenues (PR), which offset GPR and FED spending in the program. The program's main source of PR is rebates from drug manufacturers. Other sources include premiums collected from certain program participants, and other collections or recoveries.

Drug Manufacturer Rebates. Under federal law, a drug manufacturer must enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services in order for states to receive federal MA matching funds for outpatient drugs dispensed to MA patients. In 2015-16, these federally mandated rebates, along with supplemental drug rebates negotiated by the state, totaled $601.1 million.

Premiums. Households with income greater than 200% of the FPL must pay monthly premiums to maintain coverage for children in the household. In addition, adults who qualify for transitional MA must pay premiums to retain eligibility. DHS uses premium revenue to offset program costs. These provisions are discussed in greater detail in Chapter 4. Premium collections have become a smaller component of program revenue funds since the change in eligibility for parents and caretaker relatives in the 2013-15 biennial budget. In 2015-16, premium revenue totaled approximately $11.7 million.

County Contributions for Family Care. The Family Care and IRIS programs, which are described in Chapter 11, provide long-term care services for certain qualifying MA recipients. Counties in which Family Care and IRIS services are available are required to annually contribute funding to partially support Family Care and IRIS program costs. These counties had previously used other funding sources, including state funds provided under the community aids program, to support long-term care services to individuals who now receive these services under Family Care and IRIS. Each county's contribution is based on a percentage of the county's basic county allocation under the community aids program. In 2015-16, counties transferred $42.9 million under this provision.

Collections and Recoveries. DHS also makes various other collections and recoveries. These include recoveries from the estates of deceased MA recipients who received MA-funded long-term care services, and collections from other payers, such as private insurance, when health coverage for an individual is available through another source. Chapter 5 provides additional information on the estate recovery program.

Local Government Funding

In addition to the sources of funding described above that are budgeted and expended through the state budget, local units of government provide the non-federal share of certain

services. The local and county governments may retain some, all, or none of the associated federal MA matching funds, depending upon the expenditure category.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide the non-federal share for school-based health services. School-based services include speech and language therapy, occupational therapy, and nursing services that are included in a child's individualized education program (a written education plan for a child with a disability). The MA program claims federal matching funds for school-based services expenditures, with the state retaining 40% of the federal matching funds, and the remaining 60% transferred to school districts. The amount retained by the state is deposited into the general fund. In 2015-16, schools and CESAs received $60.9 million in federal matching funds associated with those school-based services, while $40.3 million was deposited in the general fund.

School districts and CESAs can also claim a portion of the federal matching funds for administrative costs associated with the provision of school-based services. Of the total federal matching funds claimed for administrative costs, schools and CESAs receive 90%, while the remaining 10% is deposited in the general fund. In 2015-16, schools and CESAs received $9.5 million in federal funds for administration and $1.0 million was deposited in the general fund.

2015 Act 55 included a provision that requires any matching funds generated from school-based services and credited to the state that exceeded $42,200,000 in 2015-16 and $41,700,000 in 2016-17 and subsequent fiscal years to be transferred to the MATF. These funds must be used to fund reductions to waiting lists for children's long-term care services and other programs benefitting children. Since collections in 2015-16 did not exceed the $42.2 million threshold, no funds were transferred to the MATF.

County-Funded Mental Health and Substance Abuse Services. The non-federal share of the cost of certain community-based and inpatient mental health and substance abuse services is paid by counties. This includes targeted case management, crisis intervention, and community support programs for persons with acute mental illness. In 2015-16, these federal matching dollars totaled approximately $63.5 million.

MA Waivers. Counties retain federal MA matching funds the state claims for costs the counties incur in providing home and community-based waiver services that exceed their state allocations. In 2016, under authority provided by 2015 Act 55, DHS announced its intention to expand the Family Care program to all counties that were not already providing long-term care services under that program, a process that is expected to occur over the next several years. Since Family Care will replace the waiver programs in those counties, counties will eventually stop receiving federal matching funds for administering waiver programs. Chapter 11 provides additional information on the Family Care and waiver programs.

CHAPTER 3

ADMINISTRATION

State law assigns DHS numerous responsibilities relating to the administration of the Medicaid program. Those duties include fiscal management, eligibility determinations, fraud investigations, recovery of improper payments, claims processing, provider enrollment, rule development, and the production of various reports. Some of these functions are conducted by state staff in the DHS Division of Medicaid Services (DMS), and the Office of Inspector General (OIG), while others are performed by contracted private firms. In addition, most program eligibility management functions for Medicaid and several other public assistance programs are performed by county staff on a regional basis through income maintenance (IM) consortia, and by tribes. In Milwaukee County, state employees in Milwaukee Enrollment Services (MilES) perform IM services.

MA and FoodShare Administrative Contracts

DHS contracts with outside entities to provide several MA-related administrative services that include processing claims, reviewing health care providers' prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Many of these services are provided by the state's MA fiscal agent, Hewlett-Packard Enterprises, Inc. (HPE), while others are provided by other private entities and state agencies.

In 2016-17, DHS expects to expend approximately $185.5 million (all funds) for contracted administrative services for EBD MA, BadgerCare Plus, Family Care, SeniorCare, FoodShare, and other related programs. Table 3.1 summarizes the Department's estimates of these contracting costs in 2016-17. Table 3.1 does not include costs related to the IM functions performed by counties, tribes, and MilES. Those IM administration activities are described later in this chapter.

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the state's MA program and several related programs. Those business functions include processing claims, certifying health care providers, reviewing prior authorization requests, and providing customer service for members and health care providers. The fiscal agent also operates a centralized document processing unit as part of the state's IM functions. In addition, the fiscal agent is responsible for maintaining the primary information system for the program, the Medicaid Management Information System (MMIS), to comply with state and federal reporting requirements. The contract with HPE first took effect in 2005, was renewed for a five-year period in 2013, and will expire in November, 2018.

Under the MMIS contract, DHS reimburses HPE for MMIS operations and maintenance activities based on a flat fee, and pays HPE for other services that are not reimbursed as part of the flat fee. The latter services include: (a) staff to conduct certain specialized services, such as implementing managed care rate setting initiatives, conducting prior authorization support for physician services, and pharmacy initiatives; (b) operating the Wisconsin Immunization Registry and the Wisconsin Chronic Disease program; (c) implementing several initiatives to reduce MA service costs and to comply with federal requirements; and (d) postage for mailings to MA recip-

Table 3.1: Summary of MA and FoodShare Administrative Contracts -- 2016-17 Estimates

	Estimated Expenditures			
	GPR	PR	FED	Total
Fiscal Agent				
Hewlett-Packard Enterprises	$19,559,400	$2,837,000	$45,223,200	$67,619,600
CARES				
Deloitte	9,911,200	923,800	26,045,300	36,880,300
State Agencies -- DOA, DWD, DCF	11,129,200	150,000	16,389,000	27,668,200
Major External Contracts				
Various	13,867,700	3,743,300	22,773,200	40,384,200
Enrollment Broker				
Automated Health Systems	1,000,000	0	1,000,000	2,000,000
FoodShare Electronic Benefits				
Fidelity National Information Systems	1,417,800	0	1,417,800	2,835,600
Inter-Agency and Intra-Agency Services				
DOA -- Division of Hearings and Appeals	1,230,700	11,700	1,197,000	2,439,400
DHS -- Disability Determination Bureau*	1,440,600	1,114,700	1,440,600	3,995,900
BOALTC - Ombudsman Services	-	0	548,200	548,200
PNCC Risk Assessment	24,000	0	24,000	48,000
General Payments				
Various	257,100	543,100	257,100	1,057,300
Grand Total	$59,837,700	$9,323,600	$116,315,400	$185,476,700

*The state match for ombudsman services provided by the Board on Aging and Long-Term Care (BOALTC) is budgeted in BOALTC.

ients and health care providers.

In 2016-17, DHS estimates that it will pay HPE approximately $67.6 million (all funds) for services.

CARES. The Client Assistance for Reemployment and Economic Support (CARES) system assists state and county staff in making eligibility determinations and maintaining case information for such programs as BadgerCare Plus, SeniorCare, Family Care, the SSI Caretaker Supplement, FoodShare, TANF/W-2, and Child Care Assistance (Wisconsin Shares). The first five of these programs, administered by DHS, account for approximately 94% of CARES cases. The other two programs are administered by the Department of Children and Families (DCF).

CARES is a mainframe system that was first implemented in January, 1994, and has been changed as additional programs were added or program needs changed. DHS contracts with Deloitte for programming and maintaining the daily operations of the system. DHS also purchases hardware hosting, network, and mainframe services from the Department of Administration's Division of Enterprise Technology (DET), the Department of Workforce Development (DWD), and DCF to connect and support IM workers. Other CARES costs include security, staff, printing, postage, and software costs.

Major External Contracts. DMS contracts with several other private entities to support the administration of the MA program. For example, DHS contracts with MetaStar, the state's external quality review organization, to conduct on-site visits of long-term care service providers to ensure that the state is complying with federal rules relating to home and community-based long-term care services, and to provide health record quality reviews. Other major external contracts include a contract with the Public Consulting Group to assist DHS in developing a new reimbursement system for services provided by federally qualified health centers, and Milliman to provide actuarial services to the state's MA program and related programs.

Enrollment Broker. Automated Health Systems currently serves as the Department's HMO enrollment broker, which provides outreach, education, and enrollment counseling services to BadgerCare Plus members who enroll in HMOs. These services are provided through a call center in Milwaukee County.

FoodShare Electronic Benefits. DMS contracts with Fidelity National Information Services to provide services relating to QUEST cards, which are electronic benefit transfer (EBT) cards used by FoodShare recipients. These services include the issuance and replacement of QUEST cards and providing customer service for recipients and retailers.

Interagency and Intra-agency Agreements. The MA program also receives administrative services from other state agencies and from other divisions within DHS. These services include proceedings before the Department of Administration's Division of Hearings and Appeals, determinations made by the DHS Disability Determination Bureau, ombudsman services provided by the Board on Aging and Long-Term Care (BOALTC), and rate-setting and other analyses performed by the University of Wisconsin Center for Health Systems Research and Analysis (UW-CHSRA).

General Payments. DMS is billed for several telecommunications and financial services it receives from private entities and the Department of Administration.

Income Maintenance Administration

Income maintenance (IM) refers to the eligibility determination and management functions for several federal and state programs, including MA, FoodShare, and Wisconsin Shares (the state's child care subsidy program). Prior to calendar year 2012, DHS contracted with each county to perform these activities.

2011 Wisconsin Act 32 (the 2011-13 biennial budget act) required counties, other than Milwaukee County, to form multi-county consortia to administer IM programs. DHS was directed to administer IM programs in Milwaukee County as a single-county consortium. Tribes could elect to administer income maintenance programs or have DHS administer those programs.

Each multi-county consortium is contractually responsible for the following:

- Operating and maintaining a call center;
- Conducting application processing and eligibility determinations;
- Conducting ongoing case management; and
- Providing "lobby services," which include, among other services, answering questions from applicants, displaying and making available to visitors state and federal publications regarding public assistance programs, scheduling appointments, accepting verification forms and other documentation, facilitating access to inter-

preter services, providing dedicated, confidential spaces for consumers' use, and providing computers for people to complete web-based applications for public assistance programs, including applications for qualified insurance plans through the federal Affordable Care Act exchange.

In addition, each contract requires DHS and the multi-county consortia to cooperate to provide the following administrative functions relating to the IM programs:

- Conducting subrogation and benefit recovery efforts;
- Participating in fair hearings; and
- Conducting fraud prevention and identification activities.

The statutes also define the administrative functions that DHS is required to perform. These include:

- Providing IM worker training;
- Performing second-party reviews;
- Administering the funeral and burial expense reimbursement program for indigent individuals;
- Providing information technology and licenses for call centers that are operated by multi-county consortia;
- Maintaining the CARES system;
- Contracting with multi-county consortia and tribal governing bodies, including establishing performance requirements;
- Monitoring contracts with multi-county consortia and tribal governing bodies, including compliance with performance standards and federal and other reporting requirements; and
- Operating a centralized document processing unit, which is currently operated under contract by HPE.

In 2017, there are 10 multi-county consortia and nine tribes providing IM services. Milwaukee County's IM program is administered by DHS staff. Table 3.2 shows the counties that are participating in each consortium in 2017.

For contract year 2016, DHS allocated approximately $40.7 million (all funds) to the IM consortia and tribes. This amount included: (a) a base allocation of approximately $27.9 million, referred to as the "income maintenance administrative allocation" (IMAA); (b) a supplement of approximately $4.7 million to fund IM workload relating to work requirements for able-bodied adults without dependent children who receive FoodShare benefits; (c) approximately $4.9 million to fund IM workload relating to implementing Medicaid-related provisions of the federal Affordable Care Act; and (d) approximately $3.2 million in performance bonuses the state received under the FoodShare program.

Table 3.3 identifies the amount of state and federal IMAA funding DHS allocated to the consortia in contract year 2016.

Most counties contribute local funds to partially support their income maintenance activities. These county contributions are referred to as "local overmatch," and are matched with federal funds to support these services. In contract year 2015, the consortia expended approximately $49.2 million (all funds) on IM functions. Consortia are reimbursed for the share of their costs at a blended rate greater than 50%, which is determined after expenses are closed and reconciled mid-year. This funding is not shown in Table 3.3.

Table 3.2: Income Maintenance Multi-County Consortia and Tribes (Calendar Year 2017)

Name	Counties	Name	Counties	Name	Counties	Name	Counties
Bay Lake	Brown*	**Great Rivers**	Eau Claire*	**Northern**	Wood*	**Western**	La Crosse*
	Door		Barron		Ashland		Buffalo
	Marinette		Burnett		Bayfield		Clark
	Oconto		Chippewa		Florence		Jackson
	Shawano		Douglas		Forest		Monroe
			Dunn		Iron		Pepin
Capital	Dane*		Pierce		Lincoln		Trempealeau
	Adams		Polk		Price		Vernon
	Columbia		St. Croix		Rusk		
	Dodge		Washburn		Sawyer	**WKRP**	Kenosha*
	Juneau				Taylor		Racine
	Richland	**IM Central**	Marathon*		Vilas		
	Sauk		Langlade			**Tribes**	Menominee
	Sheboygan		Oneida	**Southern**	Rock*		Red Cliff
			Portage		Crawford		Stockbridge Munsee
East Central	Marquette*				Grant		
IM Partnership	Calumet	**Moraine Lake**s	Fond du Lac*		Green		Potawatomi
	Green Lake		Ozaukee		Iowa		Lac du Flambeau
	Kewaunee		Walworth		Jefferson		Bad River
	Manitowoc		Washington		Lafayette		Sokaogon
	Outagamie		Waukesha				Oneida
	Waupaca						Lac Courtes Oreilles
	Waushara						
	Winnebago						

*Denotes Lead Agency

Table 3.3: Contract Year 2016 Funding Allocations to IM Agencies

	Basic Allocation	ABAWD Supplement	ACA Supplement	FoodShare Bonuses	Total
Consortium					
Bay Lake	$2,249,138	$401,268	$409,820	$265,986	$3,326,212
Capital	4,493,024	830,880	848,590	612,880	6,785,374
East Central Partnership	3,035,307	549,245	560,951	343,024	4,488,527
Great Rivers	3,082,293	535,926	547,348	327,924	4,493,491
IM Central	1,642,544	280,721	286,704	180,526	2,390,495
Moraine Lakes	2,969,018	542,236	553,794	318,432	4,383,480
Northern	2,123,838	311,914	318,562	203,284	2,957,598
Southern	2,501,245	434,970	444,241	315,222	3,695,678
Western	1,923,738	322,469	329,342	189,470	2,765,019
Kenosha-Racine	2,643,280	463,371	473,248	369,042	3,948,941
Subtotal	$26,663,425	$4,673,000	$4,772,600	$3,125,790	$39,234,815
Tribes	$1,220,375	$57,100	$134,800	$37,426	$1,412,275
Total	$27,883,800	$4,730,100	$4,907,400	$3,163,216	$40,647,090

State Administration of Milwaukee County IM Activities. As part of 2009 Wisconsin Act 15 and 2009 Act 28, DHS assumed responsibility for IM activities in Milwaukee County. The state's takeover was precipitated by a federal lawsuit in which a number of Milwaukee County residents alleged that they had been wrongfully delayed or denied benefits under the MA and FoodShare programs. In April 2009, the parties to that lawsuit entered into a settlement agreement under which they agreed to request a court order that stayed that litigation in order to provide time for the transition of responsibility for the Milwaukee County IM programs from the county to DHS. In keeping with the terms of that settlement agreement, DHS developed and implemented a plan which led to the state's administration of IM activities in Milwaukee County. Milwaukee Enrollment Services (MilES) is the DHS unit that performs IM services in Milwaukee County.

In 2016-17, DHS expects to expend approximately $37.2 million (all funds) to support MilES.

Allocation of IM Costs. The state must allocate IM-related costs to each program for federal cost reporting and claiming purposes. Since 2003, CMS has required that DHS 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.

Provider Certification and Regulation

States must determine which providers can participate in the Medicaid 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 other kinds of providers, such as physicians and pharmacies, states generally follow their own laws on licensure and monitoring.

For hospital certification, Medicare and Medicaid rely on the findings of the Joint Commission, (JC) for determining whether an institution meets program requirements. In Wisconsin, JC surveys most hospitals, limiting DHS survey activity to: (a) a sample to validate the reviews by JC; (b) investigation of violations of program requirements; (c) initial surveys of those hospitals that are not surveyed by JC; and (d) investigation of complaints by citizens, the media, and others.

For Wisconsin nursing homes and assisted living facilities, the Division of Quality Assurance in DHS performs surveys that serve as the basis for Medicare and Medicaid certification and state licensure. Under federal law, DHS 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 DHS to survey RCACs at least once every three years.

DHS may impose citations, forfeitures, and civil monetary penalties for violations of state and federal law. However, the Department is not required to impose an assessment for each citation that is issued. Further, DHS may not impose financial penalties for state violations for which federal penalties are assessed. DHS may also reduce the amount of monetary penalties under certain circumstances.

A conditional license may be issued to nursing homes for up to one year when deficiencies directly threaten resident health, welfare, and

safety continue to exist. When a conditional license is issued, a written plan of correction is developed and a time schedule for correcting the deficiencies is established. DHS may monitor or request the appointment of a receiver for a facility in certain circumstances to ensure that adequate care is provided to residents. When a facility is placed under receivership, DHS assumes the operation of the facility until residents can be relocated to another institutional facility or to the community.

Licensing and Certification Revenues. DHS currently collects revenue to support its regulatory functions by charging facilities a flat certification fee or a fixed amount per licensed bed that varies by facility type. Currently, nursing homes are required to pay $6 per licensed bed annually, while hospitals pay $18 per licensed bed. Licensing and support service revenues currently support health facility plan and rule development activities, facility licensure reviews, capital construction and remodeling plan reviews, technical assistance, and associated licensing and support costs. Technical assistance, and licensing and support costs are eligible for federal matching funds under MA.

Office of the Inspector General

The DHS Office of the Inspector General (OIG) was created in 2011 when the Department combined staff from the former Bureau of Program Integrity with staff from other units within DHS that conducted program integrity functions. OIG is attached to the DHS Secretary's office.

OIG's primary responsibilities include: (a) monitoring and auditing providers that participate in the MA program; (b) monitoring and investigating allegations of recipient and provider fraud; and (c) performing internal auditing and consultation services for all DHS programs. In fiscal year 2016-17, OIG was authorized 95.8 full-time equivalent positions to carry out these activities.

Monitoring and Auditing MA Providers. OIG's Medical and Program Audit Review sections are responsible for auditing MA providers to ensure compliance with MA rules and regulations, reviewing provider billing to detect and identify potential overpayments and fraud, investigating fraud allegations, offering technical assistance to providers to ensure compliance with program requirements, and recommending policies that promote and protect the integrity of the MA program.

OIG carries out these responsibilities by reviewing contracts with providers, conducting onsite visits with certain high-risk providers before they become certified to participate in the program, ensuring that the claims processing system has appropriate "checks" in place to prevent reimbursement of questionable claims, conducting audits of providers, and referring cases of suspected fraud to law enforcement.

Recipient and Retailer Fraud Prevention. There are several ways recipients and retailers may commit fraud in the MA, FoodShare, and other public assistance programs. For example, recipients may engage in card sharing or benefits trafficking, fail to provide accurate information on applications or report changes that affect program eligibility or benefits, or receive benefits in more than one state. Retailers participating in FoodShare and the supplemental food program for women, infants and children (WIC) may participate in schemes that enable recipients to make ineligible purchases.

Fraud prevention activities are conducted by a combination of federal, state, county, and contracted staff, pursuant to state and federal laws. In addition, the state Department of Justice operates a Medicaid Fraud Control and Elder Abuse Unit, which investigates and prosecutes fraud perpe-

trated by providers against the MA program, and crimes committed against vulnerable adults in nursing homes and other facilities.

In 2016, the Wisconsin Department of Justice, the federal Social Security Administration, and DHS entered into a memorandum of understanding to create a cooperative disability investigations (CDI) program to combat fraud by investigating statements and activities that raise suspicion of disability fraud by claimants and medical and other service providers. Based in Milwaukee, the seven-person unit (3.0 DOJ positions, 2.0 DOJ positions and 2.0 DHS positions in the DHS Bureau of Disability Determinations) began operations in the fall of 2016.

OIG's Fraud Investigation, Recovery, and Enforcement Section uses several methods to detect and prevent fraud, including monitoring out-of-state usage and the provision of FoodShare replacement cards, investigating fraud allegations received from a statewide hotline and other sources, finding individuals who advertise FoodShare cards or benefits for sale, and using state and national databases to verify recipients' self-reported information.

OIG administers the fraud prevention and investigation program (FPIP) for the MA and FoodShare programs. For calendar year 2016, DHS allocated $1.0 million (all funds) to counties (excluding MilES) and tribes to fund these activities. DHS allocated each county and tribe an amount that is based on each agency's percentage of the statewide income maintenance caseload (excluding the caseload for which MilES is responsible). All counties participate in FPIP as part of one of ten consortia around the state. In accordance with current state policy regarding consultation with tribes, tribal agencies are the only agencies that have the option to operate their FPIPs independently. If a tribal agency chooses to operate independently, the agency will still receive their FPIP allocation.

Responsibilities relating to FPIP are divided between DHS, the IM consortia, and local or contracted FPIP staff. DHS is charged with providing policy and process guidance, developing statewide education materials for program participants, providing guidance and technical assistance to local agencies on trafficking enforcement, maintaining a statewide fraud hotline, and referring cases that warrant investigations to the local agencies. Counties and tribal IM staff are responsible for "front-end verification" (FEV), referring cases to investigators, establishing claims for overpayments, timely reporting of actions taken on cases that are subject to investigations, and seeking criminal prosecution of intentional program violations. FPIP staff conduct fraud prevention investigations, enter FPIP data into CARES, conduct education on FEV and fraud referrals, participate in administrative disqualification hearings, and meet regularly to provide updates to DHS staff.

Internal Audits. OIG's Internal Audit Section performs independent consulting activities to improve DHS operations. This unit conducts internal audits of DHS programs, operations and systems, and evaluates information technology systems to ensure compliance, security, and privacy.

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. This function is referred to 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. For example, 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 in-

curred 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 individuals who have either voluntarily accepted or been assigned legal responsibility for the health care of one or more MA recipients, worker's compensation carriers, absent parents or other entities providing medical child support, and estates.

The identification of COB resources is a shared responsibility of IM consortia, 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 DMS. Once a state has determined 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. Providers are instructed to bill the responsible party before MA if health insurance or Medicare is indicated on a recipient's MA card.

DHS uses two methods to ensure that other liable payment sources are used to pay for services to MA recipients. The first 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 those sources.

The second COB method, referred to as "postpayment recovery," is where the state initially pays provider claims and then attempts to recover those payments from other potentially liable sources. The state can perform postpayment recovery in three different ways: provider-based billing, insurance-based billing, and subrogation processing.

"Provider-based billing" occurs when Medicare coverage (including coverage under Medicare Parts A, B, and D), Medicare Advantage plans, Medicare supplement policies, and commercial health insurance coverage is discovered after Medicaid has paid a provider claim. Under provider-based billing, the Medicaid program produces and sends claims to providers with instructions to bill Medicare or the other health insurance carrier. If a provider receives payment from Medicare or the other health insurance carrier for the service, the provider must adjust their initial Medicaid claim. If an adjustment is not received, or if the provider does not forward a copy of the Medicare or other health insurance denial, the Medicaid program will recoup its payment 120 days from the date of the provider-based billing.

"Insurance-based billing" occurs when Medicare Advantage, Medicare supplemental, or other commercial health or long-term care insurance coverage is discovered after Medicaid has paid a provider's claim after a provider's timely filing allowance has expired with the insurance carrier, or when a provider has not received a response in a timely manner from the other health insurance carrier. Under insurance-based billing, the Medicaid program produces and sends claims to the other health insurance carrier directly to recover the payment.

"Subrogation processing" occurs when claims are identified that are indicative of trauma, injury, poisoning, or other natural causes for the purposes of determining the legal liability of third parties. Property and casualty, automobile, worker compensation, and other similar insurance coverage are pursued directly with the insurance carrier to recover the Medicaid payment.

CHAPTER 4

ELIGIBILITY FOR BADGERCARE PLUS AND RELATED PROGRAMS

This chapter provides an overview of eligibility for BadgerCare Plus and a few related programs. Generally, BadgerCare Plus provides health care coverage to low-income individuals who meet certain financial and non-financial eligibility requirements. For a description of eligibility requirements for individuals who qualify for Medicaid due to being elderly, blind, or disabled, see Chapter 5.

Subject to program eligibility criteria, the following three main groups qualify for coverage under BadgerCare Plus:

- Children under age 19;
- Adults, including parents, caretaker relatives, and adults without dependent children; and
- Pregnant women.

Other individuals may qualify for full-benefit MA coverage, such as children in foster care, young adults formerly in foster care, or women who have been diagnosed with breast or cervical cancer under the Well Woman program.

This chapter also includes a section on special eligibility situations, including transitional MA, presumptive eligibility, retroactive eligibility, and eligibility for continuously eligible newborns. The final section describes some pertinent Medicaid eligibility provisions included in the federal Affordable Care Act.

Financial Eligibility

Individuals qualify for BadgerCare Plus coverage based on household income, measured as a percentage of the federal poverty level (FPL). The U.S. Department of Health and Human Services updates the poverty guidelines annually. Appendix 1 lists annual and monthly income at various percentages of the 2016 FPL.

