Medical Assistance, BadgerCare, SeniorCare, and Related Programs

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Introduction

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

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

States receive matching payments from the federal government to pay for covered services and program administration. The federal matching rate for program benefits, or federal financial participation (FFP) rate, is based on a formula that compares a state's per capita income to national per capita income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. In federal fiscal year 2004-05 (the period from October 1, 2004 through September 30, 2005), Wisconsin's FFP rate is 58.32%. Most administrative costs are funded on a 50% state / 50% federal basis, although certain types of administrative expenses qualify for greater federal cost-sharing. Federal law does not limit the amount of matching funds states can receive under MA. Consequently, the more funding a state provides to support the program, the more federal funding the state receives to partially support program costs.

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

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

partially budgeted in the same MA benefits appropriations that support traditional MA services.

Table 1 summarizes the funding that was budgeted for MA, BadgerCare, and SeniorCare in the 2003-05 biennium, by source. These sources include general purpose revenue (GPR), segregated revenue (SEG), program revenue (PR), and federal revenue (FED). Funding for MA includes funding for long-term care waiver programs and payments to care management organizations (CMOs) under Family Care for MA-eligible individuals. It includes funding budgeted under 2003 Wisconsin Act 33 (the 2003-05 biennial budget act) and all subsequent legislation.

Table 1: Benefits Funding by Program and Source -- 2003-05 Biennium ($ in Millions)

	2003-04	2004-05	2003-05 Biennium	% of Total Program Funding
Medical Assistance*				
GPR	$743.9	$1,520.5	$2,264.4	27.9%
SEG	641.8	103.5	745.3	9.2
PR	23.5	25.8	49.3	0.6
FED	2,540.0	2,515.9	5,055.9	62.3
Total	$3,949.2	$4,165.7	$8,114.9	100.0%
BadgerCare				
GPR	$65.9	$68.3	$134.2	31.7%
PR	6.6	9.0	15.6	3.7
FED	134.6	139.3	273.9	64.6
Total	$207.1	$216.6	$423.7	100.0%
SeniorCare				
GPR	$33.1	$39.3	$72.4	34.7%
PR	30.5	38.1	68.6	32.9
FED	31.4	36.3	67.7	32.4
Total	$95.0	$113.7	$208.7	100.0%
Grand Total - All Programs				
GPR	$842.9	$1,628.1	$2,471.0	28.2%
SEG	641.8	103.5	745.3	8.5
PR	60.6	72.9	133.5	1.5
FED	2,706.0	2,691.5	5,397.5	61.7
Total	$4,251.3	$4,496.0	$8,747.3	100.0%

* Includes funding budgeted for MA benefits under the long-term care waivers and for Family Care CMO payments for MA-eligible individuals.

CHAPTER 1

MEDICAL ASSISTANCE ELIGIBILITY

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

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

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

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

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

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

determining a family's income. The information provided here is intended to generally describe each eligibility category, not to describe all of the criteria the state uses to determine eligibility.

Eligibility for Families With Dependent Children and Pregnant Women

This section describes general eligibility criteria for Wisconsin's MA program for families with dependent children and pregnant women. For many groups, the income eligibility criteria is based on a percentage of the federal poverty level (FPL). Table 2 shows the FPL for 2004, which is based on the number of individuals in a family.

Table 2: 2004 Federal Poverty Level

Family Size	Monthly Income
1	$776
2	1,041
3	1,306
4	1,571
5	1,836
6	2,101

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

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

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

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

	Monthly Payment Level		Monthly Assistance Standard	
Family Size	Amount	% of the 2004 FPL	Amount	% of the 2004 FPL
1	$249	32.1%	$311	40.1%
2	440	42.3	550	52.8
3	518	39.7	647	49.5
4	618	39.3	772	49.1
5	708	38.6	886	48.3
6	766	36.9	958	45.6

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

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

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

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

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

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

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

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

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

- Certain pregnant women; and

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

As of November, 2004, there were approximately 206,400 individuals enrolled in MA under AFDC and AFDC-related eligibility criteria. Counties redetermine MA eligibility for families with dependent children, pregnant mothers and children every 12 months.

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

As of November, 2004, there were approximately 125,600 pregnant women and children enrolled in MA under the Healthy Start criteria.

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

- Any child under 18 years of age;

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

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

Under the spend-down provision, a person can become eligible for MA after incurring medical expenses during a six-month period in an amount that equals the amount his or her income is above the medically needy income limits established by the state. In this way, the spenddown provision offers protection against catastrophic medical costs. As of November, 2004, there were approximately 180 individuals in the low-income family group who qualified for MA by meeting the spend-down requirement.

Presumptive Eligibility for Pregnant Women. A period of "presumptive eligibility" is available for pregnant women to ensure they have access to

prenatal care. This period begins on the day on which a qualified provider determines, on the basis of preliminary information, that the household income of the woman meets MA eligibility criteria. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to apply for MA, the last day of the month following the month in which the determination of presumptive eligibility is made, whichever is earlier. As of November, 2004, approximately 270 women were eligible for MA under a presumptive eligibility determination.

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

Transitional Eligibility. Federal law requires states to extend MA eligibility for certain individuals and families for specified periods. Families that would have lost eligibility for AFDC because of a change in income they earn from employment can remain eligible for up to twelve months based on certain conditions. Families who would have lost AFDC eligibility because their child or family support payments increase can remain eligible for four months under certain conditions. A pregnant woman remains MA eligible through the month in which the 60th day after her pregnancy falls, regardless of a change in household income. Additionally, an infant can remain eligible for MA for up to one year if the infant's mother was eligible for MA on the date the infant was born. As of November, 2004, approximately 66,200 individuals were enrolled in MA under transitional eligibility criteria.

Eligibility for Elderly, Blind and Disabled Individuals

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

States may supplement federal SSI payments with state funds. However, the federal requirement to provide MA to SSI recipients only applies to those individuals who qualify for the federal SSI payment and only to those individuals who actually receive an SSI payment. In calendar year 2005, the federal income limit for SSI is $579.00 per month for an individual and $869.00 per month for a couple. (These limits apply after income is adjusted to reflect certain deductions and exemptions.) Except for section 209(b) states, states' MA programs must cover elderly and disabled individuals and couples with incomes below these limits who actually receive an SSI payment. States may provide MA coverage to individuals who receive a state-only supplemental payment and to individuals who are eligible for a SSI payment but do not receive a payment. Wisconsin's MA program covers both of these optional groups. In calendar year 2005, elderly and disabled individuals with countable income below $662.78 per month and couples with countable income below $1,001.05 per month were eligible for MA.

