Medical Assistance and Related Programs

(BadgerCare Plus, Family Care, Senior Care)

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

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

States receive federal matching funds to partially support these covered services. The federal medical assistance percentage (FMAP) is the portion of the total payment supported by these federal matching funds. Each state's FMAP is calculated annually under a formula that compares a three-year average of the state's per capita income to national per capita income. In state fiscal year 2014-15, Wisconsin's standard FMAP is approximately 58%, although costs related to certain services and certain enrollees can qualify for higher federal matching rates.

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

In addition to these two main MA components, the program has several subprograms that provide limited benefits, targeted to certain persons who are not otherwise eligible for EBD Medicaid or BadgerCare Plus. These include: (a) SeniorCare, which provides prescription drug assistance to persons age 65 and over; (b) the family planning only services program, which provides coverage for contraceptive services and testing and treatment for sexually transmitted diseases; and (c) the well woman program, which provides treatment to women diagnosed with cervical or breast cancer.

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

List of Common Acronyms

ACA	Patient Protection and Affordable Care Act of 2010
ARRA	American Recovery and Reinvestment Act of 2009
CHIP	Children's Health Insurance Program
CIP	Community Integration Program
CLTS	Children's Long-Term Support Program
CMS	Centers for Medicare and Medicaid Services (Federal)
COP	Community Options Program
DHCAA	Division of Health Care Access and Accountability (State)
DLTC	Division of Long-Term Care (State)
DHS	Department of Health Services (State)
DHHS	Department of Health and Human Services (Federal)
DQA	Division of Quality Assurance
EBD	Elderly, Blind and Disabled
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
HMO	Health Maintenance Organization
ICF-ID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IM	Income Maintenance
IMD	Institution for Mental Disease
IRIS	Include, Respect, I Self-Direct
MA	Medical Assistance
MAPP	Medical Assistance Purchase Plan
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income

CHAPTER 1

EXPENDITURE AND ENROLLMENT TRENDS

This chapter provides information on total MA expenditures and participation in recent years. Other chapters provide additional detail on specific expenditure or eligibility categories, and on SeniorCare. Total MA expenditures and caseloads have increased significantly over the past decade, due to program eligibility changes and effects of the recent economic recession. Table 1.1 shows total (all funds) MA expenditures and average monthly enrollment for state fiscal years 2004-05 through 2013-14.

Table 1.1: MA Expenditures and Participation

	Expenditures ($ in Millions)	Average Monthly Enrollment
2004-05	$4,453.9	741,000
2005-06	4,421.4	761,300
2006-07	4,692.3	765,500
2007-08	4,950.7	801,100
2008-09	5,944.9	894,500
2009-10	6,696.1	1,042,500
2010-11	7,181.7	1,098,000
2011-12	6,597.2	1,112,700
2012-13	7,187.7	1,104,100
2013-14	8,115.4	1,098,700

Expenditure Trends

Table 1.2 provides information on benefit expenditures under the state's MA and MA-related programs, by fund source, from state fiscal year 2009-10 through 2013-14. The four main sources of funding for the program are the following: (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG), which are primarily generated by assessments; and (d) program revenues (PR), such as rebates from drug manufacturers and premiums paid by certain participants. Chapter 2 describes these funding sources in more detail.

Table 1.2 shows how the relative contributions made by the funding sources have changed in recent years, including several noteworthy shifts. First, the large FED decrease in 2011-12 from the previous year resulted from the end of temporary additional federal funding provided to states under the American Recovery and Reinvestment Act of 2009 (ARRA). This additional funding was provided as an increase in the percentage of program costs covered by the federal government (the federal medical assistance percentage, or "FMAP"). Under ARRA and subsequent federal legislation, the state's FMAP reverted from the enhanced FMAP of approximately 69% to the normal formula-based rate of approximately 60% on July 1, 2011, which is reflected in the reduction in FED expenditures in 2011-12 from the previous year. The decline in total program expenditures in 2011-12 compared to the prior year is primarily due to a shift of approximately $430 million of payments from 2011-12 to 2010-11 in order to take advantage of these higher federal matching rates.

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

Table 1.2: MA Benefit Expenditures by Fund Source

	2009-10	2010-11	2011-12	2012-13	2013-14
GPR	$1,285,958,000	$1,446,356,000	$1,863,950,600	$2,072,332,900	$2,298,313,300
FED	4,675,132,000	4,960,883,300	3,979,299,400	4,359,848,500	4,607,116,200
PR	99,959,300	108,010,200	112,650,600	124,301,200	592,588,900
SEG	635,098,700	666,488,300	641,254,500	631,246,000	617,347,100
Total	**$6,696,148,000**	**$7,181,737,800**	**$6,597,155,100**	**$7,187,728,600**	**$8,115,365,500**

benefit costs, and proportionately reduced the amount of GPR and FED needed to fund the program. However, based on recommendations from the Legislative Audit Bureau, 2013 Act 20 (the 2013-15 budget act) created several new appropriations that are directly funded from these PR sources. As a result, the inclusion of these PR amounts provides a more accurate accounting of program's total expenditures.

One other way that the program funding structure has changed over the past decade is the increased use of segregated funds and provider assessments to fund the MA program. The state has recently created assessments on hospitals, critical access hospitals, and ambulatory surgical centers to fund additional MA payments to these providers and to generate SEG funding to offset GPR costs. In 2013-14, the state collected $414.5 million from hospitals, $8.8 million from critical access hospitals, and $16.6 from ambulatory surgical centers to support additional "access payments" to those providers and supplement GPR budgeted for the program.

As described in following chapters, MA recipients receive program benefits either on a fee-for-service basis or through managed care organizations (MCOs) and health maintenance organizations (HMOs) that receive monthly capitation payments for each participant they serve. Table 1.3 shows total net MA benefit expenditures in 2013-14 broken out as follows: (a) total capitation payments made to the various MCOs and HMOs; and (b) the 12 service categories that account for the largest share of fee-for-service expenditures.

The expenditure totals shown in Table 1.3 for the fee-for-service categories reflect only those services provided on that basis, and do not include the portion of the capitation payments attributable to the cost of services for participants in managed care. For example, in 2013-14, the state paid approximately $222.0 million (all funds) for physician and clinic services delivered on a fee-for-service basis. HMO enrollees also receive physician and clinic services, but reimbursement for those services is part of the monthly capitation rates paid to those enrollees' HMOs.

Program Participation

After a period of rapid growth beginning in 2008, total MA enrollment has plateaued somewhat in recent years, due to a mix of economic factors and program eligibility changes. Table 1.4 provides average monthly enrollment, by eligibility category, from 2009-10 through 2013-14.

BadgerCare Plus enrollment is particularly sensitive to the lower incomes and reduced access to employer-sponsored health insurance that occurs during an economic downturn. Consequently, the economic impact of the 2008 financial crisis and recession led to large increases in BadgerCare Plus enrollment. Eligibility changes enacted with the creation of BadgerCare Plus, effective January 1, 2008, also resulted in significant enrollment increases.

Table 1.3: Managed Care Capitation Payments and Fee-For-Service Expenditures, Fiscal Year 2013-14*

	Expenditures ($ in Millions)	% of Total
Managed Care Capitation Payments		
BadgerCare Plus Health Maintenance Organizations (HMOs) *	$1,529.6	19.0%
Family Care Managed Care Organizations (MCOs)	1,295.8	16.1
SSI Managed Care HMOs *	256.4	3.2
PACE/Partnership Programs	138.9	1.7
Other	26.9	0.3
Total	**$3,247.6**	**40.4%**
Twelve Largest Fee-For-Service Expenditure Categories		
Inpatient and Outpatient Hospitals*	$791.7	9.9%
Nursing Homes	770.0	9.6
Prescription Drugs	710.6	8.8
Long-Term Care Waiver Programs (Legacy Waiver Programs)	511.9	6.4
MA Home Care (including Home Health, Personal Care, and Hospice)	377.3	4.7
Medicare Premiums and Cost-Sharing	274.8	3.4
Physicians/Clinics	222.0	2.8
Clawback Payments to CMS (100% GPR)	178.4	2.2
Federal Funds Claimed on Certain County-Supported Services	174.2	2.2
Federally Qualified Health Centers	135.1	1.7
State Centers for Persons with Developmental Disabilities	128.3	1.6
Health Information Technology Incentive Payments (100% FED)	58.5	0.7
Total	**$4,332.7**	**54.0%**
All Other Fee-for-Service Expenditures	$450.1	5.6%
Total Benefit Expenditures**	**$8,030.4**	**100.0%**

*Includes hospital access payments and other supplemental payments.
**Total does not equal expenditure total in Table 1.2 due to differences in the accounting system used to track expenditures by category.

In some cases, as with the BadgerCare Plus core plan, enrollment changed as a result of the state's decision to expand or reduce coverage levels. Two recent eligibility changes relate to childless adults and parents. First, beginning in July, 2009, the BadgerCare Plus Core Plan, created under a waiver of federal law, began enrolling childless adults with incomes up to 200% of the federal poverty level (FPL). Enrollment in that program grew much more rapidly than originally anticipated, and DHS stopped accepting new enrollees in that program in October, 2009. That enrollment cap remained in effect, and the number of childless adults in the program slowly decreased. The 2013-15 biennial budget act and subsequent legislation effectively lifted that enrollment cap for childless adults on April 1, 2014, and provided full BadgerCare Plus coverage to childless adults with incomes up to 100% of the FPL. As of September, 2014, approximately 125,000 childless adults were enrolled in the program.

At the same time that the state extended coverage to childless adults with household income up to 100% of the FPL, the same legislation reduced income eligibility levels for parents and caretaker relatives from 200% to 100% of the FPL, effective April 1, 2014. This resulted in approximately 63,000 parents and caretakers with household income over 100% of the FPL losing access to BadgerCare Plus coverage. However, these individuals had income levels that would have qualified them for subsidies to purchase private coverage through the federal health insurance exchange created under the federal Patient

Table 1.4: Average Monthly Enrollment in MA and MA-Related Programs

	2009-10	2010-11	2011-12	2012-13	2013-14
BadgerCare Plus					
Children	442,300	466,900	477,300	479,400	478,100
Parents and Caretakers	241,000	258,600	264,000	251,500	229,000
Pregnant Women	21,000	21,400	21,000	20,700	21,100
Childless Adults	56,000	45,100	28,800	20,300	39,100
Total BadgerCare Plus	**760,300**	**792,000**	**791,100**	**771,900**	**767,300**
% Change		*4.2%*	*-0.1%*	*-2.4%*	*-0.6%*
Elderly, Blind and Disabled (EBD)					
Elderly	37,900	37,500	36,900	35,900	34,800
Disabled					
MA Only	85,300	88,600	90,800	93,300	94,400
MA/Medicare Dual Eligibles	75,600	80,500	85,800	89,300	92,500
Subtotal, Disabled	160,900	169,100	176,600	182,600	186,900
Total EBD	**198,800**	**206,600**	**213,500**	**218,500**	**221,700**
% Change		*3.9%*	*3.3%*	*2.3%*	*1.5%*
Other Groups					
Family Planning Only Services	50,100	58,900	67,300	72,900	69,800
Limited Benefit Medicare Beneficiaries	15,800	18,100	19,600	20,400	21,500
Foster Children	16,800	17,200	17,300	17,800	16,700
Well Woman MA	700	800	900	1,000	900
Basic Plan	0	4,400	3,000	1,600	800
Total Other	**83,400**	**99,400**	**108,100**	**113,700**	**109,700**
% Change		*19.2%*	*8.8%*	*5.2%*	*-3.5%*
Total MA Enrollment	**1,042,500**	**1,098,000**	**1,112,700**	**1,104,100**	**1,098,700**
% Change		*5.3%*	*1.3%*	*-0.8%*	*-0.5%*

Protection and Affordable Care Act (ACA). The combined eligibility changes for childless adults and parents is referred to as a "partial expansion" of BadgerCare Plus under the ACA, and is discussed further in Chapter 4.

Beginning in 2007-08, the state began the phased-in statewide expansion of the Family Care program. Family Care enrollment is not shown separately in Table 1.4. Instead, Family Care enrollees are included within the larger "Elderly" and "Disabled" enrollment categories.

Cost Per Enrollee

Table 1.5 shows the per-member per-month (PMPM) costs for each of the major eligibility categories in the MA program for 2013-14. The table does not include supplemental payments to providers, drug rebates, payment recoveries and collections, or payments to providers that occur outside of standard fee-for-service or capitation payments. For this reason, Table 1.5 provides a relative comparison of per member costs associated with different MA groups, and should be viewed as approximate costs for the various groups. As the table shows, individuals receiving EBD long-term care services have the highest PMPM costs of the various MA eligibility groups. Conversely, children enrolled in BadgerCare Plus, the largest MA group by enrollment, have relatively low PMPM costs compared to other full-benefit MA enrollees.

Table 1.5: Per Member Per Month Costs, by Eligibility Category, 2013-14

BadgerCare Plus**	
Children	$128.64
Parents and Caretakers	284.03
Pregnant Women***	456.90
Childless Adults	402.49
EBD Medicaid	
Elderly****	$2,290.11
Disabled	
MA Only	1,549.45
MA/Medicare Dual Eligibles****	1,500.28
Other Groups	
Family Planning Only Services	$25.54
Qualified Medicare Beneficiaries (QMB)	157.09
Specified Low-Income Medicare Beneficiaries (SLMB)	106.81
Foster Children	364.77
Well Woman MA	1,462.60
Basic Plan	215.83

*Does not include supplemental payments to providers, drug rebates, collections, or payments to providers that occur outside of the standard fee-for-service or capitation payments.

**Standard plan PMPMs only.

***PMPM for pregnant women does not include supplemental payments to HMOs for labor and delivery.

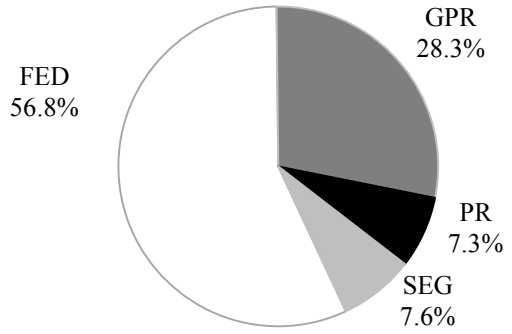
****Does not include Medicare Part B premiums.

CHAPTER 2

FUNDING SOURCES

This chapter provides additional information about revenues that fund MA benefits costs. The four main sources of funding are the following: (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG) generated by specific assessments or programs; and (d) program revenues (PR), such as rebates from drug manufacturers and premiums paid by certain participants. Figure 2.1 shows the proportion of the total MA budget supported by each of these funding categories in state fiscal year 2013-14.

Figure 2.1: Percentage of Total MA Spending, by Fund Source, 2013-14



General Purpose Revenue (GPR)

To claim federal funds for benefits provided under the program, the MA program must provide the non-federal amount. In Wisconsin, as in other states, that non-federal share is funded primarily by revenues deposited to the state's general fund (general purpose revenue). Funding for MA benefits is the second-largest GPR commitment in Wisconsin's budget, behind aids to school districts.

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

Federal Matching Funds (FED)

Federal matching funds constitute the single largest funding source for Wisconsin's MA program. Those federal funds are provided through a matching rate based on the state's federal medical assistance percentage, or FMAP. Each state's FMAP is adjusted annually based on a formula in federal law that compares the state's per capita income to national per capita income. Under that formula, Wisconsin's standard FMAP has tended to be approximately 60%, meaning that federal matching funds have typically supported approximately sixty cents of each dollar the MA program spends on benefits costs.

Wisconsin's standard FMAP for federal fiscal year 2014-15 (the period from October 1, 2014, through September 30, 2015) equals 58.27%. Higher FMAPs apply for certain enrollees and certain services. Most notably, the federal Children's Health Insurance Program (CHIP) provides enhanced federal funding to fund services for children in households with income above 100% of the FPL. With this enhanced funding, the state's FMAP for services provided to these children in federal fiscal year 2014-15 is 70.79%.

Although Wisconsin's FMAP does not generally fluctuate greatly from year to year, small

Table 2.1: Wisconsin's Federal Medical Assistance Percentages

FFY	Standard FMAP*	FMAP for CHIP
2011-12	60.53%	72.37%
2012-13	59.74	71.82
2013-14	59.06	71.34
2014-15	58.27	70.79

changes in the percentage can have large effects on the state's MA budget due to the total size of the program. Table 2.1 provides the standard FMAP, and the FMAP that applied to expenditures under CHIP, that Wisconsin received from federal fiscal year 2011-12 through 2014-15.

Federal legislation has, on occasion, temporarily increased states' FMAPs during economic downturns. The most recent temporary increase occurred under the American Recovery and Reinvestment Act of 2009 (ARRA), which increased Wisconsin's FMAP during the period October 1, 2008 through December 31, 2010, and was extended to June 30, 2011 under subsequent federal legislation (P.L. 111-226). The additional FED Wisconsin received as a result of those enhanced FMAPs temporarily reduced the amount of state funding that otherwise would have been needed to support MA enrollment increases that occurred during that period. On July 1, 2011, Wisconsin reverted to the standard formula-based FMAP of approximately 60%.

Segregated Funds (SEG)

In addition to GPR, Wisconsin funds the state share of MA benefits with segregated (SEG) funds generated from several sources. SEG revenues are credited to funds separate from the state's general fund, and may only be used for the statutorily-defined purpose of these funds. The primary SEG funding sources are provider assessments (also known as provider taxes), certified public expenditure (CPE) programs, and intergovernmental transfers (IGTs).

The main segregated fund that supports the MA program is the medical assistance trust fund (MATF). Table 2.2 shows MATF revenues and expenditures for state fiscal years 2012-13 and 2013-14, and projected revenues and expenditures for 2014-15. Revenues to the fund are described below.

Hospital Assessment. 2009 Wisconsin Act 2 authorized DHS to collect an assessment from most hospitals in the state, excluding several types of hospitals such as critical access hospitals and institutions for mental disease. The purpose of the assessment is to return a portion of the assessment, plus additional federal matching funds, to hospitals through increased MA payment rates, and use the remaining SEG revenue to supplement GPR funding for the MA program as a whole. The total annual amount of the assessment is established in statute ($414,507,300 in 2013-14 and 2014-15), with each hospital's assessment based on a uniform percentage of that hospital's gross patient revenues. In 2014-15, the assessment equaled approximately 1.19% of each hospital's gross patient revenues.

Revenues collected from the assessment are deposited to the hospital assessment trust fund. From that fund, a portion of the revenues (along with federal matching dollars) are used to fund MA payments to hospitals for providing inpatient and outpatient services to MA recipients. The additional aggregate payment amount hospitals receive through the assessment is established by a statutory formula which divides the total assessment amount ($414.5 million) by a statutorily-set factor (0.6168). In 2013-14, that formula resulted in additional MA reimbursement of approximately $672.0 million. Thus, the aggregate "net" gain to eligible hospitals in fiscal year 2013-14 from the hospital assessment was approximately $257.5 million ($672.0 million in additional reimbursement received minus the

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

	Actual 2012-13	Actual 2013-14	Projected 2014-15
Beginning Balance	**$10,058,200**	**$0**	**$0**
Revenues			
Provider Assessments			
Hospital Assessment*	$153,057,200	$151,939,900	$134,723,900
Nursing Home/ICF-ID Bed Assessment**	78,464,700	76,512,500	74,388,900
Ambulatory Surgical Center Assessment**	16,624,300	16,616,600	16,600,000
Critical Access Hospital Assessment*	0	2,548,200	1,644,100
Subtotal	$248,146,200	$247,617,200	$227,356,900
Federal MA Funds Deposited to MA Trust Fund			
Nursing Home Certified Public Expenditure Program	$47,725,500	$24,705,600	$35,134,200
Intergovernmental Transfer from UW System	7,331,400	15,955,100	14,419,200
HealthCheck-Eligible Services - Residential Care Centers	5,500,000	8,000,000	6,945,600
Hospital Certified Public Expenditure Program	6,162,500	5,178,000	5,400,000
Subtotal	$66,719,400	$53,838,700	$61,899,000
Other			
Transfer from Permanent Endowment Fund	$50,000,000	$50,000,000	$50,000,000
Interest Paid to the General Fund	-54,200	-32,300	-$100,000
Total Revenue	**$364,811,400**	**$351,423,600**	**$339,155,900**
Expenditures	**$374,869,600**	**$351,423,600**	**$339,155,900**
Ending Balance	**$0**	**$0**	**$0**

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

$414.5 in assessments paid). Since the benefit to hospitals is provided through increased MA reimbursement, hospitals with proportionately larger MA caseloads benefit to a greater degree than hospitals with fewer MA patients.

For MA recipients served on a fee-for-service basis, hospitals receive this increased reimbursement directly through the program's fee-for-service hospital payment rates. For MA recipients enrolled in HMOs, DHS makes monthly "access payments" to each HMO based on how many of their enrollees are MA recipients. The HMOs, in turn, distribute those access payments to eligible hospitals based on the number of inpatient stays and outpatient visits those hospitals provided to MA enrollees during the preceding month.

Most of the assessment revenue not used to increase MA reimbursement to hospitals is transferred to the MATF to support general MA benefits costs, reducing the amount of GPR that would otherwise be required to fund those services. In addition, 0.5% of the assessment revenue that remains after the payments to hospitals is used to fund MA administrative costs. In 2013-14, $151.9 million in hospital assessment revenues were transferred to the MATF and used to support the overall MA program. Table 2.3 shows the annual assessment amount, the amount paid to hospitals in increased MA reimbursement, and the amount credited to the MATF in fiscal years 2011-12 through 2013-14.

Table 2.3: Hospital Assessment Collections and Distributions ($ in Millions)

	Total Revenue Collected from Hospitals	Increased MA Reimbursement to Paid to Hospitals (SEG and FED)			Amount Used to Fund General MA Costs (SEG)
		SEG	FED	Total	
2011-12	$414.5	$267.0	$405.0	$672.0	$146.8
2012-13	414.5	260.6	411.4	672.0	153.1
2013-14	414.5	261.0	411.0	672.0	151.9

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

For private-pay residents, a nursing home may elect to include the assessment in their bill, either in the overall rate or as a separate amount. However, the current method DHS uses to reimburse nursing homes for the care they provide to MA recipients includes a component to offset, in the aggregate, the total estimated costs nursing homes incur to pay the nursing home assessment.

In addition, the state collects a bed assessment on all beds in intermediate care facilities for persons with intellectual disabilities (ICFs-ID) in the state. Prior to July 1, 2013, the state calculated the ICF-ID assessment by multiplying the total gross annual revenues of all ICFs-ID in the state by 5.5% (the maximum allowable federal rate for provider assessments), then dividing by the total number of licensed beds in the state. This formula was repealed in the 2013-15 biennial budget, and the assessment was statutorily set at $910 per bed per month.

All revenues generated from the nursing home and ICF-ID bed assessment are deposited in the MATF. In 2013-14, those revenues totaled approximately $76.5 million. The state has used SEG revenues from the nursing home bed assessment and associated federal matching funds, in part, to fund rate increases for nursing homes and to replace GPR funding for general MA benefits.

Ambulatory Surgical Center Assessment. Federal regulations define an ambulatory surgical center (ASC) as any distinct entity that operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization, with the expected duration of services not exceeding 24 hours following an admission. State law authorizes the Wisconsin Department of Revenue (DOR) to collect an assessment on the gross patient revenues of ASCs located in Wisconsin consistent with federal regulations, which generally limit those provider assessments to 5.5% of the applicable patient revenues.

In 2013-14, DOR collected and transferred to the MATF approximately $16.6 million in ASC assessment revenues. Those assessment revenues, along with federal matching dollars, were used to fund $20.0 million ($8.2 million SEG and $11.8 million FED) in additional reimbursement to ASCs that serve MA patients. The balance of the ASC assessment revenues not used for that purpose ($8.4 million) were used to support other MA benefit expenditures.

Critical Access Hospital Assessment. State law and federal law, define a CAH as a hospital with no more than 25 beds used exclusively for acute inpatient care located outside of a metro-

politan statistical area (or located in a rural area of an urban county), or located more than a 35-mile drive from another hospital. Before January 1, 2006, a hospital could also be certified as a CAH if the state designated it as a "necessary provider" of health care services to residents in the area. While this latter certification is no longer available, hospitals that obtained CAH status by this necessary provider status prior to January 1, 2006, can retain their CAH certification even if they do not satisfy the 35-mile distance requirement. There are currently 58 CAHs in Wisconsin.

The CAH assessment works similarly to the larger hospital assessment, except that the CAH assessment is based on gross *inpatient* revenues rather than total gross *patient* revenues, and the total amount of the CAH assessment is determined as a percentage of the larger hospital assessment, rather than a statutorily set dollar amount.

In 2013-14, the CAH assessment generated revenues of $8.8 million, a portion of which, when combined with federal matching funds, funded $14.2 million in additional MA reimbursement payments to CAHs. The remaining assessment revenues were used for the earmarked items or transferred to the MATF to support MA benefit expenditures.