Unlike eligibility criteria for elderly, blind, or disabled individuals, eligibility for BadgerCare Plus does not depend on an individual's assets,

Table 4.1: 2016 BadgerCare Plus Income Eligibility Standards for Adults, Children, and Pregnant Women

		Annual Income		
	% of the FPL	One-Person Household	Two-Person Household	Three-Person Household
Adults	100%	$11,880	$16,020	$20,160
Pregnant Women*	306	N/A**	49,021	61,690
Children*	306	36,353	49,021	61,690

*Though state statutes set income eligibility for children and pregnant women at 300% of the FPL, under the current income counting methodology, these groups may disregard an amount equal to 6% of the FPL for purposes of determining BadgerCare Plus eligibility, effectively setting the income standard for those individuals at 306% of the FPL.
**The fetus is included in a pregnant woman's household for eligibility determination purposes, so a household of size of one would not apply.

such as savings accounts or property.

Table 4.1 shows the 2016 income eligibility limits that apply to adults, children, and pregnant women, as a percent of the FPL for various household sizes. These eligibility categories are discussed in greater detail later in this chapter.

To calculate an applicant's household income for BadgerCare Plus eligibility purposes, eligibility workers determine the BadgerCare Plus "test group," based on a person's tax household. When determining the eligibility status of a tax filer who is not claimed as a dependent by anyone else, the individual's group includes the filer, his or her spouse, and any other dependents (both in and out of the home). A tax dependent's household will generally be the same as the household's tax filer, with certain exceptions based on who claims the person as a dependent.

After determining the test group, the income of its members is counted to determine whether an applicant qualifies for BadgerCare Plus. The ACA requires state Medicaid programs to use modified adjusted gross income (MAGI) to determine eligibility for most non-elderly, non-disabled individuals. MAGI is adjusted gross income (that is, an individual's taxable income as reported on federal tax forms), plus any foreign income or tax-exempt interest payments.

Prior to the ACA-mandated change to MAGI-based eligibility, states developed their own income-counting rules and allowable deductions, which resulted in variation between states as to what income counted for purposes of Medicaid eligibility. For instance, in Wisconsin, individuals could deduct the amount of court-ordered child support payments the individual was required to make. The ACA standardized the income counting methodology across states. States now apply a uniform 5% income disregard when determining Medicaid eligibility. An additional disregard may also be applied on a state-by-state basis to ensure that the change from the previous income-counting system to MAGI did not result in a systematic decrease or increase in overall program eligibility. In Wisconsin, this "conversion factor" resulted in an additional 1% allowable disregard. Consequently, in Wisconsin, a household's income is reduced by 6% to determine whether a person meets the program's income eligibility standard.

For this reason, although state statutes set income for children and pregnant women at 300% of the FPL, the effective income eligibility level for these groups equals 306% of the FPL with these disregards. However, unlike the standards for children and pregnant women, however, the state statutes specify that the income eligibility standard for adults (parents, caretaker relatives, and adults without dependent children) is *before* the application of income disregard so that the eligibility standard for these adults equals 100% of the FPL, rather than 106% of the FPL.

Pregnant women and children with household income above the normal income eligibility limits may become eligible if they have sufficiently high medical costs. For such persons, medical expenditures are treated like a deductible, after which the person has access to full MA benefits for a six-month period. For a pregnant woman, medical expenses incurred by her or members of her household during a six-month period must exceed the difference between her household income and 306% of the FPL. Eligibility lasts for the remainder of that six-month period or until the time she gives birth.

For children in households with income exceeding 306% of the FPL, the deductible is met once the household's medical expenses incurred during a six-month period exceed the difference between the child's household income and 156% of the FPL. A child in a household with income between 156% of the FPL and 306% of the FPL, but who is ineligible due to having access to a parent's employer-sponsored insurance, as discussed later in this chapter,) may also become

eligible if the household incurs medical expenses sufficient to meet the deductible requirement. In both these cases, the child's eligibility lasts for the remainder of the six-month period.

Non-Financial Eligibility

To qualify for BadgerCare Plus, individuals must satisfy the following non-financial criteria: (a) Wisconsin residency; (b) U.S. citizenship or qualified immigration status; (c) cooperation with establishment of medical support and third-party liability; (d) provision of a social security number; (e) cooperation with verification requests; and (f) compliance with other insurance requirements ("crowd-out" policies).

Residency. BadgerCare Plus recipients must be Wisconsin residents. A person generally satisfies that requirement if they are physically present in Wisconsin and express their intent to remain living in the state. An exception is made to include migrant workers, who live in another state but who are in Wisconsin for a period of less than 10 months for the purpose of agricultural work.

Citizenship. Only U.S. citizens, U.S. nationals, or certain documented immigrants may enroll in BadgerCare Plus. In general, adult immigrants who have been lawfully admitted to the United States can qualify for BadgerCare Plus coverage five years after their arrival. Exceptions to the citizenship requirements apply to certain individuals, such as those seeking asylum.

Federal law designates the documents states can accept as proof of citizenship or qualified alien status. Individuals who currently receive foster care, adoption assistance, Medicare, supplemental security income (SSI) benefits, or Social Security disability insurance (SSDI) benefits, or who have ever been eligible for MA coverage as a continuously-eligible newborn, are exempt from these documentation requirements.

Medical Support/Third-Party Liability. Individuals applying for BadgerCare Plus must cooperate in identifying outside sources of medical support, including the obligation a parent has to pay for his or her child's medical care. An example is a recipient's duty to help establish the paternity (and, in turn, a medical support obligation) of any child born out of wedlock who is covered by BadgerCare Plus. Certain good cause exceptions apply to this requirement.

Recipients must also provide information regarding third-party liability for services. Third-party liability refers to situations in which a party other than the BadgerCare Plus program or the recipient is obligated to pay the recipient's medical expenses, such as when a recipient has private health insurance. As the payer of last resort, BadgerCare Plus only pays for covered services not covered by another source. Moreover, some individuals with employer-sponsored health insurance are not eligible for coverage under BadgerCare Plus due to the program's "other insurance" rules discussed below.

Third-party liability also exists when a recipient receives a settlement (for instance, from another person's insurance policy) related to injuries for which BadgerCare Plus paid part or all of the resulting medical services. In those circumstances, the recipient must advise the state of his or her claim before they settle the case, and must assign to the state that portion of the settlement needed to reimburse BadgerCare Plus for the medical expenses it paid.

Social Security Number. Applicants must provide a social security number or apply for a number if they do not have one. Several groups do not need a social security number, such as continuously eligible newborns, pre-adoptive infants living in a foster home, non-qualifying immigrants receiving emergency services, someone

without a social security number who may only be issued one for a valid non-work reason, tax dependents of filers living outside the home, and individuals who refuse to obtain a social security number for well-established religious reasons.

Cooperation with Verification Requests. An applicant or enrollee must cooperate with requests to verify information relevant to his or her participation in BadgerCare Plus, such as citizenship, identity, immigration status, pregnancy, income, and access to other health insurance coverage.

Access to Other Insurance. BadgerCare Plus limits the eligibility of certain children for benefits if they have access to, or coverage under, a parent or caretaker's employer-sponsored insurance. These are sometimes referred to as "crowd-out" rules, as they are intended to reduce the replacement, or crowding-out, of available employer-based coverage by public coverage such as Medicaid.

These provisions apply to children ages one through five in households with income over 191% of the FPL and children ages six through 18 in households with income over 156% of the FPL. The following subsets of children are exempt from the crowd-out provisions: (a) continuously-eligible newborns; (b) children in households with income between 156% of the FPL and 306% of the FPL who become eligible through the payment of a deductible; (c) infants less than one year old; and (d) former foster care children. Parents, caretaker relatives, childless adults, and pregnant women are not subject to these crowd-out provisions.

For most children enrolled in BadgerCare Plus, the term "employer-sponsored insurance" for these purposes means health insurance offered by a current employer of an adult family member living in the applicant's household for which the employer pays at least 80% of the premium, or health insurance offered through the Wisconsin state employee health plan.

Access to coverage includes past access, current access, current coverage, and dropped coverage. "Past access" applies when a family member could have enrolled in an employer-sponsored plan, but did not. In those circumstances, any person subject to crowd-out restrictions who could have obtained coverage under that plan is not eligible for BadgerCare Plus for twelve months from the date the employer-sponsored insurance would have begun. However, that individual could qualify for coverage if one of several good cause reasons apply to an applicant's not enrolling in employer-sponsored coverage, such as if the family member's employment ends.

"Current access" applies when an individual currently has access to an employer-sponsored health plan, but is not enrolled. Current access includes circumstances where the employer-sponsored coverage would begin any time during the three months following the individual's BadgerCare Plus application filing date, his or her BadgerCare Plus annual review month, or the employed family member's employment start date. Unlike past access, there are no good cause exceptions to not enrolling in a currently accessible plan.

Eligibility Groups

This section describes the eligibility groups under BadgerCare Plus, as well as eligibility rules for children in foster care or a subsidized adoption arrangement, adults formerly in foster care, and women diagnosed with breast or cervical cancer under the Well Woman MA program.

Children. State law sets BadgerCare Plus eligibility at 300% of the FPL for children up to age 19, although the effective limit is 306% of the FPL under MAGI rules. As of July, 2016,

462,608 children were enrolled in BadgerCare Plus.

Approximately 23% of these children were covered under the federal children's health insurance program (CHIP, or "Title XXI" in reference to the authorizing federal statute enacted in 1997), a program separate from traditional Medicaid for children. CHIP allows states to cover children in households with income above the limit for traditional Medicaid. Specifically, children age one to five living in a household with income above 185% of the FPL but less than 300% of the FPL and children age six with household income above 150% of the FPL but less than 300% of the FPL qualify under CHIP. As noted in Chapter 2, states received enhanced federal matching to extend coverage to this group of children.

States have considerable flexibility in designing and administering CHIP. Wisconsin administers its traditional Medicaid and CHIP programs in combination under BadgerCare Plus. Program benefits are the same regardless of the child's eligibility status.

Eligibility for children in households with income over 201% of the FPL is generally contingent upon the payment of monthly premiums. Members of Native American tribes and children under one year of age are not subject to premiums. Table 4.2 shows the monthly premiums a household at various income levels must pay for each child enrolled in BadgerCare Plus.

Parents and Caretaker Relatives. Parents and caretaker relatives with income up to 100% of the FPL qualify for BadgerCare Plus. As of July, 2016, 171,599 parents and caretaker relatives were enrolled in the program.

Prior to April 1, 2014, parents and caretakers in households with income up to 200% of the FPL qualified for BadgerCare Plus coverage. Parents and caretakers with income above 133% of the FPL paid premiums for coverage. 2013 Wisconsin Act 28 and subsequent legislation reduced the income eligibility limit for parents and caretakers from 200% to 100% of the FPL effective April 1, 2014.

Table 4.2: BadgerCare Plus Premiums for Children, by Household Income

Family Income As % of FPL	Monthly $ Premium per Child
Below 201%	No Premium
201% to 231%	$10
231% to 241%	15
241% to 251%	23
251% to 261%	34
261% to 271%	44
271% to 281%	55
281% to 291%	68
291% to 301%	82
301% to 306%	98

Adults without Dependent Children. Adults without dependent children with income up to 100% of the FPL qualify for BadgerCare Plus. As of July, 2016, 144,437 adults without dependent children were enrolled in BadgerCare Plus.

Prior to April 1, 2014, an adult without dependent children could qualify for BadgerCare Plus coverage if he or she had enrolled in the BadgerCare Plus "Core Plan" prior to enrollment in that program's closing in October 2009. Act 28 granted full BadgerCare Plus eligibility to all adults without dependent children with household income under 100% of the FPL.

Pregnant Women. State law sets the maximum BadgerCare Plus income eligibility standard at 300% of the FPL for pregnant women, although the effective limit is 306% of the FPL under MAGI rules. As of July, 2016, 19,966 pregnant women were enrolled in BadgerCare Plus.

A pregnant woman retains her eligibility for BadgerCare Plus for an additional 60 days after the last day of her pregnancy, and the remainder of the month in which that 60th day occurs.

Foster Children and Children in Subsidized Adoptions. Children placed in private foster care settings and children living in state foster homes are eligible for MA, regardless of whether the state receives federal Title IV-E funds for the care and supervision of the child. As of July, 2016, 9,189 foster children were receiving MA benefits.

Children with special needs for whom adoption assistance agreements are in effect, and children adopted under state-established agreements are also eligible for MA. As of July, 2016, 13,966 children meeting those criteria were enrolled in the MA program.

Former Foster Children. If an individual is under 26 years of age and was in out-of-home care (such as foster care, court-ordered kinship care, or subsidized guardianship) on his or her 18th birthday, he or she qualifies for BadgerCare Plus, regardless of his or her household income. Prior to January 1, 2014, this categorical eligibility only applied to former foster children under 21 years of age. As of July, 2016, 784 former foster children were enrolled in BadgerCare Plus under this eligibility category.

Well Woman MA. Wisconsin administers two programs that provide screening and treatment services for breast and cervical cancers: the Wisconsin Well Woman Program (WWWP), administered by the DHS Division of Public Health, and the Wisconsin Well Woman MA (WWMA) program, a Medicaid subprogram.

WWWP provides uninsured and underinsured women with household income of up to 250% of the FPL with screenings for breast and cervical cancers. However, WWWP does not provide treatment for any conditions found as a result of those screenings. Women enrolled in WWWP or the family planning only services program who are diagnosed with breast or cervical cancer, or a precancerous condition of the cervix, qualify for services under the Wisconsin Well Woman MA (WWMA) program if they need treatment for those conditions and do not have other insurance that would cover that treatment. The program does not have separate income eligibility tests because eligibility for services is based on diagnosis through screening provided through the WWWP or family planning only services programs.

Women who qualify for coverage are eligible for the full range of benefits on a fee-for-service basis provided under BadgerCare Plus. As of July, 2016, 591 women were enrolled in the WWMA program.

Special Eligibility Situations

Individuals can receive BadgerCare Plus coverage under several special situations, including transitional MA coverage, presumptive eligibility, retroactive eligibility, and coverage as a continuously eligible newborn. This section describes these situations, as well as the eligibility rules applying to persons confined to a correctional institution.

Transitional MA. Under transitional MA, which is also called income extensions, children, parents and caretaker relatives who have received BadgerCare Plus coverage for at least three of the last six months may remain eligible for either a four- or 12-month period if their household income increases above 100% of the FPL due to earnings or support payments. Adults without dependent children are not eligible for transitional MA.

When the additional income is earned income, the transitional MA period is 12 months. Previously, a four-month extension applied to increases in earnings due to receipt of child support. However, as MAGI does not include child support payments as countable income, this four-

month extension now only applies when income increases due to spousal support, such as alimony.

Individuals in transitional MA remain eligible for BadgerCare Plus coverage, and are exempt from the program's crowd-out rules. However, non-pregnant, non-disabled adults on transitional MA are generally required to pay premiums. Premiums are charged on a sliding scale. The scale ranges from a premium equal to 2.0% of family income for households with income below 133% of the FPL, to 9.5% of family income for households with income at or above 300% of the FPL. Transitional MA households with income between 100% and 133% of the FPL are exempt from premiums for the first six months of their extension.

As of July, 2016, 20,588 parents and caretaker relatives and 47,279 children qualified for transitional MA coverage. [These individuals are included in the enrollment figures provided in the previous section for these groups.]

Presumptive Eligibility. Through presumptive eligibility (also called express household enrollment or temporary enrollment), adults with household income under 100% of the FPL, pregnant women with household incomes at or below 306% of the FPL, and certain children can temporarily enroll in BadgerCare Plus based on a preliminary eligibility determination. This determination can be made by a "qualified entity," which includes MA providers, as well as various certified community organizations, such as schools and public and private social service organizations.

Individuals enrolled under presumptive eligibility have until the last day of the month following the month in which their preliminary eligibility determination was made to apply for BadgerCare Plus. If they apply within that period, their presumptive eligibility continues until a county or state eligibility worker determines whether they qualify for the program. If they do not apply within that period, their presumptive eligibility ends. During the period of presumptive eligibility, an individual qualifies for full benefits under BadgerCare Plus, except for pregnant women who only qualify for pregnancy-related outpatient medical services.

Various rules apply to presumptive eligibility for different groups. For instance, for children, different income limits for presumptive eligibility apply at the following ages: (a) less than age one with household income at or below 306% of the FPL; (b) ages one through five with household income at or below 191% of the FPL; and (c) over age five with household income at or below 156% of the FPL.

Retroactive Eligibility. Under the MA program's retroactive eligibility rules, the following individuals can obtain coverage for services provided during the three months prior to their application for BadgerCare Plus if they met the program's eligibility requirements during that period: (a) adults with household income at or below 100% of the FPL; (b) children under age one in households with income at or below 306% of the FPL; (c) children between ages one and five in households with income at or below 191% of the FPL; (d) children over age five in households with income at or below 156% of the FPL; (e) former foster care youth; and (f) pregnant women.

Continuously Eligible Newborns. Infants remain eligible for BadgerCare Plus if their natural mother was determined eligible for BadgerCare Plus, other full-benefit Medicaid coverage, emergency services, or the MA prenatal program on the date of delivery. These "continuously eligible newborns" qualify for BadgerCare Plus coverage from the date they are born through the end of the month in which they turn one year old. Continuously eligible newborns are exempt from the program's other insurance crowd-out rules, citizenship and identity documentation require-

ments, and premiums. As of July, 2016, 29,937 infants were enrolled under the continuously eligible newborns program (included in the total reported for BadgerCare Plus children in the previous section).

Correctional Inmate Eligibility. A person who is otherwise eligible for or enrolled in BadgerCare Plus is not generally eligible to receive MA services when confined to a jail, prison, or other correctional facility. Instead, his or her medical costs are the responsibility of the correctional facility. However, this restriction does not apply during a period in which the inmate resides outside of the correctional institution for more than 24 hours. This exception is generally applicable to inmates who receive inpatient hospital services for a condition that requires admission to the hospital lasting more than 24 hours.

Inmates who are released from jail with limited privileges under the state's Huber law can become eligible for BadgerCare Plus if they intend to return home and if they continue to be involved in the planning for the support and care of minor children. Huber law prisoners who have release privileges for reasons other than attending to the needs of their families are not eligible for BadgerCare Plus.

BadgerCare Plus and the Affordable Care Act

The ACA made wide-ranging changes to private health insurance markets and the Medicaid program in Wisconsin and the rest of the country. The act implemented many changes to the private insurance market, including eliminating preexisting condition exclusions and requiring most individuals to obtain health care coverage. It also provides federal tax credits for individuals in households with income between 100% and 400% of the FPL to offset the cost of private insurance coverage purchased through a health insurance exchange. For more information on the private insurance provisions in the ACA, see the Legislative Fiscal Bureau informational paper entitled, "The Affordable Care Act (Summary of Major Insurance Provisions and Implementation in Wisconsin)."

Significant Medicaid-related provisions of the ACA include expansion of eligibility to "newly-eligible" groups and maintenance of effort (MOE) requirements for certain eligibility standards.

Medicaid Expansion. As enacted, the ACA required state Medicaid programs, at the risk of losing federal MA matching funds, to cover virtually all non-elderly individuals with household incomes up to 133% of the FPL, beginning January 1, 2014. This new mandatory eligibility requirement was referred to as a "full Medicaid expansion" under the ACA.

The ACA provides states an enhanced FMAP to help cover the costs of individuals who would be "newly eligible" under the Medicaid expansion. The enhanced ACA FMAP equaled 100% in 2014 through 2016, and gradually declines to 90% in 2020 and subsequent years. For these purposes, a "newly eligible" individual is a non-pregnant, non-elderly adult who is not eligible for Medicare Parts A or B, has household income not greater than 133% of the FPL, and who, as of December 1, 2009, was not eligible for full Medicaid coverage, or was eligible but not enrolled (or on a waiting list) for such coverage that has a capped or limited enrollment. In Wisconsin, adults without dependent children would be considered "newly eligible" under a full expansion.

In June, 2012, the U.S. Supreme Court issued a decision under *National Federation of Independent Business v. Sebelius* that addressed two of the ACA's main provisions -- the individual insurance mandate and the Medicaid expansion. The Court upheld the individual mandate, but

effectively made the ACA's Medicaid expansion optional for states, rather than mandatory. That is, states that do not implement the expansion do not risk losing federal funding for their existing Medicaid programs.

The Wisconsin Legislature considered the issue of Medicaid eligibility standards as part of its 2013-15 biennial budget deliberations, and 2013 Act 20 implemented what has become known as a "partial expansion" of the state's Medicaid program. Under this policy, income eligibility for parents and caretaker relatives was reduced from 200% to 100% of the FPL, and BadgerCare Plus enrollment was opened to all adults without dependent children in households with income up to 100% of the FPL.

The enhanced ACA FMAP for newly eligible individuals only applies under full Medicaid expansion. As such, the standard FMAP applies to adults without dependent children currently covered under BadgerCare Plus. Under either a full or partial expansion, the standard FMAP would apply to parents and caretakers since this group was already eligible for MA coverage on December 1, 2009.

Maintenance of Effort Requirement. The ACA prohibits states (at the risk of losing federal MA matching funds) from imposing MA eligibility standards, methodologies, or procedures that are more restrictive than those in effect as of March 23, 2010. For children under age 19, the MOE requirement continues through September 30, 2019.

A similar MOE requirement applied to adults enrolled in MA through 2014 or the establishment of a health insurance exchange. That requirement could be waived if a state certified to DHHS that it had a budget deficit. Wisconsin invoked this limited exception for non-pregnant, non-disabled adults in Wisconsin with household incomes greater than 133% of the FPL. Lifting the MOE for adults allowed DHS to alter the program's crowd-out rules, premiums, restrictive re-enrollment periods, and retroactive eligibility, effective July 1, 2012. Following the changes to eligibility under 2013 Act 28, those rules generally no longer apply to adults in the program.

CHAPTER 5

ELIGIBILITY FOR ELDERLY, BLIND, AND DISABLED MEDICAID PROGRAMS

In addition to funding services for individuals and families under the state's BadgerCare Plus program, the Medicaid program funds services for elderly, blind, and disabled individuals, under EBD Medicaid. EBD Medicaid includes the following subprograms and benefit plans:

- SSI-related Medicaid;
- Institutional Long-Term Care;
- The MA Purchase Plan (MAPP);
- The Katie Beckett Program;
- MA Coverage for Individuals with Tuberculosis;
- Medicare Cost Sharing Assistance Programs;
- Family Care;
- Family Care Partnership;
- Program for All-Inclusive Care for the Elderly (PACE);
- IRIS (Include, Respect, I Self-Direct Program); and
- Home and Community-Based Services (HCBS) Waiver Programs.

For individuals who meet eligibility requirements for both BadgerCare Plus and EBD Medicaid or one of the subprograms, the individual is enrolled in EBD Medicaid. There is an exception to this policy for pregnant women, who may be enrolled in both programs concurrently. As of July, 2016, approximately 219,474 individuals were enrolled in EBD Medicaid subprograms.

This chapter describes eligibility requirements for EBD Medicaid and several of the EBD Medicaid subprograms. Other programs that may be available to EBD Medicaid recipients are discussed in other chapters, including limited coverage plans such as MA coverage for individuals with tuberculosis and the Medicare premium assistance programs which are both in Chapter 6 and Family Care and the HCBS waiver programs, which are in Chapter 11.

Eligibility Requirements

Non-financial Eligibility. In order to be eligible for EBD Medicaid and most of the subprograms, an individual must meet nonfinancial eligibility requirements relating to state residency, citizenship, and immigration status. Additionally, an individual must be at least 65 years old, blind, or disabled.

All disability and blindness determinations are made by the DHS Disability Determination Bureau (DDB). For the purposes of determining eligibility, a disability is defined as the inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than 12 months. Blindness is defined as having vision no better than 20/200 or having a limited visual field of 20 degrees or less with the best corrective eyeglasses.

Federal law permits states to make presumptive eligibility determinations, which enable applicants to be considered disabled until a final disability determination can be completed by the state's DDB. In Wisconsin, if an individual has an urgent need for medical services and has one of a specified set of impairments, the individual can be treated as presumptively disabled.

Financial Eligibility. In order to be eligible for EBD Medicaid and most of the subprograms, individuals must meet certain financial criteria, including an asset and income test.

Assets. The asset limit for EBD Medicaid and most of the subprograms is $2,000 for an individual and $3,000 for a married couple. The limits do not apply to children under age 19. Most types of assets available to an individual that can be converted to cash are counted, including, but not limited to, funds in bank accounts, certificates of deposit, stocks, bonds, life insurance policies, and cash. Some assets are generally not counted, including the individual's home, certain burial assets, clothing, one vehicle, and other personal items.

The methods the Medicaid program uses to determine countable assets for purposes of program eligibility are complex due to the wide variety of assets individuals may own, and because some assets may be shared by an individual and his or her spouse. Additional information regarding how the Medicaid program counts assets is available in DHS' *Medicaid Eligibility Handbook*.

Income. The income limit for EBD Medicaid is determined by making several deductions from an individual's gross monthly income, which includes both earned and unearned income, to determine an individual's countable monthly income.

These deductions generally include expenses for establishing and maintaining court-ordered guardianships or protective placements; medical and remedial services and equipment; a standard Medicaid credit of $20; support and maintenance payments made to another person outside of the household; impairment-related work expenses (IRWEs); and one-half of the applicant's monthly gross job income and wages plus $65.

Once an individual's countable income is determined, this amount is compared to one of two income limits depending on the individual's marital status. In 2017, the income limit for unmarried individuals is $573.78, plus actual shelter costs up to $245, for a total of $818.78. The income limit for a married individual is $867.38, plus actual shelter costs of up to $367.67, for a total of $1,235.05.

If an individual does not qualify for Medicaid coverage only because his or her income exceeds the income limits described above, he or she may still qualify for Medicaid coverage by meeting the Medicaid deductible. An applicant meets the deductible by paying out-of-pocket health-related expenses as specified in the *Medicaid Eligibility Handbook*, for the applicant, the applicant's spouse, or the applicant's minor children that live in the household. Once the individual meets the deductible, the state Medicaid program pays for other Medicaid-covered services the individual receives during the six-month deductible period.

The individual's deductible is calculated by determining the monthly amount by which his or her counted income exceeds the medically needy income limit ($591.67 per month in 2017) and multiplying that amount by six to reflect the six-month period for which Medicaid coverage is provided.

