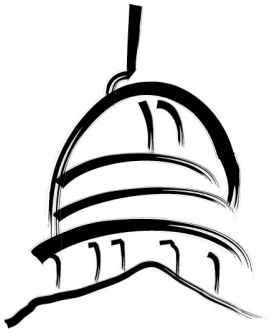
Medical Assistance and BadgerCare



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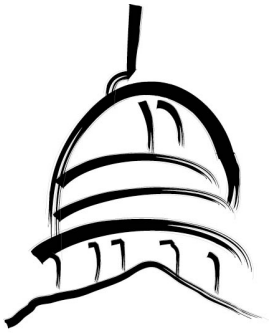

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Introduction

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

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

States receive matching payments from the federal government for expenditures made for covered services and program administration. The federal matching rate for program benefits, or federal financial participation (FFP), is based on a formula that compares a state's per capita income to national per capita income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. In federal fiscal year 2003-04, Wisconsin's FFP rate is 58.41%. Most administrative costs are funded on a 50% state / 50% federal basis. Federal law does not limit the amount of matching funds states can receive under MA. Consequently, the more funding a state provides to support the program, the more federal funding the state receives to partially support program costs.

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

On July 1, 1999, Wisconsin began enrolling individuals in the BadgerCare program, which provides health coverage to children under the age of 19 and their parents that have countable income that does not exceed 185% of the federal poverty level (FPL), are not eligible for MA, and who: (a) do not have access to an employer-sponsored health plan in which the employer pays 80% or more of the costs of the plan; and (b) do not have and have not had insurance coverage during the three calendar months before the date they apply for BadgerCare. Once enrolled, families can remain enrolled as long as their countable household income does not exceed 200% of the FPL. The services available under BadgerCare are identical to

the services available to MA enrollees, and fee-for-service providers receive the same reimbursement rates for providing services to BadgerCare enrollees as they do serving MA enrollees. BadgerCare is funded with a combination of: (a) state, general purpose revenue (GPR); (b) federal funds (FED) available under MA and Title XXI of the Social Security Act (the state children's health insurance program, commonly referred to as "SCHIP"); (c) segregated revenue from the MA trust fund (SEG); and (d) program revenue (PR) received from premiums paid by participating families with countable income that exceeds 150% of the FPL. Unlike MA, CMS provides states a sum certain, annual allocation of SCHIP funds. Wisconsin's FFP rate for SCHIP eligible services is approximately 71.2% in 2003-04.

Approximately **$**6.9 billion (all funds) is budgeted for MA program benefits in the 2001-03 biennium, including **$**3.3 billion in 2001-02 and $3.6 billion in 2002-03. An additional **$**134.1 million (all funds) in 2001-02 and $157.8 million (all funds) in 2002-03 is budgeted to support BadgerCare benefits. The GPR funds budgeted for MA and BadgerCare benefits for the 2001-03 biennium represent approximately 9.8% of the state's total general fund budget for the biennium. Table 1 summarizes MA and BadgerCare benefits funding budgeted for the 2001-03 biennium.

Table 1: MA and BadgerCare Program Benefits Gross Appropriations -- 2001-03 Biennium

	2001-02	2002-03	2001-03
Medical Assistance			
GPR	$1,071,945,100	$1,047,627,100	$2,119,572,200
FED	2,063,184,100	2,207,231,100	4,270,415,200
SEG	205,139,000	297,379,900	502,518,900
Total	$3,340,268,200	$3,552,238,100	$6,892,506,300
BadgerCare			
GPR	$43,888,900	$51,399,500	$95,288,400
FED	86,884,200	102,377,300	189,261,500
SEG	328,500	706,700	1,035,200
PR	2,994,400	3,293,400	6,287,800
Total	$134,096,000	$157,776,900	$291,872,900
Medical Assistance and BadgerCare			
GPR	$1,115,834,000	$1,099,026,600	$2,214,860,600
FED	2,150,068,300	2,309,608,400	4,459,676,700
SEG	205,467,500	298,086,600	503,554,100
PR	2,994,400	3,293,400	6,287,800
Total	$3,474,364,200	$3,710,015,000	$7,184,379,200

Note: FED and PR amounts represent estimates.

Eligibility

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

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

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

In many states, categorically needy enrollees receive a broader range of benefits than do enrollees who qualify as medically needy. However, in Wisconsin, medically needy MA enrollees receive the same benefits that are available to enrollees who qualify under the categorically needy criteria. Therefore, the distinction between medically and categorically needy enrollees is less important in Wisconsin than in other states.

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

The MA program has numerous eligibility requirements. Certain types of expenses, such as child care, are deducted from household income before determining eligibility. Additionally, certain types of income, such as W-2 payments, kinship care payments and a portion of child support payments, may not be included when determining a family's income. The information provided here is intended to generally describe each eligibility category, not to describe all of the criteria used to determine eligibility.

Eligibility for Families With Dependent Children and Pregnant Women

This section describes general eligibility criteria for Wisconsin's MA program for families with dependent children and pregnant women. For many groups, the income eligibility criteria is based on a percentage of the FPL. Table 2 shows the FPL for 2002, which is based on the number of individuals in a family.

Table 2: 2002 Federal Poverty Level

Family Size	Monthly Income
1	$738
2	995
3	1,252
4	1,508
5	1,765
6	2,022

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

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

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

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

Family Size	Monthly Payment Level Amount	Monthly Payment Level % of the 2002 FPL	Monthly Assistance Standard Amount	Monthly Assistance Standard % of the 2002 FPL
1	$249	33.7%	$311	42.1%
2	440	44.2	550	55.3
3	518	41.4	647	51.7
4	618	41.0	772	51.2
5	708	40.1	886	50.2
6	766	37.9	958	47.0

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

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

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

- Children residing in a licensed foster home or group foster home;

- Children for whom an adoption assistance agreement is in effect and children adopted under a state-established agreement;

- Children residing with a relative and for whom a kinship care payment is being made;

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

- Relative caretakers, if the child is not temporarily absent and the child is considered deprived;

- Certain pregnant women; and

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

As of November, 2002, there were 197,181 individuals enrolled in MA under AFDC and AFDC-related eligibility criteria.

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

As of November, 2002, there were 114,000 children and 6,681 women enrolled in MA under the Healthy Start criteria.

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

- Any child under 18 years of age;

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

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

Under the spend-down provision, a person can become eligible for MA after incurring medical expenses during a six-month period in an amount that equals the amount his or her income is above the medically needy income limits established by the state. In this way, the spenddown provision offers protection against catastrophic medical costs. As of November, 2002, there were 169 individuals in the low-income family group who qualified for MA by meeting the spenddown requirement.

Presumptive Eligibility. A period of "presumptive eligibility" is available for pregnant women to ensure they have access to prenatal care. This period begins on the day on which a qualified provider determines, on the basis of preliminary information, that the household income of the woman meets MA eligibility criteria. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to apply for MA, the last day of the month following the month in which the determination of presumptive eligibility is made, whichever is earlier. As of November, 2002, 301 women were eligible for MA under a presumptive eligibility determination.

Even if a woman is initially determined to be eligible for MA as a result of a presumptive eligibility determination and is later found to have been ineligible for MA at the time she received

services, the state's MA program pays the provider for services rendered to the woman during the period of presumptive eligibility.

Under the terms of a federal waiver granted to Wisconsin, beginning January 1, 2003, women between the ages of 15 and 44 may be determined eligible for MA family planning services under presumptive eligibility criteria, if their family income does not exceed 185% of the FPL.

Transitional Eligibility. Federal law requires states to extend MA eligibility for certain individuals and families for specified periods. Families that would have lost eligibility for AFDC because of a change in income earned from employment can remain eligible for up to twelve months based on certain conditions. Families who would have lost AFDC eligibility because of an increase in child or family support payments can remain eligible for four months under certain conditions. A pregnant woman remains MA eligible through the month in which the 60th day after her pregnancy falls, regardless of a change in household income. Additionally, an infant can remain eligible for MA for up to one year if the infant's mother was eligible for MA on the date the infant was born. As of November, 2002, 42,305 individuals were enrolled in MA because they qualified under an extension due to changes in their income. For that same month, 11,133 infants were enrolled in MA because their mothers were enrolled in MA on the day they were born.

Eligibility for Elderly, Blind and Disabled Individuals

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

States may supplement federal SSI payments with state funds. However, the federal requirement to provide MA to SSI recipients only applies to those individuals who qualify for the federal SSI payment and only to those individuals who actually receive an SSI payment. In calendar year 2002, the federal income limit for SSI was $545.00 per month for an individual and $817.00 per month for a couple. (These limits apply after income is adjusted to reflect certain deductions and exemptions.) Except for section 209(b) states, MA coverage must be provided to elderly and disabled individuals and couples with incomes below these limits who actually receive an SSI payment. States may provide MA coverage to individuals who receive a state-only supplemental payment and to individuals who are eligible for a SSI payment but do not receive a payment. Wisconsin's MA program covers both of these optional groups. In calendar year 2002, elderly and disabled individuals with countable income below $628.78 per month and couples with countable income below $949.05 per month were eligible for MA.

States must continue MA coverage for several groups of individuals who previously were eligible for SSI. States must provide MA coverage for certain disabled individuals who have returned to work and have lost eligibility for SSI as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all nondisability criteria for SSI except income. States must continue to provide MA coverage to such an individual if he or she needs MA coverage to continue employment and the individual's earnings are not sufficient to provide the equivalent of SSI, MA and attendant care benefits the individual would qualify for in the absence of earnings.

States must also continue MA coverage for individuals who were once eligible for both SSI and Social Security payments and who are no longer eligible for SSI because of certain cost of living adjustments in their Social Security benefits. Under federal regulations, states are required to disregard

the cost of living adjustment when considering MA eligibility. Similar MA continuations have been provided for certain other individuals who become ineligible for SSI due to eligibility for or increases in Social Security or veterans' benefits. Finally, states must maintain MA coverage for certain SSI-related groups who received benefits in 1973, including individuals who care for disabled individuals.

Low-Income Medicare Beneficiaries. States must provide limited MA coverage for several groups of Medicare beneficiaries: (1) qualified Medicare beneficiaries (QMBs); (2) two groups of specified low-income Medicare beneficiaries (SLMBs and SLMBs+); and (3) qualified disabled and working individuals (QDWIs).

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

For QMBs, MA reimburses any required Medicare premium, coinsurance and deductibles for both Part A (hospital and nursing home insurance) and Part B (physician and other outpatient services) coverage. Deductibles are paid up to the Medicare allowable amount.

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

QMBs pay copayments normally required of other MA beneficiaries. Finally, providers are required to accept the MA payment and the QMB's copayment (if any) as payment in full. As of November, 2002, 1,137 individuals were enrolled in MA under the QMB criteria.

A more limited MA benefit is provided to SLMBs. States are required to pay the Medicare Part B premium for individuals who otherwise meet the QMB requirements but have income between 100% and 120% of the FPL. No other premiums, deductibles or copayments are paid for individuals in this group. For individuals who otherwise meet the QMB requirements but have income between 120% and 135% of the FPL (SLMBs+), MA pays the full Part B premium so that there is no difference between benefits provided to this group and the original SLMBs. As of November, 2002, there were 2,882 individuals enrolled in MA under the SLMB and SLMB+ criteria.

States are required to pay the Part A premiums, but no other expenses, for QDWIs. These are people who formerly received social security disability benefits and hence Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the Part A premium. Under this category, MA eligibility for payment of the Part A premium is limited to individuals under the age of 65 with income at or below 200% of the FPL with assets up to twice the SSI resource limits and who are not otherwise MA-eligible. States may require QDWIs with income between 150% and 200% of the FPL to pay a portion of the Part A premium. The portion paid by the person must vary inversely with the individual's income. Wisconsin pays the full Part A premium for all QDWIs. As of November, 2002, there were no individuals enrolled in MA under the QDWI criteria.

Finally, states have the option to provide full MA benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a state-established income standard that is no higher than 100% of the FPL. Wisconsin does not use this option.

Medically Needy. Elderly and disabled individuals are eligible for medically needy coverage under MA. Medically needy income and asset standards must be reasonable, based on family size, and uniform for all covered groups. In the past, the AFDC cap provision was applied after disregards and deductions relating to SSI or AFDC were applied. However, in May, 2002, the federal regulations were changed to apply the AFDC cap provision after all disregards and deductions are made. The change allows states to set the medically needy income limits above the AFDC "cap" and the medically needy asset limits above the SSI limit.

Wisconsin offers MA coverage to medically needy individuals, but the income standards for the elderly and disabled are, in most cases, lower than the standards for categorically needy individuals. As previously indicated, in Wisconsin, the AFDC payment standard is not increased annually to reflect inflation, while the SSI payment levels are. Therefore, the income standard for categorically needy elderly and disabled groups increases annually, while the standard for the medically needy has reached its limit and has not increased for couples since 1988 and for individuals since 2000.

Before medical costs would be covered under the SSI-related medically needy program, the individual or family would first have to deplete assets to the respective level ($2,000 for an individual, $3,000 for a couple), and would have to spend any income over the medically needy income standard for medical expenses. As of November, 2002, 4,332 elderly and disabled individuals were enrolled in MA under this spend down option.

Because of the high cost of care in nursing homes, many elderly and disabled individuals who require nursing home care use the medically needy option. Federal regulations allow states to exclude nursing home care from coverage under the medically needy program. However, Wisconsin includes nursing home care in its medically needy program.

Individuals Receiving Institutional or Other Long-Term Care. Under federal law, states may provide MA coverage to nursing home residents and individuals participating in community-based waiver programs under a special institutional income rule. This rule permits individuals who are not categorically eligible for SSI and have income between 100% and 300% of the monthly federal SSI payment amount to be automatically eligible for MA coverage without "spending down" to the medically needy standards. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($1,635 per month in 2002).

MA enrollees who qualify for institutional care or care under a community-based waiver program under the special income limit or the medically needy standard must use any income in excess of allowable deductions for the costs of their care. Allowable deductions under the special institutional income rule include: (a) for institutionalized enrollees, $45 per month, and between $725 and $1,105 per month in 2002 for community-based waiver recipients as a personal maintenance allowance; (b) a transfer of income to a spouse and dependent children in the community; and (c) medical costs not covered by MA.

If a state provides nursing home coverage using the special institutional income rule and does not extend coverage to the medically needy, then federal law requires the state to allow individuals the option to establish a "Miller" or "qualifying income trust" to obtain eligibility for nursing home care. The practical effect of this requirement is that when a state uses the special institutional income rule, it is required to extend coverage to the medically needy either directly or through Miller trusts.

Federal law requires that: (1) Miller trusts be funded only by social security, pension and other income (and interest income accumulated by the trust); and (2) upon the death of the person, the state has first priority on any remaining funds in the trust up to the amount that was provided in MA nursing home care.

In addition to community-based waiver programs, federal rules allow states to provide MA coverage to several other classes of individuals who need the level of care provided by an institution and would be eligible if they were in an institution.

First, individuals receiving hospice benefits in lieu of institutional services and individuals of any age who are ventilator-dependent can be covered under MA.

Second, children with special health needs living at home ("Katie Beckett" children) can also be covered. Under federal law, a child may be eligible for SSI and, therefore, eligible for MA coverage while the child is institutionalized. However, the same child may not be eligible for MA or SSI if the child lives at home because of SSI rules relating to the treatment of parents' income. Before MA coverage was available for this optional group, some children remained in institutions even though their medical needs could be taken care of at home so that they would remain eligible for SSI and MA. To be eligible under this provision, an individual must: (a) be under the age of 18; (b) be eligible for MA if in an institution: (c) require the level of care provided in a hospital or a nursing facility; (d) be appropriate for home-based care: and (e) have home-care costs that do not exceed the estimated cost of institutional care. As of November, 2002, 4,713 children were eligible for MA under the Katie Beckett criteria.

MA Purchase Plan. 1999 Wisconsin Act 9 authorized DHFS to implement a new option provided under federal MA law to extend MA coverage to certain working, disabled individuals.

The program is intended to remove financial disincentives to work. A disabled person may be able to work, but may choose not to because the additional income would make him or her ineligible for MA or Medicare. The MA purchase plan (MAPP) provides individuals the opportunity to earn more without the risk of losing health care coverage. This plan also allows an individual to accumulate savings from earned income in an independence account to increase the rewards from working.

An individual is eligible to participate in the MA purchase plan if:

- The individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL ($1,845 per month for an individual and $2,487.50 per month for a two-person family in 2002). Income disregards include the first $65 of earned income plus one-half of earned income over $65, $20 disregard of any type of income, health insurance premiums and other out-of-pocket medical expenses.

- The individual's countable assets do not exceed $15,000. Countable assets do not include assets that are excluded under MA financial eligibility rules (such as a home, car with a value up to $4,500, household goods and personal effects, and property used in a business or trade) or assets accumulated in an independence account.

- The individual is determined to have a disability under SSI standards (disregarding one's ability to work)

- The individual is engaged in gainful employment or is participating in a program that is certified by DHFS to provide health and employment services that are aimed at helping the individual achieve employment goals.

- The individual is at least 18 years old.

As of November, 2002, 3,584 individuals were enrolled in MA under MAPP.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL. The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the sum of: (a) standard living allowance ($648 per month in calendar year 2002); (b) impairment-related work expenses; and (c) out-of-pocket medical and remedial expenses. The part of the premium based on earned income is equal to 3% of earned income, except that if the deductions for unearned income exceed unearned income, any remaining deductions can be applied to earned income before the 3% premium rate is applied.

Other Eligible Groups

Prescription Drug Assistance for Elderly People. 2001 Wisconsin Act 16 created a prescription drug assistance program, known as SeniorCare, for Wisconsin residents who are 65 years of age or older. Act 16 directed DHFS to seek a waiver of federal law allowing SeniorCare to operate as an MA-waiver demonstration project under Section 1115 of the Social Security.

In July, 2002, federal authorities approved a waiver under Section 1115 allowing DHFS to operate SeniorCare as an MA waiver project. Under the waiver, individuals enrolled in SeniorCare with household income at or below 200% of the FPL participate in the project and the state receives MA matching funds for approximately 59% of their costs. SeniorCare enrollees participating in the waiver project are considered MA enrollees, but do not receive any MA benefits other than prescription drug coverage.

SeniorCare enrollees with household income above 200% of the FPL do not participate in the waiver project and therefore, federal MA funds do not support a portion of costs for these enrollees.

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

The program began providing benefits September 1, 2002. As of November, 2002, there were 68,476 individuals enrolled in SeniorCare, of which 50,471 were enrolled in the MA waiver project. For more information on SeniorCare, refer to the Legislative Fiscal Bureau's Informational Paper # 43.

People with Tuberculosis. People who have tuberculosis and who meet the income and resource eligibility requirements for SSI are eligible for some MA-covered services. For these individuals, MA coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services; (e) case management services; and (f) services designed to encourage individuals to take their medications. As of November, 2002, there were 161 individuals enrolled in MA under this criteria.

Women Diagnosed with Breast or Cervical Cancer. 2001 Act 16 expanded MA eligibility to include any women under the age of 65 who: (a) has been screened for breast or cervical cancer under an early detection program authorized under the breast and cervical cancers preventive health grant from the U.S. Centers for Disease Control and Prevention (known as the well woman program in Wisconsin); (b) requires treatment for breast or cervical cancer; and (c) is not eligible for creditable health care coverage, as defined by federal law. Although the MA eligibility criteria do

not include age or income requirements, eligible women must be referred through the well woman program, which limits eligibility to women who are at least 35 years of age and under 65 years of age with household income that does not exceed 250% of the FPL. Therefore, the age and income requirements for the well-woman program apply to this group of MA enrollees. Under the provisions of Act 16, a woman can be determined presumptively eligible for MA under criteria similar to the criteria for determining presumptive eligibility for pregnant women. As of November, 2002, there were 90 women enrolled in MA as a result of a diagnosis of breast or cervical cancer.

Family Planning Services for Certain Women. 1997 Wisconsin Act 27 required DHFS to request a waiver from the U.S. Department of Health and Human Services (DHHS) that, if approved, would permit DHFS to conduct a demonstration project to provide MA-funded family planning services to any woman between the ages of 15 and 44 whose family income does not exceed 185% of the FPL. In 2002, DHHS approved the waiver request submitted by DHFS. DHFS began enrolling women under the waiver on January 1, 2003.

