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Medical Assistance and Related Programs

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

LEGISLATIVE FISCAL BUREAU

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Medical Assistance and Related Programs

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

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TABLE OF CONTENTS

Introduction 1

List of Common Acronyms 2

Chapter 1 -- Expenditure and Enrollment Trends 3
Chapter 2 -- Funding Sources 9
Chapter 3 -- Eligibility for BadgerCare Plus and Related Programs 17
Chapter 4 -- Eligibility for Elderly, Blind, and Disabled Medicaid Programs 27
Chapter 5 -- Limited Benefit Medical Assistance Programs 36
Chapter 6 -- SeniorCare and Medicare Part D 41
Chapter 7 -- Acute Care Services under BadgerCare Plus and EBD Medicaid 47
Chapter 8 -- Provider Reimbursement 59
Chapter 9 -- Nursing Home Services 71
Chapter 10 -- Family Care and Related Programs 78
Chapter 11 -- Administration 90

Appendices
Appendix 1: 2024 Federal Poverty Guidelines 99
Appendix 2: Supplemental MA Payments to County and Municipally-Owned Nursing Homes 100
Appendix 3: Services Included in Partnership, PACE, Family Care and IRIS 101
Appendix 4: Family Care County Participation and MCO Regions 102

Medical Assistance and Related Programs (BadgerCare Plus, EBD Medicaid, Family Care, and SeniorCare)

The state's Medical Assistance (MA) program provides health care services for people with limited resources. 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 Medicaid plan and federal waiver agreements negotiated between DHS and the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (DHHS).

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

States receive federal matching funds to partially support these covered services. The federal medical assistance percentage (FMAP) is the portion of the total payment supported by these federal matching funds. Each state's FMAP is calculated annually under a formula that compares a three-year average of the state's per capita income to national per capita income. Wisconsin's standard FMAP has generally ranged between 58% and 61% over the last several years, although costs related to certain services and certain enrollees qualify for higher federal matching rates.

Although Wisconsin's MA program has several components and subprograms, its two primary components are BadgerCare Plus and Medicaid for elderly, blind, and disabled individuals (EBD Medicaid). BadgerCare Plus provides MA-covered services to children and adults in low-income households. These individuals typically use their MA coverage to access primary and acute care services, such as physician services, inpatient and outpatient hospital care services, and vision and dental care. Individuals enrolled in EBD Medicaid frequently access long-term care services, in addition to the same primary and acute care services typically provided to BadgerCare Plus recipients. EBD Medicaid also provides non-traditional long-term care services under home and community-based programs, such as Family Care, as an alternative to nursing home care.

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

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

List of Common Acronyms

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

CHAPTER 1

EXPENDITURE AND ENROLLMENT TRENDS

This chapter provides information on recent trends in total MA expenditures and enrollment, as well as more detailed data on costs by service area and eligibility group. The data presented exclude expenditures and enrollment in SeniorCare, which is covered in Chapter 6.

Program Enrollment

Table 1.1 shows the average monthly MA enrollment, by major eligibility category, for the six-year period from 2018-19 to 2023-24.

MA enrollment increased rapidly with the onset of the COVID-19 pandemic, continuing through 2022-23. These enrollment increases can be attributed both to the employment and income losses occurring in the early months of the pandemic, as well as to a change in eligibility policy enacted in response to the COVID-19 public health emergency. The federal Families First Coronavirus Response Act of 2020 (FFCRA) provided an enhanced Medicaid matching rate for the duration of the federal public health emergency. As a condition of receiving the

Table 1.1: Average Monthly Enrollment in MA Eligibility Groups, by State Fiscal Year

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
BadgerCare Plus						
Children	455,135	458,132	514,208	553,511	581,874	527,678
Parents and Caretakers	157,613	163,855	200,175	224,548	245,018	234,300
Pregnant Women	20,148	19,846	26,763	32,545	36,833	26,335
Childless Adults	148,996	157,847	218,960	257,860	286,830	232,483
Total BadgerCare Plus	781,892	799,680	960,106	1,068,464	1,150,556	1,020,796
% Change		2.3%	20.1%	11.3%	7.7%	-11.3%
Elderly/Blind/Disabled (EBD)						
Elderly	67,763	73,104	79,030	84,089	89,340	88,442
Disabled Non-Elderly Adults	139,000	142,126	149,067	151,437	150,754	141,359
Disabled Children	31,570	32,149	33,227	34,741	36,515	37,131
Total EBD	238,333	247,379	261,324	270,266	276,608	266,932
% Change		3.8%	5.6%	3.4%	2.3%	-3.5%
Other Full Benefit Groups						
Foster Children	20,700	20,883	23,057	25,616	27,636	27,662
Well Woman MA	537	499	495	518	541	380
Total Full Benefit MA	1,041,462	1,068,441	1,244,983	1,364,864	1,455,340	1,315,770
% Change		2.6%	16.5%	9.6%	6.6%	-9.6%
Limited Benefit Groups						
Family Planning Only	39,976	37,081	39,691	45,649	48,371	28,612
Medicare Cost Sharing	23,920	19,542	17,073	16,244	15,583	15,488
Total MA Enrollment	1,105,358	1,125,064	1,301,747	1,426,757	1,519,294	1,359,870
% Change		1.8%	15.7%	9.6%	6.5%	-10.5%

additional matching funds, states were required to maintain Medicaid eligibility for any person who was enrolled in the program as of March 18, 2020, or who later became eligible for coverage, until the expiration of the federal public health emergency. With this "continuous coverage" policy, any increase in household income did not result in loss of Medicaid coverage.

In December of 2022, Congress passed legislation that modified FFCRA's continuous enrollment provision, to establish an end date of March 31, 2023, instead of at the termination of the public health emergency. All states, including Wisconsin, began the process of redetermining eligibility for all enrollees. For Wisconsin, this process took place throughout state fiscal year 2023-24, resulting in the decrease in average enrollment shown in Table 1.1 for that year.

Overview of MA Expenditures

Table 1.2 provides information on benefit expenditures under the state's MA program, by fund source, from state fiscal year 2018-19 through 2023-24. The program has four funding sources: (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG), which are primarily generated by assessments on medical providers; and (d) program revenues (PR), such as rebates from drug manufacturers and estate recovery. Chapter 2 describes these funding sources in more detail.

Some variation from year to year in total spending, as well as the mix of funding sources, can occur for reasons other than the overall level of enrollment or service utilization. As an example, DHS made 13, rather than 12 monthly payments to health maintenance organizations and Family Care managed care organizations in 2020-21, which increased total expenditures by approximately $375 million, relative to the baseline trend. As another example, the 2021-23 biennial budget act made transfers of $175 million in 2021-22 and $528 million in 2022-23 from the state's general fund to the medical assistance trust fund, which had the effect of decreasing the use of GPR funding for the program by those amounts and providing a corresponding increase in SEG funding. The comparatively large increase in GPR spending between 2022-23 and 2023-24 (and decrease in SEG funding) is partially attributable to the impact that this transfer had in 2022-23 compared to what expenditure levels would have otherwise been in that year.

MA benefit expenditures can be subdivided to provide a better understanding of the scope and nature of the program. Table 1.3 shows total 2023-24 MA expenditures by major service categories. The total of all expenditures in this table differs from the total in Table 1.2 primarily because drug rebates and other recoveries are reflected as a negative expenditure in this table, rather than, as a positive source of program revenue (PR) appropriation. A brief explanation of these categories is provided in the following section, but a more thorough explanation of these subprograms and services can be found in subsequent chapters of this paper.

Table 1.2: MA Benefit Expenditures by Fund Source

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
GPR	$2,994,609,100	$2,840,883,900	$3,252,847,500	$2,934,600,800	$3,059,591,500	$4,193,059,000
FED	5,440,239,600	6,127,681,300	6,960,674,900	7,803,540,300	8,188,520,900	7,678,432,300
PR	1,050,629,600	1,090,233,400	1,125,001,900	1,328,884,600	1,400,952,300	1,652,315,500
SEG	611,669,100	586,637,500	549,435,000	628,176,100	1,069,941,100	725,265,300
Total	$10,097,147,400	$10,645,436,100	$11,887,959,300	$12,695,201,800	$13,719,005,800	$14,249,072,100

Table 1.3: MA Benefits Expenditures by Major Category, Fiscal Year 2023-24 ($ in Millions)

Long-Term Care	
Family Care and Similar Programs	$2,914.8
IRIS and Children's Waiver Programs	1,406.4
Nursing Homes and Other Institutions	1,002.9
Personal Care/Home Health	226.4
Subtotal	$5,550.5
Managed Care for Medical Services	
BadgerCare Plus Managed Care	$2,227.3
SSI Managed Care	324.8
Subtotal	$2,552.1
Fee-for-Service Medical Services	
Hospitals (Excluding Access Payments)	$614.7
Hospital Access Payments and Supplements	869.2
Professional and Clinic Services	758.3
Behavioral Health (Excluding Hospital)	548.5
Subtotal	$2,790.7
Prescription Drugs	
Gross Drug Expenditures	$1,964.8
Manufacturer Rebate Payments	-1,276.3
Subtotal	$688.5
Other Program Costs	
Medicare Cost Sharing	$442.8
Medicare Part D Clawback	334.4
Transportation Services	190.7
Specialized Services/Populations	125.7
Federal Payment for Local Services	181.0
Subtotal	$1,274.6
Miscellaneous Adjustments	
Recoveries and Premiums	-$68.9
Managed Care Risk Corridor Payment	-180.1
Total	$12,607.4

Descriptions of Categories in Table 1.3

Long-Term Care

MA pays the cost of long-term care services for beneficiaries who meet criteria related to medical frailty and functionality with respect to activities of daily living. These services include nursing home care, personal care, home health services, and various other supportive services. Most long-term care services are provided to individuals who are eligible under the elderly, blind, and disabled (EBD) subcomponent of the MA program.

Family Care. Most long-term care services are delivered through the Family Care program, under which managed care organizations (MCOs) evaluate the needs of enrolled members and arrange and pay for services. Services may include care provided in a nursing home or assisted living facility for some members, but may also involve various home-based supports. MA pays Family care MCOs a monthly capitation rate for each enrolled member, which the MCOs use to pay service providers.

IRIS and Children's Long-Term Support Waivers. The IRIS program is a self-directed alternative to Family Care, under which participants receive a service budget and select their own supportive services. IRIS is offered under a federal home and community-based supports waiver. The children's long-term support waiver program provides services to disabled children meeting functional ability criteria.

Nursing Homes and Other Institutions. MA makes direct payments to private, county, and state nursing homes for care of individuals who are residents of these homes, but who are not enrolled in Family Care. Nursing home payments made through Family Care MCOs are not included in this category, but instead are reflected under Family Care. This category also includes payments to the three state veterans homes and to intermediate care facilities for individuals with intellectual disabilities, which includes the three State Centers for Persons with Developmental Disabilities.

Personal Care/Home Health/Private Duty Nursing. MA pays directly for some in-home personal care, home health care, or private duty nursing for qualifying individuals who are not enrolled in Family Care. Although these services are generally considered long-term care services, expenditures in this category include services provided to individuals who require temporary supports.

Managed Care for Medical Services

Most medical services under MA are provided on a managed care basis, through health maintenance organizations (HMOs). Similar to Family Care MCOs, HMOs receive a monthly capitation payment for each of their enrollees. The HMO contracts with providers to render medical services to individuals and to provide overall management of their care. Table 1.3 shows HMO expenditures separately for individuals covered under BadgerCare Plus, the subcomponent of MA for low-income adults and children, and for individuals covered under EBD who are eligible on the basis of their qualification for supplemental security income (SSI). Individuals who are enrolled in Family Care receive the medical services on a fee-for-service basis (described below), rather than through an HMO.

Fee-for-Service Expenditures for Medical Services

Beneficiaries who are not enrolled in an HMO receive medical services on a fee-for-service basis, meaning that MA pays providers directly upon receipt of a claim. In addition, some services, such as prescription drugs, are excluded from the HMO contract, and are instead paid on a fee-for-service basis for both HMO members and non-member beneficiaries.

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.

Hospitals. Inpatient and outpatient hospitalization accounts for the largest share of fee-for-service reimbursement under MA. Hospitals are paid for their services based on the individual's diagnosis or types of procedures, but also receive "access payments" for each MA patient discharged following an inpatient stay and for each outpatient visit, and supplemental payments targeted for specific services or facilities.

Professional and Clinic Services. This category includes payments to medical professionals, such as physicians, physician assistants, nurse practitioners, dentists, physical and occupational therapists, chiropractors, and optometrists. Also included are payments for services rendered through federally qualified health clinics and auxiliary services such as laboratory, X-ray services, and durable medical equipment and supplies.

Behavioral Health. The behavioral health category includes outpatient mental health and substance use disorder treatment, behavioral therapy for certain children with autism spectrum disorder, residential and day treatment for substance use disorder, crisis intervention, and psychosocial rehabilitation for persons with serious mental health conditions or substance use disorders who also meet functional limitation criteria. Some fee-for-service mental health services, such as inpatient hospitalization, treatment provided in a primary care setting, or in a federally qualified health center are included in those respective categories, rather than in the behavioral health line.

Prescription Drugs

MA pays pharmacies for the acquisition cost of the drug, plus a dispensing fee. The MA program collects rebates paid by drug manufacturers, which offset the total costs. Table 1.3 shows the gross payment for drugs, drug rebates, and the net cost.

Other Program Costs

Medicare Cost Sharing. Certain individuals enrolled in Medicare who do not qualify for full MA benefits are nevertheless eligible for assistance in paying Medicare premiums and cost sharing.

Medicare Part D Clawback. The federal

legislation that established the Medicare Part D prescription drug program created a requirement that states make payments to the federal government to offset a portion of the Part D costs. The Part D program reduces costs for prescription drugs that would otherwise be paid by state Medicaid programs for individuals who are eligible for both Medicare and Medicaid. The clawback payment, which is made using state funds only, is intended to recoup a portion of the savings to state Medicaid programs.

Transportation Services. MA pays transportation costs to help beneficiaries travel to medical appointments. This category also includes payments for emergency medical transportation.

Specialized Services and Populations. Included in this category are services for special eligibility groups, such as women diagnosed with breast or cervical cancer under the Well Woman program, and individuals eligible for family planning only services. Specialized services include hospice care, health services provided to children under the early and periodic screening, diagnostic and treatment benefit (EPSDT, referred to as HealthCheck in Wisconsin), end-stage renal disease, comprehensive care for certain children in foster care, and prenatal care coordination.

Federal Payment for Local Services. This category includes payments to counties for certain mental health services provided through county human services departments and to school districts for school-based services. Local entities are generally responsible for all or most of the non-federal share of the cost of these services, which is not reflected in the totals shown in Table 1.3. Instead, the table shows only the federal share of the MA reimbursement payments for these services.

Miscellaneous Adjustments

Recoveries and Premiums. This category includes audit recovery, third-party liability (for when an insurance policy or other individual is partially responsible for medical costs), estate recovery, and premiums charged for certain individuals. In Table 1.3, these collections, like drug rebates, are reflected as a negative number since they offset MA benefit costs. In the budget for the MA program, however, rebates and recoveries are reflected as a positive program revenue (PR) amount, which adds to the overall total.

Managed Care Risk Corridor Payment. The program's contracts with MCOs and HMOs include provisions that require them to make payments to the state if actual medical costs fall below capitation payment revenues by specified percentages. Conversely, the program makes additional payments to the HMOs and MCOs if their costs exceed capitation payment revenues. In 2023-24, HMOs and MCOs made payments to the state under these provisions, based on medical and long-term care costs and capitation revenues in 2022. These payments offset total MA program costs, and so this adjustment is shown as a negative expenditure in Table 1.3.

Cost Per Eligibility Category

Table 1.4 shows the estimated average, per person costs for each of the major eligibility categories in the MA program. These estimates, which are net of drug rebate revenue, are based on service utilization and enrollment in 2022-23, the latest year for which complete data were available, as of the end of 2024.

These figures represent only costs that can be reliably allocated to individuals in the program. Therefore, certain program costs, such as hospital access payments paid through HMOs and certain payments to counties for providing MA services, are not reflected in the totals. For this reason, Table 1.4 provides a relative comparison of the per member costs associated with different MA groups, and should be viewed as approximate costs for the various groups.

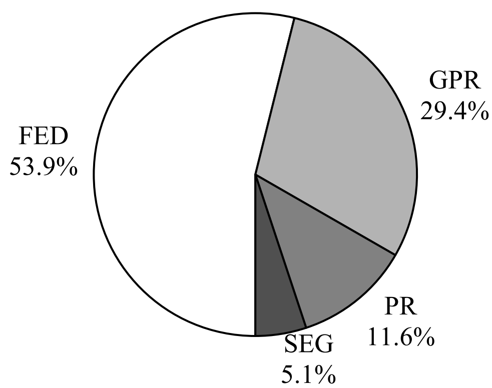
As the table shows, individuals eligible under the EBD categories have the highest average cost, as many of these individuals receive ongoing Medicaid-supported long-term care services. Children enrolled in BadgerCare Plus, the largest MA group by enrollment, have relatively low average costs compared to other full-benefit MA enrollees.

Table 1.4: Average Annual Per Member Benefit Cost by Eligibility Group

	Average Per Member Cost
Elderly, Blind, and Disabled	
Elderly	$28,586
Non-Elderly Adults	25,104
Disabled Children	17,044
EBD Average	$25,165
BadgerCare Plus	
Children	$1,989
Parents	3,602
Pregnant Women	6,590
Childless Adults	5,401
BadgerCare Plus Average	$3,330
Other Groups	
Foster Children	$6,170
Well Woman	13,080
Family Planning Only Waiver	242
Medicare Savings Programs	2,557

This chapter provides additional information about the funding sources for MA benefits. The four main sources of funding are: (a) state general purpose revenues (GPR); (b) federal funds (FED) provided as a formula-based match to state expenditures; (c) segregated revenues (SEG) generated by specific assessments or programs; and (d) program revenues (PR), such as rebates from drug manufacturers and premiums paid by certain participants. Figure 2.1 shows the proportion of the total MA budget supported by each of these funding categories in state fiscal year 2023-24.

Figure 2.1: Percentage of Total MA Spending, by Fund Source, 2023-24



General Purpose Revenue (GPR)

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

In the 2023-25 biennium, MA benefits accounted for approximately 19.5% of the total state general fund budget. Funding for MA benefits is the second-largest GPR commitment in Wisconsin's budget, surpassed only by aids to elementary and secondary school districts.

Federal Matching Funds (FED)

Federal matching funds are the largest funding source for Wisconsin's MA program. The federal government provides a match to state spending based on the state's federal medical assistance percentage, or FMAP. The FMAP indicates the percentage of MA costs for which the federal government is responsible. The FMAP is established and adjusted at the beginning of each federal fiscal year in accordance with a standard formula, but may be subject to various adjustments.

Under the standard formula, the FMAP is based on the relationship between the state's per capita income and the national per capita income (total personal income divided by population). A state which has a per capita income that is equal to the national per capita income receives an FMAP of 55% under the standard formula, while the FMAP is higher or lower than this benchmark for states that have a lower or higher per capita income, respectively, than the U.S. average. For the purpose of this calculation, the three-year average is used for per capita income. Federal statutes set the minimum allowable FMAP at 50%, and the maximum allowable FMAP at 83%. Wisconsin's standard FMAP has generally ranged from 58% to 61% over the past decade, meaning that the state share has generally been between 42% and 39%.

Under a provision of the federal Families First Coronavirus Response Act (FFCRA), each state's standard FMAP was increased by 6.2 percentage points during each calendar quarter that the federal public health emergency related to the COVID-19 pandemic was in effect. This enhanced FMAP was first applied to program expenditures in January of 2020. Thus, while Wisconsin's standard FMAP would have been at or slightly below 60% during this period, the state's actual FMAP was approximately 66%. In December of 2022, Congress passed legislation that modified FFCRA's enhanced FMAP, to establish a phase-down schedule during calendar year 2023, as follows: (a) 6.2 percentage points in the first calendar quarter; (b) 5.0 percentage points in the second quarter; (c) 2.5 percentage points in the third quarter; and (d) 1.5 percentage points in the fourth quarter. Beginning in calendar year 2024, the FMAP was calculated using the standard formula.

A higher FMAP applies for certain children eligible for MA under the federal Children's Health Insurance Program (CHIP). CHIP was established in 1997 to make healthcare coverage more affordable for children whose family's income was just above the state Medicaid program thresholds. In Wisconsin, CHIP generally funds services to children in households with income above 150% of the federal poverty level (FPL), although this threshold varies by the age of the child. The enhanced FMAP is calculated to reduce the state's share by 30%.

Under a provision of the federal Patient Protection and Affordable Care Act (ACA), the CHIP FMAP was increased on a temporary basis by 23 percentage points, from federal fiscal year 2015-16 to 2018-19. Subsequent legislation provided an 11.5 percentage point increase to the CHIP FMAP in federal fiscal year 2019-20.

Table 2.1 shows Wisconsin's standard FMAP formula result for both Medicaid and CHIP by federal fiscal year, from 2015-16 through 2024-25, as well as the weighted average FMAPs for those years, as affected by the FFRCA and ACA enhancements.

Table 2.1: Wisconsin's Federal Medical Assistance Percentages

	Standard Formula		With Enhancements	
FFY	Medicaid	CHIP	Medicaid	CHIP
2015-16	58.23	70.76%	58.23	**93.76%**
2016-17	58.51	70.96	58.51	**93.96**
2017-18	58.77	71.14	58.77	**94.14**
2018-19	59.37	71.56	59.37	**94.56**
2019-20	59.36	71.55	**64.01**	**86.31**
2020-21	59.37	71.56	**65.57**	**75.90**
2021-22	59.88	71.92	**66.08**	**76.26**
2022-23	60.10	72.07	**65.08**	**75.55**
2023-24	60.66	72.46	**61.04**	**72.72**
2024-25	60.43	72.30	60.43	72.30

Note: Matching rates subject to temporary enhancements are shown in bold.

Finally, in addition to the enhanced CHIP FMAP, several categories of service and services for particular eligibility groups qualify for federal matching funds in excess of the standard FMAP. These include expenditures for family planning services (90% federal matching rate), treatment services for certain women with breast or cervical cancer (the CHIP FMAP), and services provided through an Indian Health Service facility (100% federal matching rate).

Segregated Funds (SEG)

In addition to GPR, Wisconsin funds the state share of MA benefits with segregated (SEG) funds generated from several sources. These revenues either offset GPR spending on the program, or are used as the source for supplemental payments to service providers.

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

There are four SEG funds used in MA: (a) the medical assistance trust fund (MATF); (b) the hospital assessment trust fund; (c) the critical access hospital assessment trust fund; and (d) the ambulance service provider trust fund (although not yet in operation in 2023-24, pending federal approval of the state's plan for this fund). The MATF is the largest of these funds, and is used for general MA benefit expenditures. The two hospital assessment funds are used for the collection of hospital assessments and the payment of supplemental payments to hospitals. Assessment revenue that is not used for hospital payments is then transferred to the MATF. The ambulance service provider trust fund is to be used only for making supplemental payments to ambulance providers.