Nursing Home Certified Public Expenditure Program. DHS requested and received CMS approval to create a certified public expenditure (CPE) program under which the state receives federal MA matching funds based on unreimbursed costs county and local government facilities incur to provide nursing home care to MA recipients. All federal revenue the state collects under this nursing home CPE program is deposited to the MATF. In 2013-14, those revenues totaled $24.7 million.

For federal matching funds generated by the nursing home CPE, DHS must distribute any funds that the state receives in a fiscal year that are in excess of the amount set in the biennial budget. DHS currently distributes these funds, when available, as additional supplemental payments to nursing homes owned and operated by local governments. No excess CPE payment was made in 2013-14, as actual collections fell below the budgeted amount.

UW Intergovernmental Transfer Program. State law requires the UW System to transfer no more than $20,338,500 annually in program revenue from its general operations appropriation to the MATF. In 2013-14, the UW System transferred $16.0 million under this provision. These funds represent a portion of the federal MA matching funds generated by the supplemental MA reimbursement rates paid to UW physicians for services they provide to MA recipients. The non-federal share of the supplemental reimbursement payments is funded by the UW through an IGT payment to the MA program.

HealthCheck Services Provided by RCCs. In fiscal year 2004-05, the state began claiming federal MA matching funds for MA-eligible services provided to children in residential care centers (RCCs) under the state's early and periodic screening, diagnosis, and treatment services (EPSDT) benefit, which is called HealthCheck in Wisconsin. The non-federal share of these costs is not paid by the state, but rather by counties through a combination of community aids, youth aids, and local tax revenues. In 2013-14, $8.0 million in federal matching funds associated with these costs were deposited into the MATF.

UW Hospital Certified Public Expenditure Program. Under a separate CPE program, DHS submits claims for federal matching funds in an amount equal to the deficit the University of Wisconsin's hospital incurs to provide services to MA recipients. In 2013-14, this CPE program generated $5.2 million in federal matching funds that were deposited to the MATF.

Transfer from Permanent Endowment Fund. The permanent endowment fund is a nonlapsible trust fund that received the proceeds of

the sale of the state's rights to receive tobacco settlement payments. State law requires a $50 million annual transfer from the permanent endowment fund to the MATF. Additional information on this fund is provided in the Legislative Fiscal Bureau's informational paper entitled "Tobacco Settlement and Securitization and Repurchase Transactions."

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

Program Revenues (PR)

Program revenues include rebates from drug manufacturers, premiums collected from certain program participants, and other collections or recoveries.

Drug Manufacturer Rebates. Under federal law, a drug manufacturer must enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services in order for states to receive federal MA matching funds for outpatient drugs dispensed to MA patients. In 2013-14, these federally mandated rebates, along with supplemental drug rebates negotiated by the state, totaled $324.3 million. Those rebates are used to proportionately offset GPR and FED needed to fund MA benefits.

As discussed in Chapter 1, the 2013-15 biennial budget changed the way that the state accounts for these PR amounts, as well as making other changes to the organization of the MA appropriations. These changes were made in response to recommendations to improve program transparency in a 2011 Legislative Audit Bureau report on the program. Prior to that legislation, drug manufacturer rebates reduced state and federal expenditures, but did not appear as an expenditure in the state budget. After this change, drug manufacturer rebates are credited to a DHS appropriation to facilitate the tracking of those funds, and to more accurately represent the total size of the program.

Premiums. DHS collects premiums from certain BadgerCare Plus members, which are used to offset program costs. These provisions are discussed in more detail in Chapter 4. In 2013-14, those premiums totaled $32.0 million.

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

Local Government Funding

In addition to the sources of funding described above that are part of the state budget, local units of government provide the non-federal share of certain services. The local and county governments may retain some, all, or none of the associated federal MA matching funds, depending upon the expenditures category.

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

allocations. In fiscal year 2013-14, counties and tribes contributed approximately $36.8 million under the MA waiver programs (excluding $1.5 million spent on COP-Regular and the Family Support Program, $9.9 million of COP-Regular, Family Support Program, and Foster Care continuation funds counties used for waiver programs, and $0.3 million in Medicaid Administrative Pass Through expenditures), which generated approximately $54.2 million in additional federal matching funds.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide the non-federal match for the school-based health services. Although the MA program claims federal matching funds for local school based services expenditures to offset school costs, the state retains 40% of the federal matching funds, an amount that is deposited to the general fund. In 2013-14, federal matching dollars associated with those school-based services and claimed by the state totaled $97.5 million.

County-Funded Mental Health and Substance Abuse Services. The non-federal share of the cost of certain community-based and inpatient mental health and substance abuse services is paid by counties. This includes targeted case management, crisis intervention, and community support programs for persons with acute mental illness. In 2013-14, those federal matching dollars totaled approximately $76.5 million.

CHAPTER 3

ADMINISTRATION

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

MA and FoodShare Administrative Contracts

DHS contracts with outside entities to provide several MA-related administrative services that include claims processing, reviewing health care providers' prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Many of these services are provided by the state's MA fiscal agent, Hewlett-Packard Enterprises, Inc. (HP). The rest are provided either by other private entities such as Deloitte Consulting, the Public Consulting Group, Automated Health Systems, Inc., and PriceWaterhouseCoopers, or by other state agencies such as the Department of Administration's Division of Hearings and Appeals.

In 2013-14, DHS expended approximately $159.2 million (all funds) for contracted administrative services for EBD MA, BadgerCare Plus, Family Care, SeniorCare, FoodShare, and other related programs. Table 3.1 summarizes those contracting costs by funding source. Note that Table 3.1 does not include costs related to the IM functions performed by counties, tribes, and MilES. Those IM administration activities are described later in this chapter.

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the state's MA program and several related programs. Those business functions include processing claims, certifying health care providers, reviewing prior authorization requests, and providing customer service for members and health care providers. The fiscal agent operates a centralized document processing unit as part of the state's IM functions. In addition, the fiscal agent is responsible for maintaining the primary information system for the program, the Medicaid Management Information System (MMIS), to comply with state and federal reporting requirements. The contract with HP was established in 2008 and renewed for a five-year period in 2013.

Under the contract, DHS reimburses HP for MMIS operations and maintenance based on a flat fee, and specifies other services that are not reimbursed as part of the flat fee. The latter services include: (a) staff to conduct certain specialized services, such as analyzing drug utilization and supporting the personal care screening tool (which assists providers in estimating personal care services required by recipients); (b) pharmacy services for individuals enrolled in both managed care organizations and fee-for-service MA; (c) services HP provides for the Wisconsin Im-

Table 3.1: Summary of MA and FoodShare Administrative Contracts -- State Fiscal Year 2013-14

Service/Contracted Entities	Estimated Expenditures GPR	PR	FED	Total
Fiscal Agent				
HP Enterprises	$21,492,900	$1,874,500	$44,827,300	$68,194,700
CARES				
Deloitte	7,552,400	54,300	18,312,900	25,919,600
State Agencies -- DOA, DWD, DCF	10,566,900	0	16,269,100	26,836,000
Major External Contracts				
Various	6,052,700	1,554,200	16,987,900	24,594,800
Enrollment Broker				
Automated Health Systems	1,039,300	0	1,120,700	2,160,000
FoodShare Electronic Benefits				
Fidelity National Information Services	1,775,000	0	1,769,400	3,544,400
Interagency Agreements				
DOA -- Division of Hearings and Appeals	1,089,500	11,000	1,046,900	2,147,400
DHS -- Disability Determination Bureau	1,122,000	0	1,122,000	2,244,000
BOALTC -- Ombudsman Services	0	0	660,100	660,100
UW -- CHSRA	940,300	47,800	988,100	1,976,200
Other	108,900	0	117,000	225,900
General Payments				
Various	486,400	0	219,100	705,500
Total	**$52,226,300**	**$3,541,800**	**$103,440,500**	**$159,208,600**

munization Registry and the Wisconsin Chronic Disease Program; (d) postage for mailings to members and providers; and (e) implementation of several initiatives to reduce MA service costs and to comply with new federal requirements.

In addition, HP operates a central document processing unit in the City of Janesville as part of the state's IM activities. The totals shown in Table 3.1 include $5,555,000 ($2,597,200 GPR, $2,687,100 FED and $270,700 PR) DHS paid to HP for these services.

In 2013-14, DHS paid HP approximately $68.2 million (all funds) for these services, including $40.1 million in MMIS services covered by the flat fee and $28.1 million for the other services not funded by the flat fee.

CARES. The Client Assistance for Reemployment and Economic Support (CARES) system assists state and county staff in making eligibility determinations and maintaining case information for such programs as BadgerCare Plus, SeniorCare, Family Care, the SSI Caretaker Supplement, FoodShare, TANF/W-2, and Child Care Assistance (Wisconsin Shares). The first five of these programs, administered by DHS, accounted for approximately 94% of CARES cases in 2013-14. The other two programs are administered by the Department of Children and Families (DCF).

CARES is a mainframe system that was first implemented in January, 1994, and has been changed as additional programs were added or program needs changed. The state contracts with

Deloitte Consulting for programming and maintaining the daily operations of the system. The contract with Deloitte includes a monthly base fee and an hourly rate. DHS also purchases hardware hosting, network, and mainframe services from the Department of Administration's Division of Enterprise Technology (DET), the Department of Workforce Development (DWD), and DCF to connect and support IM workers. Other CARES costs include security and staff, printing, postage, and software costs.

Major External Contracts. DHCAA contracts with other private entities to perform certain types of administrative services. In 2013-14, these contracts included services provided by the Public Consulting Group to assist the state in maximizing federal reimbursement for several MA-eligible services. In that year, Deloitte provided consulting services for the development of the state's health information technology (HIT) plan, and HP provided consulting services relating to the state's adoption of ICD-10, which is a new billing code system providers will be required to begin using October 1, 2015. In addition, PriceWaterhouseCoopers provided actuarial services to the state's MA program and related programs.

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

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

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

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

Income Maintenance Administration

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

2011 Wisconsin Act 32 (the 2011-13 biennial budget act) required counties, other than Milwaukee County, to form multi-county consortia to administer IM programs. DHS was directed to administer IM programs in Milwaukee County as a single-county consortium. Tribes could elect to administer income maintenance programs or have DHS administer those programs. Act 32 specified that if a county chose not to participate in a multi-county consortium, or DHS determines that a multi-county consortium does not satisfy DHS performance requirements, DHS would assume responsibility for administering IM programs in the county or the geographical area of

the multi-county consortium, either by contracting with another multi-county consortium or by providing these services directly. However, if DHS assumes this responsibility, the affected counties are required to pay DHS the amount that the county expended for these services in calendar year 2009.

Beginning in 2012, each multi-county consortium is contractually responsible for the following:

- Operating and maintaining a call center;
- Conducting application processing and eligibility determinations;
- Conducting ongoing case management; and
- Providing "lobby services," which DHS has defined to include, among other services, answering questions from applicants, displaying and making available to visitors state and federal publications regarding public assistance programs, scheduling appointments, accepting verification forms and other documentation, facilitating access to interpreter services, providing dedicated, confidential spaces for consumers' use, and providing computers for people to complete web-based applications for public assistance programs, including applications for qualified plans available on Wisconsin's Federally-Facilitated Marketplace.

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

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

Under the provisions of Act 32, DHS was required to reimburse each multi-county consortium for services provided under the contract on a risk-adjusted caseload basis. This provision was modified in 2013 Wisconsin Act 20 to instead require DHS to reimburse each consortia based on a method determined by DHS.

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

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

In 2014, there were 10 multi-county consortia and nine tribes providing IM services. Milwaukee County's IM programs were administered by DHS staff, which included some individuals that were previously employed by Milwaukee County. Table 3.2 shows the counties that participated in each consortium in 2014.

County Contributions. Most counties contribute local funds to partially support their income maintenance activities. These county contributions are referred to as "local overmatch," and are matched with federal funds to support

Table 3.2. Income Maintenance Multi-County Consortia and Tribes (Calendar Year 2014)

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

*Denotes Lead Agency

these services. In calendar year 2013, county contributions for IM functions totaled $25.5 million, which were matched with the same amount of federal funds.

For calendar year 2014, DHS distributed a total of $45.7 million (all funds) to the IM consortia and tribes for basic IM services, referred to as the "income maintenance administrative allocation" (IMAA). (This amount excludes federal funding DHS claims based on county-funded IM services.) In that year, each consortia and tribe received both a "base" allocation and a "supplemental" appropriation to reflect anticipated additional cases IM agencies would manage as a result of the enactment of the federal Affordable Care Act. For each consortia and tribe, the base allocation consisted of: (a) $20,000 per county in the consortia or tribe; and (b) an amount to reflect each consortia's or tribe's proportion of open, pending and closed IM cases, based on a recent six-month average (November, 2012 through April, 2013).

Table 3.3 identifies the amount of state and federal IMAA funding DHS allocated to the consortia in calendar year 2014.

State Administration of Milwaukee County IM Activities. As part of 2009 Wisconsin Act 15 and 2009 Act 28, DHS assumed responsibility for IM activities in Milwaukee County. The state's takeover was precipitated by a federal lawsuit in which a number of Milwaukee County residents alleged that they had been wrongfully delayed or denied benefits under the MA, BadgerCare Plus, and FoodShare programs. In April 2009, the parties to that lawsuit entered into a settlement agreement under which they agreed to request a court order that stayed that litigation in order to

Table 3.3: 2014 Income Maintenance Administrative Allocations and ACA Supplemental Funding

	Base Allocation Amount	ACA Supplement	Total
Income Consortia			
Northern	$2,129,500	$1,509,200	$3,638,700
Western	1,949,200	1,336,500	3,285,700
Bay Lake	2,235,100	1,469,700	3,704,800
Great Rivers	3,180,500	2,134,800	5,315,300
Southern	2,510,800	1,671,800	4,182,600
Moraine Lakes	2,882,300	1,873,500	4,755,800
East Central	3,713,700	2,467,500	6,181,100
Capital	3,832,300	2,496,300	6,328,600
Central	1,635,400	1,080,500	2,715,900
WI Kenosha Racine Partnership	2,394,700	1,524,200	3,918,900
Tribes			
Bad River	162,200	51,800	214,000
Lac Courte Oreilles	98,500	41,200	139,700
Lac du Flambeau	164,000	68,900	323,900
Menominee	164,000	71,900	235,900
Oneida	165,100	79,100	244,200
Potawatomi	98,300	41,200	139,500
Red Cliff	162,200	52,100	214,300
Sokaogon	98,500	45,100	143,600
Stockbridge-Munsee	98,300	44,700	143,000
Total	**$27,674,500**	**$18,060,000**	**$45,734,500**

*Excludes county-funded costs and federal match the state claims for eligible county-funded costs.

provide time for the transition of responsibility for the Milwaukee County IM programs from the county to DHS. In keeping with the terms of that settlement agreement, DHS developed and implemented a plan which led to the state's administration of IM activities in Milwaukee County.

Act 28 provided one-time funding of $14 million ($7.0 million GPR and $7.0 million FED) in 2009-10 to DHS to facilitate that transfer of authority. Act 15 obligated Milwaukee County to contribute $2.7 million in 2009 for the operation of IM programs in the county. For each year after 2009, Act 15 required Milwaukee County to increase its annual contribution by the percentage increase in annual wage and benefit costs paid with respect to county employees performing services in conjunction with the state's administration of those IM activities.

2011 Wisconsin Act 32 retained the state's responsibility to provide IM services in Milwaukee County. The act repealed the Act 15 provision that required Milwaukee County to expend at least $2.7 million annually for the operation of the IM program in the county. Instead, beginning in calendar year 2012, Milwaukee County's basic county allocation under the community aids program is reduced by this amount annually. In addition, Act 32 increased positions in DHS to reflect the conversion of Milwaukee County positions that had been performing IM functions, and addressed issues relating to retirement and other benefits and rights available to former Milwaukee County staff.

Income Maintenance -- Contracted Services. As previously indicated, HP performs several IM related functions, including operating a centralized document processing unit (CDPU) in the City of Janesville.

Allocation of IM Costs. The state must allocate IM-related costs to each program for federal cost reporting and claiming purposes. Since 2003, CMS has required that DHS use a random moment sampling methodology to determine each program's proportional share of the IM costs. Each program supports its share with GPR, federal funds, local funds, or some combination of these sources.

Table 3.4 identifies estimates of the total funding expended for selected state and local IM functions in 2013-14. As with the figures provided in Table 3.1, it excludes county-funded costs and federal matching funds the state claims on

Table 3.4: 2013-14 Income Maintenance Funding Summary, by Source

	GPR	PR	FED	Total
Milwaukee Enrollment Services (MilES)	$14,271,800	$2,382,700	$14,394,900	$31,049,400
Income Maintenance Consortia Allocations	20,062,200	319,000	20,247,800	40,629,000
Total	**$34,334,000**	**$2,701,700**	**$34,642,700**	**$71,678,400**

county-funded costs. The table also excludes costs of HP's CDPU, as these costs are included in the totals for contracted services shown in Table 3.1.

Provider Certification and Regulation

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

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

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

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

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

Licensing and Certification Revenues. DHS currently collects revenue to support its regulation function by charging facilities a flat certification fee or a fixed amount per licensed bed that varies by the type of facility. Currently, nursing

homes are required to pay $6 per licensed bed annually, while hospitals pay $18 per licensed bed. Licensing and support service revenues currently support health facility plan and rule development activities, facility licensure reviews, capital construction and remodeling plan reviews, technical assistance, and associated licensing and support costs. Technical assistance, and licensing and support costs are eligible for federal matching funds under MA.

Office of the Inspector General

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

The OIG's primary responsibilities include: (a) monitoring and auditing providers that participate in the MA program; (b) overseeing and enforcing prior authorization policies for the state's MA program; (c) monitoring and investigating allegations of recipient and provider fraud; and (d) performing internal auditing and consultation services for all DHS programs. In 2014, OIG was authorized 106 full-time equivalent positions to carry out these activities.

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

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

Prior Authorization Review and Enforcement. Requiring health care providers to obtain approval prior to delivering certain MA-eligible services is intended to ensure that the state's MA program only pays for services that are medically necessary and cost effective. Prior authorization (PA) is written permission the MA program provides to a certified MA provider before a service is rendered. PA may be required before a service or treatment begins, or after a certain number of services or dollar amount of reimbursement is reached. Providers that serve individuals enrolled in managed care organizations (MCO) obtain PA approvals from the MCO in which the recipient is enrolled. Providers that serve MA recipients who are not enrolled in an MCO must submit PA requests to the state's fiscal agent. The PA decisions of the fiscal agent are reviewed by OIG staff.

For the one-year period beginning October 1, 2013, through September 30, 2014, the MA program received approximately 293,800 PA requests, of which approximately 217,700 (74.1%) were approved,

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

pate in schemes that enable recipients to make ineligible purchases.

Fraud prevention activities are conducted by a combination of federal, state, county, and contracted staff, pursuant to state and federal laws. In addition, the state Department of Justice operates a Medicaid Fraud Control and Elder Abuse Unit, which investigates and prosecutes fraud perpetrated by providers against the MA program, and crimes committed against vulnerable adults in nursing homes and other facilities.

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

OIG administers the fraud prevention and investigation program (FPIP) for the MA and FoodShare programs. For calendar year 2014, DHS allocated $500,000 (all funds) to counties and tribes to fund these activities. DHS provided each county and tribe the option of either: (a) taking the lead or participating as part of a FPIP consortium; or (b) managing these activities independently for their own county or tribe. For agencies that elect the first option, DHS allocated to each county and tribe an amount that is based on each agency's percentage of the statewide income maintenance caseload (excluding the caseload for which MilES is responsible). Counties and tribes that choose the second option receive only federal MA matching funds, based on the funding they provide for these efforts.

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

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

Coordination of Benefits

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

states are shared with the federal government in the same proportion as each state's MA benefits expenditures. Examples of other resources for COB include individuals who have either voluntarily accepted or been assigned legal responsibility for the health care of one or more MA recipient, worker's compensation carriers, absent parents or other entities providing medical child support, and estates.

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

DHS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available by requiring the service provider to obtain reimbursement from those sources.

A second COB method, referred to as "post-payment recovery," is where the state initially pays provider claims then attempts to recover those payments from other potentially liable sources.

A third COB method is called "provider-based billing," where the state initially uses MA funds to pay provider claims, but then retroactively identifies health insurance coverage that requires documentation, for example, a physician's plan of care, prescriptions or discharge notes. When that occurs, 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.

CHAPTER 4

ELIGIBILITY FOR BADGERCARE PLUS AND RELATED PROGRAMS

This chapter provides an overview of eligibility for BadgerCare Plus and several related programs. Generally, BadgerCare Plus provides health care coverage to low-income individuals who meet certain financial and non-financial eligibility requirements.

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

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

Other individuals may qualify for full-benefit BadgerCare Plus coverage, such as young adults formerly in foster care, or more limited benefits, such as family planning only services.

Financial Eligibility

Individuals qualify for BadgerCare Plus coverage based on household income, measured as a percentage of the federal poverty level (FPL). The U.S. Department of Health and Human Services updates the poverty guidelines annually. Appendix 1 lists annual and monthly income at various percentages of the 2014 FPL.

Unlike eligibility criteria for elderly, blind or disabled individuals, eligibility for BadgerCare Plus does not depend on an individual's assets, such as savings accounts or property.

Table 4.1 shows the 2014 income eligibility limits, as a percent of the FPL and as total household income for various household sizes, that apply to adults, children, and pregnant women. The eligibility levels reflect the changes made in the 2013-15 biennium to income eligibility for parents, caretaker relatives, and childless adults, ef-

Table 4.1: 2014 BadgerCare Plus Income Eligibility Standards for Adults, Children, and Pregnant Women

		Annual Income		
	% of the FPL	One-Person Household	Two-Person Household	Three-Person Household
Adults	100%	$11,670	$15,730	$19,790
Pregnant Women*	306	N/A**	48,134	60,557
Children*	306	35,710	48,134	60,557

*Though state statutes set income eligibility for children and pregnant women at 300% of the FPL, under the current income counting methodology, these groups may disregard an amount equal to 6% of the FPL for purposes of determining BadgerCare Plus eligibility, effectively setting the income standard for those individuals at 306% of the FPL.

**The fetus is included in a pregnant woman's household for eligibility determination purposes, so a household of size of one would not apply.

fective April 1, 2014, which are discussed later in this chapter.

Children. State law sets BadgerCare Plus eligibility at 300% of the FPL for children up to age 19. As of November, 2014, approximately 435,300 children were enrolled in BadgerCare Plus. (This does not include children enrolled in "Transitional MA," which is discussed in more detail below.)

Prior to enactment of the federal Patient Protection and Affordable Care Act (ACA), states could disregard or exclude certain types of income in making eligibility determinations. The ACA standardized states' methods of counting household income. In Wisconsin, a household's income is reduced by 6% to determine whether a child meets the program's income eligibility standard. This includes a standard 5% disregard required under the ACA, and a state-specific 1% disregard to account for changes in how income is counted under the modified adjusted gross income (MAGI) standard mandated under the ACA. For this reason, although state statutes set income for children at 300% of the FPL, the effective income eligibility level equals 306% of the FPL after these disregards. MAGI is discussed in more detail below.

Prior to 2013 Act 28, children in households with income greater than 300% of the FPL could participate in BadgerCare Plus by paying a premium equal to the full cost of their coverage. Act 28 eliminated eligibility for this group. Approximately 3,000 children in households with income over 300% of the FPL were enrolled in BadgerCare Plus in March, 2014, the last month that option was in effect.

A child in a household with income over 300% of the FPL may still enroll in the program if he or she incurs medical expenses in a six-month deductible period equal to the difference between the child's household income and 150% of the FPL. Children who meet this "deductible" can qualify for full BadgerCare Plus coverage for a six-month deductible period, during which the program will cover their health care costs.

Parents and Caretaker Relatives. Parents and caretaker relatives with income up to 100% of the FPL qualify for BadgerCare Plus. As of November, 2014, approximately 163,500 parents and caretakers were enrolled in BadgerCare Plus, not including Transitional MA enrollment. Unlike the standards for children and pregnant women, the income limits for parents and caretakers includes the disregard, so that the eligibility standard equals 100% of the FPL, rather than 106% of the FPL.

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

Adults Without Dependent Children. Adults without dependent children with income up to 100% of the FPL qualify for BadgerCare Plus. As of November, 2014, approximately 133,900 adults without dependent children were enrolled in BadgerCare Plus. As with parents and caretakers, no additional income "disregard" applies to the income eligibility limit for these adults.

Prior to April 1, 2014, an adult without dependent children could only access BadgerCare Plus coverage if he or she had enrolled in the "core plan" prior to enrollment in that program closing in October, 2009. Act 28 opened full BadgerCare Plus eligibility to all adults without dependent children with income under 100% of the FPL.