States must also continue MA coverage for several groups of individuals who previously were eligible for SSI. For instance, states must provide MA coverage to certain disabled individuals who have returned to work and have lost eligibility for SSI as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. States must continue to provide MA coverage to such an individual if he or she needs MA coverage to continue employment and

the individual's earnings are not sufficient to provide the equivalent of SSI, MA and attendant care benefits the individual would qualify for in the absence of earnings.

States must also continue MA coverage for individuals who were once eligible for both SSI and Social Security payments and who are no longer eligible for SSI because of certain cost of living adjustments in their Social Security benefits. Under federal regulations, states are required to disregard the cost of living adjustment when considering MA eligibility. Similar MA continuations have been provided for certain other individuals who become ineligible for SSI due to eligibility for or increases in Social Security or veterans' benefits. Finally, states must maintain MA coverage for certain SSI-related groups who received benefits in 1973, including individuals who care for disabled individuals. In November, 2004, approximately 107,500 individuals were enrolled in MA under SSI and SSI-related eligibility criteria.

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

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

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

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

QMBs pay copayments normally required of other MA beneficiaries. Providers are required to accept the MA payment and the QMB's copayment (if any) as payment in full. As of November, 2004, 1,522 individuals were enrolled in MA under the QMB criteria. States have the option to provide full MA benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a state-established income standard that is no higher than 100% of the FPL. Wisconsin does not use this option.

A more limited MA benefit is provided to SLMBs and SLMBs+. States are required to pay the Medicare Part B premium for individuals who otherwise meet the QMB requirements but have income between 100% and 120% of the FPL (SLMBs) or have income between 120% and 135% of the FPL (SLMBs+). No other premiums, deductibles or copayments are paid for individuals in this group. As of November, 2004, there were 2,606 individuals enrolled in MA under the SLMB and SLMB+ criteria.

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

Wisconsin offers MA coverage to medically needy individuals, but the income standards for the elderly and disabled are, in most cases, lower than the standards for categorically needy individuals. In calendar year 2005, the medically needy monthly income standard is $591.67 for individuals and couples, while the categorically needy monthly income standard is $662.78 for individuals and $1,001.05 for couples.

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

In order to qualify for MA benefits under the medically needy income standard, an individual is required to "spend down" to the medically needy income and asset limits by incurring sufficient medical expenses to reduce his or her income to the maximum amount allowed under the state's MA plan. Countable assets may not exceed $2,000 for an individual and $3,000 for a couple in 2004. As of November, 2004, 9,276 elderly and disabled individuals were enrolled in MA under this spend down option.

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

Institutional Resident and Community Waivers Special Income Limit. Under federal law, states may provide MA coverage to residents of institutional facilities and participants in the community-based waiver programs under a special institutional income rule. This rule permits individuals who are not categorically eligible for SSI and have income between 100% and 300% of the monthly federal SSI payment amount ($579 per month in 2005) to be automatically eligible for MA coverage without "spending down" to the medically needy standards. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($1,737 per month in 2005).

MA recipients who qualify for institutional care or care under a community-based waiver program under the special income limit or the medically needy standard must use any income in excess of allowable deductions for the costs of their care. Allowable deductions under the special institutional income rule include: (a) for institutionalized enrollees, $45 per month, and between $759 and $1,737 per month in 2005 for community-based waiver recipients as a personal maintenance allowance; (b) a transfer of income to a spouse that is the lesser of $2,377.50 or $2,081.67 plus an excess shelter allowance and a transfer of $520.42 for each dependent family member living in the community; and (c) medical costs not covered by MA.

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

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

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

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

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

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

As of the end of November, 2004, 5,018 children in Wisconsin qualified for MA under the Katie Beckett provision.

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

An individual is eligible to participate in the MA purchase plan if: (a) the individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL ($1,939.58 per month for an individual and $2,602.08 per month for a two-person family in 2004); (b) the individual's countable assets under MA financial eligibility rules do not exceed $15,000; (c) the individual has a disability, under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHFS; and (e) the individual is at least 18 years old. As of November, 2004, 7,405 individuals were enrolled in MA under MAPP.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,163.75 for an individual and $1,561.25 for a couple in 2004).

The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the sum of: (a) standard living allowance ($682 per month in calendar year 2005); (b) impairment-related work expenses; and (c) out-of-pocket medical and remedial expenses. The part of the premium based on earned income is equal to 3% of earned income, except that if the deductions for unearned income exceed unearned income, any remaining deductions can be applied to earned income before the 3% premium rate is applied.

Other Eligible Groups

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

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

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

As of November, 2004, there were approximately 48,100 women enrolled in the waiver.

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

Eligible women must be referred through either: (a) the well-woman program, which limits eligibility to women ages 35 through 65 with household income that does not exceed 250% of the FPL; or (b) the family planning waiver, which limits eligibility to women ages 15 through 44, with income that does not exceed 185% of the FPL. Therefore, the age and income requirements for the well-woman program and the family planning waiver program apply to this group of MA recipients. A woman can be determined presumptively eligible for MA under criteria similar to the criteria for determining presumptive eligibility for pregnant women.

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

As of November, 2004, there were approximately 200 women enrolled in MA as a result of a diagnosis of breast or cervical cancer.

People with Tuberculosis. People who have tuberculosis and who meet the income and resource eligibility requirements for SSI are eligible for some MA-covered services. For these individuals, MA coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services; (e) case management services; and (f) services designed to encourage individuals to take their medications. As of November, 2004, there were 200 individuals enrolled in MA under these criteria.

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

Table 4 describes, by eligibility group, the different income and asset qualifications an individual must meet to receive benefits under Wisconsin's MA program in the 2004 calendar year. The income and asset limits shown in the table reflect countable income and assets.

Additional Requirements Affecting Eligibility

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

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

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

The amount of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or request for home- and community-based waiver benefits. Federal law allows states discretion in establishing the asset protection level within maximum and minimum limits ($19,020 to $95,100 as of January 1, 2005). Both federal limits are adjusted annually, based on changes in the consumer price index.