Table 2.2 shows MATF revenues for state fiscal years 2022-23 and 2023-24. Revenues to this fund are described following the table. In most years, DHS spends all available MATF appropriation authority for MA benefits in order to minimize GPR appropriations needed for the program. However, for the two years shown in the table, a portion of the revenues was reserved for future expenditure as part of a federal incentive program for the improvement of home and community-based services (HCBS) for elderly and disabled persons. Under the federal program, the state received a 10.0 percentage point increase to its federal matching rate for HCBS services from April 1, 2021 to March 31, 2022. This enhanced rate generated state savings that CMS required

Table 2.2: Medical Assistance Trust Fund (MATF) Revenues

	2022-23	2023-24
Beginning Balance	$239,795,300	$350,914,000
Provider Assessments		
Transfer from Hospital Assessment Fund*	$207,532,600	$167,771,700
Nursing Home/ICF-IID Bed Assessment**	57,970,200	54,979,300
Transfer from Critical Access Hosp. Assessment Fund*	1,878,400	1,093,700
Federal Medicaid Funds Deposited to MA Trust Fund		
Nursing Home Certified Public Expenditure Program	$24,780,300	$674,900
Intergovernmental Transfer from UW System	12,928,600	28,448,200
UW Hospital Certified Public Expenditure Program	0	1,950,300
Other		
Transfer from General Fund	$527,783,700	$0
Transfer from Permanent Endowment Fund	133,092,600	98,049,000
Interest Earnings	15,002,600	16,121,100
Total Annual Revenue	$980,969,000	$369,088,200
Total Revenue Available	$1,220,764,300	$720,002,200
MATF Expenditures	$869,850,300	$527,177,800
Ending Balance	$350,914,000	$192,824,400

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

states to spend on HCBS improvements prior to June 30, 2025. For Wisconsin's program, this savings was retained in the MATF balance, allowing it to be expended for HCBS initiatives across multiple fiscal years.

MATF Revenues

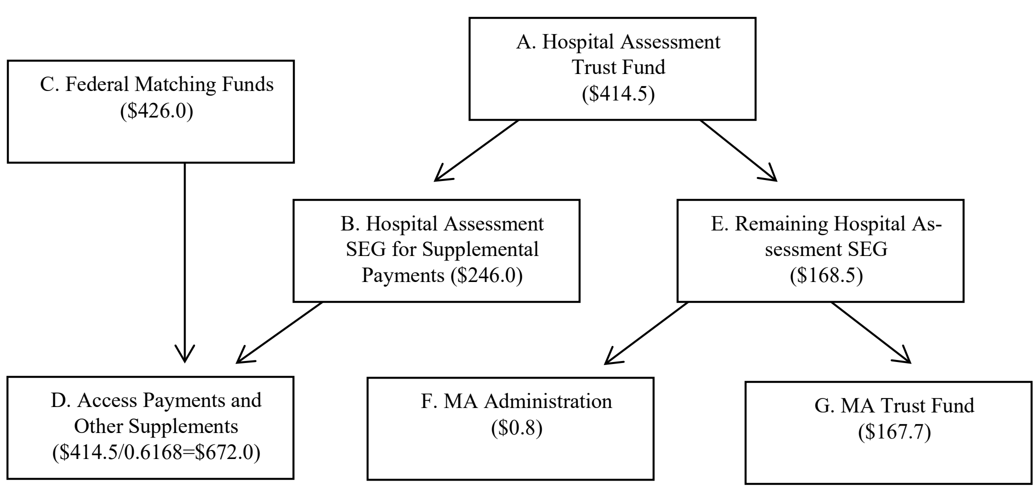
Hospital Assessment and Transfers. DHS collects an assessment from most hospitals in the state, excluding several types of hospitals such as critical access hospitals and psychiatric hospitals. A portion of the assessment revenue is used, in combination with federal matching funds, for making payments to hospitals to supplement the base reimbursement for inpatient and outpatient services. The amount of assessment revenue remaining after making these hospital payments is deposited in the MATF to supplement GPR funding for the MA program as a whole.

Figure 2.2 shows how the assessment is allocated between hospital supplemental payments and other MA benefits, using the 2023-24 allocation to illustrate. The total annual amount of the assessment is established in statute at $414,507,300, with each hospital's assessment based on a uniform percentage of that hospital's gross patient revenues (the hospital's total charges for inpatient and outpatient services, rather than the amount the hospital collects). In 2023-24, the assessment equaled 0.6306% of each hospital's gross patient revenues.

All revenue collected from the hospital assessment is initially deposited to the hospital assessment trust fund. A portion of this revenue is used to fund the state's share of MA supplemental payments to hospitals and costs of administering the assessment, while the remaining amount is transferred from the hospital assessment trust fund to the MATF. In 2023-24, $167.8 million of the $414.5 million in hospital assessment revenue was transferred from the hospital assessment trust fund to the MATF to support general MA benefits costs.

The MA program is required to make supplemental hospital payments in accordance with a formula under which the total assessment ($414.5 million) is divided by a statutorily-set fraction of 0.6168. The resulting payment of $672.0 million is shown in box "D" in Figure 2.2. (Hospital supplemental payments, including hospital access payments, are described in Chapter 9.) In order to make these payments, the program uses an amount of SEG funds from the hospital assessment fund that, when added to the associated federal matching funds, equals $672.0 million (shown in boxes "B" and "C" in Figure 2.2).

Figure 2.2: Allocation of Hospital Assessment Revenue in 2023-24 ($ in Millions)



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

Under the hospital assessment program, hospitals pay $414.5 million in assessments and receive supplemental payments totaling $672.0 million (funded with SEG and FED), resulting in a net gain to hospitals of $257.5 million.

Nursing Home and ICF-IID Bed Assessment. Nursing homes pay an assessment of $170 per month per licensed bed. 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. Nursing homes operated by the Department of Veterans Affairs are exempt from paying the nursing home bed assessment.

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

All revenues generated from the nursing home and ICF-IID bed assessment are deposited in the MATF. In 2023-24, DHS collected $55.0 million from these assessments. 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. The methods DHS uses to reimburse nursing homes for care they provide to MA beneficiaries include a supplemental Medicaid access incentive that is intended to reimburse nursing homes, in the aggregate, the approximate amount nursing homes pay under the bed assessment.

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

The CAH assessment works similarly to the previously described hospital assessment, except that the CAH assessment is based on each CAH's gross inpatient revenues, rather than on total gross inpatient and outpatient patient revenues. Further, the CAH assessment rate equals the calculated rate used for the other hospital assessment, and is not determined based on a statutorily-set dollar amount. All CAH assessment revenue is deposited in the critical access hospital fund.

In 2023-24, the CAH assessment generated revenues of $5.4 million for the CAH fund. As with the hospital assessment, a portion of the collected revenues, along with associated federal matching funds, support additional payments to critical access hospitals. As with the hospital assessment, the amount of these payments is determined by dividing the amount collected by 0.6168 ($8.7 million in 2023-24). A portion of the remaining SEG funds ($1.1 million in 2023-24) is budgeted to support the University of Wisconsin's rural physician residency assistance program and health provider loan assistance programs administered by the Wisconsin Office of Rural Health, while the rest ($1.1 million in 2023-24) is transferred to the MA trust fund to support MA benefit expenditures.

Nursing Home Certified Public Expenditure Program. Under a certified public expenditure (CPE) program, a state claims federal matching funds for Medicaid-eligible expenditures made by public entities other than the state. In Wisconsin, DHS administers a CPE program under which the state receives federal matching funds based on unreimbursed costs that county and other local government facilities incur to provide nursing home care to MA beneficiaries, up to a maximum cost equal to the amount that the federal Medicare program would pay for equivalent nursing home services. All federal revenue the state claims under this nursing home CPE program is deposited to the MATF. In 2023-24, the CPE revenue deposited in the MATF was $0.7 million. This amount is considerably lower than in prior years because an increase to the base reimbursement rate for nursing home services that was enacted as part of the 2023-25 budget narrowed the gap between the MA base reimbursement and the federal maximum, thus reducing unreimbursed costs.

If the amount of federal matching funds received under the nursing home CPE for a given fiscal year is greater than the amount that was estimated for that year for the most recent biennial budget, DHS is required to distribute the excess to nursing homes owned and operated by local governments. DHS makes these payments to eligible nursing homes in the year following the year in which DHS claims the federal funds.

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

Wisconsin has an IGT related to services provided by the University of Wisconsin Medical Foundation (UWMF). Under the program, MA makes a supplemental payment to UWMF, in addition to the standard MA reimbursement payment, for services provided by UW physicians to MA beneficiaries. The UW System also makes a transfer from its general program operations program revenue appropriation to the MA trust fund equal to the federal share of the supplemental payment, which can then be used to fund other MA benefit costs. In 2023-24, this payment was $28.4 million. Because of delays in verifying data from the prior year, the transfer in this year represented six quarters of claims, and so was higher than normal. The MA budget is also reimbursed for the non-federal share of the supplement through a transfer from UWMF, collected in a program revenue appropriation.

UW Hospital Certified Public Expenditure Program. Under a separate CPE program, DHS submits claims for federal matching funds in an amount equal to the deficit the University of Wisconsin Hospital incurs to provide services to MA recipients. DHS claimed $1.95 million under this program in 2023-24.

Transfer from Permanent Endowment Fund. The permanent endowment fund is a non-lapsable trust fund that receives the proceeds of the sale of the state's rights to receive tobacco settlement payments. In each year between 2009-10 and 2020-21, state statutes required a $50 million annual transfer from the permanent endowment fund to the MATF, with the remaining tobacco settlement money transferred to the general fund. Beginning in 2021-22, the law was changed to require all permanent endowment fund moneys to be transferred to the MATF. In 2023-24, the transfer was $98.0 million.

2021 Act 59 Transfer from the General Fund. The 2021-23 budget act (2021 Act 59) required transfers of $174.7 million in 2021-22 and $527.8 million in 2022-23 from the general fund to the MATF. These transfers have the effect of reducing the direct GPR appropriations for MA benefits and increasing the SEG appropriations by the same amount. Since the decreases in GPR appropriations are equal to the general fund transfers, there was no net impact on the general fund balance from this transaction. Since these transfers applied only in the 2021-23 biennium, there was no such transfer in 2023-24.

Ambulance Service Provider Trust Fund. The ambulance service provider trust fund is used for the collection of an ambulance provider fee and for the supplemental payments to ambulance providers. The fund and assessment were established by 2021 Act 228, although these provisions had not yet received the required federal approval for 2023-24. If approved, DHS will collect a fee from privately-owned ambulance service providers, equaling a specified percentage of net patient revenues. The Department is required to set that percentage such that the total amount collected is no less than one-quarter of one percent less than the maximum provider assessment allowed under federal law, without exceeding the maximum. Currently, federal regulations limit provider assessments to no more than 6.0% of net patient revenues, so the ambulance provider fee must be between 5.75% and 6.0%.

All revenues collected from this fee will be deposited in the ambulance service provider trust fund. DHS will then make supplemental payments to privately-owned ambulance service providers using revenues from this fund, plus the associated federal matching funds. While a portion of the revenue from other provider assessments is deposited in the MA trust fund to pay a portion of general MA benefit costs, all revenue collected from the ambulance services provider fee must be used for ambulance provider supplement payments.

Program Revenues (PR)

MA is also supported with program revenues (PR), which offset both GPR and FED spending in the program. The program's main source of PR is rebates from drug manufacturers. Other sources include premiums collected from certain program participants, estate recovery, collections from other insurance coverage, and payments from counties for certain long-term care services.

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 2023-24, these federally mandated rebates, along with supplemental drug rebates negotiated by the state, totaled $1,276.3 million.

County Contributions for Family Care. The Family Care and IRIS programs, which are described in Chapter 10, provide long-term care services for certain qualifying MA recipients. Counties are required to annually contribute funding to partially support Family Care and IRIS program costs. Counties had previously used other funding sources, including state funds provided under the community aids program, to support long-term care services for individuals who now receive these services under Family Care and IRIS. Each county's contribution is based on a percentage of the county's 2006 basic county allocation under the community aids program. In 2023-24, the program spent $46.0 million in county revenue for Family Care under this provision.

Collections, Recoveries, and Premiums. 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. In addition, certain beneficiaries are required to pay monthly premiums. In 2023-24, these other collections totaled $68.9 million.

Local Government Funding

For most MA services, health care providers receive a reimbursement payment consisting of a federal share and a non-federal share, where the non-federal share is the state's responsibility, paid with GPR or SEG funds. For some MA services, however, where a local government is the service provider, the local government receives a reimbursement payment consisting of only the federal share of the cost (or a portion of the federal share), and is thus responsible for the non-federal share of the cost. The portion of the federal share that the local government provider receives depends upon the type of service.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide some school-based health services to children enrolled in MA. These school-based services include speech and language therapy, occupational therapy, and nursing services that are included in a child's individualized education program (a written education plan for a child with a disability). The MA program claims federal matching funds for school-based services expenditures, based on the actual costs to the school districts for providing the services. Of the federal matching funds claimed for these costs, the state retains 40% and the remaining 60% is transferred to school districts. The amount retained by the state is deposited into the general fund. For administrative costs related to school-based services, the school districts or CESAs receive 90% of the federal share of the payment, while the remaining 10% is deposited in the general fund.

In 2023-24, schools and CESAs received a total of $113.5 million in federal funds for school-based services and related administrative costs. DHS credited an additional $63.6 million in these federal funds to the state general fund.

County-Funded Mental Health and Substance Abuse Services. Counties support the non-federal share of the cost of providing certain community-based and inpatient mental health and substance abuse services to MA recipients. These services include targeted case management, crisis intervention, and community support programs for persons with acute mental illness. While counties pay the non-federal share, DHS claims federal match, based on the actual cost of these services, and forwards this amount to counties. In 2023-24, DHS paid counties $67.5 million in federal matching funds for these county-administered services.

ELIGIBILITY FOR BADGERCARE PLUS AND RELATED PROGRAMS

This chapter provides an overview of eligibility policies for BadgerCare Plus. BadgerCare Plus provides health care coverage to individuals and families whose eligibility is generally based on having household income below a statutory threshold, which varies by eligibility category.

BadgerCare Plus provides coverage in the following eligibility categories: (a) children under age 19; (b) parents (or caretaker relatives) of dependent children; (c) childless adults (adults without dependent children in the household); and (d) pregnant women.

In addition to BadgerCare Plus, this chapter provides information on coverage for children in foster care or subsidized adoption, young adults formerly in foster care, and women who have been diagnosed with breast or cervical cancer under the Well Woman program. As with BadgerCare Plus, these groups receive full benefit coverage, but they are said to have "categorical eligibility" since eligibility is based primarily on medical or legal status, rather than income.

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

Financial Eligibility

Determining Income for Eligibility. Individuals qualify for BadgerCare Plus coverage based on their household income, or the combined income (with certain adjustments and exceptions) of all members of their household. 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.

For the purposes of MA eligiblity, the program generally considers the sum of the household's taxable income, although the income of a tax dependent of another member of the household is only counted if the dependent's earnings are high enough to require filing a federal tax return.

Some common sources of income that are generally not not taxable and so are not counted for the purposes of BadgerCare Plus eligiblity are veterans benefits, foster care payments, earned income tax credits, child support, supplement security income (SSI), and financial assistance received under the Wisconsin Works (W-2) program.

Eligibility for BadgerCare Plus is generally based on monthly household income in relation to the eligibility threshold for a one-month period. However, if a parent's or childless adult's household income exceeds the eligibility threshold for a particular month, but their annual income is still expected to be below the annual threshold, their eligibility is determined using their annual income.

For the purposes of eligibility determination, an applicant's "household" is based on membership of his or her household that is used for tax purposes (regardless of whether or not the household is required to file a tax return). This means, for instance, that a person who is claimed as a dependent for tax purposes is included in the household even if the person is not physically present in the same residence, such as a child who is a college student living elsewhere.

Income Eligibility Thresholds. Instead of using an annual or monthly dollar amount as an income eligibility threshold, the program's eligibility standard is expressed as a percentage of the federal poverty level (FPL). For instance, parents qualify for BadgerCare Plus if their household income is below 100% of the FPL, or, as is often expressed, if their household income "falls below the poverty line."

The actual dollar amount of the FPL varies by household size, to account for the expectation that living expenses increase with an increase in the number of individuals living in a household. The U.S. Department of Health and Human Services adjusts the FPL each year to account for inflation. Appendix 1 lists annual and monthly income, by household size, at various percentages of the 2024 FPL.

Table 3.1 shows the FPL-based percentage thresholds that apply to adults, pregnant women, and children under BadgerCare Plus, as well as the dollar equivalents for several household sizes using the 2024 FPL.

Federal Income Adjustment Rules. Since 2014, federal law has required states to use a standardized method for determining financial eligibility for low-income Medicaid coverage programs, such as Wisconsin's BadgerCare Plus. These procedures are referred to as the "MAGI" rules, since they use the modified adjusted gross income (MAGI) of the applicant's household, as defined for federal income tax purposes, as the basis for eligibility determinations.

In addition to using a standardized definition of income, MAGI rules also incorporate a standardized process for accounting for certain income and expense adjustments that states had previously used for Medicaid eligibility determination. Prior to the use of MAGI rules, states used a *net income* standard for eligibility, which involved applying certain allowable disregards to gross income, such as deductions to income for expenses like child-care or child support obligations. This net income figure was then compared to the applicable statutory income threshold for the person's eligibility category for making the final eligibility determination.

Under MAGI rules, these income disregard procedures were replaced with a standardized percentage disregard applied to all applicants. This percentage is the sum of a 5% standard disregard, used in all states, plus a "conversion factor" meant to make up the difference between the standard disregard and the average impact of the income disregards previously used by the state. This conversion factor was calculated for each state using a sample of past applicants, in order to determine the average actual disregard, as a percentage of gross income, for the sample.

Table 3.1: 2024 BadgerCare Plus Income Eligibility Standards for Parents, Childless Adults, Pregnant Women, and Children

		Annual Income		
	% of the FPL	One-Person Household	Two-Person Household	Three-Person Household
Parents and Childless Adults	100%	$15,060	$20,440	$25,820
Pregnant Women and Children	306%	N/A*	$62,546	$79,009

* For both pregnant women and children, all household units have at least two members, since a pregnant woman's household includes the expected number of babies.

Since the conversion factor calculation was based on the income disregard rules utilized by the state, and since each state used different disregard rules, the resulting percentage income disregard varies by state. For Wisconsin, the conversion factor was calculated at 1%, meaning that the full income disregard used for MAGI eligibility in the state equals 6%, or the standard

5% plus the 1% conversion factor.

The conversion factor component of the MAGI disregard was included with the intent of having each state continue to use approximately the same eligibility levels that existed in the state prior to the implementation of MAGI rules, but by using a single percentage adjustment applied to gross income for all applicants, instead of using a separate income adjustment calculation for each individual applicant.

Since the same percentage is used for all applicants within a given category, the MAGI income disregard has the same effect as an equivalent percentage *increase* to the statutory eligibility threshold percentage for that category. For this reason, eligibility thresholds are frequently expressed as this adjusted percentage of the FPL, rather than the statutory level. For instance, while Wisconsin state statutes set the income threshold for children and pregnant women at 300% of the FPL, the effective income eligibility level for these groups equals 306% of the FPL, as shown in Table 3.1.

However, unlike the standards for children and pregnant women, state statutes specify that the income eligibility standard for adults (parents, caretaker relatives, and adults without dependent children) is *before* the application of income disregard so that the eligibility standard for these adults equals 100% of the FPL, the statutory threshold for these groups.

Change in Income Reporting and Income Verification. MA beneficiaries are required to report any changes to income, household composition, or other circumstances that may affect their eligibility. Enrollment personnel use several external sources to monitor income changes and verify the information provided by applicants. Additional information on data verification is provided in Chapter 11 on MA administration.

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

For children in households with income exceeding 306% of the FPL, the deductible is met once the household's medical expenses incurred during a six-month period exceed the difference between the child's household income and 156% of the FPL. A child whose household income is between 156% of the FPL and 306% of the FPL, but who is ineligible due to having access to a parent's employer-sponsored insurance, may also become eligible if the household incurs medical expenses sufficient to meet the deductible requirement. In both cases, the child's eligibility lasts for the remainder of the six-month period.

Non-Financial Eligibility

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

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

Citizenship. Only U.S. citizens, U.S. nationals, or certain documented immigrants may enroll in BadgerCare Plus. In general, adult immigrants who have been lawfully admitted to the United States can qualify for BadgerCare Plus coverage, but only after five years have passed since their arrival in the county. Exceptions to this waiting period apply to those with refugee status, who may become eligible upon arrival.

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

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

Recipients must also provide information regarding third-party liability for services. Third-party liability refers to situations in which a party other than the BadgerCare Plus program or the recipient is obligated to pay the recipient's medical expenses, such as when a recipient has private health insurance. As the payer of last resort, BadgerCare Plus only pays for covered services not covered by another source.

Third-party liability also exists when a recipient receives a settlement (for instance, from another person's insurance policy) related to injuries for which BadgerCare Plus paid part or all of the resulting medical services. In those circumstances, the recipient must advise the state of their claim before settling the case, and must assign to the state that portion of the settlement needed to reimburse BadgerCare Plus for the medical expenses that the program 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 citizenship, identity, immigration status, pregnancy, income, and access to other health insurance coverage.

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

These crowd-out provisions apply to children whose eligiblity for MA is provided through the Children's Health Insurance Program (CHIP), rather than through standard Medicaid eligibility.

Eligibility Groups

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

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

Approximately one-quarter of children enrolled in BadgerCare Plus are covered under the federal children's health insurance program (CHIP, or "Title 21" in reference to the authorizing title of the federal Social Security Act), rather than standard Medicaid ("Title 19" of the Social Security Act). Under Wisconsin's Medicaid program, there is no difference in the type or amount of services covered by CHIP and standard Medicaid, but the state receives a higher federal matching rate for services provided to CHIP-eligible populations than for Medicaid-eligible populations. The income thresholds dividing Medicaid and CHIP vary by the age of the child. For children between the ages one and five, CHIP coverage applies for household income between 191% and 306% of the FPL, while Medicaid coverage applies for these children in households with income below 191% of the FPL. For children between the ages of six and 18, CHIP coverage applies for household income between 156% of the FPL and 306% of the FPL, while Medicaid coverage applies for these children in household income below 156% of the FPL. Children under age one are covered under Medicaid only.

Beginning in 2024, federal law requires state Medicaid programs to provide 12 months of "continuous eligibility" for children. This means that once a child is determined to be eligible, they maintain eligibility for one year regardless of any subsequent change to household income in that year that would otherwise cause them to lose financial eligibility. Previously, 12-month continuous eligibility only applied to infants born to a mother enrolled in MA.

Eligibility for children in households with income over 201% of the FPL is generally contingent upon the payment of monthly premiums. Members of Native American tribes and children under one year of age are not subject to premiums. Table 3.2 shows the monthly premiums a household at various income levels must pay for each child enrolled in BadgerCare Plus.

Table 3.2: BadgerCare Plus Premiums for Children, by Household Income

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

Parents and Caretaker Relatives. A person is considered a parent for the purposes of BadgerCare Plus eligibility if the person is natural or legally adoptive parent, or a step-parent, of a child under the age of 19 who is under the care of the person for at least 40% of the time. A person who is not a parent may be eligible for BadgerCare Plus as a caretaker relative if a child in the home is under his or her care, and if the person has a qualifying relationship to the child. The qualifying relationships include, among others, grandparent, sibling, aunt or uncle, or cousin. Parents and caretaker relatives with income up to 100% of the FPL qualify for BadgerCare Plus.

Adults without Dependent Children ("Childless Adults"). Adults without dependent children with income up to 100% of the FPL qualify for BadgerCare Plus. The coverage for childless adults in Wisconsin is provided under the terms of a federal waiver agreement, which began in 2014. An extension of the waiver, approved in October of 2018, included eligibility requirements and other conditions for childless adult coverage that are not applicable to other eligibility groups.