Additional Eligibility Options

Eligibility Related to SSI. Many EBD Medicaid recipients qualify for the standard Medicaid benefits plan because they receive cash benefits under the supplemental security income (SSI) program, or meet requirements relating to the SSI program. In calendar year 2017, the federal SSI income limit is $735 per month and the asset limit is $2,000 for an individual. For married couples, the income limit is $1,103 per month and the asset limit is $3,000. States may enter into

agreements with the Social Security Administration, which administers the SSI program, to provide all SSI recipients with Medicaid eligibility, eliminating the need for individuals to apply for both programs separately. Wisconsin's Medicaid program provides automatic coverage for individuals who receive cash assistance under the SSI program.

Most states, including Wisconsin, supplement federal SSI payments with state funds. In addition, states may provide Medicaid coverage to individuals who receive a state supplementary payment, but receive no federal SSI payment, and to individuals who are eligible for, but do not receive, SSI payments. Wisconsin's Medicaid program covers both of these groups.

Federal law requires state Medicaid programs to provide coverage for several groups of individuals who were previously eligible for SSI, but no longer receive monthly SSI payments. These includes: 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; individuals who were once eligible for both SSI and Social Security payments but who are no longer eligible for SSI because of certain cost of living adjustments in their Social Security benefits; certain other individuals who become ineligible for SSI due to changes in eligibility for, or increases in, Social Security or veterans benefits; and certain SSI-related groups who received benefits in 1973, including individuals who care for disabled individuals.

Additional information on the SSI program can be found in a Legislative Fiscal Bureau informational paper entitled, "Supplemental Security Income."

Medicaid Eligibility for Individuals who Require Long-Term Care Services. Under federal law, states may provide Medicaid coverage to residents of institutional facilities (nursing facilities, hospitals, and other medical institutions) and individuals who live in their own homes but participate in the community-based waiver programs, under a special institutional income rule. This rule permits individuals who are not eligible for SSI and have income that does not exceed 300% of the maximum monthly federal SSI payment amount to be automatically eligible for Medicaid coverage without meeting the Medicaid deductible. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($2,205 per month in 2017).

Alternatively, if an individual's gross income exceeds this standard, his or her gross income is compared to monthly medical costs, which includes the following: (a) a personal needs allowance of $45; (b) institutional care, using the private care rate; (c) health insurance; (d) support payments; (e) out-of-pocket medical costs; (f) work-related expenses; (g) costs identified in a self-support plan; (h) guardian fees; and (i) other medical and deductible expenses. If the individual's gross income is less than his or her monthly medical needs, the individual may qualify for Medicaid-funded institutional care under this methodology, which is sometimes referred to as the "medically needy" standard.

Medicaid recipients who qualify for Medicaid-funded institutional care must use any income in excess of allowable deductions for the cost of their care. The Medicaid recipient's share of these costs is referred to as patient liability. If an individual's patient liability meets or exceeds the institution's payment rate, he or she is responsible for paying the entire Medicaid rate, but is able to keep any remaining income. SSI recipients do not have a patient liability.

Additional Factors Affecting Eligibility

An individual's eligibility for EBD Medicaid

can also be affected by factors other than the individual's age, medical condition, and financial status, as described in the following sections.

Spousal Impoverishment. Spousal impoverishment protections affect legally married couples when one spouse receives certain long-term care services either in a nursing home or through an HCBS waiver program (the institutionalized spouse) while the other spouse does not (the community spouse). In such circumstances, the protections allow a portion of the couple's income and assets and income to be retained for the community spouse.

Asset Limit. The level of assets protected for the community spouse is calculated based on the couple's assets at the time of initial institutionalization or request for HCBS services. Countable assets include items owned by either spouse, but exclude the couple's home, one vehicle, assets related to burial (including insurance, trust funds, or plots), household furnishings, and clothing or other personal items.

The value of co-owned assets is divided equally among elderly, blind, and disabled Medicaid applicants only, rather than among all co-owners to prevent Medicaid applicants from reducing their countable assets by adding co-owners to their assets.

Federal law allows states discretion in establishing the asset protection level within minimum and maximum limits ($24,180 to $120,900 in calendar year 2017). Most states allow the community spouse to keep the maximum level, regardless of the amount of the couple's total assets.

Wisconsin has set its spousal asset protection level at the greater of: (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum of $120,900. As required by federal law, the state asset limits may be adjusted based on the couple's circumstances by a fair hearing or court order.

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

The following example illustrates how the asset test is currently applied in Wisconsin. Consider a couple whose combined countable resources are $120,000 at the time of initial institutionalization. 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 Medicaid. By the time the institutionalized person applies for Medicaid, the couple's combined countable resources have been reduced to $90,000. In this example, the greater of: (a) the state spousal resource standard ($50,000) or (b) the spousal share at the beginning of the initial period of institutionalization ($60,000) would be deducted from the combined countable resources at the time of application, resulting in an unprotected resource amount of $30,000 ($90,000 minus $60,000). Because $30,000 exceeds the state's asset limit of $2,000, the institutionalized spouse would not be eligible for Medicaid. 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 Medicaid asset test because his or her own assets (after excluding the community spouse's share) would be less than the current asset limit of $2,000.

Income. One way that the spousal impoverishment provisions protect the community spouse is that only the income in the institutionalized spouse's name has to be used for the cost of care

for the institutionalized spouse and for determining eligibility for Medicaid-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 the monthly maintenance needs allowance. Under federal law, states may allow income of up to $3,022.50 per month to be transferred to the community spouse in 2017. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index. Additional income may also be transferred to provide for certain dependent family members living with the community spouse.

Under federal law, the minimum amount of income that states must allow to be transferred to the community spouse is $2,002.50 per month for 2017. The federal minimum is usually increased each year as the federal poverty level increases. If the state establishes an income allowance that is below the federal maximum, the state must establish an excess shelter allowance.

In Wisconsin the maximum amount that may be transferred to the community spouse, in 2017, is $2,670.00 per month plus any shelter costs greater than $801 up to $3,022.50 combined total. Shelter expenses include the community spouse's expenses for rent, mortgage principal and interest payments, taxes and insurance for a principal place of residence, maintenance fees if the community spouse lives in a condominium or cooperative, and a standard utility allowance. In addition, Wisconsin permits the institutionalized spouse to transfer up to $667.50 per month in 2017 for each qualifying dependent family member living with the community spouse.

The federal Deficit Reduction Act of 2005 (DRA) clarified that 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. The assets of the institutionalized spouse (including annuities or other income-producing assets) can only be transferred to the community spouse if this does not cause the community spouse's income to exceed the state-approved monthly maintenance needs allowance. Otherwise, they remain attributed to the institutionalized spouse and must be used towards care costs. This calculation generally requires a couple to deplete a larger share of their assets before becoming eligible for Medicaid.

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 HCBS waiver program, the allowance is between $915 and $2,205 per month in 2017 to pay for 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 2017, if a community spouse has shelter costs of $866 per month, the excess shelter costs equal $65.00 per month ($866 - $801 = $65.00). In this case, the maximum monthly income allocation is $2,735 ($2,670 + $65 = $2,735). If the community spouse receives $200 per month as income in his or her name, the amount is subtracted from $2,735 per month to determine the spousal income allocation amount ($2,535). If the institutionalized spouse's income is $3,600, the institutionalized spouse’s nursing home liability amount would be $1,020 per month [$3,600 (the institutionalized spouse's income) - $2,535 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) =

$1,020].

Divestment. A person may be denied Medicaid coverage if that person, his or her spouse, or the person's representative engages in divestment. The following discussion provides a brief summary of state divestment rules implemented by DHS. A full description of the state divestment rules can be found in the state's *Medicaid Eligibility Handbook*.

Divestment includes disposing of certain assets for less than fair market value or not receiving assets to which he or she is entitled for the purpose of meeting the Medicaid resource test. DHS also treats the purchase of annuities as a divestment unless certain requirements listing the state as a beneficiary are met.

In order to determine whether divestment occurred, states are required to review the assets of all long-term care Medicaid applicants over a specified time period, known as the "look back" period, before the date the applicant applied for Medicaid or was institutionalized. For divestments occurring before January 1, 2009, states are required to review the assets of all long-term care Medicaid applicants for a period of 36 months before the date the applicant applied for Medicaid, or 60 months if the applicant's assets were included as part of a trust. The DRA extended the length of the look back period to 36 months for divestments occurring from January 1, 2009, to January 1, 2012, 36 to 59 months for divestments occurring from January 1, 2012, to December 31, 2013, and 60 months for divestments occurring after January 1, 2014.

Under specific circumstances, resource transfers to certain family members are permitted without adversely affecting Medicaid eligibility, including certain transfers of homestead and non-homestead property.

Divestment penalties also do not apply if the individual 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 Medicaid; (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 a serious impairment to the institutionalized person's immediate health.

If an eligibility worker determines that divestment occurred at any time during the look back period, a penalty period would be applied. The penalty period establishes the amount of time that the person would be ineligible for Medicaid-funded long-term care costs. The length of the penalty period is calculated by dividing the amount of the transfer by the daily private pay rate of nursing homes ($259.08 as of July, 2016).

For example, if a person made a transfer of $50,000 one year before applying for Medicaid, this would generate a penalty period of 192 days ($50,000/$259.08 per day = 192.99 days, rounded down). The penalty period begins on the date the individual applies for Medicaid services and meets all other eligibility criteria. Under this example, the Medicaid program would not pay for long-term care services for the individual until 192 days after the person applies and is determined to be eligible for Medicaid-funded long-term care services. If an individual is already enrolled in Medicaid but is not receiving long-term care services, the penalty period would begin when the individual is approved to receive long-term care services.

Under the rules mandated by the DRA, individuals may also be disqualified from Medicaid eligibility if the equity in their home and the land used and operated in connection with the home exceeds a certain value. In 2017, federal rules establish this threshold at $560,000. However, states that submit a state plan amendment may

increase this amount to $840,000. The limit does not apply if a spouse, minor, or disabled adult child resides in the home.

Except for the changes to the look back period, which were phased in, all of the provisions mandated by the DRA apply in Wisconsin to transactions occurring on or after January 1, 2009.

Wisconsin Long-Term Care Insurance Partnership. By purchasing an approved long-term care insurance policy, an individual may protect individual assets on a dollar-for-dollar basis for every dollar in private long-term care insurance benefits paid out by the qualified long-term care insurance policy on or after January 1, 2009. Once DHS verifies that these benefits have been paid, an individual is able to protect a corresponding amount of personal assets that equals the cash value of the insurance benefits. These protected assets are added to the $2,000 standard asset limit, as well as the protections offered under spousal impoverishment rules, to determine the total value of an individual's assets that are protected while still qualifying for Medicaid.

Estate Recovery Program. Under federal law, state Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option to recover payments for all other Medicaid services provided to these individuals, except Medicare cost-sharing paid on behalf of individuals who receive benefits under the Medicare savings programs described in Chapter 6.

Wisconsin's statutes require DHS to file claims against the estate of a deceased Medicaid recipient or the estate of the surviving spouse to recover certain costs, except in cases in which this would cause undue hardship. These costs include Medicaid payments for nursing home care and institutionalized inpatient hospital care (stays for 30 days or more) provided to MA recipients of any age. In addition, Wisconsin's estate recovery program seeks recovery of MA payments for the following services provided to noninstitutionalized individuals age 55 or older: (a) skilled nursing services; (b) home health aide services; (c) home health therapy and speech pathology services; (d) private duty nursing services; (e) personal care services; and (f) all services provided through Medicaid long-term care programs. DHS attempts to recover the full amount of the capitation payments made to managed care organizations (MCOs) on behalf of the recipient for long-term care program services delivered through managed care.

In addition, DHS may recover from all property in which the recipient had an interest at the time of death, including life estates, property held in revocable trusts, property that passes by beneficiary designation, joint tenancy property, and marital property. A full description of the program can be found in the state's *Medicaid Eligibility Handbook.*

The estate recovery program attempts to recover Medicaid costs by: (a) placing a lien against a home; (b) filing claims in a recipient's estate or in the estate of his or her surviving spouse; (c) affidavits; and (d) voluntary recoveries. Property of the Medicaid recipient that is being transferred by an affidavit or by a nonprobate transfer upon death is subject to a lien if the state's claim cannot be satisfied through available liquid assets.

Medicaid recipients who are age 55 or older may maintain continuous Medicaid eligibility and reduce a potential claim against their estates or prepay a Medicaid deductible by making voluntary payments to the estate recovery program. Except in the case of a prepayment of a Medicaid deductible, voluntary payments may

not exceed the amount paid by Medicaid to date.

EBD Medicaid Programs

While all EBD Medicaid-eligible individuals may have access to certain Medicaid-covered services (the services described in Chapter 8), the Medicaid program includes several subprograms in which the EBD Medicaid population may also participate.

SSI Managed Care. Under the SSI Managed Care program, DHS requires EBD Medicaid recipients living in a service area that has implemented an SSI managed care program who meet all of the following criteria to enroll in managed care: (a) are age 19 or older; (b) are eligible for Medicaid under SSI or SSI-related criteria due to a disability; (c) are not living in an institution or a nursing home; (d) are not participating in a HCBS waiver program; and (e) are not enrolled in Family Care, IRIS, PACE, or Family Care Partnership. Individuals who may, but are not required to, enroll in HMOs include individuals who are dually eligible for Medicaid and Medicare, and individuals participating in the MA Purchase Plan (MAPP).

Enrollees have access to all of the covered services described in Chapter 8. In addition, 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.

DHS has implemented two different enrollment models depending on the number of HMOs participating in counties where SSI managed care is offered. For counties with two or more participating HMOs, the Department has implemented an "all-in, opt-out" model. Under this model, all eligible, non-exempt individuals are automatically enrolled. Individuals must then remain in an HMO of their choice for at least 60 days. Once the 60 days have expired, an individual has 60 more days to determine whether to continue in managed care or opt out in favor of fee-for-service. Any subsequent enrollment changes may be made one year after initial enrollment. For counties with only one HMO, enrollment in SSI managed care is voluntary. During the initial six-week enrollment period individuals have the option of choosing between managed care and fee-for-service. An individual who chooses managed care has 90 days to change his or her mind. Otherwise he or she must remain in managed care for the remainder of the year.

Contracts between DHS and participating HMOs contain several requirements related to the continuity of care provided to recipients. First, the HMO must authorize and cover services with an enrollee's current provider 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. Second, the HMO must honor fee-for-service prior authorizations approved for 60 days or until the month following the HMO's completion of the assessment and care plan. Third, the HMO must assist members who wish to change HMOs or return to fee-for-service arrangements by making appropriate referrals and transferring records to the new providers.

As of July, 2016, 10 HMOs provided managed care to approximately 36,300 SSI managed care recipients. In 2015-16, approximately $204.1 million (all funds) was expended to support SSI managed care capitation payments throughout the state. Table 5.1 provides a breakdown of SSI managed care enrollees by eligibility group.

Table 5.1: SSI Managed Care Enrollees by Eligibility Group, July, 2016

MAPP - Dual Eligibles	2,293
MAPP - Medicaid Only	267
SSI - Dual Eligibles	10,304
SSI - Medicaid Only	23,484
Total	**36,348**

MA Purchase Plan (MAPP). MAPP aims to remove financial disincentives to work by permitting individuals with a disability who are working, or want to work, to become eligible or remain eligible for Medicaid by allowing enrollees higher income limits than SSI-related Medicaid. The program also allows an individual to accumulate savings from earned income in independence accounts.

Individuals are eligible to participate in MAPP if: (a) their family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL; (b) their countable assets under Medicaid financial eligibility rules do not exceed $15,000; (c) they have a disability, under SSI standards (disregarding one's ability to work); (d) they are engaged in gainful employment or are participating in a vocational program that is approved by DHS; and (e) they are at least 18 years old.

Individuals enrolled in MAPP pay a monthly premium if their individual gross monthly income, before deductions or exclusions, exceeds 150% of the FPL for their family size. 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 following deductions: (a) standard living allowance ($838 per month in calendar year 2017); (b) impairment-related work expenses; (c) out-of-pocket medical and remedial expenses; and (d) a cost of living adjustment disregard. The part of the premium based on earned income is equal to three percent of earned income. If the deductions for unearned income are greater than unearned income, any remaining deductions can be applied to earned income before the three percent premium rate is applied.

As of July, 2016, there were approximately 27,700 individuals enrolled in MAPP.

The Katie Beckett Provision. In 1982, federal Medicaid law was modified to incorporate the Katie Beckett provision. This provision permits states to extend Medicaid coverage to disabled children under the age of 19 who: (a) would be eligible for Medicaid if they were in a hospital or nursing facility; (b) require a level of care typically provided in a hospital nursing facility; (c) can appropriately receive care outside of a facility; and (d) can receive care outside of an institution that costs no more than the estimated cost of institutional care. Unlike certain other Medicaid recipients, the families of the children eligible under the Katie Beckett provision are not subject to copayment or deductible requirements. However, a parental liability may be assessed to help offset the costs of providing services for children who are eligible under the Katie Beckett provision and participate in the children’s long-term support program (CLTS). As of July, 2016, 5,283 children in Wisconsin were enrolled under this eligibility provision.

Table 5.2 summarizes asset and income eligibility limits for select Medicaid subprograms described in this chapter for CY 2017. The income and asset limits shown in the table reflect countable income and assets, and are generally applied after various deductions and exclusions described in this chapter.

Table 5.2: Income and Asset Eligibility Criteria for Medicaid by Group and Eligibility Category, CY 2017

MEDICAID				
Sub-Program	**Family Size**	**Monthly Income Limit**	**Asset Limit**	**Eligibility Requirements**
Categorically Needy	1	$818.78 (Includes the maximum shelter allowance of $245)	$2,000	• 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.
	2	$1,235.05 (Includes the maximum shelter allowance of $367.67)	$3,000	
Medically Needy	1	$591.67	$2,000	• 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.
	2	$591.67	$3,000	
Community Spouse Protected Income and Resources	2	$3,022.50	See Text	• A community spouse of an institutionalized Medicaid-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 resources, up to the federal maximum of $120,900. 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 $667.50 per month for each qualifying dependent).
Special Income Limit	1	$3,022.50	$2,000	• Individuals who are not categorically eligible for Medicaid with income not exceeding 300% of the monthly federal SSI payment level and who are residents of institutional facilities or participating in a community-based services waiver program. • Enrollees are allowed to retain $45 per month if institutionalized or between $915 and $2,205 per month if participating in a community-based services waiver program in addition to the community spouse income and resource protections described above.
MA Purchase Plan (MAPP)	1	250% of FPL	$15,000	• Disabled adults who are working or enrolled in an approved vocational program with income up to 250% of the FPL and assets below $15,000. • All services under Medicaid are covered, but a premium is charged for enrollees with income that exceeds 150% of the FPL.

CHAPTER 6

LIMITED BENEFIT MEDICAL ASSISTANCE PROGRAMS

In addition to providing comprehensive coverage for individuals enrolled in BadgerCare Plus and EBD Medicaid, the MA program provides limited benefits to certain groups. These limited benefit groups include: (a) Medicare cost sharing assistance for certain persons not eligible for full MA benefits; (b) the family planning only services program; (c) the MA prenatal program; (d) emergency services; and (e) persons diagnosed with tuberculosis. This chapter describes program eligibility and services available under these limited benefit programs. Since the cost sharing programs interact with federal Medicare program coverage, the first section begins with background information on that program.

MA Benefits for Medicare-Eligible Persons

Background on Medicare. The federal Medicare program provides health care coverage for people who are 65 years of age or older, certain disabled individuals who are under the age of 65, and persons of all ages with end-stage renal disease (people who require dialysis or a kidney transplant).

The program provides several types of health care coverage. Part A covers hospital care, noncustodial care in a skilled nursing facility following an inpatient hospital stay, hospice care, and home health services. Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Part C, also known as Medicare Advantage, is an alternative to Parts A and B, and in some cases Part D, in which Medicare enrollees elect to receive the same services through a private health plan of their choosing, rather than through the fee-for-service system used in Part A and Part B. Part D refers to Medicare outpatient drug coverage, which is discussed in greater detail, along with the state's SeniorCare program, in Chapter 7.

After reaching age 65, most individuals are entitled to coverage under Medicare Part A and do not pay a monthly premium for this coverage because they, or their spouse, have 40 or more quarters of Medicare-covered employment. For individuals that do not meet the 40 quarter requirement, Medicare coverage can still be obtained by paying a premium. In 2017, the monthly premium for Part A coverage is $413 for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment, and $227 per month for people who have 30 to 39 quarters of Medicare-covered employment.

All persons who enroll in Medicare Part A may enroll in Medicare Part B by paying a monthly premium. In calendar year 2017, individuals and married couples with annual incomes less than $85,000 and $170,000, respectively, pay monthly premiums of $134.

Individuals that receive Medicare Part A and Part B services may be subject to certain deductible and coinsurance requirements based on the length of the benefit period for which services are received. A "benefit period" is a period of consecutive days during which medical benefits for covered services are available to the individual. The benefit period is renewed when an individual has not been in a hospital or skilled nursing facility for 60 days. Under Part A, the maximum ben-

efit period is 60 full days of hospitalization, plus 30 days during which the individual pays coinsurance. An individual may also utilize up to 60 additional benefit days drawn from his or her lifetime reserve. Lifetime reserve days are not renewable. For a skilled nursing facility, the maximum benefit period is 100 days, with copayment requirements for days 21 through 100.

In 2017, Medicare Part A pays for all covered Part A services in a benefit period, except a deductible of $1,316 during the first 60 days of a hospital stay and coinsurance amounts for hospital stays that last beyond 60 days but not more than 150 days ($329 per day for days 61 through 90 and $658 per day for days 91 through 150). For care provided in a skilled nursing facility, the coinsurance amount is $164.50 per day for days 21 through 100 of each benefit period.

In 2017, Medicare Part B pays for all covered Part B services in the benefit period except a deductible of $183 per year and a cost share of 20% of the Medicare-approved amount for services after the $183 deductible is met. Providers must accept Medicare rates as full payment for any services provided to a Medicare enrollee.

Individuals who are eligible to enroll in Medicare Part A and Part B may instead enroll in a Medicare Advantage plan, which is required to provide at least the Medicare benefit package, but may also offer additional covered benefits, including some benefits commonly offered by Medicare supplemental policies. Medicare Advantage plans include managed care plans, preferred provider organization plans, private fee-for-service plans, and specialty plans. Medicare pays each plan a fixed monthly amount for each Medicare Advantage enrollee. Plans are allowed to choose their cost-sharing requirements and set rules for how enrollees must access services, such as whether to require prior authorizations or establish out-of-network restrictions.

All Medicare Advantage plans must meet minimum state and federal requirements for licensure, offered benefits, access to providers, quality of care, and reporting. Each Medicare Advantage plan has an annual election period that begins October 15 and continues through December 7, during which Medicare recipients may enroll in, or disenroll from, any Medicare Advantage plan for the following calendar year. In addition, each plan has an open enrollment period from January 1 through February 14 during which a Medicare recipient can disenroll from his or her Medicare Advantage plan, either to opt out of Medicare Advantage and return to coverage provided under Part A and Part B, or switch from one Medicare Advantage plan to another plan of the same type.

Some individuals with Medicare coverage are also eligible for either partial or full Medicaid benefits. These individuals are commonly referred to as "dual eligibles." Dual eligibles fall into two general categories: those who are not financially eligible for Medicaid, but who qualify for Medicaid-funded assistance with Medicare cost sharing requirements, and those who are fully eligible for Medicaid services. Medicare cost-sharing assistance is considered a partial Medicaid benefit and is discussed in the next section. Those dual eligibles who qualify for full Medicaid benefits also receive Medicare cost-sharing assistance, as well as Medicaid acute care services not covered by Medicare (such as vision and dental care) and the same long-term care services available to other Medicaid beneficiaries.

Cost Sharing Assistance for Dual Eligibles who are not Eligible for Full Medicaid Benefits. Congress has enacted several programs, collectively referred to as Medicare savings programs (MSPs), to help low-income Medicare recipients who do not qualify for full Medicaid benefits pay for Medicare's cost-sharing requirements. Federal law defines several groups of individuals who may participate in the MSPs, and specifies the benefits to which these individuals are entitled.

Qualified Medicare Beneficiary (QMB). QMB participants are individuals who are entitled to Medicare Part A services whose countable income (after subtracting certain credits) does not exceed 100% of the FPL, and whose resources do not exceed an asset limit of $7,390 for an individual and $11,090 for a couple in 2017. This group includes elderly individuals who are not automatically entitled to Part A coverage, but who are eligible to purchase Part A coverage by paying a monthly premium. For QMB participants, Medicaid pays any required Medicare premium, coinsurance, copayments, and deductible for both Medicare Part A and Part B coverage. As of July, 2016, there were 9,488 QMB beneficiaries.

Specified Low-Income Medicare Beneficiary (SLMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+). A more limited Medicaid benefit is provided to individuals eligible for the specified low-income Medicare beneficiary (SLMB) and the specified low-income Medicare beneficiaries plus (SLMB+) program. SLMB+ participants are referred to as Qualifying Individuals (QIs) in federal law. SLMB and SLMB+ participants are individuals who are enrolled in Medicare Part A and have income (after subtracting certain credits) that is at least 100% but less than 120% of the FPL (SLMB) or is at least 120% but less than 135% of the FPL (SLMB+). The asset limits for SLMB and SLMB+ are the same as those for QMB. State Medicaid programs are only required to pay Medicare Part B premiums for these two groups. As of July, 2016, there were 7,031 SLMB and 2,806 SLMB+ participants.

While the Medicaid program pays the same benefit (the Medicare Part B premium) on behalf of SLMB and SLMB+ participants, the source of funding for this benefit varies. The Medicare cost sharing funded by the state Medicaid program for QMB and SLMB participants is funded as a Medicaid service cost, which permits the state to claim federal matching funds for these costs without a set limit. In contrast, CMS allocates sum certain amounts of federal funds to each state to fund Medicare Part B premiums for SLMB+ participants. Consequently, these costs are 100% federally-funded. Further, unlike the assistance provided to QMB and SLMB participants, the state's obligation to fund Medicare Part B premiums for SLMB+ participants is limited to the federal funding allocation the state receives for that purpose.

Table 6.1 summarizes 2017 asset and income eligibility limits for the MSPs described in this chapter. The income and asset limits shown in the table reflect countable income (after subtracting certain credits) and assets.