People with HIV/AIDS. 1999 Wisconsin Act 9 required DHFS to request a waiver from DHHS that would allow DHFS to provide MA coverage to all individuals who have HIV infection. If DHFS obtains the waiver, DHFS is required to provide full MA benefits to people who qualify under the terms of the waiver. To date, the DHFS waiver request has not been approved.

Table 4 describes, by eligibility group, the different income and asset qualifications an individual must meet to receive benefits under Wisconsin's MA program in the 2002 calendar year. The income and asset limits shown in the table reflect countable income and assets, and therefore excludes certain types of income and assets.

Additional Requirements Affecting Eligibility

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

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

Asset Limit. When a married person enters a nursing home or a community-based, long-term care program, the county social services or human services department will, upon request, conduct an assessment of the couple's combined total assets. This "snapshot" includes all countable assets owned by either or both spouses. Countable assets do not include the couple's home, one vehicle, assets related to burial (including insurance, trusts, funds or plots), household furnishings and clothing or other personal items.

The amount of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or at the time of the request for community waivers. Federal law allows states discretion in establishing the asset protection level, but imposes some limits. In 2002, the maximum amount of assets that could be protected for the community spouse was $89,280, unless a higher amount was granted on a case by case basis under a fair hearing or court order. The minimum amount of assets that could be protected for the community spouse was the greater of: (a) $17,856; or (b) 50% of the couple's countable assets up to the federal maximum. Both federal limits are adjusted annually, based on changes in the consumer price index.

Table 4: Income Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2002)

FAMILIES, WOMEN AND CHILDREN

CATEGORICALLY NEEDY

AFDC

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

Family Size	Maximum Monthly Net Income*	Income as a % of 2002 FPL
1	$249	33.7%
2	440	44.2
3	518	41.4
4	618	41.0
5	708	40.1
6	766	37.9

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

AFDC-RELATED

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

Family Size	Maximum Monthly Net Income*	Income as a % of 2002 FPL
1	$311	42%
2	550	55
3	647	52
4	772	51
5	886	50
6	958	47

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

HEALTHY START

Pregnant Women and Children Under Age Six

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

Family Size	Maximum Monthly Income	Income as a % of 2002 FPL
1	$982	133%
2	1,323	133
3	1,665	133
4	2,006	133
5	2,347	133
6	2,689	133

HEALTHY START

Children Ages Six Through Eighteen

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

Family Size	Maximum Monthly Income	Income as a % of 2002 FPL
1	$738	100%
2	995	100
3	1,252	100
4	1,508	100
5	1,765	100
6	2,022	100

MEDICALLY NEEDY

AFDC-RELATED

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

Family Size	Maximum Monthly Income	Income as a % of 2002 FPL
1	$592	80%
2	592	59
3	689	55
4	823	55
5	944	53
6	1,021	51

HEALTHY START

Pregnant Women and Children Under Age Six

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

Family Size	Maximum Monthly Income	Income as a % of 2002 FPL
1	$1,365	185%
2	1,841	185
3	2,316	185
4	2,790	185
5	3,265	185
6	3,741	185

NOTE: Income levels are those in effect as of January 1, 2002, and federal poverty levels for the 2002 calendar year. The federal poverty level is updated annually in mid-February. There are not asset limits for individuals to qualify under these eligibility categories.

Table 4: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2002) (continued)

ELDERLY, BLIND AND DISABLED INDIVIDUALS AND COUPLES

CATEGORICALLY NEEDY

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

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2000 FPL
1	$2,000	$629[1,3]	85%
2	3,000	949[2]	95

[1] Assumes that person has actual shelter costs of at least $182.
[2] Assumes that the family has actual shelter costs of at least $272.
[3] For individuals who receive long-term care services in a nursing home or under a community-based waiver program, eligibility is based on a higher income standard, which is 300% of the federal SSI payment, ($1,635 per month in 2002).

MEDICALLY NEEDY

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

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2002 FPL
1	$2,000	$592[1,]	80%
2	3,000	592[2]	59

COMMUNITY SPOUSE PROTECTED INCOME AND RESOURCES

- A community spouse of an institutionalized MA-eligible person may retain a certain amount of monthly income and assets that do not have to be used toward the care costs for the institutionalized individual. If the total countable assets of the couple are less than $100,000, the community spouse asset share is $50,000. If the countable assets of a couple are between $100,000 and $178,560, the community spouse asset share is half of the total countable assets of the couple. If the countable assets of a couple are more than $178,560, the maximum community spouse asset share is $89,280. In each case, the institutionalized spouse may retain $2,000 in assets, in addition to the assets retained by the community spouse.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2002 FPL
2	See Text	$1,990	200%

MEDICARE BENEFICIARIES

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

Type	Asset Limit Indiv.	Asset Limit Couple	Maximum Monthly Income Indiv.	Maximum Monthly Income Couple	Benefits Paid
QMB	$4,000	$6,000	$738	$995	All Medicare premiums, coinsurance and deductibles.
SLMB[1]	4,000	6,000	886	1,194	Part B premium.
SLMB+[2]	4,000	6,000	997	1,343	Part B premium.

[1] Income equal to 100-120% of the FPL.
[2] Income equal to 120-135% of the FPL.

QUALIFIED WORKING & DISABLED INDIVIDUALS

- Disabled individuals who are working with income up to 100% of the FPL with resources at or below twice the SSI asset limit and not otherwise eligible for MA.
- MA pays Medicare Part A (hospital) premiums only.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2002 FPL
1	$4,000	$1,477	200%
2	6,000	1,990	200

MA PURCHASE PLAN

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

Family Size	Maximum Asset Limit	Monthly Income	Monthly Income as a % of 2002 FPL
1	$15,000	$1,846	250%
2	15,000	2,488	250

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

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

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

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

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

In addition, spousal impoverishment provisions may allow part of the institutional spouse's income to be transferred to the community spouse to provide an adequate income for the community spouse. Again, federal law provides states some discretion in the amount that could be transferred, but imposes limits. Under federal law, the maximum amount that may be transferred to the community spouse is an amount that would raise the community spouse's total income to $2,232 per month in 2002. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index (CPI). Additional income may also be transferred to provide for certain dependent family members living with the community spouse or if ordered by a court.

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

Wisconsin establishes its income allowance between the federally-established minimum and

maximum amounts. Specifically, Wisconsin's income allowance is, subject to the federal maximum, the sum of: (a) 200% of the federal poverty level ($1,990 per month in 2002); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the state's standard (shelter costs in excess of $597 per month in 2002). In addition, Wisconsin permits the institutionalized spouse to transfer up to $498 per month in 2002 for each qualifying dependent family member living with the community spouse. A fair hearing or court order could provide for a higher amount in an individual case if it causes undue financial hardship.

In addition to any amount transferred to the community spouse, the institutionalized spouse may retain income as a personal needs allowance. If the person is in a nursing home, the personal needs allowance is $45 per month. If the individual is enrolled in an MA community-based waiver program, the allowance is higher (between $725 and $1,105 per month) to support food, shelter and other costs. Any income in excess of the amount transferred to the community spouse and the personal needs allowance must be used to pay for long-term care costs.

The following example illustrates how the income test is applied in Wisconsin. In 2002, 200% of the FPL for a two-person family was $1,990 per month. If a community spouse has shelter costs of $756 per month, the excess shelter costs equal $159 per month ($756 - $597 = $159). In this case, the maximum monthly income allocation is $2,149 ($1,990 + $159 = $2,149). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,149 per month to determine the spousal income allocation amount ($1,949). If the institutionalized spouse's income is $3,600, the institutionalized spouse's nursing home liability amount would be $1,606 per month [$3,600 (the institutionalized spouse's income) - $1,949 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,606.

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

A person may be denied MA coverage of institutional and community-based waiver services (and other long-term care services provided on or after April 1, 1995), if that person, his or her spouse, or the person's representative disposes of certain assets for less than fair market value or does not receive assets to which he or she is entitled for the purpose of meeting the MA resource test. However, an individual who is ineligible for MA-funded long-term care services as a result of divestment may still be eligible for acute care services. If an individual is found ineligible for institutional and other long-term care services, he or she cannot be determined eligible again until he or she has satisfied certain conditions specified in federal and state laws.

If an individual divests within 36 months before he or she applies for MA or enters an institution, the individual may be determined to be ineligible for MA coverage for certain long-term care services, including nursing home services, for a period that is based on the amount of the divestment and the statewide average nursing home cost to a private pay patient ($4,292 per month in calendar year 2002). The 36-month period is referred to as the "look-back" period -- it is the maximum period the state can look back to determine whether a divestment has occurred. The look-back period is 60 months (five years) if a divestment involves a trust.

The following example illustrates how the state calculates the period of ineligibility for MA coverage of certain services. This period is referred

to as the "penalty period." If the state determines that an applicant divested $100,000 in the look-back period, the individual would be ineligible for MA-covered long-term care services for 23 months ($100,000 / $4,292 per month = 23.3 months, which is rounded down to the nearest whole number of months.) A finding that an individual divested saves the state's MA program money because during the penalty period, the individual, rather than the state MA program, is financially responsible for the costs of specified long-term care services the individual receives.

A penalty period may not be applied in two types of situations. First, no penalty period is applied if the person furnishes convincing evidence that the divestment was not made with the intent of becoming eligible for MA. This could be done, for example, by showing that, at the time of the divestment, provisions had already been made for future maintenance needs and medical costs. The other general exception is if denial of eligibility would cause an undue hardship on the person. Undue hardship is defined as a serious impairment to the person's immediate health status.

Under certain circumstances, individuals may transfer resources to certain family members are permitted without adversely affecting their MA eligibility. For example, both homestead and non-homestead property can be transferred to: (1) a spouse; or (2) a child of any age who is either blind or permanently, totally disabled. In addition, homestead property can be transferred to: (1) a child under 21 years of age; (2) a sibling who was residing in the home for at least one year immediately before the date the person became institutionalized and has a verified equity interest in the home; and (3) a child of any age who was residing in the person's home for at least two years immediately before the person became institutionalized and who provided care that permitted the person to reside at home.

Citizenship. In order to be eligible for full MA benefits, a person must be a U.S. citizen or meet criteria for certain classes of aliens (individuals who reside in the U.S., but are not U.S. citizens), such as aliens who are lawfully admitted for permanent residence in this country. Aliens who do not meet requirements for full MA benefits are eligible for emergency medical services, including labor and delivery.

In general, aliens lawfully admitted for permanent residence before August 22, 1996, are eligible for full MA benefits. Aliens admitted after August 22, 1996, are not eligible for full benefits, with certain exceptions, for five years after their admission.

Residence. States are required to cover eligible residents, including migrant workers. Federal law prohibits states from establishing a period of residency before an individual can become eligible for MA. In Wisconsin, an individual is considered a resident if he or she: (a) is physically present in the state; and (b) intends to reside in Wisconsin. A migrant worker is considered a Wisconsin resident if he or she: (a) is employed primarily in agriculture or in the cannery industry; (b) is authorized to work in the U.S.; (c) is not related by blood or marriage to the employer; and (d) routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

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

Number of MA Enrollees by Group

Table 5 identifies the annual distribution of MA caseload by the four primary groups covered un-

der the program: (a) AFDC and AFDC-related; (b) elderly; (c) disabled and blind; and (d) Healthy Start / Other for fiscal years 1993-94 through 2001-02. Table 5 also separately lists BadgerCare enrollments, beginning in 1999-00. For each category, the table provides information on the average number of people enrolled during the fiscal year and the percent of total MA beneficiaries represented by each category.

Table 5 shows that the total number of MA recipients decreased significantly from 1993-94 to 1998-99. This decrease was likely due to the elimination of the AFDC program, and with it, automatic eligibility for MA for families enrolled in AFDC. The number of individuals enrolled in MA increased significantly in 2001-02, most likely due to economic factors that particularly affected low-income families.

Table 5: Average Number of MA and BadgerCare Enrollees, by Group -- Fiscal Years 1993-94 through 2001-02

	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Medical Assistance									
AFDC and AFDC-Related									
Average Number	286,589	276,426	253,068	209,907	153,713	145,832	144,024	146,396	173,442
% Change from Previous Year	-3.9%	-3.5%	-8.5%	-17.1%	-26.8%	-5.3%	-1.2%	1.65%	18.47%
% of MA Total	58.7%	56.7%	53.6%	47.5%	38.1%	36.7%	35.6%	34.7%	37.3%
Elderly									
Average Number	53,115	53,118	50,846	49,350	47,759	46,310	45,309	44,108	43,632
% Change from Previous Year	0.2%	-0.2%	-4.1%	-2.9%	-3.2%	-3.0%	-2.2%	-2.65%	-1.08%
% of MA Total	10.9%	10.9%	10.8%	11.2%	11.8%	11.6%	11.2%	10.5%	9.4%
Blind / Disabled									
Average Number	96,237	99,855	101,075	101,156	99,630	99,070	97,815	97,689	99,164
% Change from Previous Year	9.6%	3.8%	1.2%	0.1%	-1.5%	-0.6%	-1.3%	-0.13%	1.51%
% of MA Total	19.7%	20.5%	21.4%	22.9%	24.7%	24.9%	24.2%	23.2%	21.3%
Healthy Start / Other*									
Average Number	52,303	58,333	66,785	81,182	102,665	106,322	117,183	133,229	148,608
% Change from Previous Year	42.0%	11.5%	14.5%	21.6%	26.5%	3.6%	10.2%	13.69%	11.54%
% of MA Total	10.7%	12.0%	14.2%	18.4%	25.4%	26.7%	29.0%	31.6%	32.0%
MA Total—All Groups									
Average Number	488,244	487,632	471,775	441,595	403,767	397,534	404,331	421,422	464,846
% Change from Previous Year	2.6%	-0.1%	-3.3%	-6.4%	-8.6%	-1.5%	1.7%	4.23%	10.3%
BadgerCare									
Average Number							45,906	75,957	90,408
Medical Assistance & BadgerCare									
Average Number	488,244	487,632	471,775	441,595	403,767	397,534	450,237	497,379	555,254
% Change from Previous Year	2.6%	-0.1%	-3.3%	-6.4%	-8.6%	-1.5%	13.3%	10.5%	11.6%

* Includes individuals eligible for MA that are not defined under Title XIX of the Federal Social Security Act, such as individuals formerly eligible for the relief for needy Indian individuals (RNIP) program and certain refugees. Federal financial participation is not available for MA services provided to this group.

The Healthy Start/Other category includes poverty-related pregnant women and children that qualify under the Healthy Start criteria, individuals enrolled in the MA home- and community-based waiver programs, the Katie Beckett program, individuals who are eligible for Medicare and who receive limited MA benefits, and refugees.

The growth in the Healthy Start/Other category is due to a combination of factors. The implementation of BadgerCare has likely contributed to growth in the Healthy Start population, since some of the children in families enrolled in BadgerCare may be enrolled in MA under the Healthy Start criteria. Additionally, it appears that enrollment under the Healthy Start criteria in 2001-02 has been affected by the same economic factors that affected the AFDC-related caseload.

The table shows that the average number of MA enrollees in the elderly group decreased from a high of 53,118 in 1994-95 to 43,632 in 2001-02. Over this period, elderly enrollees as a percent of all MA enrollees decreased from approximately 10.9% to 9.4 % of all enrollees.

Finally, the table shows that the average number of MA enrollees in the blind and disabled group was growing as a portion of the total MA caseload, from 19.7% in 1993-94 to a high of 24.9% in 1998-99. This trend has since been reversed, most likely due to the recent growth in the number of people who have enrolled under the AFDC-related and Healthy Start criteria.

Covered Services and Provider Reimbursement

Federal regulations define the types of services states are required to provide to categorically and medically needy MA enrollees and certain optional services states may include in their MA programs.

While some services are designated as "optional" under federal law, they may, in fact, be mandatory for certain groups of MA enrollees. For example, any service a state is permitted to cover under MA that is necessary to treat an illness or condition identified through an early and periodic screening, diagnostic and treatment (EPSDT) screen must be provided to the child who receives the EPSDT screen, regardless of whether the service is otherwise included in the state MA plan. In addition, certain "optional" services, such as drugs and medical equipment and supplies, must be provided to one or more of three groups of MA enrollees--children, pregnant women and nursing home residents. Further, although payment for "transportation services" is considered an optional service under federal regulations, states are required to assure necessary transportation for enrollees to and from providers. In addition, the use of some optional services by MA enrollees results in lower costs for mandatory services than would otherwise be incurred. In this way, several optional services serve as substitutes, rather than additions, to mandatory services. For example, although coverage for rehabilitative services is optional, enrollees currently using these services could instead receive similar treatment from hospitals on an outpatient or inpatient basis, which may be more expensive.

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

- Is consistent with the enrollee'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 enrollee's diagnosis, symptoms, or other medically necessary services the enrollee receives;

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

• Is not duplicative with respect to other services provided to the enrollee;

• Is not solely for the convenience of the enrollee, the enrollee's family or a provider;

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

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

Table 6 lists the statutory benefits and services that are covered under Wisconsin's MA program, distinguishing between federally-mandated services and services identified as optional under federal law.

Service Limitations

Subject to federal limitations, states may use a variety of methods to control service utilization and costs under MA. The following is a summary of the major utilization controls used by the Wisconsin MA program.

Limitations on Quantity of Services. Certain services are subject to limits on the number of billable units of service that can be made on behalf of an MA enrollee during a specified time period. For example, Wisconsin's MA program pays for one comprehensive, routine physical examination provided to an MA enrollee in each calendar year.

Prior Authorization. Prior authorization is designed to safeguard against unnecessary utilization of care, promote the most effective and appropriate use of available services, and contain program costs. Providers are required to obtain prior authorization for certain specified services before delivery of those services. Payment for services that require prior authorization is made only if: (a) prior authorization is approved by qualified medical professionals and staff according to criteria established by DHFS; and (b) the service is performed between the dates indicated on the prior authorization request form. Generally, authorizations are valid for up to one year unless the authorization specifies a more limited period.

Second Surgical Opinion. MA enrollees receiving services on a fee-for-service basis are required to get a second surgical opinion for certain elective surgical procedures. The requirement is designed to give enrollees the opportunity to make an informed decision and effectively reduces the number of elective surgeries that might otherwise be performed. Second opinions can be performed by any MA-certified physician. Examples of surgical procedures that require a second surgical opinion include cataract extractions, hysterectomies, tonsillectomies, hip or knee joint replacement, and varicose vein surgery. The second surgical opinion requirement applies only to non-emergency procedures.

Copayments. Federal regulations permit states to require MA enrollees to share in the cost of receiving certain services through the payment of a flat, nominal fee per service. These fees, commonly referred to as copayments, provide a minor funding source for services and also serve as a means of controlling utilization. Federal regulations establish maximum copayments for services and exempt some services and groups of MA enrollees from copayment requirements altogether, such as emergency services, any service provided to children under the age of 18 years, services provided to individuals in nursing homes, services relating to pregnancy, and services provided through a health maintenance organization (HMO). These copayments range from $0.50 to $3.00 per visit, service, item or procedure.