Among these conditions was a requirement that enrollees under the age of 50 participate in at least 80 hours per calendar month of community engagement activities, such as paid work, self employment, schooling, or vounteer activities. A childless adult failing to meet these requirements could have remained enrolled in BadgerCare Plus, but would be subject to a 48-month time limit on the program. However, in April of 2021, and before this requirement had been implemented, CMS withdrew approval of this component of the waiver.

Another condition included in the childless adult waiver was a monthly premium, applicable to childless adults with incomes of at least 50% of the federal poverty level. The premium was set at $8 per household, except that this amount would be reduced to $4 for a household in which the members do not engage in certain behaviors that increase health risks or attest to actively monitoring unhealthy behaviors. Qualification for the healthy behaviors discount was determined using a health risk assessment.

Although the premium provisions were implemented in February of 2020, they were suspended in April of 2020, to comply with federal prohibitions against eligiblity restrictions enacted at the start of the COVID-19 pandemic. Then, in November of 2023, CMS notified the state that it would no longer allow the state to implement the premium provisions as part of the childless adult waiver.

The remaining waiver provision applicable specifically to childless adults is a $8 copay applicable for the non-emergency use of hospital emergency department services.

Pregnant Women. Pregnant women with household income under 306% of the FPL are eligible for BadgerCare Plus coverage. Eligibility continues for a postpartum period after the end of the pregnancy. Under federal law, the postpartum eligibility period continues until the last day of the month in which the 60th day following the end of the pregnancy occurs, although states may elect to extend coverage for a full year following the end of the pregnancy. A provision of the 2021-23 budget act required the Department to request a federal waiver to provide postpartum coverage to the end of the month in which the 90th day following delivery occurs (an additional 30 days of coverage), however this request has been denied. As of the end of 2024, all states but Wisconsin and Arkansas have adopted the full-year postpartum extension coverage option.

Children in Out-of-Home Care and Children with Subsidized Adoption Agreements. In Wisconsin, all children and youths who are placed in foster care (regardless of whether the state claims federal funding under Title IV-E for their care and supervision), subsidized guardianship, or court-ordered kinship care are eligible for Medicaid coverage, beginning on the date the child enters out-of-home care and ending only after the child is discharged from out-of-home care and is determined ineligible for all other categories of BadgerCare Plus and Medicaid eligibility.

In addition, children with special needs for whom adoption assistance agreements are in effect, and children adopted under state-established agreements are eligible for MA.

These children and youths are categorically eligible for MA, meaning that household income is not a factor in determining their eligibility.

Youths Previously in Out-of-Home Care. Pursuant to provisions enacted as part of the federal Affordable Care Act, the state's MA program provides coverage to all youths up to age 26 who were in foster care, subsidized guardianships, or court-ordered kinship care on their 18^{th} birthday, regardless of the state they lived in when they turned 19. These youths are eligible for MA coverage, regardless of their household income.

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

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

Women who qualify for coverage are eligible for the full range of benefits on a fee-for-service basis provided under BadgerCare Plus.

COVID-19 Continuous Eligibility and Subsequent Eligibility Redetermination

The federal Families First Coronavirus Response Act of 2020 (FFCRA) provided enhanced Medicaid matching rate for the duration of the federal public health emergency for the COVID-19 pandemic. As a condition of receiving the additional matching funds, states were required to maintain Medicaid eligibility for any person who was enrolled in the program as of March 18, 2020, or who later became eligible for coverage.

Initially, this continuous enrollment period was to last until the expiration of the federal public health emergency related to the pandemic, but Congress later modified the provision so that it would instead expire at the end of March of 2023. At that time, states were then required to redetermine eligibility of all enrolled beneficiaries, a process that came to be known as "Medicaid unwinding." Given the large volume of enrollees needing eligibility reviews, states were allowed to spread the unwinding workload across a full 12-month redetermination cycle. Wisconsin, like most states, elected to use this 12-month schedule, although since the renewal or termination of coverage occurs 45 days after the renewal is initiated, the time between the first renewal notices were sent and the final renewals or terminations lasted for a total of about 14 months.

During the roughly three-year period that the continuous eligibility policy was in place, BadgerCare Plus enrollment increased by over 50%, or by just over 411,000 enrollees. At the completion of the unwinding period, in July of 2024, enrollment in these categories had decreased by just over 277,000. Overall, enrollment was 17% higher in July of 2024 than it had been in January of 2020.

Table 3.3 shows the enrollment for each of the BadgerCare Plus and related program eligibility groups in January of 2020, which was just prior to the continuous enrollment policy, in May of 2023, the final month before unwinding disenrollments appeared in the data, and in July of 2024, 14 months following the first unwinding disenrollment.

Table 3.3: Trends in Enrollment in BadgerCare Plus (Including Foster Care/Subsidized Adoption)

Eligibility Category	January 2020	May 2023	Change from January 2020	July 2024	Change from May 2023
Children	446,325	591,958	145,633	500,421	-91,537
Parents	158,055	253,083	95,028	209,183	-43,900
Childless Adults	151,020	298,723	147,703	184,302	-114,421
Pregnant Women	17,700	35,403	17,703	16,760	-18,643
Foster Care/Sub. Adopt.	20,704	29,340	8,636	20,451	-8,889
Total	793,804	1,208,507	414,703	931,117	-277,390

Special Eligibility Situations

Individuals can receive BadgerCare Plus coverage under several special circumstances, including transitional MA coverage, presumptive eligibility, and retroactive eligibility. This section describes these situations, as well as the eligibility rules that apply to persons confined to correctional institutions.

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

Prior to the continuous enrollment period between 2020 and 2023, about 10% to 15% of all enrolled children and about 15% to 20% of all enrolled parents and caretaker relatives were enrolled under transitional MA. (During the continuous enrollment period and throughout unwinding period, these percentages were higher due to how enrollments were categorized during that time.) Those individuals enrolled under transitional MA are included in the parents and children categories shown in Table 3.3.

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

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

Presumptive eligibility does not apply to children whose household income would place them in the CHIP eligibility income ranges, rather than the standard Medicaid income ranges.

Retroactive Eligibility. Under the MA program's retroactive eligibility rules, adults, pregnant women, and children (other than those covered under CHIP) 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.

Coverage of Services to Correctional Inmates. Under a policy known as the "inmate exclusion," federal law prohibits Medicaid coverage of services for a person while confined to a jail, prison, or other correctional facility. Instead, their medical costs are the responsibility of the correctional facility. This restriction does not apply during a period in which the inmate resides outside of the correctional institution for more than 24 hours, which is generally applicable to inmates who receive inpatient hospital services for a condition that requires admission to the hospital lasting more than 24 hours.

In Wisconsin, individuals who were enrolled at the time that they were incarcerated have their enrollment suspended, rather than revoked. Upon release, the individual can be restored to active enrollment status, with immediate eligibility for services, without the need to reapply, unless their enrollment otherwise expired during the period of incarceration. As of July of 2024, there were approximately 8,600 incarcerated individuals enrolled in BadgerCare Plus with suspended status. These individuals are not included in Table 3.3, since they are not eligible to receive MA services.

Beginning in 2025, federal Medicaid law requires states to make limited exceptions to the inmate exclusion for incarcerated youth. During 30-day period immediately prior to a scheduled release, the program must provide screenings and diagnostic services to an eligible juvenile that meet reasonable standards of medical and dental practice. In addition, during the 30 days prior to release and for at least 30 days following release, the state must provide targeted case management services, including referals to appropriate care and services. Coverage of any services that may be indicated or recommended as the result of screening or targeted case management are not included in this exception, and so would continue to be the responsibility of the correctional institution. For the purposes of this provision, an eligible juvenile is an incarcerated individual who is under 21 years of age.

Medicaid Expansion 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 prohibiting the practice of basing premiums on health status. It also provides federal tax credits for individuals to offset the cost of private insurance coverage purchased through a health insurance exchange. For more information on the private insurance provisions in the ACA, see the Legislative Fiscal Bureau's informational paper entitled, "The Affordable Care Act (Summary of Major Insurance Provisions and Implementation in Wisconsin)."

A significant Medicaid-related provision of the ACA was the expansion of eligibility to "newly-eligible" groups. As enacted, the ACA required state Medicaid programs, at the risk of losing federal MA matching funds, to cover virtually all non-elderly individuals with household incomes up to 138% of the FPL beginning January 1, 2014.[1] This new mandatory eligibility requirement was referred to as a "Medicaid expansion" under the ACA.

However, in June, 2012, the U.S. Supreme Court issued a decision under *National Federation of Independent Business v. Sebelius* that addressed some of the ACA's principal provisions. While the

[1] Unlike for other eligiblity groups covered by state Medicaid programs, federal law specifies that the standard income disregard percentage for the Medicaid expansion group is 5%, with no separate conversion factor. Therefore, while the statutory income eligibilty threshold for Medicaid expansion is 133% of the FPL, the effective threshold is 138% of the FPL.

Court upheld some challenged provisions, it ruled that states cannot be compelled to adopt the Medicaid expansion provision, which effectively made the ACA's Medicaid expansion optional for states.

The Wisconsin Legislature considered the issue of Medicaid eligibility standards as part of its 2013-15 biennial budget deliberations, but ultimately elected to adopt what has become known as a "partial expansion" of the state's Medicaid program. Under this policy, income eligibility for parents and childless adults was set at 100% of the FPL, rather than the full Medicaid expansion standard of 138% of the FPL.

For states that adopt full Medicaid expansion, the ACA provides states an enhanced FMAP to help cover the costs of individuals who would be "newly eligible" under the Medicaid expansion. The enhanced ACA FMAP equaled 100% in 2014 through 2016, gradually declining to 90% in 2020 and subsequent years.

Under the ACA's definition of a "newly eligible" group, childless adults would be considered "newly eligible" in Wisconsin if the state adopted full Medicaid expansion. Since Wisconsin's partial expansion does not the meet the minimum standard for full expansion, the state is not eligible for the enhanced FMAP, and instead receives the lower, standard FMAP for childless adults.

In 2021, Congress passed the American Rescue Plan Act (ARPA), which provides an additional incentive to encourage states to adopt full Medicaid expansion. Under this provision, any non-expansion state that adopts full expansion would become eligible for a 5.0 percentage point increase to the state's FMAP, applicable for two years following implementation. This FMAP increase would apply to most Medicaid expenditures that would otherwise be subject to the standard FMAP, thereby reducing state expenditures during the incentive period.

As of the end of 2024, 40 states, plus the District of Columbia had adopted full Medicaid expansion, including three--Missouri, North Carolina, and Oklahoma--that qualified for the ARPA incentive. In addition to Wisconsin, the following states had not adopted full expansion: Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, and Wyoming.

ELIGIBILITY FOR ELDERLY, BLIND, AND DISABLED MEDICAID PROGRAMS

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

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

For individuals who meet eligibility requirements for both BadgerCare Plus and EBD Medicaid or one of the subprograms, the individual is enrolled in EBD Medicaid, except for pregnant women, who are enrolled in BadgerCare Plus. As of October, 2024, 244,926 individuals were categorized by DHS as having elderly and disabled MA full benefit coverage.

This chapter describes eligibility requirements for EBD Medicaid and several of the EBD Medicaid subprograms. Other programs that may be available to EBD Medicaid recipients are discussed in other chapters, including limited coverage plans such as MA coverage for individuals with tuberculosis and the Medicare premium assistance programs (Chapter 5) and Family Care and other long-term care programs (Chapter 10).

Eligibility Requirements

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

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

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

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

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

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

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

Examples of the applied deductions include: expenses for establishing and maintaining court-ordered guardianships or protective placements; medical and remedial services and equipment; a standard Medicaid credit of $20; support and maintenance payments made to another person outside of the household; impairment-related work expenses (IRWEs); and partial credit for monthly gross job income and wages.

Once an individual's countable income is determined, this amount is compared to one of two income limits depending on the individual's marital status. In 2025, the monthly income limit for unmarried individuals is $1,050.78 and $1,582.05 for married individuals.

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

The individual's deductible is calculated by determining the monthly amount by which their counted income exceeds the medically needy income limit ($1,255 per month in 2024) and multiplying that amount by six to reflect the six-month period for which Medicaid coverage is provided.

Other 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.

Categorical Eligibility for SSI Recipients. Many EBD Medicaid recipients qualify for the standard Medicaid benefit plan because they receive cash benefits under the supplemental security income (SSI) program, or meet requirements relating to the SSI program. This is sometimes called categorical SSI eligibility because an individual is deemed eligible for MA on the basis of qualifying for SSI benefits, without having to separately demonstrate eligibility under EBD

Medicaid's financial and non-financial standards.

In calendar year 2025, the federal SSI income limit is $967 per month and the asset limit is $2,000 for an individual. For married couples, the income limit is $1,450 per month and the asset limit is $3,000. States may enter into agreements with the Social Security Administration, which administers the SSI program, to provide all SSI recipients with Medicaid eligibility, eliminating the need for individuals to apply for both programs separately. Wisconsin's Medicaid program provides automatic coverage for individuals who receive cash assistance under the SSI program.

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

Federal law requires state Medicaid programs to provide coverage for several groups of individuals who were previously eligible for SSI, but no longer receive monthly SSI payments. These include: (a) 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; (b) individuals who were once eligible for both SSI and Social Security payments but who are no longer eligible for SSI because of certain cost of living adjustments in their Social Security benefits; and (c) certain other individuals who become ineligible for SSI due to changes in eligibility for, or increases in, Social Security or veterans benefits.

Additional information on the SSI program can be found in the Legislative Fiscal Bureau's 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 homes, hospitals, and other medical institutions) and individuals who live in their own homes but participate in home and 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 ($2,901 per month in 2025).

Alternatively, if an individual's gross income exceeds this standard, their gross income is compared to their monthly medical costs, which includes the following: (a) a personal needs allowance of $55; (b) institutional care, using the private care rate; (c) health insurance; (d) support payments; (e) out-of-pocket medical costs; (f) impairment-related work expenses; (g) costs identified in a self-support plan; (h) guardian and other court-ordered legal fees; and (i) other medical and remedial expenses. If the individual's gross income is less than their monthly medical needs, the individual may qualify for Medicaid-funded institutional care under this methodology, which is sometimes referred to as the "medically needy" standard.

Medicaid recipients who qualify for Medicaid-funded institutional care must use any income in excess of allowable deductions for the cost of their care. The Medicaid recipient's share of these costs is referred to as patient liability. If an individual's patient liability meets or exceeds the institution's payment rate, they are responsible for paying the entire Medicaid rate, but are able to keep any remaining income.

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

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

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

Federal law allows states discretion in establishing the asset protection level within minimum and maximum limits ($31,584 to $157,920 in calendar year 2025). 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 $157,920 in 2025. As required by federal law, the state asset limits may be adjusted based on the couple's circumstances by a fair hearing or court order.

In addition to the assets protected for the community spouse, the institutionalized spouse may retain $2,000 of their own assets. Any countable assets in excess of these protected amounts must be expended before the institutionalized spouse can become eligible for Medicaid. 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.

The following example illustrates how the asset test is currently applied in Wisconsin. Consider a couple whose combined countable resources are $120,000 at the time of initial institutionalization. The spousal share, which is equal to one-half of the couple's countable resources, is $60,000. After a period of time, the institutionalized spouse applies for Medicaid. By the time the institutionalized person applies for Medicaid, the couple's combined countable resources have been reduced to $90,000.

In this example, the greater of: (a) the state spousal resource standard ($50,000) or (b) the spousal share at the beginning of the initial period of institutionalization ($60,000) would be deducted from the combined countable resources at the time of application, resulting in an unprotected resource amount of $30,000 ($90,000 minus $60,000). Because $30,000 exceeds the state's asset limit of $2,000, the institutionalized spouse would not be eligible for Medicaid. However, if, during that same period of institutionalization, the couple's combined resources are reduced to less than $62,000, the institutionalized spouse would meet the Medicaid asset test because their own assets (after excluding the community spouse's share) would be less than the current asset limit of $2,000.

Income. One way that the spousal impoverishment provisions protect the community spouse is that only the income in the institutionalized spouse's name has to be used for the cost of care for the institutionalized spouse and for determining eligibility for Medicaid-supported long-term care services.

In addition, spousal impoverishment provisions allow part of the institutional spouse's income to be transferred to the community spouse to provide income for the community spouse under the monthly maintenance needs allowance. Under federal law, states may allow income of up to $3,948 per month to be transferred to the community spouse in 2025. 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 (except Hawaii and Alaska) must allow to be transferred to the community spouse is $2,555 per month for 2025. The federal minimum is usually increased each year as the federal poverty level increases. If the state establishes an income allowance that is below the federal maximum, the state must establish an excess shelter allowance.

In Wisconsin, the maximum amount that may be transferred to the community spouse in 2025 is the lesser of $3,948.00 per month or $3,406.66 plus any shelter costs greater than $1,022. Shelter expenses include the community spouse's expenses for rent, mortgage principal and interest payments, taxes and insurance for a principal place of residence, maintenance fees if the community spouse lives in a condominium or cooperative, and a standard utility allowance. In addition, Wisconsin permits the institutionalized spouse to transfer up to $851.67 per month for each qualifying dependent family member living with the community spouse.

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

In addition to any amount transferred to the community spouse, the institutionalized spouse may retain income as a personal needs allowance. If the person is in a nursing home, the personal needs allowance is $55 per month. If the individual is enrolled in an HCBS waiver program, the allowance is between $1,147 to $2,901 per month for food, shelter, and other costs, in 2025. 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 2025, if a community spouse has shelter costs of $1,100 per month, the excess shelter costs equal $78 per month ($1,100 - $1,022 = $78). In this case, the maximum monthly income allocation is $3,505.66 ($3,406.66 + $78 = $3,484.66). If the community spouse receives $200 per month as income in their name, the amount is subtracted from $3,484.66 per month to determine the spousal income allocation amount ($3,284.66). If the institutionalized spouse's income is $3,600, the institutionalized spouse’s nursing home liability amount would be $260.34 per month [$3,600 (the institutionalized spouse's income) - $3,284.66 (the spousal income allocation) - $55 (the institutionalized spouse's personal needs allowance) = $260.34].

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

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

In order to determine whether divestment occurred, states are required to review the assets of all long-term care Medicaid applicants over a specified period, known as the "look back" period, before the date the applicant applied for Medicaid, was institutionalized, or found to meet the required level of care for home and community-based waiver enrollment. The look back period is 60 months for all divestments occurring after January 1, 2014.

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

Divestment penalties also do not apply if the individual demonstrates that: (a) the individual intended to dispose of the assets either at fair market value or for other valuable consideration; (b) the assets were transferred exclusively for a purpose other than to qualify for Medicaid; (c) the community spouse divested assets that were part of the community spouse asset share; (d) all of the assets transferred for less than fair market value have been returned to the individual; (e) the division or loss of property occurred as a result of a divorce, separation action, foreclosure, or repossession; or (f) imposition of a penalty would result in a serious impairment to the institutionalized person's immediate health.

If an eligibility worker determines that divestment occurred at any time during the look back period, a penalty period would be applied. The penalty period establishes the amount of time that the person would be ineligible for Medicaid-funded long-term care costs. The length of the penalty period is calculated by dividing the amount of the transfer by the average daily nursing home private pay rate in effect at the time of the application ($340.99 as of January 1, 2025). This rate is updated annually on January 1.

For example, if a person made a transfer of $50,000 one year before applying for Medicaid, this would generate a penalty period of 146 days ($50,000/$340.99 per day = 146 days, rounded down). The penalty period begins on the date the individual applies for Medicaid services and meets all other eligibility criteria. Under this example, the Medicaid program would not pay for long-term care services for the individual until 146 days after the person applies and is determined to be eligible for Medicaid-funded long-term care services.

However, divestment does not affect eligibility for Medicaid card services, with the exception of services covered within the daily institutional care rate for nursing homes. Similarly, an individual ineligible for home and community-based services due to a divestment may still be eligible for other primary and acute Medicaid services.

Individuals may also be disqualified from Medicaid eligibility if the equity in their home and the land used and operated in connection with the home exceeds a certain value. In 2025, federal rules require states to exempt a minimum of $730,000 in home equity from a beneficiary's countable assets.

The Wisconsin home equity value limit is $750,000. The home equity provision applies only to individuals who are applying for MA-funded long-term care services. It does not apply to individuals who were receiving Medicaid long-term care services as of January 1, 2009, as long as they remain continuously eligible for MA long-term care services after that date. Additionally, the limit does not apply if a spouse, minor, or disabled adult child resides in the home.

Wisconsin Long-Term Care Insurance Partnership. By purchasing an approved long-term care insurance policy, an individual may protect individual assets on a dollar-for-dollar basis for every dollar in private long-term care insurance benefits paid out by the qualified long-term care insurance policy on or after January 1, 2009. Once DHS verifies that these benefits have been paid, an individual is able to protect a corresponding amount of personal assets that equals the cash value of the insurance benefits. These protected assets are added to the $2,000 standard asset limit, as well as the protections offered under spousal impoverishment rules, to determine the total value of an individual's assets that are protected while still qualifying for Medicaid. These assets are also protected from, and not recoverable by, the estate recovery program.

Estate Recovery Program. Under federal law, state Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing home services, home and community-based services, and related hospital and prescription drug services. States have the option to recover payments for all other Medicaid services provided to these individuals, except Medicare cost-sharing paid on behalf of individuals who receive benefits under the Medicare savings programs described in Chapter 5.

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

In addition, DHS may recover from all property in which the recipient had an interest at the time of death, including life estates, property held in revocable trusts, property that passes by beneficiary designation, joint tenancy property, and marital property. A full description of the program can be found in the *Wisconsin Estate Recovery Program 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 their surviving spouse; (c) filing affidavits; and (d) seeking voluntary recoveries. Property of the Medicaid recipient transferred by an affidavit or by a non-probate transfer upon death is subject to a lien if the state's claim cannot be satisfied through available liquid assets.

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

MA Purchase Plan (MAPP). MAPP enables adults determined to have a disability under SSI standards (disregarding the individual's ability to work), to remain eligible for Medicaid if their earnings would otherwise disqualify them from coverage under the state's Medicaid program.

Income. An individual may qualify for MAPP if the individual's adjusted net household income is less than 250% of the FPL ($3,137.50 per month for an individual and $4,258.33 per month for a family of two in 2024). Income deductions for MAPP eligibility include: verified impairment related work expenses, verified out-of-pocket medical or remedial expenses (if those expenses are over $500 a month), and the earned income deduction.

Assets. An individual may qualify for MAPP if their non-exempt assets do not exceed $15,000.

However, MAPP participants can save up to 50% of their gross earnings in an "independence account." If the participant goes over this amount, they will have to pay a penalty. Amounts deposited in an independence account from income they earn while enrolled in MAPP are not counted toward the $15,000 asset limit.

Existing retirement accounts may be registered as independence accounts once an individual is eligible for MAPP, but the account's balance prior to MAPP eligibility will not be exempt (i.e., the amount will be counted toward the $15,000 asset limit) -- only the amounts accrued while the individual is eligible for MAPP may be exempt. If the individual opens an account, such as a savings account, to serve as an independence account, the account may only be established and registered while an individual is eligible for MAPP.

Amounts that accrue in an independence account are not counted in determining eligibility for other Medicaid long-term care programs, including Family Care, IRIS, the Family Care Partnership program, SSI-related Medicaid, and Medicare savings programs (MSPs).

Premium Structure. A participant with gross individual income less than 100% of the FPL ($1,255 per month in 2024) pays no monthly premiums. For other MAPP participants, the premium is calculated by first subtracting any verified impairment-related work expenses and monthly out-of-pocket medical or remedial expenses from the individual's gross income. If the net amount after subtracting these expenses is at or below 100% of the FPL, the premium amount will be $25 per month. If the net amount is above 100% of the FPL, the amount that exceeds the FPL is multiplied by 3% and added to $25, rounded down to the nearest whole dollar, to determine the monthly premium amount.