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

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

Table 4: Income Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2004)

FAMILIES, WOMEN AND CHILDREN

CATEGORICALLY NEEDY

AFDC

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

Family Size	Maximum Monthly Net Income*	Income as a % of 2004 FPL
1	$249	32.1%
2	440	42.3
3	518	39.7
4	618	39.3
5	708	38.6
6	766	36.9

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

AFDC-RELATED

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

Family Size	Maximum Monthly Net Income*	Income as a % of 2004 FPL
1	$311	40.1%
2	550	52.8
3	647	49.5
4	772	49.1
5	886	48.3
6	958	45.6

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

HEALTHY START

Pregnant Women and Children Under Age Six

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

Family Size	Maximum Monthly Income	Income as a % of 2004 FPL
1	$1,032	133%
2	1,384	133
3	1,737	133
4	2,089	133
5	2,442	133
6	2,794	133

HEALTHY START

Children Ages Six Through Eighteen

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

Family Size	Maximum Monthly Income	Income as a % of 2004 FPL
1	$775	100%
2	1,041	100
3	1,306	100
4	1,571	100
5	1,836	100
6	2,101	100

MEDICALLY NEEDY

AFDC-RELATED

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

Family Size	Maximum Monthly Income	Income as a % of 2004 FPL
1	$592	76.3%
2	592	56.9
3	689	52.8
4	823	52.4
5	944	51.4
6	1,021	48.6

HEALTHY START

Pregnant Women and Children Under Age Six

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

Family Size	Maximum Monthly Income	Income as a % of 2004 FPL
1	$1,435	185%
2	1,926	185
3	2,416	185
4	2,906	185
5	3,396	185
6	3,887	185

Note: Income levels are those in effect as of January 1, 2004, and federal poverty levels for the 2004 calendar year. The federal poverty level is updated annually in mid-February. There are not asset limits for individuals to qualify under these eligibility categories.

Table 4: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2004) (continued)

ELDERLY, BLIND AND DISABLED INDIVIDUALS AND COUPLES

CATEGORICALLY NEEDY

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

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2004 FPL
1	$2,000	$648[1]	84%
2	3,000	978[2]	94

[1] Assumes that person has actual shelter costs of at least $188.
[2] Assumes that the family has actual shelter costs of at least $282.

MEDICALLY NEEDY

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

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2004 FPL
1	$2,000	$592	76%
2	3,000	592	57

COMMUNITY SPOUSE PROTECTED INCOME AND RESOURCES

- A community spouse of an institutionalized MA-eligible person may retain a certain amount of monthly income and assets that do not have to be used towards the care costs for the institutionalized individual. The spousal asset protection level is the greater of (a) $50,000; or (b) 50% of the couple's resource, up to the federal maximum of $92,760. (The federal minimum spousal asset share amount is $18,552.) 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 $520.42 per month for each qualifying dependent).

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2004 FPL
2	See Text	$2,319	223%

MEDICARE BENEFICIARIES

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

Type	Asset Limit Indiv.	Asset Limit Couple	Maximum Monthly Income Indiv.	Maximum Monthly Income Couple	Benefits Paid
QMB	$4,000	$6,000	$776	$1,041	All Medicare premiums, coinsurance and deductibles.
SLMB	$4,000	$6,000	$931	$1,249	Part B premium.
SLMB+	$4,000	$6,000	$1,048	$1,405	Part B premium.

SPECIAL INCOME LIMIT

- Individuals who are not categorically eligible for MA with income between 100 and 300% of the monthly federal SSI payment level and who are residents of institutional facilities or participating in a community-based waiver program.
- Enrollees are allowed to retain $45 per month if institutionalized or between $744 and $1,692 per month if participating in a community-based waiver program in addition to the community spouse income and resource protections described above.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2004 FPL
1	$2,000	$1,692	300%

MA PURCHASE PLAN

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

Family Size	Maximum Asset Limit	Monthly Income	Monthly Income as a % of 2004 FPL
1	$15,000	$1,940	250%
2	15,000	2,603	250

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

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

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

In addition, spousal impoverishment provisions allow part of the institutional spouse's income to be transferred to the community spouse to provide income for the community spouse. Under federal law, the maximum amount that may be transferred to the community spouse is an amount that would raise the community spouse's total income to $2,377.50 per month as of January 1, 2005. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index (CPI). Additional income may also be transferred to provide for certain dependent family members living with the community spouse or if ordered by a court.

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

Wisconsin establishes its income allowance between the federally-established minimum and maximum amounts. Specifically, Wisconsin's income allowance is the sum of: (a) 200% of the federal poverty level ($2,082 per month in 2004); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the state's standard (shelter costs in excess of $624.50 per month as of January 1, 2005). In addition, Wisconsin currently permits the institutionalized spouse to transfer up to $520.42 per month for each qualifying dependent family member living with the community spouse.

In addition to any amount transferred to the community spouse, the institutionalized spouse may retain income as a personal needs allowance. If the person is in a nursing home, the personal needs allowance is $45 per month. If the individual is enrolled in an MA community-based waiver program, the allowance is higher ($759 and $1,737 per month) to support food, shelter and other costs. Any income in excess of the amount transferred to

the community spouse, the personal needs allowance, health insurance premiums, court-ordered support, and other allowable income deductions, must be used to pay for long-term care costs.

The following example illustrates how the income test is applied in Wisconsin. In 2004, 200% of the FPL for a two-person family was $2,082 per month. If a community spouse has shelter costs of $774.50 per month, the excess shelter costs equal $150 per month ($774.50 - $624.50 = $150). In this case, the maximum monthly income allocation is $2,232 ($2,082 + $150 = $2,232). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,232 per month to determine the spousal income allocation amount ($2,032). If the institutionalized spouse's income is $3,600, the institutionalized spouse's nursing home liability amount would be $1,523 per month [$3,600 (the institutionalized spouse's income) - $2,032 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,523].

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

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

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

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

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

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

divested assets that were part of the community spouse asset share; (d) all of the assets transferred for less than fair market value have been returned to the individual; (e) the division or loss of property occurred as a result of a divorce, separation action, foreclosure, or repossession; or (f) imposition of a penalty would result in an undue hardship. Undue hardship is currently considered as a serious impairment to the institutionalized person's immediate health.