Table 6.1 2017 Asset and Income Eligibility Limits for Medicare Savings Programs

MSP	Family Size	Income Limit (% of FPL)	Asset Limit	Benefits Paid
QMB	1	100	$7,390	Medicare Part A and B premiums, coinsurance, and deductibles
	2	100	$11,090	
SLMB	1	100 - <120	$7,390	Part B premiums
	2	100 - <120	$11,090	
SLMB+	1	100 - <135	$7,390	Part B premiums
	2	100 - <135	$11,090	

Other Limited-Benefit MA Programs

Family Planning Only Services Program. The family planning only services program provides contraception and related services to individuals with income up to 306% of the FPL. The program is the successor (with modifications) to the previous family planning waiver program, and is now incorporated into the state MA plan. In July, 2016, there were 38,283 individuals enrolled in the family planning only services program.

Both males and females can enroll in the program if they meet the following criteria: (a) they are of child bearing or reproductive age; (b) they are not enrolled in BadgerCare Plus or other full benefit Medicaid coverage; (c) for individuals under age 19, are lawfully present in the United States; and (d) for individuals over age 19, are a U.S. citizen or meet specified criteria for immigrant groups (including a five-year waiting period for benefits for most lawfully-admitted immigrants). Only the applicant's income is counted for the purposes of this program, rather than total household income. Consequently, for minors, a parents' income is not counted. The program has an express enrollment feature similar to that available to pregnant women and children under BadgerCare Plus.

Depending upon the enrollee, covered services include contraceptive services and supplies, natural family planning supplies, family planning pharmacy visits, Pap tests, tubal ligations, testing and treatment of sexually transmitted infections, voluntary sterilizations for men 21 years of age or older, and routine preventive services if they are related to family planning. The federal matching rate for family planning only services is 90%, instead of the standard matching rate of approximately 58%.

Prenatal Program. Pregnant women who meet the eligibility requirements for BadgerCare Plus, including income of no more than 306% of the FPL, but who do not qualify for that program because they are inmates of public institutions or are non-qualifying immigrants may receive prenatal services under the MA prenatal program. Covered services include prenatal care, doctor and clinic visits, prescription drugs (including prenatal drugs), and labor and delivery.

Coverage under the program begins the first day of the month when the state receives an application, and continues through the end of the month after the pregnancy ends. As of July, 2016, there were 1,890 women who qualified for benefits under prenatal program rules.

Emergency Services. BadgerCare Plus provides coverage for emergency services to documented immigrants who have not been in the United States for at least five years, and for undocumented immigrants. To qualify, an individual must meet all BadgerCare Plus eligibility criteria except the citizenship and social security number requirements, and income cannot exceed the following limits: (a) for pregnant women and newborns up to age one, 306% of the FPL; (b) for children ages one through five, 191% of the FPL (c) for children ages six through 18, 156% of the FPL; (d) for parents and caretaker relatives, 100% of the FPL; and (e) for youths exiting out-of-home care, no maximum income. Childless adults who would have otherwise qualified for BadgerCare Plus are not eligible for emergency services.

For the purposes of this eligibility rule, an emergency is a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity, including severe pain, such that the lack of immediate medical treatment could result in serious jeopardy of the patient's health, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part. The program only covers medical services needed to treat the emergency medical condition, and all

labor and delivery services for eligible individuals.

A pregnant woman who is a non-qualifying immigrant qualifies for emergency services up to one calendar month before her due date, through the end of the calendar month in which the 60th day after the end of her pregnancy occurs. A child born to a mother covered under BadgerCare Plus emergency services is eligible for BadgerCare Plus as a continuously eligible newborn if he or she satisfies all other eligibility conditions for those children.

People with Tuberculosis. An individual who is infected with tuberculosis (TB), but who is not blind, disabled, or over the age of 65 may be eligible to receive certain Medicaid-funded services if he or she has countable assets of $2,000 or less and gross income of up to $1,555 per month. For these individuals, coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services and services provided by federally-qualified health centers; (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 July, 2016, there were 150 individuals enrolled in Medicaid that met these criteria.

CHAPTER 7

SENIORCARE AND MEDICARE PART D

The SeniorCare program, partially funded with federal Medicaid funds, assists low-income seniors with drug purchases. This chapter describes the provisions of this program, and provides expenditure and enrollment data. Subsequent to the creation of SeniorCare, the federal government established Medicare Part D, which also assists seniors with prescription drug insurance. As this federal program has similar objectives to SeniorCare, this chapter also provides a description of Medicare Part D.

SeniorCare

2001 Wisconsin Act 16 created SeniorCare to help certain low-income Wisconsin seniors purchase prescription drugs. As federal Medicaid matching funds partially support the program, it is considered a limited-benefit subcomponent of the state's MA program. As part of the MA program, many of SeniorCare's administrative and provider reimbursement provisions are the same as those applying to the pharmacy benefit offered under full-benefit MA programs. This section describes the eligibility and cost-sharing requirements for the program, and provides information on program enrollment and financing.

Eligibility. SeniorCare eligibility is based on age and income. Wisconsin residents age 65 and older who are U.S. citizens or qualified immigrants, are eligible for benefits if their household income does not exceed 240% of the federal poverty level (FPL), provided that they do not also qualify for and enroll in EBD Medicaid. Persons with household income above 240% of the FPL may enroll in the program, but do not become eligible for benefits unless they meet the program's "spend down" rules by incurring annual prescription drug costs in an amount equal to the difference between their income and 240% of the FPL. For married couples with both spouses participating in the program, purchases of prescription drugs for either spouse count towards their spend-down requirement. There is no asset test for SeniorCare program eligibility.

Cost-Sharing Requirements. SeniorCare participants must pay a $30 annual enrollment fee. Once in the program, beneficiaries must meet deductible and copayment requirements.

The amount of a participant's deductible, if any, depends on his or her household income level. For the purposes of the program, the "household" includes the beneficiary and his or her spouse, if they live together. The income of spouses living together in a nursing home is not combined, and the income of a spouse eligible for SSI is not included. When calculating income, the program includes gross earned and unearned income, such as social security income, and self-employment income, net of expenses, losses, and depreciation. The program uses prospective income for the 12 calendar months starting with the month of application.

Three income range categories apply when determining deductibles, as shown in Table 7.1. The amount that a person whose income exceeds 240% of the FPL spends on prescription drugs to meet "spend-down" eligibility does not count toward that person's annual deductible. Consequently, to receive benefits, a person in this category must incur prescription drug expenses equal to the spend-down amount, plus an $850 deductible.

Table 7.1: SeniorCare Deductible Requirements

Income Level	Deductible
Less than 160% of FPL	None
160% of FPL to 200% of FPL	$500
More than 200% of FPL	$850

After satisfying any deductible requirement, participants pay a copayment for each prescription drug they obtain under SeniorCare of $5 for each generic drug prescription and $15 for each brand name drug prescription.

Benefits and Pharmacy Reimbursement. SeniorCare drug coverage resembles the pharmacy benefits under BadgerCare Plus and EBD Medicaid, although SeniorCare is more restrictive in some areas. For instance, unlike the full-benefit MA programs, SeniorCare does not cover over-the-counter drugs, except for insulin, even if the beneficiary has a prescription for the drug. SeniorCare also does not cover drugs administered in a physician's office or in a hospital.

As with the full-benefit programs, SeniorCare covers generic drugs unless a physician indicates in a prescription that a brand-name drug is medically necessary. Since 2012, the program has also covered medication therapy management for beneficiaries with complex medication needs.

In order for SeniorCare to cover a prescription, a physician certified to participate in Wisconsin's MA program must write the prescription.

SeniorCare pays only the cost of drugs not covered by any other insurance policy of the beneficiary, such as Medicare Part D. During the deductible period, only the beneficiary's out-of-pocket costs count toward the deductible.

SeniorCare also uses the same pharmacy reimbursement policies as those used for other MA programs, as described in Chapter 9 For most drugs, the ingredient fee is equal to the national average drug acquisition cost. The pharmacy dispensing fee varies depending upon the annual volume of drugs dispensed by the pharmacy, as follows: (a) volume of 0 to 32,999 prescriptions, $21.03; (b) 33,000 to 65,999, $13.95; (c) 66,000 to 98,999, $9.94; and (d) 99,000 or more, $9.50. These policies, effective April 1, 2017, replaced reimbursement policies that generally provided a marginal profit above the wholesale acquisition price for the drug ingredient, but provided a lower dispensing fee of $3.44 for brand-name drugs and $3.94 for generic drugs.

Funding Sources. State GPR, drug manufacturer rebates, and federal Medicaid matching funds support SeniorCare benefits (net of participant cost-sharing and payments from other sources such as some participants' Medicare Part D coverage).

The state budgets GPR funding for benefits in a sum certain appropriation. Under current law, if DHS exhausts the GPR budgeted for the program, benefits are suspended, although this has not occurred in the history of the program.

Rebate revenue received from pharmaceutical manufacturers is deposited into a program revenue (PR) appropriation.

The state receives federal Medicaid matching funds for drugs provided to beneficiaries with incomes below 200% of the FPL. Any program costs associated with participants above that level are paid exclusively with GPR and drug rebate revenues. Table 7.2 shows SeniorCare expenditures, by fund source, from 2009-10 through 2015-16.

A Medicaid waiver authorizes federal financial participation for SeniorCare. Certain budget neutrality conditions apply to the waiver, meaning that the state must demonstrate that the program produces savings for the Medicaid program or other federal programs that offset program costs. In its waiver application, the state asserts that the coverage of prescription drugs reduces the rate at which seniors enter full-benefit EBD

Table 7.2: SeniorCare Benefit Expenditures

State Fiscal Year	GPR	FED	PR	Total
2009-10	$18,273,100	$16,741,000	$79,682,300	$114,696,400
2010-11	20,407,200	23,130,600	64,348,800	107,886,600
2011-12	21,200,200	15,382,300	51,614,800	88,197,300
2012-13	16,097,600	13,338,200	49,154,300	78,590,100
2013-14	16,036,300	17,254,500	52,938,800	86,229,600
2014-15	16,319,900	14,909,700	59,445,000	90,674,500
2015-16*	19,931,600	19,255,400	62,303,800	101,490,800

*Budgeted amounts.

Medicaid (through a reduction in spend-down eligibility) and, therefore, reduces Medicaid-funded expenditures for nursing home care and other long-term care services.

CMS initially approved the SeniorCare waiver in 2002, and has renewed it three times since that time. The current waiver authority will expire on December 31, 2018, if not renewed.

Program revenue generated by the $30 enrollment fee, GPR, and federal Medicaid matching funds support SeniorCare administrative costs.

Program Participation. Enrollment in SeniorCare increased briefly with the start of Medicare Part D in 2006, reaching a peak of over 110,000 in that year. In the following three years, enrollment declined slightly and has generally remained between 85,000 and 90,000 since that time. Table 7.3 shows the average monthly enrollment for fiscal year 2008-09 through 2015-16, and Table 7.4 shows the monthly average enrollment by income level in 2015-16.

Table 7.5 shows the 2015-16 average weekly cost to the program by income eligibility group. As shown in the table, the average per-beneficiary program cost varies widely between the income groups. In particular, the spend-down group has significantly lower average costs than the other groups. This is in part because the program's spend-down and deductible rules for this tier require program participants to contribute to the cost of drugs prior to receiving program benefits. It also partly reflects differences in the health and age of participants in each of the income tiers. Beneficiaries in the spend-down group tend to be, on average, healthier than other program participants and they tend use the program as a form of stop-gap insurance as an alternative to Medicare Part D coverage.

Table 7.3: SeniorCare Average Monthly Enrollment

2008-09	87,823
2009-10	87,693
2010-11	89,401
2011-12	87,693
2012-13	85,276
2013-14	84,420
2014-15	85,740
2015-16	87,899

Table 7.4: SeniorCare Enrollment, by Income Eligibility Group, 2015-16

Income Level	Enrollment
Less than 160% of FPL	30,992
160% of FPL to 200% of FPL	16,691
200% of FPL to 240% of FPL	10,125
Greater than 240% of FPL (Spend-Down)	30,092
Total Enrollment	87,899

Table 7.5: 2015-16 Average Weekly SeniorCare Cost by Income Eligibility Group

Income Eligibility Group	Average Weekly Cost
Less than 160% of FPL	$33.82
160% of FPL to 200% of FPL	31.00
200% of FPL to 240% of FPL	23.29
Greater than 240% of FPL (Spend-Down)	1.58
Program Average	$21.63

Medicare Part D

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created Medicare Part D to offer subsidized outpatient prescription drug coverage for Medicare recipients. Coverage under the program began on January 1, 2006, although some transitional prescription drug assistance was provided in 2004 and 2005.

Eligibility. U.S. citizens age 65 and older, as well as certain people under age 65 with certain disabilities or end-stage renal disease, qualify for Medicare Part D. Participation in Medicare Part D is voluntary, although some individuals such as "dual eligibles" (individuals who are eligible for coverage under both the Medicare and Medicaid programs) are automatically enrolled in a Medicare Part D plan.

Coverage under Medicare Part D. Federally-approved private entities called stand-alone prescription drug plans (PDPs), and Medicare Advantage prescription drug plans (MA-PD plans) deliver Medicare Part D drug benefits. Federal law defines the standard coverage available under Part D in terms of the covered drugs and the structure of that coverage. Part D plans must cover at least two drugs in every therapeutic category of prescription drugs, as well as all, or substantially all, drugs in six categories: antineoplastics (anti-tumor), anticonvulsants, antiretrovirals, antipsychotics, antidepressants, and immunosuppressants. The program does not cover prescription vitamins and minerals, or drugs prescribed for weight gain or loss, cosmetic purposes or hair growth, fertility, anorexia, and relief of cold symptoms. Subject to these limitations, Medicare Part D plans can establish their own formularies.

Within certain limits, Part D plans may vary in terms of their premiums, deductibles, coinsurance, and copayments, but they must be "actuarially equivalent" to the program's "standard benefit" plan (excluding supplemental coverage options). That is, on average, the share of prescription drug costs paid by the plan (as opposed to the share paid by the beneficiary) must be the same as the standard benefit plan. Plans may not establish a higher deductible or a higher maximum out-of-pocket limit than the standard benefit.

The share of drug costs the beneficiary must pay varies within a plan year. The standard benefit structure consists of a deductible stage, an initial coverage phase, a coverage gap (also known as the "donut hole"), and the catastrophic coverage phase. In 2017, the expenditure thresholds are as follows:

- Initially, the beneficiary pays 100% of retail drug costs, up to an annual deductible of $400;

- After the annual deductible has been reached, the beneficiary pays a coinsurance of 25% of drug costs until total spending, including the deductible, reaches the "initial coverage limit" of $3,700 (the plan pays 75% in this range);

- After the beneficiary reaches the initial coverage limit, he or she enters the donut hole, in which he or she was historically required to pay all drug costs. Beginning in 2011, mandatory manufacturer discounts and federal subsidies to Part D plans reduce these costs (explained be-

low); and

- Once out-of-pocket costs (as opposed to total spending) reaches $4,950, the beneficiary receives catastrophic coverage, in which he or she pays a copayment of $3.30 for generic drugs and $8.25 for brand name drugs, or 5% of retail price, whichever is greater. All other costs are paid by the plan and the Part D program.

The dollar thresholds for these phases and copayments change annually in accordance with changes in per capita drug spending.

As originally enacted, the standard Medicare Part D benefit required enrollees to pay 100% of the cost of prescription drugs purchased in the donut hole. The Patient Protection and Affordable Care Act (ACA) gradually reduces enrollee cost-sharing in the donut hole from 100% in 2010 to 25% by 2020 for both brand name drugs and generic drugs. The reduction is provided through a combination of a 50% mandatory manufacturer discount on brand name drugs and federal subsidies to Part D plans, which then cover an additional percentage of the cost for both brand name and generic drugs.

In 2017, after the ACA changes, enrollees will pay 40% of the cost of brand name drugs, while the 50% discount plus a 10% federal subsidy to the plan covers the rest. For generic drugs, the beneficiary will pay 51% of the cost, while a 49% plan subsidy covers the rest. Both the amount paid by the beneficiary and the amount of the discount count towards the out-of-pocket threshold for catastrophic coverage. However, amounts paid by the Part D plan as a result of the federal subsidy do not count towards reaching this threshold.

Premiums and the Role of Medicare Program Funding. The Medicare Part D program subsidizes the cost of drug plan premiums for all beneficiaries. Part D per capita payments directly subsidize plans, and the program's role in financing drug costs above the out-of-pocket threshold indirectly subsidizes program costs.

Direct premium subsidies are set so that Medicare pays 74.5% of the nationwide average cost of basic coverage, excluding catastrophic coverage paid with federal funds. CMS bases this average on bids submitted annually by plan providers. In 2017, the base monthly premium is $35.63.

Although this procedure establishes a base subsidy and premium, subsidies to individual plans are adjusted to account for the health and other characteristics of the actual enrollees in each plan. The actual premium paid by an enrollee will depend upon how his or her plan's bid differs from the nationwide average, as well as other characteristics of the plan, such as if it provides additional coverage not required in the standard benefit. For instance, although the structure of the standard benefit includes a deductible, many plans do not require a deductible, resulting in a higher premium. According to an examination of 2017 stand-alone plans, conducted by the Kaiser Family Foundation, the average monthly premium for plans offered in Wisconsin is $43.68.

Although the program pays 74.5% of the average cost of basic coverage and the beneficiary pays 25.5%, persons with higher incomes must make an additional payment to support benefit costs. These additional payments are collected separately from the premium, and are established on a sliding scale such that the percentage of average costs covered increases with income. Additional payments begin at an annual income of $85,000 for an individual or $170,000 for a couple. At this level, the additional payment is set such that the beneficiary pays 35% of average program costs. The share of costs covered by the beneficiary reaches a maximum of 80% at an income level above $214,000 for individuals and $428,000 for couples.

The cost of plan coverage is reduced indirect-

ly through the payment by Medicare of 80% of drug costs above the out-of-pocket threshold. This provision has the effect of reducing the cost and risk associated with high-cost beneficiaries.

Low-Income Subsidy. Medicare Part D provides financial assistance to some of its enrollees under a low-income subsidy (LIS) program. The amount of assistance, commonly known as "Extra Help," varies by the type of beneficiary, income, and assets. In Wisconsin, approximately one-quarter of Part D participants receive Extra Help assistance.

Most people who qualify for the full subsidy are dually-eligible for Medicare and full benefits under Medicaid. These beneficiaries do not pay a Part D premium or a deductible (assuming they enroll in a plan with coverage that is at or below a specified benchmark), but they do pay a copayment. In 2017, LIS beneficiaries with incomes at or below 100% of the FPL will pay a $1.20 copayment for generic drugs and a $3.70 copayment for other drugs. Dually-eligible beneficiaries with incomes greater than 100% of the FPL pay copayments of $3.30 for generic drugs and $8.25 for brand name drugs. Neither group of these dually-eligible beneficiaries pays copayments after reaching the out-of-pocket limits. In this case, copayments paid by the beneficiary, as well as cost sharing subsidies paid by the program, count as out-of-pocket spending.

Medicare recipients who do not qualify for full benefits under Medicaid, but qualify for limited-benefit Medicaid may also qualify for some LIS assistance with premiums and cost sharing. Medicare beneficiaries, who receive SSI, and other individuals with incomes less than 135% of the FPL and limited assets, can qualify for the same Part D low-income subsidies as full-benefit dual eligibles with incomes greater than 100% of the FPL, as described above. Beneficiaries with incomes above 135% of the FPL, but less than 150% of the FPL must pay premiums, deductibles, coinsurance, and copayments, but at lower levels than the standard benefit for non-LIS beneficiaries. In 2017, these individuals pay income-based sliding-scale premiums and an $82 deductible. After satisfying their deductible, they pay 15% of their drug costs up to the maximum out-of-pocket threshold, beyond which they pay copayments of $3.30 for generic drugs and $8.25 for brand-name drugs.

Funding and State "Clawback" Payments. Nationwide, Medicare Part D program expenditures for benefits and administrative costs totaled $89.8 billion in 2015. These costs are supported by payments from the federal government's general fund (76%), enrollee premiums (14%), and payments from states (10%).

States contribute to the Medicare Part D program through a "clawback" mechanism, established to recognize that state Medicaid programs no longer reimburse pharmacies for most prescription drugs purchased by dually-eligible individuals. The clawback payment is based on 75% of the calendar year 2003 non-federal share of prescription drug costs state MA programs paid for dual eligibles, inflated to the current year. In state fiscal year 2015-16, the Wisconsin MA program made clawback payments to CMS of $205.5 million.

Medicare Part D Participation in Wisconsin. In 2015 (the last year for which complete data were available at the time of publication), there were approximately 420,000 Wisconsin residents obtaining Part D coverage through PDPs and 268,000 residents with coverage through MA-PDs.

CHAPTER 8

ACUTE CARE SERVICES UNDER BADGERCARE PLUS AND EBD MEDICAID

BadgerCare Plus and EBD (elderly, blind, and disabled) Medicaid provide coverage for a variety of procedures and services that are deemed medically necessary by a physician or other medical professional. State statutes, DHS administrative codes, and program handbooks outline the covered services, as well as the provider requirements and limitations associated with each covered service. This chapter provides a description of the general requirements for medical services covered under the MA program, as well as the specific service categories offered under the programs. This chapter covers primarily the acute care medical services offered to MA recipients, rather than the long-term care provided to EBD Medicaid recipients in an institution or as part of a community-based Medicaid program such as Family Care. Additional information on the MA program's long-term care services is provided in Chapter 10 and Chapter 11.

General MA Requirements and Procedures

Medical Necessity. The primary limitation on services provided under the MA program is a requirement that those services must be deemed "medically necessary." A medically necessary service is defined by administrative rule as one that is required to prevent, identify, or treat a recipient's illness, injury, or disability and that 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 DHS 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;
- Is cost-effective compared to an alternative medically necessary service that 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.

Prior Authorization Requirements. The requirement that services be medically necessary is a general limitation under the MA program. More specific limitations include the dollar, numeric, or duration limits the MA program imposes on otherwise covered services. Often those limitations work in conjunction with the program's prior authorization rules. For example, the program provides full coverage, subject to nominal co-

payments, for physical therapy services. However, prior authorization is required for more than 35 treatment days.

As discussed in the next chapter, MA recipients may receive services on a fee-for-service basis, in which reimbursement is made directly to the provider, or else be enrolled in a health maintenance organization (HMO). Each HMO that participates in the program establishes its own prior authorization policies. The procedures described below are those that apply specifically to the state's review of prior authorization requests involving fee-for-service providers.

The Department's rules specify that the following factors should be considered when reviewing a prior authorization request: (a) the medical necessity of the service; (b) the appropriateness of the service; (c) the cost of the service; (d) the frequency of furnishing the service; (e) the quality and timeliness of the service; (f) the extent to which less expensive alternative services are available; (g) the effective and appropriate use of available services; (h) the misutilization practices of providers and recipients; (i) the limitations imposed by pertinent federal or state statutes, rules, regulations, or interpretations, including Medicare, or private insurance guidelines; (j) the need to ensure that there is closer professional scrutiny for care which is of unacceptable quality; (k) the flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and (l) the professional acceptability of unproven or experimental care, as determined by consultants to the Department.

Prior authorization requests are reviewed by DHS staff or by a DHS contractor. For each request, the reviewer makes one of three determinations: (a) approval; (b) approval with modifications; or (c) denial. Prior authorization requests that are denied or approved with modifications can be appealed by the MA enrollee. These cases are adjudicated by the Division of Hearings and Appeals within the Department of Administration.

Service Categories

Inpatient and Outpatient Hospitals Services. For the purposes of the MA program, an inpatient hospital stay occurs when the patient is admitted to a medical institution on the recommendation of a physician or dentist and receives room, board, and professional services in the institution for a period of 24 hours or longer under the direction of a physician or dentist.

An outpatient hospital service occurs when care is provided at an organized medical facility or distinct part of the facility for less than a 24-hour period, regardless of the hour of admission, whether or not a bed is used, and whether or not the patient remained in the facility past midnight. An outpatient hospital service is a preventive, diagnostic, therapeutic, rehabilitative, or palliative service that is furnished to an outpatient under the direction of a physician or dentist at a state-licensed hospital that meets the requirements for participation in Medicare as a hospital.

The MA program reimburses hospitals for outpatient services provided to MA participants if the services are provided within the hospital's inpatient licensed facility. The program does not provide outpatient reimbursement to hospitals for services provided off the physical premises of the licensed hospital facility or in an unlicensed portion of the hospital facility.

MA program reimbursement for inpatient and outpatient hospital services does not include payment for services provided by physicians, dentists, or certain other medical professionals within a hospital, since the MA program pays these professionals separately for services they provide at hospitals. The MA program's hospital

reimbursement policies, including supplemental payments made to certain hospitals that serve targeted populations, are discussed in the next chapter.

Physician Services. Physician services are 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 supervision of, a physician. Although Wisconsin's MA law provides general coverage of physician services, many specific services are subject to the prior authorization requirements, or other limitations identified in Wisconsin administrative rules. For instance, major organ transplants require prior authorization.

Prescription Drugs and Over-the-Counter Drugs. Prescription drugs and over-the-counter drugs and supplies are covered by the MA program, provided that they are prescribed by a licensed physician, dentist, podiatrist, optometrist, advanced nurse practitioner, or when a physician delegates the prescription of drugs to a nurse practitioner or physician assistant. However, the Department may exclude from coverage drugs that are considered experimental or that lack medically accepted indications.

The DHS Secretary is required by law to appoint members to the Wisconsin Medicaid Pharmacy Prior Authorization Advisory Committee to review matters related to drugs covered under MA. Membership of the Committee must include a specified number of physicians, pharmacists, advocates, and consumers. The Department makes recommendations to the Committee on whether a particular covered drug should be classified as "preferred" or "non-preferred," based on an evaluation of the drug's relative safety, effectiveness, clinical outcomes, and cost in comparison to alternatives in the same drug class (although not all drugs are evaluated). The Committee makes the final determination on which drugs to place on the preferred drug list (PDL). In general, drugs not included on the PDL require prior authorization, while those drugs on the PDL do not. A prior authorization request may be approved in certain circumstances, such as when a non-preferred drug is prescribed in place of PDL drug that has proven ineffective or has caused an adverse reaction.

MA 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 brand name drugs. MA recipients must have a prescription for payment of any nonprescription drug. Coverage of over-the-counter drugs is typically limited to antacids, analgesics, insulin, contraceptives, cough preparations, ophthalmic lubricants, and iron supplements for pregnant women.