Pregnant Women. State law sets BadgerCare

Plus eligibility at 300% of the FPL for pregnant women. As of November, 2014, approximately 19,300 pregnant women were enrolled in BadgerCare Plus.

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

The same 6% income disregard household income when determining eligibility. Consequently, the effective income eligibility limit for pregnant women is 306% of the FPL.

Pregnant women with higher incomes can qualify for BadgerCare Plus if they meet a deductible equal to the amount by which their income exceeds 300% of the FPL.

Foster Children and Children in Subsidized Adoptions. Children placed in private foster care settings and children living in state foster homes are eligible for MA, regardless of whether the state receives federal Title IV-E matching funds for their maintenance payments. As of November, 2014, approximately 7,600 such foster children were receiving MA benefits.

Children with special needs for whom adoption assistance agreements are in effect and children adopted under state-established agreements are also eligible for MA. As of November, 2014, there were approximately 13,600 such children enrolled in the MA program.

Former Foster Children. If an individual is under 26 years of age, and was in out-of-home care (such as foster care, court-ordered kinship care, or subsidized guardianship) on their 18th birthday, he or she qualifies for BadgerCare Plus, regardless of their household income. Prior to January 1, 2014, this categorical eligibility only applied to former foster children under 21 years of age. As of November, 2014, 654 former foster children were enrolled in BadgerCare Plus.

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

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

As previously indicated, prior to the ACA-mandated change to MAGI-based eligibility, states developed their own income-counting rules and allowable deductions, which resulted in variation between states as to what income counted for purposes of MA eligibility. For instance, in Wisconsin, individuals could deduct the amount of court-ordered child support payments the individual was required to make. The ACA standardized the income-counting methodology across states. States must disregard 5% of an individual's income when determining Medicaid eligibility, and may not apply any other type of income disregard. The only exception is an additional disregard may be applied on a state-by-state basis to ensure that the change from the previous income-counting system to MAGI did not result in a systematic decrease or increase in overall program eligibility. In Wisconsin, this "conversion factor" resulted in an additional 1% allowable disregard.

Non-Financial Eligibility

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

Residency. BadgerCare Plus recipients must be Wisconsin residents. A person generally satisfies that requirement if they are physically present in Wisconsin, and express their intent to remain living in the state.

Citizenship. Only U.S. citizens, U.S. nationals, or certain documented immigrants may enroll in BadgerCare Plus. In general, adult immigrants who have been lawfully admitted to the United States can qualify for BadgerCare Plus coverage after five years have passed since their arrival. Certain special categories apply to immigrants for eligibility (such as individuals who seek asylum) or for ineligibility (such as individuals who are temporarily present for seasonal agricultural work).

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

Medical Support/Third-Party Liability. Individuals applying for BadgerCare Plus must cooperate in establishing medical support and third-party liability for medical expenses. Medical support is the obligation a parent has to pay for his or her child's medical care, either through health insurance or through direct payment. An example is a BadgerCare Plus member's duty to help establish the paternity (and, in turn, a medical support obligation) of any child born out of wedlock who is covered by BadgerCare Plus. Certain good cause exceptions apply to this requirement.

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

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

Social Security Number. Applicants must provide a social security number or apply for a number if they do not have one. Several groups do not need a social security number, such as continuously eligible newborns, pre-adoptive infants living in a foster home, non-qualifying immigrants receiving emergency services, someone without a social security number who may only be issued one for a valid non-work reason, tax

dependents of filers living outside the home, and individuals who refuse to obtain a social security number for well-established religious reasons.

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

Access to Other Insurance. BadgerCare Plus limits some applicants' eligibility for benefits if they have access to, or coverage under employer-sponsored insurance. These are referred to as "crowd-out" rules, as they are intended to reduce the crowding out of employer-based coverage by public coverage.

These provisions apply to the following individuals: (a) children ages one through five in households with income over 191% of the FPL; (b) children ages six through 18 in households with income over 156% of the FPL; and (c) pregnant women at any income level in the BadgerCare Plus prenatal program. The following subsets of these groups are exempt from the crowd-out provisions: (a) continuously-eligible newborns; (b) children who have met a deductible; (c) infants less than one year old; and (d) former foster care children. Parents, caretaker relatives, childless adults, and pregnant women (besides those in the prenatal program) are not subject to these crowd-out provisions.

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

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

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

A person subject to crowd-out restrictions who is currently covered by employer-sponsored insurance is not eligible for BadgerCare Plus. In addition, individuals who discontinue their employer-sponsored coverage cannot enroll in BadgerCare Plus for three months thereafter. If a person discontinues their employer-sponsored coverage but continues to have access to that coverage, they will be subject to the current access rules described above.

Prior to the changes in 2013 Act 28, a different set of crowd-out rules applied to non-pregnant, non-disabled parents and caretakers with household incomes greater than 133% of the FPL (not including individuals in transitional MA). In addition to the standard that an employer must pay at least 80% of the premium, these adults were not eligible for BadgerCare Plus if they had access to employer-sponsored insurance where the employee's share of the premium for

employee-only coverage did not exceed 9.5% of family income. After Act 28 lowered the income eligibility limit to 100% of the FPL for parents and caretakers, this crowd-out policy no longer applied to any adults in the program.

Other Related Programs or Groups

Other MA subprograms provide coverage to certain groups of individuals, or cover specific services. These include the family planning only services program, the prenatal program, emergency services, well woman MA, and care coordination programs for children in multiple systems of care.

Family Planning Only Services Program. The family planning only services program provides contraception and related services to individuals with income up to 306% of the FPL. The program is the successor (with modifications) to the previous family planning waiver program, and is now incorporated into the state MA plan. As of November, 2014 approximately 49,400 individuals were enrolled in the family planning only services program.

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

Depending upon the enrollee, covered services include contraceptive services and supplies, natural family planning supplies, family planning pharmacy visits, Pap tests, tubal ligations, testing and treatment of STDs, voluntary sterilizations for men 21 years of age or older, and routine preventive services if they are related to family planning.

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

Coverage under the program begins the first day of the month when the state receives an application, and continues through the end of the month after the pregnancy ends. As of November, 2014, 1,374 women were enrolled in the prenatal program.

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

gency services.

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

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

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

Women who qualify for coverage are eligible for the full range of benefits on a fee-for-service basis provided under BadgerCare Plus. As of November, 2014, 798 women were enrolled in the WWMA.

Children Come First, Wraparound Milwaukee and Care4Kids. The Wraparound Milwaukee (WM) program and Dane County's Children Come First (CCF) program provide case management services to children with mental health and other emotional or behavioral problems, and who are involved with two or more systems of care (such as mental health or juvenile justice). These programs aim to divert children from inpatient psychiatric care and provide a comprehensive level of services that includes a care coordinator and individualized services. In other counties, similar care coordination is available through coordinated services teams outside of the MA program.

These programs coordinate a child's care across multiple systems, based on an individualized plan of care. 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.

Under CCF, DHS contracts with Dane County to arrange services for program clients. In calendar year 2014, the MA program paid a monthly capitation payment of $1,586 per CCF enrollee, with Dane County providing additional funding. In fiscal year 2013-14, average monthly enrollment in CCF was 116 children.

Milwaukee County’s Behavioral Health Division operates the Wraparound Milwaukee program. In calendar year 2014, the MA program paid a monthly capitation rate of $1,871 per enrollee, with Milwaukee County and the Bureau of Milwaukee Child Welfare in the Department of Children and Families contributing funds to pay

for the costs not covered by MA. In state fiscal year 2013-14, average monthly enrollment in the WM program was 1,025 children.

Care4Kids, a similar managed care program for children in foster care, began in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha Counties on January 1, 2014. DHS contracts with Children's Hospital of Wisconsin to administer the program. Based on a medical home model, this program develops individual treatment plans for children in foster care, and coordinates a child's physical, behavioral, and oral care needs. As of November, 2014, 2,161 children were enrolled in Care4Kids.

Special Eligibility Situations

Individuals can receive coverage under several special situations, include transitional MA coverage, presumptive eligibility, coverage as a continuously eligible newborn, and retroactive eligibility. In addition, some groups must pay a premium to participate in the program.

Transitional MA. Under "transitional MA," also called "income extensions," parents, caretaker relatives, and their children who have received BadgerCare Plus coverage for at least three of the last six months may remain eligible for either a four- or 12-month period if household income increases above 100% of the FPL due to earnings or support payments.

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

Individuals in transitional MA remain eligible for BadgerCare Plus coverage, and are exempt from the program's crowd-out rules. Non-pregnant, non-disabled adults with household incomes greater than 133% of the FPL are subject to premium requirements, and parents and caretakers with income between 100% and 133% are subject to premiums during the last four months of an earned income extension.

Presumptive Eligibility. Through presumptive eligibility (also called express household enrollment or temporary enrollment), adults with household income under 100% of the FPL, pregnant women with household incomes at or below 306% of the FPL and certain children can temporarily enroll in BadgerCare Plus based on a preliminary eligibility determination. For children, different income limits for presumptive eligibility apply at the following ages: (a) less than age one with household income at or below 306% of the FPL; (b) ages one through five with household income at or below 191% of the FPL; and (c) over age five with household income at or below 156% of the FPL.

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

Presumptive enrollment for WWMA is available for women screened in by the WWWP, covering the date of diagnosis through the last day of the following month.

Continuously Eligible Newborns. Infants remain eligible for BadgerCare Plus if their natu-

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

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

Premiums. Some individuals are required to pay monthly premiums to obtain coverage under BadgerCare Plus, depending upon their household income and other factors. Premiums only apply to children with household income over 201% of the FPL, and to parents and caretakers in transitional MA. Members of Native American tribes are not subject to premiums.

Children. Table 4.2 shows the monthly premiums a household at various income levels must pay for each child enrolled in BadgerCare Plus. Children in households with income below 201% of the FPL, or in transitional MA, are not subject to premiums.

Table 4.2: BadgerCare Plus Premiums for Children, by Household Income, as of July 1, 2014

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

Adults in Transitional MA. Adults who qualify for BadgerCare Plus through transitional MA due to an increase in income must pay premiums for coverage. Premiums are charged on a sliding scale based on household income that mirrors the premium methodology used in the ACA federal marketplace. The scale ranges from a premium equal to 3.0% of family income for households with income at 133% of the FPL, to 9.5% of family income for households with income at or above 300% of the FPL. Transitional MA households with income between 100% and 133% of the FPL are exempt from premiums for the first six months of their extension, and subject to premiums equal to 2.0% of income for the remainder of the extension.

Table 4.3 shows the transitional MA premium requirements as a percentage of household income, and a monthly dollar amount, for a household of three.

Prior to 2013 Act 28, adults in BadgerCare Plus with household income greater than 133% of the FPL were required to pay premiums that mirrored the amounts charged through the ACA marketplace. After Act 28, no non-pregnant, non-disabled adults are eligible for BadgerCare Plus at those income levels, unless they are in transitional MA.

Table 4.3: Premiums for Adults in Transitional MA in a Three-Person Household, as of January 1, 2014*

Family Income As % of FPL	Monthly Premium as % of Household Income	Monthly Premium
100% to 133%	2.0%	$33 to $44
133% to 140%	3.0	66 to 69
140% to 149%	3.5	81 to 87
150% to 159%	4.0	99 to 106
160% to 169%	4.5	119 to 126
170% to 179%	4.9	137 to 145
180% to 189%	5.4	160 to 169
190% to 199%	5.8	182 to 191
200% to 209%	6.3	208 to 218
210% to 219%	6.7	232 to 243
220% to 229%	7.0	254 to 266
230% to 239%	7.4	281 to 293
240% to 249%	7.7	305 to 317
250% to 259%	8.1	334 to 347
260% to 269%	8.3	356 to 370
270% to 279%	8.6	383 to 397
280% to 289%	8.9	411 to 426
290% to 299%	9.2	440 to 455
300% or Greater	9.5	470 and up

*Amounts shown are for all adults in the household. Children in families in transitional MA are not subject to a premium.

Restrictive Re-enrollment Period. BadgerCare Plus participants who fail to pay a premium when due are subject to a three-month restrictive re-enrollment period during which the individual cannot re-enroll in the program. An individual may make a late payment of the premiums owed at any time during the RRP, and become eligible for coverage. There are several limited good cause exceptions for failing to pay a BadgerCare Plus premium.

Standard Plan and Discontinued Plans

Individuals who satisfy the non-financial and financial requirements outlined above are eligible for benefits under the BadgerCare Plus "standard plan." Chapter 49 of the Wisconsin Statutes and DHS Administrative Rule 107 describe the services covered by the standard plan. The covered services also reflect federal MA law, which requires state MA programs to cover many basic services, such as physician and hospital services, while making coverage of other services optional, such as prescription drugs, physical therapy, personal care, and chiropractic services. Wisconsin's MA program covers all federally-optional services. Chapter 5 of this paper describes the benefits offered under the standard plan in more detail.

Prior to April 1, 2014, certain individuals received BadgerCare Plus coverage through plans that offered more limited benefits than the standard plan. These included the following: (a) the "benchmark plan," for certain participants with incomes above 200% of the FPL; (b) the "core plan" for childless adults with income up to 200% of the FPL, which had enrollment capped in October, 2009; and (c) the "basic plan" for childless adults who were on the waiting list for core plan coverage.

Benchmark Plan. Prior to April 1, 2014, certain BadgerCare Plus enrollees with income over 200% of the FPL received coverage under the "benchmark plan" rather than the standard plan. Benchmark plan benefits were based on the benefit package offered by the state's largest HMO, and contained certain benefit limits not included in the standard plan, such as limits on the number of days a person could receive a service, and had higher copayments for services than the standard plan. After the eligibility changes contained in 2013 Act 28, all BadgerCare Plus enrollees receive coverage under the standard plan.

Core Plan. The 2007-09 biennial budget act authorized DHS to request a waiver from CMS to provide services to non-elderly adults without dependent children and whose incomes do not exceed 200% of the FPL. The resulting waiver program, called the BadgerCare Plus core plan, had a more limited benefit package and more rig-

orous insurance crowd-out rules than BadgerCare Plus.

DHS began providing services to core plan enrollees in January, 2009. Most of the initial participants had previously been enrolled in Milwaukee County's general assistance medical program (GAMP). The core plan was expanded statewide in July, 2009. Demand for the new program quickly exceeded budget projections, and DHS responded by capping enrollment in that plan in October, 2009. Core plan enrollment declined as individuals left the program without new enrollees entering the program, falling from a peak of 65,300 in January, 2010, to 13,900 by March, 2014.

2013 Act 20 authorized DHS to seek a new waiver to extend BadgerCare Plus coverage to all adults without dependent children in households with income up to 100% of the FPL, effectively lifting the cap on the childless adult enrollment at that income level. Adults with household income over 100% of the FPL who had been enrolled in the core plan lost access to that coverage. The number of adults without dependent children enrolled in MA has grown rapidly since the implementation of that change in April, 2014.

Basic Plan. When DHS capped core plan enrollment, it established a waitlist for people who applied for that program after the implementation of the cap. 2009 Wisconsin Act 219 authorized DHS to create the BadgerCare Plus basic plan to provide coverage for those individuals. Under that legislation, people on the waitlist who satisfied all of the core plan's eligibility requirements could enroll in the basic plan.

The basic plan was not a medical assistance program and was not subject to federal or state MA laws. It was intended to be financed wholly by the premiums paid by plan participants (with supplemental funding provided, as needed, through a federal grant), and provided an even more limited set of benefits than the core plan.

DHS began providing coverage to basic plan participants in July, 2010. Enrollment in the program peaked in April, 2011 at approximately 6,000 participants. Over the life of the program, premiums increased from $130 per month to $325 per month.

Act 20 eliminated the basic plan. In March, 2014 (the last month of the program) 711 individuals were enrolled in the program.

BadgerCare Plus and the Affordable Care Act

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

Significant Medicaid-related provisions of the ACA include the following: (a) expansion of eligibility to "newly-eligible" groups; (b) maintenance of effort (MOE) requirements for certain eligibility standards; and (c) increases to the amount of federal reimbursement states receive under the children's health insurance program (CHIP).

Medicaid Expansion. As enacted, the ACA required state MA programs, at the risk of losing federal MA matching funds, to cover virtually all

non-elderly individuals with household incomes up to 133% of the FPL, beginning January 1, 2014. This new mandatory eligibility requirement was referred to as a "full Medicaid expansion" under the ACA.

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

In June, 2012, the U.S. Supreme Court issued a decision under *National Federation of Independent Business v. Sebelius* that addressed two of the ACA's main provisions -- the individual insurance mandate and the Medicaid expansion. The Court upheld the individual mandate, but effectively made the ACA's Medicaid expansion optional, rather than mandatory. States that do not implement the expansion will not risk losing federal funding for their existing MA programs.

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

The enhanced ACA FMAP for newly eligible individuals only applies under full Medicaid expansion. As such, the standard FMAP applies to adults without dependent children currently covered under BadgerCare Plus. Under either a full or partial expansion, the standard FMAP would apply to parents and caretakers.

Maintenance of Effort Requirement. The ACA prohibits states (at the risk of losing federal MA matching funds) from imposing MA eligibility standards, methodologies, or procedures more restrictive than those in effect as of March 23, 2010. For adults, this maintenance of effort (MOE) requirement continued until the DHHS Secretary determines that a health benefit exchange established by the state is fully operational. For children under age 19, the MOE requirement continues through September 30, 2019.

Although the ACA generally linked the MOE for adults to the establishment of the exchange, the MOE requirement for these individuals could be waived if a state certified to DHHS that it had a budget deficit. Wisconsin invoked this limited exception for non-pregnant, non-disabled adults in Wisconsin with household incomes greater than 133% of the FPL. Lifting the MOE for adults allowed DHS, with the approval of the Joint Finance Committee and CMS, to alter the program's crowd-out rules, premiums, restrictive re-enrollment periods, and retroactive eligibility, effective July 1, 2012. Following the 2013 Act 28 eligibility changes, those rules generally no longer apply to adults in the program.

Enhanced FMAP for the Children's Health Insurance Program (CHIP). The ACA extends the current reauthorization for the CHIP program for two years, through September 30, 2015, and increases the already-enhanced FMAP for children eligible for CHIP funding by 23 percentage points during the four-year period beginning October 1, 2015. In Wisconsin, this will increase the CHIP FMAP to approximately 95% during that four-year period.

CHAPTER 5

SERVICES UNDER BADGER CARE PLUS AND EBD MEDICAID

BadgerCare Plus and EBD (elderly, blind, an disabled) Medicaid provide coverage for a variety of procedures and services that are deemed medically necessary by a physician or other medical professional. State statutes, DHS administrative codes, and program handbooks outline the covered services, as well as the provider requirements and limitations associated with each covered service. This chapter provides a description of the general requirements for medical services covered under the MA program, as well as of the specific service categories offered under the programs. This chapter covers primarily the acute care medical services offered MA recipients, rather than the long-term care provided to EBD Medicaid recipients in an institution or as part of a community-based Medicaid waiver program. Additional information on the MA program's long-term care services and community-based waiver programs is provided in Chapters 8 through 10.

General MA Requirements and Procedures

Medical Necessity. The primary limitation on services provided under the MA program is a requirement that those services must be deemed "medically necessary." A medically necessary service is defined by administrative rule as one that is required to prevent, identify, or treat a recipient's illness, injury, or disability and that meets all of the following standards:

- Is consistent with the recipient's symptoms or with prevention, diagnosis, or treatment of the enrollee's illness, injury, or disability;
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
- Is appropriate with regard to generally accepted standards of medical practice;
- Is not medically contraindicated with regard to the recipient's diagnosis, symptoms, or other medically necessary services the recipient receives;
- Is of proven medical value or usefulness and, consistent with DHS rules, is not experimental in nature;
- Is not duplicative with respect to other services provided to the recipient;
- Is not solely for the convenience of the recipient, the recipient's family, or a provider;
- Is cost-effective compared to an alternative medically necessary service that is reasonably accessible to the recipient; and
- Is the most appropriate supply or level of service that can be safely and effectively provided to the recipient.

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

provides full coverage, subject to nominal co-payments, for physical therapy services. Prior authorization is required, however, for more than 35 treatment days.

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

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

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

Service Categories

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

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

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

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

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

Physician Services. Physician services are diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided to a recipient. These services may be provided in the physician's office, hospital, nursing home, recipient's residence, or elsewhere, and must be performed by, or under the direct supervision of, a physician. Although Wisconsin's MA law provides general coverage of physician services, many specific services are subject to the prior authorization requirements, or other limitations identified in Wisconsin administrative rules. For instance, major organ transplants require prior authorization.

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

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

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

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

Under federal law, states are required to conduct reviews of the usage of drugs for the purpose of detecting and preventing provider and consumer fraud or abuse, as well as detecting

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

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

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

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

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

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

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

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

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

In most cases, transportation providers receive reimbursement through MTM. Under the terms of the current transportation services contract, DHS pays MTM a monthly capitation payment based on the number of beneficiaries enrolled in the month. This fee, which remains fixed for the three years of the contract, is $16.86 per month for EBD enrollees, $1.32 per month for BadgerCare Plus children, and $3.34 per month for BadgerCare Plus parents and caretakers. Since adults without dependent children were not eligible for transportation services at the time the original contract was signed, there is not yet a standard rate for this population. The rate will be retrospectively set based on actual costs.

Chiropractor Services. The MA program covers manual manipulations of the spine to treat a subluxation (a partial dislocation of the normal functioning of a bone or joint). Covered services may also include x-rays and spinal supports, office visits, diagnostic analysis, and chiropractic adjustments. Prior authorization is required for more than 20 spinal manipulations per spell of illness.

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

Speech and Language Pathology Services. The MA program covers medically necessary diagnostic, screening, preventive, or corrective speech and language pathology services prescribed by a physician and provided by a certified speech-language pathologist or under the direct, immediate, on-premises supervision of a certified speech-language pathologist. Covered services include evaluation procedures and speech treatments. Prior authorization is required for all services that exceed 35 treatment days.

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

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

DME includes medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment, and prostheses. A physician, podiatrist, nurse practitioner, or chiropractor must prescribe all DME services, including purchases, 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. In cases where DHS determines that a piece of equipment will only be needed on a short-term basis, equipment is rented, rather than purchased, for the recipient.

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

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

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

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

Inpatient hospital services for mental health or AODA conditions are covered under the MA program if provided in a general hospital. Typically mental health and AODA services provided in a general hospital are on a short-term basis. Inpatient mental health and AODA care provided for a longer period of time is usually provided in a psychiatric hospital or state mental health institute. Under federal law, the MA program does not cover mental health or AODA services provided in an institute for mental disease (IMD) unless the person is under 21 years of age or 65 years of age or older. An IMD is defined as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in diagnosis, treatment, or care of persons with mental diseases.

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

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

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

children at risk of serious physical, mental, or emotional dysfunction, including lead poisoning, risk of maltreatment, involvement with the juvenile justice system, or where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.

Case management providers are required to perform a written comprehensive assessment of a person's abilities, deficits, and needs. Following the assessment, providers develop a case plan to address the needs of the client, and provide ongoing monitoring and service coordination. The services must be provided by qualified private, nonprofit agencies or qualified public agencies.

Case management services are generally provided at the option of counties and the non-federal share of MA case management costs is paid by counties. There are, however, exceptions to this general rule. For instance, the Department of Children and Families pays the non-federal share of case management services provided for children removed from the home by the Bureau of Milwaukee Child Welfare. In addition, operators of independent living centers for the disabled may elect to provide case management services for MA-eligible residents, in which case the non-federal share is paid either with funds from the county or from state grants for independent living centers. Finally, the Department of Corrections receives MA reimbursement for case management services provided for juveniles who are under correctional supervision, but who are not confined to a correctional institution. In this case, the Department of Corrections pays the non-federal share of the cost of these services.

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

MA reimburses providers of hospice care based on the following types of care: (a) routine home care, with a per diem rate for less than eight hours of care per day; (b) continuous home care, with an hourly rate for between eight and 24 hours of care per day; (c) inpatient respite care in a hospital or nursing facility; (d) general inpatient care in a hospital or nursing facility; and (e) nursing home room and board. Unlike many MA services, CMS annually establishes minimum reimbursement rates for hospice care.

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

Care Coordination and Follow-up for Individuals with Lead Poisoning or Lead Exposure. MA covers care coordination and follow-up services for children with lead poisoning or lead exposure. Home inspections are covered after a child is shown to have lead poisoning. All environmental inspections are subject to prior author-

ization.

School-Based Medical Services. MA school-based medical services are services provided to MA-eligible students by school districts or cooperative educational service agencies (CESAs). School-based medical services eligible for reimbursement under MA include the following: (a) speech, language, hearing and audiological services; (b) occupational and physical therapy services; (c) nursing services; (d) psychological counseling and social work services; (e) developmental testing and assessments; (f) transportation, if provided on a day the student receives other school medical services; and (g) durable medical equipment.