Table 6: MA-Covered Services

Federally-Mandated Benefits

- Physicians' services
- Early and periodic screening, diagnosis and treatment (EPSDT) of individuals under 21 years of age
- Rural health clinic services
- The following medical services if prescribed by a physician:
    - Inpatient hospital services other than services in an institution for mental disease (IMD)
    - Outpatient hospital services
    - Skilled nursing home services other than in an IMD
    - Home health services, or nursing services if a home health agency is unavailable
    - Laboratory and x-ray services
    - Family planning services and supplies
    - Nurse-midwifery services
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under MA that are required for enrollment in a group health plan

Optional Benefits

- Dental services
- Optometrists' or opticians' services
- Transportation:
    - By emergency medical vehicle to obtain emergency medical care
    - By specialized medical vehicle to obtain medical care
    - By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Eyeglasses
- The following medical services if prescribed by a physician:
    - Intermediate care facility (ICF) services, other than IMD services
    - Physical and occupational therapy
    - Speech, hearing and language disorder services
    - Medical supplies and equipment
    - Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
      --who are under 21 years of age
      --are under 22 years of age and received services immediately prior to reaching age 21
      --who are 65 years of age or older
    - Medical day treatment, mental health and substance abuse services, including services provided by a psychiatrist and services provided in an individual's home or in the community
    - Nursing services, including services performed by a nurse practitioner
    - Legend drugs and over-the-counter drugs listed in the Wisconsin's MA drug index
    - Personal care services
    - Substance abuse day treatment services
    - Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
    - Community-based psychosocial services
    - Respiratory care services for ventilator-dependent individuals
- Home and community-based services authorized under a waiver
- Case management services for enrollees with certain conditions, including children with severe emotional disturbances or asthma, individuals with developmental disabilities, chronic mental illness, Alzheimer's disease, or individuals that are alcohol or drug dependence, 65 years or age or over, infected with HIV or tuberculosis or are members of families with a child at risk of serious physical, mental or emotional dysfunction
- Hospice care
- Podiatry services
- Care coordination for women with high-risk pregnancies
- Prenatal, post partum and young child care coordination services for certain residents of Milwaukee County
- Care coordination and follow-up of individuals having lead poisoning or lead exposure, including lead inspections
- School medical services
- Mental health crisis intervention services
- Case management services for enrollees with high-cost chronic health conditions or high-cost catastrophic health conditions
- Substance abuse residential treatment services
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act

Federal Reimbursement Requirements

Federal law provides states considerable flexibility in designing reimbursement methods for services provided to MA enrollees. However, four basic requirements apply to all services. First, with the exception of copayment requirements, providers must accept MA reimbursement levels as full payment of services, thereby prohibiting providers from billing enrollees for additional payment. Second, payment rates must be sufficient to attract enough providers to ensure that the availability of health care services to MA enrollees is no less than for the general population. Third, MA payment is secondary to any other health coverage or third-party payment source available to enrollees, including Medicare. Fourth, the state's methods and procedures used to determine payments must assure that payments will be "consistent with efficiency, economy and quality of care."

Federal law also contains requirements specific to certain types of services. One requirement limits the amount states may reimburse providers for inpatient hospital and nursing home services. Specifically, aggregate payments for inpatient hospital services (or long-term care facility services provided in hospitals) and nursing facilities may not exceed the amount that the state estimates would have been paid under Medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "Medicare upper limit." Several upper limits apply, based on the type of facility and whether or not the facility is operated by the state. Further, if a state uses a separate rate-setting methodology within these categories of facilities, an upper payment limit is applied to each group of facilities under each of the separate reimbursement methodologies.

Before 1998, states were required to comply with the "Boren Amendment" or "EEO requirement." This requirement directed states to establish reimbursement rates for inpatient hospitals and nursing homes that were "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers." The EEO requirement was replaced with new legislation that requires states to: (a) use a public process for determining rates; (b) publish proposed and final rates and the methodologies underlying them; and (c) provide a reasonable opportunity to review and respond to the proposed rates.

Nursing Facilities

In 2001-02, MA expenditures for nursing home care totaled $1,127.5 million (all funds), representing approximately 31.1% of gross MA expenditures in that year. As of December 1, 2002, there were 450 licensed nursing homes with 46,292 licensed beds. Only six of these nursing homes were not certified to serve MA-eligible patients. The 2001 nursing home survey indicated that, on average, 84.6% of licensed nursing home beds were occupied and that 66.7% of nursing home residents were supported by MA. Under the MA program, nursing homes are categorized into three groups: (1) nursing facilities, which consist of skilled nursing facilities (SNF) and intermediate care facilities (ICFs); (2) intermediate care facilities for the mentally retarded (ICFs-MR); and (3) institutions for mental diseases (IMDs).

In the mid-1980s, Wisconsin established a statewide nursing home bed cap to control MA nursing home expenditures. The bed cap established a statutory limit on the total number of nursing home beds that could be licensed. The bed cap limit can and is adjusted by DHFS under limited conditions. Because the current average occupancy percentage is only 85%, the cap it not currently as important as it once was.

Federal law requires states to provide nursing facility services for categorically needy, but not medically needy, enrollees. States have the option of covering ICF-MR and IMD services for categorically needy, as well as medically needy enrollees. Federal law prohibits states from

covering IMD services for individuals between the ages of 22 to 65. Of the 450 licensed nursing homes, 408 are nursing facilities, 39 are ICFs-MR and three are IMDs.

Nursing facilities are institutions that provide: (1) skilled nursing care and related services for residents who require medical or nursing care; (2) rehabilitation services for the rehabilitation of injured, disabled or sick individuals; or (3) on a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities. An institution primarily for the care and treatment of mental diseases does not qualify as a nursing facility.

Federal MA rules require that a physician personally approve a recommendation that an individual be admitted to a nursing facility. No later than fourteen days following admission, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity must be conducted or coordinated by a registered nurse. An assessment must be conducted at least once every 12 months and after a significant change in the resident's condition. Federal law also requires that states establish preadmission screening and annual resident review (PASARR) programs to determine whether individuals with mental illness and mental retardation require the level of services provided by nursing homes. PASARR requirements are intended to prevent the inappropriate placement of people with mental illness or mental retardation in nursing facilities where they do not receive the care and specialized services they need for their conditions.

Federal rules delineate a two-step screening process. The first step, referred to as a Level I screen, is used to identify whether or not the individual is suspected of having a serious mental illness or a developmental disability. If the Level I screen indicates one of these conditions, then except in certain short-term admissions cases, a Level II screen must be completed. This is a more extensive review that must be completed by appropriate medical professionals, such as psychiatrists and physicians. In fiscal year 2001-02, 30,427 Level I screens were completed at a total cost of $912,800 ($30 per screen) while 5,102 Level II screens were completed at a cost of $1.1 million ($214 per screen).

Federal law requires that nursing facilities protect and promote residents' rights by providing residents: (a) free choice of a personal attending physician and the right to be fully informed in advance about care and treatment and any changes and (unless the resident is judged incompetent) to participate in planning treatment; (b) freedom from restraints, including being free from physical or mental abuse or punishment, involuntary seclusion, and any physical or chemical restraints, unless necessary to ensure the physical safety of the resident or other residents and only with a written physician's order specifying the length of restraint; (c) the right to privacy regarding accommodations, medical treatment, communications, visits and meetings of family or resident groups; and (d) confidentiality of personal and clinical records. The nursing facility must inform each resident, orally and in writing, at admission of the resident's legal rights during the stay and periodically of the services available and the related charges.

Federal law also provides residents transfer and discharge rights. A facility cannot transfer or discharge a resident unless: (a) it is necessary for the resident's welfare; (b) the resident's health has improved and the facility's services are no longer needed; (c) the health or safety of residents is endangered; (d) the resident has failed, after reasonable notice, to pay any allowable charges; or (e) the facility has closed. All discharges and the reasons for the discharges, except in the case of closure, must be documented in the clinical record by a physician (the attending physician in the first two instances). The resident (and a family member, if

known) must be notified at least 30 days in advance of a transfer or discharge unless the resident's health or safety is endangered, health improvements have made continued stay unnecessary, urgent medical needs require a more immediate transfer or discharge or the resident has not been in the facility for 30 days. Each notice must include the resident's right to appeal under the state-established appeal process and the name, mailing address and telephone number of the state long-term care ombudsman. The nursing facility must provide sufficient preparation to residents to ensure a safe and orderly transfer or discharge.

ICF-MR services may be covered under MA if: (1) the primary purpose of the institution is to provide health or rehabilitative services; (2) the institution meets requisite certification requirements; and (3) residents of the ICF-MR receive continuous, active treatment. The institution must provide ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitation services to help each individual function at his or her greatest ability. Active treatment does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous, active treatment program.

An institution for mental diseases (IMD) is defined by federal law as a hospital, nursing home or other institution of 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. Whether or not a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

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

Reimbursement of Nursing Homes Other than State Facilities. Under state law, DHFS is required to reimburse nursing homes for care provided to MA enrollees according to a prospective payment system that is updated annually. The Department's formula must reflect a prudent buyer approach under which a reasonable price, recognizing select factors that influence costs, is paid for service of acceptable quality. DHFS must establish payment standards, using recent cost reports submitted by nursing homes. In conjunction with the federal repeal of the EEO requirement, 1997 Wisconsin Act 27 repealed the state requirement that MA payments to nursing homes be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Although the state's general EEO requirement was repealed, Act 27 retained the requirement that DHFS pay a facility's allowable costs, by cost center, up to the median cost level for all state nursing homes. In essence, state statutes imposed a specific interpretation of the EEO requirement but not a general EEO requirement. However, 1999 Wisconsin Act 9 repealed the state requirement that the standard be not less than the median. Consequently, DHFS is only required to establish standards that take into account these costs.

When DHFS constructs the prospective daily payment rate, both patient levels of care and categories of expenditures are considered. Many states use this "cost center" approach to establish nursing home payment rates. State law requires that DHFS consider six cost centers and permits DHFS to consider a seventh, over-the-counter-drugs, when developing facility-specific nursing home rates. These cost centers include: (1) direct care; (2) support services; (3) administrative and general; (4) fuel and other utilities; (5) property taxes, municipal services or assessments; (6) over-the-counter drugs; and (7) capital. The first six cost centers constitute

what is generally referred to as the operations portion of a facility's rate.

In general, nursing homes are reimbursed for their expenses in a given cost center as long as their expenses per resident day do not exceed "targets" (maximum rates) that are based on the costs for all nursing homes in the state.

Direct Care Expenses. Direct care expenses are comprised of direct care services and direct care supplies. DHFS is required, by statute, to establish "targets" for payment of allowable direct care costs that are based on direct care costs for all facilities, as adjusted to reflect regional labor cost variations and respective case mixes. Table 7 shows the different maximum per diem rates for the different levels of care for fiscal year 2002-03 before adjustment for regional cost valuation by the Medicare hospital wage index. State law permits DHFS to provide higher rates or supplements to these standard rates in certain cases.

Table 7: Maximum Daily Per Patient Payment Rates for Direct Care Services and Supplies Before Labor Cost and Inflation Adjustments by Level of Care (Fiscal Year 2002-03)

Level of Care		Rate
Nursing		
Intense Skilled Nursing (ISN)		$82.29
Skilled Nursing Care (SNF)		63.30
Intermediate Care (ICF 1)		44.31
Limited Care (ICF 2)		31.65
Personal Care (ICF 3)		15.83
Residential Care (ICF 4)		15.83
Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)		
DD-1a	(Fragile Health & Active Treatment)	$117.11
DD-1b	(Extensive Guidance & Active Treatment Needed)	117.11
DD2	(Moderately Retarded Adults Needing Active Treatment)	98.12
DD3	(Mildly Retarded Adults Needing Active Treatment)	69.63

Note: This rates will be adjusted for each nursing home based on the relative cost of labor in the area in which the home is located. In 2002-03, the adjustments for labor costs ranged from a decrease of 6% to an increase of 17%. Also, nursing facilities with 50 or fewer beds benefit from a 20% increase in the maximum rate.

The direct care facility rate is determined by calculating and combining the direct care services allowance and the direct care supplies allowance. The individual rates are determined by comparing actual allowable direct care cost information of the facility (adjusted for inflation) to the applicable direct care target for each of the services and supplies categories. A higher, intense skilled nursing care (ISN) rate is paid to qualifying homes for the care of residents requiring supplemental skilled care due to complex medical conditions. Services for individuals with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC) and individuals who are ventilator-dependent are paid under special per diem rates. For fiscal year 2002-03, the AIDS/ARC rate was $150 per patient day and the ventilator-dependent rate was $375 per patient day. The target rate for nursing facilities with 50 or fewer beds is 20% greater than the target rate for other nursing facilities.

Support Services. Support services are costs incurred by nursing homes related to the provision of meals, housekeeping, laundry, security and other services. The support services component of a facility's rate is established by comparing the actual allowable support services costs of the facility (adjusted for inflation) to the applicable support services targets. DHFS may provide an efficiency incentive payment to a facility with support service costs below the target and to reimburse a portion of costs above the target.

For 2002-03, DHFS established two targets, $21.90 and $22.64 per patient day. If the facility's costs were below $21.90, the facility would be paid the sum of their costs, an inflation adjustment of $0.74 per patient day and an incentive payment of 50% of the difference between the facility's actual costs and target of $21.90. If a facility's actual costs were between $21.90 and $22.64, the payment per patient day would be $22.64. For facilities with costs in excess of $22.64 per patient day, the

facility's payment would be equal to the sum $22.64 plus a cost share that is less than 5% of the amount that actual costs exceed this second target.

Administrative and General Expenses. Administrative and general expenses associated with a facility's operation are paid under this cost center. State law requires that such expenses be paid at no less than a target established by DHFS based on administrative and general costs for a sample of all facilities within the state. DHFS also provides an efficiency payment for facilities with costs below the standard.

For 2002-03, DHFS established a maximum of $13.13 per patient day for all nursing homes. If the facility's cost was less than $13.13 per patient day, the facility was paid the sum of its cost and an inflation adjustment of $0.42 per patient day plus an efficiency payment of 50 percent of the difference between the target amount and the allowable expense. If the facility's cost was greater than the maximum, the facility was paid the respective maximum ($13.13 per patient day) plus the inflation adjustment.

Fuel and Utility Expenses. Fuel and utility expenses, including the costs of electrical, water and sewer services, are paid as a separate cost center. The statutes direct DHFS to establish targets for these expenses based on fuel and other utility costs for a sample of all facilities within the state. DHFS may adjust the target for regional heating cost variations based on heating degree day variation. In addition, DHFS may provide an efficiency incentive payment to a facility whose costs are below the target and to reimburse a portion of costs above the target.

For 2002-03, DHFS established targets for six different regions in the state that varied from a low of $2.62 (Southeastern Wisconsin) to $2.77 (Bayfield and Douglas Counties) per patient day. If a facility's cost was less than the target, it was paid its cost plus an inflation adjustment of 4%. A facility could not receive a payment greater than the maximum, adjusted for inflation (the target multiplied by 1.04). DHFS also provides an efficiency payment for costs below the target equal to 50 percent of the difference between the established maximum and the allowable expense.

Property Taxes, Municipal Services and Assessments. Property taxes, municipal services and assessments are also recognized as a cost center. For tax-paying facilities, the statutes direct that the payment be equal to the lesser of the actual tax amount due or a maximum established by the DHFS. For municipal service fees paid by tax-exempt facilities, the statutory provisions are the same, except that the payment period is determined by DHFS and does not have to be based on the previous calendar year. Because of federal requirements, the assessment on occupied nursing home beds is not an allowable expense under this, or any other, cost center.

For 2002-03, the payment to a facility for property taxes or municipal service fees was subject to a maximum payment of the previous year tax or fees plus an inflation adjustment factor (7% for real estate taxes and municipal fees).

Capital Costs. Capital costs include payments necessary for the provision of service over time, including allowable facility expenses for suitable space, furnishings, property insurance and movable equipment for patient care. The statutes require that the capital payments be based on a replacement value for the facility, as determined by a commercial estimator hired by DHFS. However, the statutes permit DHFS to establish limits on the capital payments. By statute, a facility's final capital payment may not be reduced from its previous year's rate by more than $3.50 per patient day.

For 2002-03, DHFS limits the allowed value for a facility to no more than $52,900 per bed. Also, allowable property-related expenses cannot exceed 15% of the allowed value. If allowable property-related expenses are below 6.0% of allowed value (a minimum amount), the facility's payment rate is

equal to the sum of its costs, an inflation adjustment and an efficiency payment equal to 20% of the difference between its costs and the minimum amount. Costs between 6.0% and 7.5% of allowed value are also fully reimbursed plus an inflation adjustment, but no efficiency payment is provided. For allowable expenses exceeding 7.5% of value, 20% of the excess is reimbursed by the state. The inflation adjustment per patient day was $1.06 for nursing facilities and $3.29 for ICFs-MR.

Bed Bank Provision. Most nursing facilities are subject to a minimum occupancy standard (currently 90.5%) to promote increased efficiency. Facilities falling below the established minimum occupancy standard are penalized in the rate-setting calculation. However, the bed bank provision allows facilities to meet the occupancy standard by banking beds, which effectively removes those beds from the rate-setting calculation. Since the beds for rate setting are based on the number of licensed beds at the end of the base cost reporting period less any banked beds during the same time period, nursing facilities can avoid the minimum occupancy penalties under this provision.

Provider Incentives. In 2002-03, nursing homes could receive three types of incentives payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 70% or more of MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.50 per patient day to $2.50 per patient day for facilities with more than 50 beds and from $1.50 to $4.00 for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA/Medicare increases).

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

Finally, an incentive payment is provided for facilities that complete a remodeling or renovation project specifically designed to reduce energy use. The incentive payment is made for two years and is equal to 25% of the lesser of the approved projected cost or the actual cost of the project. As a result, one-half of the project's cost can be funded from higher MA per diem rates. This incentive payment is in addition to the normal recovery of project expenses under the capital cost center.

Hold Harmless Rate. If the facility's projected expenses are greater than the rates determined for the operations portion of the facility's rate, then the facility is guaranteed that the payment rate for operational costs will not be less than the rate that was effective for June 30, 1994. Thus, a facility will not, in general, be subject to a operational payment rate less than the rate in 1993-94. The hold harmless determination does not include the capital payment, payment for ancillary services and materials, or the special payments to counties under the FFP program.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for the operations component of the formula, the capital payment, payment for ancillary services and materials and supplemental payments (for residents dependent upon ventilators and residents with complex medical conditions). Ancillary services and materials are specifically-identified services and materials that could be billed separately to the MA program by an independent provider of the service, such as home health services.

County Supplemental Payments. County- and municipal-operated nursing facilities with operating costs that are not fully reimbursed by the MA per diem rate described above are eligible to apply for supplemental funding. In recognition of the higher costs of these nursing homes, $77.1 million in both 2001-02 and 2002-03 is budgeted to support supplemental payments to these facilities. These

supplemental funds will be distributed to first fund any unreimbursed expenses in the direct care cost center, and then, if funding is available, to fund part or all of unreimbursed expenses in other cost centers. Government operated facilities that have entered into phase down agreements with DHFS are given first priority for supplemental payments. State rules prohibit a supplemental payment that would exceed the amount of the nursing home's deficit. For 2001-02, counties had unreimbursed expenses of $98.6 million. In 2001-02, $76.7 million in supplemental payments were made to county-operated facilities.

Reimbursement for State Facilities. Payment for care at the three state centers for the developmentally disabled and the Veterans Home at King is determined by DHFS separately from the methods established for all other nursing facilities. The state centers and the Veterans Home at King are paid based on their actual and allowable costs, except that payment cannot exceed the Medicare upper limit or the amount appropriated by state law. Interim payment rates are established for these facilities, but a cost reconciliation is done at the end of the state fiscal year to adjust payments to actual costs within the general limitations. For the 2002-03 fiscal year, MA expenditures for the three state centers are estimated to be approximately $124.7 million, while MA expenditures related to the Veterans Home at King are projected to be approximately $22.3 million.

State Supplement for IMD Nursing Homes. Although federal law does not permit states to provide services in an IMD for individuals between the ages of 22 and 65 using federal MA funds, Wisconsin provides state funding for counties to pay a portion of the care of individuals between the ages of 22 and 65 in IMDs. This funding is not intended to cover all individuals in this group, but instead, funds services for individuals previously eligible for MA coverage who resided in a nursing home that was found to be an IMD before July 1, 1989, or for individuals who are eligible for MA who are admitted to replace those individuals. Thus, the total number of individuals supported under this program cannot, in general, exceed the number covered in 1989-90. Funding supporting one of these individuals is continued if the individual relocates from the IMD to a community-based setting. These restrictions are intended to limit the state's liability for funding of IMDs and the institutional care of mentally ill individuals. In the 2001-03 biennium, $12.3 million is budgeted annually to support these payments.

For each individual, the county receives 90% of the facility rate in effect on July 1, 1988, (on average, IMDs were receiving $65.00 per day per patient at that time) and $2.14 per day per patient to cover outpatient health services. The funds are provided to the Chapter 51 board of the county of residence of the individual or, if the county of residence cannot be determined, to the Chapter 51 board of the county in which the facility is located. The boards contract with IMDs for care for these individuals. Contracts are submitted to the county board for review and approval. Most counties supplement the IMD payment with their own funds.