MAPP participants may ask for a temporary waiver of the premium. If DHS determines that a temporary difficulty has occurred that makes paying the premium a hardship on the individual, the premium must be waived. If an individual who is required to pay a premium does not pay the monthly premium in the benefit month, their coverage will end. They may regain coverage at any time by re-enrolling in MAPP and paying their initial premium for the month of re-enrollment.

Work Requirement. In order to be found eligible for the program, MAPP participants must meet a work requirement. Currently, participants are required to engage in a work activity at least once per month or enroll in a health and employment counseling (HEC) program. An individual is also considered to be working if they are engaged in in-kind work in lieu of employment.

As of October, 2024, 28,809 individuals were enrolled in MAPP.

The Katie Beckett Provision. Under a federal law provision commonly referred to as the Katie Beckett program, states may 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 home; (b) require a level of care typically provided in a hospital or nursing home; (c) can appropriately receive care outside of a facility and in the child's home; and (d) can receive care outside of an institution that costs no more than the estimated cost of institutional care. The families of children eligible under the Katie Beckett provision are not subject to copayment or deductible requirements. As of

October, 2024, 10,631 children in Wisconsin were enrolled under this eligibility provision.

Summary of Income and Asset Limits for EBD Medicaid Eligibility. Table 4.1 summarizes asset and income eligibility limits for select Medicaid subprograms described in this chapter for 2025. 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 4.1: Income and Asset Eligibility Criteria for Medicaid by Group and Eligibility Category, CY 2025

MEDICAID				
Sub-Program	**Family Size**	**Monthly Income Limit**	**Asset Limit**	**Eligibility Requirements**
Categorically Needy	1	$1,050.78	$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	$1,582.05	$3,000	
Medically Needy*	1	$1,255	$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	$1,703.33	$3,000	
Community Spouse Protected Income and Resources	2	$3,948	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 $157,920. 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 $851.67 per month for each qualifying dependent).
Special Income Limit	1	$2,901	$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 $55 per month if institutionalized or between $1,147 and $2,901 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 100% of the FPL.

* 2024 limit

Limited Benefit Medical Assistance Programs

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

MA Benefits for Medicare-Eligible Persons

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

The program provides several types of health care coverage. Medicare Part A covers hospital care, non-custodial care in a nursing home following an inpatient hospital stay, hospice care, and home health services. Medicare Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Medicare Part C, also known as Medicare Advantage, is an alternative to Parts A and B, and in some cases Part D, in which Medicare enrollees elect to receive the same services through a private health plan of their choosing, rather than through the fee-for-service system used in Part A and Part B. Medicare Part D refers to Medicare outpatient drug coverage, which is discussed in greater detail, along with the state's SeniorCare program, in Chapter 6.

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. Individuals that do not meet the 40-quarter requirement may purchase Part A coverage by paying monthly premiums. In 2025, the monthly premium for Part A coverage is $518 for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment, and $285 per month for people who have 30 to 39 quarters of Medicare-covered employment.

Individuals who enroll in Medicare Part A may enroll in Medicare Part B. Unlike Part A, all Part B enrollees must pay a monthly premium, or have the premium paid on their behalf through their state's Medicaid program. In calendar year 2025, individuals and married couples (filing joint tax returns) with annual incomes less than or equal to $106,000 and $212,000, respectively, pay monthly premiums of $185. Individuals and married couples with incomes above these thresholds pay higher premiums.

Individuals enrolled in Medicare Part A and Part B may be subject to certain deductible and coinsurance requirements, based on the length of the benefit period for which they receive services. 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 nursing home for 60 days.

Under Part A, the maximum benefit period is 60 full days of hospitalization coverage after meeting a deductible, plus 30 days during which the individual must make a daily copayment. An individual may also use up to 60 additional benefit days drawn from their lifetime reserve, also with a copayment requirement. Lifetime reserve days are not renewable. For a nursing home, the maximum benefit period is 100 days, with copayment requirements for days 21 through 100.

In 2025, the deductible for each benefit period is $1,676. Copayments are $419 per day for days 61 through 90 of the benefit period and $838 per day for days drawn from the beneficiary's lifetime reserve. The beneficiary is responsible for all costs beyond the lifetime reserve days.

In 2025, for care provided in a nursing home, the copayment is $209.50 per day for days 21 through 100 of each benefit period. For days 101 and beyond, the beneficiary is responsible for all costs.

In 2025, Medicare Part B pays 80% for all covered Part B services in a benefit period after an individual meets a $257 annual deductible. The individual is responsible for making a 20% coinsurance payment for the remaining cost. Providers must accept Medicare rates as full payment for any services provided to a Medicare enrollee.

Individuals enrolled in Part A and Part B often have supplemental coverage, including Medicare supplemental insurance ("Medigap policies"), or coverage from former employers, to support Medicare deductibles, copayments, and coinsurance.

Individuals who are eligible to enroll in Medicare Part A and Part B may instead enroll in a Medicare Advantage plan (Part C), which is required to provide all of the services covered under Part A and Part B, but may also offer additional benefits. Some of these plans also offer coverage for outpatient drugs, which are otherwise covered under Medicare Part D. Individuals enrolled in Medicare Advantage plans cannot buy, and do not need Medigap 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 March 31 during which a Medicare recipient can disenroll from their Medicare Advantage plan, either to opt out of Medicare Advantage and return to coverage provided under Part A and Part B, or switch from one Medicare Advantage plan to another plan of the same type.

Medicare and Medicaid. Some individuals with Medicare coverage are also eligible for either partial or full Medicaid benefits. These individuals are commonly referred to as "dual eligibles." If an individual is enrolled in Medicare and also qualifies for full Medicaid benefits by meeting Medicaid's financial eligibility standards, Medicare pays for all Medicare-covered services, including those services that are also covered by Medicaid. Medicaid pays for services that are not covered by Medicare (but that are eligible for Medicaid), and all Medicare premiums and cost-sharing (deductibles, copayments, and coinsurance) that would otherwise be paid by the individual.

Medicare Savings Program. The federal Medicare savings programs (MSPs) were established to help low-income Medicare recipients who do not qualify for full Medicaid benefits to pay for Medicare's premiums and cost-sharing requirements. Federal law defines several groups of individuals who may participate in the MSPs, and specifies the benefits to which these individuals are entitled.

Qualified Medicare Beneficiaries (QMBs). QMBs are individuals who are entitled to Medicare Part A services whose countable income (after subtracting certain credits) does not exceed 100% of the FPL, and whose resources do not exceed an asset limit of $9,660 for an individual and $14,470 for a couple in 2025. 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 QMBs, Medicaid pays all required Medicare premiums, coinsurance, copayments, and deductibles for both Medicare Part A and Part B coverage. As of October, 2024, Wisconsin's Medicaid program provided cost-sharing assistance to 3,968 QMBs.

Specified Low-Income Medicare Beneficiaries (SLMBs) and Specified Low-Income Medicare Beneficiaries Plus (SLMBs+). A more limited cost-sharing assistance benefit is provided to individuals who qualify as specified low-income Medicare beneficiaries (SLMBs) and the specified low-income Medicare beneficiaries plus (SLMBs+, referred to as "qualifying individuals" in federal law). SLMBs are individuals who are enrolled in Medicare Part A and have income (after subtracting certain credits) of 100% but less than 120% of the FPL. SLMBs+ are individuals with income of at least 120% but less than 135% of the FPL. The asset limits for SLMBs and SLMBs+ are the same as those for QMBs. State Medicaid programs are required to pay Medicare Part B premiums for these two groups. As of October, 2024, Wisconsin's Medicaid program provided this cost-sharing assistance to 8,524 SLMBs and 5,049 SLMBs+.

While the Medicaid program pays the same benefit (the Medicare Part B premium) on behalf of SLMBs and SLMBs+, the source of funding for this benefit varies. The Medicare cost sharing assistance for QMBs and SLMBs 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 SLMBs+. Consequently, these costs are 100% federally-funded. Further, unlike the assistance provided to QMBs and SLMBs, the state's obligation to fund Medicare Part B premiums for SLMBs+ is limited to the federal funding allocation the state receives for that purpose.

Table 5.1 summarizes 2025 asset and income eligibility limits for the MSPs described in this chapter. The income limits shown in the table reflect countable income (after subtracting certain credits).

Table 5.1 2025 Asset and Income Eligibility Limits for Medicare Savings Programs

MSP	Family Size	Income Limit (% of FPL)	Asset Limit	Benefits Paid
QMB	1	100	$9,660	Medicare Part A and B premiums, coinsurance, and deductibles
	2	100	$14,470	
SLMB	1	100 - <120	$9,660	Part B premiums
	2	100 - <120	$14,470	
SLMB+	1	120 - <135	$9,660	Part B premiums
	2	120 - <135	$14,470	

Other Limited-Benefit MA Programs

Family Planning Only Services Program. The family planning only services program provides contraception and related services to individuals with income up to 306% of the FPL. The program is the successor (with modifications) to the previous family planning waiver program, and is now incorporated into the state Medicaid plan. In October of 2024, there were 29,344 individuals enrolled in the family planning only services program.

Both males and females can enroll in the program if they meet the following criteria: (a) are of child bearing or reproductive age; (b) 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 parent's income is not counted. The program has an express enrollment feature similar to that available to pregnant women and children under BadgerCare Plus.

Depending upon the enrollee, covered services include contraceptive services and supplies, natural family planning supplies, family planning pharmacy visits, Pap tests, tubal ligations, testing and treatment of sexually transmitted infections, voluntary sterilizations for men 21 years of age or older, and routine preventive services if they are related to family planning. The federal matching rate for family planning only services is 90%, instead of the standard matching rate of approximately 60%.

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

Coverage under the program begins the first day of the month when the state receives an application, and continues through the end of the month after the pregnancy ends.

Emergency Services. MA reimburses providers for emergency services rendered to immigrants who are not otherwise eligible for coverage for MA due to their immigration status. This includes immigrants who have legal presence, but who have not been in the United States for the minimum of five years needed to qualify for full coverage, and also for immigrants without legal presence in the county. Reimbursement payments are only made for services provided to a parent of a dependent child or for services provided to a child who would otherwise qualify for BadgerCare Plus coverage under the Medicaid (federal Title XIX) income thresholds. Services provided to childless adult immigrants or to immigrant children who are above the Title XIX thresholds--even if they would meet the higher CHIP standards (Title XXI) --are not eligible for emergency services reimbursement.

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

A pregnant woman who is a non-qualifying immigrant qualifies for emergency services up to one calendar month before her due date, through the end of the calendar month in which the 60th day after the end of her pregnancy occurs. A child born to a mother covered under BadgerCare Plus emergency services is eligible for standard coverage under BadgerCare Plus.

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 their gross income is not more than $1,971 per month for one adult or $2,915 per month if the person is married (equivalent to approximately 130% of the 2024 FPL standards for a single adult or 142% of the FPL for a married person). These income levels apply regardless of the number of other individuals who may live in the applicant's household. For these individuals, coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services and services provided by federally-qualified health centers; (e) targeted 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 October of 2024, there were 253 individuals enrolled in Medicaid that met these criteria.

CHAPTER 6

SENIORCARE AND MEDICARE PART D

The SeniorCare program, partially funded with federal Medicaid funds, assists low-income seniors with drug purchases and certain vaccines. This chapter describes 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 purchases. 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. Although federal Medicaid matching funds partially support the program, and it is considered a limited-benefit subcomponent of the state's MA program, the state budgets for the program separately from MA. Many of SeniorCare's administrative and provider reimbursement provisions are the same as those applying to the pharmacy benefit offered under full-benefit MA programs. This section describes the eligibility and cost-sharing requirements for the program, and provides information on program enrollment and financing.

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

Cost-Sharing Requirements. SeniorCare participants must pay a $30 annual enrollment fee. Once in the program, beneficiaries must meet deductible and copayment requirements. Unlike Medicare Part D, there are no monthly premiums in SeniorCare.

The amount of a participant's deductible, if any, depends on their household income level. For the purposes of the program, the "household" includes the beneficiary and their 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 6.1. 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 6.1: 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. The copayment is $5 for each generic drug prescription and $15 for each brand name drug prescription. There are no copayment requirements for vaccines covered under the program.

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

As with the full-benefit programs, SeniorCare covers generic drugs unless a physician indicates in a prescription that a brand-name drug is medically necessary. The program also covers 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 8. For most drugs, the ingredient fee is equal to the national average drug acquisition cost. The pharmacy dispensing fee varies depending upon the annual volume of drugs dispensed by the pharmacy. For pharmacies with annual prescription volume of less than 35,000, the dispensing fee is $15.69, while for pharmacies with an annual prescription volume of 35,000 or more, the dispensing fee is $10.51.

In addition to prescription drugs, SeniorCare also provides coverage of any vaccination that is recommended for adults by the U.S. Advisory Committee on Immunization Practices (ACIP). As with prescription drugs, SeniorCare only covers vaccinations that are not covered by other insurance, such as Medicare Part D or Medicare Part B. SeniorCare only covers vaccinations administered through a pharmacy, not those provided in a doctor's office or other setting. Members have no out-of-pocket cost for covered vaccinations.

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 Medicare Part D coverage). Table 6.2 shows SeniorCare expenditures, by fund source, from 2014-15 through 2023-24.

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.

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

A Medicaid waiver authorizes federal financial participation for SeniorCare. Certain budget

Table 6.2: SeniorCare Benefit Expenditures

State Fiscal Year	GPR	FED	PR	Total
2014-15	$16,319,900	$14,909,700	$59,445,000	$90,674,500
2015-16	18,241,800	17,180,800	66,440,300	101,862,900
2016-17	9,740,300	12,764,000	76,016,800	98,521,100
2017-18	17,204,000	17,249,800	70,833,500	105,287,300
2018-19	9,847,700	10,606,500	84,959,600	105,413,900
2019-20	9,922,100	15,201,100	84,234,500	109,357,700
2020-21	12,480,800	13,771,200	83,240,700	109,492,700
2021-22	13,692,800	18,475,700	83,718,100	115,886,600
2022-23	15,220,700	18,058,300	84,722,000	118,001,000
2023-24	21,135,300	13,985,300	89,715,500	124,836,100

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) and, therefore, reduces Medicaid-funded expenditures for nursing home care and other long-term care services. The waiver was most recently renewed in 2019, extending authorization through 2028.

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

Program Participation. Enrollment in SeniorCare generally remained between 85,000 and 95,000 from 2010 through 2019. Then, in the spring of 2020, enrollment began steadily increasing, due in large part to the restrictions on Medicaid disenrollment during the COVID-19 public health emergency. As with enrollment in MA, the number of enrollees declined with the expiration of the continuous enrollment policy. Table 6.3 shows the average monthly enrollment for fiscal year 2014-15 through 2023-24.

The distribution of enrollees among the four income tiers has changed over time. Table 6.4 shows the average monthly enrollment by income level in 2014-15 and 2023-24. Over this period, enrollment in the lowest two income groups has gradually decreased, while enrollment in the highest-income (spend-down) segment has nearly doubled.

Table 6.3: SeniorCare Average Monthly Enrollment

2014-15	85,740
2015-16	87,899
2016-17	90,790
2017-18	92,371
2018-19	93,484
2019-20	95,045
2020-21	101,366
2021-22	108,312
2022-23	115,122
2023-24	101,087

Table 6.4: SeniorCare Enrollment, by Income Eligibility Group

Income Level	2014-15	2023-24
Less than 160% of FPL	32,574	21,116
160% of FPL to 200% of FPL	16,692	14,892
200% of FPL to 240% of FPL	9,789	10,653
Greater than 240% of FPL (spend-down)	26,685	50,426
Total Enrollment	85,740	101,087

Table 6.5 shows the 2023-24 average annual cost to the program by income eligibility group.

Table 6.5: 2023-24 Average Annual SeniorCare Cost by Income Eligibility Group

Income Eligibility Group	Average Annual Cost
Less than 160% of FPL	$2,654
160% of FPL to 200% of FPL	2,436
200% of FPL to 240% of FPL	1,412
Greater than 240% of FPL (spend-down)	81
Program Average	$1,208

As shown in the table, the average per-beneficiary program cost varies widely between the income groups. In particular, the spend-down group has significantly lower average costs than the other groups, largely due to the fact that most beneficiaries in this group do not meet the program's spend-down and deductible thresholds necessary to begin receiving program benefits. Beneficiaries in the spend-down group tend to use the program as a form of stop-gap insurance as an alternative to purchasing Medicare Part D coverage.

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. The plans establish their own formularies and coverage policies, but are subject to certain minimum requirements. For instance, 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 Inflation Reduction Act of 2022 (IRA) established new coverage requirements for Part D plans. Beginning in 2023, plans must cover vaccines with no cost sharing, other than vaccines already covered under Medicare Part B. In addition, beginning in 2023, plans must cap the enrollee's cost for insulin products at $35 per month.

Benefit Structure. 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 available with certain plans). That is, on average, the share of prescription drug costs paid by the plan (as opposed to the share paid by the beneficiary) must be the same as the standard benefit plan. Plans may not establish a higher deductible or a higher maximum out-of-pocket limit than the standard benefit.

Under the standard benefit plan, beneficiaries are responsible for all drug costs until meeting the deductible. Then, for any drug expenditures in excess of the deductible, beneficiaries are responsible for 25% of the cost, until reaching the "catastrophic coverage" threshold. Previously, beneficiaries paid 5% of drug costs after reaching the catastrophic coverage level, but the Inflation Reduction Act eliminated this coinsurance rate, beginning in 2024, which has the effect of capping total out-of-pocket drug expenditures at the catastrophic coverage threshold. Costs that are not paid by the beneficiary are split between the Part D plans, drug manufacturer discounts, and payments from Medicare (federal funds), in proportions that vary by coverage phase and the type of drug (brand or generic).

For the 2025 plan year, the deductible for the standard benefit is $590 and the total out-of-pocket cap is set at $2,000. These amounts are adjusted annually by the annual growth rate in Part D drug costs.

Premiums and the Role of Medicare Program Funding. The Medicare Part D program subsidizes the cost of drug plan premiums for all beneficiaries. The program makes Part D per capita payments to the plans, which directly subsidize the premiums paid by beneficiaries, while the program's role in financing drug costs above the deductible threshold has the effect of indirectly subsidizing beneficiary costs.

Direct premium subsidies are calculated based on bids submitted by Part D plan sponsors. Each participating sponsor's bid is an estimate of the average monthly revenue requirement that it would require to support a uniform benefit package to enrollees with a national average risk profile. Based on these bids, CMS calculates a national average, weighted by plan enrollment.

Normally, the per capita premium subsidy, which is paid directly to the plan sponsor on behalf of each enrollee, is set to equal 74.5% of the nationwide average bid. The remainder of the cost, or 25.5%, is the "base premium," or the enrollee's share. However, under a provision of the Inflation Reduction Act, the annual growth in the base premium for plan years 2024 to 2029 is limited to 6%. As a result, the federal government's premium subsidy percentage will be higher than 74.5% in any year in which the average bid increases by more than 6%. For the 2025 plan year, the standard calculation would have resulted in a base premium of $55.98, but the 6% growth cap resulted in a base premium of $36.78, with the federal subsidy adjusted to cover the remainder.

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.

While the base premium calculation is used to set the subsidy payment to plans, the actual premium paid by an enrollee will vary depending on the plan's benefit structure and other factors. For instance, although the structure of the standard benefit includes a deductible, many plans do not require a deductible, resulting in a higher premium. Therefore, while the base premium was $36.78 in 2025, the nationwide average Part D premium for standalone Part D plans was $46.50. On the other hand, the Part D portion of premiums for Medicare Advantage plans that include Part D coverage is typically lower than the base premium.

Persons with higher incomes are required to pay an additional amount for coverage, which reduces the federal cost for those enrollees. 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 $103,000 for an individual or $206,000 for a couple (in 2025, adjusted annually). Above this level, the additional payment is set such that the beneficiary pays between 35% and 85% of the cost, depending on income.

Low-Income Subsidy. Medicare Part D provides financial assistance to some of its enrollees under a low-income subsidy (LIS) program, also known as Extra Help. In Wisconsin, approximately 17% of Part D participants receive Extra Help assistance.

All enrollees who are dually eligible for Medicare and Medicaid (including for partial Medicaid benefits under the Medicare savings program) qualify for an LIS subsidy. In addition, a Part D enrollee who is not eligible for Medicaid, but whose household income is below 150% of the FPL and who has countable assets below specified limits is also eligible for LIS. In 2025, the LIS asset eligibility limit was $16,100 for an individual and $32,130 for a couple.

Part D enrollees with LIS 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 most are required to make copayments for filled prescriptions. In 2025, LIS beneficiaries who are full dual eligibles (that is Medicare and full-benefit EBD Medicaid) and have an income at or below 100% of the FPL pay a $1.60 copayment for generic drugs and a $4.80 copayment for other drugs. Full dual-eligible LIS beneficiaries who have an income between 100% of the FPL and 150% of the FPL, and non-full dual eligible LIS beneficiaries, are required to make copayments of $4.90 for generic drugs and $12.15 for brand name drugs. LIS beneficiaries who are institutionalized or who are receiving home- and community-based services under Medicaid are exempted from copayment requirements.

LIS beneficiaries are not required to make copayments for drugs after reaching the out-of-pocket limit. In this case, copayments paid by the beneficiary, as well as cost sharing subsidies paid by the program, count as out-of-pocket spending.

Funding and State "Clawback" Payments. Nationwide, Medicare Part D program expenditures for benefits and administrative costs totaled $129.6 billion in federal fiscal year 2023. These costs are supported by payments from the federal government's general fund (74%), enrollee premiums (14%), and payments from states (12%).

States contribute to a portion of the cost of the Medicare Part D program through a "clawback" mechanism. The clawback was established with the legislation that created the program, on the grounds that Part D resulted in savings to state Medicaid programs since they would no longer incur drug costs for dual eligibles. The clawback payment is based on 75% of the calendar year 2003 non-federal share of prescription drug costs state MA programs paid for dual eligibles, inflated to the current year. In state fiscal year 2023-24, the Wisconsin MA program made clawback payments to CMS of $334.4 million.

Medicare Part D Participation in Wisconsin. In October, 2024, there were approximately 409,000 Wisconsin residents obtaining coverage through standalone Part D prescription drug plans and 713,000 residents with coverage provided as part of a Medicare Advantage plan.

Acute Care Services Under BadgerCare Plus and EBD Medicaid

BadgerCare Plus and EBD 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 rules, and program handbooks outline the covered services, as well as the provider requirements and limitations associated with each covered service. This chapter provides a description of the general requirements for medical services covered under the MA program, as well as the specific service categories offered under the programs. This chapter covers primarily the acute care medical services offered to MA recipients, rather than the long-term care provided to EBD Medicaid recipients in an institution or as part of a community-based Medicaid program such as Family Care. Additional information on the MA program's long-term care services is provided in Chapter 9 and Chapter 10.

General MA Requirements and Procedures

Medical Necessity. To be eligible for coverage under the MA program, 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 is:

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

- 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;

- Appropriate with regard to generally accepted standards of medical practice;

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

- Of proven medical value or usefulness and, consistent with DHS rules, not experimental in nature;

- Not duplicative with respect to other services provided to the recipient;

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

- Cost-effective compared to an alternative medically necessary service that is reasonably accessible to the recipient; and

- 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 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 copayments, for physical therapy services. However, prior authorization from DHS is required for more than 35 treatment days.