To be eligible for reimbursement under the MA program, a school-based service must be deemed medically necessary, as well as meet the following conditions: (a) it must identify, treat, manage, or address a medical problem or a mental, emotional, or physical disability; (b) it must be identified in an individualized education plan (IEP); (c) it must be deemed necessary in order for a recipient to benefit from special education; and (d) it must be referred or prescribed by a physician or advanced practice nurse, where appropriate, or a psychologist, where appropriate. Parental consent is required in order for a child to receive the special education and related services defined in an IEP. Separate parental consent is not required, however, in order for the school-based services provider to seek reimbursement from the state's MA program.

Schools provide the non-federal match for school-based health services. Although the MA program may claim federal matching funds on these expenditures, the school district or CESA receives only 60% of the federal matching funds as reimbursement. The state retains the other 40% of the federal funds, an amount credited to the state's general fund.

Early and Periodic Screening, Diagnostic and Treatment Services ("HealthCheck"). Federal law requires coverage of screening, diagnostic, and treatment services for MA-eligible persons under the age of 21. In Wisconsin, these screenings are referred to "HealthCheck" services. HealthCheck screening examinations are distinguished from other preventive health services under MA because they include a significant health education component, a schedule for periodic examinations, detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the patient is appropriately referred for care.

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

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

Federal law also requires states to provide MA coverage for diagnostic and treatment services that are medically necessary to correct or ameliorate physical and mental illnesses and conditions discovered as part of a screen. Any federally reimbursable MA service must be pro-

vided, even if the service is not otherwise covered under a state's MA program, although it may be subject to applicable prior authorization requirements.

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

Skilled Nursing Services. A recipient is eligible for skilled nursing services delivered in the home if they are provided under a plan of care that requires less than eight hours of direct, skilled nursing services in a 24-hour period, the recipient does not reside in a hospital or nursing facility, and the recipient requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence. These services are provided exclusively by registered nurses and licensed practical nurses. In determining whether 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 Therapy Services. Wisconsin's MA program covers medically necessary skilled physical therapy, occupational therapy, and speech and language pathology services provided as part of a home health service. The physical therapists, occupational therapists, and speech-language pathologists that provide these services may be employed by a home health agency, by an agency under contract with the home health agency, or they may be independent providers under contract with the home health agency. A therapy evaluation must be completed before a therapy plan of care is provided for the recipient.

Home Health Aide Services. MA covers aide services for recipients who require assistance with activities of daily living when provided in conjunction with medically-oriented tasks, and incidental household tasks required to facilitate treatment of a recipient's medical condition or to maintain their health. To be eligible for reimbursement under MA, a registered nurse must determine that the medically-oriented tasks cannot be safely delegated to a personal care worker who has not received special training in performing tasks for the specific individual. Examples of home health aide tasks include administration of medications and, with certain restrictions, activities of daily living, such as bathing, dressing, and skin, foot, and ear care.

Personal Care Services. Personal care services are medically-oriented activities related to assisting recipients with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services are provided under the written orders of a physician and are performed by a personal care worker under the plan and supervision of a registered nurse. A personal care worker can only perform those tasks for which they have been trained. Covered personal care services include assistance with specific activities of daily living (such as eating, dressing, and bathing), meal preparation, and accompanying an individual to obtain medical diagnosis and treatment.

Home health agencies, independent living centers, Wisconsin tribes and bands, certain county departments, and freestanding personal care agencies can be enrolled to provide personal care services. Prior authorization is required for personal care services after 50 hours of service have been provided in a calendar year.

Private Duty Nursing Services. A recipient

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

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

Family Planning Services and Supplies. MA recipients may receive family planning services that are prescribed by a physician and furnished, directed, or supervised by a physician, registered nurse, nurse practitioner, licensed practical nurse, or nurse midwife. Covered services include physical examinations and health histories, office visits, laboratory services, counseling services, the provision of contraceptives and supplies, and prescribing medication for specific treatments. Services and items that are provided for the purpose of enhancing the prospects of fertility in males or females are not covered. Unlike other MA services, most family planning services receive a 90% federal match.

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

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

CHAPTER 6

PROVIDER REIMBURSEMENT

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

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

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

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

Fee-for-Service and Managed Care Reimbursement

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

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

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

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

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

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

As of November, 2014, approximately 87% of all BadgerCare Plus participants were enrolled in one of the 18 HMOs participating in the program throughout the state. In areas where two or more HMOs participate, individuals can be required to enroll in an HMO, although they generally have the option to select their HMO. If the participant does not make a selection, they will be automatically enrolled in an HMO. Under federal law, states typically cannot require MA recipients to enroll in an HMO unless they have a choice of at least two HMOs. CMS has, however, approved an amendment to Wisconsin's MA plan that permits DHS to require certain MA participants in eligible rural counties to enroll in an HMO even if only one HMO is participating in the program.

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

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

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

Working with its contracted actuary, DHS adjusts MA capitation rates each calendar year by analyzing prior years' encounter data submitted by the HMOs, pricing that encounter data at the Department's fee-for-service rates, and then making adjustments to reflect projected utilization

trends and changes in applicable law and policy. The rates also include an administrative component paid to the HMO, which, in 2015, ranges from 10% to 14%, depending upon the eligibility group of the enrollee.

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

MA Copayments

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

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

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

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

Hospital Reimbursement

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

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

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

Under the DRG payment system, an inpatient hospital stay is classified based on the major diagnostic categories used by the Medicare program. However, since the Medicare system is designed for serving a different population than the MA program, DHS employs various modifications to include, for instance, refined diagnostic categories for neonatal care. Each DRG is assigned a weight based on the relative resource consumption associated with a particular diagnosis. For example, a diagnosis that consumes 50% more hospital resources than the weighted average of all diagnoses, will be assigned a weight of 1.5. The DRG weights are determined from an analysis of past MA services provided by hospitals and the relative cost of providing those services.

For each inpatient stay, the MA program payment is calculated by multiplying the DRG weight by a hospital-specific base rate. To develop the base rates, DHS first establishes a uniform "standard DRG group rate" for the year based on the MA program's target budget and anticipated inpatient utilization and case mix for that year. For rate year 2015, the standard DRG group rate is $3,507.

The standard DRG group rate is then converted to a hospital-specific DRG base rate by making adjustments for a series of factors, including the following: (a) a wage index applicable to the hospital's geographic location; (b) an add-on for allowable capital costs; (c) the hospital's direct graduate medical education costs; and (d) an increase for non-critical access hospitals that qualify for a rural hospital percentage adjustment (limited, in the aggregate, to $5 million annually).

While the DRG system is used to reimburse hospitals for most fee-for-service inpatient services, there are exceptions for some AIDS patient care, ventilator patient care, and brain injury cases, all of which may be billed on a per diem rate or as negotiated with DHS. Hospitals can also receive an outlier payment in addition to their standard DRG-based payment for inpatient stays for which the costs exceed a specified "trim-point." For 2015, outlier payments are projected to be 40% of the total amount distributed under the inpatient DRG reimbursement formula to acute care hospitals.

As noted above, the FFS rates are constrained by the target budget. However, the total amount the MA program pays for inpatient hospital services in a year may be more or less than the target budget if hospital usage by MA beneficiaries is more or less than anticipated in that year.

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

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

Hospitals outside of Wisconsin can be reimbursed for inpatient services provided to Wisconsin MA recipients. If the hospital is a "major border status" hospital (defined as a hospital that had at least 75 Wisconsin MA inpatient discharges or $750,000 in inpatient charges related to Wisconsin MA recipients during the combined preceding two fiscal years), it is reimbursed under the same hospital-specific DRG methodology as Wisconsin hospitals. If the hospital is a "minor border status" hospital (a border status hospital that does not meet the criteria to be a "major border status" hospital) or an out-of-state hospital that does not have major border or minor border status, it is reimbursed at a single DRG-based rate that does not consider the hospital-specific costs outlined above. Like other hospitals, however, minor border status and non-border status out-of-state hospitals can receive "outlier" payments for particularly expensive inpatient stays. All non-emergency hospital services provided by non-border status out-of-state hospitals require prior authorization.

Inpatient Reimbursement for Rehabilitation Hospitals and Psychiatric Hospitals. Rehabilitation hospitals and psychiatric hospitals are reimbursed for inpatient services on a per diem basis. The rate is set at 85% of the average daily cost of serving MA patients. Costs are calculated using prior year cost reports and inflated to the current year using an inflation forecast. The cost of providing patient services includes fixed as well as variable costs, although capital costs are limited to 8% of the total.

For psychiatric hospitals that are classified as institutes for mental disease (IMDs), federal law restricts MA reimbursement to patients who are age 65 and older or under the age of 21 (except that persons who were in the hospital upon turning age 21 may receive MA-reimbursed services as long as they remain in the hospital, up until turning age 22). Federal law defines an IMD as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care for individuals with mental diseases, including medical care, nursing care, and related services.

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

Under the EAPG system, DHS calculates a standard EAPG group rate based on outpatient cost data, averaged across all procedures and services statewide, and the MA program target budget for outpatient services. For 2015, the un-

adjusted EAPG base rate is $72.46. A slight hospital-specific adjustment is made to this rate for direct graduate medical education costs, but unlike the DRG base rate, the EAPG rate is not adjusted for other hospital-specific factors such as wage differentials and capital costs.

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

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

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

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

Performance-Based Payments. DHS withholds 1.5% of a hospital's total fee-for-service claims payments (excluding supplemental payments, described below) to fund an incentive program based on various hospital performance measures. Hospitals that meet performance targets can earn back their share of withheld funds. Those hospitals may also be eligible for bonus payments, drawn from funds withheld from hospitals that did not meet performance targets. The performance standards include 30-day hospital re-admission rates, asthma care for children, antibiotics for community-acquired pneumonia, and healthcare personnel influenza vaccinations, among others. Wisconsin-based acute care hospitals (other than long-term care hospitals), children's hospitals, critical access hospitals, and psychiatric hospitals are included in the withhold-based payment program.

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

Hospital Access Payments. In addition to the reimbursement policies outlined above, most Wisconsin hospitals (except for psychiatric hospitals and state mental health institutes) also re-

ceive "access" payments for serving MA recipients. These hospital access payments are funded by the state's hospital assessment, along with a portion of the federal MA matching funds received by the state when assessment funds are expended under the MA program.

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

For an MA recipient receiving hospital services on an FFS basis, the MA program makes an access payment directly to the hospital for each inpatient discharge and outpatient visit. The current FFS access payment for each inpatient discharge (for dates of discharge starting July 1, 2014) is $3,816 for non-CAH hospitals and $951 for CAHs, while the access payment for each outpatient visit is $329 for non-CAH hospitals and $36 for CAHs.

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

In 2014-15, DHS will distribute a total of $657.5 million in access payments for non-CAH hospitals and $13.1 million in access payments for critical access hospitals.

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

Disproportionate Share Hospital Payments. Under federal law, states are eligible for federal MA matching funds to provide supplemental reimbursement to hospitals that serve relatively high numbers of MA recipients and low-income patients ("disproportionate share hospitals," or DSHs). The 2013-15 biennial budget requires DHS to make DSH payments of $36.8 million in 2013-14 and $36.7 million in 2014-15. DHS distributes these funds to general hospitals for which MA patient-days make up at least 6% of total inpatient days. For each qualifying hospital, the payments are calculated using an add-on percentage, multiplied by the hospital's base inpatient payment. The add-on percentage is proportional to the hospital's MA patient days percentage, such that those hospitals with a higher proportion of MA patients have a higher percentage. The maximum payment that a hospital may receive in each of the two years is $2.5 million.

Essential Access City Hospital Payments. Hospitals that meet the definition of an essential access city hospital (EACH) are eligible for a supplemental payment under the MA program. An EACH is an acute care hospital with medical surgical, neonatal intensive care, emergency, and obstetrical services, located in the inner city of Milwaukee, as defined by certain zip codes. In addition, an EACH must have 30% or more of its total inpatient days attributable to MA patients, including MA patients enrolled in an HMO, and at least 30% of its MA inpatient stays must be for MA recipients who reside in the inner city of Milwaukee. In 2014-15, two hospitals received a supplemental EACH payment: Aurora Sinai Medical Center ($3.0 million) and Wheaton Franciscan-St. Joseph Hospital ($1.0 million).

Level I Adult Trauma Centers. State law authorizes DHS to make annual payments not to exceed $8 million in the aggregate to hospitals that satisfy the criteria established by the American College of Surgeons for classification as a

Level I adult trauma center. These payments are funded by proceeds of the hospital assessment and by federal MA matching funds. UW Hospital and Clinics and Froedert Memorial Lutheran Hospital are currently the only hospitals that receive these supplemental payments.

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

Pediatric Inpatient Supplement. DHS makes supplemental payments to acute care hospitals that have inpatient days in the hospital's acute care and intensive care pediatric units that exceed 12,000 days in the second calendar year prior to the hospital's current fiscal year. Days for neonatal intensive care units are not included in that determination. The pediatric supplement, in the aggregate, is limited to $2.0 million annually. In 2014-15, UW Hospital and Clinics and Children's Hospital of Wisconsin received supplemental payments under this provision.

Rural Hospital Adjustment. Under the Department's inpatient hospital state plan, DHS is authorized to make lump sum rural adjustment payments of $300,000 each to hospitals which are classified as rural under the Medicare wage index but which are not eligible for the rural hospital percentage adjustment to their DRG rate. DHS made lump sum supplemental payments totaling $1.5 million in 2014-15 under this provision. These payments are funded with proceeds of the hospital assessment and associated federal matching funds.

In addition, 2011 Wisconsin Act 32 authorized DHS to make a payment of $300,000 annually to a hospital that: (a) is located in a city that has a municipal border that is also a state border; (b) has an MA recipient case mix that consists of at least 25 percent of residents from a border state; (c) is located in a city with a poverty level, as determined from the 2000 U.S. Census, that is greater than 5 percent; and (d) is located in a city with a population of less than 15,000. In 2014-15, the only hospital that met these criteria and received the $300,000 supplemental payment was the Bay Area Medical Center in Marinette. This payment is funded with state GPR funds in the MA budget.

Enhanced Reimbursement for Certain Services

The MA program provides enhanced reimbursement for some medical services in order to encourage provider participation in the program or to target certain MA populations. These enhanced reimbursement policies are authorized under federal law. The following section describes these provisions.

Rural Health Clinic Services. Rural health clinics (RHCs) are Medicare-certified outpatient health clinics located in rural areas with a shortage of personal health services or primary medical care professionals, as determined by the U.S. Department of Health and Human Services. Each RHC is operated under the medical direction of a physician and is staffed by at least one nurse practitioner or physician assistant. A physician, physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner may furnish services. RHC services are primary care services provided by RHC-approved professionals that meet all applicable MA eligibility requirements. RHCs are eligible for cost-based reimbursement (based on their reasonable costs determined using Medicare cost principles) for the RHC services they provide to MA enrollees. For services other than RHC services that are nonetheless covered by MA, RHCs are eligible

for MA fee-for-service reimbursement. There are currently 53 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics, and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. As required by federal law, DHS reimburses FQHCs for 100% of the reasonable costs of providing services to MA recipients. This reimbursement requirement recognizes that FQHCs serve a disproportionate share of the state's MA, Medicare, and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 19 community health centers in Wisconsin that are FQHCs and two FQHCs located in border areas of other states that are approved to serve Wisconsin MA recipients. Some FQHCs have multiple clinic locations. In addition, there are 12 health centers operated by federally-recognized Native American Tribes that are classified as FQHCs, but that are subject to different reimbursement policies, as described below.

Indian Health Services. Some MA services are provided to Native Americans through Indian Health Services (IHS) and tribe-owned facilities. MA state plans must provide that an IHS facility, meeting state requirements for MA participation, be accepted as an MA provider on the same basis as any other qualified provider. Under federal law, the state may claim 100% federal reimbursement for all services rendered to tribally-affiliated MA recipients who are seen in tribal clinics. If the MA services are provided through a tribe-owned or operated facility to non-tribal members, federal funding is available at the state's usual federal matching rate.

Health Professional Shortage Areas. The U.S. Department of Health and Human Services may designate a health professional shortage area (HPSA), which allows certain services to be eligible for enhanced reimbursement under the MA program. In this context, an "area" can be a rural or urban geographic area, but also may include a targeted population group, or a public or nonprofit medical facility. Designation is generally based on the ratio of service providers to total population. For instance, to receive a designation as a medical service HPSA, a geographic area must have a population to primary care physician ratio of at least 3,500 to 1, or at least 3,000 to 1 if it is determined that the resident population of the area has unusually high needs.

Physicians in general practice, obstetrics, gynecology, family practice, internal medicine, or pediatrics, as well as physician assistants, nurse practitioners, and nurse midwives, are eligible for enhanced reimbursement for certain services. General office visits, emergency department services, newborn care, preventive medicine, obstetrical services, and vaccinations are eligible services. Obstetrical services provided in a HPSA are eligible for an additional payment equal to 50% of the normal maximum fee, while other services are eligible for a 20% additional fee. There are 53 designated HPSAs in the state.

Reimbursement for Prescription Drugs

The MA program's pharmacy reimbursement rate includes an ingredient component and a dispensing component. Federal law specifies that the ingredient reimbursement for each drug must be no more than the pharmacy's estimated acquisition cost for the drug. The estimated acquisition cost is calculated for each drug based on the published wholesale cost for drugs, with certain adjustments to reflect actual acquisition costs. A pharmacy may submit a request for review of the state's ingredient reimbursement payment for a particular drug if the pharmacy can demonstrate

that the actual price paid for a drug was higher than the state's reimbursement payment. DHS may adjust the reimbursement rate for a drug based on such a review.

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

In addition to reimbursing pharmacies for the ingredient cost, the MA program pays pharmacies a dispensing fee for each prescription they fill. The dispensing fee is $3.44 for brand name drugs and $3.94 for generic drugs. The pharmacy can receive higher fees if they have to compound or repackage drugs.

In addition to a standard dispensing fee, pharmacies can also receive enhanced dispensing fees if they provide certain types of medication therapy management services for the participant. This care must go beyond the basic activities required by state and federal standards, and must result in a positive outcome for both the participant and the program. Examples include increasing patient compliance, preventing potential adverse drug reactions, or a scheduled private consultation with the pharmacist to review the patient's drug therapy regimen.

CHAPTER 7

ELIGIBILITY FOR ELDERLY, BLIND AND DISABLED MEDICAID PROGRAMS

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

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

For individuals who meet eligibility requirements for both BadgerCare Plus and one or more of the EBD Medicaid subprograms, the individual is enrolled in EBD Medicaid. There is an exception to this policy for pregnant women, who may be enrolled in both programs concurrently. As of November 1, 2014, approximately 214,200 individuals were enrolled in EBD Medicaid subprograms.

This chapter describes nonfinancial and financial eligibility requirements for EBD Medicaid, additional requirements affecting eligibility for EBD Medicaid, and several of the EBD Medicaid subprograms. Several other EBD Medicaid subprograms are discussed in other chapters, including Family Care (Chapter 9) and the home and community-based services (HCBS) waiver programs (Chapter 10).

Eligibility Requirements

Nonfinancial Eligibility. In order to be eligible for most of the EBD Medicaid subprograms, an individual must meet the following nonfinancial eligibility requirements: (a) be at least 65 years old, blind, or disabled; (b) be a state resident; (c) be a U.S. citizen or qualifying immigrant; (d) cooperate with medical support liability and third party liability; (e) provide a social security number or apply for a social security number; and (f) pay any required premium or other cost-sharing amount.

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

Federal law permits states to make presumptive eligibility determinations, which enable applicants to be considered disabled until a final disability determination can be completed by the

DHS Disability Determination Bureau. In Wisconsin, if an individual has an urgent need for medical services and has one of a specified set of impairments, the individual can be treated as presumptively disabled.

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

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

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

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

- Individuals with income from a job benefit from the $65 and one-half earned income deduction, which is calculated by subtracting $65 from the applicant's monthly gross job income and wages, dividing the remaining amount by two, then adding back the $65.

- A legal expense credit equal to expenses for establishing and maintaining court-ordered guardianships or protective placements, including court-ordered attorney and guardian fees.

- If the individual is blind or disabled, income the individual receives to purchase training or equipment under an approved self-support plan.

- Support payments an applicant or recipient makes to another person outside of the household for the purpose of supporting and maintaining that person.

- For a person in an institution who has a home or apartment, an amount that allows the individual to maintain the home or apartment that does not exceed the SSI payment level plus the SSI "exceptional expense supplement" for one person.

- Heating and electricity for a property listed for sale, if the person is residing in a nursing home.

- Depreciation and business losses from self-employment.

- Medical and remedial expenses that are not covered by other sources, such as out-of-pocket deductibles, co-payments and premiums, and expenses for goods and services that are provided for the purpose of relieving or reducing a medical or health condition.

- Impairment related work expenses (IREs), which are expenses by the individual that are related to the member's impairment and employment, such as modified audio/visual equipment, reading aids, and vehicle modifications.

- A standard Medicaid credit of $20.

Once an applicant's countable income is determined, his or her counted income is compared with two monthly income limits -- one that is used for single individuals, and the second for married individuals. In 2015, the income limit for individuals is $572.45, plus actual shelter costs up to $244.33, for a total of $816.78. The income limit for an individual who is married is $865.38, plus actual shelter costs of up to $366.67, for a total of $1,232.05.

If an individual does not qualify for Medicaid coverage only because the individual's income exceeds the income limits described above, he or she may still qualify for Medicaid coverage by meeting the Medicaid deductible. An applicant meets the deductible by paying or incurring out-of-pocket health-related expenses, including medical expenses, remedial expenses, ambulance and other transportation services, health insurance premiums, and other expenses specified in the *Medicaid Eligibility Handbook*, for the applicant, the applicant's spouse, or the applicant's minor children that live in the household. Once the individual meets the deductible, other Medicaid-covered services the individual receives during a six-month deductible period are paid by the state Medicaid program.

The applicant's deductible is calculated by determining the monthly amount by which the individual's counted income exceeds the medically needy income limit ($591.67 per month in 2015) and multiplying that amount by six to reflect the six-month period for which Medicaid coverage is provided.

The applicant can choose to begin the deductible period as early as three months prior to the month of application, and as late as the month of application. However, an applicant cannot choose a deductible period that includes a month in which, if the applicant had applied, the applicant would have been ineligible due to excess assets.

Additional Eligibility Options

SSI-Related Eligibility. Many EBD Medicaid recipients qualify for the standard Medicaid benefits plan because they receive cash benefits under the supplemental security income (SSI) program, or meet requirements relating to the SSI program. In calendar year 2015, the federal SSI income limit is $733 per month and the asset limit is $2,000 for an individual. For couples, the income limit is $1,100 per month and the asset limit is $3,000. States may enter into agreements with the Social Security Administration, which administers the SSI program, to provide all SSI recipients with Medicaid eligibility, eliminating the need for individuals to apply for both programs separately. Wisconsin's Medicaid program provides automatic coverage for individuals who receive cash assistance under the SSI program.

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

Federal law requires state Medicaid programs to provide coverage for several groups of individuals who were previously eligible for SSI, but no longer receive monthly SSI payments. For instance, states must provide Medicaid coverage to certain disabled individuals who have returned to work and have lost eligibility for SSI as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. States must continue to provide Medicaid coverage to these individuals if they need Medicaid coverage to continue employment and their earnings are not sufficient to provide the equivalent of SSI Medicaid and attendant care benefits

they would qualify for in the absence of earnings.

States must also continue Medicaid 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 Medicaid eligibility. Similar Medicaid continuations have been provided for certain other individuals who become ineligible for SSI due to changes in eligibility for, or increases in, Social Security or veterans benefits. Finally, states must maintain Medicaid coverage for certain SSI-related groups who received benefits in 1973, including individuals who care for disabled individuals.

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

Medicaid Eligibility for Individuals Who Require Long-Term Care Services. Under federal law, states may provide Medicaid coverage to residents of institutional facilities (nursing facilities, hospitals and other medical institutions) and individuals who live in their own homes but participate in the community-based waiver programs, under a special institutional income rule. This rule permits individuals who are not eligible for SSI and have income that does not exceed 300% of the maximum monthly federal SSI payment amount to be automatically eligible for Medicaid coverage without meeting the Medicaid deductible. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($2,199 per month in 2015).

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

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

Additional Factors Affecting Eligibility

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

Spousal Impoverishment. Spousal impoverishment protections refer to features of the Medicaid program that affect legally married couples for whom one spouse receives certain long-term care services (the institutionalized spouse) while the other does not reside in a nursing home or medical institution (the community spouse). The protections allow a portion of the couple's income and assets to be retained for the community spouse. The institutionalized spouse can be receiving long-term services either in a nursing home or through a HCBS 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 requests a community-based long-term care program, the county social services or human services department will, upon request, conduct an assessment of the couple's combined total assets. Countable assets include items owned by either spouse, but exclude the couple's home, one vehicle, assets related to burial (including insurance, trust funds, or plots), household furnishings, and clothing or other personal items.