Funds are also provided to counties to pay a portion of community-based care for individuals relocated from IMDs. These payments are intended to provide counties an incentive to relocate mentally ill individuals between the ages of 21 and 65 to the community. While in the community, these individuals' medical care and some nonmedical services are funded by MA and, therefore, eligible for federal MA funds at the regular matching rate.

For individuals who were relocated from an IMD before January 1, 1993, a county receives up to 60% of the July 1, 1988, per diem rate. This calculation results in payments to counties of $35 to $40 per day of care. In order to encourage community placements, for relocations on or after January 1, 1993, a county can receive up to 90% of the per diem rate if the IMD closes a bed. If the facility does not close a bed, a payment of up to 60% of the per diem can still be made if DHFS waives the bed-

closing requirement (certain requirements must be met) or if the IMD agrees to receive a permanent limitation on the facility's payment under this program for each person relocated. State IMD coverage allows payment to an IMD for individuals who are relocated from an IMD, but who re-enter the facility within a six-month period.

Previously, any facility that was at risk of being declared an IMD had been required, if appropriate, to license a distinct part of their institution as an IMD nursing home. Distinct part licensure was intended to allow the state to continue to collect federal matching MA funds for all other appropriately placed nursing home residents in the facility. However, in 1992, the federal government determined that it would no longer pay for care for individuals in distinct part IMDs. Since this federal action, one IMD, the Badger Prairie Health Care Center in Dane County, has been resurveyed and reclassified as a nursing facility.

Hospitals

Inpatient Services. In fiscal year 2001-02, MA payments for inpatient hospital services totaled approximately $305.0 million, representing 8.4% of gross MA expenditures in that year.

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

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

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

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

- Have in effect a utilization review plan applicable to all MA patients that meet federally-defined requirements.

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

The DRG payment system covers most general and specialty hospitals in the state, hospital IMDs and most major border states' hospitals. MA payment for inpatient hospital services provided at the two state-operated IMDs (Mendota Mental Health Institute and Winnebago Mental Health Institute) are initially paid on a per diem basis. At the end of each state hospital's fiscal year, its costs for services provided in that year are determined and a final reimbursement settlement is made to reflect the hospital's actual costs of providing services, except that total reimbursement cannot exceed the hospital's charges.

Two privately-operated, rehabilitation hospitals, Sacred Heart Rehabilitation Hospital in the City of Milwaukee and Lakeview Rehabilitation Hospital in the Village of Waterford, do not receive payments based on the DRG system. Instead, these hospitals are paid on a per diem basis to reflect the special nature of the patient mix at these facilities.

Under the DRG system, the hospital determines the patient diagnosis and then bills MA for the hospital-specific DRG rate related to that condition and treatment. All inpatient stays are reimbursed under the DRG-based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury cases. The DRG includes all covered services except professional services pro-

vided at the hospital, including physicians, dentists, anesthesia assistants, pharmacy, specialized medical vehicle transportation and durable medical equipment and supplies for non-hospital use. The certified provider bills these services separately.

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

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

Disproportionate Share Hospitals. An adjustment may be made to a hospital's DRG base rate if the hospital provides a disproportionate share of services to MA and low-income patients. A hospital may qualify for a disproportionate share adjustment if: (1) the hospital's MA utilization rate, as measured by the percent of inpatient days attributable to MA patients is at least one standard deviation above the mean MA utilization rate for hospitals receiving MA payment and not less than 1%; or (2) the hospital has a "low-income utilization rate" of more than 25% and not less than a 1% MA utilization rate.

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

In fiscal year 2001-02, 25 hospitals (including ten out-of-state hospitals) qualified for disproportionate share payments, ranging from approximately 3% to approximately 13.6% of each hospital's total DRG payments. Total disproportionate share payments totaled approximately $12.4 million in 2001-02.

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

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

- As of January 1, 1991, Medicare classified the hospital in a rural wage area;

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

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

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

In 2001-02, approximately $2.2 million was paid to hospitals as rural hospital DRG adjustments.

Indirect Medical Education Adjustment. This adjustment is intended to reimburse hospitals for the additional costs associating with operating a medical education program. Adjustments for indirect costs are based on the Medicare indirect GME payment formula, which adjusts a hospital's base DRG rate based on the hospital's ratio of residents to its available beds. In 2001-02, 30 hospitals qualified for indirect medical education DRG adjustments, which increased MA payments to these hospitals by approximately $18.2 million.

Direct Medical Education Payments. Direct medical education payments are added to a hospital's base DRG rate to reimburse hospitals for costs directly related to operating a medical education program. Direct GME costs are those costs associated with payment of salaries and fringe benefits for residents and interns. Hospitals located in Wisconsin are eligible for this payment. In 2001-02, 31 hospitals qualified for direct medical education payments, totaling approximately $9.7 million.

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

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

Outpatient Services. Under MA, hospitals are initially paid an interim rate for outpatient services provided throughout the year. At the end of a hospital's fiscal year, a retrospective final settlement is made, based on the hospital's audited cost report. The final settlement identifies a hospital's allowable outpatient costs and is limited to the lesser of the following:

- Customary outpatient charges in the final settlement year; or

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

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

The outpatient rate per visit is based on a hospital's base year, which is its first fiscal year after January 1, 1987, modified to reflect several factors. These factors are: (a) the cost of mental health services; (b) capital costs reductions; and (c) inflationary costs from the base year forward. 2001 Wisconsin Act 16, provided funding to increase outpatient rates per visit, for those hospitals with the lowest rates relative to their audited allowable costs. In 2001-02, 62 hospitals received increases in their outpatient rates per visit based on the funding provided in Act 16.

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

noted.

Essential Access City Hospitals. DHFS pays up to $4,748,000 (all funds) annually to hospitals that meet the definition of an essential access city hospital (EACH). An EACH is defined as an acute care general hospital with medical and surgical, neonatal intensive care, emergency and obstetrical services, in the City of Milwaukee. An EACH must have 30% or more of its total inpatient days attributable to MA patients, including MA patients enrolled in an HMO and at least 30% of its MA inpatient stays must be for MA recipients who reside in the inner City of Milwaukee. Since the creation of this supplemental payment in 1991, the only hospital that has met the criteria for this supplemental payment is Sinai-Samaritan Hospital in the City of Milwaukee.

General Relief/Inter-Governmental Transfer Payments. DHFS makes supplemental MA payments to hospitals that provide a significant quantity of services to low-income individuals covered by a county administered general assistance program and to MA recipients. In 2001-02, five hospitals in Milwaukee County received a total of $27.1 million in general relief supplement payments. Of this amount, approximately $6.5 million was GPR, approximately $15.9 million was FED, and $4.66 million was program revenue received as an intergovernmental transfer (IGT) from Milwaukee County. The IGT payment is used to match federal MA funds available for costs for individuals participating in Milwaukee County's general assistance medical program. These supplements are paid once annually.

Pediatric Inpatient Supplement. DHFS makes supplemental payments to acute care hospitals in Wisconsin that provide a significant amount of services to individuals under the age of 18. In order to qualify for the supplement, a hospital must: (a) be an acute care hospital; and (b) have inpatient days for stays in the hospital's acute care pediatric units of the facility that exceed 12,000 days in the second calendar year preceding the hospital's fiscal year. For 2001-02, this calculation is based on a hospital's inpatient days in the hospital's fiscal year that ends in calendar year 1999. Days for neonatal intensive care units are not included in this determination.

The pediatric supplement is limited to $2.0 million annually. In 2001-02, Children's Hospital of Wisconsin received approximately $1.7 million and University of Wisconsin Hospital received approximately $263,000 as a pediatric inpatient supplemental payment.

Hospital Operating Deficit Reduction Program. Similar to the nursing home federal county FFP program, this program allows state, county, municipal or village-owned hospitals with operating deficits to use state or local funds as match for federal funds. Annually, $3,300,000 FED is budgeted for these matching payments. While this option remains available under current law, no publicly-owned hospital has claimed FFP under this benefit since John Doyne Hospital in Milwaukee County closed in 1995.

Managed Care Supplement. Hospitals participating in the state's MA managed care initiative are eligible to receive supplemental payments of up to $250,000 annually. To be eligible, a hospital must qualify for a DRG disproportionate share adjustment, have more than 9.0% of its patient days for newborns, be located in a county other than Milwaukee County, participate in MA managed care for that year, and be a major provider of managed care services to MA recipients in that county. In 2001-02, St. Luke's Memorial Hospital in Racine County received the full amount of the supplement.

Border/Metropolitan Statistical Area Supplement. Hospitals located in MSAs outside of Wisconsin that serve primarily urban areas may be eligible for a supplement totaling up to $250,000. The total amount paid is based on each qualifying hospitals' outpatient services provided to Wisconsin MA recipients. Five hospitals received this supplement

in 2001-02.

Other Services

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

Many types of physicians' services are subject to prior authorization requirements. In addition, medical services that are considered by DHFS to be obsolete, unnecessary or ineffective are not covered. Among these services are acupuncture, artificial insemination, cosmetic services, personal comfort items and vitamin C injections. Further, MA does not cover services that are considered to be experimental in nature. A service is considered experimental if DHFS has determined that the procedure or service is not generally recognized by the professional medical community as effective or proven treatment for the condition for which it is being used.

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

Early and Periodic Screening, Diagnostic and Treatment Services (HealthCheck). This service, commonly referred to as "HealthCheck," provides comprehensive screenings to MA enrollees under the age of 21. HealthCheck screening examinations are distinguished from other preventive health services covered under MA because they include a significant health education component, a schedule for periodic examinations, detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the client is appropriately referred for care.

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

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

Rural Health Clinic Services. Rural health clinics (RHCs) are Medicare-certified outpatient health clinics located in rural areas with a shortage of personal health services or primary medical care professionals, as determined by the U.S. Department of Health and Human Services. Each RHC is operated under the medical direction of a physician and is staffed by at least one nurse practitioner or physician assistant. A physician, physician assistant, nurse practitioner, nurse midwife or other special-

ized nurse practitioner may furnish services. Other Medicaid-covered ambulatory services, such as podiatry and optician services, may be provided at an RHC if professionals that meet all applicable MA provider eligibility criteria furnish these services. For clinics based in hospitals with fewer than 50 beds, MA pays 100% of the clinics' cost for services. For other clinics, the MA payment equals the Medicare per visit rate for rural health clinic services, which is currently $64.78 per visit. As of December, 2002, there were 59 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. FQHCs are currently paid 100% of their reasonable costs, recognizing that FQHCs serve a disproportionate share of the state's MA, Medicare and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 28 FQHCs operating in Wisconsin, including 15 centers operating under federal grants from the U.S. Public Health Service**,** 11 Indian tribal clinics, one urban Indian health center, and one health center that meets the operating requirements of federally-funded community health centers but does not receive federal operating grants (a "look-alike" FQHC).

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

Home Health Services. Home health agencies provide a variety of services in an individual's home, including: (a) home health services provided by nurses and aides; (b) therapy services provided by physical therapists, occupational therapists and speech and language pathologists; (c) private duty nursing services; (d) respiratory care services; and (e) personal care services. All home health services eligible for payment under the MA program must be certified as necessary by a physician and specified in a written plan of care. MA enrollees who receive private duty nursing services and respiratory care services may receive these services outside of a home setting during those hours when normal life activities take the enrollee outside of that setting. Nurses in independent practice also provide private duty nursing and respiratory care services.

Home Health Nursing Services. These services are medically necessary skilled-nursing services provided in the client's home. These services are available to individuals who require less than eight hours of direct, skilled-nursing services per day. In determining whether or not a service requires the skills of a registered nurse or licensed practical nurse, the complexity of the service, the condition of the client and the accepted standards of medical and nursing practice are considered.

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

Skilled-Therapy Services. Services provided by physical therapists, occupational therapists and

speech and language pathologists are covered as a home health service if certain guidelines are met. For example, such services must be reasonable and necessary within the context of the enrollee's medical condition, and be considered, under accepted standards of medical practice, to be specific and effective treatment for the individual's condition or for the restoration or maintenance of an individual's function.

Private-Duty Nursing Services. These services are medically necessary skilled-nursing services for an individual who requires eight or more hours of direct, skilled-nursing services per calendar day. All providers must receive prior authorization before providing these services to MA enrollees.

Respiratory Care Services. Skilled nursing services are provided under the private duty nursing benefit to ventilator-dependent individuals residing at home. A registered nurse or a licensed practical nurse must perform these services.

Personal Care Services. These services are medically-oriented activities related to assisting an individual with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services may only be provided under the written orders of a physician. Covered personal care services include activities of daily living (such as assistance with eating, dressing and bathing), meal preparation, and accompanying an individual to obtain medical diagnosis and treatment. Prior authorization is required in order for any enrollee to receive more than 50 hours of personal care services in a calendar year.

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.

MA payment for home health services is based on the lesser of a home health agency's usual and customary charges or a maximum allowable fee schedule determined by DHFS. Home health aides, home health nurses and therapists are reimbursed on a per visit basis. Private duty nurses, personal care workers and providers of respiratory care services are reimbursed on an hourly basis.

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

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

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

service.

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

Vision Care Services. Vision care services provided by optometrists and ophthalmologists include services related to the dispensing and repair of eyeglasses, as well as evaluation and diagnostic services. Opticians may be reimbursed for services relating to the supply, dispensing and repair of eyeglasses. Eyeglass frames, lenses and replacement parts must be provided by dispensing opticians, optometrists and ophthalmologists in accordance with the Department's vision care volume purchase plan, unless prior authorization is provided to purchase these materials from an alternative source. Certain types of services are not covered, including spare eyeglasses, tinted lenses, sunglasses and services or items provided principally for convenience or cosmetic reasons.

Transportation. Under Wisconsin's MA program, three modes of transportation services may be provided to MA enrollees: (a) ambulance; (b) specialized medical vehicle (SMV); and (c) public common carrier or private motor vehicles.

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

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

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

Counties, through contracts with common carriers and private motor vehicles, provide transportation services for clients who are able to walk. Such services may be provided by buses, trains, taxis, and in some instances, airplanes. In providing these services, counties must use the least expensive means the individual is capable of using

and that is reasonably available at the time the service is required. These services are covered only after a county department of human services approves the service. Unlike other services, common carrier transportation services are reimbursed as an administrative expense under federal law, and therefore, are eligible for 50% federal matching funds, rather than 59% available for other services.

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

Physical and Occupational Therapy. Therapies prescribed by a physician that are provided by certified physical and occupational therapists, or by a certified physical or occupational therapy assistant under the direct, immediate on-premise supervision of a certified physical or occupational therapist, are covered under Wisconsin's MA program. Prior authorization is required for therapy services that exceed 35 treatment days per spell of illness, except if the therapy is provided to a hospital inpatient or an individual who receives the service through a home health agency.

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

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

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

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

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

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

lished by DHFS.

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

Prior authorization is required for both mental health and substance abuse outpatient services if MA payments for services exceed $500 or after 15 hours of services are provided to an enrollee in a calendar year.

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

1999 Wisconsin Act 9 provided that MA recipients could receive up to 45 days of residential substance abuse treatment services if a county, city, town or village elects to become a certified provider of such services or contracts with a certified provider. Local governments that elect this option are required to pay the state share of the total MA costs of providing these services. Under current law, this provision expires after June 30, 2003. As of January, 2003, DHFS has not implemented this benefit.

Independent Nurse Practitioner Services. Wisconsin's MA program covers nursing services delegated in a written protocol to licensed nurse practitioners and clinical nurse specialists by a licensed physician. Such services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative service provided in a medical setting, the enrollee's home or elsewhere. Nurse practitioners and clinical nurse specialists are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

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

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

Federal law also requires drug use review programs to assure that prescriptions are appropriate, medically necessary and unlikely to produce adverse effects. The drug use review must be both prospective and retrospective. The prospective part of this review, conducted by the pharmacist at the point of sale or distribution, must include a screening for drug interactions and incorrect dosage and a processing system to identify patterns of fraud, abuse or inappropriate care.

DHFS reimburses pharmacists and physicians licensed to practice medicine and surgery for all covered prescription drugs at the lesser of: (a) the usual and customary charge; or (b) the estimated acquisition cost (EAC) plus a dispensing fee. The EAC for brand name and not readily-available generic drugs is generally equivalent to the average wholesale price (AWP), as reported by pharmaceutical manufacturers to First Data Bank, minus 11.25%. The EAC for readily-available generic drugs is determined based on the maximum allowable cost (MAC) list, developed by DHFS.

MA reimburses pharmacies for the generic ver-

sion of a prescription drug and will not reimburse a pharmacist for the brand-name version of that drug, unless: (a) the prescribing professional indicates in his or her own handwriting on the face of the prescription, that the brand-name medication is medically necessary; or (b) a generic version of the drug is not available.

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

Under the incentive-based pharmacy payment system, pharmacies may receive an enhanced dispensing fee if they provide services that achieve a positive patient outcome, such as increasing patient compliance or preventing potential adverse drug reactions.

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

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

1997 Wisconsin Act 27 created a community-based psychosocial benefit targeted to MA recipients whose mental health needs are more than outpatient counseling, but less than the services provided by CSPs. Counties that elect to provide this service are responsible for providing the state matching funds for this service. As of January, 2003, DHFS had not implemented this benefit.

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

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

Case management services must be provided by qualified private, nonprofit agencies or qualified public agencies. Payment for case management services is based on a uniform, contracted hourly rate. The MA program pays the federal share of this rate; case management agencies must provide the state MA match by using funding provided through other programs, such as the local

tax levy, community aids, community options program, family support program or Alzheimer's caregiver support funds.

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

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

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

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

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

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

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

Schools provide the state's match for school-based health services. Of the federal matching

funds received for school-based services, 60% is distributed to school providers and 40% is credited to the state's general fund.

MA Funding of Abortion Services. Under Wisconsin's MA program, abortions may be covered if one of the following conditions apply:

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

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

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

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

Managed Care

Wisconsin uses managed care to provide health services to certain MA populations to better meet the needs of these populations and improve the quality of services they receive.

Health maintenance organizations (HMOs) are health care plans that provide comprehensive health services to enrolled members for a fixed, periodic payment ("capitation rate"). If enrollees use more, or more costly, services than anticipated, the HMO may incur a financial loss. If enrollees use the estimated number of services, or fewer or less costly services, the HMO may realize a profit. In this way, the delivery of services through HMOs provides an alternative to the fee-for-services method, since the HMO, rather than the state, assumes the financial risks associated with utilization of most MA services by the covered population. The delivery of MA benefits through HMOs is also considered a method for increasing the use of preventive services and improving continuity of care for MA recipients.

Low-Income Families

Currently, the managed care program for low-income families enrolled in MA and BadgerCare operates in 68 of 72 counties. As of November, 2002, 13 HMOs were providing health care services to 318,787 recipients, of which approximately 77% were enrolled in MA and the remainder were enrolled in BadgerCare. Table 8 lists the participating HMOs and their enrollment as of November, 2002. As a condition of serving low-income families enrolled in MA, HMOs must agree to also serve families enrolled in BadgerCare.

Table 8: HMOs with MA and BadgerCare Enrollees as of November, 2002

HMO	Enrollment
Atrium Health Plan	26,772
Dean Health Plan	11,708
Group Health Cooperative of Eau Claire	13,284
Group Health Cooperative of South Central WI	2,448
Health Tradition Health Plan	5,308
Managed Health Services	98,176
Mercy Care Health Plan	7,592
Network Health Plan	33,248
Security Health Plan	24,233
Touchpoint Health Plan	16,301
United Healthcare of WI	75,411
Unity Health Plan	3,434
Valley Health Plan	872
Total	318,787

Enrollment. Low-income families and children enrolled in MA and BadgerCare are required to enroll in an HMO if they live in some counties (or zip codes within counties) and may enroll in HMOs if they live in other counties or zip codes within counties. HMO enrollment is mandatory in counties with two or more participating HMOs. In areas where there is only one participating HMO, enrollment is voluntary. MA recipients living in counties that do not have a participating HMO receive MA benefits on a fee-for-service basis. In order to participate in the program, an HMO must be licensed by the Wisconsin Office of the Commissioner of Insurance and must meet MA standards for quality assurance, cultural competency, enrollment capacity, and coordination of care. Table 9 provides a summary of each county's status for HMO enrollment, as of March 1, 2002.