As discussed in Chapter 8, 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 misuse 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.

Services Provided via Telehealth. For the MA program, telehealth refers to the use of telecommunications technology to deliver functionally equivalent health care services, including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data. The communication between a provider and patient that consists solely of email, text, or fax transmission is not considered telehealth delivery, and so is not eligible for reimbursement.

By statute and by policies established by administrative rule, DHS is required to cover most MA-eligible services if they are provided via telehealth in a manner that is functionally equivalent to a face-to-face visit. In addition, the program covers the following: (a) consultation between MA-certified providers regarding the care for a MA beneficiary; (b) remote physiologic monitoring of patient's health data; and (c) asynchronous telehealth service.

Services provided via telehealth are reimbursed at the same rate as services provided in person, and are subject to the same conditions and prior authorization requirements. Additionally, if a patient receiving services via telehealth is located in a hospital, clinic or medical office, pharmacy, nursing home, or any of several mental health or substance use disorder treatment facilities, this facility can also receive reimbursement as the "originating site." This originating site facility fee, set at $22.69, can only be claimed by those specified patient sites, although the telehealth service itself can be reimbursed regardless of where the patient is located. Originating sites must provide access to suitable technology, internet connectivity, and privacy.

Service Categories

Inpatient and Outpatient Hospital Services. MA reimburses hospitals for inpatient and outpatient stays separately from the payments to physicians, dentists, or other medical professionals for services provided within a hospital.

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 the federal Medicare program as a hospital.

The MA program reimburses a hospital for outpatient services provided to MA beneficiaries 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.

The MA program's hospital reimbursement policies, including supplemental payments made to certain hospitals that serve targeted populations, are discussed in Chapter 8.

Physician Services. Physician services consist of diagnostic, preventive, therapeutic, rehabilitative, or palliative services. For the purposes of this service category, the rendering providers include primary care and specialist physicians, but also other professionals operating within their own scope of practice, including physician assistants, nurse practitioners, pharmacists, and nurse midwives. These non-physician providers are subject to varying requirements with respect to general or direct supervision of a physician. In addition, certain services provided by ancillary providers working under the direct supervision of a physician are reimbursable as a physician services. Examples of an ancillary provider are clinic staff nurses, dieticians, and health educators.

Physician services may be provided in the physician's office or clinic, a hospital, a nursing home, or for certain services, the recipient's residence or other locations. Although MA provides general coverage of physician services, many specific services are subject to prior authorization requirements, or other limitations identified in Wisconsin administrative rules or program policies.

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

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

MA covers certain over-the-counter medications to substitute for more expensive medications that may only be available with a prescription, although MA recipients must have a prescription for payment of any non-prescription drug. Coverage of over-the-counter drugs is typically limited to antacids, analgesics, insulin, cold and 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. Drug rebates for most brand name drugs are based on a "best price" policy, meaning that generally the rebate is the difference between the average manufacturer price and the "best price" offered to any other private or public purchaser, with some exceptions. Other federal requirements, however, may result in larger rebates. For brand name drugs, for instance, the minimum rebate is 23.1% of the average manufacturer price (or 17.1% for clotting factors or for drugs used exclusively for pediatric indications), which could result in a larger rebate than the best price standard. In addition, an adjustment to the rebate is applied if the price of a drug has risen faster than inflation since its initial launch.

For generic drugs, the rebate is not based on the best price standard, but rather is equal to 13% of the average manufacturer price. 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.

Pharmacists. Pharmacists may enroll as an MA provider, which permits them to deliver certain services that are within the pharmacists' scope of practice, but that are not typically included in the outpatient drug pharmacy benefit. Examples of these services include administering non-vaccine drugs (vaccine administration is included in the pharmacy benefit), member education and training, and other services delegated by a physician to the pharmacist under a collaborative practice agreement.

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 for children. Hospitals are eligible for enhanced reimbursement for dental services that require sedation and that are provided in an acute hospital setting.

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.

Hearing Services. MA covers professional audiology services, hearing aids, hearing aid accessories, assistive listening devices, bone-anchored hearing devices, and cochlear implants. Professional audiology services include audiological evaluations, aural rehabilitation, hearing device performance checks, and certain speech and language pathology services. Audiologists must establish a written plan of care prior to providing audiology services.

All hearing services require a prescription from a physician, except for certain hearing aid accessories, batteries, and repairs. Certain hearing services require prior authorization, including all hearing instruments, aural rehabilitation, bone-anchored hearing devices, and cochlear implants.

MA will generally only cover hearing aids supplied by manufacturers with which DHS has a volume purchase contract. A non-contracted device will only be covered, subject to prior authorization, if the provider indicates that the contracted devices do not meet the person's needs.

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 supervision of a certified speech-language pathologist. Covered services include evaluation procedures and speech, cognition, and swallow treatments. Prior authorization is required for all services that exceed 35 treatment days.

Non-Emergency Medical Transportation. Wisconsin's MA program covers non-emergency medical transportation (NEMT) to a covered appointment if the MA recipient has no other means of transportation.

The Department contracts with a transportation broker to arrange and pay for NEMT services. The transportation broker 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 them from traveling safely by other means.

An SMV may be used to transport an MA recipient if the recipient has a documented physical or mental disability that prevents them from traveling safely in a common motor carrier or a private motor vehicle.

Common carrier transportation is any transportation 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 exceptions related to age or condition.

In most cases, transportation providers receive reimbursement through the NEMT broker. Historically, the NEMT broker was paid using a monthly capitated payment for all enrollees. The broker would then be responsible for arranging and paying for transportation services, supported with capitation payment revenue. However, since November of 2021, because of changes in utilization related to the COVID-19 pandemic, DHS has paid a "full costs" reimbursement. This reimbursement is paired with a fixed administrative payment and an incentive payment to encourage the broker to achieve cost savings over time.

Emergency Ambulance Transportation. MA covers emergency transportation by ground ambulance or, under certain limited circumstances, by fixed-wing, helicopter, or water ambulance. Ambulance providers receive reimbursement at a base rate, which varies depending upon the mode and level (basic life support or advanced life support for ground ambulance), plus a transport mileage rate. Certain basic first-aid supplies are assumed to be included in the base rate, while other more specialized supplies can be reimbursed separately. Providers can also be reimbursed for rendering first aid at the scene if there is no transport.

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). Chiropractors may also be reimbursed separately for evaluation and management upon the initial office visit for each spell of illness, and for x-ray and laboratory services. Prior authorization is required for more than 20 spinal manipulations per spell of illness and for spinal supports costing more than $75.

In 2024, the reimbursement rates paid to chiropractors for evaluation and management, x-ray, and laboratory procedure codes were increased to match the rates paid for physicians for performing the same procedures.

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.

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

Medical supplies are disposable, consumable, expendable, or nondurable medically necessary supplies that have a very limited life expectancy.

Examples include catheters, syringes, and incontinence supplies.

DME includes medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment, and prostheses. A physician, podiatrist, nurse practitioner, or chiropractor must prescribe all DME services, including purchases, rentals, and repairs. The item must be necessary and 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 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 or nursing home services, rather than as a separate service. An exception is made for individually configured power and manual wheelchairs and other devices classified as complex rehabilitative technology; when provided in a nursing home, this equipment is reimbursed separately from the nursing home daily rate.

Mental Health and Substance Use Disorder Services. Several types of mental health, and substance use disorder services are covered by Wisconsin's MA program. Those services include: (a) outpatient mental health and substance use disorder treatment, including psychotherapy and counseling; (b) mental health and substance use disorder day treatment; (c) crisis intervention services; (d) narcotic treatment services; (e) residential substance abuse treatment; and (f) psychosocial rehabilitation services, which are programs that provide treatment and social support services for persons with severe and persistent mental illness.

Inpatient hospital services for mental health or substance use disorder conditions are covered under the MA program if provided in a general hospital or, with restrictions, in a psychiatric hospital. Typically, mental health and substance use disorder services provided in a general hospital are on a short-term basis. Inpatient mental health and substance use treatment 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 generally prohibits coverage of mental health or substance use disorder services provided in an institute for mental disease (IMD) for persons between the age of 22 and 64. 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. However, under provisions of a federal waiver initially approved in 2018, MA may now cover substance use disorder treatment in an IMD for nonelderly adults.

For additional information on MA program coverage of mental health and substance use disorder services, see the Legislative Fiscal Bureau's informational paper entitled, "Services for Persons with Mental Illness and Substance Use Disorders."

Behavioral Treatment for Children with Autism Spectrum Disorder. Behavioral treatment services are intended to teach children with autism spectrum disorder in the skills that children would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to alter a child's social, behavioral, and communicative skills in order to demonstrate measurable outcomes in these areas and overall developmental changes in both home and community settings. The intent is for the child to make clinically significant changes in behavior and have fewer needs in the future as a result of the service.

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

Targeted Case Management Services. Targeted 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: (a) developmental disability; (b) chronic mental illness; (c) alcoholism or drug dependency; (d) physical or sensory disability; (e) HIV infection; (f) asthma (children only); (g) Alzheimer's disease or related dementia; and (h) tuberculosis. The targeted populations are: (a) women age 45 through age 64 who do not reside in nursing homes; (b) severely emotionally disturbed children; (c) children enrolled in the Birth to 3 program; (d) individuals age 65 or older; and (e) families with children with medical complexity or at risk of serious physical, mental, or emotional dysfunction, including lead poisoning, risk of maltreatment, involvement with the juvenile justice system, or where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.

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

Case management services are generally provided at the option of counties and the non-federal share of MA case management costs is paid by counties. However, there are exceptions to this general rule. For instance, operators of independent living centers for individuals with disabilities 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.

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

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.

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

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

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

Federal regulations require state Medicaid plans to establish a schedule for these screenings that is consistent with reasonable standards of medical and dental practice. Wisconsin's state plan uses the schedule determined by the American Academy of Pediatrics, which includes seven screenings before the child's first birthday, three the following year, two between their second and third birthdays, and annual screenings from age three to 21. MA does not reimburse for screenings performed more frequently than this.

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

Lead investigations are provided for children enrolled in the MA program as a part of the EPSDT benefit. Under current Department policy, an environmental investigation of the home of a lead-poisoned child is reimbursable through the MA program if all of the following conditions are met: (a) the child's blood lead level (BLL) is found to be greater than five micrograms per deciliter of blood; (b) a certified risk assessor or hazard investigator performs the service; and (c) prior authorization is received. The investigation entails the identification of potential sources of high dose exposure to lead, as well as education for parents about identified and potential sources of lead and ways to reduce exposure. A follow-up investigation may also be provided.

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 enrolled Medicare providers in addition to being certified under MA. A physician or non-physician practitioner must have a face-to-face visit with a recipient prior to an initial prescription for home health services. 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.

All home health service providers are required to use an electronic visit verification system to document information for each visit. The system collects data on the recipient, individual provider, the type and location of the service, and the beginning and ending time of the visit.

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 per day, the recipient does not reside in a hospital or nursing home, and the recipient requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence. These services are provided exclusively by registered nurses and licensed practical nurses. In determining whether a service requires the skills of a registered nurse or licensed practical nurse, MA considers the complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

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 practitioners that provide these services may be employed directly by a home health agency or be 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.

Private Duty Nursing Services. A recipient is eligible for private duty nursing services from a registered nurse or licensed practical nurse if they have 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 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 that families and other health professionals are able to provide. All providers must receive prior authorization before providing these services to MA recipients.

Personal Care Services. Personal care services are medically-oriented activities that assist a recipient with activities of daily living necessary to maintain the individual in their 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 certified 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.

All personal care providers are required must use an electronic visit verification system to document information for each visit. The system collects data on the recipient, individual provider, the type and location of the service, and the beginning and ending time of the visit.

Certified Nurse-Midwife and Certified Professional Midwife Services. MA covers midwife services provided by both certified nurse-midwives and certified professional midwives. Certification as a nurse-midwife requires the practitioner to be a registered nurse and hold a degree from an accredited nurse-midwifery education program. Nurse midwives provide primary care related to family planning and other reproductive issues, pregnancy, and childbirth for women, as well as postpartum care for newborns. Birth-related services are typically provided in a hospital setting.

To obtain certification as a professional midwife (also sometimes called a "certified midwife") a practitioner must complete a midwifery apprenticeship program or graduate from an accredited midwifery education program, which is commonly a two-year associate degree program. A professional midwife typically provides maternity care, including birth-related services for low-risk pregnancies in settings other than hospitals, such as private homes and standalone birth centers.

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.

CHAPTER 8

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 the provider's usual and customary charges or the provider's costs 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). For certain services or for certain provider types, MA also makes an additional "reconciliation" payment that is equal to the difference between the initial reimbursement payment and the provider's reported cost for rendering the service.

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

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

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

Fee-for-Service and Managed Care Reimbursement

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

Fee-for-Service Reimbursement. Most non-institutional services that are reimbursed on an FFS basis are paid using "maximum allowable fees." These are set based on various factors, including a review of usual and customary charges submitted by providers, the MA program'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.

Managed Care Program Delivery. 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.

HMO enrollees obtain some covered services on an FFS basis, rather than through the HMO. For instance, MA beneficiaries, including those enrolled in HMOs, access the program's prescription drug benefit on an FFS basis; dental services are provided through HMOs in Milwaukee and the surrounding counties, but are provided on an FFS basis elsewhere in the state. In addition, non-emergency medical transportation services are provided through an arrangement with a transportation broker, and so are not included in the HMO contract.

With a few exceptions, enrollment in an HMO is mandatory for BadgerCare Plus beneficiaries. Generally, over 90% of all BadgerCare Plus participants are enrolled in one of the HMOs participating in the program. Exceptions to mandatory HMO enrollment are granted upon request of the beneficiary or the HMO for certain reasons specified in the state's HMO contract. For instance, infants with low birth weight or residents of a nursing home may be excluded from HMO enrollment. In addition, newly-enrolled beneficiaries may be exempt from HMO enrollment during a transitionary period.

HMO enrollment is also mandatory for individuals age 19 and over who are enrolled in EBD Medicaid and who are not also eligible for Medicare and are not participating in the medical assistance purchase plan (MAPP). Because most EBD individuals who are subject to this mandatory HMO enrollment requirement are eligible for MA based on SSI categorical eligibility, the service delivery program for these beneficiaries is typically called SSI managed care. Dual eligibles and MAPP participants may choose to enroll in an SSI HMO, but are not required to do so. EBD Medicaid beneficiaries who are participating in an MA long-term care program (such as FamilyCare or IRIS) are not permitted to enroll in an HMO for acute care services.

Because most EBD Medicaid beneficiaries are dually-eligible for Medicare and Medicaid or are receiving long-term care services, the share of EBD beneficiaries enrolled in an SSI HMO for acute care services is lower than for BadgerCare Plus beneficiaries. About 20% of EBD beneficiaries are enrolled in an SSI HMO for acute care services.

The relationship between the MA program and participating HMOs is governed by federal and state regulations, and by the contracts between DHS and the HMOs. The contract sets forth 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 contracted providers' costs are covered.

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

Working with its contracted actuary, DHS adjusts MA capitation rates each calendar year by analyzing prior years' encounter data submitted by the HMOs, pricing that encounter data at the Department's FFS rates, and then making adjustments to reflect projected utilization trends and changes in applicable law and policy.

The rates also include an administrative component paid to the HMO, which is established as a percentage of the medical cost component. For the 2025 capitation rates, the administrative percentages are set at 11.5% for childless adults, 16.0% for parents and children, 9.5% for EBD MA-only beneficiaries, and 13% for dually-eligible EBD beneficiaries. In addition to the administrative percentage, the capitation rates include an additional two percentage point risk margin.

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

MA Copayments

In addition to MA reimbursement payments, medical providers also collect copayments from MA recipients in certain circumstances. Although federal law allows states to establish copayment requirements for Medicaid recipients, the amount, types of services for which copayments may be required, and collection procedures are subject to federal restrictions. Federal regulations establish maximum copayment amounts that prohibit 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. Federal regulations also limit the combined amount of Medicaid premiums and copays an MA recipient incurs each month to five percent of their monthly household income. 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.

No copayments are collected for services provided to: (a) pregnant women; (b) children under age 19; (c) nursing home residents; (d) adults with no reportable income; or (e) American Indians, with limited exceptions. 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.

Childless adults enrolled in BadgerCare Plus are required to pay an $8 copayment for non-emergency use of a hospital emergency department.

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

Hospital Base Rate Reimbursement

Reimbursement for hospital inpatient and outpatient care provided to MA recipients is based on methods that vary depending on the type of care provided and the type of hospital. For most hospital services, reimbursement consists of a base rate payment, plus supplemental payments. This section describes the methods DHS uses to determine the base reimbursement rate for acute care hospitals, critical access hospitals, and rehabilitation, long-term care, and psychiatric hospitals. The following section provides a description of the various supplemental payments the MA program makes to hospitals.

Inpatient Reimbursement for Acute Care Hospitals. The MA program reimburses for inpatient services provided at acute care hospitals using a base rate per inpatient stay, adjusted for individual hospital cost factors, and weighted for the expected resource utilization associated with each inpatient diagnosis. The reimbursement methodology described here applies to acute care hospitals that are not classified as critical access hospitals. At the end of 2024, there were 83 of these hospitals in Wisconsin that are treated as separate entities for the purposes of reimbursement, as well as eight non-Wisconsin, "border status" hospitals that are reimbursed using the same methodology.

The Department determines the payment rates using a "diagnosis-related group" (DRG) hospital reimbursement system. The DRG reimbursement is intended to allocate a total funding pool designated for MA inpatient hospital services based on the relative hospital resource utilization associated with each inpatient service provided to MA patients during the year. The actual payment is generally determined using the patient's diagnosis upon admission. In addition to MA, DRG is also used for hospital reimbursement by Medicare and commercial insurers.

As the first step in determining the payment rates, DHS establishes a uniform statewide base rate each year. The statewide base rate is then converted to a hospital-specific DRG base rate by making adjustments for a series of factors, including a wage index applicable to the hospital's geographic location and the hospital's direct graduate medical education costs.

Each inpatient admission is assigned a DRG weight based on the relative resource consumption associated with a particular diagnosis and illness severity of the patient. 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. For each inpatient stay, the MA program payment is calculated by multiplying the DRG weight by the hospital-specific base rate.

In addition, the MA program uses "policy adjuster" factors that increase reimbursement for certain services or patients. In 2025, the following policy adjustment add-ons are applied to the DRG base payment: (a) for pediatric services (children up to age 17), a 20% add-on; (b) for trauma services, a 30% add-on; (c) for neonatal services, a 30% add-on; (d) for organ transplants, a 50% add-on; (e) for newborn patients, an 80% add-on; and (f) for behavioral health unit services, an 80% add-on.

While the DRG-based payment is designed to reimburse hospitals based on the relative, average cost of a particular diagnosis, hospitals can also receive an outlier payment in addition to their standard DRG-based payment when an inpatient stay has extremely high costs. The outlier payment is determined using a three-step process. The first step involves determining the unreimbursed cost, which is derived by subtracting the actual DRG-based payment from an estimate of the hospital's actual cost of treating the patient. In the second step, the unreimbursed cost is compared to an outlier formula constant, called the "trim point," which in 2025 is $46,587. The amount by which the unreimbursed cost exceeds the trim point is considered the "excess cost." Third, this excess cost is then multiplied by a percentage to determine the outlier payment. This percentage is 80% for patients classified as having mild or moderate illness and 95% for patients with severe or extreme illness. If the unreimbursed cost is less than the trim point, then no outlier payment is made.

Although the outlier payment is intended to provide additional revenue to the hospital for particularly high-cost patients, it does not typically make up the full difference between the base payment and the hospital's actual costs.

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 are billed separately by these providers. The same is true for pharmacy services for take-home drugs on the date of discharge, durable medical equipment and supplies for non-hospital use, specialized medical vehicle transport, and ambulance service. The DRG methodology is intended to reflect all other hospital services and costs in the reimbursement methodology, including services that may be procured from third parties, such as drugs used within the hospital, services of independent physical, occupational, and speech and language therapists, services of medical residents and interns, and independent laboratory and imaging services.

Hospitals outside of Wisconsin can be reimbursed for inpatient services provided to Wisconsin MA recipients. If the hospital is designated as a "border status" hospital, it is reimbursed under the same hospital-specific DRG methodology as Wisconsin hospitals. In order to qualify for border status, an out-of-state hospital must average 100 or more Wisconsin MA claims annually, combining fee-for-service and managed care claims, over three consecutive years. Out-of-state hospitals that do not meet the criteria for border status are reimbursed at a single DRG-based rate that does not consider the hospital-specific costs outlined above. Like other hospitals, however, non-border status out-of-state hospitals can receive outlier payments for particularly expensive inpatient stays. All non-emergency hospital services provided by non-border status out-of-state hospitals require prior authorization.

As part of the rate-setting process, DHS models the total expected hospital payments under the new rates. For 2025, the predicted payments to acute care hospitals for inpatient care total $1,121.4 million. This includes outlier payments, and the base reimbursement for both FFS and HMO services, but excludes the payments discussed in the section, "Hospital Reimbursement Supplements."

Inpatient Reimbursement for Rehabilitation Hospitals and Psychiatric Hospitals. Rehabilitation, long-term care, and psychiatric hospitals are reimbursed for inpatient services on a per diem basis. The per diem rate is set for each hospital and adjusted annually to approximate 85.08% of the hospital's average daily cost of providing care. Costs are calculated using prior year cost reports and inflated to the current year using an inflation forecast. The cost of providing patient services includes fixed as well as variable costs.

Federal law defines an institution for mental disease (IMD) as a hospital, nursing home, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care for individuals with mental diseases, including medical care, nursing care, and related services.

For psychiatric hospitals that are classified as IMDs, federal law has historically restricted MA reimbursement to patients who are age 65 and older or under the age of 21, except that persons who were in an IMD hospital on their 21st birthday may receive MA-reimbursed services as long as they remain in the hospital, up to age 22. However, Medicaid HMOs are allowed to utilize IMD services for non-elderly adults as a substitute for other covered services that the individual would otherwise use, provided that the patient is in the IMD voluntarily and the stay does not exceed 15 days in a calendar month.

Under a federal waiver, all beneficiaries ages 21 through 64 have access to substance use disorder (SUD) treatment services provided to individuals with SUD who are short-term residents in residential or inpatient treatment facilities that meet the definition of an IMD. These services would otherwise be excluded from federal reimbursement.

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 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 base rate each year, which is then used to determine final payments for each outpatient visit. A hospital-specific adjustment is made to the 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. Unlike the DRG system, the EAPG reimbursement system does not include a mechanism for outlier payments.

The predicted total payments for outpatient care at acute care and rehabilitation hospitals are $381.4 million in 2025 under the updated EAPG rate. As for the inpatient modeled costs, this prediction includes care covered by HMOs.

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.

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 nursing home-level care), that provides inpatient care for an average stay of no more than 96 hours per patient, and that provides emergency care 24 hours per day. In addition, the hospital must meet other criteria designed to generally limit the designation to hospitals in rural areas where there are few other general hospitals. There are currently 58 CAHs in Wisconsin.

The MA program reimburses CAHs for both inpatient and outpatient care using a similar methodology to that used for the non-critical access hospitals. However, instead of using a statewide DRG and EAPG base rates, DHS calculates payment rates for each CAH to approximate the actual cost incurred by the hospital in the prior year (or latest year for which a cost report is available). There is no adjustment made to the hospital's payment rate in the event that actual costs differ from the cost projections, but CAHs can still receive outlier payments for unusually expensive claims. These are determined by a calculation similar to the one described previously, except with a much lower trim point ($300) and payment of 100% of excess costs beyond that point instead of only 80% or 95%.