The level of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or request for HCBS waiver benefits. Federal law allows states discretion in establishing the asset protection level within minimum and maximum limits ($23,844 to $119,220 in calendar year 2015). Most states allow the community spouse to keep the maximum level, regardless of the amount of the couple's total assets.

Wisconsin has set its spousal asset protection level at the greater of: (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum of $119,220. 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 his or her own assets. These excess assets may be used to pay for long-term care services or for other purposes, such as home repair or improvement, vehicle repair or replacement, clothing or other household expenses. Any countable assets in excess of these protected amounts must be expended before the institutionalized spouse can become eligible for Medicaid.

The following example illustrates how the asset test is currently applied in Wisconsin. Consider a couple whose combined countable resources are $120,000 at the initial period of continuous institutionalization. The spousal share, which is equal to one-half of the couple's countable resources, is $60,000. After a period of time, the institutionalized spouse applies for Medicaid. By the time the institutionalized person applies for Medicaid, the couple's combined countable resources have been reduced to $90,000. In this example, the greater of: (a) the spousal share at the beginning of the initial period of institutionalization ($60,000); or (b) the state spousal resource standard ($50,000) would be deducted from the combined countable resources at the time of application, resulting in an unprotected resource amount of $30,000 ($90,000 minus $60,000). Because $30,000 exceeds the state's asset limit of $2,000, the institutionalized spouse would not be eligible for Medicaid. However, if, during that same period of institutionalization, the couple's combined resources are reduced to less than $62,000, the institutionalized spouse would meet the Medicaid asset test because their assets would be 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 Medicaid. 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 Medicaid. 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 Medicaid-supported long-term care services.

In addition, spousal impoverishment provisions allow part of the institutional spouse's income to be transferred to the community spouse to provide income for the community spouse. Under federal law, the maximum amount of income that states must allow to be transferred to the community spouse is an amount that would

raise the community spouse's total income for 2015 to either $2,980.50 per month or $2,621.67 per month plus any shelter costs greater than $786.50. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index. Additional income may also be transferred to provide for certain dependent family members living with the community spouse.

Under federal law, the minimum amount of income that states must allow to be transferred to the community spouse is an amount that would bring the community spouse's total income up to the sum of: (a) 150% of the FPL for a family of two; and (b) an excess shelter allowance equal to the amount by which shelter costs exceed 30% of the federal minimum amount. Since the FPL is usually adjusted each year to reflect increases in the cost of living, the federal minimum is usually 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. For 2015, the maximum amount that may be transferred to the community spouse is an amount that would raise the community spouse's total income to either $2,980.50 per month or $2,621.67 per month plus any shelter costs greater than $786.50. Shelter expenses include the community spouse's expenses for rent, mortgage principal and interest payments, taxes and insurance for a principal place of residence, maintenance fees if the community spouse lives in a condominium or cooperative, and a standard utility allowance. In addition, Wisconsin currently permits the institutionalized spouse to transfer up to $655.42 per month in 2015 for each qualifying dependent family member living with the community spouse.

The federal Deficit Reduction Act of 2005 (DRA) clarified that transfers of resources from the institutionalized spouse to the community spouse under these circumstances must follow the "income first" method. Under the "income first" method, the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet the minimum monthly maintenance needs allowance. Any remaining income is then applied to the institutionalized spouse's cost of care. Under this method, the assets of the institutionalized spouse (including annuities or other income-producing assets) can only be transferred to the community spouse if such a transfer would not cause the community spouse's income to exceed the state-approved monthly maintenance needs allowance. Otherwise, they remain attributed to the institutionalized spouse and must be used towards care costs. This option generally requires a couple to deplete a larger share of their assets before becoming eligible for Medicaid.

In addition to any amount transferred to the community spouse, the institutionalized spouse may retain income as a personal needs allowance. If the person is in a nursing home, the personal needs allowance is $45 per month. If the individual is enrolled in an HCBS waiver program, the allowance is higher to support food, shelter, and other costs (between $913 and $2,199 per month in 2015). Any income in excess of the amount transferred to the community spouse, the personal needs allowance, health insurance premiums, court-ordered support, and other allowable income deductions, must be used to pay for long-term care costs.

The following example illustrates how the income test is applied in Wisconsin. In 2015, if a community spouse has shelter costs of $866 per month, the excess shelter costs equal $79.50 per month ($866 - $786.50 = $79.50). In this case, the maximum monthly income allocation is $2,675.50 ($2,621.67 + $79.50 = $2,701.17). If the community spouse receives $200 per month as income in his or her name, the amount is subtracted from $2,701.17 per month to determine the spousal income allocation amount ($2,501.17). If the institutionalized spouse's in-

come is $3,600, the institutionalized spouse's nursing home liability amount would be $879.50 per month [$3,600 (the institutionalized spouse's income) - $2,501.17 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,053.83].

Divestment. State and federal Medicaid law include provisions that are intended to prevent individuals with financial resources from disposing of assets or income for less than market value for the purpose of becoming eligible for Medicaid. The following discussion provides a brief summary of state divestment rules implemented by DHS. A full description of the state divestment rules can be found in the state's *Medicaid Eligibility Handbook*.

Divestment occurs when an individual transfers income, non-exempt assets, or other homestead property that belongs to an institutionalized person or his or her spouse for less than the fair market value, or when an individual takes an action to avoid receiving income or assets to which he or she is entitled. In the latter case, actions that would cause income or assets not to be received include: (a) irrevocably waiving pension income; (b) disclaiming an inheritance; (c) not accepting or accessing injury settlements; (d) diverting tort settlements into a trust or similar device; (e) refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony; and (f) refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate if the value of the abandoned portion is clearly identified and there is certainty that the action would be successful.

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

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

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

Divestment penalties also do not apply if the individual demonstrates that: (a) the individual intended to dispose of the assets either at fair market value or for other valuable consideration; (b) the assets were transferred exclusively for a purpose other than to qualify for Medicaid; (c) the community spouse divested assets that were part of the community spouse asset share; (d) all of the assets transferred for less than fair market

value have been returned to the individual; (e) the division or loss of property occurred as a result of a divorce, separation action, foreclosure, or repossession; or (f) imposition of a penalty would result in an undue hardship. Undue hardship is considered a serious impairment to the institutionalized person's immediate health.

A person may be denied Medicaid coverage 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 Medicaid resource test. States are required to review the assets of all long-term care Medicaid applicants over a specified time period, known as the "look back" period, before the date the applicant applied for Medicaid or was institutionalized. For divestments occurring before January 1, 2009, states are required to review the assets of all long-term care Medicaid applicants for a period of 36 months before the date the applicant applied for Medicaid, or 60 months if the applicant's assets were included as part of a trust. The DRA extended the length of the look back period to 26 months for divestments occurring from January 1, 2009, to January 1, 2012, 37 to 59 months for divestments occurring from January 1, 2012, to December 31, 2013, and 61 months for divestments occurring after January 1, 2014.

If an eligibility worker determines that an individual transferred resources any time during the look back period, a penalty period would be calculated. The penalty period establishes the amount of time that the person would be ineligible for Medicaid-funded long-term care costs. The length of the penalty period is calculated by dividing the amount of the transfer by the daily private pay rate of nursing homes ($241.78 beginning in July, 2014). The penalty period begins on the date the individual applies for Medicaid services and meets all other eligibility criteria.

For example, if a person made a transfer of $50,000 one year before applying for Medicaid, this would generate a penalty period of 206 days ($50,000/$241.78 per day = 206.8 days, rounded down). The penalty period begins on the date the person is determined to be eligible for Medicaid and would be receiving care in a nursing home or services under a HCBS waiver program, based on an approved application for such care. Under this example, the Medicaid program would not pay for long-term care services for the individual until 206 days after the person applies and is determined to be eligible for Medicaid-funded long-term care services. If an individual is already enrolled in Medicaid but is not receiving long-term care services, the penalty period would begin when the individual is approved to receive long-term care services.

In addition to extending the look back period, the DRA also addressed how the state must consider annuities. As a result, applicants and recipients of long-term care services are now required to disclose any annuities they or their community spouse own and whether the annuity is irrevocable or counted as an asset. The purchase of an annuity may be considered a divestment unless one of the following conditions are met: (a) the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid benefits received; (b) the state is named as a beneficiary in the second position behind a community spouse, a minor, or a disabled child; or (c) the state is named in the first position if the spouse or the child's representative disposes of any remainder for less than fair market value.

Under the rules mandated by the DRA, individuals may also be disqualified from Medicaid eligibility if the equity in their home and the land used and operated in connection with the home exceeds a certain value. Federal rules establish this threshold at $500,000. However, states that submit a state plan amendment may increase this amount to $750,000. Wisconsin has elected to adopt this higher threshold. The limit does not apply if a spouse, minor, or disabled child resides

in the home.

Finally, the DRA expanded the types of assets that may be counted as a resource that can be used by an individual to contribute to the cost of care prior to receiving Medicaid. If an individual resides in a continuing care or life care community at the time he or she applies for Medicaid, the entrance fee paid upon admission to the community is considered an available resource to the extent the individual: (a) has the ability to use the fee to pay for care; (b) is eligible for a refund of any remaining entrance fee upon death or termination of the contract; and (c) the entrance fee does not confer ownership interest in the community. Similarly, a life estate purchased by a Medicaid-eligible individual may also be counted as a divestment of available resources, unless the purchaser resides in the home for at least one year after the date of purchase.

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

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

Estate Recovery Program. Under the estate recovery program, DHS recovers from the estates of deceased Medicaid recipients or from the estates of their surviving spouses Medicaid payments for nursing home care and institutionalized inpatient hospital care, which are used to offset Medicaid program costs. In addition, the state may recover Medicaid payments for certain home health services and for all services received while participating in a long-term care program for individuals who are age 55 and over. Long-term care programs include the HCBS waiver programs, Family Care, Family Care Partnership, the Program for All-Inclusive Care for the Elderly (PACE) and Include, Respect, I Self-Direct (IRIS). DHS recovers the full amount of the capitation payments made to managed care organizations (MCOs) on behalf of the recipient for long-term care program services delivered through managed care.

State law requires the state to file claims against the estate of a Medicaid recipient or the estate or the surviving spouse to recover certain costs, except in cases that would cause undue hardship. In addition, DHS may recover from all property in which the recipient had an interest in at death, including life estates, property held in revocable trusts, property that passes by beneficiary designation, joint tenancy property, and marital property. The following discussion provides a brief summary of the estate recovery program. A full description of the program can be found in the state's *Medicaid Eligibility Handbook*.

The estate recovery program attempts to recover Medicaid costs by: (a) placing a lien against a home; (b) filing claims in a recipient's estate or in the estate of his or her surviving spouse; (c) affidavits; and (d) voluntary recoveries. DHS may place a lien on the home of a Medicaid recipient who is in a nursing home or hospital facility if the individual is not expected to be discharged from the nursing home or hospital, is required to contribute to the cost of care, and if

certain family members do not reside in the home. These family members include the Medicaid recipient's spouse, the recipient's child who is under 21, blind, or disabled, or the recipient's sibling who has an equity interest in the home and who has lived in the home continuously beginning at least 12 months before the recipient was admitted to the nursing home or hospital. Before placing a lien, DHS must notify the recipient in writing of its intention and advise the recipient that he or she has a right to a hearing on whether the necessary conditions have been satisfied.

DHS can also place other claims against a recipient's estate or the estate of his or her surviving spouse. A claim on the estate may not be paid while a spouse, or a child under age 21, blind, or disabled, survives the recipient. The heir or beneficiary of the deceased member's estate may apply for a waiver of the claim if any of three hardships exist: (a) the waiver applicant would become eligible for certain state assistance programs if the estate claim is pursued; (b) the real property is part of the waiver applicant's business and the claim would result in the loss of his or her means of livelihood; or (c) the waiver applicant is receiving general relief or veterans benefits under the economic assistance subsistence grant. Heirs, co-owners, and beneficiaries of a deceased recipient's property transferred by affidavit or through non-probate transfer may also apply for a waiver due to hardship.

Property of the Medicaid recipient that is being transferred by an affidavit or by a non-probate transfer on death is subject to a lien if the state's claim cannot be satisfied through available liquid assets. DHS cannot enforce that lien, however, while a spouse, or a child under age 21, blind or disabled, survives the recipient. DHS may also send an affidavit to an heir, beneficiary or co-owner who claims or transfers the recipient's property to recover any property remaining after burial and estate administration costs have been paid.

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

EBD Medicaid Programs

While all EBD Medicaid-eligible individuals have access to certain Medicaid-covered services (the services described in Chapter 5), the Medicaid program includes several programs in which the EBD Medicaid population may also participate. These programs, excluding Family Care and related programs discussed in Chapter 9 and the HCBS waiver programs discussed in Chapter 10, are discussed below.

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

Enrollees have access to all of the covered services described in Chapter 5. In addition, enrollees receive a complete assessment of medical and social needs, a care plan for medical and social services, assistance from a health care coor-

dinator, and transportation to and from appointments and covered services.

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

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

The Medicaid SSI contract for January, 2014 through December, 2015 specifies that the state will pay SSI managed care organizations capitation rates that are actuarially sound and determined based on medical status, Medicare coverage levels, and service utilization rates. In 2009, DHS also implemented a multi-year pay-for-performance (P4P) program that was intended to improve the performance of the health care delivery system as well as improve the health and health care outcomes of Medicaid members.

As of October, 2014, seven HMOs provided managed care to approximately 37,651 SSI managed care recipients. In 2013-14, approximately $256.4 million (all funds) was expended to support SSI managed care capitation payments throughout the state. That amount includes hospital access payments DHS made to SSI HMOs. Table 7.1 provides a breakdown of SSI managed care enrollees by eligibility group.

Table 7.1: SSI Managed Care Enrollees by Eligibility Group, October, 2014

MAPP - Duals	1,676
MAPP - Medicaid Only	367
SSI - Duals	6,693
SSI - Medicaid Only	23,236
SSI Related - Duals	3,230
SSI Related - Medicaid Only	2,449
Total	**37,651**

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

Individuals are eligible to participate in MAPP if: (a) their family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL; (b) their countable assets under Medicaid financial eligibility rules do not exceed $15,000; (c) they have a disability, under SSI standards (disregarding one's ability to

work); (d) they are engaged in gainful employment or are participating in a vocational program that is approved by DHS; and (e) they are at least 18 years old.

Individuals enrolled in MAPP pay a monthly premium if their individual gross monthly income, before deductions or exclusions, exceeds 150% of the FPL for their family size. The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the following deductions: (a) standard living allowance ($836 per month in calendar year 2015); (b) impairment-related work expenses; (c) out-of-pocket medical and remedial expenses; and (d) a cost of living adjustment disregard. The part of the premium based on earned income is equal to three percent of earned income. If the deductions for unearned income are greater than unearned income, any remaining deductions can be applied to earned income before the three percent premium rate is applied.

As of November, 2014, there were approximately 24,700 individuals enrolled in MAPP.

People with Tuberculosis. An individual who is infected with tuberculosis (TB), but who is not blind, disabled or over the age of 65 may be eligible to receive certain Medicaid-funded services if he or she has countable assets of $2,000 or less and gross income of up to $1,527 per month. For these individuals, Medicaid coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services and services provided by federally-qualified health centers; (e) case management services; (f) services designed to encourage individuals to take their medications; and (g) services that are necessary as a result of side effects of medications prescribed to treat tuberculosis. As of July, 2014, there were 204 individuals enrolled in Medicaid that met these criteria.

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

In 1982, federal Medicaid law was modified to incorporate the Katie Beckett provision. This provision permits states to extend Medicaid coverage to disabled children under the age of 19 who: (a) would be eligible for Medicaid if they were in a hospital or nursing facility; (b) require a level of care typically provided in a hospital nursing facility; (c) can appropriately receive care outside of a facility; and (d) can receive care outside of an institution that costs no more than the estimated cost of institutional care. Unlike certain other Medicaid recipients, the families of the children eligible under the Katie Beckett provision are not subject to copayment or deductible requirements. However, a parental liability may be assessed to help offset the costs of providing services for children who are eligible under the Katie Beckett provision and participate in the children's long-term support program (CLTS). As of July 1, 2014, 4,994 children in Wisconsin were enrolled in the Katie Beckett program.

Medicare and Dual Eligibles

The federal Medicare program provides health care coverage for people who are 65 years

of age or older, certain disabled individuals who are under the age of 65, and persons of all ages with end-stage renal disease (people who require dialysis or a kidney transplant).

The program provides several types of health care coverage. Part A covers hospital care, non-custodial care in a skilled nursing facility following an inpatient hospital stay, hospice care, and home health services. Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Part C, also known as Medicare Advantage, is an alternative to Parts A and B, and in some cases Part D, in which Medicare enrollees choose to receive the same services through a private health plan of their choosing, rather than through the fee-for-service system used in Part A and Part B. Part D refers to Medicare outpatient drug coverage, which is discussed in greater detail in Chapter 11.

Medicare Part A and B Cost-Sharing. After reaching age 65, most individuals are entitled to coverage under Medicare Part A and do not pay a monthly premium for this coverage because they or their spouse have 40 or more quarters of Medicare-covered employment. For individuals that do not meet the 40 quarter requirement, Medicare coverage can still be obtained by paying a premium. In 2015, the monthly premium for Part A coverage is $407 for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment, and $224 per month for people who have 30 to 39 quarters of Medicare-covered employment.

All persons who enroll in Medicare Part A may enroll in Medicare Part B by paying a monthly premium. In calendar year 2015, individuals and married couples with annual incomes less than $85,000 and $170,000, respectively, pay monthly premiums of $104.90 and $146.90.

Individuals that receive Medicare Part A and B services may be subject to certain deductible and coinsurance requirements based on the length of the benefit period for which services are received. A "benefit period" is a period of consecutive days during which medical benefits for covered services are available to the individual. The benefit period is renewed when an individual has not been in a hospital or skilled nursing facility for 60 days. Under Part A, the maximum benefit period is 60 full days of hospitalization, plus 30 days during which the individual pays coinsurance. An individual may also utilize up to 60 additional benefit days drawn from his or her lifetime reserve. Lifetime reserve days are not renewable. For a skilled nursing facility, the maximum benefit period is 100 days, with copayment requirements for days 21 through 100.

In 2015, Medicare Part A pays for all covered Part A services in a benefit period, except a deductible of $1,216 during the first 60 days of a hospital stay and coinsurance amounts for hospital stays that last beyond 60 days but not more than 150 days ($315 per day for days 61 through 90 and $630 per day for days 91 through 150). For care provided in a skilled nursing facility, the coinsurance amount is $157.50 per day for days 21 through 100 each benefit period.

In 2015, Medicare Part B pays for all covered Part B services in the benefit period except a deductible of $147 per year and a cost share of 20% of the Medicare-approved amount for services after the $147 deductible is met. The cost share for outpatient mental health is 20% to 40% of the Medicare-approved amount after the deductible. Providers must accept Medicare rates as full payment for any services provided to a Medicare enrollee.

Dual Eligibles. Some individuals with Medicare coverage are also eligible for some form of Medicaid benefit. These individuals are commonly referred to as "dual eligibles." There are several groups of dual eligibles. These groups differ based on eligibility criteria and the scope of the benefit funded by the state's Medicaid program.

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

1. *Qualified Medicare Beneficiary (QMB)*. QMB participants are individuals who are entitled to Medicare Part A services whose income does not exceed 100% of the FPL, and whose resources do not exceed a resource limit of $7,280 for an individual and $10,930 for a couple in 2015. This group includes elderly individuals who are not automatically entitled to Part A coverage, but who are eligible to purchase Part A coverage by paying a monthly premium. For QMB participants, Medicaid pays any required Medicare premium, coinsurance, copayments, and deductible for both Medicare Part A and Part B coverage.

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

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

3. *Qualified Disabled and Working Individual (QDWI)*. Under federal law, a disabled Medicare recipient who works and who previously qualified for Medicare due to a disability, but who lost eligibility for Medicare because of his or her return to work may purchase Medicare Part A and Part B coverage. If the individual's income is less than 200% of the FPL and his or her resources do not exceed twice the SSI limit ($4,000 for an individual and $6,000 for a couple) but the individual does not otherwise qualify for Medicaid Assistance, Medicaid will pay for the individual's Medicare Part A premiums.

Dual Eligibles with Full Benefits. Some dual eligibles qualify for full Medicaid coverage. If these individuals meet the QMB, SLMB, or SLMB+ eligibility criteria described above, they may also receive assistance with some combination of their Part A and B premiums, coinsurance, and deductibles.

For most full benefit dual eligibles, Medicare covers eligible services up to Medicare cost-sharing and service limitations. Any costs not covered by Medicare are covered first by other supplemental coverage the person may have and

last by Medicaid. Medicaid is always the last payer. Supplemental coverage, sometimes referred to as Medigap coverage, is private insurance a Medicare recipient may purchase to cover the cost of Medicare Part A and B cost-sharing. Supplemental plans are not available to Part C participants.

For example, following an inpatient hospital stay, an individual may require care in a skilled nursing facility. In this example, the Medicare program would pay for the covered Medicare services the individual receives, such as the first 100 days of care in the skilled nursing facility, but the Medicaid program would pay for all Medicaid covered services that are not covered under Medicare, including the days of care in the facility that exceed 100 days and any deductibles, premiums, and coinsurance. In these cases, the Medicaid coverage the individual receives is said to "wrap around" the more limited coverage available under Medicare.

Medicare Crossover Claims. Medicare crossover claims are claims submitted to the state's Medicaid program for services provided to dual eligibles that are covered under Medicare that require Medicaid payment for deductibles and coinsurance (dual eligibles with full benefits and QMB participants). The firm with which CMS contracts to administer the Medicare Part B benefit in Wisconsin automatically forwards claims to the Medicaid program in cases where: (a) the firm has identified that the service was provided to a dual eligible; and (b) the claim is for a recipient who is not enrolled in a Medicare Advantage plan (Medicare Part C). Other crossover claims are submitted by health care providers, including claims for services provided to dual eligibles enrolled in Medicare Advantage plans and claims that were initially submitted by the firm that were not processed by the Medicaid program within 30 days.

State and federal law restrict the amount of reimbursement Medicare providers can receive for a service. Under federal law, the total payment a health care provider receives as reimbursement for services may not exceed the Medicare-allowed amount for that service. This means providers cannot seek reimbursement above the Medicare rate from recipients or their supplemental plans. State law also limits Medicaid reimbursement for coinsurance and copayment for Medicare Part B services and inpatient hospital services provided under Part A. Medicaid payments for these services are limited to an amount no greater than the allowable charge under Medicaid less the direct Medicare payment the provider receives.

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

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

to opt out of Medicare Part C and return to coverage provided under Part A and B, or switch from one Medicare Advantage plan to another plan of the same type.

Table 7.2 summarizes asset and income eligibility limits for select Medicaid subprograms and the MSPs described in this chapter as of January 1, 2014. The income and asset limits shown in the table reflect countable income and assets, and are generally applied after various deductions and exclusions described in this chapter.

Table 7.2: Income and Asset Eligibility Criteria for Medicaid by Group and Eligibility Category, As of January 1, 2015

MEDICAID				
Sub-Program	**Family Size**	**Monthly Income Limit**	**Asset Limit**	**Eligibility Requirements**
Categorically Needy	1	$816 (Includes the maximum shelter allowance of $244)	$2,000	• People who meet eligibility requirements for the supplemental security income (SSI) program, including: (a) people who are over age 65; (b) people who are totally and permanently disabled; and (c) people who are totally and permanently blind.
	2	$1,232 (Includes the maximum shelter allowance of $367)	$3,000	
Medically Needy	1	$592	$2,000	• People who meet the demographic eligibility criteria for the elderly, blind and disabled group who incur medical expenses, resulting in their "spending down" to medically needy asset and income criteria.
	2	$592	$3,000	
Community Spouse Protected Income and Resources	2	$2,980	See Text	• A community spouse of an institutionalized Medicaid-eligible person may retain a certain amount of monthly income and assets that do not have to be used towards the care costs for the institutionalized individual. The spousal asset protection level is the greater of (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum of $119,220. In each case, the institutionalized spouse may retain $2,000 in assets. In addition to the assets retained by the community spouse, part of the institutional spouse's income may be transferred to the community spouse to provide income for the community spouse and any dependents living with the community spouse (an additional $655.42 per month for each qualifying dependent).
Special Income Limit	1	$2,199	$2,000	• Individuals who are not categorically eligible for Medicaid with income not exceeding 300% of the monthly federal SSI payment level and who are residents of institutional facilities or participating in a community-based services waiver program. • Enrollees are allowed to retain $45 per month if institutionalized or between $913 and $2,199 per month if participating in a community-based services waiver program in addition to the community spouse income and resource protections described above.
MA Purchase Plan (MAPP)	1	250% of FPL	$15,000	• Disabled adults who are working or enrolled in an approved vocational program with income up to 250% of the FPL and assets below $15,000. • All services under Medicaid are covered, but a premium is charged for enrollees with income that exceeds 150% of the FPL.
	2	250% of FPL	$15,000	
MEDICARE SAVINGS PROGRAMS				
Sub-Program	**Family Size**	**Income Limit**	**Asset Limit**	**Benefits Paid**
QMB	1	100% FPL	$7,280	Medicare Part A and B premiums, coinsurance and deductibles
	2	100% FPL	$10,930	
SLMB	1	100 - <120% FPL	$7,280	Part B premium
	2	100 - <120% FPL	$10,930	
SLMB+	1	120 - <135% FPL	$7,280	Part B premium
	2	100 - <135% FPL	$10,930	
QDWI	1	200% FPL	$4,000	Part A premium
	2	200% FPL	$6,000	

CHAPTER 8

NURSING HOME SERVICES

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

In state fiscal year 2014, there was an average of 34,835 licensed nursing home beds in the state, including beds in state nursing homes. Of this total, an average of 82.6% of the beds were occupied, with 65.7% of occupied beds occupied by MA recipients.