Table 9: Mandatory and Voluntary HMO Enrollment -- Calendar Year 2002 Contract Period

Mandatory

Barron	Brown	Burnett	Calumet
Chippewa	Dane	Dodge	Dunn
Eau Claire	Fond du Lac	Green Lake	Jackson
Kenosha	LaCrosse	Manitowoc	Marathon
Milwaukee	Monroe	Outagamie	Ozaukee
Pierce	Polk	Rock	Rusk
St. Croix	Sheboygan	Vernon	Walworth
Washburn	Washington	Waukesha	Waupaca
Waushara	Winnebago	Wood	

Voluntary & Mandatory*	**Voluntary & Fee for Service****	**Voluntary Only**	**Fee-for-Service Only**
Ashland	Adams	Forest	Door
Bayfield	Columbia	Langlade	Florence
Buffalo	Green	Lincoln	Kewaunee
Clark	Iowa	Marquette	Marinette
Crawford	Iron	Menominee	
Douglas	Lafayette	Oconto	
Grant	Richland	Oneida	
Jefferson	Sauk	Portage	
Juneau		Price	
Pepin		Shawano	
Racine		Vilas	
Sawyer			
Taylor			
Trempealeau			

*Mandatory participation for selected zip codes and voluntary participation for other zip codes.

** Voluntary participation for selected zip codes and fee for service in other zip codes.

Services. Individuals who are enrolled in MA and BadgerCare and receive services through HMOs are generally entitled to receive, as needed, all services that are available to MA enrollees who do not participate in an HMO plan. There are a number of exceptions to this rule. HMOs have the option of covering dental and chiropractic services. If an HMO decides not to provide these services, it must accept a lower capitation rate. If the HMO does not offer these services, enrollees may obtain them from MA-certified providers on a fee-for-services basis. While HMOs are responsible for providing family planning services, enrollees may obtain these services from a primary physician of choice, whether or not that provider is in the HMO's plan. If the enrollee chooses a primary care physician outside of the HMO, those services will be reimbursed on a fee-for-service basis. Finally, HMOs may provide services that are not MA-covered services. HMOs must provide all services at no cost to the recipient.

Payments. Table 10 provides a summary of aggregated 2003 capitation rates by region. The actual capitation payment for each enrollee is based on the age and gender of the enrollee, and the region in which the enrollee lives.

There are a number of services that are reimbursed outside of the capitation payment system. DHFS reimburses HMOs for a portion of neonatal intensive care unit (NICU) costs if the HMO's average number of NICU days per thousand member years exceeds 75 days per thousand member years. DHFS also fully reimburses HMOs for costs incurred for qualifying individuals with HIV or AIDS and ventilator-assisted patients.

Table 10: 2003 Aggregated Monthly HMO Rates for AFDC/Healthy Start MA Enrollees

County or Region	Eligibility Group	Base Capitation Rate	Dental	Chiropractic	Comprehensive Rate
Region 1	AFDC / Healthy Start Children	$121.10	$5.57	$0.89	$127.56
(Duluth / Superior)	Pregnant Women	594.46	6.05	1.02	601.53
Region 2	AFDC / Healthy Start Children	122.98	5.19	0.83	129.00
(Wausau / Rhinelander)	Pregnant Women	567.63	3.25	1.26	572.14
Region 3	AFDC / Healthy Start Children	114.34	5.25	0.71	120.30
(Green Bay)	Pregnant Women	560.76	3.33	0.59	564.68
Region 4	AFDC / Healthy Start Children	123.81	7.40	1.65	132.86
(Twin Cities)	Pregnant Women	564.36	6.26	1.58	572.20
Region 5	AFDC / Healthy Start Children	121.79	5.85	0.78	128.42
(Marshfield / Stevens Pt)	Pregnant Women	580.31	3.64	1.18	585.13
Region 6	AFDC / Healthy Start Children	115.04	5.40	0.80	121.24
(Appleton / Oshkosh)	Pregnant Women	558.93	4.44	0.64	564.01
Region 7	AFDC / Healthy Start Children	113.45	5.64	1.04	120.13
(La Crosse)	Pregnant Women	566.04	4.85	1.17	572.06
Region 8	AFDC / Healthy Start Children	133.16	6.35	0.51	140.02
(Madison / South Central)	Pregnant Women	585.08	4.63	0.60	590.31
Region 9	AFDC / Healthy Start Children	122.91	5.29	0.42	128.62
(Southeast)	Pregnant Women	572.67	3.23	0.55	576.45
Region 10	AFDC / Healthy Start Children	138.26	5.21	0.15	143.62
(Milwaukee County)	Pregnant Women	688.21	1.87	0.20	690.28
Region 11	AFDC / Healthy Start Children	119.82	4.11	0.56	124.49
(Dane County)	Pregnant Women	626.17	2.48	0.42	629.07
Region 12	AFDC / Healthy Start Children	116.39	5.63	1.98	124.00
(Eau Claire)	Pregnant Women	683.69	2.93	1.79	688.41
Region 13	AFDC / Healthy Start Children	129.16	6.52	0.22	135.90
(Kenosha)	Pregnant Women	633.26	4.61	0.14	638.01
Region 14	AFDC / Healthy Start Children	136.94	5.92	0.60	143.46
(Waukesha)	Pregnant Women	584.31	3.87	0.27	588.45

Quality and Accessibility. The contracts between DHFS and participating HMOs contain a number of requirements relating to certain activities that are intended to improve the quality of care received by HMO enrollees and ensure that enrollees have appropriate access to services. For example, HMOs must report to DHFS the number of HealthCheck screens that they conduct for MA children enrolled in the HMO. If an HMO fails to screen at least 80% of the number of expected screens, as calculated according to the contract, DHFS would penalize the HMO by recouping MA payments from the HMO. Additionally, each HMO is required to provide medical care to its enrollees that is as accessible to them, in terms of timeliness, amount, duration and scope, as those services are to MA recipients not enrolled in an HMO within the area served by the HMO. The contract also requires that HMOs have an MA-certified primary care provider within a 20-mile distance from any enrollee residing in the HMO service area. Further, HMOs are required to have a mental health or substance abuse provider, or dental provider (if the HMO provides dental services) within a 35-mile distance from any enrollee residing in the HMO service area or no further than the distance for MA

clients not enrolled in an HMO, giving consideration to whether the providers are accepting new patients and where full or part-time coverage is available.

One of the quality improvement features of the contract is the requirement that HMOs monitor and evaluate the quality of care and services through performance improvement projects for at least two priority areas. Each HMO can select from a list of clinical and non-clinical priority areas developed by DHFS or it can request approval to study a different priority area. The clinical priority areas listed in the contract include: (a) prenatal services; (b) identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; (c) evaluating the need for specialty services; (d) availability of comprehensive, ongoing nutrition education, counseling, and assessments; (e) smoking cessation; (f) children with special health care needs; (g) outpatient management of asthma; (h) the provision of family planning services; (i) early postpartum discharge of mothers and infants; (j) sexually-transmitted disease screening and treatment; (k) high-volume / high risk services selected by the HMO; (l) prevention and care of acute and chronic conditions; and (m) coordination and continuity of care.

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

Other MA Managed Care Programs

Community Care Case Management for High-Cost Recipients. DHFS administers a targeted case management program that assigns high-cost, SSI-related MA enrollees to case managers contracted by DHFS to coordinate medical care and monitor services to ensure that these clients receive the most efficient and cost-effective treatment alternatives. In order to qualify for case management services under this program, an individual must have MA costs that exceed $25,000 annually. In addition, participants are required to receive services through a contracted facility. In 2002, DHFS paid case managers $87.25 per month per enrollee under this program to provide this service.

Independent Care Program. The independent care (I-Care) program provides coordinated medical and social services for SSI-related MA enrollees ages 15 and older in Milwaukee County. Individuals who are eligible for MA home- and community-based waivers or who are enrolled in the CSP program are not eligible for I-Care. The program operates under a joint venture agreement between the Milwaukee Center for Independence (a community vocational training agency) and Humana (a health maintenance organization).

Under the program, care coordinators assess the medical needs of enrollees and develop case plans with enrollees and their providers. Individuals enrolled in I-Care receive certain benefits that are not available to MA enrollees who receive services on a fee-for-service basis, including ongoing care coordination services, exemption from copayments, more convenient access to transportation, and access to certain non-standard services. In 2002, the MA program paid Humana a capitation rate of $744.82 per month for individuals enrolled in the program who received SSI cash payments and $504.61 per month for disabled enrollees who did not receive SSI cash payments. As of November, 2002, there were 5,186 individuals enrolled in the program.

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

community. These voluntary programs are available to people that are eligible for both MA and Medicare.

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

There is currently one PACE site in Wisconsin, Community Care for the Elderly (CCE) in Milwaukee County, which began operating in 1989. DHFS is currently expanding the program to Racine County. CCE also operates one of four WPP sites, along with Eldercare, the Community Living Alliance, and the Community Health Partnership. Eldercare of Dane County began providing services in 1996. The Community Living Alliance (CLA) of Dane County began operating a WPP site in 1996 that exclusively enrolls disabled individuals under 65 years of age. Finally, in 1997, the Community Health Partnership (CHP) began operating a multi-county WPP program, serving both younger disabled and elderly individuals who reside in Eau Claire, Chippewa, and Dunn Counties.

The state pays PACE and WPP sites a monthly capitation rate to fund services for each enrollee. During the first three years of operation of a WPP site, the state shared in any costs that exceeded the capitation rate. However, beginning with the 2001 contract year, the state's risk-sharing arrangement ended. The MA capitation rates DHFS pays to provide services for elderly clients vary by site. In 2002, DHFS paid CCE $2,873.50 per month per client for both its PACE site and WPP site. DHFS paid Eldercare $2,819.43 per month for services provided at its WPP site and $2,819.43 per month for CHP to provide services at its site. Capitation rates for disabled clients varied from $3,512.23 per month for CHP to $3,804.02 per month for CLA. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services. The MA capitation rate reflects an estimated 5% savings from the average fee-for-service equivalent for nursing home care. As of November, 2002, there were 1,187 individuals enrolled in these programs.

Children Come First and Wraparound Milwaukee. The children come first (CCF) program, which has been operated by CCF Managed Care in Dane County since 1989, provides community-based mental health and substance abuse services to eligible children with severe emotional disturbances (SED). These programs serve as an alternative to inpatient psychiatric care and provide a more comprehensive level of services that includes a care coordinator and individualized services. To be eligible for services, a child must have a severe emotional disturbance and be in an out-of-home placement or at risk of admission to a psychiatric hospital or placement in a residential care center for children and youth or a juvenile corrections facility. Children residing in a nursing facility, psychiatric hospital or psychiatric unit of a general hospital at the time of enrollment are not eligible. All necessary mental health and substance abuse services are funded on a capitated basis with MA and county-matching funds. Reimbursement for all other medical services provided to MA-eligible children enrolled in the programs is provided on a fee-for-service basis.

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

Under the program, Dane County contracts with CCF Managed Care, Inc., a limited service health organization, to arrange services for program clients. In calendar year 2002, the total capitation rate was approximately $3,500 per child per month, of which $1,706.20 was paid by MA and the remainder was paid by Dane County. The amount paid by MA reflects an estimate of the amount MA would have paid for services to enrollees if, instead, they received services under the MA fee-for-service system. As of November, 2002, 89 children were enrolled in CCF.

The Wraparound Milwaukee program is operated by the Children and Adolescent Treatment Center in Milwaukee. From April, 2002, through December, 2002, the monthly capitation rate was approximately $4,800 per child, of which $1,557 was paid by MA. The remainder was paid by Milwaukee County or the DHFS Bureau of Milwaukee Child Welfare, depending on which entity had responsibility for the child. As of November, 2002, 390 children were enrolled in the Wraparound Milwaukee program.

Milwaukee County Children in Out-of-Home Care Project. 1999 Wisconsin Act 9 required DHFS to request a waiver from the Secretary of the U.S. Department of Health and Human Services, by January 1, 2001, that would allow DHFS to require children in foster care who live in Milwaukee County to enroll in a managed care plan as a condition of receiving benefits under MA. Unlike the Child Come First and Wraparound Milwaukee projects, which provide behavioral health services to a select group of children, this project will involve providing comprehensive health care, including physical and behavioral health services, to children in out-of-home care in Milwaukee County.

As of January, 2003, DHFS staff were continuing to plan and develop the project. However, it appears that DHFS will not need to submit a waiver to implement the project. DHFS anticipates issuing a request-for-proposal (RFP) to potential vendors that would serve children under the project in March, 2003, and begin enrolling children in July, 2003.

Home- and Community-Based Waiver Services

CMS may waive certain requirements of federal MA law to permit states to develop innovative methods of delivering or paying for MA services. For example, CMS may permit states to limit enrollees' freedom to choose providers to enable states to enroll individuals in managed care programs. In Wisconsin, CMS has approved waivers to enable the state to deliver services to certain MA populations through HMOs and to provide home- and community-based services as an alternative to institutional care.

Under the community-based waiver provisions of federal MA law, states may offer medical and support services to certain groups of MA enrollees. Community-based waiver services provide a cost-effective alternative to institutional care through the provision of services that may not otherwise be available to MA recipients. Medical support and social services generally excluded from MA coverage that can be offered to waiver participants include supportive home care services that are significantly broader than MA personal care services, home modifications, adaptive aids, transportation services to nonmedical destinations, adult day care and supportive services in community-based residential facilities, as well as any other services requested by the state and approved by CMS. The appendix to this paper provides a list of waiver services.

Potential waiver participants are evaluated to determine the level of care they require, including care in a hospital, nursing facility or ICF-MR. Individuals who meet the level of care requirements must be informed of the availability of the MA-waiver services, but cannot be required to participate in MA-waiver programs. Under

federal regulations, MA waiver participants may be either relocated or diverted from institutions.

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

Before 1994, the number of waiver participants was limited to the number of individuals who would have been served in an institution in the absence of the waiver. However, this limit is no longer applicable. Also, although a state's waiver application is required to specify a limit on the number of individuals who will participate in the waiver, CMS usually increases the limit at the state's request. Waivers are granted for an initial period of three years. Waiver renewals are usually authorized for five-year periods.

Under four federal MA waivers, Wisconsin operates six programs that are intended to reduce the number of individuals who would receive long-term care services in nursing homes or institutions. Individuals who are elderly and physically disabled are served under one federal waiver that encompasses two state programs – the community options waiver program (COP-W) and the community integration (CIP II) program. Individuals with developmental disabilities may receive services under four state programs authorized under three federal waivers. The community integration programs CIP IA and CIP IB are authorized under one federal waiver, while the brain injury waiver (BIW) and the community supported living arrangements waiver (CSLA) programs are authorized under separate federal waivers.

Community Integration Program -- CIP IA. This program provides community-based services to individuals who previously resided at one of the three state centers for the developmentally disabled (Northern Center in Chippewa Falls, Central Center in Madison and Southern Center near Union Grove). State law requires that following a CIP IA placement, a center bed must be held vacant for 360 days and then closed.

For the 2002-03 fiscal year, DHFS provides counties a maximum average per day allowance of $125 for each person relocated from the centers before July 1, 1995, $153 for relocations that occurred between July 1, 1995 and June 30, 1997, and $225 for individuals placed on or after July 1, 2002. For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed for approximately 59% of the difference between the state rate and the actual costs of providing the service as long as the average cost of CIP IA placements statewide does not exceed the average cost of care at the centers. As of December 31, 2002, 1,095 individuals were participating in CIP IA. In 2001-02, MA expenditures under CIP IA totaled $64.9 million (all funds).

The average cost of serving residents at the three state centers was $383 per day in 2001, compared to $250 per day for individuals enrolled in CIP IA when MA card services expenditures are included.

Community Integration Program -- CIP IB. This program provides community-based services for individuals who are relocated or diverted from ICFs-MR other than the state centers for the developmentally disabled. In 2002-03, the maximum average per day allowance for state reimbursement under CIP IB is $49.67, although a higher rate is available for placements from facilities that close or have on file a Department-approved plan for sig-

nificant downsizing over five years. The enhanced rate is determined by a formula that is related to the facility's MA reimbursement rate. For county costs in excess of state reimbursement, federal matching funds can be claimed for costs up to a maximum of the average cost of care in an ICF-MR (approximately $134.97 per day). As of December 31, 2002, there were 8,592 state-funded individuals participating in CIP IB. In addition to these state-matched slots, Wisconsin claims federal funding for individuals for whom counties elect to provide the state match with county funds. In fiscal year 2002, MA expenditures for waiver services for CIP IB participants totaled $159.7 million.

The average cost of serving individuals with developmental disabilities in ICFs-MR other than the state centers was $147 per day in 2001. In comparison, the average actual cost to serve a person under CIP IB was $130 per day, when costs for MA card services are included.

As of December 31, 2001, 1,769 developmentally disabled individuals resided in ICFs-MR other than the three state centers, and 147 developmentally disabled individuals resided in other nursing homes. Combined with the 821 residents at the three state centers, 2,737 Wisconsin residents with developmental disabilities were residing in ICFs-MR or nursing homes as of that date. In contrast, 10,429 individuals with developmental disabilities were participating in CIP IA and CIP IB on that date.

Community Integration Program -- CIP II. CIP II participants are individuals who are either over the age of 65 years or physically disabled who are relocated or diverted from nursing homes. Under state statutes, a CIP II placement requires the closing of a nursing facility bed. Once a nursing home bed has been delicensed and a community "slot" has been established, the number of MA recipients who receive CIP II services at any time may not exceed the number of MA beds that are closed.

For 2002-03, the daily reimbursement rate available to counties serving CIP II clients is $41.86. In order to maximize state funding, counties are more likely to place higher cost, disabled individuals in the CIP II program for which the county has a fixed number of slots, than under the COP-waiver program, for which the county is allocated a fixed amount of funding. In fiscal year 2001-02, there were 2,728 CIP II slots budgeted for counties. In 2001-02, MA expenditures for waiver services provided to CIP II participants totaled $41.7 million.

Community Options Waiver Program. The community options waiver program (COP-W) provides services to elderly and physically disabled individuals who would otherwise receive care in a nursing facility. Used primarily to divert individuals from nursing homes, COP-W was initiated when federal funding became available to support the types of community-based care services that were already being provided under the state-funded COP program. COP-W serves MA-eligible individuals who, with medical and support services, can be cared for in the community. The original waiver for this program became effective January 1, 1987.

In calendar year 2001, 9,538 individuals received services supported by COP-W funds. MA expenditures for COP-W waiver services totaled $74.6 million. Unlike other community-waiver programs, under COP-W, counties are allocated a given amount of dollars, rather than a given number of slots or placements. Thus, a county can serve more or fewer clients depending on the average cost per client. However, counties are subject to the federally imposed waiver-requirement that the average cost of care statewide under COP-W does not exceed the average cost of care in nursing homes. Because of this federal limit, DHFS limits the average expenditure per COP-W client to $41.86 per day, which is the same limit as under CIP II.

Although it is not an MA waiver program and is not eligible for federal MA matching dollars,

Wisconsin's state-funded COP program provides additional resources to promote community-based services for elderly, physically disabled, developmentally disabled, and chronically mentally ill individuals and with Alzheimer's disease.

In calendar year 2001 $67.4 million GPR was expended under the COP program, providing services to 2,254 individuals not served under the waiver programs. COP provides a means to serve some groups that would not be eligible under one of the waiver programs. In addition, COP funds are used for MA-waiver clients for some services that are not eligible under the MA waiver programs and for MA-eligible services when costs exceed the state reimbursement rate for that waiver program.

DHFS prepares an annual report that compares the average cost of care for participants in the COP-W and CIP II programs to the cost for MA enrollees in nursing homes. This comparison includes not only direct costs, but other costs such as MA card costs for hospital care and other services and SSI costs. The calendar year 2000 report indicated that the average total cost of care for COP-W and CIP II participants was $64.16 per day, while the average cost for MA nursing home recipients was $90.26 per day.