A person may be denied MA coverage of institutional and community-based waiver services, if that person, his or her spouse, or the person's representative disposes of certain assets for less than fair market value or does not receive assets to which he or she is entitled for the purpose of meeting the MA resource test. For instance, if an individual divests within 36 months before he or she applies for MA or enters an institution, the individual may be determined to be ineligible for MA coverage for certain long-term care services, including nursing home services, for a period, beginning during the month of divestment, that is based on the amount of the divestment and the statewide average nursing home cost to a private pay patient ($4,827 per month in calendar year 2004). For example, if an individual divested approximately $100,000, then the penalty period would be 20 months from the time of divestment ($100,000/$4,827) since any fractions are rounded down. The 36-month period is referred to as the "look-back" period and it represents the maximum period the state can look back to determine whether a divestment has occurred. The look-back period is 60 months if a divestment involves a trust.

Two divestment changes were made under 2003 Wisconsin Act 33 including: (a) limiting individuals' ability to use annuities to become eligible for MA by treating annuities as a countable asset if there is a market in which the annuity could be sold; and (b) ensuring that assets transferred to a community spouse are for the sole benefit of the community spouse. In addition, on January 1, 2004, DHFS changed the treatment of jointly-held assets to prevent MA applicants from reducing their countable assets by adding co-owners to their assets. This change ensures that the value of the asset is allocated equally among elderly, blind, and disabled MA applicants only, rather than among all co-owners.

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

Aliens who do not meet requirements for full MA benefits may be eligible for emergency medical services, including labor and delivery services for pregnant women. Emergency treatment lasts from the time of the first treatment for the emergency until the condition is no longer an emergency.

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

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

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

Number of MA Recipients by Group

Table 5 identifies the annual distribution of MA caseload by the four primary groups covered under the program: (a) AFDC and AFDC-related; (b) elderly; (c) disabled and blind; and (d) Healthy Start / Other for fiscal years 1995-96 through 2003-04. For each category, the table provides information on the average number of people enrolled during the fiscal year and the percent of total MA beneficiaries represented by each category.

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

Table 5 shows that the total number of MA beneficiaries decreased significantly from 1995-96 to 1998-99. This decrease was likely due to the elimination of the AFDC program, and with it, automatic eligibility for MA for families enrolled in AFDC. Also, strong economic growth during this time period may have affected the number of individuals that were eligible for the program. The number of individuals enrolled in MA has increased significantly since 1999-00 due to several factors. First, in 1999-00, the state implemented BadgerCare, which increased MA enrollment because some families that applied for BadgerCare were determined to be eligible for MA instead under the Healthy Start eligibility criteria. Second, beginning in 2001-02, economic factors may have made more people, especially families, eligible under the AFDC and AFDC-related and Healthy Start / Other criteria. Third, beginning in January, 2003, DHFS began enrolling women in the family planning waiver. These women are included under the Healthy Start / Other category.

Other trends include a steady decrease in the number of elderly MA recipients, and recent growth in the blind and disabled categories.

Table 5: Average Number of MA Recipients, by Group -- Fiscal Years 1995-96 through 2003-04

	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
AFDC and AFDC-Related									
Average Number	253,068	209,907	153,713	145,832	144,024	146,396	173,442	208,295	229,957
% Change	-8.5%	-17.1%	-26.8%	-5.1%	-1.2%	1.6%	18.5%	20.1%	10.4%
% of Total	53.6%	47.5%	38.1%	36.7%	35.6%	34.6%	37.3%	39.8%	39.6%
Elderly									
Average Number	50,846	49,350	47,759	46,310	45,300	44,108	43,632	42,842	41,600
% Change	-4.1%	-2.9%	-3.2%	-3.0%	-2.2%	-2.6%	-1.1%	-1.8%	-2.9%
% of Total	10.8%	11.2%	11.8%	11.6%	11.2%	10.4%	9.4%	8.2%	7.2%
Disabled / Blind									
Average Number	101,075	101,156	99,630	99,070	97,815	97,689	99,164	102,426	106,518
% Change	1.2%	0.1%	-1.5%	-0.6%	-1.3%	-0.1%	1.5%	3.3%	4.0%
% of Total	21.4%	22.9%	24.7%	24.9%	24.2%	23.1%	21.3%	19.6%	18.4%
Healthy Start / Other									
Average Number	66,785	81,182	102,665	106,322	117,183	134,604	148,745	169,740	202,170
% Change	14.5%	21.6%	26.5%	3.6%	10.2%	14.9%	10.5%	14.1%	19.1%
% of Total	14.2%	18.4%	25.4%	26.7%	29.0%	31.8%	32.0%	32.4%	34.8%
Total									
Average Number	471,775	441,595	403,767	397,533	404,322	422,797	464,983	523,304	580,244
% Change from Previous Year	-3.3%	-6.4%	-8.6%	-1.5%	1.7%	4.6%	10.0%	12.5%	10.9%

CHAPTER 2

COVERED SERVICES AND PROVIDER REIMBURSEMENT

Mandatory and Optional Services

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

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

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

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

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

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

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

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

Medical Necessity

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

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

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

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

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

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

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

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

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

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

Service Limitations

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

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

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

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

cal opinion requirement applies only to non-emergency procedures.

Copayments. Federal regulations permit states to require MA recipients to share in the cost of receiving certain services by paying a flat, nominal fee per service. Providers collect these fees (copayments) from MA recipients, and MA payments for services that require copayments are reduced by a corresponding amount. Federal regulations establish maximum copayments for services and exempt some services and groups of MA recipients from copayment requirements altogether. Currently, these copayments range from $0.50 to $3.00 per visit, service, item or procedure.

Federal Reimbursement Requirements

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

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

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

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

Nursing Homes

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

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

Table 6: MA-Covered Services and Benefits

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

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

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

In 2003-04, MA expenditures for nursing home care, excluding care provided at the state centers for the developmentally disabled, totaled $972.2 million (all funds) representing approximately 26% of gross MA expenditures in that year. According to the 2003 Wisconsin Nursing Homes and Residents report, as of December 31, 2003, there were 403 licensed nursing homes with 40,633 licensed beds in Wisconsin. Of these nursing homes, 398 were skilled nursing facilities, two were ICFs, and three were IMDs. On average, 87.3% of licensed nursing home beds were occupied and 63.9% of nursing home residents were supported by MA in 2003.