Most, but not all nursing homes are certified to serve MA recipients. As of August, 2014, there were 379 MA-certified nursing homes in Wisconsin (including state-operated facilities) with a total of 32,777 licensed beds. Approximately 85.8% of these facilities were privately owned and operated (31.4% non-profit and 54.4% for-profit), while the remaining 14.2% were owned and operated by state and local governments.

In addition to nursing homes, there were seven ICFs-ID in the state, excluding the three State Centers for Persons with Developmental Disabilities. These seven ICFs-ID had a total of 208 licensed beds. Each licensed ICF-ID was MA-certified.

Table 8.1 shows the total number of MA-certified nursing facilities and MA-certified ICFs-ID in Wisconsin, including state facilities, by ownership type, as of August 2014.

Table 8.1: MA-Certified Nursing and ICF-ID Facilities (August, 2014)

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	206	17,222
Non-Profit	119	9,847
Government	54	5,708
Total	**379**	**32,777**
ICF-ID		
For-Profit	1	9
Non-Profit	1	55
Government	8	584
Total	**10**	**648**

Facility Types and Services

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

Nursing home care is a covered service under MA when the services are provided to an MA-eligible individual in an MA-certified facility and the following conditions are met: (a) a registered nurse has conducted a comprehensive, accurate, standardized, reproducible assessment of the res-

ident's functional capacity; (b) the facility conducts an assessment of the resident within 14 days of admission to a facility, promptly after a significant change in the resident's physical or mental condition, and at least once every three months; (c) the assessment is a reflection of each resident's plan of care; and (d) the assessment is coordinated with any state-required pre-admission screening to avoid duplication of assessments.

Nursing facilities may not admit a person who is mentally ill or intellectually disabled unless a pre-admission screening and annual resident review (PASARR) determines that the individual requires the level of services provided by a nursing facility. Nursing facilities use different levels of PASARR screens, which provide differing levels of review of the resident's condition and needs.

ICFs-ID. Federal law defines an ICF-MR as an institution or a distinct part of an institution that: (a) primarily provides health or rehabilitative services for mentally retarded individuals; and (b) provides active treatment services to individuals who are mentally retarded. 2011 Wisconsin Act 126 replaced "mentally retarded" and "mental retardation" with "intellectual disability" in state statutes, and retitled ICFs-MR as ICFs-ID. However, federal law continues to refer to these facilities as ICFs-MR.

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

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

Facility Reimbursement

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

Facilities classified as nursing homes make up the largest component of institutional long-term care spending. MA fee-for-service payments to nursing homes, ICFs-ID, veterans homes, and

state centers totaled approximately $898.3 million (all funds) in fiscal year 2013-14, which represented approximately 11.8% of total MA expenditures in that year. Fee-for-service payments to non-state nursing home facilities totaled approximately $724.3 million.

Total MA payments to nursing homes have generally decreased in recent years, as more individuals receive home and community-based services under programs such as Family Care. Table 8.2 summarizes the total MA fee-for-service payments to facilities by facility type during each of the last three state fiscal years.

Table 8.2: Total MA Fee-For-Service Payments to Nursing Homes and ICFs-ID (All Funds -- $ in Millions)

Facility Type	2011-12	2012-13	2013-14
Non-State Facilities	$726.4	$715.7	$676.4
State DD Centers	119.7	120.0	120.1
Veterans Homes	38.9	40.9	45.8
Total	**$885.0**	**$876.6**	**$842.3**

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

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

Current law requires DHS to incorporate case-mix when calculating reimbursement rates for individual nursing facilities. In particular, the formula must include factors that: (a) incorporate acuity measurements under the most recent resource utilization groupings (RUGs) resident classification methodology adopted by CMS to determine case-mix adjustment factors; (b) determine the average case-mix index for each MA-supported nursing facility for residents who are primarily supported by MA four times each year on the last day of each calendar quarter; (c) incorporate payment adjustments for dementia, behavioral needs, or other complex medical conditions; and (d) may include incentives for providing high quality levels of care. This formula relies on acuity measures independently established and regularly updated by health care providers, based on the diagnosed care needs of each facility's residents. As a result, nursing facilities that serve higher-needs individuals will be compensated at a higher rate than facilities that serve lower-needs individuals, reflecting the higher cost of providing services to these individuals.

Under MA nursing home reimbursement methods, DHS considers five cost centers when developing facility-specific nursing home rates. These cost centers include: (a) direct care; (b) support services; (c) property tax and municipal services; (d) property acquisitions; and (e) allowable interest expenses.

Previously, these cost centers played a greater role in determining the distribution of funding between nursing homes. Facilities could expect to be reimbursed up to their actual expenditure, provided that they did not exceed the targeted cost. However, as funding provided for nursing home reimbursement has lagged behind industry cost growth and inflation, the targeted rates set for cost centers have covered a smaller percent-

age of average actual nursing home costs. DHS staff estimate that, in 2012, 70.8% of facilities experienced direct care costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives. However, when Medicaid costs across all cost centers are considered, 97.6% reported total costs that were greater than the total fee for service rate, largely due to significant deficits in the support services cost center.

Direct Care. DHS is required to establish payment for allowable direct care nursing services and direct care supplies and services. Direct care nursing services include the services of registered nurses, nurse practitioners, licensed practical nurses, resident living staff, feeding staff, nurse's assistants, nurse aide training and training supplies. Direct care supplies and services include personal comfort supplies; medical supplies; over-the-counter drugs; and the nonbillable services of a ward clerk, activity person, recreation person, social workers, volunteer coordinator, certain teachers or vocational counselors, religious persons, therapy aides, and counselors on resident living. Allowable expenses are limited to expenses incurred by the nursing facility related solely to patient care, including all necessary and proper expenses that are appropriate in developing and maintaining the operation of the nursing home facility and services.

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

Separate rates are calculated for services provided to persons with developmental disabilities. In certain circumstances DHS may also provide special rates and supplements to these standard rates. For instance, institutions receive a special per diem rate in lieu of the daily rate for individuals who are ventilator-dependent ($561 per patient day in fiscal year 2014-15). Facilities may also receive a specialized psychiatric rehabilitative services supplement of $9 per patient day to their daily rate if they prepare a specialized psychiatric rehabilitative services care plan for each resident receiving the services and submit a PASARR screen biennially that indicates that nursing home care is appropriate and specialized services are necessary.

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

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

For 2014-15, the payment to a facility for property taxes or municipal service fees is subject to a maximum payment of the previous year's tax or fees plus an inflation adjustment factor of 0.7% for real estate taxes and municipal fees.

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

For 2014-15, DHS limited the allowed replacement value to no more than $75,900 per bed. Facilities that have received DHS approval for an innovative construction and total replacement project are subject to a limit of $135,000 per bed.

Provider Incentives. The MA program pays certain qualifying nursing homes incentive payments, which are specified in the annual nursing home reimbursement formula. In 2014-15, nursing homes can receive six types of incentive payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 70% or more MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.50 per patient day to $2.70 per patient day for facilities with more than 50 beds and from $1.50 to $4.20 per patient day for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA/Medicare increases). A separate incentive payment is available for facilities located within the City of Milwaukee that ranges from $1.65 per patient day to $4.60 per patient day.

Second, a nursing facility can receive a private room incentive based on the ratio of private rooms to total licensed beds. Facilities with 15% or more of their beds in private rooms can receive a per patient day incentive equal to $1.00 multiplied by the percentage of private beds. Facilities that have replaced all of their rooms since July 1, 2000, and have 90% or more of their beds in private rooms can receive an incentive per patient day equal to $2.00 multiplied by the percentage of private beds. To receive either incentive payment, 65% of the facility's total patient days must come from MA and Medicare patients. Facilities can only receive one private room incentive payment.

Third, an incentive payment is provided to facilities that need to acquire bariatric moveable equipment during the cost reporting period to serve obese patients. This incentive allows nursing facilities to partially recoup the cost of providing services to this particular population of patients. During 2014-15, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease arrangements do not generally qualify for the incentive.

Fourth, an MA access incentive is provided to nursing facilities at a rate of $9.65 per patient day and to ICFs-ID at a rate of $33.24 per patient day during 2014-15.

Fifth, facilities can receive incentive adjustments if they have been approved for an innovative capital construction project. For proposals approved prior to July 1, 2012, a $10 per day incentive is provided to facilities receiving approval for innovative capital construction. A new innovative construction program also went into effect July 1, 2013, in which facilities can apply for one of four construction options. Options for innovative construction projects include those projects aimed at improving care, reducing the number of the facility's licensed nursing home beds, and replacing or renovating the facility. To be approved, projects must demonstrate savings for the Department in excess of any additional compensation the facility would receive. Depending on the option they select, facilities either receive fixed MA reimbursement during the phase-down period or have their un-depreciated replacement cost increased from $75,900 to $135,000 per bed and receive either a $5 or $10 add-on to the Medicaid rate per Medicaid patient day.

Sixth, two different behavior incentives are offered, which provide additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties. Each facility is assessed to calculate Behavior/Cognitive Impairment access and improvement scores, which are then multiplied by supplement base values to determine the Behavior/Cognitive Impairment Incentive. In 2014-15, the supplement base rates equaled $.380 and $0.369 per day, and were determined based on the facility's behavioral score and improvements to this score.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for direct care, support services, the property tax components, and the property allowance. In 2013-14, the average MA payment rate to nursing homes was $160.67 per day, excluding the veterans homes and state centers. Of that amount, patient liability accounted for $32.35 (20.1%) and MA payment accounted for $128.32 (79.9%).

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

County Supplemental Payment. County and municipally-operated nursing facilities and Family Care managed care organizations (MCOs) with nursing home operating costs that are not fully reimbursed by the MA per diem rate are eligible to apply for supplemental MA funding. The statutes permit DHS to provide up to $39.1 million each fiscal year to support supplemental payments to these facilities to offset operating deficits.

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

If the funding budgeted for supplemental payments is not sufficient to support each qualifying facility's eligible direct care operating deficit (EDCD), DHS then calculates an EDCD per MA day by dividing the amount of available supplemental funds by the total number of MA patient days for all facilities, factoring in the limits of each facility's EDCD. This per day amount would then be paid for each MA day, up to the amount of each qualifying facility's EDCD amount. Any funds in excess of all facilities' EDCD will be allocated based on the MA patient days with an adjustment for each facility's non-direct care deficits. In 2013-14 the rate used to allocate the supplemental payments was $34.89 per patient day.

Certified Public Expenditure Supplement. 2005 Wisconsin Act 107 created a permanent mechanism by which additional funding may be available through the nursing home certified public expenditure (CPE) program to provide additional supplemental payments to municipally-owned nursing homes. In every biennial budget, DHS estimates the amount of federal revenues it expects to receive as the federal match for the operating losses of municipally-owned nursing homes in each of the next two years. In many cases the nursing homes incurred the losses in one or more years earlier. If the amount of federal revenues received in a fiscal year exceeds the amount of revenues budgeted in that same year,

all revenues in excess of the budgeted amount are disbursed among the municipal nursing homes. No federal revenue is disbursed to municipal nursing homes when the revenues are less than the budgeted amount.

In 2013-14, no CPE payments were made to municipally-operated facilities and to Family Care MCOs. Appendix 2 identifies actual supplemental MA payments to county and municipally-operated nursing homes by county and payments made to Family Care MCOs from 2007-08 through 2013-14.

IMD Exclusion. Federal law prevents states from claiming federal MA matching funds for care provided in an institute for mental disease (IMD) for individuals between the ages of 21 and 65. Federal law defines an IMD as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care for individuals with mental diseases, including medical care, nursing care, and related services. The Trempealeau County Health Care Center is the only MA-certified, stand-alone nursing facility that is classified as an IMD. [The state-operated Mendota Mental Health Institute, also an IMD, has a geropsychiatric unit for patients that require intermediate or skilled nursing care.] DHS provides funding outside of the MA program to assist counties in supporting residents of IMDs and individuals relocated from IMDs to community-based treatment programs. In the 2013-15 biennium, the Department budgeted approximately $9.6 million GPR annually for this purpose.

Reimbursement of State Facilities. MA payments for care provided at the state centers and the veterans homes are determined by DHS separately from the methods established for all other nursing facilities. The state centers are paid based on actual costs because the RUGS system under Medicare does not establish rates for care levels that apply to individuals with developmental disabilities. Interim payment rates are established for these facilities, but DHS reconciles costs at the end of each state fiscal year to adjust payments to actual costs within the general limitations.

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

Managed Care Capitation Payments. Nursing facilities receive payment for services they provide to MA recipients participating in the state's long-term care managed care programs (Family Care, PACE and the Family Care Partnership programs). The rates paid to nursing facilities to cover the costs of services provided to these individuals are included in the capitation payments paid to managed care organizations.

CHAPTER 9

FAMILY CARE AND RELATED PROGRAMS

The state offers several Medicaid-funded managed care programs that provide long-term care services to eligible recipients. Under the Family Care program, managed care organizations (MCOs) provide long-term care services to elderly individuals, adults with developmental disabilities, and adults with physical disabilities. Although the program is not currently operating in all Wisconsin counties, the program has expanded to additional areas of the state during the past several years, replacing the county-administered Medicaid waiver programs that formerly provided community-based long-term care services to residents in these counties. These "legacy" waiver programs are described in Chapter 10. Individuals in some counties have access to two additional, fully-integrated managed care programs, the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership (Partnership) program. Additionally, individuals with long-term care needs who qualify for MA-funded community-based services, but do not wish to enroll in Family Care, have the option to participate in the state's self-directed supports long-term care program, IRIS (Include, Respect, I Self-Direct), the fee-for-service alternative to Family Care.

Expansion of Managed Long-Term Care

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

1999 Wisconsin Act 9 created the Family Care benefit, which was modeled after the PACE and Partnership programs. In 2000, Fond du Lac, La Crosse, Milwaukee, and Portage Counties began offering Family Care. Richland County began offering the program in 2001. 2007 Wisconsin Act 20 authorized DHS to expand the Family Care program statewide in all counties that choose to participate in the program. Later, the federal Centers for Medicare and Medicaid Services (CMS) required the state to offer an alternative to managed care. Consequently, Wisconsin began offering the fee-for-service, self-directed IRIS program in Family Care counties to comply with this requirement in 2008.

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

Table 9.1 shows the growth in PACE, Partnership, Family Care, and IRIS enrollment from 1997 to 2014. As of January, 2015, two counties offered PACE and 14 counties offered Partner-

Table 9.1: PACE, Partnership, Family Care, and IRIS Enrollment

	PACE	Partnership	Family Care	IRIS
1997	427	252		
1998	461	482		
1999	484	689		
2000	505	917	1,676	
2001	436	1,188	4,107	
2002	417	1,352	6,537	
2003	449	1,563	7,746	
2004	510	1,745	8,946	
2005	558	1,977	9,478	
2006	750	2,159	9,897	
2007	808	2,657	11,738	
2008	878	3,052	16,310	
2009	868	3,393	24,324	700
2010	845	3,635	30,963	2,623
2011	883	3,857	33,257	4,926
2012	784	4,000	35,058	6,965
2013	743	2,781	37,276	9,344
2014*	700	2,907	37,790	10,808

* All numbers reflect enrollment as of September 30, except 2014, which shows enrollment as of July 1.

ship. In addition, 57 counties offered Family Care and IRIS. However, on November 12, 2014, the Legislature's Joint Committee on Finance approved the implementation of Family Care in seven northeastern counties: Brown, Kewaunee, Door, Menominee, Oconto, Marinette, and Shawano. Under the approved expansion, Family Care will be phased-in to the seven northeastern counties beginning in June, 2015.

The remainder of this chapter describes each of these programs in further detail.

Family Care

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

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

An individual meets the functional eligibility criteria if the person's functional capacity requires a nursing home level of care, which is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance, or supervision, or the person's functional capacity is at the non-nursing home level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

Financial Eligibility. Individuals must meet elderly, blind, and disabled (EBD) Medicaid's asset and income test to be eligible for the Family Care benefit. As described in Chapter 7, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income limit is based on an individual's countable income and, in 2014, may not exceed $805 per month for individuals ($1,214 for married couples) that are deemed categorically needy or $592 per month for individuals that are deemed medically needy.

Provisions of Medicaid law relating to eligibility for institutional care also apply to the Family Care program. For example, an individual is financially eligible for Family Care if his or her income is no greater than 300% of the applicable SSI payment level ($2,163 per month in 2014). The same spousal impoverishment protections also apply to spouses that receive services through the Family Care program. In addition, individuals receiving services through the Family Care program may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance. In 2014, the personal needs allowance ranges from $901 to $2,163 per month.

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

In addition to long-term care services, card services that may be provided through the MCO include, but are not limited to, care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit. Table 9.2 shows Family Care service expenditures, by category, in calendar years 2011, 2012, and 2013.

Each MCO develops and manages a comprehensive network of long-term care services and supports, either through contracts with providers, or by providing care directly through its employees. DHS may contract with different entities to serve as MCOs, including the following: (a) a long-term care district; (b) a governing body of a tribe or band or the Great Lakes inter-tribal council; (c) a county; or (d) a private organization that has no significant connection to an entity that operates an Aging and Disability Resource Center (ADRC) or is establishing an ADRC. Regardless of the type of entity, however, all MCOs must ensure the following:

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

Table 9.2: Family Care Service Expenditures ($ in Millions)

	2011	2012	2013
Non-Nursing Home Residential Care (including CBRFs, AFHs, and RCACs)	$455.2	$482.5	$529.2
Supportive Home Care	160.5	166.0	171.8
Case Management	72.2	81.6	104.4
Day Center Services	51.4	51.1	50.8
Prevocational Services	33.4	39.8	39.8
Transportation	28.9	24.9	23.9
DME and Supplies	26.4	25.6	27.5
Home Health Care	16.0	10.0	8.8
Adult Day Care	12.9	12.0	11.9
Supported Employment	10.4	4.9	4.8
Financial Management	6.3	6.7	7.0
Skilled Nursing Services	6.2	5.5	5.1
Respite Care	5.9	4.7	4.7
All Other Services	16.0	14.8	14.6
Total	**$901.7**	**$930.1**	**$1,004.3**

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

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

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

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

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

The MCO capitation rates are reviewed and updated annually. DHS contracts with an actuarial firm to calculate the rates and ensure that all rates are actuarially sound, a requirement of federal law. Monthly capitation rates paid to MCOs in calendar year 2014 ranged from $2,541 to $3,542 for nursing home care and $542 to $593 for non-nursing home care.

During the first five years Family Care services are available in a county, the county's contributions to the costs of the program are determined by a formula established in 2007 Wisconsin Act 20. A county's contribution is based on whether the actual amount the county spent to provide long-term care services in calendar year 2006 was greater than or less than 22% of the county's basic community aids allocation in 2006. If the county's long-term care expenditures were less than 22% of its basic community aids allocation, the county's ongoing contribution is set at its 2006 long-term care expenditure level. If the county's long-term care expenditures were greater than 22% of its basic community allocation, the county's Family Care contribution equals its 2006 level for the first year and then decreases for the next three years by 25% of the difference between its long-term care expenditure level and 22% of its basic community aids allocation. The county's ongoing contribution is then set at 22% of the county 2006 basic community aids allocation. Appendix 4 shows how the required county contribution changes for each county during the first five years the county participates in the program.

Administration. DHS has a number of statutory responsibilities with respect to administering the Family Care program, including: (a) developing and implementing the monthly per person rate structure to support the costs of the Family Care benefit; (b) maintaining continuous quality assurance and quality improvements; (c) requiring, by contract, that ADRCs and MCOs establish procedures under which an individual who applies for or receives the Family Care benefit may register a complaint or grievance and procedures for resolving complaints and grievances; (d) developing criteria to assign priority equitably for persons waiting to enroll in Family Care; and (e) ensuring that each MCO is financially viable through maintenance of sound business practices.

Statewide Expansion. Under current law, if DHS proposes to contract with entities to administer the Family Care benefit in new geographic areas, it must first submit the proposed contract to the Joint Committee on Finance (JFC). In ad-

dition to the contract, DHS must also submit the following items to JFC prior to contracting with an MCO: (a) an estimate of the fiscal impact of the proposed expansion; (b) documentation that each county affected by the proposal consents to the administration of the Family Care benefit in the county; (c) each county's Family Care contribution; and (d) each county's proposal for how it will use any county expenditure savings that result from the Family Care benefit being available in the county. The fiscal estimate must demonstrate that the expansion will be cost neutral, including startup, transitional, and ongoing operational costs, and any proposed county contribution. DHS may only enter into the proposed contract if JFC approves the contract.

DHS uses a model to estimate costs and offsetting cost savings of expanding Family Care to new areas of the state. The cost model incorporates the following: (a) assumptions regarding the anticipated starting dates of services for various counties: (b) target groups of expected enrollees for each county; (c) cost adjustments based on health and service use histories by population group; (d) information on expected costs based on utilization patterns of current waiver enrollees and known waitlist populations; (e) estimates of new enrollees based on prior counties' experience with Family Care; (f) program and administrative cost trends adjusted for the difference in expected MCO performance from start-up through stabilization; and (g) other factors based on the costs and operating experiences from the Family Care expansion in Racine and Kenosha Counties, the current statewide waiver programs, and the state's eligible population in general.

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

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

For the first one or two years, Family Care expansion generally results in cost savings to the state. These program savings reflect the impact of a gradual phase-in of enrollment, collection of county contributions, and projected savings that accrue from providing long-term care services to individuals through one capitated rate, rather than on a fee-for-service basis. In later years, individuals from the waitlist are enrolled and the program becomes an entitlement to all eligible individuals.

Appendix 5 shows the counties that currently offer the Family Care benefit, and the MCO regions as of January, 2015. However, the attachment does not reflect the planned expansion to the seven northeastern counties in spring of 2015.

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

The plans should indicate the state's intended steps for coming into compliance with the new settings requirements, which must be completed no later than March, 2019.

In response to the CMS regulations, DHS released a transition plan proposing an assessment and subsequent compliance process for settings in which waiver services are delivered. The transition plan was open for public comment during August, 2014, and the plan was submitted to CMS in October, 2014.

PACE and Partnership

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

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

Similar to the Family Care program, the state's Medicaid program makes capitation payments to PACE and Partnership MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. In addition to the Medicaid capitation rate, these agencies also receive a Medicare capitation rate for acute care services. In calendar year 2014, monthly capitation rates paid to MCOs participating in the PACE and Partnership programs ranged from $3,044 to $3,991.

Table 9.3 shows a breakdown of PACE and Partnership service expenditures in calendar years 2012 and 2013.

Table 9.3: PACE and Partnership Service Expenditures ($ in Millions)

	2012	2013
Acute & Primary Services		
Inpatient Hospital	$34.9	$27.8
Medications	33.2	24.1
Office or Outpatient Assessments	12.1	8.8
Dental	1.7	1.0
Other	34.3	31.6
Subtotal	$116.2	$93.3
Long-Term Care Services		
Residential Services	$51.2	$29.9
Care Management	36.2	21.3
Institutional (Nursing Home and ICF-ID)	28.9	18.3
Home Care (Personal Care and Supportive Home Care)	19.9	16.9
Transportation	8.2	8.0
Adaptive/Durable Medical Equipment	5.5	4.8
Home Health Care	5.3	4.2
Adult Day Activities	5.0	4.7
Habilitation	2.5	1.3
Vocational	2.0	0.4
Respite Care	0.2	0.1
Other	11.5	6.3
Subtotal	$176.4	$116.2
Total	**$292.6**	**$209.5**

IRIS (Include, Respect, I Self-Direct)

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

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

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

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

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

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

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

Individuals participating in the IRIS program receive an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person may use funds from his or her individual budget to obtain the services needed on a fee-for-service basis.

Individuals are not permitted to use any of their individual budget to pay for room and board. However, individuals receiving IRIS services may reside, on a short-term basis, in any living arrangement, such as a community-based

residential facility (CBRF), adult family home, or a residential care apartment complex (RCAC), as long as it is not a nursing home or other institutional facility.