With limited exceptions, federal law restricts federal cost participation to drugs that are produced by manufacturers that have entered into rebate agreements with the U.S. Department of Health and Human Services. For most drugs, the amount of the rebate equals the unit volume of drugs purchased by the MA program multiplied by 23.1% of the average manufacturer price for most brand name drugs, or by 13.0% for generic name drugs. The rebate percentage for brand name drugs that are clotting factors or that are used exclusively for pediatric indications is 17.1%. Rebates are received by the state and are used to offset a portion of MA program costs. Wisconsin's MA program also has a supplemental rebate agreement with manufacturers of drugs on the PDL.

Under federal law, states are required to conduct reviews of the usage of drugs for the purpose of detecting and preventing provider and

consumer fraud or abuse, as well as detecting clinical misuse. This is done on both a prospective and retrospective basis. Prospective reviews, for instance, are intended to stop the dispensing of drugs in quantities that exceed the amount prescribed or that are contraindicated for a patient's diagnosis. Retrospective reviews are used to identify patterns of fraud, abuse, or medically unnecessary care.

Ambulatory Surgical Center Services. The MA program covers services of an ambulatory surgical center (ASC) provided by, or under the supervision of, a physician if a physician determines that the procedure is medically necessary, requires general or local anesthesia and a post-anesthesia observation time, and that the services cannot be safely performed in an office setting. Prior authorization requirements are the same as those for surgical procedures provided in inpatient hospital facilities. Reimbursement for ASC services is for costs related to the use of the facilities, nursing and technician services, drugs and supplies directly related to the surgical procedure, anesthesia materials, and administrative, recordkeeping, and housekeeping services. The services offered by physicians within an ASC, as well as laboratory and X-ray services not directly related to the surgical procedure are not included in the ASC reimbursement, since these services are reimbursed separately.

Dental Services. Wisconsin's MA program covers the following categories of dental services when the services are provided by or under the supervision of a dentist: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) palliative emergency services; and (i) general anesthesia, intravenous conscious sedation, nitrous oxide, and non-intravenous conscious sedation. The program also covers various services provided by dental hygienists, including oral screening and preliminary examinations, prophylaxis, pit and fissure sealants, and periodontal maintenance. Orthodontic services are not covered unless the services are determined to be medically necessary as the result of a HealthCheck screen.

Vision Care Services. Covered vision care services include eyeglasses and medically necessary services provided by optometrists, opticians, and physicians related to the dispensing and repair of eyeglasses, as well as evaluation and diagnostic services. 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 and materials are not covered, including spare eyeglasses, tinted lenses, sunglasses, and services or items provided principally for convenience or cosmetic reasons.

Transportation. Wisconsin's MA program covers emergency and non-emergency medical transportation. In general, emergency transportation by ambulance is covered when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition. The program covers non-emergency medical transportation (NEMT) to a covered appointment if the MA recipient has no other way to receive a ride.

The Department contracts with Medical Transportation Management, Inc. (MTM) to arrange and pay for NEMT services. MTM is required to arrange the least costly type of ride that meets the person's medical and transportation needs. Rides may be provided by ambulance, specialized medical vehicle (SMV), or by public or private common carrier.

Ambulance transportation services may be covered for a non-emergency situation if the recipient requires life support, requires transport in a supine position, or suffers from an illness or injury that prevents him or her from traveling

safely by other means.

SMVs may be used to transport MA recipients if the recipient has a documented physical or mental disability that prevents him or her from traveling safely in a common motor carrier or a private motor vehicle.

Common carrier transportation is any transportation by a mode other than ambulance or SMV. Common carrier vehicles include public transportation and volunteer vehicles. MA recipients may be required to ride a bus to covered appointments if the person lives within one-half mile of a bus stop, the appointment is at a location within one-half mile of a bus stop, and the person does not have a physical or mental condition that prevents the person from taking a bus or otherwise meets various other exceptions related to age or condition.

In most cases, transportation providers receive reimbursement through MTM. Under the terms of the current transportation services contract, DHS pays MTM a monthly capitation payment based on the number of beneficiaries enrolled in the month. This fee, which was increased at the beginning of fiscal year 2017, and will remain fixed for the remaining duration of the contract, is $17.56 per month for EBD enrollees, $1.25 per month for BadgerCare Plus children, $6.19 per month for BadgerCare Plus parents and caretakers, and $12.76 of adults without dependent children The rate is retrospectively set based on actual costs.

Chiropractor Services. The 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 spinal manipulations per spell of illness.

Physical and Occupational Therapy. Medically necessary physical therapy services prescribed by a physician and provided by a qualified physical therapist, or a certified physical therapy assistant under the supervision of a certified physical therapist, are covered under Wisconsin's MA program. Prior authorization is required for therapy services that exceed 35 treatment days. Similar rules apply to medically necessary occupational therapy services prescribed by a physician and performed by a certified occupational therapist, or a certified occupational therapist assistant under the direction of a certified occupational therapist.

Speech and Language Pathology Services. The 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 include evaluation procedures and speech treatments. Prior authorization is required for all services that exceed 35 treatment days.

Medical Supplies and Equipment. The MA program covers disposable medical supplies and durable medical equipment (DME) when prescribed by a physician and supplied by a certified provider.

Medical supplies are disposable, consumable, expendable, or nondurable medically necessary supplies that have a very limited life expectancy. Examples include catheters, syringes, and incontinence supplies.

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, rentals, and repairs. The item must be necessary and rea-

sonable for treating an illness or injury, or for improving the function of a malformed body part. In cases where DHS determines that a piece of equipment will only be needed on a short-term basis, equipment is rented, rather than purchased, for the recipient.

DHS maintains DME and medical supplies indices on its website that identify the items covered under MA, and whether purchase of the item requires prior authorization. The purchase, rental, repair, or modification of items not contained in those indices requires prior authorization.

Medical supplies or DME that are ordered for a patient in a hospital or nursing home, or that are provided to a hospital inpatient to take home on the date of discharge, are considered part of the institution's cost, and so are reimbursed as part of the inpatient hospital services, rather than as a separate service.

Mental Health and Substance Abuse Services. Several types of mental health, and alcohol and other drug abuse (AODA) services are covered by Wisconsin's MA program. Those services include: (a) outpatient mental health treatment; (b) outpatient AODA treatment; (c) mental health and AODA day treatment; (d) crisis management services; and (e) psychosocial rehabilitation services (programs that provide treatment and social support services for persons with severe and persistent mental illness).

Wisconsin counties are responsible for establishing systems for the treatment of mental health and AODA conditions for MA recipients. In some cases counties are certified providers for these services and in other cases the county contracts for services.

Inpatient hospital services for mental health or AODA conditions are covered under the MA program if provided in a general hospital. Typically mental health and AODA services provided in a general hospital are on a short-term basis. Inpatient mental health and AODA care provided for a longer period of time is usually provided in a psychiatric hospital or state mental health institute. Under federal law, the MA program restricts coverage of mental health or AODA services provided in an institute for mental disease (IMD) for persons between the age of 22 and 64. IMD services for such persons may only be covered if the person is enrolled in an HMO and the IMD stay if for less than 15 days in a calendar month. An IMD is defined as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in diagnosis, treatment, or care of persons with mental diseases.

2015 Wisconsin Act 55 included provisions that directed DHS to seek a state plan amendment to authorize DHS to provide MA coverage of residential-based substance abuse treatment services provided by a medically monitored treatment service or a transitional residential treatment service. A medically monitored treatment service is statutorily defined as a 24-hour, community-based service providing observation, monitoring, and treatment by a multidisciplinary team under the supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient. A transitional residential treatment service is statutorily defined as a clinically supervised, peer supported, therapeutic environment with clinical involvement providing substance abuse treatment in the form of counseling for three to 11 hours per week for each patient. As of January 1, 2017, DHS had not submitted a state plan amendment to authorize coverage of these services.

For additional information on MA program coverage of mental health care, see the Legislative Fiscal Bureau informational paper entitled, "Services for Persons with Mental Illness and Substance Abuse Disorders."

Autism Treatment Services. Autism treatment services are intended to teach children with autism spectrum disorder the skills that children

would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to improve a child's social, behavioral, and communicative skills in order to demonstrate measurable outcomes in these areas and overall developmental benefits in both home and community settings. The intent is for the child to make clinically significant improvements and have fewer needs in the future as a result of the service.

On July 7, 2014, CMS released an Informational Bulletin to state Medicaid agencies providing guidance on the treatment of children with autism spectrum disorders. This bulletin requires states covering autism treatment services through a waiver program, such as Wisconsin, to transition coverage of medically necessary autism treatment services from a waiver to the state plan. As of January 1, 2017, behavioral treatment services for autism spectrum disorders are covered exclusively as a regular MA benefit statewide.

Under the MA program, the behavioral treatment benefit includes both comprehensive and focused treatment for children with autism spectrum disorders. Comprehensive treatment is an early intervention treatment approach designed to address multiple aspects of development and behavior; typically, it involves higher weekly hours and longer duration. Focused treatment is dedicated to addressing specific behaviors or developmental deficits; typically, it involves fewer weekly hours and shorter duration. Prior authorization is required for these services.

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.

Case Management Services. Case management services help recipients and their families gain access to, coordinate, and monitor necessary medical, social, educational, vocational, and other services covered by MA and other programs. MA recipients may be eligible for case management services based on having one or more specified conditions or being a member of a specified target population. The covered conditions are as follows: (a) developmental disability; (b) serious and persistent mental illness; (c) alcoholism or drug dependency; (d) physical disability; (e) HIV infection; (f) asthma (children only); (g) Alzheimer's disease; and (h) tuberculosis. The targeted populations are, as follows: (a) women age 45 through age 64 who are not in a nursing home; (b) severely emotionally disturbed children; (c) children enrolled in the birth-to-3 program; (d) persons age 65 or older; and (e) families with children at risk of serious physical, mental, or emotional dysfunction, including lead poisoning, risk of maltreatment, involvement with the juvenile justice system, or where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.

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, and provide ongoing monitoring and service coordination. The services must be provided by qualified private, nonprofit agencies or qualified public agencies.

Case management services are generally provided at the option of counties and the non-federal share of MA case management costs is paid by counties. However, there are exceptions to this general rule. For instance, the Department of Children and Families pays the non-federal share of case management services provided for children removed from the home by the Bureau of Milwaukee Child Welfare. In addition, operators of independent living centers for individuals with disabilities may elect to provide case man-

agement services for MA-eligible residents, in which case the non-federal share is paid either with funds from the county or from state grants for independent living centers. Finally, the Department of Corrections receives MA reimbursement for case management services provided for juveniles who are under correctional supervision, but who are not confined to a correctional institution. In this case, the Department of Corrections pays the non-federal share of the cost of these services.

Hospice Care. Covered hospice services are services that are necessary for the mitigation and management of terminal illness and related conditions. Core hospice services include nursing care by, or under the supervision of, a registered nurse, physician services, medical social services provided by a social worker under the direction of a physician, and counseling services. Other services include physical therapy, occupational therapy, speech pathology, home health aide and homemaker services, durable medical equipment and supplies, and drugs. Inpatient hospital services necessary for pain control, symptom management, and respite purposes are also covered, but the aggregate number of inpatient days eligible for MA reimbursement is limited to 20% of the aggregate total number of hospice care days provided to all MA recipients receiving hospice services during the year (excluding inpatient days for AIDS patients).

MA reimburses providers of hospice care based on 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; and (e) nursing home room and board. Unlike many MA services, CMS annually establishes minimum reimbursement rates for hospice care.

Prenatal Care Coordination Services. Prenatal care coordination services help women and 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 MA-eligible women who are at high risk for adverse pregnancy outcomes, as determined through the use of a risk assessment tool developed by DHS. Covered services include outreach, administration of the initial risk assessment, care planning, ongoing care coordination and monitoring, health education, and nutrition counseling.

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. All environmental inspections are subject to prior authorization.

School-Based Medical Services. MA school-based medical services are services provided to MA-eligible students by school districts or cooperative educational service agencies (CESAs). School-based medical services eligible for reimbursement under MA include the following: (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; (f) transportation, if provided on a day the student receives other school medical services; and (g) durable medical equipment.

To be eligible for reimbursement under the MA program, a school-based service must be deemed medically necessary, as well as meet the following conditions: (a) it must identify, treat, manage, or address a medical problem or a mental, emotional, or physical disability; (b) it must be identified in an individualized education plan (IEP); (c) it must be deemed necessary in order for a recipient to benefit from special education;

and (d) it must be referred or prescribed by a physician or advanced practice nurse, where appropriate, or a psychologist, where appropriate. Parental consent is required in order for a child to receive the special education and related services defined in an IEP. However, separate parental consent is not required in order for the school-based services provider to seek reimbursement from the state's MA program.

Early and Periodic Screening, Diagnostic and Treatment Services ("HealthCheck"). Federal law requires coverage of screening, diagnostic, and treatment services for MA-eligible persons under the age of 21. In Wisconsin, these screenings are referred to as "HealthCheck" services. HealthCheck screenings are distinguished from other preventive health services 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 to ensure that the patient is appropriately referred for care.

Each comprehensive HealthCheck screen must include the following components: (a) a comprehensive health and developmental history (including preventive health education); (b) a comprehensive unclothed physical examination; (c) vision screening; (d) hearing screening; (e) dental assessment, evaluation services, and direct referral to a dentist for children beginning at three years of age; (f) appropriate immunizations; (g) laboratory tests, including lead toxicity screening; and (h) developmental and behavioral screening.

Federal regulations require state MA plans to establish a schedule for these screenings that is consistent with reasonable standards of medical and dental practice. Wisconsin's schedule limits the number of comprehensive screenings during a continuous 12-month period as follows: (a) birth to first birthday, six screenings; (b) first birthday to second birthday, three screenings; (c) second birthday to third birthday, two screenings; and (d) third birthday to twenty-first birthday, one screening.

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

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 under Medicare and by DHS. 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. The three types of home health services are described below.

Skilled Nursing Services. A recipient is eligible for skilled nursing services delivered in the home if they are provided under a plan of care that requires less than eight hours of direct, skilled nursing services in a 24-hour period, the recipient does not reside in a hospital or nursing facility, and the recipient 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 and licensed practical nurses. In determining whether 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.

Home Health Therapy Services. Wisconsin's MA program covers medically necessary skilled physical therapy, occupational therapy, and speech and language pathology services provided as part of a home health service. The physical therapists, occupational therapists, and speech-language pathologists that provide these services may be employed by a home health agency, by an agency under contract with the home health agency, or they may be 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. MA covers aide services for recipients who require assistance with activities of daily living when provided in conjunction with medically-oriented tasks, and incidental household tasks required to facilitate treatment of a recipient's medical condition or to maintain their health. To be eligible for reimbursement under MA, a registered nurse must determine that the medically-oriented tasks cannot be safely delegated to a personal care worker who has not received special training in performing tasks for the specific individual. Examples of home health aide tasks include administration of medications and, with certain restrictions, activities of daily living, such as bathing, dressing, and skin, foot, and ear care.

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 are provided under the written orders of a physician and are performed by a personal care worker under the plan and supervision of a registered nurse. A personal care worker can only perform those tasks for which they have been trained. 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, independent living centers, Wisconsin tribes and bands, certain county departments, and freestanding personal care agencies can be enrolled to provide personal care services. Prior authorization is required for personal care services after 50 hours of service have been provided in a calendar year.

Provisions included in 2015 Wisconsin Act 55 authorized DHS to contract with a private entity to conduct assessments to determine the amount and frequency of personal care services before an MA recipient begins receiving personal care services on a fee-for-service basis. DHS has entered into a three-year contract with Liberty Healthcare Corporation, and expects the independent assessments to begin early in 2017.

Private Duty Nursing Services. A recipient is eligible for private duty nursing services from a registered nurse or licensed practical nurse if he or she has a medical condition requiring more continuous skilled care than can be provided on a part-time, intermittent basis. Private duty nursing care is covered only when prescribed by a physician and the prescription calls for a level of care for which a nurse is licensed and competent to provide. A written plan of care must be established for every recipient, in consultation with the recipient and the physician. The plan of care must include a functional assessment and a list of the medications and treatment orders for the recipient.

These services supplement the care families and other health professionals are able to provide. All providers must receive prior authorization before providing these services to MA recipients.

Certified Nurse-Midwife and Certified Professional Midwife Services. MA covers midwife services provided by both certified nurse-midwives and certified professional midwives. Certification as a nurse-midwife requires the practitioner to be a registered nurse and hold a degree from an accredited nurse-midwifery edu-

cation program. Nurse midwives provide primary care related to family planning and other reproductive issues, pregnancy, and childbirth for women, as well as postpartum care for newborns. Birth-related services are typically provided in a hospital setting.

To obtain certification as a professional midwife (also sometimes called a "certified midwife") a practitioner must complete a midwifery apprenticeship program or graduate from an accredited midwifery education program, which is commonly a two-year associated degree program. A professional midwife typically provides maternity care, including birth-related services for low-risk pregnancies in an out-of-hospital setting, including in a private home or standalone birth center.

Nurse midwife services are a mandatory Medicaid benefit under federal law, whereas professional midwife services are an optional service. The 2015-17 biennial budget act directed DHS to submit a state plan amendment to CMS to authorize coverage for midwife services provided by a professional midwife. On August 23, 2016, CMS approved the state's plan amendment, and coverage of these services began on January 1, 2017.

Family Planning Services and Supplies. MA recipients may receive family planning services that are prescribed by a physician and furnished, directed, or supervised by a physician, registered nurse, nurse practitioner, licensed practical nurse, or nurse-midwife. Covered 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. Services and items that are provided for the purpose of enhancing the prospects of fertility in males or females are not covered. Unlike other MA services, most family planning services receive a 90% federal match.

Abortion Services. Wisconsin's MA program only covers abortion services under three conditions. The first circumstance is when the physician signs a certification prior to the procedure attesting that upon his or her best clinical judgment, the abortion is directly and medically necessary to save the life of the woman. The second circumstance is in the case of sexual assault or incest, provided the crime has been reported to the police and the physician signs a certification prior to the procedure attesting to his or her belief that sexual assault or incest has occurred. The third circumstance is when, due to a medical condition existing prior to the abortion, the physician, upon his or her best clinical judgment, determines the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, and the physician signs a certification so attesting prior to the abortion. When an abortion meets the state and federal requirements for MA payment, the program covers office visits and all other medically necessary related services.

Other Services. In addition to the services described above, the MA program covers the following services: (a) diagnostic testing, such as laboratory and x-ray services; (b) dialysis; (c) blood; (d) anesthesiology services; (e) nurse-midwifery services; (f) podiatry services; (g) audiology services; and (h) respiratory care for ventilator-assisted recipients.

CHAPTER 9

PROVIDER REIMBURSEMENT

The MA program pays health care providers, such as physicians, dentists, and hospitals, for services they provide to MA recipients. These payments are often referred to as "provider reimbursement," although in most cases the MA program pays a pre-established fee, rather than an amount equal to the provider's usual and customary charges or the provider's cost of providing the service. Provider reimbursement occurs either on a fee-for-service (FFS) basis, or under a managed care model through a health maintenance organization (HMO).

Federal law gives states flexibility in designing MA reimbursement methods, subject to four basic requirements. First, with the exception of copayment requirements, providers must accept program reimbursement as full payment for services, thereby prohibiting them from billing recipients for additional payment. Second, payment rates must be sufficient to attract enough providers to ensure that the availability of health care services to MA recipients is no less than the availability of these services for the general population. Third, with limited exceptions, MA payment is secondary to any other coverage or third-party payment source available to recipients, including Medicare. Fourth, the state's procedures relating to the utilization of, and the payment for, care and services must be adequate to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care.

States must use a public process for determining provider reimbursement rates that includes the following features: (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.

This chapter describes the basic procedures for provider reimbursement for Wisconsin's MA program. In addition, it provides more detailed information about the reimbursement of hospitals, including the use of hospital assessment revenues for making hospital access payments, and the reimbursement of pharmacies for prescription and non-prescription drugs. Finally, it describes various supplemental payments and alternative funding mechanisms for providers that serve certain targeted populations.

Fee-for-Service and Managed Care Reimbursement

Medical services under BadgerCare Plus and EBD Medicaid are provided either on an FFS basis or through managed care. In an FFS arrangement, recipients obtain services through MA-certified health care providers who, in turn, submit claims directly to the MA program and are reimbursed according to rates established for the specific service provided. In the case of inpatient hospital services, FFS reimbursement is based on the patient's diagnosis, rather than the specific services provided.

Most services that are reimbursed on an FFS basis are paid using "maximum allowable fees." Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted by providers, the MA pro-

gram's budgetary constraints, and other relevant economic limitations. Providers are reimbursed either at the amount they bill for the service or at the MA program's maximum allowable fee for the procedure, whichever is less. The MA program's FFS fees are typically below rates paid by commercial insurance. Consequently, the reimbursement payment is usually equal to the MA program's maximum allowable fee.

Under a managed care arrangement, the state pays an HMO a pre-established monthly capitation payment for each MA participant enrolled with that HMO. In return for those capitation payments, the HMO, through its provider network, delivers covered services to its MA enrollees. Generally speaking, if enrollees use more services or more costly services than anticipated, the HMO's financial returns may be less than expected. If enrollees use fewer or less costly services than anticipated, the HMO may realize greater than expected returns. In this way, the HMO, rather than the state, assumes some of the financial risk associated with their members' utilization of services.

MA participants enrolled in HMOs receive most of the program's covered services through their HMO and its network of providers. The HMO may establish its own reimbursement policies for outside providers, but these rates are typically similar to FFS reimbursement rates for the same services.

In some cases, HMO enrollees obtain covered services on a FFS basis, rather than through the HMO. For instance, most MA beneficiaries, including those enrolled in HMOs, access the program's prescription drug benefit on an FFS basis, and most participants receive dental care on an FFS basis.

As of October, 2016, approximately 89% of all BadgerCare Plus participants were enrolled in one of the 18 HMOs participating in the program throughout the state. In areas where two or more HMOs participate, individuals can be required to enroll in an HMO, although they generally have the option to select their HMO. If the participant does not make a selection, they will be automatically enrolled in an HMO. Under federal law, states typically cannot require MA recipients to enroll in an HMO unless they have a choice of at least two HMOs. However, CMS has approved an amendment to Wisconsin's MA plan that permits DHS to require certain MA participants in eligible rural counties to enroll in an HMO even if only one HMO is participating in the program.

As of October, 2016, approximately 16% of EBD beneficiaries were enrolled in an HMO for acute care medical services. A smaller percentage of EBD beneficiaries are enrolled in HMOs, compared to BadgerCare Plus recipients, generally because more enrollment exemptions apply to that population. For instance, EBD beneficiaries who also are eligible for Medicare may be enrolled in a Medicare Advantage HMO, and thus exempted from MA HMO enrollment. Further, EBD recipients who are in a nursing home or other institution or who are enrolled in a managed care organization for the delivery of long-term care services are also exempt from enrollment in an MA HMO for acute care services.

The relationship between the MA program and participating HMOs is governed by federal and state regulations, and by the contracts between DHS and these HMOs. The current model contract sets forth in detail the parties' respective duties regarding the adequacy and accessibility of health care services, payment procedures, billing, enrollment, and grievances and appeals.

Federal regulations require MA capitation rates to be "actuarially sound," meaning that rates should generally support the HMO's expected medical and administrative costs. However, since the HMO generally reimburses outside providers at rates equal to FFS reimbursement, which is usually below the provider's customary charge, the "actuarially sound" requirement does not en-

sure that the HMO's providers' costs are covered.

Capitation rates vary across the six DHS rate regions throughout the state. The rates also vary within each region depending on each enrollee's age, the plan in which he or she participates, and whether chiropractic and/or dental services are provided through the HMO or separately on a FFS basis.

Working with its contracted actuary, DHS adjusts MA capitation rates each calendar year by analyzing prior years' encounter data submitted by the HMOs, pricing that encounter data at the Department's FFS rates, and then making adjustments to reflect projected utilization trends and changes in applicable law and policy. The rates also include an administrative component paid to the HMO, which, in 2017, ranges from 12% to 16%, depending upon the eligibility group of the enrollee, as well as a margin allowance of 2%.

In addition to standard capitation payments, the MA program makes additional payments to the HMO on certain occasions or for each enrollee who has certain conditions. For instance, the state makes an additional payment to the HMO when an enrolled member gives birth and makes supplemental payments for members who require ventilator care. The purpose of these additional payments is to remove particularly high costs from the capitation rate calculations for which the incidence may be more difficult to predict. These additional payments for high cost but low incidence events lessen the financial risks to the HMO associated with enrolling MA beneficiaries.

MA Copayments

In addition to MA reimbursement payments, medical providers also collect copayments from MA recipients in certain circumstances. Although federal law allows states to establish copayment requirements for Medicaid recipients, the amount, type of services for which copayments may be required, and collection procedures are subject to federal restrictions. Federal regulations establish maximum copayment amounts, in accordance with federal Medicaid law that prohibits states from requiring copayments that are above a "nominal" level. For Wisconsin's MA program, copayments range from $0.50 to $3.00, per service or item, depending upon the type of service or item. In some cases, other caps may apply to limit the amount the recipient owes over a given period. For instance, the copayment for inpatient hospital service is $3.00 per day, but the hospital may not collect more than $75 per hospital stay (the amount owed for a 25-day stay). State law specifies that the provider is required to collect the copayment unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Under state and federal law, no copayments may be required from the following persons: (a) pregnant women, for services related to pregnancy; (b) children under the age of 18; (c) nursing home residents; or (d) MA recipients enrolled in an HMO, for services delivered through the HMO. In addition, federal law does not allow copayments for emergency services or family planning services, and the rules exempt other services, such as hospice care, certain transportation services, case management, and alcohol and drug abuse treatment.

Medical providers are not allowed to deny service to an MA recipient because of the inability to pay the copayment, although the inability to pay does not relieve the recipient of the liability for the copayment.

The Department reduces the amount of the FFS reimbursement by the amount of the copayment, regardless of whether the copayment is collected.

Hospital Reimbursement

Reimbursement of hospital inpatient and outpatient care provided to MA recipients is based on methods that vary based on the type of care (inpatient or outpatient) provided and the type of hospital. This section describes the methods DHS uses to reimburse acute care hospitals, critical access hospitals, rehabilitation hospitals, and psychiatric hospitals, and the various supplemental payments DHS makes to hospitals.

Inpatient Reimbursement for Acute Care Hospitals. The MA program reimburses for inpatient services provided at acute care hospitals using a diagnosis-related group (DRG) weighting system, in conjunction with a hospital-specific base rate.