Brain Injury Waiver (BIW). Individuals who are substantially handicapped by a brain injury and receive, or are eligible for, post acute rehabilitation institutional care may receive community services under this special waiver program, which began on January 1, 1995. On December 31, 2002, the program was serving 257 individuals. Expenditures under the BIW totaled $13.5 million in 2001-02. Currently, the maximum reimbursement rate is $180 per day. Before DHFS implemented this program, brain-injured individuals would typically have to be institutionalized because the other MA waiver programs for which these individuals are eligible do not provide sufficient funding to meet the needs of this group and people who suffer a brain injury after they are 21 years old are not considered developmentally disabled and therefore are not eligible for services provided under CIP IA or CIP IB.

Community Supported Living Arrangements Waiver (CSLA). Individuals who meet a developmental disability level of care are eligible for care under CLSA if: (1) the person/guardian, identifies and chooses the supports and services which best meet the recipient's needs; and (2) the recipient lives in his or her own home where the setting is controlled by the person/guardian and not a service provider. The CSLA waiver was first available to counties beginning in 1996, and from 1992 through September 30, 1995, Wisconsin was one of eight states that participated in a CSLA demonstration grant. The CSLA waiver serves both children and adults and is a federal/local match program similar to locally-matched slots in CIP IB. Counties may use a variety of funding sources to provide the required local matching funds, including community aids, GPR COP funds, funds available under the family support program and county property taxes. In calendar year 2001, expenditures under the program totaled $1,354,700 ($800,800 FED and $553,900 county). On December 31, 2002, there were 224 active participants in the program.

Family Care

Family Care is a pilot program that was created to change the manner in which state residents receive long-term care services. The Family Care program replaces other long-term care programs available in participating counties as the means of consolidating eligibility and services.

Family Care provides services to elderly individuals, physically disabled adults, and, to a limited degree, adults with developmental disabilities. Children and individuals with chronic mental illness may not participate in the Family Care pilot program.

Family Care includes two major components: resource centers and care management organizations (CMOs). Resource centers provide information, assessments, eligibility determinations and other preliminary services to potential long-term care users and their families so that they are aware of the alternatives to nursing homes. In areas where a resource center is established, nursing homes and other long-term care facilities must inform and refer any prospective residents to the resource center before admitting them.

Second, CMOs provide long-term care services for every person enrolled in Family Care under a capitated, risk-based payment system. CMOs are required to monitor and report a number of measures, such as the rate of hospitalization, so that their performance can be assessed. CMOs must meet performance standards that are part of the CMO contract.

The CMOs manage and deliver the Family Care benefit, which provides a comprehensive range of long-term-care services, including the types of services currently available under COP, the MA community-based waiver programs, and the MA fee-for-service program. Examples of services CMOs must provide include supportive living services, supported employment services, adult day care, respite care, supportive home care, residential services, nursing home services, personal care services, home health services, and therapy services. In addition, CMOs may provide any other service that enrollees may need.

The Family Care benefit does not provide acute care services, such as hospital care or physician care, which enrollees continue to receive on a fee-for-service basis. Although acute care is not provided by CMOs, the CMOs' case managers must coordinate acute care to ensure the enrollees' total health care needs are met.

In addition to providing benefits to individuals who meet a nursing home level of care standard, Family Care serves individuals with fewer long-term care needs, but who are at risk of losing their independence or functional capacity unless they receive some assistance. There are two capitation rates CMOs may receive: (a) a comprehensive rate to support services for enrollees who meet a nursing home level of care standard; and (b) an intermediate level rate to support services for enrollees whose independence is threatened.

As of January 1, 2003, nine counties were operating resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau Counties), while five counties were operating CMOs (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland Counties). The capitation rates differ by county to reflect the experience of long-term care enrollees in each county. The calendar year 2003 rates at the comprehensive level range from $1,768 per month in Milwaukee County to $2,368 per month in Portage County. The intermediate rate is the same for all five CMOs -- $657 per month. The Milwaukee County CMO only serves individuals over the age of 60 who are frail, physically disabled or developmentally disabled, while the other four CMOs serve all three Family Care target groups -- elderly individuals, individuals with physical disabilities and people with developmental disabilities age 18 and over.

Nonfinancial Eligibility. All Family Care enrollees must be at least 18 years of age or older and their primary disability must be something other that mental illness, substance abuse or developmental disability, although individuals with developmental disabilities may participate in counties or tribes where a CMO has operated before July 1, 2003.

In order to enroll in the program a person must meet one of the following three functional eligibility criteria.

a. The person's functional capacity is at the comprehensive level, which is defined as a long-term or irreversible condition, expected to last at

least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance or supervision.

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

c. The person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by DHFS, funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county.

The comprehensive level of functional capacity is approximately equivalent to a nursing home level of care under MA. The distinction between comprehensive and intermediate levels is important, since it may affect whether a person is entitled to Family Care services.

Financial Eligibility. A person is financially eligible for the Family Care benefit if, as determined by DHFS or its designee, the person: (a) is eligible for MA and accepts MA unless he or she is exempt from the acceptance under DHFS rules (Family Care MA); or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rule (Family Care non-MA). Because the deductions and allowances for Family Care non-MA are more generous, individuals not eligible for MA may still be eligible for Family Care.

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

Entitlement. A primary goal of Family Care is to eliminate waiting lists for community-based long-term care. To achieve this goal, certain individuals are entitled to the Family Care benefit. A person is entitled to the Family Care benefit through enrollment in a CMO if he or she meets eligibility requirements, fulfills any applicable cost-sharing requirements and: (a) is functionally eligible at the comprehensive level; (b) is functionally eligible at the intermediate level and is eligible for MA; (c) is functionally eligible at the intermediate level and is determined to be in need or protective services or protective placement; (d) has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, the person first applies for eligibility for the Family Care benefit within 36 months after the date on which the Family Care benefit is initially available in the person's county of residence, and on the date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or had been receiving for at least 60 days, under a written plan of care, long-term care services funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county; or (e) has a primary disabling condition that is a developmental disability, is at least 18 years of age and is a resident of a county or tribe that has operated a CMO before July 1, 2003.

Within each county and for each client group, entitlement first applies on the effective date of a contract under which a CMO accepts a capitated payment. However, during the first 24 months

after this date, the CMO is provided a phase-in period to build the capacity to serve all entitled individuals in that county. A person who is eligible for Family Care but who is not entitled to receive the Family Care benefit can be put on a waiting list for services even after the phase-in period for building capacity. However, while waiting for enrollment, a person who is eligible but not entitled to Family Care services may purchase services from a CMO.

Alternative Funding Sources

During the late 1980s and early 1990s, states' MA expenditures grew significantly due to rising health care costs, expanding access to care and increasing reimbursement to providers. In response to rising program costs, many states enacted various mechanisms permitted under federal law, to capture additional federal matching funds for MA costs. In general, funds from these other sources are used in place of the state match for MA funds.

Under federal law, states may use:

- Provider taxes, which may be levied on classes of health care providers, including nursing facility services, hospital services, physician services and other health care services for which the state has enacted a licensing or certification fee.

- Donations or voluntary contributions made by health care providers to a state or local government.

- Assessments, including licensing and certification fees imposed on health care providers or institutions.

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

While many of these mechanisms have existed since the inception of the MA program, states have increasingly used these options since the 1980s. However, federal changes have placed restrictions on a number of these provisions, including:

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

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

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

- A limit of 25% on the allowable share of state MA funds that may be collected from a provider assessment;

- A limit of 12% of total MA expenditures for payments to hospitals serving a disproportionate share of the indigent population; and

- Intergovernmental transfers from local governments funded by taxes or donations prohibited under MA law cannot be used as a state match for federal dollars.

Wisconsin has used both the provider assessment and intergovernmental transfers as a way to increase federal matching dollars.

Provider Assessments. Beginning in 1991-92, the state established a provider assessment on nursing homes. Initially, the assessment was only applied to MA nursing home revenues and the assessment was an allowable cost for MA reimbursement. Subsequent changes in federal law required the state to change its provider assessment so that now the provider assessment is a broad-based assessment, rather than an assessment limited to MA residents. Currently, the nursing home assessment is an amount per occupied nursing

home bed and applies to all nursing home beds, except those in the state centers for the developmentally disabled, the state Veterans Home at King and beds occupied by Medicare beneficiaries. The current monthly rate per bed is $32 for nursing facilities and $100 for ICFs-MR. Because the federal government funds approximately 59% of MA nursing home expenditures, the estimated $14.5 million in assessments in 2002-03 will generate approximately $20.4 million in federal dollars.

Although federal rules prohibit any hold harmless provisions that directly tie MA reimbursement levels to the amount of the tax paid by the provider, nursing homes indirectly benefit since the assessment and the federal matching funds are used to fund higher MA provider payments, which permits nursing facilities to recover more of their costs related to their MA residents. Non-MA residents may benefit to some degree if higher MA provider rates result in less cost-shifting to private-pay patients or if the resident ultimately becomes eligible for MA. Nursing homes with few or no MA patients and their residents do not receive significant benefits from higher MA provider rates. However, most nursing homes have a large number of MA residents. As of December 1, 2002, only six of the 450 licensed nursing homes in the state were not certified to serve MA patients. On December 31, 2000, approximately 66.8% of Wisconsin nursing home residents used MA as their primary source of payment for services. For private pay residents, a nursing home may elect to include the assessment in their bill, either in the overall rate or as a separate, billable amount.

Intergovernmental Transfer Program. Under an intergovernmental transfer program (IGT), the state certifies counties' MA allowable expenditures and claims federal matching funds for those expenditures at the regular federal matching rate of 59%. The largest source of intergovernmental transfers has been county expenditures for nursing homes that are based on the difference between actual MA payments and the Medicare upper limit.

Table 11 illustrates the expansion of IGT claims and the distribution of the additional federal MA funds generated under the program. In conjunction with the expansion, the state began using part of the IGT funds to support general nursing home, hospital, and select non-institutional rate increases. As shown in Table 11, the amount of IGT will increase to an estimated $336 million in 2002-03, of which $77.1 million will be used for special payments to county-owned nursing homes, $144 million will be used to fund the general MA rate payments to nursing homes, and $39.1 million will be used to fund rate payments to hospitals and non-institutional providers. Beginning in 2000-01, a portion of IGT revenues has been not been used to fund MA benefits, but instead has been retained in the MA trust fund.

Wisconsin currently claims federal MA funds using an electronic transfer method. Under this methodology, the difference between actual MA payments and the applicable Medi-

Table 11 : Intergovernmental Transfer Program ($ in Millions)

Total Fiscal Year	County Certified Losses	IGT Used as County Supplemental Payments	IGT Used for General Rate Payments to Nursing Homes	Total IGT
1994-95	$48.1	$37.1	$30.4	$67.5
1995-96	56.4*	37.1	26.1	63.2
1996-97	61.1	46.1	72.4**	118.5**
1997-98	65.8	40.2	53.9	94.1
1998-99	66.7	37.1	58.3	95.4
1999-00	73.6	39.7	65.3	105.0
2000-01***	90.3	40.5	78.1	372.8
2001-02****	98.6	77.1	143.0	351.7
2002-03 (est.)	112.2	77.1	144.0	318.2

*The state only certified losses of $52.2 million in 1995-96 because of concerns of exceeding the Medicare upper limit.
**This higher amount resulted from accelerating the claiming of IGT funds, which cannot be repeated in future years.
*** IGT claimed for nursing homes is based on allowable payments up to an aggregate nursing home upper limit beginning in fiscal year 2000-01.
****General rate payments were also provided to hospitals and non-institutional providers using IGT funds beginning in 2001-02.

care Upper Limit is first determined. Then, this amount is transferred from county-operated facilities to the state via a wire transfer and the amount is returned to the participating counties (Sheboygan, Rock and Walworth) by the state on the same day. Since the transfer is considered a payment to facilities, the state is able to claim federal matching funds on the wire transfer amount based on the current federal share (59%). The IGT revenues are then deposited into the MA trust fund.

In December, 2000, Congress passed new legislation that established separate Medicare upper limits for various categories of nursing homes and required states to adjust existing IGT programs to comply with new standards over a period of several years. Under a negotiated agreement, beginning in 2003-04, Wisconsin will no longer be able to claim IGT revenues under the method it used in the previous three years. IGT claims are expected to decrease from approximately $327.1 million in 2002-03 to $41.6 million in 2003-04.

Although the use of county nursing home expenditures is commonly referred to as the state's IGT program, there are several other services provided under the state's MA program where county expenditures are used to generate federal matching funds. For example, the state does not support case management services with GPR, but permits counties to capture federal matching dollars ($17.9 million in 2001-02) for county-provided services. Under CIP IB, the state allows counties to claim federal matching dollars for county-supported placements and county costs in excess of the state reimbursement level, but below the federal limit. In fiscal year 2001-02, county CIP IB expenditures generated approximately $64.9 million in federal matching funds. Counties can also claim federal matching dollars for their spending on allowable costs that exceed the state maximum reimbursement rates for other community-based waiver programs (CIP IA and COP-W). Finally, there are several other MA services, similar to case management services, for which the counties are required to provide the state match. In 2001-02, DHFS claimed the following amounts for these services: community support program, $18.4 million, county deficit reduction program, $12.2 million, crisis intervention services, $5.6 million, and other county-matched services, $0.1 million for a total of $54.2 million.

Table 12 presents information on MA trust fund revenues, expenditures and balances for the 2000-01 and 2001-02 fiscal years and current projections of the funds revenues and balances based on the DHFS 2003-05 budget request.

Table 12 : MA Trust Fund Balances for Fiscal Years 2001-02 thru 2004-05 (Based on DHFS' 2003-05 Budget Request)

	2000-01 Actual	2001-02 Actual	2002-03 Estimate	2003-04 Estimate	2004-05 Estimate
Opening Balance	$0	$275,298,200	$361,655,000	$399,400,800	$152,864,900
Revenues					
IGT Claims	$372,754,200	$351,665,600	$327,054,300	$41,579,800	$37,950,800
Interest Earnings	0	4,856,400	8,893,100	9,379,200	752,200
Disallowance	0	-61,697,600	0	0	0
Interest Penalty	0	-707,300	0	0	0
Subtotal	$372,754,200	$294,117,100	$335,947,400	$50,959,000	$38,703,000
Expenditures					
MA and BadgerCare Benefits	$94,603,200	$205,467,500	$298,086,600	$297,379,900	$191,452,900
Cost of Wire Transfers	2,852,800	2,292,800	115,000	115,000	115,000
Subtotal	$97,456,000	$207,760,300	$298,201,600	$297,494,900	$191,567,900
Estimated Balance	$275,298,200	$361,655,000	$399,400,800	$152,864,900	$0

Coordination With Other Payment Sources

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 enrollees, and to establish procedures for paying claims where other resources are available. DHFS refers to this activity as coordination of benefits (COB). COB seeks payment from any individual, entity or program that is, or may be, able to pay all or part of the expenditures for MA services furnished by the state. Wisconsin law requires the use of other health insurance benefits, such as Medicare, commercial health insurance and settlements resulting from subrogation (injury, medical malpractice, product liability) to defray the costs incurred by MA. Any COB savings generated by states are shared with the federal government in the same proportion as each state's MA benefits expenditures. The use of MA as the payer of last resort is important because federal and state MA costs are reduced without affecting the quality of MA services, or access to health care.

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

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

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

Table 13 summarizes all coordination of benefits savings achieved in 2001-02 and funds received through estate recovery.

Estate Recovery Program

DHFS uses estate recovery to offset MA program costs. Under the estate recovery program, MA enrollees share in the cost of their health care, after death, through payments from their estates. The estate recovery program allows the state to recover MA payments for nursing home care (and for hospital care if the person was required to contribute to the cost of care). In addition, the state

Table 13: Coordination of Benefits and Estate Recovery Payments -- Fiscal Year 2001-02

Category	Cost Avoidance	Postpayment Recoveries	Claims Adjustments
Medicare	$747,292,700		
Other Health Insurance	196,248,100*	$7,846,000	
Subrogation		3,942,100	
Provider-Based Bills		319,100	$8,680,200
Medical Support Liability		21,461,900	
Estate Recovery		16,974,100	
Miscellaneous		8,864,300	
Total	$943,540,800	$59,407,500	$8,680,200
Grand Total			$1,011,628,500

*Includes claims returned because: (a) insurance carrier payments equaled or exceeded the MA rate, (b) other carrier coverage appears on file, (c) use of other carrier denial is invalid, or (d) other coverage is suspected.

may recover MA payments for personal care, home- and community-based waiver services and related hospital and prescription drug services provided to individuals who are age 55 years and over. State law requires the state to file claims against the estate of a MA enrollee to recover certain costs, except in cases that would cause undue hardship.

The estate recovery program has two ways to recover MA costs. First, DHFS may place liens on the home of an MA enrollee who is in a nursing home or hospital facility if the individual is not expected to be discharged from the nursing home or hospital and if certain family members do not reside in the home. These family members include the MA enrollee's spouse, the enrollee's child who is under 21 or disabled, or the enrollee's sibling who is an owner of the home and who has lived in the home continuously beginning at least 12 months before the enrollee was admitted to the nursing home.

Before placing a lien, DHFS must notify the enrollee in writing that the enrollee is not expected to be discharged, that DHFS intends to obtain a lien and that the enrollee has a right to a hearing on whether the conditions for placing a lien have been satisfied. DHFS may enforce a lien before the enrollee's death if the enrollee sells the home, but not if the enrollee has: (a) a living spouse; (b) a child who is under 21 or disabled; (c) a sibling who resides in the home, if the sibling resided in the home for at least 12 months before the enrollee was admitted to the nursing home; or (d) a child of any age who resides in the home, if that child resided in the home for at least 24 months before the enrollee was admitted to the nursing home and provided care to the enrollee that delayed the enrollee's admission to the nursing home.

In addition to placing liens, DHFS can place claims against an enrollee's estate. When the program was created, the state could also recover from the estates of surviving spouses of MA enrollees. However, in 1995, the Wisconsin Court of Appeals ruled that MA estate recovery could not be applied to the estates of surviving spouses. Beginning April 1, 1995, except in cases of undue hardship, claims must be filed. The claim may be up to the amount MA paid for the MA services subject to estate recovery.

A court may reduce claims against the enrollee's estate by up to $5,000, if it determines that it is necessary to allow the enrollee's heirs to retain certain personal property, including: (a) the decedent's wearing apparel and jewelry; (b) household furniture, furnishings and appliances; and (c) tangible personal property that is not used in trade, agriculture or other business and does not exceed $3,000 in value.

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

Administration

The state's MA program is operated in accordance with an MA state plan that describes the state's basic eligibility, coverage, reimbursement and administrative policies. The plan must be approved by CMS and is periodically updated to reflect changes in state policy or to conform to new federal requirements. As the state's administering agency, DHFS's responsibilities include: (a) eligibility determinations; (b) provider certification; (c) claims processing; (d) review and inspections of facilities providing care; and (e) maintenance of the program's integrity and administration. Federal MA regulations require each state to establish an MA advisory committee, including provider and beneficiary representatives, to review and make recommendations on MA policy.

Counties and tribal governing bodies are responsible for: (a) determining MA eligibility and informing recipients of their rights and duties; (b) recovering incorrect payments; (c) authorizing payments for certain mental health benefits for certain MA recipients; (d) establishing a program of medical support liability; and (e) health insurance reporting (for which counties receive an incentive payment).

DHFS contracts with outside providers for most of the remaining administrative functions, such as processing claims, reviewing prior authorization requests, providing actuarial services, and other consulting services and administrative activities. Most of these services are provided under a contract with the current MA fiscal agent, Electronic Data Systems, Inc. (EDS).

MA and BadgerCare administrative expenses totaled approximately $181.4 million ($79.1 million GPR/PR and $102.3 million FED) in 2001-02. Of this amount, $42.7 million ($15 million GPR/PR and $27.7 million FED) was paid for services provided by the state's fiscal agent. The share of county income maintenance administration costs and other costs totaled approximately $44.6 million ($19 million GPR/PR and $25.6 million FED) in 2001-02. Costs for DHFS operations and other contract costs totaled approximately $94.1 million (all funds) in 2001-02. Generally, administrative contracts are eligible for 50% federal funding. However, some administrative costs, including the fiscal agent contract, are matched at a higher rate. Table 14 summarizes MA and BadgerCare administrative costs in 2001-02.