IRIS enrollees are provided an annual budget based on their functional needs and a comparison to people with similar needs in the managed care programs, as well as the historical service cost of representative Family Care members. Once the care plan and budget have been determined, the FEA then assists enrollees in managing the payments for services received. Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed. Table 9.4 shows a breakdown of IRIS service expenditures in calendar years 2011, 2012, and 2013.

Until 2015, DHS contracted with one agency, The Management Group, to serve as the ICA, and another agency, iLIFE, to serve as the FEA. However, by not providing enrollees a choice between two or more ICAs, the state was only eligible to receive the federal administrative matching rate (approximately 50 percent) for these services. By contracting with multiple agencies to fulfill these responsibilities, DHS may obtain the higher services matching rate on funds provided to these agencies (approximately 58 percent).

Aging and Disability Resource Centers

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

The contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating

Table 9.4: IRIS Service Expenditures ($ in Millions)

	2011	2012	2013
Supportive Home Care	$64.3	$87.8	$115.2
Home Health Care	12.8	23.3	37.4
Non-Nursing Home Residential Care (including CBRFs, AFHs, and RCACs)	10.8	13.3	16.3
Transportation	4.9	6.9	7.9
Respite Care	4.8	6.8	8.8
Day Center Services	3.1	5.8	8.3
Adult Day Care	3.7	3.1	2.4
Prevocational Services	2.3	3.2	4.0
Other Allowable MCO Services	2.6	2.4	1.7
Daily Living Skills Training	1.3	1.9	2.8
Supported Employment	1.4	1.6	1.7
DME and Supplies	0.9	1.4	1.9
All Other Services	1.2	1.2	1.7
Total	**$113.9**	**$158.6**	**$210.1**

ADRCs. State funding to support ADRCs is allocated based on the estimated size of the population served in each area and estimates of the amount of time required to carry out the ADRC functions. If actual costs exceed this limit, the ADRC is responsible for those costs.

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

Because ADRCs provide services to, and respond to, inquiries from individuals and their families regardless of Medicaid eligibility, federal cost sharing for their operation is limited to the amount that can be documented as supporting services for Medicaid-eligible individuals. DHS estimates that approximately 65 percent of ADRC expenditures were eligible for federal Medicaid administrative matching funds between July 1, 2014, and October 29, 2014, meaning that approximately 32.5 percent of ADRC expenditures are currently paid by federal matching funds. However, DHS noted that this percentage is highly volatile across months. Additionally, DHS recognizes a downward trend in this percentage due to the gradual elimination of wait lists for long-term care services and ADRCs completing more activities that are not eligible for a federal match, such as dementia care.

Table 9.5 shows ADRC direct program operation expenditures for fiscal years 2007-08 through 2013-14. As of August, 2014, there were 41 ADRCs operating in Wisconsin, including 28 single county ADRCs and 13 multi-county/tribe regional ADRCs, serving all 72 counties and 11 tribes. Appendix 6 lists each ADRC and ADRS, as well as the counties that each serves.

Table 9.5: ADRC Expenditures ($ in Millions)

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
GPR	$13.1	$18.2	$23.1	$27.8	$29.1	$32.4	$33.4
FED	3.8	7.8	14.2	18.8	21.4	23.7	24.3
Total	**$16.9**	**$26.0**	**$37.3**	**$46.6**	**$50.5**	**$56.1**	**$57.7**

CHAPTER 10

HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

This chapter provides a description of the state's fee-for-service home and community-based services (HCBS) waiver programs. These programs are known as the "legacy" HCBS programs because they provided long-term care services in all counties before the state began implementing Family Care, and have been replaced by Family Care, IRIS, and PACE/Partnership in most counties.

Under the community-based waiver provisions of federal Medicaid law, states may offer medical and support services to certain groups of Medicaid recipients. For example, medical support and social services generally excluded from traditional Medicaid coverage can be offered to waiver participants, including supportive home care services, home modifications, adaptive aids, specialized transportation services, adult day care, and supportive services in community-based residential facilities, as well as any other services requested by the state and approved by CMS. These services offered under a waiver of federal Medicaid law are designed to provide a cost-effective alternative to institutional care that may not otherwise be available to Medicaid recipients.

In order to obtain a federal Medicaid HCBS waiver from CMS, a state must demonstrate that the projected average per member cost for individuals receiving services under a waiver does not exceed the costs that would have been incurred for the same group of individuals had the waiver not been granted. States must also provide assurances that safeguards are in place to protect the health and welfare of waiver participants, that providers are qualified, and that service plans address participant's needs.

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

DHS also provides counties with GPR funding through the community options program (COP-Regular) and the Family Support Program (FSP) for individuals with community-based long-term care needs. Counties can use COP-Regular or FSP funds as the non-federal share for additional Medicaid eligible services for individuals in other HCBS waiver programs or to pay the full amount of costs not eligible for federal MA matching funds. Appendix 7 to this paper provides a list of long-term care services currently available under the various HCBS waiver programs.

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

limited by funding allocated in state and county budgets. As a result, eligible individuals may be placed on waiting lists for these programs until funding becomes available.

Eligibility

In order to participate in the HCBS waiver programs, individuals must meet both non-financial and financial eligibility criteria. Table 10.1 shows enrollment in the HCBS waiver programs in calendar year 2013.

Table 10.1: HCBS Waiver Participants, Calendar Year 2013

CIP 1A	246
CIP 1B	3,182
CIP II	2,194
COP-W	1,273
BIW	86
CLTS	5,809
COP-Regular*	879
Total	**13,669**

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

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

Financial Criteria. Several provisions of Medicaid law relating to eligibility for institutional care, as described in Chapter 8, also apply to the HCBS waiver programs. For instance, states may provide nursing home and Medicaid waiver services to individuals with income up to 300% of the applicable SSI payment level. The same spousal impoverishment protections also apply to spouses that receive services under the HCBS waiver programs. However, individuals who qualify under the special income limit and receive services in the community may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance than individuals who reside in nursing homes. In 2014, under the HCBS waiver programs, the personal needs allowance ranges from $901 to $2,163 per month, whereas nursing home residents may retain $45 per month. The personal needs allowance is larger, in part, because room and board costs are not an allowable benefit under the HCBS waiver programs, and participants must use their personal needs allowance to support these costs.

Funding

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

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

DHS also allows counties to treat funding for many of the waiver programs as an allocation. However, counties are still limited to serving only as many individuals as they have been awarded slots. Table 10.2 lists the calendar year 2014 county allocations of GPR funding budgeted for

Table 10.2: Estimated GPR Medicaid Home and Community-Based Waiver Allocations by County, Calendar Year 2014*

County	COP-W	CIP II	CIP 1A	CIP 1B
Adams	$179,394	$324,528	$234,114	$66,885
Brown	1,878,382	2,929,344	1,662,795	2,092,812
Dane	2,982,870	3,772,243	2,299,569	3,242,526
Door	131,006	389,329	113,252	331,703
Florence	48,704	17,253	18,652	37,158
Forest	99,272	136,256	0	0
Forest-Oneida-Vilas	0	0	525,674	701,447
Kewaunee	231,988	198,000	212,030	215,657
Marinette	353,420	657,338	206,062	281,108
Menominee	99,104	55,517	0	29,727
Oconto	178,226	503,014	268,432	256,384
Oneida	153,094	607,100	0	0
Rock	1,157,598	2,684,210	712,786	812,087
Shawano	493,582	641,643	420,105	257,870
Taylor	177,526	247,320	324,984	237,064
Vilas	266,294	342,365	0	0
Total	**$8,430,460**	**$13,505,460**	**$6,998,455**	**$8,562,428**

*Contract amounts for CY 2014 will not be finalized until 2015.

these various Medicaid waiver services, and Appendix 8 provides calendar year 2013 county allocations of GPR for services funded under COP-Regular.

The state contributions are supplemented with federal matching funds. In 2013-14, the state and federal responsibility for Medicaid service expenditures was approximately 41 percent and 59 percent, respectively. Counties may also obtain federal MA matching funds for waiver-covered services supported by county funds.

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

Program Descriptions

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

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

The state provides a lump sum allocation for counties to serve individuals under CIP 1A. However, counties are limited to serving a specific number of individuals based on the number of slots they have been awarded. In calendar year 2013, there were 246 individuals participating in the CIP 1A program, with 240 receiving services in the average month.

Community Integration Program (CIP 1B). CIP 1B provides community-based services for

individuals who are relocated or diverted from ICFs-ID other than the state centers.

The state provides a lump sum allocation for individuals receiving services under CIP 1B. This allocation was $49.67 per individual per day in fiscal year 2013-14. Additionally, the state claims federal matching funds for county costs that exceed the state payment rates up to a maximum of the average cost of care in an ICF-ID (approximately $223.40 per day in 2013). In calendar year 2013, 3,182 individuals participated in the CIP 1B program.

ICF-ID Restructuring Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-ID. With limited exceptions, the act prohibits an individual with a developmental disability from being placed in an ICF-ID and prohibits an ICF-ID from admitting an individual unless, before the placement or admission and after considering a plan developed by the county, a court finds that the placement is the most integrated setting appropriate to the needs of the individual.

In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services in ICFs-ID and nursing homes other than the state centers. The change was intended to increase access to community-based, long-term care services for individuals with developmental disabilities by allowing counties access to funding that had been previously designated solely for institutional care, and to instead use those funds to support non-institutional services for these individuals, as long as total program costs for institutional and community services could be managed within the same allowable funding limit. Act 33 also provided funding for phase-down payments to ICFs-ID that agreed to reduce their number of licensed beds.

From fiscal years 2005-06 through 2012-13, 844 persons with developmental disabilities were relocated from ICFs-ID and nursing homes, other than state centers, to community-based residential settings.

Under the relocation initiative, DHS establishes a single budget to provide services to all eligible individuals, including institutionalized and non-institutionalized individuals. In 2014-15, the amount budgeted to support services under this initiative is approximately $20.9 million (all funds).

Community Integration Program (CIP II). CIP II participants are individuals who are either over the age of 65 years or physically disabled, and are relocated or diverted from nursing homes. Two initiatives under the CIP II umbrella, the Community Relocation Initiative (CRI) and the Nursing Home Diversion program (NH Diversion) are intended to move individuals out of or prevent admission to nursing homes and institutions.

The CRI is directed to those individuals residing in nursing homes who wish to relocate. If an individual relocated under the CRI receives services for at least 180 days before leaving the program, the county retains the funding allocated to provide services to the other eligible individuals who may be on the county's waiting list for services, but not yet residing in a nursing home.

The NH Diversion program is directed to those individuals who were on the county's waitlist for services and were determined to be at higher risk of entry to a nursing home. These individuals are allocated a "slot." Costs for these individuals may not exceed $85 per day. If an individual leaves the NH Diversion program, the county may retain the slot to serve another individual who meets the high-risk criteria.

The aggregate cost of serving these individuals in the community must be less than the esti-

mated cost of serving these individuals in a nursing home. Counties are reimbursed by the state for expenses for each CIP II participant up to the county's state funding allocation. For calendar year 2015, the daily reimbursement rate to counties serving CIP II clients is $41.86 per person, unless a variance is granted by the Department to exceed this amount.

In calendar year 2013, 2,194 individuals received Medicaid services under CIP II, including those in the CRI and NH Diversion programs.

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

COP-W provides most of the same services as the community options program (COP-Regular) described in the next section, except for those services prohibited under the federal waiver requirements, such as room and board. Unlike COP-Regular, services provided under COP-W are eligible for federal matching funds. Counties are subject to the federally-imposed waiver requirement that the average cost of care statewide under COP-W does not exceed the average cost of care in nursing homes. DHS limits the average expenditure per COP-W client to a combined COP-W and CIP II amount of $41.86 per day, unless a variance is approved by the Department to exceed that average.

In calendar year 2013, 1,273 individuals received services in the COP-W program.

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

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

The functional criteria require a child to have a severe physical disability, developmental disability, or severe emotional disturbance which is diagnosed medically, behaviorally, or psychologically. The impairment must be characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation, or other services that result in eligibility for Medicaid if the child: (1) is in a hospital or nursing facility; (2) requires a level of care typically provided in a hospital nursing facility; (3) can appropriately receive care outside of the facility; and (4) can receive care outside of an institution that costs not more than the estimated cost of institutional care.

The financial eligibility criteria require that in 2014, the child's income not exceed $2,163 per month and, for those aged 18 and over, countable assets not exceed $2,000. Children with greater income and/or assets may become eligible for Medicaid by "spending down" to the CLTS income and asset criteria.

Although the income of the parents of the child is not considered in determining program eligibility, some families are required to contribute to the cost of services based on their income level and family size. Families with income that exceeds 330% of the FPL ($65,307 for a family

of three in 2014) are required to share in program costs on a sliding scale based on income.

The services provided under the CLTS waiver are similar to those available under other HCBS waiver programs. However, some of the services that are necessary for adults, such as home-delivered meals and adult day care, are not available to children under the waivers. The CLTS waiver also supports services that are not available under other waivers, including autism treatment services. In addition to receiving waiver services, CLTS participants have access to all Medicaid-covered card services. County support and service coordinators develop an individualized service plan (ISP) with the family to identify the type of service and supports needed by the child, the provider, and the number of hours of service to be delivered.

DHS provides each county with a funding allocation to provide CLTS services. Counties must serve children on a first-come, first-served basis, so long as funds are available, and may serve as many children as their allocation allows. Counties may also serve additional children by supplying the local match to obtain the federal financial participation on these services. Children applying for state-matched funding must meet the functional level of care requirement and be determined disabled by the DDB. Children applying for county-matched funding need only meet the functional level of care requirements. Once funding has been allocated, counties then have the authority to serve as many individuals as available funds will allow.

Similar to other HCBS waiver programs, counties may establish waiting lists for services when the funding provided by the state is not sufficient to provide services to all eligible individuals. Children may continue to receive services under the waiver until they reach the age of 22 as long they continue to be eligible for Medicaid, after which they would need to apply for services under an adult waiver program. This could result in some individuals being placed on waiting lists for HCBS waiver programs once they reach 22 years of age, although counties can prevent a disruption in services by placing children already receiving services under CLTS on waiting lists for adult waiver slots.

As of December, 2014, 5,613 children are enrolled in the CLTS waiver program, including 3,151 children who received exclusively CLTS services other than autism treatment services. As of December, 2014, an additional 2,173 children were on the CLTS wait list, waiting for available CLTS waiver, COP-Regular, or Family Support Program funding.

Autism Treatment Services. 2003 Wisconsin Act 33 created the intensive in-home treatment services benefit for children with autism spectrum disorders. In 2011, the Department began to phase out its former intensive in-home treatment program and instead created two distinct levels of autism treatment services -- the Early Intensive Behavioral Intervention (EIBI) service and the Consultative Behavioral Intervention (CBI) service -- to reflect the most recent research into the benefits of early intervention. The services remain fundamentally the same in the two programs, but children in the EIBI service receive 30 to 40 hours of face-to-face treatment and children in the CBI service receive 10 to 20 hours of face-to-face treatment.

In order to qualify for autism treatment services, a child must have a verified diagnosis of autism spectrum disorder, in addition to all other CLTS waiver eligibility criteria.

Autism treatment services are intended to teach children with autism spectrum disorder the skills that developing children would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to improve a child's social, behavioral, and communicative skills in order to demonstrate measurable outcomes in these areas

and overall developmental benefits in both home and community settings. The intent is for the child to make clinically significant improvements and have fewer needs in the future as a result of the service.

An ISP is developed for each participant to identify the type and number of hours of autism treatment service that each individual requires. A child is eligible for autism treatment services at the EIBI or CBI levels for up to three years as long as the child is placed on the state waitlist for these services before the time he or she is eight years old. Weekly services received prior to the CLTS waiver are figured into this total regardless of whether private insurance or public funding provided the service. Each week children receive their weekly hours of treatment and case management services.

Children who have received autism treatment services, EIBI or CBI, based on each child's individual needs as identified in the service plan for at least 12 of the past 18 months are eligible to receive ongoing CLTS waiver services. Ongoing services must be identified in the ISP, and may include any services allowable under the waiver in which the child is enrolled, including respite and adaptive aids, but do not focus on direct treatment. In fiscal year 2013-14, 1,164 children received autism services, while 1,991 children received ongoing autism services.

The waitlist for autism services is managed at the state level and functions on a first-come, first-served basis. Each week a specific number of names are released from the autism wait list. Once a child's name is released from the wait list, the child's county and provider meet with the child to determine the number of hours of treatment the child will need each week. The county receives the corresponding rate for that level of treatment. The annual amount for the autism services is added to the county's contract at the end of the year. Once the child leaves the program, the funding for the slot is returned to the state and is used to fund autism services for other children.

Children receiving ongoing autism services are eligible for costs up to $30.60 per day. Counties may contribute additional funding, or use an average cost based on the child's individual needs as identified in the service plan. When a child is no longer eligible for ongoing autism services, the county retains the funding to serve other children in need of those services. Counties are permitted to claim up to 7% of direct service and case management costs to support administrative expenses in both the CLTS waiver and the autism treatment program.

On July 7, 2014, CMS released an Informational Bulletin to State Medicaid Agencies providing guidance on the treatment of children with autism spectrum disorders. This bulletin requires states covering autism treatment services through a waiver program, such as Wisconsin, to transition coverage of medically necessary autism treatment services from a waiver to the state plan. DHS has begun this transition in accordance with guidance from CMS.

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

Non-Financial Eligibility. There are two groups of individuals that are eligible for COP-Regular services that are not eligible for Medicaid waiver services. The first are individuals

with early stages of Alzheimer's disease who do not require a skilled nursing facility level of care. The second are individuals with chronic mental illness who would likely require long-term care or repeated hospitalization if they did not receive long-term, community support services.

Before becoming eligible for services supported by COP-Regular funds, an individual must be a resident of Wisconsin for at least 180 days and have a long-term care need that is expected to last a year or more.

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

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

The formula used by DHS to implement this six-month spend down provision compares the sum of the individual's assets and the individual's projected income, after certain exclusions, over the next six months, with the average cost of nursing home care for six months. If the sum of assets and income is less than the cost of nursing home care, the individual is financially eligible for COP-Regular services.

Although COP-Regular is not part of Medicaid, spousal impoverishment and divestment provisions still apply.

Services and Funding. COP-Regular funds may be used to develop assessments and case plans for non-Medicaid as well as Medicaid-eligible applicants. They may also be used to develop Medicaid waiver services or to initiate services while a future waiver client is still residing in an institution, for a period of up to 90 days. For example, counties may use COP-Regular funds to pay the security deposit on an apartment, to install a telephone, to purchase furnishings or to make housing modifications before a person's move from an institution. However, for individuals in a HCBS waiver program, these types of transitional expenses must be billed to the waiver program if they were incurred within 180 days of the individual's move.

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

Finally, counties may use COP-Regular funding to supplement state funding for the non-federal share of Medicaid waiver services in those instances where the total amount provided under the waiver, together with other available sources of funding, is insufficient to support the Medicaid-allowable costs of providing community-based services. The Department refers to the use of COP-Regular funding in this way as "overmatch" for a Medicaid waiver.

In calendar year 2014, per person per month COP-Regular spending could not exceed $1,809. In calendar year 2013, 2,930 individuals received services funded with COP-Regular, with 879 individuals receiving only COP-Regular services and 2,051 adults and children using COP-Regular for match or supplemental funding.

CHAPTER 11

SENIORCARE AND MEDICARE PART D

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

SeniorCare

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

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

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

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

Three income range categories apply when determining deductibles, as shown in Table 11.1. The amount that a person whose income exceeds 240% of the FPL spends on prescription drugs to meet "spend-down" eligibility does not count toward that person's annual deductible. Consequently, to receive benefits, a person in this category must incur prescription drug expenses equal to the spend-down amount, plus an $850 deductible.

Table 11.1: SeniorCare Deductible Requirements

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

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

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

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

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

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

SeniorCare also uses the same pharmacy reimbursement policies as those used for other MA programs, as described in Chapter 6. For most drugs, the ingredient fee is equal to the estimated acquisition cost. The dispensing fee equals $3.44 for brand name drugs and $3.94 for generic drugs. The reimbursement fee is reduced by the amount of the copayment.

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

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

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

The state receives federal Medicaid matching funds for beneficiaries with incomes below 200% of the FPL. Any program costs associated with participants above that level are paid exclusively with GPR and drug rebate revenues.

A Medicaid waiver authorizes federal financial participation for SeniorCare. Certain budget neutrality conditions apply to the waiver, meaning that the state must demonstrate that the program produces savings for the Medicaid program or other federal programs that offset program costs. In its waiver application, the state asserts that the coverage of prescription drugs reduces the rate at which seniors enter full-benefit EBD Medicaid (through a reduction in spend-down eligibility), reduces hospitalizations (a Medicare program savings), and reduces Medicaid-funded nursing home admissions.

The CMS initially approved the SeniorCare waiver in 2002, and has renewed it twice since that time. The current waiver authority will expire on December 31, 2015, if not renewed.

Program revenue generated by the $30 en-

rollment fee, GPR, and federal MA matching funds support SeniorCare administrative costs.

Program Participation and Expenditures. Enrollment in SeniorCare increased briefly with the start of Medicare Part D in 2006, but has generally declined since that time, a trend likely attributable to some seniors' decision to participate exclusively in Part D. Table 11.2 shows the average monthly enrollment for fiscal year 2006-07 through 2013-14, Table 11.3 shows the enrollment by income level, as of September, 2014, and Table 11.4 shows SeniorCare expenditures, by fund source, from 2008-09 to 2013-14.

Table 11.2: SeniorCare Average Monthly Enrollment

2006-07	104,420
2007-08	93,337
2008-09	87,823
2009-10	87,693
2010-11	89,401
2011-12	87,693
2012-13	85,276
2013-14	84,420

Table 11.3: SeniorCare Enrollment, by Income Level, November 2014

Income Level	Enrollment
Less than 160% of FPL	32,487
160% of FPL to 200% of FPL	16,533
200% of FPL to 240% of FPL	9,653
Greater than 240% of FPL (Spend-Down)	25,979
Total Enrollment	**84,652**

Table 11.4: SeniorCare Benefit Expenditures

State Fiscal Year	GPR	FED	PR	Total
2008-09	$33,983,200	$50,696,300	$40,033,800	$124,713,300
2009-10	18,273,100	16,741,000	79,682,300	114,696,400
2010-11	20,407,200	23,130,600	64,348,800	107,886,600
2011-12	21,200,200	15,382,300	51,614,800	88,197,300
2012-13	16,097,600	13,338,200	49,154,300	78,590,100
2013-14	16,036,300	17,254,500	52,938,800	86,229,600

Medicare Part D

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

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

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

formularies.

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

The share of drug costs the beneficiary must pay varies within a plan year. The standard benefit structure consists of a deductible stage, an initial coverage phase, a coverage gap (also known as the "donut hole"), and the catastrophic coverage phase. In 2015, the expenditure thresholds are as follows:

- Initially, the beneficiary pays 100% of retail drug costs, up to an annual deductible of $320;

- After the annual deductible has been reached, the beneficiary pays a coinsurance of 25% of drug costs until total spending, including the deductible, reaches the "initial coverage limit" of $2,960 (the plan pays 75% in this range);

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

- Once out-of-pocket costs reach $4,700, the beneficiary receives catastrophic coverage, in which he or she pays a copayment of $2.65 for generic drugs and $6.60 for brand name drugs, or 5% of retail price, whichever is greater. All other costs are paid by the plan and the Part D program.

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

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

In 2015, after the ACA changes, enrollees will pay 45% of the cost of brand name drugs, while the 50% discount plus a 5% federal subsidy to the plan covers the rest. For generic drugs, the beneficiary will pay 65% of the cost, while a 35% plan subsidy covers the rest. Both the amount paid by the beneficiary and the amount of the discount count towards the out-of-pocket threshold for catastrophic coverage. Amounts paid by the Part D plan as a result of the federal subsidy, however, do not count towards reaching this threshold.

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

Direct premium subsidies are set so that Medicare pays 74.5% of the nationwide average cost of basic coverage (excluding catastrophic coverage paid with federal funds). CMS bases this average on bids submitted annually by plan providers. From this calculation, the program establishes a base premium, equal to 25.5% of adjusted

average costs (the inverse of the subsidy). In 2015, the base monthly premium is $33.13.

Although this procedure establishes a base subsidy and premium, subsidies to individual plans are adjusted to account for the health and other characteristics of the actual enrollees in each plan. The actual premium paid by an enrollee will depend upon how his or her plan's bid differs from the nationwide average, as well as other characteristics of the plan, such as if it provides additional coverage not required in the standard benefit. The average monthly premium was $59 in 2014 for stand-alone plans in Wisconsin.