Base reimbursement payments to CAHs account for approximately 5% of payments for all inpatient services provided by general acute care hospitals and about one-third of payments for all outpatient hospital services.

Payment Withholds for Performance-Based Payments. MA withholds a portion of base reimbursement payments as part of two performance-based incentive programs.

Potentially-Preventable Readmissions Incentive. DHS withholds 3% of a hospital's total inpatient and outpatient FFS claims payments to fund an incentive program based on each hospital's performance on a metric for potentially preventable readmissions (PPRs). A PPR is a readmission to a hospital (including a different hospital from the original admission) that occurs within 30 days after a hospital discharge, when the readmission is determined to have been potentially preventable with better discharge planning and care coordination following the initial discharge. DHS uses a proprietary software program to analyze patient data to make the PPR determination. Certain types of admissions are excluded, such as those for neonates, cancer-related admissions, drug and alcohol services, and chronic kidney disease. Hospitals that are paid on a per diem basis, and hospitals with fewer than 25 qualifying admissions per year are also excluded.

Performance on the PPR metric is assessed for each hospital relative to a hospital-specific benchmark, which is based on the number of PPRs in a prior year. For the 2024 measurement, the benchmark is based on 2022 PPRs. Hospitals that demonstrate improvement over their benchmark rates 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. Under this framework, hospitals may receive up to 10% of their inpatient claim payments as an incentive. Hospitals that perform worse than their benchmark will be penalized, but by no more than the 3 percent that the withhold represents.

Health Information Exchange Incentive. DHS also withholds 1.5% of FFS inpatient and outpatient claims for non-psychiatric hospitals and 1.0% of FFS payments for psychiatric hospitals to fund a health information exchange (HIE) incentive payment program. An HIE facilitates the sharing of patient health data across different providers with the goal of improving the coordination of care. Hospitals can earn incentive payments by participating in health information exchange interfaces established by the Wisconsin Statewide Health Information Network (WISHIN). Prior to 2025, the HIE incentive was a payment in addition to the base reimbursement, funded from the MA program's GPR appropriation, instead of a payment funded through payment withholds.

Hospital Reimbursement Supplements

In addition to the base rate reimbursement, hospitals receive various supplemental payments. In some cases, these payments are made on a per-patient basis, while others are lump sum payments made to the hospital.

Hospital Access Payments. Acute care hospitals, CAHs, and rehabilitation hospitals receive "access" payments for serving MA recipients, in addition to the base reimbursement payment. As described in Chapter 2, these hospital access payments are funded with the hospital assessment revenue, along with a portion of the federal MA matching funds received by the state when assessment funds are expended under the MA program. Access payments for CAHs are funded from a separate assessment applying to those hospitals.

For an MA recipient receiving hospital services on an FFS basis, the MA program makes an access payment directly to the hospital for certain inpatient discharges and outpatient visits. For 2023-2024, the FFS access payment for each inpatient discharge (for dates of discharge starting July 1, 2024) was $3,101 for non-CAHs and $581 for CAHs, while the access payment for each outpatient visit is $581 for non-CAHs and $16 for CAHs.

To fund the cost of 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.

DHS annually determines the amount of the access payments to fully distribute the total funding pool for these payments. The non-CAH access payment pool is $654.0 million, an amount equal to the total supplements paid from the hospital assessment fund ($672.0 million, as determined by statute), minus the amounts distributed under several other targeted supplemental payments (currently $18.0 million). The CAH access payment pool varies depending upon the amount of CAH assessment revenue collected in the year. In 2023-24, the CAH access payment pool was $8.1 million.

Disproportionate Share Hospital and Rural Critical Care Supplement Payments. Under federal law, states are eligible for federal Medicaid matching funds to provide supplemental reimbursement to certain hospitals that serve a high proportion of Medicaid, Medicare, or uninsured patients ("disproportionate share hospitals," or DSHs). Under Wisconsin's DSH payment program, DHS is required to allocate $71.6 million GPR annually, plus the associated federal matching funds, for DSH payments. In 2023-24, DSH payments, including both the GPR and federal share, totaled $186.1 million.

Under a formula established by state statute, DHS distributes these funds to general hospitals for which MA patient-days make up at least 6% of total inpatient days. For each qualifying hospital, the payments are calculated using an add-on percentage, multiplied by the hospital's base inpatient payment. The add-on percentage is generally proportional to the hospital's MA patient days percentage, such that those hospitals with a higher proportion of MA patients have a higher percentage. However, the maximum payment that a hospital may receive in a year is capped at 6.77% of the all-funds total amount available for DSH payments in each fiscal year. In 2023-24, the DSH payment was capped at a maximum of $12,565,822 for four hospitals.

Some critical access hospitals would qualify for a DSH payment based on meeting the minimum MA patient threshold, but do not receive a payment because they do not meet the criteria to be a disproportionate share hospital under federal law, generally because they offer less comprehensive services. For these hospitals, Wisconsin's MA program makes a rural critical care supplement payment. Under this supplement program, the Department is required to allocate $4.5 million GPR annually, along with the associated federal matching funds, for rural critical care supplement payments. Funding is distributed among qualifying hospitals under a formula similar to the one used for DSH payments, but based on all charges for services instead of patient-days. In 2023-24, DHS distributed a total of $11.9 million combined GPR and federal funding under this supplemental payment program.

In 2023-24, out of a total of 80 non-CAH general hospitals, 66 met the 6% minimum inpatient days threshold to receive a payment, representing 83% of these hospitals. Of the 58 critical access hospitals, 16 received a DSH payment and 28 received a critical care supplement payment. Thus, 44 CAHs, or 76% of the total, received a supplement under one of these programs.

Other Targeted Hospital Supplemental Payments.

Inpatient Pay-for-Performance Incentive. DHS administers a pay-for-performance program, limited to inpatient admissions, totaling $5 million annually for acute care hospitals, children's hospitals, and rehabilitation hospitals located in Wisconsin. These hospitals can receive payments under this program if they meet performance measures on three factors: perinatal care, prevention of central line associated blood stream infections, and patient experience surveys. This pay-for-performance program is funded with hospital assessment revenue and federal matching funds.

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 city of Milwaukee, as defined by certain zip codes. In 2023-24, two hospitals received a supplemental EACH payment: Aurora Sinai Medical Center ($3 million) and Wheaton Franciscan-St. Joseph Hospital ($1 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 Froedtert 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. This payment is funded only with state funds since it is ineligible for 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 million annually. In 2023-24, UW Hospital and Clinics and Children's Wisconsin each received $1 million supplemental payments under this provision.

Rural Hospital Supplements. DHS makes supplemental payments to certain rural hospitals. In order to qualify for these supplemental payments, a hospital must be located in a rural core-based statistical area (CBSA) as designated by the federal Office of Management and Budget, and must not be a critical access hospital. The annual payment is equally divided among qualifying hospitals, and is capped at $300,000 per hospital. The total amount expended under the program annually is capped at $5 million. In 2023-24, DHS made supplemental payments to 18 qualifying hospitals, each of which received $277,777.

In addition, DHS is authorized 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% 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%; and (d) is located in a city with a population of less than 15,000. Since this provision was created, the only hospital that has met these criteria and received the $300,000 supplemental payment is the Aurora Medical Center - Bay Area in Marinette. This payment is funded with GPR.

Supplemental Payment for Graduate Medical Education (GME). DHS distributes grants to support GME programs in hospitals, in three components: (a) hospitals to fund the creation of new accredited graduate medical training programs; (b) hospitals for the addition of positions to existing programs in hospitals serving a rural or underserved community; and (c) GME consortia to support training programs in rural and underserved areas of the state. These grants are separate from the direct graduate medical education add-on adjustment to the DRG reimbursement rate for existing GME positions.

In 2023-24, DHS distributed a total of $682,700 to seven hospitals to establish new residency programs. By statute, hospitals in the City of Milwaukee are ineligible for these funds.

Under the program to expand existing residency programs, payments may not exceed an amount equal to $75,000 in state funds per position per year, plus any associated federal matching funds. With the matching funds, the per-position limit is $180,500. In 2023-24, the Department distributed $1.7 million in grants through this program to eight hospitals.

Under the program to establish new graduate medical education consortia, DHS awarded $1.9 million to be distributed between 2024-2025 and 2028-29 to the Wisconsin Northern and Central Consortium. A GME consortium is defined as an independent nonprofit organization formed with support from two or more entities to separately sponsor GME programs operating in hospitals in rural or underserved areas.

Reimbursement for Prescription Drugs

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

For the ingredient component, in most cases the program pays the generic drug price when a generic drug is available. However, the program may cover a brand name drug if the prescriber indicates that the brand name drug is medically necessary. Prior authorization is required for brand name drug coverage in these circumstances. In all cases, the amount the state pays the pharmacy is reduced by the copayments paid by program participants. For most drugs, the ingredient fee is equal to the national average drug acquisition cost, which is updated weekly by an accounting firm under contract with CMS.

In addition to reimbursing pharmacies for the ingredient cost, the MA program pays pharmacies a dispensing fee for each prescription they fill. The pharmacy dispensing fee varies depending upon the annual volume of drugs dispensed by the pharmacy. For pharmacies with annual prescription volume of less than 35,000, the dispensing fee is $15.69, while for pharmacies with an annual prescription volume of 35,000 or more, the dispensing fee is $10.51.

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. The following section describes these provisions.

Ambulance Services. Two distinct programs were established by 2021 Act 228 to provide supplementary reimbursement to ambulance providers. One of these payments applies only to privately-owned providers, while the other applies only to publicly-owned providers. As of the end of 2024, these programs had not yet been implemented since they were still awaiting federal approval.

For private ambulance providers, Act 228 requires DHS to collect a provider assessment from private ambulance providers, equal to a uniform percentage of net patient revenue, and deposit the proceeds in an ambulance service provider trust fund. The Department must make payments using the assessment revenue, along with associated federal matching funds, to supplement the base MA reimbursement paid to private ambulance providers. Supplemental payments will be determined based on services provided to MA enrollees.

For public providers, Act 228 requires DHS to administer a certified public expenditure (CPE) program. Subject to federal regulations, this will allow local governments to claim federal matching funds for certain local government costs attributable to MA patients that exceed the MA reimbursement they receive for ground emergency medical transportation. DHS is required to pass through the full amount of federal revenue received from these claims in the form of supplemental payments to ambulance providers.

Rural Health Clinic Services. Rural health clinics (RHCs) are Medicare-certified outpatient health clinics located in rural areas with a shortage of 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 were 141 RHC locations in the state in 2024.

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.

Federal law establishes a minimum payment rate for FQHCs using a prospective payment system (PPS). The PPS rate is calculated for each FQHC from its per-visit costs in previous years, adjusted based on an annual measure of medical cost inflation and any changes in the scope of services that an FQHC offers.

The enhanced reimbursement requirement for FQHCs recognizes that these facilities serve a disproportionate share of the state's MA, Medicare, and uninsured population and so have a narrow range of payers from which to finance their operations. There are currently 16 community health center organizations in Wisconsin qualified as FQHCs, with 76 clinic locations in total. Also, there are two FQHCs located in other states (Iowa and Michigan) that are approved to serve Wisconsin MA recipients and two "look-alike" FQHCs, which do not receive federal grant funding for that qualification despite meeting the requirements to be an FQHC.

In addition to these FQHCs, there are 11 health centers operated by federally-recognized Native American Tribes that are classified as FQHCs with a total of 12 clinic locations, in addition to one Urban Indian Health Center. The tribal FQHCs are also paid using a PPS methodology, although the rate is established by the federal Indian Health Service.

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, among other factors.

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

HPSAs are designated in three categories: primary care, dental care, and mental health. In 2024, there were 163 primary care, 166 dental care, and 171 mental health designated HPSAs in the state.

CHAPTER 9

NURSING HOME SERVICES

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

In 2022-23, there was an average of 27,158 licensed nursing home beds in the state, including beds at the three state veterans homes. Based on 2022 nursing home cost reports, the most recent audited reports available, an average of 65.2% of the beds were occupied, with 64% of occupied nursing home beds occupied by MA recipients.

Most, but not all, nursing homes in Wisconsin are certified to serve MA recipients. As of October, 2024, there were 317 MA-certified nursing homes in Wisconsin (including state-operated nursing homes) with a total of 24,882 licensed beds. Approximately 86% of these nursing homes were privately owned and operated (26% non-profit and 60% for-profit and limited liability companies), while the remaining 14% were owned and operated by federal, state, and local governments.

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

In addition to nursing homes, there were seven licensed ICFs-IID in the state, including the three State Centers for Persons with Developmental Disabilities, three county-operated facilities, and one private, for-profit facility. The state facilities had a total of 440 licensed beds and the four non-state facilities, all of which were MA-certified, had a total of 92 licensed beds.

Table 9.1 shows the total number of MA-certified nursing facilities and MA-certified ICFs-IID in Wisconsin, including state facilities, by ownership type, as of October, 2024.

Table 9.1: MA-Certified Nursing and ICF-IID Facilities (October, 2024)

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	192	15,038
Non-Profit	82	5,908
Government	43	3,936
Total	317	24,882
ICF-IID		
For-Profit	1	5
Government	6	527
Total	7	532

Facility Types and Services

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

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

Preadmission Screening and Resident Review (PASRR) is a federal requirement established to identify individuals with mental illness or intellectual developmental disability to ensure appropriate placement in the community or a nursing home.

PASRR requires all applicants to Medicaid-certified nursing homes be assessed to determine whether they might have an intellectual disability or mental illness. This is called a Level I screen.

The purpose of a Level I screen is to identify individuals whose total needs require that they receive additional services for their intellectual disabilities or serious mental illness. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an intellectual disability or mental illness for PASRR purposes. This is a Level II screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care and if placement in a nursing home is appropriate.

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

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

Medicaid Reimbursement

Facilities classified as nursing homes make up the largest component of institutional long-term care spending. MA fee-for-service payments to nursing homes, ICFs-IID, veterans homes, and state centers (excluding supplemental payments to eligible county and municipally owned and operated facilities, as well as payments for ancillary services and hospice room and board) totaled $902.1 million (all funds) in 2023-24.

The annual number of days of nursing home care paid by Medicaid on a fee-for-service bases has continued to decrease annually, despite increases in the state's elderly population. This trend is due primarily to the increase in home and community-based services available to Medicaid recipients under the state's long-term care waiver programs, including Family Care and IRIS.

Until 2021-22, Medicaid fee-for-service spending for nursing home services had decreased for a number of years. However, substantial rate increases in 2019 Act 9, 2021 Act 58, and 2023 Act 19 have resulted in increases in Medicaid costs of nursing home services.

Table 9.2 summarizes the total MA fee-for-service payments to facilities by facility type during the last two state fiscal years (excluding supplemental payments to eligible county and municipally owned and operated facilities, as well as payments for ancillary services and hospice room and board).

Table 9.2: Total MA Fee-For-Service Payments to Nursing Homes and ICFs-IID ($ in Millions)

Facility Type	2022-23	2023-24
FFS Nursing Homes	$566.5	$715.1
ICFs-IID (Non-State)	9.6	10.7
State DD Centers	153.4	148.2
Veterans Homes	28.3	28.1
Total	$757.8	$902.1

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

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

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

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

Facilities expect to be reimbursed up to their actual costs, provided that they not exceed the targeted cost established by DHS. However, based on 2021 nursing home cost reports and inflated forward, DHS estimates that, in 2022-23, 64.2% of nursing homes had direct care nursing costs in excess of the Medicaid rates they received for that cost center, after factoring in direct care-related provider incentives.

Medicaid deficits for 2023-24, based on 2022 cost reports inflated forward, show that 14.9% of nursing homes had direct care nursing costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives.

When projected Medicaid deficits across all cost centers are considered, DHS estimates that 96.6% of facilities had costs greater than the total reimbursement rate in 2022-23. In 2023-24, when deficits across all cost centers are considered, 18.0% of facilities had costs greater than the total reimbursement rate.

Direct Care. DHS is required to establish payment rates 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, qualified intellectual disabilities personnel, certified nursing assistants, feeding assistants, nurse aide training and nurse aide training supplies. Direct care supplies and services include: (a) personal comfort supplies; (b) medical supplies; (c) over-the-counter drugs; and (d) the 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.

Beginning in 2022-23, DHS set a payment standard for the direct care nursing allowance. DHS sets each facility's direct care nursing allowance at the lesser of the facility's inflated costs or the median plus 25% of inflated direct care costs for all facilities, controlling for acuity. The latter was $126.31 per patient day in 2022-23, and $137.45 per patient day in 2023-24. Facilities can expect to be reimbursed up to their actual costs, provided that they do not exceed the targeted cost.

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 ($949.15 per patient day in 2024-25). Facilities may also receive a specialized psychiatric rehabilitative services supplement of $24.87 per patient day if they prepare a specialized psychiatric rehabilitative services care plan for each resident receiving the services and submit a PASRR screen biennially that indicates that nursing home care is appropriate and specialized services are necessary.

Support Services. Support services include dietary services, maintenance, transportation, housekeeping, laundry, security services, fuel and utility costs, and administrative and general costs. The expenses may include those salaries, employee fringe benefits, supplies, purchased services, and other expenses that are directly related to providing the services and other allowable expenses that cannot be appropriately recognized in other cost centers. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage, and general employee benefit insurance), working capital interest expenses, amortized financing acquisition costs, and other similar expenses. This rate was $57.50 per patient day in 2021-22, and $89.65 in 2022-23. 2023 Wisconsin Act 19 directed the Department to set the support services rate in a manner equivalent to the direct care nursing allowance. As such, the support services allowance is a priced allowance set at 125% of the median inflation adjusted expense per patient day based on the cost reports used for setting rates for the given rate year, subject to certain reductions. In 2023-24 the rate increased to $157.73 and to $171.26 in 2024-25.

Property Taxes. For tax-paying facilities, the statutes direct that the payment be made for the amount of the previous calendar year's tax or the amount of municipal service costs, adjusted by 0.7% for inflation. Tax-exempt facilities may also receive a per patient day property tax allowance for the costs of municipal service fees actually paid by the facility.

Property Payment Allowances. Allowable property-related costs include property insurance, lease costs, depreciation, plant asset interest, property cost amortizations, and mortgage insurance. The statutes require that the capital payments be based on a replacement value for the facility, as determined by a commercial estimator that is paid for upfront by the facility and subsequently reimbursed by DHS.

Provider Incentives. The MA program pays certain qualifying nursing homes incentive payments, which are specified in the annual nursing home reimbursement formula. In 2024-25, nursing homes can receive seven types of incentive payments. The first is for nursing homes, not operated by a governmental entity, with above average MA populations. If a nursing home's total patient days consists of 50% or more MA residents, the facility receives an exceptional MA utilization incentive payment that ranges from $0.75 per patient day to $5.97 per patient day (the rate increases as the percentage of patient days that are MA increases). The incentive is calculated according to the Medicaid percentage, which is the facility's Medicaid fee-for-service, Medicaid hospice, and managed care Medicaid patient days divided by the facility's total patient days.

Second, a nursing facility can receive a private room incentive. Nursing facilities may receive this incentive by signing a cost report affidavit stating the facility will not charge Medicaid residents a surcharge for private rooms as allowed under administrative code for the entire rate year. The amount of the incentive is determined using the excess of the percentage of licensed beds in private rooms over the percentage of cost report patient days associated with non-Medicaid residents. This excess, if greater than zero, is divided by the percentage of cost report patient days associated with Medicaid residents and the result is multiplied by $1.50 per patient day.

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 2024-25, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease purchase agreements and rentals do not generally qualify for the incentive.

Fourth, an MA access incentive is provided to nursing homes at a rate of $9.65 per patient day and to ICFs-IID at a rate of $33.24 per patient day during 2024-25.

Fifth, facilities may be eligible for the innovative area incentive by requesting DHS approval for improvement of the physical environment and the quality of resident life through renovation or replacement of the building. The facility must improve the physical plant and operations in which nursing care is provided in a manner that will not increase the overall cost to the Medicaid program.

Sixth, two different behavior incentives are offered, which provide additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties. Each facility is assessed to calculate behavioral and cognitive impairment access and improvement scores, which are then multiplied by supplement base values to determine the behavioral/cognitive impairment incentive. In 2024-25, the supplement base rates equaled $7.27 per day for the access incentive and $0.69 per day for the improvement incentive, and were determined based on the facility's behavioral score and improvements to this score.

Seventh, facilities with 50 or fewer licensed beds are eligible for the small facility incentive of $17.74 per patient day in additional reimbursement. DHS indicates that the rationale for this incentive is to encourage smaller and more community-like nursing facility settings, and to recognize the lack of purchasing power and the spread of fixed overhead associated with a smaller facility size.

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 2023-24, based on claims data through October 1, 2024, the average MA payment rate to nursing homes was $345.47 per day, excluding the state centers and the veterans homes. Of that amount, patient liability accounted for $41.99 (12.2%) and MA payment accounted for $303.48 (87.8%).

Recent Rate Increases. 2019 Act 9 provided two forms of additional funding for nursing homes. First, Act 9 required that DHS increase MA rates paid to nursing facilities and ICFs-IID by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments in 2019-20 and 2020-21 to support staff in those facilities who perform direct care. At the time of passage, this provision was estimated to provide $36,909,400 ($15,000,000 GPR and $21,909,400 FED) in 2019- 20 and $37,082,800 ($15,000,000 GPR and $22,082,800) in 2020-21 to increase MA reimbursement for nursing home services in the 2019-21 biennium. As such, the Department applied 58.7% to the direct care nursing cost center, 10.0% to the direct care other supplies and services cost center, and 31.2% to the support services cost center. Additionally, Act 9 provided funding to increase the MA rates paid for direct care to nursing facilities and ICFs-IID by 1% annually related to an increase in acuity of patients in these facilities ($17,416,700 all funds over the 2019- 21 biennium).

Subsequently, 2021 Act 58 provided $82,034,300 ($30,474,700 GPR and $51,559,600 FED) in 2021-22 and $170,375,400 ($67,600,700 GPR and $102,774,700 FED) in 2022-23 to increase MA reimbursement paid to skilled nursing facilities and ICFs-IID, beyond acuity adjustments to the payment rates. Of this amount, DHS was required to increase MA rates paid to skilled nursing facilities and ICFs-IID by a budgeted sum of $20,000,000, as the state share of payments, and the matching federal share of payments, in 2021-22, and by a budgeted sum of $20,000,000, as the state share of payments, and the matching federal share of payments, in 2022-23, to support staff in those facilities who perform direct care. At the time of passage this provision was estimated to provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to be directed at staff who perform direct care.

Most recently, 2023 Act 19 provided $73,200,000 ($28,167,400 GPR and $45,032,600 FED) in 2023-24 and $73,200,000 ($28,774,900 GPR and $44,425,100 FED) in 2024-25 to increase the support services portion of Medical Assistance program reimbursement for nursing homes and, as previously described, required the Department to establish and implement a priced rate for nursing home support services based on median facility costs plus 25 percent.

Supplementary Payments. 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 section.

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

Recently, the Department transitioned to paying the county supplement as a per diem add-on (as opposed to the previous lump sum payments). DHS calculates per-diem add-ons for each applicable provider based on calculated Medicaid deficits from the provider-submitted cost reports. To calculate total deficits, each applicable provider's Medicaid patient days are multiplied by their facility-specific Medicaid per patient day deficit.

As such, from July 1, 2023, through March 31, 2024, eligible facilities were offered the lesser of $153.71 per patient day or their direct care deficit. Following the transition, from April 1, 2024, through June 30, 2024, each facility was offered payments equal to their direct care deficit. The average supplemental payment per patient day was $184.33.