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

Nursing facilities are responsible for conducting PASARR Level I screens to identify whether or not an individual is suspected of having a serious mental illness or a developmental disability. Level 2 screens are completed under contract with Behavioral Consulting Services and are a more extensive review that must be completed by appropriate medical professionals, such as psychiatrists and physicians. In fiscal year 2003-04, MA paid for 30,790 Level I screens and 5,869 Level II screens.

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

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

Federal law prohibits states from covering IMD services under their MA programs for individuals

between the ages of 22 to 65. However, Wisconsin provides GPR funding to support a portion of the care cost for these individuals.

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

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

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

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

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

The direct care facility rate is determined by calculating and combining the direct care nursing services allowance and the direct care supplies and services allowance. The direct care nursing rate is determined by comparing actual allowable direct care cost information of the facility (adjusted for inflation) to the direct care nursing target. Facilities are reimbursed for their actual allowable expenses in this category up to the established direct care nursing target. For direct care supplies and services, DHFS establishes a single direct care supplies and services target that is provided to all facilities regardless of actual expenditures. In 2004-05, the direct care nursing base rate is $57.14 per patient day and the direct care supplies and services rate is $9.53 per patient day.

A higher, intense skilled nursing care (ISN) rate is paid to qualifying homes for the care of residents requiring supplemental skilled care due to complex medical conditions. For instance, services for individuals with AIDS or AIDS-related complex (ARC) and individuals who are ventilator-dependent are paid under special per diem rates in lieu of the facility's daily rate. For fiscal year 2004-05, the AIDS/ARC rate was $150 per patient day and the ventilator-dependent rate was $400 per patient day. Facilities may also receive a specialized psychiatric rehabilitative services supplement of $9 per patient day to their daily rate. In order to receive the specialized services supplement, the nursing home must meet the following conditions: (a) prepare a specialized psychiatric rehabilitative services care plan for each resident receiving the services; and (b) complete and submit a Level II PASARR screen every two years that indicates that nursing home care is appropriate and that these specialized services are necessary.

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

For 2004-05, the dietary and environmental services allowance is the sum of $22.85 and an inflation increment of $0.74 per patient day. The administrative and general services allowance is $13.70 plus an inflation increment of $0.42 per patient day and the fuel and utility allowance is the sum of $2.89 plus an inflation increment of $0.12 per patient day.

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

For 2004-05, the payment to a facility for property taxes or municipal service fees was subject to a maximum payment of the previous year tax or fees plus an inflation adjustment factor of 7% for real estate taxes and municipal fees.

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

For 2004-05, DHFS limits the allowed value for most facilities to no more than $55,800 per bed. Facilities that entered into a major phase-down agreement after July 1, 2003, are subject to a limit of $72,000 per bed. Also, allowable property-related expenses cannot exceed 15% of the equalized value

of the facility. If allowable property-related expenses are below 6.0% of allowed value (a minimum amount), the facility's payment rate is equal to the sum of its costs and an efficiency payment equal to 20% of the difference between its costs and the minimum amount. Costs between 6.0% and 7.5% of allowed value are also fully reimbursed but no efficiency payment is provided. For allowable expenses exceeding 7.5% of value, facilities receive 7.5% of allowed value plus 20% to 40% of costs above the target.

Provider Incentives. In 2004-05, nursing homes can receive four types of incentives payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 65% or more of MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.30 per patient day to $2.50 per patient day for facilities with more than 50 beds and from $1.50 to $4.00 per patient day for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA/Medicare increases). A separate incentive payment is available for facilities located within the City of Milwaukee that ranges from $1.45 per patient day to $4.40 per patient day.

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

Third, an incentive payment is provided to facilities that complete an approved remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy. The incentive payment is made for two years and is equal to 25% of the lesser of the approved projected cost or 25% of the actual cost of the project per year for two years.

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

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

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

County Supplemental Payments. County- and municipally-operated nursing facilities and Family Care care management organization (CMO) counties with nursing home operating costs that are not fully reimbursed by the MA per diem rate described above are eligible to apply for supplemental MA funding. Under 2003 Wisconsin Act 33, $37.1 million in both 2003-04 and 2004-05 was budgeted to support supplemental payments to

these facilities. In addition to these amounts, 2003 Wisconsin Act 100 requires DHFS to allocate, in each year of the 2003-05 biennium, any additional revenue the state receives above the Act 33 budgeted amounts as a result of nursing home intergovernmental transfer (IGT) claiming to support supplemental MA payments to county and municipal nursing homes. In 2003-04, approximately $13.0 million in additional supplemental payments were made to county and municipal nursing homes and to Family Care CMO counties as a result of 2003 Wisconsin Act 100.

In order to distribute these supplemental funds, DHFS currently determines: (1) the projected overall operating deficits for each county and municipal home (the difference between allowable costs per patient day and MA payments per day); (2) the projected direct care operating deficit (the difference between allowable costs per patient day and MA payments per day); (3) the eligible direct care deficit for each county and municipal home (the lesser of the overall operating deficit and the direct care deficit); (4) the non-direct care operating deficit (the difference between the projected overall operating deficit and the projected direct care operating deficit); and (5) transfer agreement participation payments equal to $100,000 per year for each of the counties participating in the IGT (Walworth, Sheboygan and Rock Counties).

DHFS then distributes the supplemental funds by: (1) allocating the transfer agreement payment to counties participating in the wire transfer; (2) summing the Medicare gap (the difference between what Medicare would pay for services and what MA would pay for those services) for all facilities; (3) allocating the remaining funds proportionally to the Medicare gap; (4) limiting any individual awards to the facility's eligible direct care deficit per day; and (5) repeating the previous two steps until all of the funds are allocated. If supplemental funding remains after all eligible facilities have been reimbursed for their direct care deficits, the same process is followed to address any non-direct care deficits. In 2003-04, $50.1 million in supplemental payments were made to county-operated facilities and to Family Care CMOs. After accounting for the supplemental payments, counties had unreimbursed expenses of approximately $81.4 million. Appendix I identifies actual supplemental MA payments to county- and municipally-operated nursing homes by county and payments made to Family Care CMOs in 2003-04.