Table 14: MA and BadgerCare Administrative Costs -- Fiscal Year 2001-02

	GPR/PR	FED	Total
Fiscal Agent Contract	$14,991,700	$27,691,400	$42,683,100
Eligibility Determinations and Related Costs	18,994,300	25,576,700	44,571,000
Other DHFS Contracts and Operations	45,090,700	49,025,900	94,116,600
Total	$79,076,700	$102,294,000	$181,370,700

Since MA eligibility for families with dependent children is tied to the AFDC program, as it existed on July 16, 1996, eligibility for cash assistance under the W-2 program [Wisconsin's temporary assistance to needy families (TANF) program] does not automatically confer eligibility for MA. However, applicants for the W-2 program will typically be evaluated for MA eligibility as part of the application process at the W-2 agency.

In Wisconsin, except for SSI-recipients, MA eligibility is determined by county income maintenance (IM) workers under contract with DHFS. SSI-related individuals (someone who meets the non-financial criteria of SSI but not the financial requirements), as well as the medically needy, pregnant women and children and families with dependent children, are included in the groups whose eligibility is reviewed by county IM workers.

Federal regulations require states to conduct periodic redeterminations of eligibility and to take action between redeterminations if states become aware of changes in a beneficiary's circumstances. In general, federal regulations require that redetermination must occur at least every 12 months, although longer intervals are permissible for blind or disabled beneficiaries.

In Wisconsin, the redetermination interval for families with dependent children, pregnant mothers and children is 12 months, but if the family or individual is receiving food stamps, the case is reviewed every three months under requirements for food stamps. Families or individuals with earned income must submit monthly financial statements. Although review of impairments may be infrequent for disabled recipients, income and resource evaluations are done at least yearly for disabled and elderly recipients. Applicants who are denied eligibility must be given notice and an opportunity for a fair hearing.

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

Fiscal Agent Services. The MA fiscal agent provides a variety of administrative services. In 2001-02, DHFS paid EDS approximately $42.7 million for services related to the administration of the state's MA program. Of this amount, approximately $18.4 million was paid for processing claims submitted by providers. Other services provided by EDS include distribution of MA cards to recipients, coordination of benefits activities, review and approval of prior authorization requests, operation of the pharmacy point-of-sale system and collection of premiums from BadgerCare recipients.

Provider Certification. States must determine which service providers are eligible to participate in the MA program. Federal law specifies the standards and certification procedures for institutional providers, such as hospitals and nursing homes. For certain other kinds of providers, such as physicians and pharmacies, states generally follow their own laws on licensure and monitoring.

Both Medicare and MA use state certification agencies to determine compliance by institutional providers with program standards. For hospital certification, both Medicare and MA rely on the findings of one of two organizations (the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, whichever is appropriate) for determining whether an institution meets most program requirements. In Wisconsin, the Joint Commission on the Accreditation of Health Care Organizations surveys most hospitals and DHFS survey activity is limited to a sample to validate the reviews by the Joint Commission and to surveys of a few hospitals that are not surveyed by the Joint Commission. For Wisconsin nursing homes, surveys performed by DHFS serve as the basis for Medicare and MA certification and state licensure.

A state may terminate the certification of a facility that no longer meets the requirements for participation. If the deficiencies do not immediately jeopardize the health and safety of patients, the provider may be granted a reasonable period of time to achieve compliance and may be subject to other sanctions. In the case of nursing homes where the deficiencies threaten patient health and safety, a nursing home monitor can be established to ensure that adequate care is being provided. If the nursing home is unable to provide adequate care, DHFS can petition the court to place the nursing home into receivership, which allows DHFS to

assume operation of the facility until residents can be relocated to another facility or other type of care setting.

Program Controls. Federal regulations require states to conduct activities to ensure that the MA program is properly administered. One of these activities is state monitoring of its administrative performance. The chief focus for MA eligibility quality control is to identify eligibility errors that may result in improper federal payments. States with high error rates may be subject to financial penalties. Since the 1996-97 fiscal year, Wisconsin has had a waiver from this requirement. Under the waiver, the state is able to conduct special studies in place of routine case recorded reviews.

Most states are required to operate a computerized Medicaid management information system (MMIS), which maintains information on beneficiaries and providers, processes claims, and produces program reports. In Wisconsin, as in most states, the state's fiscal agent maintains the MMIS.

Federal MA law and regulations include detailed provisions relating to the quality and appropriateness of care rendered to MA enrollees. Required state activities include development of a utilization review plan and provision for external reviews of certain facilities. Activities conducted by the facilities themselves include initial and periodic recertification of each patient's need for care, development of plans for the care of each patient and operation of an approved utilization review (UR) program.

One of the methods used by Wisconsin to assure quality and appropriateness of care is to conduct peer reviews through an administrative contract with MetaStar, Inc. In order for a state to receive federal MA matching funds, a peer review organization must review services provided to MA recipients. MetaStar provides quality of care and utilization review services through data analysis, auditing, and quality improvement initiatives. In 2001-02, DHFS paid MetaStar approximately $1.1 million to conduct such reviews.

Each state is required to establish methods for identifying and investigating cases of potential fraud and abuse. One service performed as part of this program is surveillance and utilization review (SUR). Under SUR, potential cases of abuse by providers (providing unnecessary services or overcharging) and recipients (overutilization of services) are identified using information on paid claims.

In addition, federal funding is available for state MA fraud control units (MFCUs), which investigate allegations of state law fraud violations. Wisconsin has established a MFCU in the Attorney General's Office that receives federal funding to investigate MA fraud in the state. In 2001-02, $928,900 ($211,200 GPR and $717,700 FED), was expended to support 11.0 full-time positions to conduct these investigations. Investigations are initiated based on referrals or on leads developed by investigators in the Department of Justice. Most referrals are from employees of providers, recipients, self-generated investigations from DHFS and anonymous tips.

Introduction

1997 Wisconsin Act 27 established BadgerCare, a health insurance program for certain low-income families. The program began enrolling families in July, 1999. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery and administration. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available from two federal programs; (a) the state children's health insurance program (SCHIP); and (b) MA. Therefore, BadgerCare operates under federal requirements for both of these programs. Further, Wisconsin received approval of a waiver of certain federal requirements under MA in order to implement BadgerCare. This waiver approval was granted based on a plan submitted and approved by CMS. BadgerCare also operates under the parameters established in that approved plan.

Eligibility

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

Uninsured families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before the family is no longer eligible for the program. There is no asset limit for eligibility for BadgerCare. Table 15 identifies the initial income eligibility levels for BadgerCare and the ongoing income eligibility limits based on the 2002 FPL.

Table 15: BadgerCare Eligibility -- Maximum Countable Monthly Income (Based on 2002 FPL)

Family Size	Initial Eligibility 185% of FPL	Ongoing Eligibility 200% of FPL
1	$1,366	$1,477
2	1,841	1,990
3	2,316	2,503
4	2,790	3,017
5	3,265	3,530
6	3,740	4,043

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

Families with incomes above 150% of the FPL are required to pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 3% of the family's income. Table 16 provides a schedule of the minimum and maximum premiums a family would be required to pay based on their countable income, using the 2002 FPL.

The financial eligibility criteria for BadgerCare are similar to the financial eligibility criteria for

Table 16: BadgerCare Premium Schedule

Family Size	Monthly Income* Minimum	Monthly Income* Maximum	Monthly Premium Minimum	Monthly Premium Maximum
1	$1,108	$1,477	$30	$30
2	1,493	1,990	30	45
3	1,878	2,503	45	75
4	2,263	3,017	60	90
5	2,648	3,530	75	105
6	3,033	4,043	90	120

* Based on 2002 federal poverty level.

MA Healthy Start. Healthy Start covers pregnant women and children under age six in families with income not exceeding 185% of the FPL and there is no asset limit. However, Healthy Start does not cover non-pregnant parents with income that exceeds the AFDC-related criteria, nor does it cover children six and older in families with income above 100% of the FPL. However, these individuals are often eligible for BadgerCare.

The nonfinancial eligibility criteria for BadgerCare are significantly different than MA eligibility criteria. Under MA, a family that meets the financial and demographic criteria is eligible regardless of whether the family has access to health insurance. Because MA is a payer of last resort, if a person has access to other health insurance, MA would only pay for those services that are not covered from another source. Under BadgerCare, individuals in families that have insurance or have access to a group health insurance plan for which an employer subsidizes at least 80% of the monthly premium cost are not eligible. In addition, individuals who have health care coverage or had health care coverage any time during the three months before they apply for BadgerCare are ineligible. DHFS may waive these provisions for good cause.

When a family applies for BadgerCare, all family members are first reviewed to determine whether they may be eligible for MA. If one or more of the family members were found to be eligible for MA, those individuals would be enrolled in MA. The remaining family members are reviewed for eligibility for BadgerCare and enrolled in BadgerCare if they meet that eligibility criteria.

Services

Individuals enrolled in BadgerCare are eligible to receive all of the benefits available to MA recipients. BadgerCare recipients may receive services from any MA certified provider.

Approximately 72% of BadgerCare recipients are enrolled in HMOs. HMOs that enroll MA recipients are required to enroll BadgerCare clients as well. Capitation rates for BadgerCare clients are generally higher than the rates paid for AFDC-related and Healthy Start MA recipients. As with MA capitation rates, the actual amount paid to an HMO for an enrollee is based on the enrollee's age, gender and residence. Table 17 identifies the aggregated capitation rates for BadgerCare enrollees by region.

Table 17: BadgerCare Capitation Rates -- Aggregated by Region Calendar Year 2003

Region	Base Rate	Dental	Chiro.	Comprehensive Rate
Region 1 (Duluth / Superior)	$131.29	$6.04	$0.95	$138.28
Region 2 (Wausau / Rhinelander)	137.27	5.78	0.93	143.98
Region 3 (Green Bay)	131.84	6.05	0.79	138.68
Region 4 (Twin Cities)	124.72	7.46	1.66	133.84
Region 5 (Marshfield / Stevens Point)	129.88	6.21	0.84	136.93
Region 6 (Appleton / Oshkosh)	121.16	5.70	0.85	127.71
Region 7 (LaCrosse)	119.55	5.93	1.09	126.57
Region 8 (South Central)	127.06	6.06	0.47	133.59
Region 9 (Southeast)	130.40	5.62	0.44	136.46
Region 10 (Milwaukee County)	143.71	5.44	0.15	149.30
Region 11 (Dane County)	125.94	4.30	0.56	130.80
Region 12 (Eau Claire County)	127.28	6.16	2.15	135.59
Region 13 (Kenosha County)	134.15	6.80	0.23	141.18
Region 14 (Waukesha County)	151.75	6.56	0.68	158.99

Funding

BadgerCare costs are supported with GPR, federal funding available under MA and SCHIP, premiums paid by some recipients and segregated funding available from the MA trust fund. Table 18 identifies the amounts budgeted for BadgerCare in the 2001-03 biennium. In addition to the amounts identified in Table 18, $227,000 SEG was transferred in 2001-02 and an estimated $454,000 in 2002-03 is expected to be transferred from the MA benefits appropriation to the BadgerCare appropriation to fund BadgerCare costs related to an increase in the outpatient hospital reimbursement rates enacted as part of 2001 Wisconsin Act 16 (the 2001-03 biennial budget act).

Table 18: BadgerCare Budgeted Funding -- 2001-03 Biennium

	2001-02	2002-03	Total
GPR	$43,888,900	$51,399,500	$95,288,400
FED	86,884,200	102,377,300	189,261,500
PR	2,994,400	3,293,400	6,287,800
SEG	328,500	706,700	1,035,200
Total	$134,096,000	$157,776,900	$291,872,900

MA funding is available to support approximately 59% of the costs of services for adults with income at or below 100% of the FPL. SCHIP funding is available to support approximately 71% of the costs of services for children enrolled in BadgerCare. In January, 2001, DHFS received approval of its request to waive provisions of federal law that prohibit the use of SCHIP funds for services provided to adults. Under the terms of the waiver, DHFS may claim reimbursement under SCHIP for the costs of adults with household income above 100% of the FPL. Federal funds, available under both SCHIP and MA, are estimated to fund approximately 65% of BadgerCare costs in 2002-03.

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

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

Enrollment

As of the end of November, 2002, 103,133 people were enrolled in BadgerCare, including 68,973 adults and 34,160 children. Approximately 83% of enrollees were in families that had countable income less than 150% of the FPL and therefore did not pay monthly premiums. Table 19 identifies enrollment in BadgerCare as of the end of November, 2002, by income.

Enrollment in BadgerCare has continually increased since the program's implementation. As shown in Figure 1, enrollment grew rapidly in the first year of implementation and continues to grow steadily.

A weaker economy in 2001 and 2002 likely contributed to the growth in BadgerCare enrollment during that period. Slower growth in personal income and rising unemployment rates in 2001 and 2002 suggest that more families were likely to meet the financial eligibility criteria during that time period.

It is less clear to what extent rising health care premiums contributed to enrollment growth in BadgerCare. Many employers have seen health insurance premiums for their employees increase by more than 10% per year for the first two years of this decade. Such increases are significant compared with the growth in workers' wages over that period. Many groups representing employers and national health policy experts suggest that such premiums increases cannot, or will not, be sustained by many employers, causing employers to discontinue subsidizing health insurance for their employees or decrease their contribution towards the cost of coverage.

The extent to which such actions by employers have affected or will affect BadgerCare enrollment has yet to be demonstrated. As shown in Table 20, the portion of children covered by private insurance has remained relatively stable from 1998 through 2001. If such actions occurred in 2002, the effect of such actions would not be reflected in the data included in Table 20.

Table 19: BadgerCare Enrollment -- November, 2002

Income Range Based On the % of FPL	Adults	Children	Total	% of Total
No More than 100%	28,383	n/a *	28,383	27.5%
Greater than 100% but No More than 150%	30,947	26,329	57,276	55.5
Greater than 150% but No More than 185%	8,200	6,372	14,572	14.1
Greater than 185% but No More than 200%	1,443	1,459	2,902	2.8
Total	68,973	34,160	103,133	100%

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

Table 20: Children's Health Insurance Coverage by Type, Wisconsin*

	Private Insurance	MA	Other Combination	No Insurance
1998	85%	8%	2%	4%
1999	83	7	4	6
2000	83	9	3	5
2001	84	13	n/a	3

*Percentages are rounded and may not total 100%.
Source: DHFS Bureau of Health Information

Figure 1: BadgerCare Enrollment, by Quarter -- June, 1999 - September, 2002

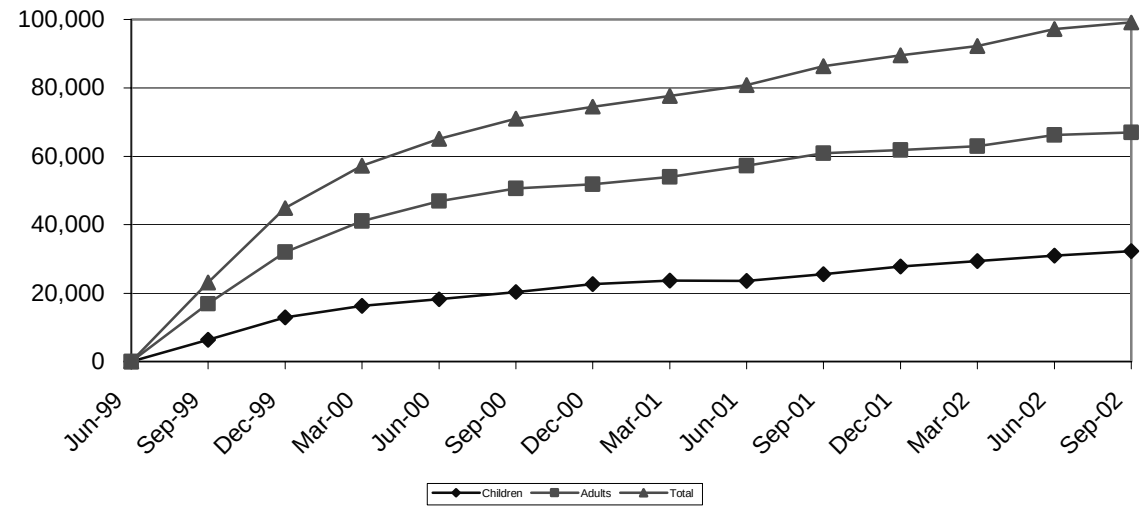

Table 21 provides historical information on MA and BadgerCare benefit expenditures, by source, for 1990-91 through 2001-02, and the percent change in expenditures from the previous year. The table shows that MA benefit expenditures increased significantly in the early 1990s but decreased to the 3% to 4% range in the mid- and late-1990s.

A number of factors may have contributed to the reduced rate of growth in program costs during the mid- and late-1990s, including: (a) increased use of managed care, which may have slowed the growth in hospital, physicians' and clinic services; (b) enactment of new federal and state divestment provisions that have tightened eligibility requirements for MA-supported nursing home services; (c) increased availability and access to lower-cost or community-based services, which may result in decreased use of inpatient hospital and nursing home services; (d) reductions in AFDC-related caseload; and (e) the use of IGT revenues to offset MA expenditures. The larger increases from 1999-00 through 2001-02 primarily reflect creation of BadgerCare and Family Care, as well as increasing costs per person.

Expenditures by Type of Enrollee

Table 22 provides information on the average number of people enrolled in each eligibility group and program expenditures for the 1992-93 through 2001-02 fiscal years. The AFDC, Healthy Start, BadgerCare and Other groups are combined in the low-income families and others group. For each year, information is provided on the total number of enrollees in each group and that group's percentage of total MA and BadgerCare recipients. Corresponding information on expenditures for each group is also provided, along with the annual average cost per enrollee.

Table 21: MA and BadgerCare Benefit Expenditures

	GPR / SEG		FED		All Funds	
Fiscal Year	Amount	% Change from Previous Year	Amount	% Change from Previous Year	Amount	% Change from Previous Year
1990-91	$659,903,700	12.1%	$995,906,600	19.4%	$1,655,810,300	16.4%
1991-92	759,254,100	15.1	1,166,618,800	17.1	1,925,872,800	16.3
1992-93	801,366,500	5.5	1,262,895,100	8.3	2,064,261,500	7.2
1993-94	834,672,500	4.2	1,368,388,000	8.4	2,203,060,500	6.7
1994-95	843,300,500	1.0	1,449,711,600	5.9	2,293,012,000	4.1
1995-96	877,119,800	4.0	1,496,161,100	3.2	2,373,281,000	3.5
1996-97	865,590,400	-1.3	1,589,367,100	6.2	2,454,957,400	3.4
1997-98	904,817,400	4.5	1,614,030,300	1.6	2,518,847,700	2.6
1998-99	927,869,500	2.5	1,677,182,600	3.9	2,605,052,100	3.4
1999-00	992,970,800	7.0	1,871,054,000	11.6	2,864,024,800	9.9
2000-01	1,051,689,181	5.9	2,100,922,567	12.3	3,152,611,748	7.3
2001-02	1,325,160,415	26.0	2,278,940,713	8.5	3,604,101,128	14.3

*1999-00 includes approximately $21.9 million GPR and $35.7 million FED for BadgerCare.
*2000-01 includes approximately $57.5 million for Family Care and $127.6 million for BadgerCare
*2001-02 includes approximately $100.8 million for Family Care and $135.7 million for BadgerCare

This information for fiscal year 2001-02 is shown graphically in Figures 2 and 3. Although low-income families and others represented 72.8% of all MA and BadgerCare enrollees in 2001-02, they accounted for only 27.8% of all MA and BadgerCare expenditures. In contrast, the elderly, who represented 7.6% of all enrollees, accounted for 29.9% of all expenditures. Disabled MA enrollees accounted for 42.3% of all expenditures in 2001-2002 although they represented only 19.6% of all enrollees. As shown in Table 22, the average annual cost per person for each group in 2001-02 was as follows: (a) elderly, $21,724; (b) disabled, $11,956; and (c) low-income families and others; $2,107.