In 2023-24, there were 30 county and municipal providers that qualified for supplemental payments. In 2024-25, each facility was offered a supplemental payment equal to their direct care deficit. The average supplemental payment per patient day was $79.41. There were 34 county and municipal providers that qualified for these supplemental payments.

Certified Public Expenditure Supplement (CPE). State law contains a mechanism by which additional funding may be available through the nursing home CPE program to provide supplemental payments to county and municipally-operated 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 county and municipally-operated 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 county and municipal nursing homes. No federal revenue is disbursed to county and municipal nursing homes when the revenues are less than the budgeted amount. Prior to 2017-18, no extra CPE payments had been made to county and municipal facilities since 2011-12. However, in 2017-18, DHS paid $17.4 million in excess CPE supplemental payments to county and municipal nursing homes. Subsequently, DHS paid $16.4 million in 2018-19, $7.9 million in 2019-20, and $11.5 million in 2020-21 to county and municipal nursing homes under this provision.

In 2021-22, 2022-23, and 2023-24, no extra CPE payments were made to county and municipal facilities.

Appendix 2 identifies actual supplemental MA payments to county and municipally-owned nursing homes from both the county supplemental payment and the CPE supplement, from 2017-18 through 2022-23, the most recent year available.

Reimbursement of State Operated Facilities. MA payments for care provided at the state centers and the veterans homes are determined by DHS separately from the methods established for all other nursing facilities. The state centers are paid based on actual costs. Interim payment rates are established for these facilities, but DHS reconciles costs at the end of each state fiscal year to adjust payments to actual costs within general limitations.

DHS pays the state veterans homes an amount 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 homes 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 homes to cover the costs of services provided to these individuals are equal to the Medicaid fee-for-service reimbursement rates, and are included in the capitation payments paid to managed care organizations.

CHAPTER 10

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. Alternatively, individuals who are eligible for long-term care services have the option to enroll in IRIS (Include, Respect, I Self-Direct), which is a fee-for-service, self-directed program. 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.

Prior to the expansion of Family Care and IRIS services, there were five county-administered programs that provided home and community-based care to elderly adults and individuals with disabilities. These programs included: (1) the community integration program 1A (CIP 1A); (2) the community integration program 1B (CIP 1B); (3) the intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) restructuring initiative (CIPI); (4) the community options program Medicaid waiver for frail elders or persons with physical disabilities; and (5) the non-waiver community options program (COP). Collectively these programs are referred to as the "legacy waiver" programs.

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 program, which was modeled after the PACE and Partnership programs. In 2000, Fond du Lac, La Crosse, Milwaukee, and Portage counties began offering Family Care. Richland County began offering the program in 2001. 2007 Wisconsin Act 20 authorized DHS to expand the Family Care program statewide in all counties that chose to participate in the program. Later, 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. In 2018, Wisconsin amended its Family Care waiver to make enrollment in Family Care mandatory in order to receive Family Care benefits. This change removed the requirement that the state offer an alternative to managed care.

2015 Wisconsin Act 55 required DHS to submit, to the federal Department of Health and Human Services, the documentation necessary to allow DHS to administer Family Care in every county in the state by January 1, 2017, or a later date selected by DHS. Statewide expansion of Family Care and IRIS was completed in July, 2018. However, by statute, all eligible individuals within a participating county are entitled to receive program benefits 36 months after the start of county participation. In February, 2021, the last adult waiting to join one of Wisconsin's long-term care programs was enrolled in IRIS, thereby eliminating the waiting list for eligible adults.

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

Table 10.1 shows Family Care, IRIS, Partnership, and PACE enrollment from 2014 to 2024. Since July 2018, all 72 counties offer Family Care and IRIS. In addition, as of November, 2024, 18 counties offer Partnership and four counties offer PACE.

Table 10.1: Family Care, IRIS, Partnership and PACE Enrollment as of October 1

	Family Care	IRIS	Partnership	PACE
2014	38,180	11,139	2,925	681
2015	41,791	12,533	2,968	651
2016	44,191	13,901	2,978	603
2017	46,451	15,292	3,098	560
2018	48,636	17,846	3,427	569
2019	49,925	19,633	3,646	544
2020	51,084	21,794	3,712	545
2021	51,435	23,360	3,745	515
2022	52,915	24,582	3,695	524
2023	53,444	25,854	3,656	525
2024	52,936	26,805	3,349	497

Family Care

Non-Financial Eligibility. All Family Care enrollees must be at least 18 years of age or older and have a primary disability that is not related to mental illness or substance abuse. Additionally, members must meet non-financial eligibility requirements of full benefit EBD Medicaid.

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

An individual can meet the functional eligibility criteria in two ways. First, the criteria are met if the person's functional capacity requires a nursing home level of care, which is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance, or supervision. Alternatively, the eligibility criteria are met if the person's functional capacity is at the non-nursing home level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and they are at risk of losing their independence or functional capacity unless they receive assistance from others.

Financial Eligibility. Individuals must meet the Family Care income and asset requirements to be eligible for the Family Care benefit. As described in Chapter 5, the asset limit is $2,000 for an individual and $3,000 for a married couple. An individual's income cannot exceed the cost of appropriate institutional care by more than the medically needy income limit.

The spousal impoverishment protections,

discussed in Chapter 5, also apply to spouses that receive services through the Family Care program. However, individuals receiving services through the Family Care program may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance. In 2025, the allowable income retained ranges from $1,147 to $2,901 per month.

Services and Funding. Individuals enroll in an MCO to receive the Family Care benefit. Enrollees have access to a broad range of services, including certain long-term care Medicaid card services, nursing home services, and services previously provided under the legacy waiver programs.

In addition to long-term care services, card services that may be provided through the MCO include, but are not limited to: care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit. Table 10.2 shows Family Care service expenditures, by category, in calendar years 2022 and 2023.

Table 10.2: Family Care Service Expenditures ($ in Millions)

	2022	2023
Residential Care	$1,036.9	$1,104.2
Home Care	352.7	379.2
Institutional Care (NH/ICF-IID)	285.4	353.9
Case Management	255.6	270.8
Habilitation/Health	77.9	85.1
Transportation	71.2	87.4
Adaptive Equipment, DME, and DMS	35.8	40.7
Vocational	34.3	34.1
Home Health Care	22.3	25.6
Financial Management	14.6	16.0
Adult Day Activities	10.0	11.2
Respite Care	10.1	10.1
Other LTC Services	1.5	2.1
Total	$2,208.3	$2,420.4

Each MCO develops and manages a network of long-term care services and supports, either through contracts with providers or by providing case management services directly through its employees. DHS may contract with different entities to serve as MCOs, including governing bodies of tribes or bands, the Great Lakes Inter-Tribal Council, counties, or private organizations that have no significant connection to an entity that operates an aging and disability resource center (ADRC) or is establishing an ADRC. However, regardless of the type of entity, all MCOs must ensure the following:

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

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

- 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 case management services specified in the proposed contract.

DHS makes capitation payments to MCOs, which are funded from a combination of GPR, federal MA matching funds, and county contributions. Two different capitation rates are paid to each MCO: a nursing home rate, for enrollees that meet the nursing home level of care standard, and a non-nursing home rate, for enrollees that need a lower level of care. The capitation payments DHS makes to MCOs represent the average cost calculated across all members of each respective MCO in each geographic service area. 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 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 2024 ranged from $3,163.49 to $4,968.59 for individuals who meet a nursing home level of care standard and from $640.60 to $750.91 for other qualifying individuals who do not meet the nursing home level of care standard.

During the first five years that Family Care services were available in a county, the county's contributions to the costs of the program were determined by a formula established in 2007 Wisconsin Act 20. A county's contribution was based on whether the actual amount the county spent on 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 was 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 equaled 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 was then set at 22% of the county 2006 basic community aids allocation. By calendar year 2023, all counties completed their five-year transitionary period.

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.

Appendix 4 shows the regions served by the Family Care MCOs in 2025.

Direct Care Workforce Funding Supplement. 2017 Act 59 directed DHS to collaborate with the MCOs and CMS to develop an allowable payment mechanism to increase the direct care and services portion of the capitation rates to address the direct caregiver workforce challenges in the state. In response, DHS received CMS approval to distribute the additional funding provided in Act 59 through the direct care workforce funding supplement. Under the supplement, MCOs are required to use the funding to pay providers for wage increases, bonuses, or additional paid time off, as well as employer payroll tax increases that result from increasing workers' wages, for eligible direct care workers.

DHS estimates that the 2023–2025 biennial budget provided a total of $136 million (all funds) in 2023–24 and $146 million in 2024–25 (all funds) for direct care workforce funding initiative payments. The Department anticipates making four payments and two redistribution payments over the 2023-25 biennium to expend the budgeted funds.

IRIS (Include, Respect, I Self-Direct)

Previously, CMS required the state to offer an alternative to managed care in order to provide individuals with sufficient choice in obtaining long-term care services. The IRIS program (Include, Respect, I Self-Direct) is a fee-for-service, self-directed support waiver under the Medicaid HCBS waiver authority, through which individuals may direct their long-term care supports and services through management of a designated budget amount. Like Family Care, IRIS is available statewide.

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

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

Services and Funding. The services available under the IRIS program are limited to the home and community-based services not available as Medicaid card services. This differs from Family Care, which covers all long-term care services, including those otherwise available as Medicaid card services. IRIS enrollees have the option of self-directing their personal care services with the help of the IRIS consulting agency (ICA). Currently, approximately 58 percent of IRIS enrollees choose this option.

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

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

Administration. As of April, 2024, DHS had contracts with six ICAs and four fiscal employment agencies (FEAs), to administer the IRIS program. The ICAs are responsible for assisting individuals in developing an individualized support and service plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must ensure the individual will be healthy and safe. The FEA assures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements, such as paying providers and ensuring that employment and tax regulations are met.

IRIS enrollees receive an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs, as well as the historical service cost of other people with similar needs in IRIS. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person uses funds from their 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 an adult family home or a residential care apartment complex, as long as it is not a nursing home or other institutional facility.

Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed. Table 10.3 shows a breakdown of IRIS service expenditures in 2022 and 2023.

Table 10.3: IRIS Service Expenditures*
($ in Millions)

	2022	2023
Support Services	$414.1	$439.4
Self-Directed Personal Care	248.9	302.2
ICA Services	67.6	70.6
Living Situation/Residential	40.8	48.5
FEA Services	30.0	31.1
Day Services	27.7	33.0
Respite Care	24.2	27.9
Transportation	19.5	23.2
Vocational	18.2	19.1
Aids, Equipment, and Supplies	4.9	5.0
Daily Living Skills	3.3	4.2
Home Modifications	3.5	2.0
Treatment/Therapeutic Services	2.8	3.2
Vehicle Modifications	1.4	1.4
Customized Goods and Services	0.9	0.4
Education/Training	0.3	0.4
Total	$908.1	$1,011.6

*Excluding self-directed personal care screening costs.

PACE and Partnership

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

To be eligible for Partnership, the individual must be financially eligible for Medicaid and if the individual is eligible for Medicare, they must be enrolled in Medicare Parts A, B, and D and obtain their Medicare coverage from the MCO's Partnership Medicare Special Needs Plan.

To be eligible for PACE, the individual must be financially eligible for Medicaid, or Medicare, or both Medicaid and Medicare, or neither Medicaid or Medicare but able to pay for the program out of pocket.

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

Similar to the Family Care program, the state's Medicaid program makes capitation payments to PACE and Partnership MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. In addition to the Medicaid capitation rate, these agencies may receive a Medicare capitation rate for acute care services. In calendar year 2024, monthly capitation rates paid to MCOs participating in the Partnership program ranged from $4,375.72 to $6,536.52. For PACE, in 2024, monthly capitation rates ranged from $4,124.61 for a frail elderly individual eligible for Medicare to $7,504.75 for an individual with a developmental disability who is not eligible for Medicare.

Table 10.4 shows PACE and Partnership service expenditures in calendar years 2022 and 2023.

Table 10.4: Partnership and PACE Service Expenditures ($ in Millions)

	2022	2023
Acute & Primary Services		
Partnership	$77.2	$104.6
PACE	8.9	14.2
Subtotal	$86.1	$118.8
Long-Term Care Services		
Partnership	$157.7	$163.1
PACE	29.2	28.6
Subtotal	$186.9	$191.7
Care Management		
Partnership	$25.2	$27.6
PACE	5.5	5.9
Subtotal	$30.7	$33.5
Total	$303.7	$344.0

Children's Long-Term Support (CLTS) Waiver Program

The CLTS waiver program operates under a federal waiver to provide Medicaid-funded, community-based supports and services to eligible children who would otherwise qualify for care in a hospital, nursing home, or ICF-IID. In some cases, parents are required to pay a share of the program's service costs to the child's county waiver agency (CWA). Parents whose income is below 330% of the federal poverty level are not liable for any portion of the costs of the participant's CLTS waiver program services.

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

Children may continue to receive services under the waiver until they reach the age of 22 as long as they continue to be eligible for Medicaid. However, most children receiving CLTS services transition to IRIS or Family Care upon turning 18. Counties can prevent a disruption in services for children already receiving services under CLTS by planning for their transition to Family Care or IRIS.

CWAs help confirm program eligibility and enroll children in CLTS, as follows: (1) CWAs complete the CLTS functional screen; (2) if a child is eligible, the CWA enters the child's data in the Program Participation System (PPS); (3) on a first-come, first-served basis, DHS confirms that the child's services can be funded and that the child is ready to enroll; and (4) the CWA enrolls the child in CLTS and updates PPS.

As of October, 2024, 24,672 children were enrolled in the CLTS waiver program and an additional 1,563 children were eligible for the program and could begin receiving services based on available funding, but were waiting for the county agency to enroll them in the program. Counties must serve children on a first-come, first-served basis, so long as funds are available.

CLTS Waiting List. In the past, some counties served additional children by supplying the non-federal share of matching funds to obtain federal matching funds on CLTS services.

Historically, counties kept their own waiting lists of children who qualified for CLTS services, but for whom no funding was available. However, CMS required that the state transition to a statewide enrollment process managed by DHS.

To facilitate the transition to a statewide waiting list, 2017 Wisconsin Act 59 authorized DHS to require counties to continue to provide funding that the counties had previously been contributing to partially support program costs, and required counties to cooperate with DHS to determine an equitable funding methodology and county contribution mechanism for contributing local funds to support CLTS services. Currently, CWA contribution amounts are based on 2016 expenditures for the program and total approximately $6.1 million annually.

The state may establish a waiting list for CLTS services when the state does not have sufficient funding to provide services to all eligible individuals.

Recent Funding Increases. 2017 Act 59 provided DHS with an additional $14.2 million (all funds) in 2017-18 and an additional $25.4 million (all funds) in 2018-19 to fund CLTS services for children who were on the waiting list. These amounts were calculated based on the number of children on the waiting list for services at the time Act 59 was deliberated. However, the waiting list for CLTS services subsequently grew. Since the funding budgeted for this effort was sum certain, rather than sum sufficient, the waiting list was not eliminated in that biennium.

Subsequent budgets provided funding at such levels that although enrollment has exceeded budgeted estimates, no eligible children are currently being denied services due to the lack of available funds. In 2023-24, $293 million (all funds) was expended under the program.

Home and Community Based Services (HCBS) Enhanced FMAP

The American Rescue Plan Act (ARPA) included federal incentives for states to improve their HCBS programs. Under ARPA, states received a 10.0 percentage point increase in the FMAP for base HCBS expenditures during a 12-month period from April 1, 2021, to March 31, 2022. Initially, states were required to spend the state funds savings resulting from the enhanced federal matching funds to improve HCBS programs over a two-year period, from April 1, 2022, through March 31, 2024. However, the deadline was subsequently extended to March 31, 2025, with CMS further extending Wisconsin's expenditure deadline to align with the end of the state fiscal year (June 30, 2025).

States were required to submit an expenditure plan to CMS for HCBS enhancements. In its submission, DHS anticipated claiming an additional $353 million in enhanced federal matching funds for HCBS expenditures during the period from April 1, 2021, to March 31, 2022. Overall, the Department estimated that the reinvestment plan will total approximately $701 million, since an estimated additional $348 million in federal funds can be claimed on any of the $353 million spent on Medicaid eligible activities (both benefit and administrative activities).

Under Wisconsin's expenditure plan, which was approved by CMS, the Department anticipated six areas of spending: (a) Medicaid HCBS workforce, provider capacity, and fiscal stability; (b) promoting quality and innovation resources; (c) tribal long-term care systems; (d) independent living and family/informal caregiver resources; (e) access to HCBS information and services; and (f) assisted living information, analysis, and quality oversight. Descriptions of major components of the Department's spending plan follows.

Medicaid HCBS Rate Increase. Beginning in January, 2022, a 5% rate increase was provided to eligible HCBS providers participating in Family Care, IRIS, Medicaid fee-for-service, and CLTS.

This portion of the Department's plan was approved by the Joint Committee on Finance, with the condition that the rate increases were to be funded with ARPA HCBS reinvestment funding through March 31, 2024. The 2023-25 biennial budget act (2023 Act 19) provided $43,707,300 ($17,194,500 GPR and $26,512,800 FED) in 2023-24 and $181,951,800 ($71,525,000 GPR and $110,426,800 FED) in 2024-25 to fund estimated costs associated with the 5% rate increase from April 1, 2024, through June 30, 2025.

Minimum Fee Schedule. DHS established a minimum fee schedule, effective October 1, 2024, which requires that managed care organizations reimburse certain providers no less than the minimum rates.

The minimum fee schedule affects payment rates for the following providers:

• Residential assisted living providers, specifically adult family homes (AFHs), community based residential facilities (CBRFs), and residential care apartment complexes (RCACs). For CBRFs and AFHs, there are three payment tiers based on enrollee needs and corresponding staffing. Further, rates for these provider types vary based on the size of the facility. There is one rate for RCACs.

• Supportive home care (SHC), which are services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Currently, SHC services can be self-directed or provided via an agency, and the minimum fee schedule established one rate for each delivery model based on the difference in associated overhead and administrative costs.

Under the minimum fee schedule, MCOs are still contractually required to negotiate rates and pay above the minimum when needed to secure enrollee care.

Costs associated with the minimum fee schedule are fully funded with HCBS ARPA funds in 2024-25. DHS estimates that total funding required to continue this initiative in the 2025-27 biennium is expected to be $516.0 million AF ($203.5 million GPR) and is included as part of the agency's 2025-27 budget request.

HCBS Grants. Under the Department's plan, two rounds of grants were issued to enhance, expand, and strengthen HCBS. DHS anticipates distributing a total of approximately $30 million geographically across the state in both urban and rural areas, and to support diverse organizations and populations. Eligible applicants included HCBS providers, MCOs, and IRIS consultant agencies, as well as local governments and advocacy groups whose work supports HCBS providers or participants.

In late 2022, the first round of grants provided a total of $17.3 million to 69 organizations. Actual grant amounts were determined based on the application, with allowable grant applications ranging from $25,000 to $2 million. In its selection, DHS prioritized grants focused on workforce such as projects related to marketing, recruitment and retention strategies, and technology to address workforce shortages including remote monitoring.

The Department started accepting applications for the second round of funding in February, 2023. For this round, DHS received 449 applications requesting more than $86 million in grant funding. Ultimately, DHS selected 89 applicant projects and disbursed over $12.4 million in project funding.

Independent Living Pilot. Starting in July, 2023, eligible individuals enrolled in the pilot through which people at risk of receiving Medicaid-funded long-term care services could receive up to $7,200 worth of short-term, flexible, and limited services and supports. The goal of the pilot was to allow people to stay in their own homes, while delaying or preventing enrollment in a Medicaid long-term care program, through the provision of services such as specialized medical equipment and supplies, respite, home and vehicle modifications, transportation, personal care services, and supportive home care.

To be eligible for this pilot, selected program participants must: (a) be an adult Wisconsin resident; (b) live in a pilot ADRC or Tribal ADRS agency service area; (c) not be currently enrolled in Medicaid long-term care programs or living in a licensed or certified residential facility; (d) earn less than 300% of the federal poverty level with no deductible or consideration of spousal income; (e) have at least one eligible functional need; and (f) have a qualifying diagnosis (may be a long-term disability) if under age 55.

Since the start of the project, 3,700 individuals have enrolled in the program. As of November, 2024, there were 2,800 active participants in the program and cumulative program expenditures totaled $14.6 million, including costs for both program benefits and administration. Additional expenditures for this program are expected before the end of the ARPA HCBS reinvestment period closes.

Miscellaneous Projects. Other concepts approved by CMS include: staff stability surveys to help assess turnover, wages, benefits, and other factors; a statewide professional certification system to improve competency and career advancement; a statewide workforce platform; a "no wrong door" system for children and their families to access long-term care services including a website with access to information across programs; tribal long-term care enhancements; an online tracking system for certifying 1-2 bed adult family homes; an online system to review potential HCBS setting providers as it pertains to compliance with federal law; the development and implementation of an adult incident reporting system to support increased coordination between state provider licensing, medical services, and protective services; and aging and disability resource center (ADRC) modernization efforts including online networks for individuals to review resources in their community, ask questions about services available to them, and provide a point of contact for their local ADRC.

Federal Home and Community Based Services (HCBS) Settings Rule

In 2014, CMS published the HCBS settings rule. The federal requirements define the qualities of settings eligible for reimbursement for Medicaid home and community-based services. CMS requires all states that operate HCBS waivers to comply with the federal settings rule. However, the process of assessing settings for compliance with the HCBS settings rule does not affect licensure or certification. As such, programs that do not rely on HCBS waiver funding may continue to use non-compliant settings for their program participants.

The settings rule establishes requirements for residential and non-residential service settings in Medicaid waiver programs. The purpose of the settings rule is to ensure that people receiving services through HCBS waiver programs have access to the benefits of community living and are able to receive services in the most integrated settings.

In Wisconsin, the HCBS settings rule applies to service settings for Family Care, Partnership, IRIS, and CLTS. Under the federal requirements, DHS must ensure that settings in which home and community-based services are provided meet and remain in compliance with the settings rule requirements.

Residential Service Providers. DHS began to enforce compliance on March 1, 2019, for adult residential settings, which for purposes of the HCBS settings rule, includes: licensed community-based residential facilities; licensed 3-4 bed adult family homes; certified 1-2 bed adult family homes; and certified residential care apartment complexes. According to CMS, the transition period for complying with the criteria of a home and community-based setting expired on March 17, 2023.

Non-Residential Service Providers. Non-residential settings subject to the HCBS settings rule include: adult day services settings; adult day care settings; prevocational settings; group supported employment settings; and children's day services settings.

All non-residential settings must meet conditions that ensure specific rights of people receiving HCBS in those settings. Generally those rights focus on settings not isolating people from the broader community, and ensuring that programs provide opportunities for adults, children, and youth to do the following in an age and developmentally appropriate manner: seek employment; work in competitive integrated settings; engage in community life; receive services in the community; interact with peers who do not have disabilities; participate in community events and activities; and access and control personal resources.

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. Additionally, physicians, hospital discharge planners, or other professionals who work with elderly or disabled individuals can also use the ADRCs' information services. ADRCs must provide all of their services at no cost to recipients.

The contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating ADRCs, although some do. 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 the ADRC's allocation, the ADRC is responsible for those costs.