In general, the DRG hospital reimbursement system is intended to allocate a targeted MA hospital budget based on anticipated hospital usage by MA patients. Although the allocation system is based on the relative cost of providing hospital services for various patient diagnoses, the amount of the payments for acute care hospitals does not generally equal hospitals' costs. The targeted hospital budget is an amount that the Department has made available for hospitals from the overall MA budget, but this amount may be less than the total costs that hospitals incur to serve MA patients. In other words, the DRG-based fees are constrained by the target budget.

Under the DRG payment system in place prior to 2017, an inpatient hospital stay was classified based on the major diagnostic categories used by the Medicare program, known as the Medicare Severity Diagnosis Related Group (MS-DRG). However, recognizing that the Medicare system is designed for serving a different population than the MA program, DHS transitioned to a new DRG system, the All Patient Refined Diagnosis Related Group (APR DRG), to classify and calculate pricing beginning on January 1, 2017. This change was made in order to align the classification of encounters more appropriately with the needs of the MA population.

Each DRG is assigned a weight based on the relative resource consumption associated with a particular diagnosis. For example, a diagnosis that consumes 50% more hospital resources than the weighted average of all diagnoses, will be assigned a weight of 1.5. The DRG weights are determined from an analysis of past MA services provided by hospitals and the relative cost of providing those services. For each inpatient stay, the MA program payment is calculated by multiplying the DRG weight by a hospital-specific base rate and any applicable "policy adjuster" that increases reimbursement for certain services, such as services provided to children up to age 17. To develop the base rates, DHS first establishes a uniform statewide DRG base rate for the year based on the MA program's target budget and anticipated inpatient utilization and case mix for that year. For rate year 2017, the statewide DRG base rate is $5,645.

The statewide DRG base rate is then converted to a hospital-specific DRG base rate by making adjustments for a series of factors, including the following: (a) a wage index applicable to the hospital's geographic location; and (b) the hospital's direct graduate medical education costs.

While the DRG system is used to reimburse hospitals for most FFS inpatient services, there are exceptions for some AIDS patient care, ventilator patient care, and brain injury cases, all of which may be billed on a per diem rate or as negotiated with DHS. Hospitals can also receive an outlier payment in addition to their standard DRG-based payment for inpatient stays with costs exceeding a specified "trimpoint."

As noted above, the FFS rates are constrained by the target budget. However, the total amount the MA program pays for inpatient hospital ser-

vices in a year may be more or less than the target budget if hospital usage by MA beneficiaries is more or less than anticipated in that year.

While DHS uses the DRG methodology to establish FFS inpatient hospital rates, those rates do not necessarily correspond to the amounts HMOs pay hospitals for serving their MA enrollees. Instead, the HMO payment rates to hospitals (as with other types of service providers) are set in the contracts between the HMOs and the hospitals and may vary from the Department's FFS rates.

The DRG hospital reimbursement system is not used to reimburse individual professionals, such as physicians, psychiatrists, psychologists, dentists, chiropractors, or anesthesia assistants for the services they provide to hospital inpatients. Those professional services must be billed separately by these providers. The same is true for pharmacy services for take home drugs on the date of discharge, durable medical equipment and supplies for non-hospital use, specialized medical vehicle transport, and ambulance service. The DRG methodology is intended to reflect all other hospital services and costs in the reimbursement methodology, including services that may be procured from third parties, such as drugs used within the hospital, services of independent physical, occupational, and speech and language therapists, services of medical residents and interns, and independent laboratory and imaging services.

Hospitals outside of Wisconsin can be reimbursed for inpatient services provided to Wisconsin MA recipients. If the hospital is designated as a "border status" hospital, it is reimbursed under the same hospital-specific DRG methodology as Wisconsin hospitals. DHS has recently simplified the process for classifying border status hospitals. Beginning in rate year 2017, in order to qualify for border status, an out-of-state hospital must have a written request for border status consideration on file with the Department, and must average 100 or more claims annually (either from fee for-service or managed care claims or both) over three consecutive state fiscal years. Out-of-state hospitals that do not meet the criteria for border status are reimbursed at a single DRG-based rate that does not consider the hospital-specific costs outlined above. Like other hospitals, however, non-border status out-of-state hospitals can receive "outlier" payments for particularly expensive inpatient stays. All non-emergency hospital services provided by non-border status out-of-state hospitals require prior authorization.

Inpatient Reimbursement for Rehabilitation Hospitals and Psychiatric Hospitals. Rehabilitation hospitals and psychiatric hospitals are reimbursed for inpatient services on a per diem basis. The rate is set at 85% of the average daily cost of serving MA patients. Costs are calculated using prior year cost reports and inflated to the current year using an inflation forecast. The cost of providing patient services includes fixed as well as variable costs.

Federal law defines an institution for mental disease (IMD) 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.

For psychiatric hospitals that are classified as IMDs, federal law has historically restricted MA reimbursement to patients who are age 65 and older or under the age of 21, except that persons who were in an IMD hospital on their 21st birthday may receive MA-reimbursed services as long as they remain in the hospital, up to age 22. However, under recent changes to federal rules, Medicaid HMOs are now allowed to pay for IMD care for non-elderly adults in certain circumstances. Specifically, IMD reimbursement is allowed if the HMO enrollee is a patient in the IMD voluntarily and the stay does not exceed 15 days in a calendar month

Outpatient Hospital Reimbursement. The methodology for developing outpatient reimbursement rates is similar to the DRG method used for inpatient reimbursement for acute care hospitals. For outpatient care, DHS uses an "enhanced ambulatory patient grouping" system (EAPG). Unlike the DRG classification system, which is based on diagnostic groupings, the EAPG system is based largely on individual procedures and services. However, the EAPG system also combines related services together for the purpose of establishing a bundled payment for an outpatient visit. The EAPG outpatient reimbursement method is used for outpatient services provided at acute care hospitals, rehabilitation hospitals, and psychiatric hospitals.

Under the EAPG system, DHS calculates a standard EAPG group rate based on outpatient cost data, averaged across all procedures and services statewide, and the MA program target budget for outpatient services. For 2017, the unadjusted EAPG base rate is $80.71. A slight hospital-specific adjustment is made to this rate for direct graduate medical education costs, but unlike the DRG base rate, the EAPG rate is not adjusted for other hospital-specific factors such as wage differentials and capital costs.

The hospital-specific base rate is multiplied by an EAPG weighting factor to determine the final payment for each procedure or service. As with the DRG methodology, the EAPG weights are calculated using cost data and are intended to reflect the use of hospital resources for a particular procedure, item, or service, relative to the outpatient procedure average.

Certain services and items are reimbursed separately from the EAPG system. For instance, clinical diagnostic laboratory services are reimbursed using the maximum allowable fee system. Durable medical equipment, therapy services, and end-stage renal disease services are excluded from the EAPG system. Unlike the DRG system used for inpatient hospital reimbursement, the EAPG reimbursement system does not include a mechanism for outlier payments.

Critical Access Hospital Reimbursement. A critical access hospital (CAH) is a hospital that has no more than 25 inpatient beds used for acute inpatient care or as "swing beds" (beds used for skilled nursing facility-level care), that provides inpatient care for an average stay of no more than 96 hours per patient, and that provides emergency care 24 hours per day. In addition, the hospital must meet other criteria designed to generally limit the designation to hospitals in rural areas where there are few other general hospitals. There are currently 58 critical access hospitals in Wisconsin.

The MA program reimburses CAHs for both inpatient and outpatient care on a prospective cost basis. DHS calculates payment rates using the DRG system for inpatient care and the EAPG system for outpatient care, but unlike the reimbursement for other acute care hospitals, the CAH base rate is set so that each procedure, service, or item approximates the actual cost incurred by the hospital in the prior year (or latest year for which a cost report is available). However, there is no adjustment made to the payments in the event that actual costs differ from the cost projections on which the rates were based.

Performance-Based Payments. DHS withholds 1.5% of a hospital's total inpatient and outpatient FFS claims payments (excluding supplemental payments, described below) to fund an incentive program based on various hospital performance measures. Hospitals that meet performance targets can earn back their share of withheld funds. Those hospitals may also be eligible for bonus payments, drawn from funds withheld from hospitals that did not meet performance targets. The performance standards include 30-day hospital re-admission rates, asthma care for children, antibiotics for community-acquired pneumonia, and healthcare personnel influenza vac-

cinations, among others. Wisconsin-based acute care hospitals (other than long-term care hospitals), children's hospitals, CAHs, and psychiatric hospitals are included in the withholding-based payment program.

DHS also maintains a second pay-for-performance program, limited to inpatient admissions, totaling $5 million annually for acute care hospitals, children's hospitals, and rehabilitation hospitals located in Wisconsin. These hospitals can receive payments under this program if they meet performance measures on a range of factors, including perinatal care, prevention of surgical infections, and consumer assessments. This pay-for-performance program is funded with hospital assessment revenue, and the associated federal matching funds.

Hospital Access Payments. In addition to the reimbursement policies outlined above, most Wisconsin hospitals (except for psychiatric hospitals and state mental health institutes) also receive "access" payments for serving MA recipients. As described in Chapter 2, these hospital access payments are funded by the state's hospital assessment, along with a portion of the federal MA matching funds received by the state when assessment funds are expended under the MA program.

When the hospital assessment was initially created in 2009, critical access hospitals were excluded from the assessment and the resulting access payments. However, beginning in state fiscal year 2010-11, a separate assessment and access payment was created for critical access hospitals.

For an MA recipient receiving hospital services on an FFS basis, the MA program makes an access payment directly to the hospital for certain inpatient discharges and outpatient visits. The current FFS access payment for each inpatient discharge (for dates of discharge starting July 1, 2016) is $3,899 for non-CAHs and $832 for CAHs, while the access payment for each outpatient visit is $327 for non-CAHs and $27 for CAHs.

To cover access payments for HMO enrollee discharges and visits, DHS makes a monthly add-on payment to HMOs for each MA program enrollee. The HMO, in turn, is required to make payments to hospitals in proportion to the number of hospital discharges and visits involving its enrollees in the previous month. This methodology is intended to generate HMO access payments that are, on average, approximately the same as the FFS access payments.

In 2015-16, DHS distributed a total of $657.5 million in access payments for non-CAHs and $12.3 million in access payments for CAHs.

Other Hospital Payment Adjustments and Supplements. Some hospitals are eligible for additional payments from the MA program based on the patients or geographic areas they serve.

Disproportionate Share Hospital Payments. Under federal law, states are eligible for federal MA matching funds to provide supplemental reimbursement to hospitals that serve relatively high numbers of MA recipients and low-income patients ("disproportionate share hospitals," or DSHs). DHS is required to allocate $15.0 million GPR annually, plus the associated federal matching funds, for DSH payments. In 2015-16, total DSH payments (GPR and FED) totaled $36.0 million. DHS distributes these funds to general hospitals for which MA patient-days make up at least 6% of total inpatient days. For each qualifying hospital, the payments are calculated using an add-on percentage, multiplied by the hospital's base inpatient payment. The add-on percentage is generally proportional to the hospital's MA patient days percentage, such that those hospitals with a higher proportion of MA patients have a higher percentage. However, the maximum payment that a hospital may receive in a year is $2.5 million.

Essential Access City Hospital Payments. Hospitals that meet the definition of an essential access city hospital (EACH) are eligible for a supplemental payment under the MA program. An EACH is an acute care hospital with medical-surgical, neonatal intensive care, emergency, and obstetrical services, located in the inner city of Milwaukee, as defined by certain zip codes. In 2015-16, two hospitals received a supplemental EACH payment: Aurora Sinai Medical Center ($3.0 million) and Wheaton Franciscan-St. Joseph Hospital ($1.0 million).

Level I Adult Trauma Centers. State law authorizes DHS to make annual payments not to exceed $8 million in the aggregate to hospitals that satisfy the criteria established by the American College of Surgeons for classification as a Level I adult trauma center. These payments are funded by proceeds of the hospital assessment and by federal MA matching funds. UW Hospital and Clinics and Froedert Memorial Lutheran Hospital are currently the only hospitals that receive these supplemental payments.

Supplemental Payment for Uncompensated Care. DHS is required to make a supplemental payment of $3 million annually to UW Hospital and Clinics for care that is not otherwise compensated. As with the trauma center payment, this payment is funded from the proceeds of the hospital assessment and associated federal matching funds.

Pediatric Inpatient Supplement. DHS makes supplemental payments to acute care hospitals that have inpatient days in the hospital's acute care and intensive care pediatric units that exceed 12,000 days in the second calendar year prior to the hospital's current fiscal year. Days for neonatal intensive care units are not included in that determination. The pediatric supplement, in the aggregate, is limited to $2.0 million annually. In 2015-16, UW Hospital and Clinics and Children's Hospital of Wisconsin received supplemental payments under this provision.

Rural Hospital Adjustment. Prior to rate year 2017, under the Department's inpatient hospital state plan, DHS was authorized to make lump sum rural adjustment payments of $300,000 each to hospitals that were classified as rural under the Medicare wage index but which were not eligible for the rural hospital percentage adjustment to their DRG rate. DHS made lump sum supplemental payments totaling $1.5 million in 2016-17 under this provision. In order qualify for these supplemental payments starting in rate year 2017, a hospital must be located in a rural core-based statistical area (CBSA) designated by the federal Office of Management and Budget, and must not be a critical access hospital. The rural hospital percentage adjustment to the DRG rate will no longer be applied. In rate year 2017, DHS intends to expend up to $5.0 million to make these supplemental payments to qualifying hospitals.

In addition, 2011 Wisconsin Act 32 authorized DHS to make a payment of $300,000 annually to a hospital that: (a) is located in a city that has a municipal border that is also a state border; (b) has an MA recipient case mix that consists of at least 25 percent of residents from a border state; (c) is located in a city with a poverty level, as determined from the 2000 U.S. Census, that is greater than 5 percent; and (d) is located in a city with a population of less than 15,000. In 2015-16, the only hospital that met these criteria and received the $300,000 supplemental payment was the Bay Area Medical Center in Marinette. This payment is funded with state GPR funds in the MA budget.

Enhanced Reimbursement for Certain Services

The MA program provides enhanced reimbursement for some medical services in order to encourage provider participation in the program or to target certain MA populations. These en-

hanced reimbursement policies are authorized under federal law. The following section describes these provisions.

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. RHCs are eligible for cost-based reimbursement (based on their reasonable costs determined using Medicare cost principles) for the RHC services they provide to MA enrollees. For services other than RHC services that are nonetheless covered by MA, RHCs are eligible for MA fee-for-service reimbursement. There are currently 76 RHC locations 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. Prior to 2016, DHS reimbursed FQHCs for 100% of the reasonable costs of providing services to MA recipients, accounting for the cost of services after they have been provided. However, 2015 Act 55 directed DHS to begin reimbursing FQHCs using a prospective payment system (PPS), where the payment rate is established prior to services being provided.

Under federal law, the PPS rate specific to each FQHC equals, at a minimum, the per-visit cost at an FQHC in 1999 and 2000, adjusted by an annual measure of medical cost inflation, and any changes in the scope of services that an FQHC offers. In order to more accurately reflect FQHCs actual costs, DHS will use fiscal year 2014-15 cost reports as the base year to set the PPS rate, making adjustments to reflect changes in medical costs and scope of services.

The enhanced reimbursement requirement for FQHCs recognizes that these facilities 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 17 community health centers in Wisconsin that are FQHCs and two FQHCs located in border areas of other states that are approved to serve Wisconsin MA recipients. Some FQHCs have multiple clinic locations. In addition, there are 12 health centers operated by federally-recognized Native American Tribes that are classified as FQHCs, but that are subject to different reimbursement policies, as described below.

Indian Health Services. 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, the state may claim 100% federal reimbursement for all services rendered to tribally-affiliated MA recipients who are seen in tribal clinics. If the MA services are provided through a tribe-owned or operated facility to non-tribal members, federal funding is available at the state's usual federal matching rate.

Health Professional Shortage Areas. The U.S. Department of Health and Human Services may designate a health professional shortage area (HPSA), which allows certain services to be eligible for enhanced reimbursement under the MA program. In this context, an "area" can be a rural or urban geographic area, but also may include a

targeted population group, or a public or nonprofit medical facility. Designation is generally based on the ratio of service providers to total population. For instance, to receive a designation as a medical service HPSA, a geographic area must have a population to primary care physician ratio of at least 3,500 to 1, or at least 3,000 to 1 if it is determined that the resident population of the area has unusually high needs.

Physicians in general practice, obstetrics, gynecology, family practice, internal medicine, or pediatrics, as well as physician assistants, nurse practitioners, and nurse-midwives, are eligible for enhanced reimbursement for certain services. General office visits, emergency department services, newborn care, preventive medicine, obstetrical services, and vaccinations are eligible services. Obstetrical services provided in a HPSA are eligible for an additional payment equal to 50% of the normal maximum fee, while other services are eligible for a 20% additional fee.

HPSAs are designated in three categories: primary care, dental care, and mental health. In 2016, there were 130 primary care, 124 dental care, and 133 mental health designated HPSAs in the state.

Reimbursement for Prescription Drugs

The MA program's pharmacy reimbursement rate includes an ingredient component and a dispensing component.

In most cases, the program pays the generic drug price when a generic drug is available. However, the program may cover a brand name drug if the prescriber indicates that the brand name drug is medically necessary. Prior authorization is required for brand name drug coverage in these circumstances. In all cases, the amount the state pays the pharmacy is reduced by the co-payments paid by program participants. For most drugs, the ingredient fee is equal to the national average drug acquisition cost.

In addition to reimbursing pharmacies for the ingredient cost, the MA program pays pharmacies a dispensing fee for each prescription they fill. The pharmacy dispensing fee varies depending upon the annual volume of drugs dispensed by the pharmacy, as follows: (a) volume of 0 to 32,999 prescriptions, $21.03; (b) 33,000 to 65,999, $13.95; (c) 66,000 to 98,999, $9.94; and (d) 99,000 or more, $9.50. These policies, effective April 1, 2017, replaced reimbursement policies that generally provided a marginal profit above the wholesale acquisition price for the drug ingredient, but provided a lower dispensing fee of $3.44 for brand-name drugs and $3.94 for generic drugs.

CHAPTER 10

NURSING HOME SERVICES

This chapter describes MA coverage of care provided by nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), and how the MA program reimburses these facilities for the care they provide.

In state fiscal year 2015, there was an average of 32,860 licensed nursing home beds in the state, including beds in state operated nursing homes. Of this total, an average of 79% of the beds were occupied, with 64.1% of these beds occupied by MA recipients.

Most, but not all nursing homes are certified to serve MA recipients. As of July, 2016, there were 372 MA-certified nursing homes in Wisconsin (including state-operated facilities) with a total of 32,854 licensed beds. Approximately 86.8% of these facilities were privately owned and operated (29.8% non-profit and 57.0% for-profit), while the remaining 13.2% were owned and operated by state and local governments.

Chapter 150 of the statutes establishes statewide limits on the number of beds DHS may license in nursing homes (51,795) and facilities that primarily serve individuals with developmental disabilities (3,704), but provides DHS authority to modify these limits under specified circumstances. In addition, Chapter 150 establishes procedures DHS must use in reviewing and approving applications facilities submit to increase the number of their licensed beds.

In addition to nursing homes, there were seven licensed ICFs-IID in the state, including the three State Centers for Persons with Developmental Disabilities, three county-operated facilities, and one private, for-profit facility. The state facilities had a total of 440 licensed beds and the four non-state facilities, all of which were MA-certified, had a total of 99 licensed beds.

Table 10.1: MA-Certified Nursing and ICF-IID Facilities (July, 2016)

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	212	18,237
Non-Profit	111	9,199
Government	49	5,418
Total	**372**	**32,854**
ICF-IID		
For-Profit	1	8
Government	6	531
Total	**7**	**539**

Table 10.1 shows the total number of MA-certified nursing facilities and MA-certified ICFs-IID in Wisconsin, including state facilities, by ownership type, as of July, 2016.

Facility Types and Services

Nursing Homes. Nursing facilities are institutions that provide rehabilitation services for injured, disabled, or sick individuals, as well as skilled nursing and health-related care and services to individuals who, because of their mental or physical condition, require care and services that can be made available to them only through institutional facilities. A facility that primarily provides for the care and treatment of mental diseases is not a nursing facility.

Nursing home care is a covered service under MA when the medically necessary services are provided to an MA-eligible individual in an MA-certified facility.

Nursing facilities may not admit an individual with a mental illness or an intellectual disability unless a pre-admission screening and resident review (PASRR) determines that the individual requires the level of services provided by a nursing facility. Specifically, every resident who enters a nursing home must undergo a PASRR Level 1 screen. If the Level 1 screen is positive then a Level 2 screen is conducted to determine if a mental illness or developmental disability is actually present, if specialized services are required, and if placement in a skilled nursing facility is appropriate.

ICFs-IID. Federal law defines an ICF-IID as an institution or a distinct part of an institution that: (a) primarily provides health or rehabilitative services for individuals with intellectual disabilities; and (b) provides active treatment services to individuals with intellectual disabilities.

Federal law specifies that ICF-IID 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 the provision of health or rehabilitation services. In addition, ICFs-IID must meet certain conditions relating to governance and management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment, and dietetic services.

Federal Requirements for All Facility Types. Federal law requires that long-term care facilities, regardless of facility type, protect and promote residents' rights. Residents' rights include, but are not limited to: (a) receiving 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; (b) protecting one's funds; (c) choosing a personal attending physician; (d) being fully informed in advance about care and treatment and any changes in that care and treatment; (e) participating in planning care and treatment, unless the resident is judged incompetent; (f) having privacy and confidentiality; (g) voicing grievances without discrimination or reprisal and facilities responding promptly to residents' grievances; (h) receiving information from outside agencies and reviewing nursing home surveys; (i) choosing whether or not to perform services for the facility; (j) having privacy in written and telephone communications; (k) having access to, and receive visits from, outside individuals; (l) retaining and using personal property; (m) sharing a room with a spouse if both are located in the same facility; (n) self-administering drugs if it can be done safely; and (o) refusing the transfer to another room in the same facility under certain circumstances. Federal law also provides residents admission, transfer, and discharge rights.

Facility Reimbursement

The MA program reimburses nursing homes and ICFs-IID for the services they provide to MA recipients. These facilities may be eligible to receive GPR, SEG, and federal MA matching funds, depending on the populations they serve and the services they provide.

Facilities classified as nursing homes make up the largest component of institutional long-term care spending. MA fee-for-service payments to nursing homes, ICFs-IID, veterans homes, and state centers totaled approximately $780.0 million (all funds) in SFY 2016, which represented approximately 9.6% of total MA expenditures in that year.

Total MA payments to nursing homes have generally decreased in recent years, as more indi-

Table 10.2: Total MA Fee-For-Service Payments to Nursing Homes and ICFs-IID (All Funds -- $ in Millions)

Facility Type	2014-15	2015-16
FFS Nursing Homes	$643.6	$608.8
ICF-IIDs	11.0	8.7
State DD Centers	112.5	120.1
Veterans Homes	43.4	42.4
Total	**$810.5**	**$780.0**

viduals receive home and community-based services under programs such as Family Care. Table 10.2 summarizes the total MA fee-for-service payments to facilities by facility type during the last two state fiscal years.

DHS is responsible for determining the rates paid to these facilities based on factors such as case-mix and the services provided, as well as relevant state and federal regulations.

Reimbursement of Non-State Nursing Home Facilities. Under state law, DHS is required to reimburse nursing homes for fee-for-service care provided to MA recipients according to a prospective payment system that DHS must update annually. The payment system must include 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 each of these facilities.

When calculating reimbursement rates for individual nursing facilities, DHS uses a formula that includes resident acuity measurements, the average case-mix index for each MA-supported nursing facility for residents who are primarily supported by MA, payment adjustments for dementia, behavioral needs, or other complex medical conditions, and incentives for providing high quality levels of care. This formula relies on acuity measures independently established and regularly updated by health care providers, based on the diagnosed care needs of each facility's residents. As a result, nursing facilities that serve higher-need individuals are generally compensated at a higher rate than facilities that serve lower-need individuals, reflecting the higher cost of providing services to these individuals.

Under MA nursing home reimbursement methods, DHS considers five cost centers when developing facility-specific nursing home rates. These cost centers include direct care, support services, property payment allowances, and provider incentives.

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 they did not exceed the targeted cost. However, as funding provided for nursing home reimbursement has lagged behind industry cost growth and inflation, the targeted rates set for cost centers have covered a smaller percentage of average actual nursing home costs. DHS staff estimate that, in 2015, 74% of facilities experienced direct care costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives. However, when Medicaid costs across all cost centers are considered, 94.5% of nursing homes reported total costs that were greater than the total fee-for-service reimbursement rate, largely due to significant deficits in the support services cost center.

Direct Care. DHS is required to establish payment for allowable 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, resident living staff, feeding staff,

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 nonbillable services of a ward clerk, activity person, recreation person, social workers, volunteer coordinator, certain teachers or vocational counselors, religious persons, therapy aides, and counselors on resident living. Allowable expenses are limited to expenses incurred by the nursing facility related solely to patient care, including all necessary and proper expenses that are appropriate in developing and maintaining the operation of the nursing home facility and services.

DHS determines a base direct care target rate using the actual direct care costs of facilities in the state, adjusting for inflation, amounts budgeted by the Legislature for nursing home reimbursements, and the relative costs of labor. Costs used in the calculation are obtained from annual cost reports submitted by nursing facilities to DHS and reflect the actual cost incurred by these facilities to provide services to residents. This base rate is then adjusted to reflect a facility's average acuity case-mix index and labor cost index.

Separate rates are calculated for services provided to persons with developmental disabilities. In certain circumstances DHS may also provide special rates and supplements to these standard rates. For instance, institutions receive a special per diem rate in lieu of the daily rate for individuals who are ventilator-dependent ($561 per patient day in fiscal year 2016-17). Facilities may also receive a specialized psychiatric rehabilitative services supplement of $9 per patient day if they prepare a specialized psychiatric rehabilitative services care plan for each resident receiving the services and submit a PASRR screen biennially that indicates that nursing home care is appropriate and 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 based on support service costs for a sample of all facilities within the state plus an inflation increment per patient day.

Property Taxes. 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, adjusted by 0.7% for inflation. Tax-exempt facilities may also receive a per patient day property tax allowance for the costs of municipal service fees actually paid by the facility.

Property Payment Allowances. Allowable property-related costs include property insurance, lease costs, depreciation, plant asset interest, property cost amortizations, and mortgage insurance. 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 upfront by the facility and subsequently reimbursed by DHS.