Reimbursement for State Facilities. MA payments for care provided at the state centers for the developmentally disabled and the Veterans Home at King is determined by DHFS separately from the methods established for all other nursing facilities. The state centers and the Veterans Home are paid based on their actual and allowable costs plus the MA access incentive, except that payment cannot exceed the Medicare upper limit or the amount appropriated by state law. Interim payment rates are established for these facilities, but a cost reconciliation is done at the end of the state fiscal year to adjust payments to actual costs within the general limitations. For the 2004-05 fiscal year, approximately $108.3 million is budgeted to support MA payments to the three state centers and $19 million to support MA payments to the Veterans Homes at King and Union Grove.

State Supplement for IMD Nursing Homes. Although federal law does not permit states to use federal MA funds to support services for individuals between the ages of 22 ad 65 in IMDs, Wisconsin provides state funding for counties to support a portion of the costs of care for this population. The state provides a GPR supplement of $9 per person per day to support the care of individuals who receive specialized mental health services in an institutional setting under the nursing home reimbursement formula. In addition, DHFS distributes $10,914,700 GPR in each fiscal year to assist counties in supporting residents of IMDs and individuals relocated from IMDs to community-based treatment programs. Another $830,000 annually is budgeted to support relocation services for individuals who have a mental illness, are otherwise eligible for MA, and are in need of active treatment

but whose needs can be met in the community.

Hospitals

Inpatient Services. In fiscal year 2003-04, MA payments for inpatient hospital services totaled approximately $323.3 million, representing approximately 7.7% of total MA expenditures in that year.

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

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

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

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

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

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

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

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

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

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

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

In order for a hospital to receive its disproportionate share adjustment, it must have at least two

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

In fiscal year 2003-04, 23 hospitals qualified for disproportionate share rate adjustments totaling approximately $10.0 million in 2003-04. In addition, two types of supplemental payments -- payments to hospitals in Milwaukee County under the general assistance medical program and to essential access city hospitals -- that are described later in this section, are considered disproportionate share payments.

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

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

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

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

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

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

In 2003-04, the MA program paid approximately $1.4 million to 27 hospitals as rural hospital DRG adjustments.

Direct Medical Education Payments. Adjustments for direct graduate medical education (GME) costs are added to certain hospitals' base DRG rates to partially reimburse these hospitals for costs directly related to operating a medical education program. Direct GME costs are those costs associated with payment of salaries and fringe benefits for residents and interns. Hospitals located in Wisconsin are eligible for this payment.

Under provisions in 2003 Wisconsin Act 33, funding for direct GME adjustments was reduced on a one-time basis in 2003-04 to approximately $2.4 million. However, based on claims submitted, the actual amount spent on direct GME payment adjustments for 32 hospitals totaled $3.4 million. Under Act 33, $9.7 million is budgeted to support these payments in 2004-05, which is equal to the amount that had been budgeted for these payments before 2003-04.

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

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

necessity of resources and the length of stay for all outlier cases before it makes an outlier payment. In 2003-04, MA paid hospitals approximately $52.3 million in outlier payments for inpatient services.

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

Three privately-operated rehabilitation hospitals, Sacred Heart Rehabilitation Hospital in the City of Milwaukee, Lakeview Rehabilitation Hospital in the Village of Waterford, and Bethesda Lutheran Hospital in St. Paul, Minnesota, are paid on a per diem basis to reflect the special nature of the patient mix at these facilities, which usually require long lengths of stay.

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

CAHs are initially paid interim rates as claims are submitted throughout the year. Once DHFS receives a final cost report for the fiscal year, a final payment adjustment is made to ensure that the CAH is paid its reasonable costs. CAHs are not eligible for supplemental payments or other payment adjustments, since their reimbursement is limited to its reasonable costs. In 2003-04, there were 39 hospitals in Wisconsin that were certified as CAHs. These hospitals received reimbursements totaling approximately $14.6 million in that year for both inpatient and outpatient services.

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

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

Minor border status hospitals do not meet the criteria for a major border status hospital. These hospitals are reimbursed under a DRG payment methodology, but their payment is based on a standard DRG base rate without adjustments for

hospital-specific differences. However, these hospitals can request an administrative adjustment to their payment that would consider such differences.

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

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

- Customary outpatient charges in the final settlement year; or

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

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

The outpatient rate per visit is based on a hospital's outpatient cost per visit, as documented in an audited cost report, which is inflated to the current fiscal year and adjusted to reflect the amount of funding available and other limits on outpatient hospital payments. In 2003-04, payments to hospitals for outpatient services totaled approximately $80.8 million.

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

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

General Relief/Inter-Governmental Transfer Payments. DHFS makes supplemental MA payments to hospitals that have at least: (a) 13% of their annual operating costs attributable to MA recipients and low-income individuals covered by a county administered general assistance medical program (GAMP), of which at least two percent is attributable to services provided to GAMP participants; or (b) $5.0 million of its annual operating expenses attributable to services provided to MA recipients

and GAMP participants, of which at least $3.5 million must be attributable to GAMP participants. In addition, the hospital must have an MA inpatient utilization rate of at least one percent, a contract with Milwaukee County to serve individuals covered by GAMP, and at least two obstetricians with staff privileges that have agreed to provide obstetrical care to MA recipients, unless the hospital predominately serves patients under age 18 or the hospital did not provide non-emergency obstetrical care as of December 21, 1987.

In 2003-04, five hospitals in Milwaukee County received a total of $27.8 million in general relief supplement payments. Of this amount, approximately $6.1 million was GPR, approximately $17.0 million was FED, and $4.7 million was program revenue received as an inter-governmental transfer (IGT) from Milwaukee County. The IGT payment is used as the state's match for a portion of the supplemental payment.

Pediatric Inpatient Supplement. DHFS makes supplemental payments to acute care hospitals in Wisconsin that provide a significant amount of services to individuals under the age of 18. In order to qualify for the supplement, a hospital must: (a) be an acute care hospital located in Wisconsin; and (b) have inpatient days for stays in the hospital's acute and intensive care pediatric units that exceed 12,000 days in the second calendar year preceding the hospital's fiscal year. For 2003-04, this calculation is based on a hospital's inpatient days in the hospital's fiscal year that ends in calendar year 2001. Days for neonatal intensive care units are not included in this determination.

The pediatric supplement is limited to $2.0 million annually. In 2003-04, Children's Hospital of Wisconsin received approximately $1.7 million and University of Wisconsin Hospital received approximately $263,000 as a pediatric inpatient supplemental payment.