Tribes may choose to have their own aging and disability resource specialist (ADRS) that works with one or more established county or multi-county/tribe ADRCs. An ADRS serves as a consumer advocate for tribal members using the ADRC, with the ADRS providing technical assistance to the ADRC regarding resources available through tribes and culturally appropriate services, and the ADRC enrolling individuals and administering long-term care functional screens, unless administered by a certified ADRS. Alternatively, tribes may operate their own ADRC or operate an ADRC in conjunction with another county or non-profit. However, as of November, 2024, there were no tribal ADRCs.

Because ADRCs provide services to 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 and outreach services. DHS estimates that between January 1, 2024, and March 30, 2024, 45.7% of ADRC expenditures were reimbursed through federal matching funds. However, DHS noted that this percentage is highly volatile across months and between ADRCs.

Table 10.5 shows ADRC direct program operation expenditures for fiscal years 2017-18 through 2023-24. As of October, 2024, there were 51 ADRCs serving all 72 counties and 11 tribes, including 40 single-county ADRCs, 11 multi-county/tribe regional ADRCs. Ten of the 11 Tribal nations employ at least one Tribal ADRS.

Table 10.5 ADRC Expenditures ($ in Millions)

Year	GPR	FED	Total
2017-18	$38.8	$25.1	$63.9
2018-19	40.6	27.5	68.1
2019-20	40.0	32.4	72.4
2020-21	37.7	30.4	68.1
2021-22	41.0	30.0	71.0
2022-23	41.0	31.1	72.1
2023-24	43.8	31.8	75.6

CHAPTER 11

ADMINISTRATION

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

DMS staff work primarily with the administration of all Medicaid-supported programs, including BadgerCare Plus, Medicaid for elderly, blind, and disabled individuals, and the state's Medicaid-supported long-term care programs and several other public assistance programs, such as the federal supplemental nutrition assistance program (FoodShare), and supplemental security income (SSI) benefits.

As of November 1, 2024, the Division of Medicaid Services was authorized 1,119.96 full-time equivalent (FTE) positions (373.81 GPR positions, 718.96 FED positions, and 27.19 PR positions). Of these positions, 442.00 worked in MilES, 255.46 worked in the DHS Disability Determinations Bureau, and 420.50 worked in other bureaus and offices within the Division of Medicaid Services.

MA and FoodShare Administrative Contracts

DHS contracts with outside entities to provide several MA-related administrative services, including processing claims, reviewing health care providers' prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Many of these services are provided by the state's MA fiscal agent, Gainwell Technologies, while others are provided by other private entities and state agencies.

In 2024-25, DHS expects to expend $363.4 million ($122.1 million GPR, $241.9 million FED, and $0.4 million PR) for contracted administrative services provided by private firms, and charges for services provided by other state agencies and units within DHS for EBD Medicaid, BadgerCare Plus, Family Care, SeniorCare, FoodShare, and other related programs. These services are described briefly below.

Fiscal Agent. 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. Gainwell Technologies, the current fiscal agent, is the contracted vendor for the state's Medicaid management information system (MMIS).

MMIS. Each state maintains an MMIS, which is a system of software and hardware used to process MA claims and to retrieve and produce service utilization and management information required by the Medicaid agency for program administration and audit purposes. Federal regulations and guidance establish minimum requirements for such systems. To comply with guidance from CMS, during the past several biennia, DHS has been restructuring its MMIS by creating "modules" that will enable various functions to be modified without disruptions to the entire system.

Client Assistance for Reemployment and Economic Support. The client assistance for reemployment and economic support (CARES) system assists state and county staff in making eligibility determinations and maintaining case information for several public assistance programs, including BadgerCare Plus, SeniorCare, Family Care, the SSI Caretaker Supplement, FoodShare, TANF/W-2, and Wisconsin Shares (child care assistance). The first five of these programs, administered by DHS, account for approximately 95% of CARES cases. The other two programs are administered by the Department of Children and Families.

DHS contracts with Deloitte for programming and maintaining the daily operations of the CARES system. DHS also purchases hardware hosting, network, and mainframe services from the Department of Administration's Division of Enterprise Technology.

Other Contracts. DMS contracts with several other private entities to support the administration of the MA program. For example, DHS contracts with MetaStar, the state's external quality review organization, to conduct on-site visits of long-term care service providers to ensure that the state is complying with federal rules relating to home and community-based long-term care services, and to provide health record quality reviews. Other major external contracts include a contract with Milliman to provide actuarial services to the state's MA program and related programs.

Telecommunications and Inter-Agency/Intra-Agency Charges. DMS is billed for several telecommunications and financial services it receives from private entities and the Department of Administration (DOA). This category also includes costs of MA- and FoodShare-related hearings conducted by DOA's Division of Hearings and Appeals and functional eligibility determinations conducted by the DHS Disability Determinations Bureau.

Table 11.1 shows amounts DHS expects to expend for these administrative contracts and services in 2024-25.

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. Prior to calendar year 2012, DHS contracted with each county to perform these activities. However, due to changes enacted in 2011 Wisconsin Act 32, counties, other than Milwaukee County, are required to form multi-county consortia to administer IM

Table 11.1: 2024-25 Planned Spending for MA and FoodShare Administrative Contracts, by Major Category and Source

	GPR	FED	PR	Total
Fiscal Agent/MMIS Operations	$40,055,600	$86,074,300	$397,900	$126,527,800
MMIS -- Modules and Related Contracts	7,529,100	19,609,000	0	27,138,100
CARES	44,042,100	88,963,200	0	133,005,300
Other Contracts	23,363,700	38,664,200	0	62,027,900
Telecommunications	2,072,900	3,463,800	0	5,536,700
Hearings and Appeals and Functional Disability Determinations	3,582,100	1,163,900	10,500	4,756,500
FoodShare Electronic Benefit Transactions Contract	1,495,300	3,962,300	0	5,457,600
Total	$122,140,800	$241,900,700	$408,400	$363,449,900

programs. DHS is directed to administer IM programs in Milwaukee County as a single-county consortium. Tribes may elect to administer income maintenance programs or have DHS administer IM functions for their tribal members.

Each multi-county consortium is contractually responsible for the following: (a) operating and maintaining a call center; (b) conducting application processing and eligibility determinations; (c) conducting ongoing case management; and (d) providing certain in-person services such as answering questions from applicants, displaying and making state and federal publications regarding public assistance programs available to visitors, 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 insurance plans through the federal Affordable Care Act exchange.

In addition, each contract requires DHS and the multi-county consortia to cooperate to provide the following administrative functions relating to the IM programs: (a) conducting subrogation and benefit recovery efforts; (b) participating in fair hearings; and (c) conducting fraud prevention and identification activities.

There are ten multi-county consortia and nine tribes providing IM services. Table 11.2 shows the counties that are participating in each consortium in 2025. Each consortium is represented by a lead county agency.

DHS provides state and federal funds to support the operations of the IM consortia. The state (GPR) funding available to the consortia is a sum certain amount authorized as part of the state budget. Most counties contribute local funds to supplement the state and federal funds they receive from DHS to support their income maintenance activities. County contributions are also matched with federal funds.

Table 11.3 show the funding the income maintenance consortia expended, by source, in calendar years 2019 through 2023. The amounts in the table and percentages include funding for fraud prevention and investigations allocated by the DHS Office of the Inspector General, which is described later in this chapter.

State Administration of Milwaukee County IM Activities. As part of 2009 Wisconsin Act 15 and 2009 Act 28, DHS assumed responsibility for IM activities in Milwaukee County. The state's takeover was precipitated by a federal lawsuit in which a number of Milwaukee County residents alleged that they had been wrongfully delayed or denied benefits under the MA and FoodShare

Table 11.2: Income Maintenance Consortia

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

Bold indicates the lead county for each consortium.

Table 11.3: Income Maintenance Consortia Expenditures

Calendar	Funding Sources				
Year	GPR	FED Match on GPR	Local	FED Match on Local	Total
2019	$13,581,000	$22,549,000	$26,042,000	$43,240,000	$105,412,000
2020	14,405,000	21,948,000	27,257,000	41,530,000	105,140,000
2021	14,818,000	21,481,000	28,161,100	40,824,000	105,284,000
2022	14,862,000	21,127,000	29,434,000	41,842,000	107,265,000
2023	15,074,000	23,581,000	28,688,000	42,588,000	109,931,000

programs. In April 2009, the parties to that lawsuit entered into a settlement agreement under which they agreed to request a court order that stayed that litigation in order to provide time for the transition of responsibility for the Milwaukee County IM programs from the county to DHS. In keeping with the terms of that settlement agreement, DHS developed and implemented a plan which led to the state's administration of IM activities in Milwaukee County. Milwaukee Enrollment Services (MilES) is the DHS unit that performs IM services in Milwaukee County.

In 2024-25, DHS is budgeted $43.9 million ($18.6 million GPR, $23.3 million FED, and $4.1 million PR) to fund MilES. This funding is budgeted as part of the DMS general program operations budget.

Allocation of IM Costs. The federal share of the costs of conducting enrollment and eligibility determinations differ for MA and FoodShare. Under MA, these costs are generally eligible for a 75% federal match, while under FoodShare, the costs of these services are eligible for a 50% match. 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 for consortia and MilES costs to determine each program's proportional share reimbursement. Tribal agencies use 100% time reporting to report their costs for the purpose of claiming federal reimbursement.

Medicaid "Unwinding." As a condition of receiving a temporary 6.2 percentage point increase in their federal medical assistance percentages, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 pandemic. Federal legislation passed in December of 2022 established an ending date for this continuous enrollment policy of March 31, 2023, after which all renewals that were postponed were to be reprocessed. States were provided up to 12 months to initiate pending verifications, redeterminations based on changes in families' circumstances, and renewals, and return to normal eligibility and enrollment operations. After that, states were provided an additional two months to complete all pending actions. In addition, states were required to take steps to transition individuals who, after the public health emergency (PHE) ended, were determined to no longer qualify for Medicaid, to other affordable insurance programs, including qualified health plans offered under the Affordable Care Act.

Application for Benefits. Individuals may apply for MA and other public assistance benefits by using the state's ACCESS website. Once enrolled in the program, an individual can create an account and use a mobile app that enables them to check their benefits, report changes, submit documents, view letters, apply for other programs, and submit renewals.

After an applicant provides income and other information, ACCESS determines other programs for which the individual may be eligible, including food programs, the Wisconsin Shares child care subsidy program, drug coverage under SeniorCare and Medicare Part D, assistance with housing and utility costs, job programs, Medicaid long-term care programs, and state tax credits and insurance programs.

Individuals may also apply for MA benefits through a telephone or in-person interview.

IM agencies are required to verify certain verbal and written information that applicants provide at the time of application, renewal, and when there are changes in circumstances that may affect an applicant's eligibility or benefits. IM agencies must verify certain information, including social security numbers, citizenship, immigrant status, income, health insurance access and coverage, and information pertaining to certain eligibility groups, such as youths previously in foster care and tribal members.

IM staff use several external databases to verify information. IM staff use databases maintained by the Social Security Administration to verify social security numbers, citizenship status, birth and death dates, social security benefits, supplemental security income, and Medicare enrollment. Information maintained by the DHS Disability Determination Bureau is used to verify disability status. The Federal Data Services Hub and the Systematic Alien Verification for Entitlements (SAVE) program assist in verifying information on immigration status. IM staff access the Department of Workforce Development (DWD) to verify information on unemployment benefits.

In addition, federal law requires states to check data exchanges to determine whether additional verification of income and assets is needed. Wisconsin IM agencies use the following data exchanges to check income: (a) wages reported by employers to DWD, which is the state wage information collection agency (SWICA) and Equifax, a consumer credit reporting agency.

DHS also enters into agreements with financial institutions to operate a financial record matching program. The program enables IM agency staff to access information on the accounts belonging to MA applicants and recipients.

DHS also verifies information provided by public assistance recipients by contacting employers. State law requires employers to respond to agencies' information requests within seven days of receiving a request.

Provider Certification and Regulation

State and federal law establish standards and certification requirements that health care providers must meet in order to participate in their state's Medicaid programs.

In Wisconsin, the following providers must be certified to participate in the MA program: (a) institutional providers; (b) noninstitutional providers; (c) provider assistants; (d) group billing providers; and (e) providers performing certain professional services for inpatient hospitals, as specified by rule. Certain providers are not required to be certified, including dental hygienists, nursing aides, home health aides, x-ray technicians, and dieticians. Noncertified providers may be reimbursed for providing emergency care for Wisconsin MA recipients. Provider certification requirements are established by rule (DHS 105).

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

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

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

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

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

Office of the Inspector General

The DHS Office of the Inspector General (OIG) was created in 2011 and is attached to the DHS Secretary's office. OIG's primary responsibilities include: (a) monitoring and auditing providers that participate in the MA program; (b) monitoring and investigating allegations of recipient and provider fraud; and (c) performing internal auditing and consultation services for all DHS programs. As of November 1, 2024, OIG was staffed with 99.0 FTE positions.

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 on-site visits with certain high-risk providers before they become certified to participate in the program, ensuring that the claims processing system has appropriate "checks" in place to prevent reimbursement of questionable claims, conducting audits of providers, and referring cases of suspected fraud to law enforcement.

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, as well as crimes committed against vulnerable adults in nursing homes and other facilities.

OIG administers the fraud prevention and investigation program (FPIP) for the MA and FoodShare programs. For calendar year 2024, DHS allocated $3 million (all funds) to counties (other than Milwaukee County) and tribes to fund these activities. DHS allocated each county and tribe an amount that is based on each agency's percentage of the statewide income maintenance caseload for the first six months of 2023 (excluding the caseload for which MilES is responsible).

Fraud prevention and investigation consortia, comprised of the same counties that make up the IM consortia, provide local public assistance program integrity activities. Each consortia selects one county agency to administer the program and determines what staff will conduct investigations, which may include agency staff, contracted staff, local law enforcement staff, or any combination determined by each consortium. DHS requires that each FPIP emphasize fraud prevention over fraud detection, and that the programs are cost neutral, such that total program costs do not exceed total program savings.

In accordance with current state policy regarding consultation with tribes, tribal agencies are the only agencies that have the option to operate their FPIPs independently. If a tribal agency chooses to operate independently, the agency will still receive their FPIP allocation.

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

PARIS. The Public Assistance Reporting Information System (PARIS), administered by the DHHS Administration for Children and Families, is a data matching service that checks to determine if public assistance recipients receive duplicate benefits in two or more states. PARIS matches help identify improper payments in the following programs: (a) Medicaid; (b) the Temporary Assistance to Needy Families (TANF); (c) workers' compensation; (d) child care; and (e) the Supplemental Nutrition Assistance Program (SNAP). OIG staff investigate all PARIS "matches," determine overpayments, and process intentional program violations.

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 for which other resources are available. This function is referred to as coordination of benefits (COB). DHS 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 recipients, worker's compensation carriers, absent parents or other entities providing medical child support, and estates.

The identification of COB resources is a shared responsibility of IM consortia, county child support agencies, district offices of the Social Security Administration, the state's MA fiscal agent, and DMS. Once a state has determined that a health or liability insurance company is responsible for an MA recipient's medical costs, the state must assure that these resources are used.

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

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

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

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

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

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2024 Federal Poverty Guidelines

	Percent of Federal Poverty Level						
Family Size	100%	138%	150%	185%	200%	240%	306%
Annual							
One	$15,060	$20,783	$22,590	$27,861	$30,120	$36,144	$46,084
Two	20,440	28,207	30,660	37,814	40,880	49,056	62,546
Three	25,820	35,632	38,730	47,767	51,640	61,968	79,009
Four	31,200	43,056	46,800	57,720	62,400	74,880	95,472
Five	36,580	50,480	54,870	67,673	73,160	87,792	111,935
Monthly							
One	$1,255	$1,732	$1,883	$2,322	$2,510	$3,012	$3,840
Two	1,703	2,351	2,555	3,151	3,407	4,088	5,212
Three	2,152	2,969	3,228	3,981	4,303	5,164	6,584
Four	2,600	3,588	3,900	4,810	5,200	6,240	7,956
Five	3,048	4,207	4,573	5,639	6,097	7,316	9,328

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

APPENDIX 2

Supplemental MA Payments to County and Municipally-Owned Nursing Homes

County	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Brown	$1,398,913	$1,458,292	$1,226,443	$1,425,832	$1,046,200	$1,458,800
Clark	2,965,831	3,126,240	2,716,532	2,740,482	2,068,000	1,800,900
Columbia	1,278,274	1,152,388	1,019,330	966,801	729,800	88,600
Dane	2,558,213	2,691,541	2,403,875	2,620,613	1,961,300	9,535,300
Dodge	2,609,790	2,603,633	2,157,258	2,437,088	1,593,600	1,759,200
Dunn	907,131	823,900	927,700	1,479,409	1,280,500	765,600
Fond du Lac	1,342,666	1,012,971	579,152	662,900	530,400	101,100
Grant	1,468,955	1,742,422	1,765,692	1,512,934	1,080,600	1,857,000
Green	1,594,078	1,704,720	1,345,007	1,541,014	1,144,500	287,400
Iowa	831,038	767,258	561,155	525,612	405,900	0
Kenosha	1,791,473	1,654,800	1,204,580	1,279,112	970,500	992,900
La Crosse	4,696,423	4,036,215	3,051,796	3,031,835	2,208,200	1,454,900
Lafayette	555,338	703,296	502,000	454,500	419,500	68,300
Lincoln	2,601,187	2,920,466	2,714,640	2,780,290	2,188,600	1,089,700
Marathon	3,401,613	3,403,951	2,688,753	3,255,441	2,406,600	1,312,000
Monroe	1,042,002	1,114,858	1,020,093	1,176,206	915,100	208,900
Outagamie	2,085,457	2,275,807	2,113,977	2,309,994	1,778,700	1,247,600
Ozaukee	1,758,198	2,126,499	1,842,157	1,656,295	1,331,600	1,820,900
Polk	1,344,247	1,196,358	1,120,400	1,044,293	810,000	59,200
Portage	963,702	847,663	594,216	624,486	439,700	714,000
Racine	498,944	0	0	0	0	0
Richland	929,300	766,800	679,700	729,100	613,200	182,100
Rock	2,402,647	2,228,078	1,817,758	2,008,124	1,660,400	3,647,600
Sauk	1,149,694	1,221,461	1,081,135	1,169,585	854,000	310,100
Sheboygan	2,165,753	2,302,527	1,873,939	2,119,030	1,588,600	494,700
St. Croix	770,084	701,129	469,300	461,398	402,800	434,400
Trempealeau	1,111,592	934,248	907,035	1,276,009	1,070,400	508,200
Vernon	881,120	719,084	809,383	918,734	667,300	413,700
Walworth	1,585,162	1,742,778	1,440,268	1,476,105	1,242,600	1,414,800
Washington	2,103,964	1,962,693	1,575,748	1,418,177	1,244,900	229,300
Winnebago	2,817,774	2,877,395	2,420,439	2,823,673	2,132,700	3,270,800
Wood	1,258,227	1,463,305	1,200,808	1,555,730	1,134,000	1,360,100
Municipality						
Algoma, City of	586,250	429,000	217,100	239,400	362,200	47,000
Elmwood, Village of	77,000	0	14,600	7,000	0	22,900
Galesville, City of	426,901	299,300	427,647	425,237	395,000	56,300
Prairie Farm, Village of	0	0	54,300	28,200	57,900	17,300
Westby, City of	587,105	496,800	492,100	449,400	364,700	68,400
Total Payments	$56,546,047	$55,507,876	$47,036,016	$50,630,039	$39,100,000	$39,100,000

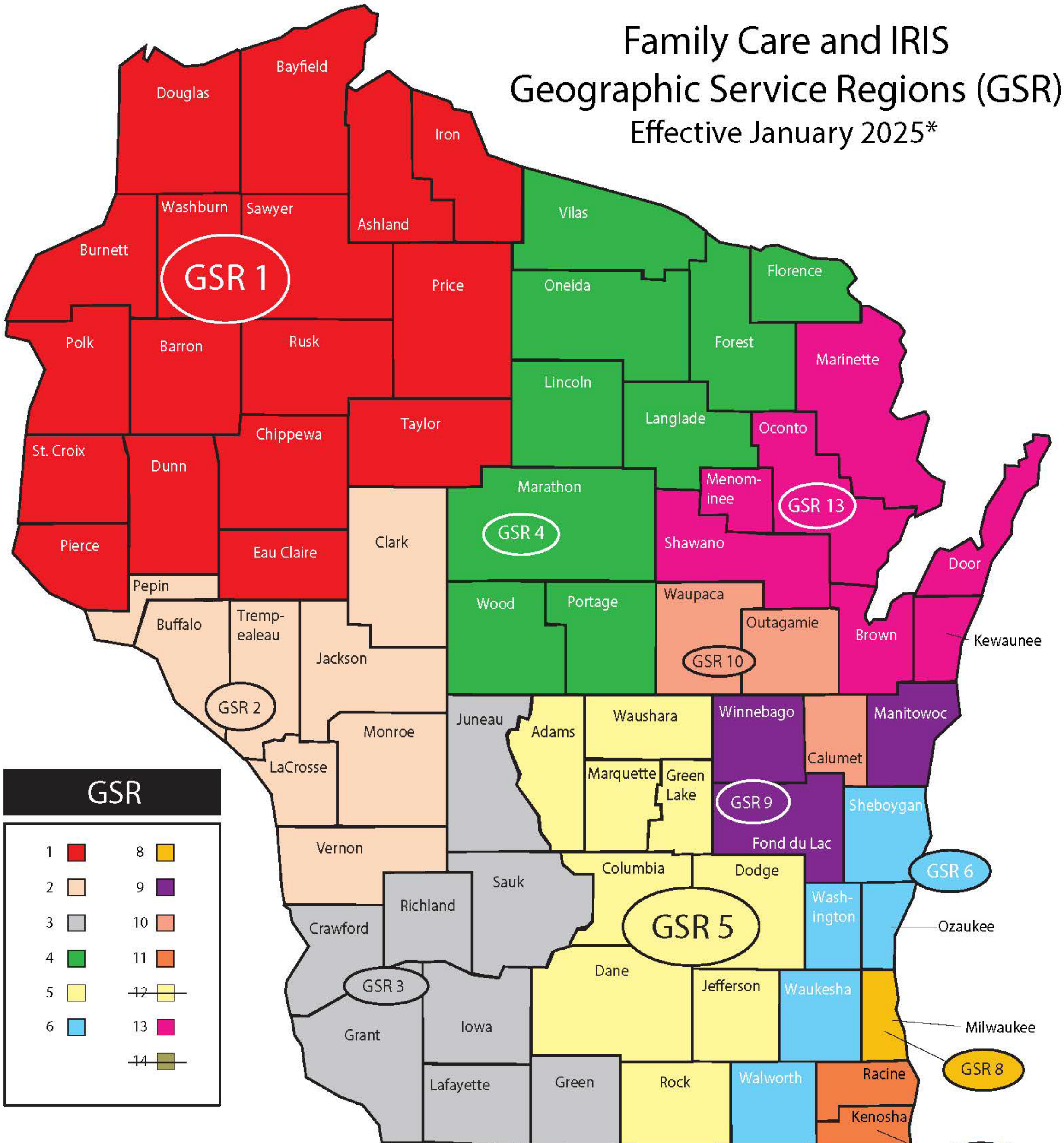
APPENDIX 3

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

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

*Family Care participants access acute/primary services with their Medicaid card.
**IRIS participants access Medicaid card services - Long-Term Care services and acute/primary services with their Medicaid card.
***Individuals enrolled in IRIS or Family Care may also be eligible for Medicare.

APPENDIX 4



***Note:** This map consolidates Adams, Columbia, Dane, Dodge, Green Lake, Jefferson, Marquette, Rock, and Waushara counties (formerly GSRs 5, 12, and 14) into new GSR 5.