Expenditures by Type of Service

Figure 4 provides information on MA and BadgerCare funding, by major service category, for the 2001-02 year. The table shows that spending for nursing home services, including the state centers for the developmentally disabled, accounted for 30.2% of total spending in 2001-02, while programs for community-based long term care accounted for 13.6% of total spending. Long-term care services costs represented 43.8% of all spending. Acute care spending represented 52.2% of gross expenditures.

Figure 5 shows MA and BadgerCare fee-for-service spending in 2001-02 by major acute care services categories. Inpatient hospital and net drug expenditures represent 9.1% and 11.8%, respectively, of fee-for-service acute care expenditures. Physician and clinic services, which account for 2.1% of fee-for-service acute care, is the next largest category.

Information on payments to providers in 2001-02 is illustrated in Table 23. Table 24 shows how the composition of payments has changed between 1997-98 to 2001-02. The service categories identified in Table 23 have been collapsed in Table 24 to highlight historical trends in major service areas. Tables 23 and 24 do not represent a complete picture of MA expenditures since certain miscellaneous expenditures and various offsets to program expenditures are not included.

Table 24 indicates several trends over the recent five-year period. First, payments for institutional, long-term care have grown at a very slow rate (average annual rate of 3.2%), while payments for community-based long-term care have increased at a high rate (average annual rate of 8.6%). Second, managed care has grown rapidly (21.0% average annual rate) while payments for fee-for-service non-institutional services have increased at a lesser pace (14.5% annually on average).

Table 22: MA and BadgerCare Expenditures and Enrollees by Eligibility Group

	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Elderly										
Total Expenditures	$689,135,200	$723,421,600	$767,127,000	$788,708,200	$794,906,000	$808,754,400	$823,386,200	$850,746,300	$871,232,400	$933,113,700
Percent of Total	35.9%	36.3%	36.3%	37.3%	36.6%	36.9%	36.3%	33.9%	31.6%	29.9%
Average Enrollees	53,760	53,784	53,024	50,625	48,935	47,335	45,674	44,629	43,515	42,954
Percent of Total	11.1%	10.8%	10.7%	10.6%	10.9%	11.5%	11.3%	9.8%	8.6%	7.6%
Average Cost / Person	$12,819	$13,450	$14,468	$15,579	$16,244	$17,086	$18,027	$19,063	$20,022	$21,724
Blind/Disabled										
Total Expenditures	$728,921,100	$756,974,600	$809,407,500	$808,043,000	$854,798,400	$909,117,600	$950,205,200	$1,073,025,700	$1,164,579,300	$1,317,853,600
Percent of Total	38.0%	37.9%	38.3%	38.2%	39.4%	41.5%	41.9%	42.7%	42.3%	42.3%
Average Enrollees	89,335	97,601	103,709	106,687	107,807	107,867	107,126	106,853	107,272	110,227
Percent of Total	18.4%	19.7%	20.9%	22.3%	24.0%	26.3%	26.5%	23.4%	21.2%	19.6%
Average Cost / Person	$8,159	$7,756	$7,805	$7,574	$7,929	$8,428	$8,870	$10,042	$10,856	$11,956
Low-Income Families & Others										
Total Expenditures	$501,208,200	$514,735,900	$538,410,300	$518,488,800	$521,102,000	$473,783,500	$492,713,300	$586,790,600	$720,312,600	$864,988,000
Percent of Total	26.1%	25.8%	25.5%	24.5%	24.0%	21.6%	21.7%	23.4%	26.1%	27.8%
Average Enrollees	341,108	345,175	338,478	321,744	291,666	255,053	251,098	304,354	355,731	410,575
Percent of Total	70.4%	69.5%	68.4%	67.2%	65.0%	62.2%	62.2%	66.8%	70.2%	72.8%
Average Cost / Person	$1,469	$1,491	$1,591	$1,611	$1,787	$1,858	$1,962	$1,928	$2,025	$2,107
Total Expenditures	$1,919,264,500	$1,995,132,100	$2,114,944,800	$2,115,240,000	$2,170,806,400	$2,191,655,500	$2,266,304,700	$2,510,562,600	$2,756,124,300	$3,115,955,300
Total Average Enrollees	484,203	496,560	495,211	479,056	448,408	410,255	403,898	455,836	506,518	563,756

NOTE: Data includes only expenditures made through the EDS-Federal, automated MA payment system. Certain MA expenditures that are not attributable to a specific claim or that relate to a waiver program, such as services provided under the community integration program and the community options program, are not included in these totals.

FIGURE 2

Average Monthly MA and BadgerCare Recipients by Group
Fiscal Year 2001-02

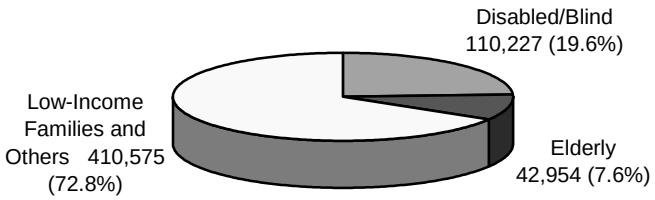

FIGURE 3

Total MA and BadgerCare Expenditures by Group
Fiscal Year 2001-02
($ In Millions)

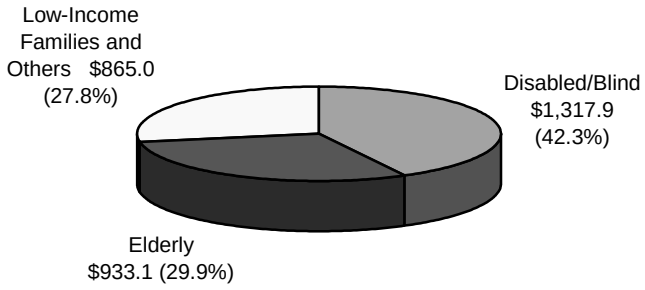

FIGURE 4

Selected Services as a Percent of Gross MA and BadgerCare Expenditures
Fiscal Year 2001-02

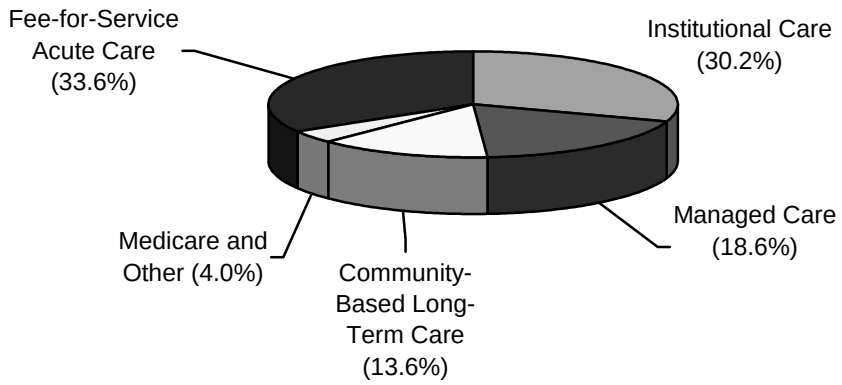

FIGURE 5

Fee-for-Service Expenditures for Acute Care Services
Fiscal Year 2001-02

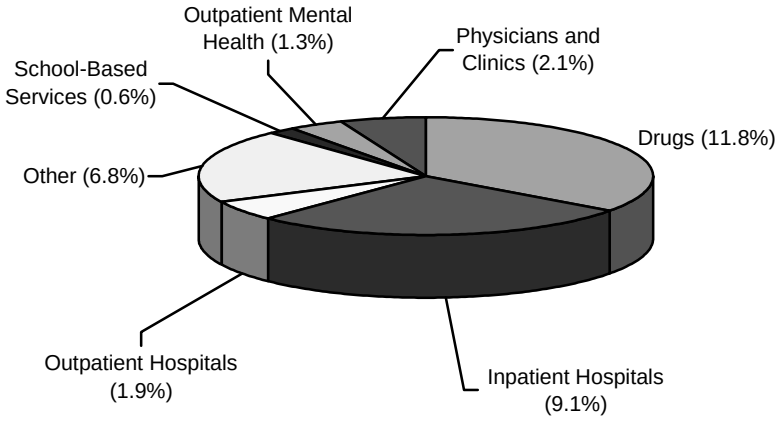

Table 23: MA and BadgerCare Benefit Expenditures, by Service Category -- Fiscal Year 2001-02

Long-Term Care Services		
Institutional Services		
Nursing Homes - SNF	$814,952,400	22.2%
Nursing Homes - ICF	64,835,200	1.8
Nursing Homes - ICFs-MR	100,790,600	2.7
State Centers	126,885,800	3.5
Subtotal	$1,107,464,000	30.2%
Community-Based Services		
CIP IA	$64,881,326	1.8%
CIP IB	159,711,124	4.4
CIP II	41,658,463	1.1
COP-Waiver	44,885,855	1.2
CSLA	821,662	0.0
Brain Injury	13,455,017	0.4
Personal Care	104,476,400	2.8
Respiratory Care Services	22,359,000	0.6
Home Health	21,586,500	0.6
Private Duty Nursing	15,203,700	0.4
Hospice	8,683,400	0.2
Subtotal	$498,663,369	13.6%
Total Long-Term Care Services	$1,606,127,369	43.8%
Acute Care Services		
Institutional Fee-for-Service Providers		
Inpatient Hospital	$333,197,900	9.1%
Outpatient Hosptial	61,730,400	1.7
Outpatient Hospital-Psychiatric	7,872,100	0.2
Subtotal	$402,800,400	11.0%
Non-Institutional Fee-for-Service Providers		
Drugs	$432,478,200	11.8%
Physicians and Clinics	78,703,500	2.1
County Matched Services	54,189,700	1.5
Outpatient Mental Health	47,813,300	1.3
DME/DMS	37,766,700	1.0
Dental	23,717,300	0.6
School Based Services	23,102,200	0.6
Laboratory and X-Ray	22,796,600	0.6
SMV Transportation	21,344,600	0.6
Other Care	19,291,700	0.5
FQHCs	17,297,000	0.5
Therapies	15,230,800	0.4
Healthcheck	12,696,200	0.3
Family Planning	7,709,000	0.2
Ambulance	4,935,600	0.1
Vision	4,314,100	0.1
Prenatal Care Coordination	2,520,100	0.1
Rural Health Clinics	2,491,000	0.1
Chiropractic	2,001,400	0.1
Subtotal	$830,399,000	22.6%
Total Acute Care Services	$1,233,199,400	33.6%
Managed Care		
Capitation Payments*	$675,169,900	18.4%
Supplemental Payments	6,672,500	0.2
Subtotal	681,842,400	18.6%
Other Provider Payments		
Medicare Crossovers - Part A	$35,159,200	1.0%
Medicare Crossovers - Part B	52,542,700	1.4
Medicare Buy-in Premiums	62,249,500	1.7
Subtotal	$149,951,400	4.1%
Total Provider Payments**	$3,671,120,569	100.0%

*Includes payments to HMOs for low-income families and payments to Family Care CMOs and other managed care programs.
**Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs/CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disturbances.

Table 24: Major MA Expenditure Categories -- Fiscal Years 1997-98 through 2001-02

Service Type	Expenditures 1997-98	1998-99	1999-00	2000-01	2001-02	Percent Change Over Previous Year 1998-99	1999-00	2000-01	2001-02	Ave. Annual Percentage Change
Long-Term Care Services										
Institutional Services										
Nursing Homes	$872,222,500	$888,329,100	$906,281,500	$916,181,000	$980,578,200	1.8%	2.0%	1.1%	7.0%	3.0%
State Centers	105,327,600	100,861,800	135,932,400	115,304,000	126,885,800	-4.2	34.8	-15.2	10.0	6.4
Subtotal	$977,550,100	$989,190,900	$1,042,213,900	$1,031,485,000	$1,107,464,000	1.2%	5.4%	-1.0%	7.4%	3.2%
Community-Based Services										
Waivers	$243,427,989	$262,790,277	$325,929,862	$316,190,944	$326,354,369	8.0%	24.0%	-3.0%	3.2%	8.1%
Home Health	23,515,300	25,401,700	24,138,900	22,165,700	21,586,500	8.0	-5.0	-8.2	-2.6	-1.9
Personal Care	62,214,100	66,951,700	74,380,800	100,427,700	104,476,400	7.6	11.1	35.0	4.0	14.4
Other Home Care	31,876,100	34,868,600	40,126,600	44,238,800	46,246,100	9.4	15.1	10.2	4.5	9.8
Subtotal	$361,033,489	$390,012,277	$464,576,162	$483,023,144	$498,663,369	8.0%	19.1%	4.0%	3.2%	8.6%
Total Long-Term Care Services	$1,338,583,589	$1,379,203,177	$1,506,790,062	$1,514,508,144	$1,606,127,369	3.0%	9.3%	0.5%	6.0%	4.7%
Acute Care Services										
Institutional Fee-for-Service										
Inpatient Hospital	$253,100,400	$238,242,900	$270,613,700	$297,828,400	$333,197,900	-5.9%	13.6%	10.1%	11.9%	7.4%
Outpatient Hospital	49,375,300	48,399,600	55,267,900	58,663,600	69,602,500	-2.0	14.2	6.1	18.6	9.3
Subtotal	$302,475,700	$286,642,500	$325,881,600	$356,492,000	$402,800,400	-5.2%	13.7%	9.4%	13.0%	7.7%
Non-Institutional Fee-for-Service										
Drugs	$224,904,000	$259,343,900	$336,550,300	$373,633,800	$432,478,200	15.3%	29.8%	11.0%	15.7%	18.0%
Physicians	57,429,800	53,318,600	63,184,200	72,401,200	78,703,500	-7.2	18.5	14.6	8.7	8.7
Outpatient Mental Health	23,293,900	27,663,500	35,205,200	40,625,400	47,813,300	18.8	27.3	15.4	17.7	19.8
DME/DMS	29,967,500	30,721,700	32,187,500	33,970,100	37,766,700	2.5	4.8	5.5	11.2	6.0
Dental	14,719,200	14,877,500	19,645,600	21,601,600	23,717,300	1.1	32.0	10.0	9.8	13.2
SMV Transportation	28,783,900	25,800,500	24,681,200	21,899,900	21,344,600	-10.4	-4.3	-11.3	-2.5	-7.1
Other	106,043,500	121,824,400	140,117,300	161,970,100	188,575,400	14.9	15.0	15.6	16.4	15.5
Subtotal	$485,141,800	$533,550,100	$651,571,300	$726,102,100	$830,399,000	10.0%	22.1%	11.4%	14.4%	14.5%
Total Acute Care Services	$787,617,500	$820,192,600	$977,452,900	$1,082,594,100	$1,233,199,400	4.1%	19.2%	10.8%	13.9%	12.0%
Managed Care Payments*	$323,550,400	$339,017,800	$394,389,300	$523,590,900	$681,842,400	4.8%	16.3%	32.8%	30.2%	21.0%
Medicare Premiums and Payments	$124,996,100	$127,813,700	$131,260,600	$131,946,200	$149,951,400	2.3%	2.7%	0.5%	13.6%	4.8%
Total Provider Payments**	$2,574,747,589	$2,666,227,277	$3,009,892,862	$3,252,639,344	$3,671,120,569	3.6%	12.9%	8.1%	12.9%	9.3%

*Includes payments to HMOs for low-income families and payments to Family Care CMOs and other managed care programs.

** Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs/CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disturbances.

APPENDIX

Medical Assistance Waiver Services*

CIP IA, CIP IB, BIW, CSLA, CIP II and COP Waivers

Service	CIP IA CIP IB	BIW	CSLA	COP-W CIP II
Adaptive aids include devices, controls or appliances which enable individuals to increase their ability to perform activities of daily living independently.	Yes	Yes	Yes	Yes
Adult day care provides social or health-supportive services for part of a day in a group setting.	Yes	No	No	Yes
Adult family home is a residence in which care and maintenance above the level of room and board, but not including nursing care, are provided to three or four residents by a person whose lives in the home.	Yes	Yes	No	Yes
Case management includes the planning and coordination of an individual's program plan, along with advocacy and defense services, outreach, and referral.	Yes	Yes	Yes	Yes
Children's foster home is a loving, caring and supportive substitute family for one to four children.	Yes	Yes	No	Yes
Communication aids/interpreter services are devices or services to assist individuals with hearing, speech or vision.	Yes	Yes	Yes	Yes
Community-based residential facility is a residence for five or more unrelated adults that provides care, treatment or services above the level of room and board.	Yes	Yes	No	Yes
Consumer directed supports are services that provide support, care and assistance to an individual with a disability, prevent the person's institutionalization and allow the person to live an inclusive life. Consume-directed supports are designed to build, strengthen or maintain informal networks of community support for the person.	Yes	No	Yes	No
Consumer training and education help a person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.	Yes	No	Yes	No
Counseling and therapeutic resources provide treatment oriented services for a personal, social, behavioral, mental or alcohol or drug abuse disorder.	Yes	Yes	Yes	Yes
Daily living skills training include services intended to improve a client's or caretaker's ability to perform routine daily living tasks and utilize community resources.	Yes	Yes	Yes	Yes
Day services include activities to enhance social development.	Yes	Yes	No	Yes
Home modifications include changes to ensure accessibility and safety of the individual's home (such as ramps, lofts, door widening and other physical alterations).	Yes	Yes	Yes	Yes

Service	CIP IA CIP IB	BIW	CSLA	COP-W CIP II
Home delivered meals is the provision of meals to individuals at risk of institutional care due to inadequate nutrition. Individuals who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician. Home delivered meals cannot meet the full daily nutritional needs of an individual.	No	No	No	Yes
Housing counseling provides assistance in acquiring housing in the community, where ownership or rental of housing is separate from service provision.	Yes	No	Yes	No
Nursing services are medically necessary skilled nursing services that cannot be provided safely and effectively without the skills of an advance practice nurse, a registered nurse or a licensed practical nurse under the supervision of a registered nurse. Nursing services may include, but are not limited to, periodic assessments of a participant's medical condition and monitoring when the evaluation requires a skilled nurse and the monitoring of a participant with a history of non-compliance with medical needs. Nursing services that are covered as an MA card service are not eligible under the waiver program.	No	No	No	Yes
Personal emergency response systems (PERS) are community-based electronic communications devices activated by the consumer in the event of a physical, emotional or environmental emergency.	Yes	Yes	Yes	Yes
Prevocational services include teaching and activities related to concepts to prepare an individual for paid or unpaid employment such as work directions and routines, mobility training, interpersonal skills development and transportation to and from work.	Yes	Yes	No	No
Protective payment/guardianship services involve managing the client's money or supervising the client's use of funds. Services are provided to individuals who have an agency as guardian and/or who have demonstrated a lack of ability to use their funds properly.	No	No	No	Yes
Residential care complex is a residence for 5 or more adults that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, and individual bathroom, sleeping and living areas, and that provides not more than 28 hours per week of supportive, personal and nursing services.	No	No	No	Yes
Respite care services provide temporary relief to the primary caregiver.	Yes	Yes	Yes	Yes
Supported employment services include individualized assessments, job development and placement, on-the-job training, performance monitoring, and related support and training to enhance employment.	Yes	Yes	Yes	No
Supportive home care are services to maintain individuals in independent or supervised living situations.	Yes	Yes	Yes	Yes

Service	CIP IA CIP IB	BIW	CSLA	COP-W CIP II
Specialized transportation are services to improve access to needed community services and the ability to perform tasks independently.	Yes	Yes	Yes	Yes

*Services vary from one waiver to another in terms of scope, frequency, duration and other limitations.

Note: CIP IA and CIP IB funds services for individuals who are relocated from the state centers for the developmentally disabled (CIP IA) and individuals who are relocated or diverted from other intermediate care facilities for the mentally retarded (CIP IB). The brain injury waiver (BIW) program funds services to individuals with brain injuries who require post acute rehabilitation institutional care. The community supported living arrangements (CSLA) funds services from certain individuals with developmental disabilities who live at home. The community options waiver program (COP-W) and the community integration program (CIP II) provide community based services for elderly and physically disabled individuals.