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

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

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

Most people who qualify for the full subsidy are dually-eligible for Medicare and for full benefits under Medicaid. These beneficiaries do not pay a Part D premium or a deductible (assuming they enroll in a plan with coverage that is at or below a specified benchmark), but they do pay a copayment. In 2015, LIS beneficiaries with incomes at or below 100% of the FPL will pay a $1.20 copayment for generic drugs and a $3.60 copayment for other drugs. Dually-eligible beneficiaries with incomes greater than 100% of the FPL pay copayments of $2.65 for generic drugs and $6.60 for brand name drugs. Neither group of these dually-eligible beneficiaries pays copayments after reaching the out-of-pocket limits. In this case, copayments paid by the beneficiary, as well as cost sharing subsidies paid by the program, count as out-of-pocket spending.

Medicare recipients who do not qualify for full benefits under Medicaid, but qualify for limited-benefit Medicaid may also qualify for some LIS assistance with premiums and cost sharing. Medicare beneficiaries who receive SSI, and other individuals with incomes less than 135% of the FPL and limited assets can qualify for the same Part D low-income subsidies as full-benefit duals with incomes greater than 100% of the FPL, as described above. Beneficiaries with incomes above 135% of the FPL, but less than 150% of the FPL must pay premiums, deductibles, coinsurance, and copayments, but at lower levels than the standard benefit for non-LIS beneficiaries. In 2015, these individuals pay income-based sliding-scale premiums and a $66 deductible. After satisfying their deductible, they pay 15% of their drug costs up to the maximum out-of-pocket threshold, beyond which they pay copayments of $2.65 for generic drugs and $6.60 for brand-name drugs.

Funding and State "Clawback" Payments. Nationwide, program expenditures for benefits and administrative costs totaled $69.7 billion in 2013. These costs are supported by payments from the federal government's general fund

(73%), enrollee premiums (14%), and payments from states (13%).

States contribute to the Medicare Part D program through a "clawback" mechanism, established to recognize that state Medicaid programs no longer reimburse pharmacies for most prescription drugs purchased by dually-eligible individuals. The clawback payment is based on a declining percentage of the calendar year 2003 non-federal share of prescription drug costs state MA programs paid for dual eligibles, inflated to the current year. The percentage began at 90% in 2006 and decreased annually to reach 75% in 2015 and will remain at that percentage annually thereafter. In fiscal year 2013-14, the Wisconsin MA program made clawback payments to CMS of $178.6 million.

Medicare Part D Participation in Wisconsin. In 2014, 414,800 Wisconsin residents were obtaining Part D coverage through PDPs and 250,500 state residents were obtaining Part D coverage through MA-PDs, for a total of 665,300.

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2014 Federal Poverty Guidelines

	Percent of Federal Poverty Level							
Family Size	100%	133%	150%	185%	200%	240%	300%	306%
Annual								
One	$11,670	$15,521	$17,505	$21,590	$23,340	$28,008	$35,010	$35,710
Two	15,730	20,921	23,595	29,101	31,460	37,752	47,190	48,134
Three	19,790	26,321	29,685	36,612	39,580	47,496	59,370	60,557
Four	23,850	31,721	35,775	44,123	47,700	57,240	71,550	72,981
Five	27,910	37,120	41,865	51,634	55,820	66,984	83,730	85,405
Six	31,970	42,520	47,955	59,145	63,940	76,728	95,910	97,828
Seven	36,030	47,920	54,045	66,656	72,060	86,472	108,090	110,252
Eight	40,090	53,320	60,135	74,167	80,180	96,216	120,270	122,675
Monthly								
One	$973	$1,293	$1,459	$1,799	$1,945	$2,334	$2,918	$2,976
Two	1,311	1,743	1,966	2,425	2,622	3,146	3,933	4,011
Three	1,649	2,193	2,474	3,051	3,298	3,958	4,948	5,046
Four	1,988	2,643	2,981	3,677	3,975	4,770	5,963	6,082
Five	2,326	3,093	3,489	4,303	4,652	5,582	6,978	7,117
Six	2,664	3,543	3,996	4,929	5,328	6,394	7,993	8,152
Seven	3,003	3,993	4,504	5,555	6,005	7,206	9,008	9,188
Eight	3,341	4,443	5,011	6,181	6,682	8,018	10,023	10,223

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

APPENDIX 2

Supplemental MA Payments to County and Municipally-Operated Nursing Homes

County	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Barron	$348,911	$598,184	$485,346	$515,000	$676,305	$602,200	$728,600
Brown	494,862	647,647	582,588	620,700	633,783	602,700	1,474,200
Calumet	216,588	158,825	52,546	0	0	0	0
Clark	1,272,522	1,823,697	1,561,458	1,596,000	1,854,241	1,551,300	835,200
Columbia	741,026	1,023,601	833,273	823,100	1,001,173	866,600	1,243,100
Dane	855,541	1,253,381	1,017,664	1,038,900	1,180,690	1,137,000	1,654,700
Dodge	1,709,935	2,292,131	1,718,519	1,770,100	2,065,154	1,726,600	720,500
Dunn	918,271	982,599	704,314	710,900	836,826	717,700	904,200
Eau Claire	1,015	3,582	0	0	0	0	0
Fond du Lac	898,647	1,238,415	923,610	907,200	1,021,526	884,200	1,176,500
Grant	917,578	1,139,872	1,087,818	1,132,800	1,381,033	1,339,200	920,700
Green	795,798	1,156,187	979,785	1,010,100	1,199,780	994,700	505,600
Iowa	411,509	570,524	435,304	469,700	588,630	524,500	1,048,600
Jefferson	796,109	1,158,965	867,407	0	0	0	0
Kenosha	811,833	1,123,651	827,184	931,600	1,189,495	$1,102,100	$1,827,600
Kewaunee	333,245	380,127	296,933	441,800	499,303	466,300	567,300
La Crosse	1,828,967	2,417,384	1,965,088	2,094,100	2,575,044	1,961,800	1,729,400
Lafayette	473,761	606,255	504,372	544,400	645,255	574,300	2,083,100
Lincoln	1,283,228	1,465,296	1,492,934	1,534,500	1,743,489	1,632,100	1,383,100
Manitowoc	624,838	0	0	0	0	0	0
Marathon	2,212,014	3,019,262	2,258,168	2,082,500	2,344,553	2,025,800	759,800
Milwaukee	1,136,977	1,541,768	1,232,672	1,256,100	1,330,974	1,059,300	1,692,400
Monroe	648,926	882,558	728,585	801,800	1,004,705	833,800	1,358,100
Outagamie	1,320,029	1,853,282	1,435,187	1,419,600	1,721,423	1,657,100	1,020,500
Ozaukee	1,305,978	1,874,013	1,472,522	1,516,400	1,566,245	1,346,900	315,300
Pierce	164,577	0	25,643	0	64,171	0	1,265,500
Polk	696,721	728,594	649,033	894,700	1,044,514	982,300	526,100
Portage	400,742	542,501	403,143	405,000	473,833	391,200	1,364,800
Racine	1,331,906	1,844,600	1,335,015	1,265,100	1,359,365	1,199,700	642,100
Richland	386,994	477,630	425,270	505,200	640,585	599,100	1,130,600
Rock	1,093,437	1,475,410	1,175,353	1,268,100	1,474,493	1,314,000	414,500
Rusk	400,635	497,011	439,249	466,200	544,441	490,400	0
Sauk	619,700	746,160	683,674	602,600	726,779	614,000	728,800
Shawano	560,244	797,170	439,278	0	0	0	0
Sheboygan	973,903	1,312,031	1,147,909	1,265,000	1,396,895	1,199,500	879,800
St. Croix	562,763	554,238	501,170	594,200	685,517	442,800	986,100
Trempealeau	962,257	967,021	611,485	787,900	1,029,233	968,000	916,600
Vernon	728,982	832,976	746,216	881,400	1,013,465	880,300	380,000
Walworth	901,400	1,243,172	946,052	927,200	1,152,523	971,600	1,587,600
Washington	1,180,160	1,463,916	1,259,687	1,169,800	1,158,579	1,077,000	687,400
Waupaca	344,421	422,459	336,820	317,600	443,399	393,800	503,400
Winnebago	1,456,339	1,816,266	1,433,872	1,470,800	1,752,623	1,627,300	37,500
Wood	984,634	1,265,049	972,953	957,000	979,226	737,900	500,700
Subtotal	$36,107,923	$46,197,409	$36,995,100	$36,995,100	$42,999,269	$37,495,100	$36,500,000
Family Care Awards	$992,077	$1,200,000	$1,104,900	$1,104,900	$1,604,900	$1,604,900	$2,600,000
Total Payments	**$37,100,000**	**$47,397,409**	**$38,100,000**	**$38,100,000**	**$44,604,169**	**$39,100,000**	**$39,100,000**

APPENDIX 3

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

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

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

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

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

APPENDIX 4

Family Care County Contributions

County	Year 1	Year 2	Year 3	Year 4	Year 5
Adams	$64,135	$64,135	$64,135	$64,135	$64,135
Ashland	315,828	297,719	279,610	261,501	243,392
Barron	444,660	444,660	444,660	444,660	444,660
Bayfield	524,276	438,024	351,771	265,519	179,267
Brown	4,532,084	3,917,809	3,303,535	2,689,260	2,074,985
Buffalo	232,323	221,470	210,616	199,763	188,910
Burnett	194,520	191,843	189,165	186,488	183,810
Calumet	1,176,529	950,443	724,356	498,270	272,184
Chippewa	760,293	722,977	685,662	648,346	611,030
Clark	1,009,956	862,657	715,359	568,060	420,762
Columbia	2,106,230	1,685,672	1,265,114	844,556	423,998
Crawford	324,679	322,529	320,378	318,228	316,077
Dane	17,558,420	14,142,096	10,725,773	7,309,449	3,893,126
Dodge	1,366,396	1,195,350	1,024,305	853,260	682,215
Door	466,825	412,773	358,721	304,670	250,618
Douglas	787,061	753,088	719,115	685,142	651,169
Dunn	811,982	708,087	604,192	500,297	396,401
Eau Claire	1,698,176	1,558,595	1,419,015	1,279,434	1,139,854
Florence	57	57	57	57	57
Fond du Lac	0	0	0	0	0
Forest	75,024	75,024	75,024	75,024	75,024
Grant	302,632	302,632	302,632	302,632	302,632
Green	218,004	218,004	218,004	218,004	218,004
Green Lake	586,947	485,349	383,750	282,152	180,554
Iowa	117,953	117,953	117,953	117,953	117,953
Iron	71,382	71,382	71,382	71,382	71,382
Jackson	571,901	505,874	439,847	373,819	307,792
Jefferson	2,026,925	1,676,468	1,326,011	975,554	625,097
Juneau	111,577	111,577	111,577	111,577	111,577
Kenosha	2,193,399	2,082,383	1,971,368	1,860,353	1,749,337
Kewaunee	450,225	386,156	322,087	258,019	193,950
La Crosse	0	0	0	0	0
Lafayette	410,454	356,026	301,598	247,170	192,742
Langlade	646,007	549,386	452,765	356,144	259,523
Lincoln	1,125,771	916,790	707,810	498,829	289,849
Manitowoc	1,158,794	1,086,358	1,013,921	941,485	869,048
Marathon	3,620,966	2,997,046	2,373,127	1,749,207	1,125,287
Marinette	265,268	265,268	265,268	265,268	265,268
Marquette	197,953	184,722	171,492	158,261	145,031
Menominee	0	0	0	0	0

APPENDIX 4 (continued)

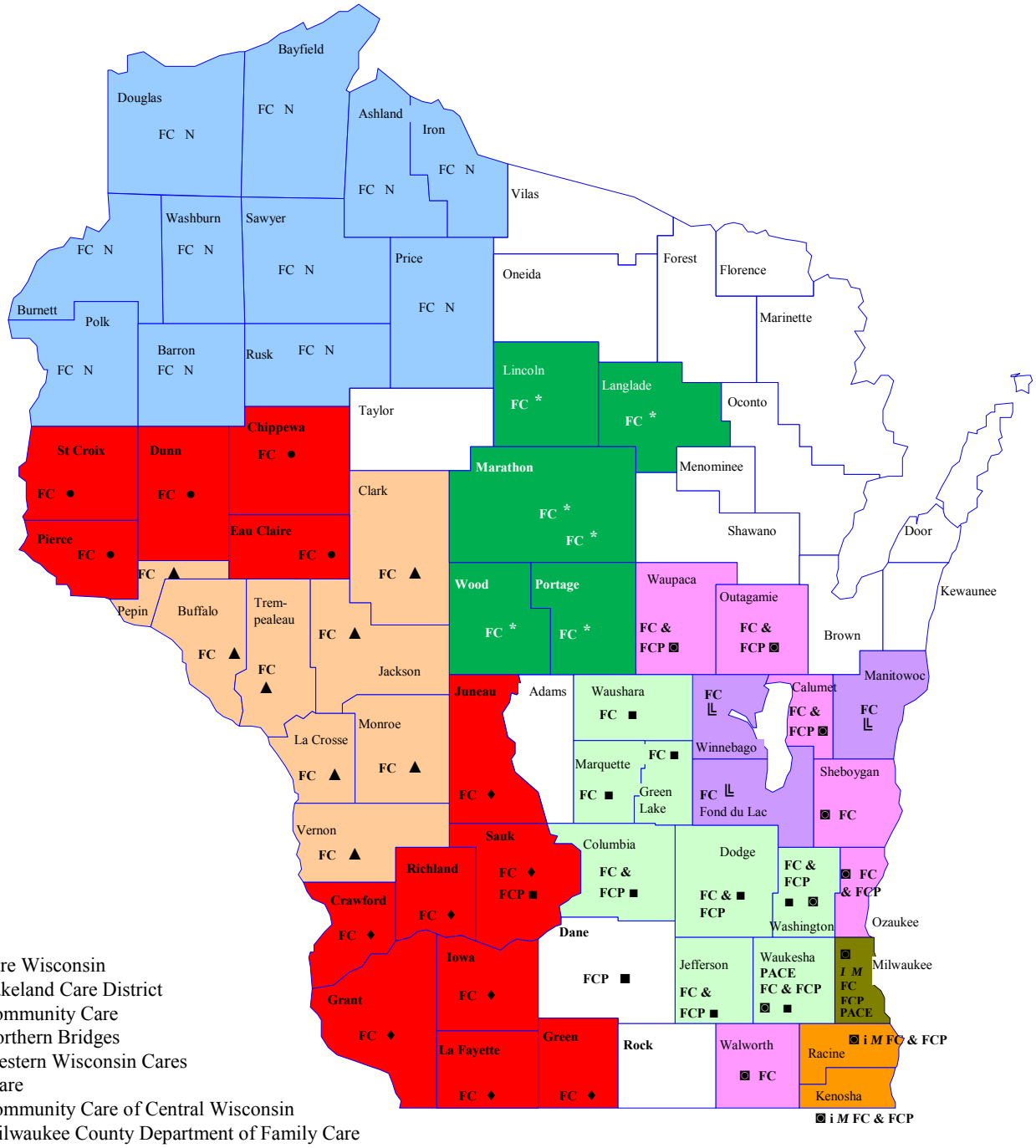
Family Care County Contributions

County	Year 1	Year 2	Year 3	Year 4	Year 5
Milwaukee - Disabled	$8,305,873	$8,305,873	$8,305,873	$8,305,873	$8,305,873
Milwaukee - Elderly	0	0	0	0	0
Monroe	698,862	627,909	556,955	486,001	415,047
Oconto	1,630,558	1,297,842	965,126	632,410	299,694
Oneida	408,381	388,801	369,220	349,639	330,059
Outagamie	2,987,511	2,590,951	2,194,390	1,797,829	1,401,268
Ozaukee	2,190,999	1,787,157	1,383,315	979,473	575,631
Pepin	119,713	119,713	119,713	119,713	119,713
Pierce	334,319	327,681	321,042	314,404	307,765
Polk	610,810	562,210	513,611	465,011	416,412
Portage	0	0	0	0	0
Price	395,635	343,621	291,607	239,594	187,580
Racine	1,106,213	1,106,213	1,106,213	1,106,213	1,106,213
Richland	0	0	0	0	0
Rock	3,559,579	3,176,381	2,793,183	2,409,985	2,026,787
Rusk	366,768	335,435	304,103	272,770	241,438
Sauk	1,274,226	1,083,382	892,537	701,693	510,849
Sawyer	87,961	87,961	87,961	87,961	87,961
Shawano	638,774	569,301	499,829	430,356	360,883
Sheboygan	2,330,950	2,024,301	1,717,652	1,411,003	1,104,354
St. Croix	2,669,902	2,096,428	1,522,954	949,480	376,005
Taylor	160,621	160,621	160,621	160,621	160,621
Trempealeau	481,156	447,178	413,199	379,221	345,242
Vernon	527,913	476,513	425,114	373,714	322,315
Vilas	195,240	194,822	194,403	193,984	193,565
Walworth	1,390,495	1,230,275	1,070,054	909,833	749,612
Washburn	578,294	483,286	388,277	293,268	198,260
Washington	2,713,307	2,226,815	1,740,324	1,253,833	767,341
Waukesha	4,379,582	3,910,841	3,442,100	2,973,359	2,504,618
Waupaca	1,397,312	1,156,849	916,386	675,922	435,459
Waushara	419,444	373,579	327,714	281,848	235,983
Winnebago	5,501,277	4,524,614	3,547,950	2,571,287	1,594,624
Wood	1,096,804	1,024,548	952,293	880,038	807,783

* The table reflects the annualized amount of the county contribution beginning with the county's first year of Family Care implementation.

APPENDIX 5

Family Care County Participation and MCO Regions
January, 2015



■ Care Wisconsin
LL Lakeland Care District
◙ Community Care
N Northern Bridges
▲ Western Wisconsin Cares
i *i*Care
* Community Care of Central Wisconsin
M Milwaukee County Department of Family Care
♦ Southwest Family Care Alliance
FC Family Care
FCP Family Care Partnership

APPENDIX 6

Aging and Disability Resource Centers (ADRCs)
As of July, 2014

Single County ADRCs:

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

Tribal ADRSs*:

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

Multi-County/Tribe ADRCs**:

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

*Tribes in this group have chosen to have their own Tribal Aging and Disability Resource Specialist (ADRS) that works with an ADRC.
**Tribes in this group have chosen to partner directly with an ADRC and do not have their own ADRS.

APPENDIX 7

Medical Assistance Waiver Services*

CIP 1A, CIP 1B, CLTS, CIP II and COP Waivers

Service	CIP 1A CIP 1B	CLTS	COP-W CIP II
Adaptive aids include devices, controls or appliances which enable individuals to increase their ability to perform activities of daily living independently.	Yes	Yes	Yes
Adult day care provides social or health-supportive services for part of a day in a group setting.	Yes	No	Yes
Adult family home is a residence in which care and maintenance above the level of room and board are provided to no more than four residents by a person who lives in the home, including up to seven hours per week of nursing care.	Yes	Yes	Yes
Care management includes the planning and coordination of an individual's program plan, along with advocacy and defense services, outreach, and referral.	Yes	Yes	Yes
Children's foster care includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs (including personal care provision beyond those age activities expected for a child, skilled tasks, monitoring of complex medical needs, and comprehensive behavioral intervention plans).	No	Yes	No
Communication aids/interpreter services are devices or services to assist individuals with hearing, speech or vision impairments or a language barrier to effectively communicate with family, friends, caregivers, service providers, medical professionals or the community at large.	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	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	No
Consumer and family directed supports are designed to assist children and their families to build, strengthen, and maintain informal networks of community supports. Specific supports may include adaptive and communication aids, consumer education, counseling, daily living skills training, day services, foster care, home modification, respite care, supportive home care, and supported employment.	No	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	Yes	No
Counseling and therapeutic services provide treatment-oriented services for a personal, social, behavioral, mental or alcohol or drug abuse disorder.	Yes	Yes	Yes
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
Day services include activities to enhance social development.	Yes	Yes	Yes
Financial management services include the services of a fiscal intermediary for those receiving consumer-directed services to ensure that appropriate compensation is paid to providers of services, and provision of assistance managing personal funds for those unable to manage their money themselves.	Yes	Yes	Yes
Home modifications include changes to ensure accessibility and safety of the individual's home (such as ramps, lifts, door widening and other physical alterations).	Yes	Yes	Yes
Home delivered meals refers to 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.	Yes	No	Yes

Service	CIP 1A CIP 1B	CLTS	COP-W CIP II
Housing counseling provides assistance in acquiring housing in the community, where ownership or rental of housing is separate from service provision.	Yes	Yes	No
Housing start up provides assistance in establishing housing arrangements in the community after relocation from an institution, including security deposits, furnishings, and household equipment.	Yes	Yes	No
Intensive in-home autism services are one-on-one behavioral modification therapy services for children **with** autism disorder, Asperger's disorder, or Pervasive Developmental Disorder, not otherwise specified.	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.	Yes	Yes	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
Pre-vocational 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	No	No
Relocation related utilities and housing start-up provide assistance for certain relocation costs for individuals that move from an institution to an alternative community living arrangement, including establishment of utility services, or person-specific services, supports or goods used in preparation of the relocation.	No	No	Yes
Residential care complex is a residence for five or more adults that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, and individual bathroom, sleeping and living areas, and that provides not more than 28 hours per week of supportive, personal and nursing services.	No	No	Yes
Respite care services provide temporary relief to the primary caregiver.	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	No
Supportive home care refers to the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community.	Yes	Yes	Yes
Specialized medical and therapeutic supplies are items and devices that are necessary to maintain the participant's health, manage a medical or physical condition, or improve functioning, or enhance independence.	Yes	Yes	Yes
Specialized transportation refers to services to improve access to needed community services and the ability to perform tasks independently.	Yes	Yes	Yes
Vocational futures planning provide consumer directed, team based comprehensive employment services to help individuals obtain, maintain or advance in employment.	No	No	Yes

*The community integration programs (CIP 1A and CIP 1B) fund services for individuals who are relocated from the State Centers for People with Developmental Disabilities (CIP 1A) and individuals who are relocated or diverted from other intermediate care facilities for the intellectually disabled (CIP 1B). The Children's Long-Term Support Program (CLTS) provides services to children with developmental disabilities, physical disabilities, or severe emotional disturbances. The community options waiver program (COP-W) and the community integration program (CIP II) provide community-based services for elderly and physically disabled individuals.

APPENDIX 8

COP Allocations by County, Calendar Year 2013*

Adams	$284,051
Ashland	27,018
Barron	174,231
Bayfield	79,839
Brown	2,823,981
Buffalo	94,341
Burnett	57,200
Calumet	138,207
Chippewa	165,455
Clark	201,169
Columbia	130,323
Crawford	119,454
Dane	5,543,534
Dodge	106,831
Door	285,068
Douglas	129,468
Dunn	112,811
Eau Claire	556,780
Florence	91,784
Fond du Lac	586,811
Forest	199,514
Grant	129,734
Green	95,389
Green Lake	22,509
Grant/Iowa	106,799
Iron	14,730
Jackson	98,732
Jefferson	161,785
Juneau	94,552
Kenosha	605,232
Kewanee	270,995
La Crosse	523,898
Lafayette	12,995
Langlade-Lincoln-Marathon	416,604
Manitowoc	345,908
Marinette	529,909
Marquette	27,376
Menominee	176,927
Milwaukee	1,525,673
Monroe	174,167
Oconto	$402,231
Oneida	475,281
Outagamie	295,558
Ozaukee	88,604
Pepin	24,955
Pierce	115,459
Polk	194,918
Portage	216,716
Price	74,026
Racine	878,816
Richland	122,077
Rock	1,285,041
Rock's 51.437 Board	906,734
Rusk	170,700
St. Croix	423,424
Sauk	170,767
Sawyer	44,991
Shawano, Department of Social Services	193,830
Shawano, Department of Community Programs**	330,829
Sheboygan	275,712
Taylor	243,478
Trempealeau	98,870
Vernon	36,401
Vilas	287,324
Walworth	169,523
Washburn	80,124
Washington	132,895
Waukesha	411,331
Waupaca	170,568
Waushara	77,571
Winnebago	1,063,468
Wood	196,182
Oneida Tribe	110,302
Total Counties and Tribes	**$27,010,490**

*Includes base allocation, one-time high cost funds, and one-time capacity building funds. One time high-cost funds are provided by the department to assist counties in serving individuals with above-average costs who have exceptional one-time service needs. One-time funding is also provided for specialized training for providers of such high-cost services and start-up costs for developing needed services.

**Includes $146,828 provided for long-term care planning by a multi-county group. Shawano County served as the fiscal agent for the County Planning Group.

Additional Resources

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

Wisconsin Department of Health Services (DHS)

ForwardHealth
www.dhs.wisconsin.gov/forwardhealth/

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

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

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

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

Centers for Medicare and Medicaid Services (CMS)

www.cms.gov/

Congressional Budget Office (CBO)

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

Government Accountability Office (GAO)

www.gao.gov/key_issues/medicaid_financing_access_integrity/issue_summary

National Conference of State Legislatures (NCSL)

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