For 2016-17, DHS limited the allowed replacement value to no more than $75,900 per bed. Facilities that have received DHS approval for an innovative construction and total replacement project are subject to a limit of $135,000 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 2016-17, nursing homes can receive six types of incentive payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 70% or more MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.50 per patient day to $2.70 per patient day for

facilities with more than 50 beds and from $1.50 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 $1.65 per patient day to $4.60 per patient day.

Second, a nursing facility can receive a private room incentive based on the ratio of private rooms to total licensed beds. Facilities with 15% or more of their beds in private rooms can receive a per patient day incentive equal to $1.00 multiplied by the percentage of private beds. Facilities that have replaced 100% of their rooms since July 1, 2000 (not necessarily with private rooms), and have 90% or more of their beds in private rooms can receive an incentive per patient day equal to $2.00 multiplied by the percentage of private beds. To receive either incentive payment, 65% of the facility's total patient days must come from MA and Medicare patients. Facilities can only receive one private room incentive payment.

Third, an incentive payment is provided to facilities that need to acquire bariatric moveable equipment during the cost reporting period to serve obese patients. This incentive allows nursing facilities to partially recoup the cost of providing services to this particular population of patients. During 2016-17, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease purchase agreements do not generally qualify for the incentive.

Fourth, an MA access incentive is provided to nursing facilities at a rate of $9.65 per patient day and to ICFs-IID at a rate of $33.24 per patient day during 2016-17.

Fifth, facilities can receive incentive adjustments if they have been approved for an innovative capital construction project. Innovative construction projects include those projects aimed at improving care, reducing the number of the facility's licensed nursing home beds, and replacing or renovating the facility. To be approved, the cost of the increased reimbursement rate must not exceed documented savings to DHS. Additionally, the facility must demonstrate that the total financial impact of the project will not increase overall Medicaid costs. Depending on the option they select, facilities receive either fixed MA reimbursement or have their undepreciated replacement cost increased from $75,900 to $135,000 per bed and could receive an additional $5 or $10 add-on to the Medicaid rate per Medicaid patient day.

Sixth, two different behavior incentives are offered, which provide additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties. Each facility is assessed to calculate Behavioral/Cognitive Impairment access and improvement scores, which are then multiplied by supplement base values to determine the Behavioral/Cognitive Impairment Incentive. In 2016-17, the supplement base rates equaled $0.468 per day for the access incentive and $0.454 per day for the improvement incentive, and were determined based on the facility's behavioral score and improvements to this score.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for direct care, support services, the property tax components, and the property allowance. In 2015-16, the average MA payment rate to nursing homes was $170.49 per day, excluding the state centers but including the veterans homes. Of that amount, patient liability accounted for $38.74 (22.7%) and MA payment accounted for $131.75 (77.3%).

Ancillary services and materials are specifically identified and billed separately to the MA program, often by an independent provider of the service. The special allowances for government-operated facilities represent supplemental MA payments to facilities that are described in the

following paragraphs.

County Supplemental Payment. County and municipally-owned nursing facilities with nursing home operating costs that are not fully reimbursed by the MA per diem rate are eligible to apply for supplemental MA funding. The statutes permit DHS to provide up to $39.1 million each fiscal year to support supplemental payments to these facilities to offset operating deficits. Appendix 2 identifies actual supplemental MA payments to county and municipally-owned nursing homes from 2010-11 through 2015-16.

In order to distribute these supplemental funds, DHS currently determines: (a) the projected overall operating deficits (OAOD) for each county and municipal home (the difference between allowable operating costs per patient day and MA payments per day); (b) the projected direct care operating deficit (DCOD) (the difference between allowable direct care costs per patient day and MA payments per day); (c) the eligible direct care deficit (EDCD) for each county and municipal home (the lesser of the OAOD and the DCOD); and (d) the projected non-direct care deficit (equal to the OAOD less the EDCD).

If the funding budgeted for supplemental payments is not sufficient to support each qualifying facility's EDCD, DHS then calculates an EDCD per MA day by dividing the $39.1 million by the total number of MA patient days for all facilities, factoring in the limits of each facility's EDCD. This per day amount would then be paid for each MA day, up to the amount of each qualifying facility's EDCD amount. Any funds in excess of all facilities' EDCD will be allocated based on the MA patient days with an adjustment for each facility's non-direct care deficits. In SFY 2016, the rate used to allocate the supplemental payments was $37.45 per patient day. Forty county-owned nursing homes received supplemental payments and six municipally-owned facilities received supplemental payments in SFY 2016.

Certified Public Expenditure Supplement (CPE). 2005 Wisconsin Act 107 created a permanent mechanism by which additional funding may be available through the nursing home CPE program to provide supplemental payments to municipally-owned nursing homes. In every biennial budget, DHS estimates the amount of federal revenues it expects to receive as the federal match for the operating losses of municipally-owned nursing homes in each of the next two years. In many cases the nursing homes incurred the losses in one or more years earlier. If the amount of federal revenues received in a fiscal year exceeds the amount of revenues budgeted in that same year, all revenues in excess of the budgeted amount are disbursed among the municipal nursing homes. No federal revenue is disbursed to municipal nursing homes when the revenues are less than the budgeted amount. No extra CPE payments have been made to municipally-owned facilities since SFY 2012.

Reimbursement of State Operated Facilities. MA payments for care provided at the state centers and the veterans homes are determined by DHS separately from the methods established for all other nursing facilities. The state centers are paid based on actual costs because ICF-IID residents do not receive Long-Term Care Minimum Data Set (MDS) assessments so the resource utilization groupings (RUGS) methodology is inapplicable. Interim payment rates are established for these facilities, but DHS reconciles costs at the end of each state fiscal year to adjust payments to actual costs within general limitations.

DHS pays the veterans homes MA payment rates equal to the "Medicare Upper Limit," which is the rate Medicare would pay, based on the acuity of the resident population. These rates may exceed the veterans homes' actual costs of caring for its MA-eligible residents.

Managed Care Capitation Payments. Nursing facilities receive payment for services they provide to MA recipients participating in the

state's long-term care managed care programs (Family Care, PACE and the Family Care Partnership programs). The rates paid to nursing facilities to cover the costs of services provided to these individuals are included in the capitation payments paid to managed care organizations.

CHAPTER 11

FAMILY CARE AND RELATED PROGRAMS

The state offers several Medicaid-funded managed care programs that provide long-term care services to eligible recipients. Under the Family Care program, managed care organizations (MCOs) provide long-term care services to elderly individuals, adults with developmental disabilities, and adults with physical disabilities. Individuals in some counties have access to two additional, fully-integrated managed care programs, the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership (Partnership) program. In all but seven counties (Adams, Dane, Florence, Forest, Oneida, Taylor, and Vilas) Family Care has replaced the county-administered Medicaid waiver programs that formerly provided community-based long-term care services to residents in these counties. However, the Department of Health Services plans to commence the transition of these remaining counties to Family Care in 2017 (2018 for Dane County). These "legacy" waiver programs are described briefly at the end of this chapter.

Expansion of Managed Long-Term Care

Wisconsin was one of the first states to offer integrated, managed long-term care services. In 1990, the state instituted PACE, a national pilot program to provide all services through an integrated, managed care model. In 1994, Wisconsin began developing a similar integrated, managed care program known as the Partnership Program.

1999 Wisconsin Act 9 created the Family Care benefit, which was modeled after the PACE and Partnership programs. In 2000, Fond du Lac, La Crosse, Milwaukee, and Portage Counties began offering Family Care. Richland County began offering the program in 2001. 2007 Wisconsin Act 20 authorized DHS to expand the Family Care program statewide in all counties that chose to participate in the program. Later, the federal Centers for Medicare and Medicaid Services (CMS) required the state to offer an alternative to managed care. Consequently, Wisconsin began offering the fee-for-service, self-directed IRIS program in Family Care counties to comply with this requirement in 2008. Most recently, 2015 Wisconsin Act 55 required DHS to submit, to the federal Department of Health and Human Services, the documentation necessary to allow DHS to administer Family Care in every county in the state by January 1, 2017, or a later date selected by DHS.

The Family Care, PACE, and Partnership programs each offer a managed long-term care option with varying levels of service integration. The PACE and Partnership programs provide the most integrated service delivery, as they offer primary and acute medical care, long-term care, and prescription drug coverage. Family Care, on the other hand, offers long-term care services and some services traditionally received as Medicaid card (state plan) services. IRIS, the least-integrated program, offers only long-term care services through a fee-for-service system. Appendix 3 provides a list of the services offered under each of these programs, as well as a visual representation of the level of service integration offered by the different programs.

Table 11.1 shows the growth in Family Care, IRIS, Partnership, and PACE enrollment from 1997 to 2016. As of July 2016, 65 counties of-

Table 11.1: Family Care, IRIS, Partnership and PACE, Enrollment

	Family Care	IRIS	Partnership	PACE
1997			252	427
1998			482	461
1999			689	484
2000	1,676		917	505
2001	4,107		1,188	436
2002	6,537		1,352	417
2003	7,746		1,563	449
2004	8,946		1,745	510
2005	9,478		1,977	558
2006	9,897		2,159	750
2007	11,738		2,657	808
2008	16,310		3,052	878
2009	24,324	700	3,393	868
2010	30,963	2,623	3,635	845
2011	33,257	4,926	3,857	883
2012	35,058	6,965	4,000	784
2013	37,276	9,344	2,781	743
2014	38,180	11,139	2,925	681
2015	41,791	12,533	2,968	651
2016	43,735	13,901	2,989	617

fered Family Care and IRIS. In addition, 14 counties offered Partnership and two counties offered PACE. DHS is currently in the process of expanding Family Care with plans for the program to be available statewide by 2018.

Family Care

Non-Financial Eligibility. All Family Care enrollees must be at least 18 years of age or older, reside in a county where the Family Care benefit is offered, and have a primary disability that is not related to mental illness or substance abuse.

All potential enrollees are screened to determine whether they meet the program's functional eligibility requirements. Functional eligibility is measured based on an individual's ability to perform both "activities of daily living" (ADLs), which include bathing, dressing, toileting, mobility, and eating; and "instrumental activities of daily living" (IADLs), which consist of meal preparation, managing medications and treatments, money management, and using the telephone. In addition, the screen has questions about cognition, behavior, diagnoses, medically-oriented tasks, transportation, and employment, as well as indicators for mental health concerns, substance abuse, and other conditions that may put a person at risk of institutionalization.

An individual can meet the functional eligibility criteria in two ways. First, the criteria is met if the person's functional capacity requires a nursing home level of care, 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. Alternatively, the eligibility criteria is met if the person's functional capacity is at the non-nursing home 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 he or she is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

Financial Eligibility. Individuals must meet elderly, blind, and disabled (EBD) Medicaid's asset and income test to be eligible for the Family Care benefit. As described in Chapter 5, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income limit is based on an individual's countable income and, in 2017, may not exceed $818.78 per month for individuals ($1,235.05 for married couples) that are deemed categorically needy or $591.67 per month for individuals that are deemed medically needy.

Provisions of Medicaid law relating to eligibility for institutional care also apply to the Family Care program. For example, an individual is financially eligible for Family Care if his or her income is no greater than 300% of the applicable SSI payment level ($2,205 per month in 2017).

The spousal impoverishment protections, discussed in Chapter 5, also apply to spouses that receive services through the Family Care program. However, individuals receiving services through the Family Care program may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance. In CY 2017, the personal needs allowance ranges from $915 to $2,205 per month.

Services and Funding. Individuals enroll in an MCO to receive the Family Care benefit. Enrollees have access to a broad range of services, including long-term care Medicaid card services, nursing home services, and services traditionally provided under the other Medicaid home and community-based services (HCBS) waiver programs.

In addition to long-term care services, card services that may be provided through the MCO include, but are not limited to: care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit. Table 11.2 shows Family Care service expenditures, by category, in calendar years 2013, 2014, and 2015.

Each MCO develops and manages a comprehensive network of long-term care services and supports, either through contracts with providers or by providing care directly through its employees. DHS may contract with different entities to serve as MCOs, including long-term care districts, governing bodies of tribes or bands, the Great Lakes inter-tribal council, counties, or private organizations that have no significant connection to an entity that operates an Aging and Disability Resource Center (ADRC) or is establishing an ADRC. However, regardless of the type of entity, all MCOs must ensure the following:

- Adequate availability of providers that have the expertise and ability to provide services that can meet the needs of Family Care recipients and are able and willing to perform all tasks that will be included in an individual's service plan;

- Adequate availability of residential and day services as well as other supported living arrangements that are geographically accessible and meet the needs and preferences of individual participants;

Table 11.2: Family Care Service Expenditures ($ in Millions)

	2013	2014	2015
Institutional and Residential Care	$705.0	$741.3	$808.8
Supportive Home Care	172.7	175.1	185.0
Case Management	154.3	158.4	160.2
Day Center Services	50.9	49.4	52.3
Prevocational Services	39.9	38.6	37.7
Transportation	31.8	32.5	34.8
DME and Supplies	27.7	26.8	28.4
Home Health Care	15.0	13.1	13.9
Adult Day Care	11.9	11.6	12.2
Supported Employment	4.8	4.8	5.2
Financial Management	7.0	6.8	7.7
Skilled Nursing Services	5.2	4.6	4.5
Respite Care	4.7	4.9	5.2
All Other Services	14.7	14.3	15.3
Total	**$1,245.6**	**$1,282.2**	**$1,371.2**

- Expertise and knowledge in providing long-term care and other community services;

- Ability to develop strong linkages with systems and services that provide adequate coverage for a specific geographic area; and

- Employment of competent staff properly trained to perform and provide all services specified in the proposed contract.

DHS makes capitation payments to MCOs, which are funded from a combination of GPR, federal MA matching funds, and county contributions. Two different capitation rates are paid to each MCO -- a nursing home rate, for enrollees that meet the nursing home level of care standard, and a non-nursing home rate, for enrollees that need a lower level of care. The capitation payments DHS makes to MCOs represent the average cost calculated across all members of each respective MCO. These average costs reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. Capitation rates differ by MCO to reflect differences in acuity of people served by each MCO.

The MCO capitation rates are reviewed and updated annually. DHS contracts with an actuarial firm to calculate the rates and ensure that all rates are actuarially sound, a requirement of federal law. Monthly capitation rates paid to MCOs in calendar year 2016 ranged from $2,843 to $3,600 for individuals who meet a nursing home level of care standard and $471 to $510 for other qualifying individuals who do not meet the nursing home level of care standard.

During the first five years Family Care services are available in a county, the county's contributions to the costs of the program are determined by a formula established in 2007 Wisconsin Act 20. A county's contribution is based on whether the actual amount the county spent to provide long-term care services in calendar year 2006 was greater than or less than 22% of the county's basic community aids allocation in 2006. If the county's long-term care expenditures were less than 22% of its basic community aids allocation, the county's ongoing contribution is set at its 2006 long-term care expenditure level. If the county's long-term care expenditures were greater than 22% of its basic community allocation, the county's Family Care contribution equals its 2006 level for the first year and then decreases for the next three years by 25% of the difference between its long-term care expenditure level and 22% of its basic community aids allocation. The county's ongoing contribution is then set at 22% of the county 2006 basic community aids allocation.

Administration. DHS has a number of statutory responsibilities with respect to 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 MCOs 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; (d) developing criteria to assign priority equitably for persons waiting to enroll in Family Care; and (e) ensuring that each MCO is financially viable through maintenance of sound business practices.

Statewide Expansion. Originally, when DHS proposed to contract with entities to administer the Family Care benefit in new geographic areas, it was required to submit the proposed contract and other documentation, including a fiscal estimate, to the Joint Committee on Finance (JFC). The fiscal estimate had to demonstrate that the expansion would be cost neutral, including startup, transitional, and ongoing operational costs, and any proposed county contribution. DHS would only be allowed to enter into the proposed contract if JFC approved the contract.

However, 2015 Act 55 changed the requirements surrounding expansion of Family Care into new counties. Specifically, Act 55 required DHS to submit, to the federal Department of Health and Human Services, the documentation necessary to allow DHS to administer Family Care in every county in the state and to no longer require approval from JFC for such expansion. Further, Act 55 required that DHS ensure that Family Care is available to eligible residents of every county in the state by January 1, 2017, or by a date specified by DHS, whichever is later. As such, DHS intends to contract for Family Care services and offer IRIS services in Adams, Florence, Forest, Oneida, Taylor, and Vilas counties beginning in July of 2017, and offer these programs in Dane County beginning during the first quarter of 2018.

During the expansion process, MCOs first enroll participants currently in the current HCBS waiver programs into Family Care, followed by individuals on waiting lists for these services, individuals supported by Medicaid in the community who may have unmet long-term care needs, and individuals who are not currently enrolled in Medicaid. Medicaid-eligible individuals receiving institutional care who choose to relocate to the community may enroll in Family Care at any time because the Medicaid costs to support an individual in the community are generally less than the costs in an institution.

Funding for the expansion of the Family Care program is supported with: (a) additional state and federal MA funding provided as part of the state budget process; (b) reallocations of base funds that support Medicaid fee-for-service payments and Medicaid waiver services; and (c) county funds, including reallocations of community aids, and revenue from the county tax levy.

Appendix 4 shows the counties that offered Family Care and the MCO regions as of July, 2016.

HCBS Statewide Transition Plan. In January, 2014, CMS issued regulations regarding home and community-based services settings requirements. These regulations require states to submit a Statewide Transition Plan (STP) with 1915(c) waiver or section 1915(i) state plan benefit renewals. The transition plans outline the state's intended actions to bring the state's waivers into compliance with the new home and community-based services settings regulations, including ensuring that any Medicaid waiver programs provide community integration, person-centered planning, and participant choice regarding services. The plans should indicate the state's intended steps, to be completed by March, 2019, for coming into compliance with the new settings requirements.

In response to the CMS regulations, DHS released a transition plan proposing an assessment and subsequent compliance process for settings where waiver services are delivered. Following public comment, DHS submitted the transition plan to CMS in October, 2014. In March, 2015, CMS requested that DHS submit additional information to the STP. DHS submitted a revised draft, to which CMS responded in October, 2015. This response indicated that Wisconsin's STP is in the clarifications and modifications stage, meaning that public comment, input, and summary requirements were completed, but there are other issues that must be resolved prior to initial approval. Specifically, CMS requested further detail pertaining to settings included in the STP, assessment processes and outcomes, ongoing monitoring, remedial action processes, and heightened scrutiny.

IRIS (Include, Respect, I Self-Direct)

CMS required the state to offer an alternative to managed care in order to provide individuals

with sufficient choice in obtaining long-term care services. The IRIS program (Include, Respect, I Self-Direct) is a fee-for-service, self-directed support waiver under the Medicaid HCBS waiver authority, through which individuals may direct their long-term care supports and services through management of a designated budget amount. IRIS is available in counties where Family Care is offered.

Individuals with long-term care needs who qualify for MA-funded community-based services, but do not wish to enroll in Family Care, have the option to participate in IRIS.

Eligibility. To be eligible for IRIS services, an individual must reside in a county where Family Care is available and meet the same financial and non-financial eligibility requirements as Family Care participants. This includes meeting a nursing home level of care as determined by the long-term care functional screen. Eligible individuals then have the option to enroll in either a managed care option or IRIS. DHS permits individuals to switch between these options.

Services and Funding. The services available under the IRIS program are limited to the home and community-based services not available through Medicaid card services. This differs from Family Care, which covers all long-term care services, including those otherwise available through Medicaid card services. IRIS enrollees have the option of self-directing their personal care services with the help of the IRIS consulting agency (ICA). Currently, over 40 percent of IRIS enrollees choose this option.

IRIS allows enrollees to receive customized goods and services that address a long-term support need and enhance the individual's opportunity to achieve outcomes related to living arrangements, relationships, community inclusion, work, and functional or medical status. To qualify as a customized good and service, the service, support, or good must: (a) be designed to meet the participant's assessed long-term support need related to functional, vocational, medical, or social needs; (b) advance the desired outcomes specified in the individual service plan; (c) be documented in the individual service plan; (d) not be prohibited by federal and state statutes or guidance; (e) be unavailable through another source; and (f) be non-experimental in nature.

In addition to meeting all of these criteria, the service, support, or good must also meet at least one of the following: (a) maintain or increase the participant's safety in the home or community environment; (b) decrease or prevent increased dependence on other Medicaid-funded services; (c) maintain or increase the participant's functioning related to the disability; or (d) address a long-term support need and maintain or increase the participant's access to or presence in the community.

Administration. As of October, 2016, DHS had contracts with five ICAs and three fiscal employment agencies (FEAs) to administer the IRIS program. The ICAs are responsible for assisting individuals in developing an individualized support and service plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must ensure the individual will be healthy and safe. The FEA assures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements, such as paying providers and ensuring that employment and tax regulations are met.

Individuals participating in the IRIS program receive an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs, as well as the historical service cost of representative Family Care members. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person uses funds from his or her individual

budget to obtain the services needed on a fee-for-service basis.

Individuals are not permitted to use any of their individual budget to pay for room and board. However, individuals receiving IRIS services may reside, on a short-term basis, in any living arrangement, such as a community-based residential facility (CBRF), adult family home, or a residential care apartment complex (RCAC), as long as it is not a nursing home or other institutional facility.

Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed. Table 11.3 shows a breakdown of IRIS service expenditures in calendar years 2013, 2014, and 2015.

PACE and Partnership

In addition to Family Care and IRIS, the state offers two fully-integrated long-term care programs. PACE and Partnership are managed care programs that provide both primary and acute health care and long-term care services to elderly individuals and individuals with disabilities who need a nursing home level of care. Enrollment in the PACE program is limited to individuals age 55 and older, while both elderly individuals and individuals with disabilities may enroll in Partnership. These voluntary programs are available to people that are eligible for both Medicaid and Medicare (dual eligibles).

There are two primary differences between PACE and Partnership. First, PACE enrollees regularly visit a PACE center to receive many health and long-term care services. In contrast, Partnership focuses on providing comprehensive services in the participants' home or community. Second, PACE requires that the client's primary physician be a member of the PACE organization, while Partnership attempts to retain the client's current primary physician by recruiting that physician to the Partnership network.

Similar to the Family Care program, the state's Medicaid program makes capitation payments to PACE and Partnership MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. In addition to the Medi-

Table 11.3: IRIS Service Expenditures ($ in Millions)

	2013	2014	2015
Supportive Home Care	$115.2	$137.5	$149.9
Home Health Care	37.4	56.9	73.1
Non-Nursing Home Residential Care (including CBRFs, AFHs, and RCACs)	16.3	16.8	16.8
Transportation	8.0	9.1	10.4
Respite Care	8.8	10.7	11.2
Day Center Services	8.4	10.9	12.5
Adult Day Care	2.4	1.4	1.7
Prevocational Services	4.0	4.4	4.7
Other Allowable MCO Services	1.7	0.5	0.4
Daily Living Skills Training	2.8	3.3	2.8
Supported Employment	1.7	1.6	1.7
DME and Supplies	1.9	2.5	2.6
All Other Services	1.7	2.5	3.3
Total	**$210.3**	**$258.1**	**$291.1**

caid capitation rate, these agencies also receive a Medicare capitation rate for acute care services. In calendar year 2016, monthly capitation rates paid to MCOs participating in the PACE and Partnership programs ranged from $3,126 to $4,571.

Table 11.4 shows a breakdown of PACE and Partnership service expenditures in calendar years 2014 and 2015.

Table 11.4: PACE and Partnership Service Expenditures ($ in Millions)

	2014	2015
Acute & Primary Services		
Inpatient Hospital	$29.8	$29.8
Medications	27.8	29.6
Office or Outpatient Assessments	9.3	7.6
Dental	1.3	1.3
Other	26.2	26.7
Subtotal	$94.4	$95.0
Long-Term Care Services		
Residential Services	$34.8	$42.0
Care Management	29.9	21.7
Institutional (Nursing Home and ICF-IID)	23.0	21.4
Home Care (Personal Care and Supportive Home Care)	17.4	22.2
Transportation	8.1	8.2
Adaptive/Durable Medical Equipment	5.0	5.4
Home Health Care	6.4	4.8
Adult Day Activities	5.3	4.7
Habilitation	2.3	2.2
Vocational	0.4	0.4
Respite Care	0.3	0.5
Other	1.3	1.6
Subtotal	$134.2	$135.1
Total	**$228.6**	**$230.1**

Aging and Disability Resource Centers

Aging and disability resource centers (ADRCs) are a gateway for individuals who need, or expect to need, long-term care services. ADRC services include: (a) providing information and assistance to individuals in need of long-term care services; (b) benefits counseling; (c) short-term service coordination; (d) conducting functional screens; and (e) enrollment counseling and processing. In addition to assisting potential long-term care users and their families, physicians, hospital discharge planners, or other professionals who work with elderly or disabled individuals can also use the information services ADRCs provide. ADRCs must provide all of their services at no cost to recipients.

The contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating ADRCs. State funding to support ADRCs is allocated based on the estimated size of the population served in each area and estimates of the amount of time required to carry out the ADRC functions. If actual costs exceed this limit, the ADRC is responsible for those costs.

In addition to ADRCs operated by counties, tribes may operate their own ADRC or operate an ADRC in conjunction with another county. Additionally, tribes may choose to have their own aging and disability resource specialist (ADRS) that works with one or more established county or multi-county/tribe ADRCs. An ADRS serves as a consumer advocate for tribal members using the ADRC, with the ADRS providing technical assistance to the ADRC regarding resources available through tribes and culturally appropriate services, and the ADRC enrolling individuals and administering long-term care functional screens.

Because ADRCs provide services to, and respond to, inquiries from individuals and their families regardless of Medicaid eligibility, federal cost sharing for their operation is limited to the amount that can be documented as supporting services for Medicaid-eligible individuals. DHS estimates that between January, 2016, and March, 2016, approximately 38.5 percent of ADRC expenditures were paid by federal match-

ing funds. However, DHS noted that this percentage is highly volatile across months. Additionally, DHS recognizes a downward trend in this percentage due to the gradual elimination of waitlists for long-term care services and ADRCs completing more activities that are not eligible for a federal match, such as dementia care.

Table 11.5 shows ADRC direct program operation expenditures for fiscal years 2007-08 through 2015-16. As of September, 2016, there were 40 ADRCs operating in Wisconsin, including 27 single county ADRCs and 13 multi-county/tribe regional ADRCs, serving all 72 counties and 11 tribes. Appendix 5 lists each ADRC and ADRS, as well as the counties and tribes that each serves.