Managed Care Supplement. Hospitals participating in the state's MA managed care initiative are eligible to receive supplemental payments of up to $250,000 annually. To be eligible, a hospital must qualify for a DRG disproportionate share adjustment, have more than 9.0% of its patient days for newborns, be located in a county other than Milwaukee County, participate in MA managed care for that year, and be a major provider of managed care services to MA recipients in that county. In 2003-04, St. Luke's Memorial Hospital in Racine County received the full amount of the supplement.

Border/Metropolitan Statistical Area Supplement. A Wisconsin hospital located within an MSA that has its primary urban area located outside of Wisconsin may be eligible for a supplement totaling up to $250,000. The total amount paid is based on each qualifying hospitals' outpatient services provided to Wisconsin MA recipients. Four hospitals received this supplement in 2003-04 totaling approximately $130,000.

Other Services

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

Physicians must obtain prior authorization before they perform selected surgeries or provide injections related to infertility treatment. In addition, medical services that are considered by DHFS to be obsolete, unnecessary or ineffective are not covered. Among these services are acupuncture, artificial insemination, cosmetic services, personal comfort items and vitamin C injections. Further, MA does not cover services that are considered to be experimental in nature. A service is considered experimental if DHFS has determined that the proce-

dure or service is not generally recognized by the professional medical community as effective or proven treatment for the condition for which it is being used.

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

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

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

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

Rural Health Clinic Services. Rural health clinics (RHCs) are Medicare-certified outpatient health clinics located in rural areas with a shortage of personal health services or primary medical care professionals, as determined by the U.S. Department of Health and Human Services. Each RHC is operated under the medical direction of a physician and is staffed by at least one nurse practitioner or physician assistant. A physician, physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner may furnish services. RHC services are primary care services provided by RHC-approved professionals that meet all applicable MA eligibility requirements. For clinics based in hospitals with fewer than 50 beds, MA pays 100% of the clinics' reasonable costs for services. For other clinics, the MA payment is limited to the Medicare per visit rate for rural health clinic services. For the most recent audited year of 2002, the Medicare per visit rate is $64.78. In 2003-04, there were 66 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health

clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. FQHCs are currently paid 100% of their reasonable costs, recognizing that FQHCs serve a disproportionate share of the state's MA, Medicare, and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 28 FQHCs operating in Wisconsin, including 18 centers operating under federal grants from the U.S. Public Health Service**,** nine Indian tribal clinics, and one health center that meets the operating requirements of federally-funded community health centers but does not receive federal operating grants (a "look-alike" FQHC).

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

Home Health Services. Home health services are nursing and home health aide services provided in an individual's home.

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

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

All home health services must be provided in accordance with orders from the client's physician in a written plan of care. A physician must periodically review the plan according to specified guidelines or when the client's medical condition changes.

Home health services are provided by home health agencies, which must be licensed to provide home health services under Medicare, and be licensed by DHFS. In addition to home health services, home health agencies may provide physical and occupational therapy services, speech and language pathology services, private duty nursing, respiratory care services, and personal care services.

MA payment for home health services is based on the lesser of a home health agency's usual and customary charges or a maximum allowable fee schedule determined by DHFS, which is established as a rate per visit.

Private-Duty Nursing Services. These services are medically necessary skilled-nursing services for individuals who require eight or more hours of direct, skilled-nursing services per calendar day. Home health agencies and nurses in independent practice can be certified to provide private-duty nursing services. All providers must receive prior authorization before providing these services to MA recipients. Providers are reimbursed on an hourly basis.

Respiratory Care Services. Skilled nursing services are provided under the private duty nursing benefit to individuals residing at home who are ventilator-dependent for life support. Respiratory care services include airway management, oxygen therapy, respiratory assessment, ventilator management, and various modes of ventilatory support, and operation and interpretation of monitoring devices. A home health agency or a nurse in independent practice can be certified to provide these services, but a registered nurse or a licensed practical nurse must perform the services. All respiratory care services require prior authorization. Reimbursement rates are established on an hourly basis.

Personal Care Services. These services are related to assisting an individual with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services may only be provided under the written orders of a physician. Covered personal care services include assistance with specific activities of daily living (such as eating, dressing and bathing), meal preparation, and accompanying an individual to obtain medical diagnosis and treatment.

Home health agencies, certain county agencies, and independent living centers that receive state and federal funding can be certified to provide personal care services. Prior authorization is required: (a) for any recipient to receive more than 50 hours of personal care services in a calendar year; and (b) for all personal care hours provided to a recipient that is also receiving private-duty nursing or respiratory care services. Reimbursement rates are established on an hourly basis.

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

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

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

Dental Services. Wisconsin's MA program covers basic dental services within the following categories of service: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) orthodontics; and (i) adjunctive general services. Limitations apply to the frequency and type of covered dental services. For example, examinations and teeth cleanings are limited to twice per year for children through the age of 12. For clients 13 years of age and older, clean-

ings are limited to twice per year and exams are limited to once per year. A tooth extraction is only covered in cases of a medical emergency or when it is necessary for orthodontia. Orthodontic services are provided only to children up to age 20 with cases of severe malocclusion and only after the orthodontist receives prior authorization. MA payment for dental services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prior authorization is required for both mental health and substance abuse outpatient services if MA payments for services exceed $500 or after 15

hours of services are provided to a recipient in a calendar year.

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

Nurse Practitioner Services. Wisconsin's MA program covers nursing services within the scope of practice and delegated medical acts and services provided under protocols, collaborative agreements, or written or verbal orders from a physician. Such services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a medical setting, the recipient's home or elsewhere. Nurse practitioners and clinical nurse specialists, like physicians, are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

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

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

Reimbursement Rate. DHFS reimburses pharmacists and physicians licensed to practice medicine and surgery for all covered prescription drugs at the lesser of: (a) the usual and customary charge; or (b) the estimated acquisition cost (EAC) plus a dispensing fee. The EAC for brand name and not readily-available generic drugs is equivalent to the average wholesale price (AWP), as reported by pharmaceutical manufacturers, less a discount. In 2004-05, the amount of the discount is 13%. The EAC for readily-available generic drugs is determined based on the maximum allowable cost (MAC) list, which is developed by DHFS.