Table 11.5 ADRC Expenditures ($ in Millions)

Year	GPR	FED	Total
2007-08	$13.1	$3.8	$16.9
2008-09	18.2	7.8	26.0
2009-10	23.1	14.2	37.3
2010-11	27.8	18.8	46.6
2011-12	29.1	21.4	50.5
2012-13	32.4	23.7	56.1
2013-14	33.4	24.3	57.7
2014-15	39.9	30.6	70.5
2015-16	38.8	30.2	69.0

Legacy Home and Community-Based Services Waiver Programs and the Children's Long Term Care Services Program

The state's fee-for-service home and community-based services (HCBS) waiver programs are known as the "legacy" HCBS programs because they provided long-term care services in all counties before the state began implementing Family Care, and have been replaced by Family Care, IRIS, and PACE and Partnership in all but seven counties.

Under the community-based waiver provisions of federal Medicaid law, states may offer medical and support services to certain groups of Medicaid recipients including medical support and social services generally excluded from traditional Medicaid coverage. These services are designed to provide a cost-effective alternative to institutional care that may not otherwise be available to Medicaid recipients.

Wisconsin operates five federal waiver programs, in addition to Family Care and IRIS, which are intended to reduce the number of individuals receiving long-term care services in nursing homes or institutions. Adults with developmental disabilities are served under one federal waiver that encompasses two state programs, the community integration programs CIP 1A and CIP 1B. Adults with physical disabilities and elderly individuals are also served under one federal waiver that encompasses the community options waiver program (COP-W) and the community integration program (CIP II). The children's long-term support (CLTS) program is authorized under one combined federal waiver and provides supports and services to eligible children who meet the level of care requirements due to developmental disabilities, physical disabilities, and severe emotional disturbance.

DHS also provides counties with GPR funding through the community options program (COP-Regular) for individuals with community-based long-term care needs. Counties can use COP-Regular funds as the non-federal share for additional Medicaid eligible services for individuals in other HCBS waiver programs or to pay the full amount of costs not eligible for federal MA matching funds.

Unlike Medicaid card services, , Family Care, and IRIS, which are entitlements to all individuals who qualify for such services, the amount of home and community-based services available to qualifying individuals through the fee-for-service waiver programs is limited by funding allocated

in state and county budgets. As a result, eligible individuals may be placed on waiting lists for these programs until funding becomes available. Table 11.6 shows enrollment in the HCBS waiver programs in calendar year 2015.

Table 11.6: HCBS Waiver Participants, Calendar Year 2015

CIP 1A	246
CIP 1B	3,298
CIP II	2,289
COP-W	1,158
CLTS	6,961
COP-Regular*	845
Total	**14,797**

*Includes COP-Regular Only participants. Does not include the 1,794 individuals using COP-Regular as match or supplemental funding for other HCBS waiver programs.

Eligibility. To participate in the HCBS waiver programs, individuals must meet both non-financial and financial eligibility criteria.

Non-financial Criteria. Individuals must meet nursing home level of care requirements in order to qualify for the state's long-term care waiver programs. Individuals must also receive Medicaid card services, and card services must not be supplanted or duplicated by the HCBS waiver programs.

Financial Criteria. Several provisions of Medicaid law relating to eligibility for institutional care, as described earlier, also apply to the HCBS waiver programs. For instance, states may provide nursing home and Medicaid waiver services to individuals with income up to 300% of the applicable SSI payment level. The same spousal impoverishment protections also apply to spouses that receive services under the HCBS waiver programs. However, individuals 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.

Funding. DHS allocates the funding budgeted for each waiver program to participating counties on a calendar year basis. Counties in which the Family Care benefit is available do not receive funding allocations for COP-W, CIP 1A, CIP 1B, CIP II, or for waiver services provided to individuals over age 18 in the CLTS program.

Funding allocations for the waiver programs were originally based on a waiver reimbursement rate per individual, number of allocated slots, and total number of days in the contract year. Funding for slots is now based on a combination of the historical budget allocations, the addition of the care plan costs for new program enrollees, and, in some cases, the rate DHS associates with a new slot.

DHS allows counties to treat funding for many of the waiver programs as an allocation. However, counties are still limited to serving only as many individuals as they have been awarded slots.

As with most other MA-eligible services, federal MA matching funds support approximately 58% of the total cost of waiver services, including eligible waiver costs incurred by counties.

The rest of this chapter describes each of the HCBS waiver programs.

Community Integration Program (CIP 1A). CIP 1A provides community-based services to individuals who previously resided at one of the three State Centers for People with Intellectual Disabilities (state centers).

State law requires that a state center must not fill a bed that has been left vacant because of relocation under CIP 1A. Accordingly, when an individual is relocated, funding for the state centers is reduced by the cost of the individual's care

plan under CIP 1A and is reallocated to fund the CIP 1A slot.

The state provides a lump sum allocation for counties to serve individuals under CIP 1A. However, counties are limited to serving a specific number of individuals based on the number of slots they have been awarded under relocations from the state centers.

Community Integration Program (CIP 1B). CIP 1B provides community-based services for individuals who are relocated or diverted from ICFs-IID other than the state centers.

The state provides a lump sum allocation for individuals receiving services under CIP 1B. As of July, 2016, this allocation was $49.67 per individual per day. Additionally, 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-IID (approximately $225.53 per day in 2015).

ICF-IID Restructuring 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-IID. These changes included prohibiting an ICF-IID from admitting an individual unless a court finds that the placement is the most integrated setting appropriate to the needs of the individual; providing counties access to funding to support non-institutional services; and providing funding for phase-down payments to ICFs-IID that agreed to reduce their number of licensed beds.

Community Integration Program (CIP II). CIP II participants are either individuals with physical disabilities or individuals who are over the age of 65, and are relocated or diverted from nursing homes. Two initiatives under the CIP II umbrella, the Community Relocation Initiative (CRI) and the Nursing Home Diversion program (NH Diversion) are intended to move individuals out of, or prevent admission to, nursing homes and institutions. During CY 2015, 2,289 individuals received Medicaid services under these two initiatives.

The aggregate cost of serving these individuals in the community must be less than the estimated cost of serving these individuals in a nursing home. The state reimburses counties for expenses for each participant up to the county's state funding allocation. For CY 2016, the daily reimbursement rate to counties serving CIP II clients is $41.86 per person, unless a variance is granted by DHS to exceed this amount.

Community Options Waiver Program (COP-W). COP-W provides services to elderly individuals and persons with physical disabilities who would otherwise receive care in a nursing facility.

COP-W provides most of the same services as the community options program (COP-Regular), except for those services prohibited under the federal waiver requirements, such as room and board. Unlike COP-Regular, services provided under COP-W are eligible for federal matching funds. 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. DHS limits the average expenditure per COP-W client to a combined COP-W and CIP II amount of $41.86 per day, unless a variance is approved by the Department to exceed that average.

Brain Injury Waiver (BIW). Previously, individuals with a substantial disability caused by a brain injury received, or were eligible for, post-acute rehabilitation institutional care could receive community services under this special waiver program. However, effective April, 2014, the BIW program was terminated. Participants in the program were transitioned to the CIP or COP waivers to continue receiving services.

Children's Long-Term Support (CLTS) Program. The CLTS waiver program operates under one combined federal waiver to provide Medicaid-funded, community-based supports and services to eligible children meeting the functional level of care criteria. The program seeks to improve access to services, choice, coordination of care, quality, and financing of long-term care services for children with physical and developmental disabilities, and severe emotional disturbance.

The services provided under the CLTS waiver are similar to those available under other HCBS waiver programs. However, some of the services that are necessary for adults, such as home-delivered meals and adult day care, are not available to children under the waivers. In addition to receiving waiver services, CLTS participants have access to all Medicaid-covered card services.

Children may continue to receive services under the waiver until they reach the age of 22 as long they continue to be eligible for Medicaid, after which they would need to apply for services under an adult waiver program, Family Care, or IRIS.

Prior to CY 2016, all MA-supported autism treatment services were provided as part of the CLTS waiver program. In 2014, CMS modified its policy regarding these services and notified states that, if states wished to receive federal financial participation to support the cost of these services, they should be provided as state plan services, rather than as waiver services. In 2016, DHS began transitioning these services from waiver services to state plan services and, as of January, 2017, all autism treatment services are provided as state plan services.

Community Options Program (Non-Waiver). The non-waiver community options program (COP-Regular) is a 100% GPR-supported program. Counties can use COP-Regular funds as the non-federal share for additional Medicaid-eligible services provided to individuals in other HCBS waiver programs or to pay the full costs of services not eligible for federal MA matching funds. Counties also use this funding as the local match to fund services for additional waiver enrollees or to draw down federal matching funds on Medicaid allowable costs that exceed the waiver daily rate. This funding may also be used to support non-Medicaid allowable expenditures, such as room and board costs or certain medical supplies and care provided by a spouse or parent of a minor.

In CY2016, per person per month COP-Regular spending could not exceed $1,898.24. In CY 2015, 2,639 individuals received services funded with COP-Regular, with 845 individuals receiving only COP-Regular services and 1,794 individuals using COP-Regular for match or supplemental funding.

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2016 Federal Poverty Guidelines

	Percent of Federal Poverty Level							
Family Size	100%	133%	150%	185%	200%	240%	300%	306%
Annual								
One	$11,880	$15,800	$17,820	$21,978	$23,760	$28,512	$35,640	$36,353
Two	16,020	21,307	24,030	29,637	32,040	38,448	48,060	49,021
Three	20,160	26,813	30,240	37,296	40,320	48,384	60,480	61,690
Four	24,300	32,319	36,450	44,955	48,600	58,320	72,900	74,358
Five	28,440	37,825	42,660	52,614	56,880	68,256	85,320	87,026
Six	32,580	43,331	48,870	60,273	65,160	78,192	97,740	99,695
Seven	36,730	48,851	55,095	67,951	73,460	88,152	110,190	112,394
Eight	40,890	54,384	61,335	75,647	81,780	98,136	122,670	125,123
Monthly								
One	$990	$1,317	$1,485	$1,832	$1,980	$2,376	$2,970	$3,029
Two	1,335	1,776	2,003	2,470	2,670	3,204	4,005	4,085
Three	1,680	2,234	2,520	3,108	3,360	4,032	5,040	5,141
Four	2,025	2,693	3,038	3,747	4,050	4,860	6,075	6,197
Five	2,370	3,152	3,555	4,385	4,740	5,688	7,110	7,252
Six	2,715	3,611	4,073	5,023	5,430	6,516	8,145	8,308
Seven	3,061	4,071	4,591	5,663	6,122	7,346	9,183	9,366
Eight	3,408	4,532	5,111	6,304	6,815	8,178	10,223	10,427

Note: DHHS updates the federal poverty guideline in January or February of each year.

APPENDIX 2

Supplemental MA Payments to County and Municipally-Owned Nursing Homes

County	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Brown	620,700	633,783	602,700	728,600	765,600	778,000
Clark	1,615,933	1,901,130	1,628,385	1,596,428	1,612,179	1,534,800
Columbia	833,353	1,011,064	869,540	846,879	877,283	826,500
Dane	1,061,446	1,180,690	1,157,469	1,282,542	1,402,997	1,437,300
Dodge	1,771,662	2,068,335	1,732,028	1,661,258	1,772,944	1,989,400
Dunn	785,328	943,175	815,129	833,896	860,949	1,070,200
Fond du Lac	975,272	1,128,126	1,024,759	1,044,545	1,023,055	928,300
Grant	1,134,408	1,407,177	1,359,731	1,246,242	1,224,708	1,198,400
Green	1,011,894	1,211,869	1,036,369	1,000,996	1,158,921	1,031,000
Iowa	469,700	594,183	535,901	520,558	497,033	478,700
Kenosha	931,600	1,189,495	1,102,100	1,048,600	1,043,800	942,800
La Crosse	2,414,003	2,966,662	2,331,202	2,492,229	2,710,952	2,826,800
Lafayette	544,400	645,255	574,300	567,300	454,800	471,400
Lincoln	1,534,500	1,743,489	1,634,246	1,747,374	1,691,035	1,704,300
Marathon	2,133,392	2,344,553	2,069,335	2,121,776	2,103,405	1,972,900
Milwaukee	1,308,863	1,530,678	1,184,446	1,533,090	968,137	197,200
Monroe	821,981	1,019,011	884,412	893,420	871,701	887,000
Outagamie	1,419,600	1,721,423	1,657,100	1,692,400	1,570,200	1,536,300
Ozaukee	1,539,905	1,566,245	1,389,362	1,399,457	1,349,059	1,349,500
Polk	897,484	1,083,537	991,228	1,030,384	997,300	1,149,800
Portage	569,011	491,629	506,951	440,926	510,296	642,500
Racine	1,278,569	1,554,731	1,274,747	1,358,122	1,443,173	1,542,700
Richland	648,799	714,910	716,811	710,602	827,401	860,000
Rock	1,268,100	1,634,962	1,314,000	1,364,800	1,337,200	1,254,900
Rusk	466,200	544,441	490,400	0	0	0
Sauk	607,038	726,856	625,790	657,705	685,289	668,700
Sheboygan	1,265,000	1,408,675	1,230,234	1,202,352	1,103,057	1,116,600
St. Croix	483,177	504,239	396,738	417,276	438,148	450,900
Trempealeau	599,114	780,655	843,196	767,487	778,695	746,000
Vernon	669,021	645,676	565,247	676,135	718,354	729,600
Walworth	927,200	1,197,099	971,600	986,100	979,700	919,900
Washington	1,203,403	1,158,579	1,117,144	1,021,739	1,127,498	1,214,300
Waupaca	317,600	488,167	411,002	417,767	360,768	384,500
Winnebago	1,470,800	1,765,059	1,638,468	1,605,550	1,543,975	1,663,500
Wood	957,000	982,774	757,824	712,674	756,958	840,200
Municipality						
Algoma, City of	441,800	499,303	466,300	503,400	506,400	550,200
Baldwin, Village of	112,708	197,184	46,700	0	0	0
Chetek, City of	515,000	539,414	515,175	469,136	493,155	418,000
Elmwood, Village of	0	64,171	0	37,500	21,364	23,400
Galesville, City of	216,126	304,240	162,786	65,052	111,649	211,800
Prairie Farm, Village of	0	143,735	89,700	42,300	0	136,300
Westby, City of	258,910	367,789	379,445	355,403	400,862	415,400
Total Payments	**$38,100,000**	**$44,604,169**	**$39,100,000**	**$39,100,000**	**$39,100,000**	**$39,100,000**

APPENDIX 3

Services Included in Partnership, PACE, Family Care, and IRIS

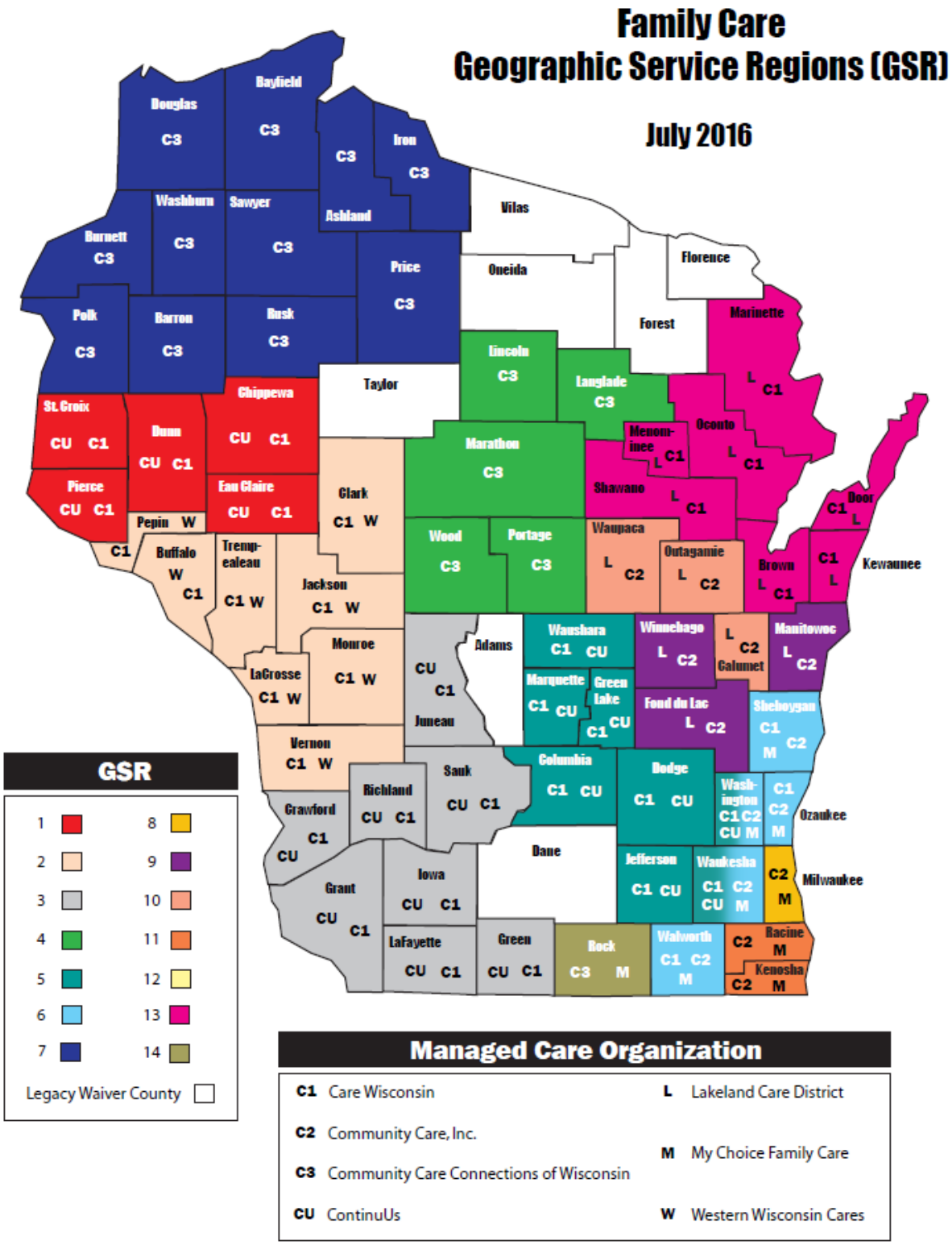
Family Care Partnership & Program of All Inclusive Care for the Elderly (PACE)			
		Family Care	
			IRIS*
Medicare Services^	**Acute/Primary Medicaid Services**	**Medicaid Card Services - Long-Term Care Services**	**Home and Community-Based Waiver Services**
• Ambulance services • Ambulatory surgical centers • Blood • Durable medical equipment, prosthetics, and supplies • Cardiac rehab • Extremely limited chiropractic services • Diabetes supplies • Diagnostic tests, x-rays, and lab services • Physician services • Emergency and urgent care services • Home health care if homebound and need skilled nursing or therapy services • Hospice care • Inpatient hospital care • Inpatient mental health care • Outpatient mental health care • Outpatient hospital services, including outpatient surgery • Limited post-hospital skilled nursing facility if daily skilled nursing and/or rehabilitation services needed • Physical/speech/occupational therapy • Podiatry services, limited to treatment of foot injuries or diseases • Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D • Very limited dental, hearing, and vision services • Outpatient substance abuse treatment • Various preventative services, screenings, vaccinations, and yearly wellness visits	• Physician services • Laboratory and x-ray services • Inpatient hospital • Outpatient hospital services • EPSDT (under 21) • Family planning services and supplies • Federally-qualified health center services • Rural health clinic services • Nurse midwife services • Certified nurse practitioner services • Prescribed drugs (very limited if Medicare-eligible) • Diagnostic, screening, preventative, and rehabilitation services • Clinic services • Primary care case management services • Dental services, dentures • Dialysis service • Hospice care • Prosthetic devices, eyeglasses • Tuberculosis-related services • Other specific medical and remedial care • Inpatient mental health • Chiropractic services • Podiatry services • Outpatient mental health provided by a physician • Outpatient substance abuse provided by a physician • Outpatient surgery • Ambulance services • Emergency care • Urgent care • Diagnostic services • Hearing and vision services	• Alcohol and other drug abuse day treatment and services • Case management • Community Support Program • Durable medical equipment, except hearing aids and prosthetics • Home health • Medical supplies • Mental health day treatment services • Mental health services, except those provided by a physician or on an in-patient basis • Nursing facility, except IMD between ages 21-64 • Nursing services • Occupational therapy, except in-patient hospital • Personal care • Physical Therapy • Speech and language pathology services, except in-patient hospital • Transportation to receive non-emergency medical, except ambulance	• Adaptive aids (general and vehicle) • Adult day care • Care/case management (Family Care only) • Communication aids/interpreter services • Consultative clinical/therapeutic services for caregivers (Family Care only) • Consumer education and training • Counseling and therapeutic resources • Customized goods and services (IRIS only) • Daily living skills training • Day services/treatment • Financial management services (Family Care only) • Fiscal employer agent payroll services (IRIS only) • Home delivered meals • Home modifications • Housing counseling • Live-in caregiver (IRIS only) • Personal Emergency Response System services • Prevocational services • Relocation services • Residential services, including adult family homes, community-based residential facilities (CBRF), and certified residential care apartment complexes (RCAC) • Respite care • Self-directed personal care (IRIS only) • Skilled nursing (above the amount available with MA card) • Specialized medical equipment and supplies • Specialized transportation • Support broker • Supported employment • Supportive home care • Training services for unpaid caregivers (Family Care only) • Vocational futures planning

*Family Care participants access acute/primary services with their Medicaid card.

**IRIS participants access Medicaid card services - Long-Term Care services and acute/primary services with their Medicaid card.

^Individuals enrolled in IRIS or Family Care may also be eligible for Medicare.

APPENDIX 4


Family Care
Geographic Service Regions (GSR)
July 2016
Douglas C3
Bayfield C3
Iron C3
Ashland C3
Washburn C3
Sawyer C3
Burnett C3
Price C3
Polk C3
Barron C3
Rusk C3
Vilas
Oneida
Florence
Forest
Marinette L C1
Taylor
Lincoln C3
Langlade C3
Oconto L C1
St Croix CU C1
Dunn CU C1
Chippewa CU C1
Eau Claire CU C1
Pierce CU C1
Pepin W
C1
Buffalo W C1
Trempealeau C1 W
Clark C1 W
Jackson C1 W
Marathon C3
Menominee L C1
Shawano L C1
Door C1 L
Kewaunee
Wood C3
Portage C3
Waupaca L C2
Outagamie L C2
Brown L C1
C1 L
Monroe C1 W
LaCrosse C1 W
Adams
CU C1
Juneau
Waushara C1 CU
Winnebago L C2
L C2 Calumet
Manitowoc L C2
Marquette C1 CU
Green Lake C1 CU
Fond du Lac L C2
Sheboygan C1 M C2
Vernon C1 W
Columbia C1 CU
Sauk CU C1
Dodge C1 CU
Richland CU C1
Crawford C1 CU
Wash-ington C1 C2 CU M
C1 C2 M
Ozaukee
Dane
Jefferson C1 CU
Waukesha C1 C2 CU M
C2 M
Milwaukee
Grant CU C1
Iowa CU C1
LaFayette CU C1
Green CU C1
Rock C3 M
Walworth C1 C2 M
C2 Racine M
C2 Kenosha M
GSR
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14
Legacy Waiver County
Managed Care Organization
C1 Care Wisconsin
C2 Community Care, Inc.
C3 Community Care Connections of Wisconsin
CU ContinuUs
L Lakeland Care District
M My Choice Family Care
W Western Wisconsin Cares

APPENDIX 5

Aging and Disability Resource Centers (ADRCs)
As of July, 2016

Single County ADRCs:

Brown
Chippewa
Columbia
Dane
Dodge
Door
Douglas
Dunn
Eau Claire
Florence
Fond du Lac
Jefferson
Kenosha
Marinette
Milwaukee (Aging Resource Center)
Milwaukee (Disability Resource Center)
Ozaukee
Pierce
Portage
Racine
Rock
Sheboygan
St. Croix
Trempealeau
Walworth
Washington
Waukesha
Winnebago

Tribal ADRSs*:

Bad River Band of the Lake Superior Tribe of Chippewa Indians
Ho Chunk Nation
Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin
Menominee Indian Tribe of Wisconsin
Oneida Tribe of Indians of Wisconsin
Red Cliff Band of Lake Superior Chippewa Indians

Multi-County/Tribe ADRCs**:

ADRC of Adams, Green Lake, Marquette, and Waushara
ADRC of Barron, Rusk, and Washburn
ADRC of Buffalo, Clark, and Pepin
ADRC of Calumet, Outagamie, and Waupaca
ADRC of Central Wisconsin (Langlade, Lincoln, Marathon, and Wood)
ADRC of Eagle Country (Crawford, Juneau, Richland, and Sauk)
ADRC of the Lakeshore (Kewaunee and Manitowoc)
ADRC of the North (Ashland, Bayfield, Iron, Price, and Sawyer)
ADRC of Northwest Wisconsin (Burnett, Polk, and St. Croix Chippewa Indians of Wisconsin)
ADRC of the Northwoods (Forest, Forest County Potawatomi Community, Lac du Flambeau Band of Lake Superior Chippewa Indians, Oneida, Sokaogon Chippewa Community (Mole Lake), Taylor, and Vilas)
ADRC of Southwest Wisconsin (Grant, Green, Iowa, and Lafayette)
ADRC of Western Wisconsin (Jackson, La Crosse, Monroe, and Vernon)
ADRC of the Wolf River Region (Menominee, Oconto, Shawano, and Stockbridge Munsee Community)

*Tribes in this group have chosen to have their own Tribal Aging and Disability Resource Specialist (ADRS) that works with an ADRC.

**Tribes in this group have chosen to partner directly with an ADRC and do not have their own ADRS.

Additional Resources

Additional information on MA and related programs can be found through the following resources.

Wisconsin Department of Health Services (DHS)

ForwardHealth
www.dhs.wisconsin.gov/forwardhealth/

Regularly Updated Enrollment Data
www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage

BadgerCare Plus Eligibility Handbook
www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm

EBD Medicaid Eligibility Handbook
www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm

Income Maintenance Manual
www.emhandbooks.wisconsin.gov/imm/imm.htm

Centers for Medicare and Medicaid Services (CMS)

www.cms.gov/

Congressional Budget Office (CBO)

www.cbo.gov/topics/health-care/medicaid-and-chip

Government Accountability Office (GAO)

www.gao.gov/key_issues/medicaid_financing_access_integrity/issue_summary

National Conference of State Legislatures (NCSL)

www.ncsl.org/research/health/medicaid-and-chip.aspx