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

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

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

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

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

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

As of December, 2004, DHFS had developed a plan to implement a PDL for 24 classes of drugs. The Department's decisions regarding the list of preferred medications are based on a review of the relative clinical effectiveness and cost of products within these therapeutic classes. Appendix II identifies the implementation schedule.

In addition to the therapeutic classes for which a preferred drug list has been or will be developed, the MA program currently requires prior authorization for certain drugs in drug categories to determine their medical necessity. Appendix III lists these drug categories.

Medicare Prescription Drug Benefit and MA Recipients. Beginning January 1, 2006, MA recipients that are eligible for all MA services and eligible for Medicare ("dual eligibles"), will no longer receive drug coverage under MA. Rather, they will receive drug coverage under the new Medicare prescription drug benefit (Medicare Part D) authorized in the 2003 Medicare Prescription Drug and Program Improvement Act of 2003 (P.L. 108-173). Currently, state MA programs pay 100% of the prescription drug costs for these individuals. Under provisions in P.L. 108-173, even though the Medicare benefit will be administered by private prescription drug plans under requirements of the Medicare program, MA will pay for prescription drug costs for these individuals. Beginning in 2006, each state's MA contribution will be 90% of the state's share of per capita MA expenditures on prescription drugs covered under Medicare Part D for dual eligibles during 2003, trended forward. The state contribution will be reduced in each year until 2015, when state MA programs will be responsible for 75% of these costs.

It is estimated that as many as 115,000 MA recipients will receive drug coverage under the Medicare Part D benefit, rather than MA, beginning in January, 2006. P.L. 108-173 provides that cost-sharing would be limited for these beneficiaries to $1 for generic medications and $3 for brand-name medications, the current copayments required under MA. However, there may be differences between the drugs covered by the private prescription drug plans that administer the Medicare drug benefit in Wisconsin and the drugs cur-

rently covered under MA. States can choose to wraparound the Medicare coverage, but, with limited exceptions, these costs are not eligible for federal MA matching funds.

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

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

Community-Based Psychosocial Services. Beginning in 2004-05, a new benefit, community-based psychosocial services, sometimes referred to as comprehensive community services (CCS), is available to MA recipients with mental health or substance abuse conditions, as a county-funded service. Counties must elect to provide the service and provide the state's share of the costs of the benefit. Recipients must have impairment in major areas of community living, as evidenced by the need for ongoing and comprehensive services of either high-intensity or low-intensity nature. Services can include medical and remedial services and supportive activities intended to provide for a maximum reduction of the effects of the individual's mental health or substance abuse condition and restoration to the best possible level of functioning and to facilitate the individual's recovery. An MA recipient must have a physician's prescription to receive these services. All services must be consistent with needs identified through a comprehensive assessment. The assessment is completed by a recovery team made up of the individual, a licensed mental health professional, the individual's family, and others as appropriate.

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

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

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

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

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

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

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

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

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

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

prior authorization.

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

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

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

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

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

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

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

CHAPTER 3

MANAGED CARE FOR LOW-INCOME FAMILIES

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

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

As of November, 2004, 14 HMOs were providing health care services to approximately 348,200 individuals enrolled in MA (285,600) and BadgerCare (62,600). Table 7 lists the participating HMOs and their enrollment as of November, 2004.

Enrollment. HMOs do not serve MA and BadgerCare recipients in all areas of the state. Under federal law, unless a state obtains a waiver, it cannot require an MA recipient to enroll in an HMO unless the recipient has a choice of at least two HMOs. If only one HMO offers services in an area, the recipient has the option to enroll in the HMO or receive services on a fee-for-service basis.

Table 7: HMOs with MA and BadgerCare Enrollees

HMO	November, 2004 Enrollment
Abri Health Plan	215
Atrium Health Plan	28,283
Dean Health Plan	11,947
Group Health Cooperative of Eau Claire	13,931
Group Health Cooperative of South Central WI	2,868
Health Tradition Health Plan	5,557
Managed Health Services	118,235
MercyCare Health Plan	8,894
Network Health Plan	47,894
Security Health Plan	20,257
Touchpoint Health Plan	19,502
United Healthcare of WI	66,163
Unity Health Plan	3,488
Valley Health Plan	963
Total	348,197

In areas where no HMOs offer services, all MA and BadgerCare recipients receive services on a fee-for-service basis.

Appendix IV provides information, by county, on the enrollment status of this population, as of October, 2004.

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

Services. MA and BadgerCare recipients that are enrolled in HMOs are entitled to receive, as needed, all services that are available to MA recipi-

ents who are not enrolled in HMOs. HMOs have the option of covering dental and chiropractic services. In 2004, HMOs serving Milwaukee, Waukesha, Racine, and Kenosha Counties chose to cover dental services for enrollees in those counties. Of the 14 HMOs, five chose to cover chiropractic services. Recipients enrolled in HMOs that do not cover dental and chiropractic services may obtain these services from MA-certified providers on a fee-for-services basis.

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

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

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

Table 8 identifies aggregated capitation rates the state paid to HMOs for serving MA and BadgerCare recipients in each of these 14 regions during the period from May through December, 2004. The combined rate identified in the table represents the total amount an HMO would be paid per enrollee if the HMO elected to cover dental and chiropractic care.

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

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

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

Table 8: Aggregated Monthly HMO Rates for MA and BadgerCare Enrollees Effective May thru December, 2004

County or Region	Base Capitation Rate	Dental	Chiropractic	Combined Rate
AFDC/Healthy Start Children				
Region 1 (Duluth / Superior)	$129.58	$5.96	$0.95	$136.49
Region 2 (Wausau / Rhinelander)	128.63	5.43	0.87	134.93
Region 3 (Green Bay)	122.34	5.62	0.76	128.72
Region 4 (Twin Cities)	132.48	7.92	1.77	142.17
Region 5 (Marshfield / Steven Pt)	126.91	6.10	0.81	133.82
Region 6 (Appleton / Oshkosh)	123.10	5.78	0.86	129.74
Region 7 (La Crosse)	121.40	6.03	1.11	128.54
Region 8 (Madison / South Central)	139.15	6.64	0.53	146.32
Region 9 (Southeast)	131.51	5.66	0.45	137.62
Region 10 (Milwaukee County)	142.41	5.37	0.15	147.93
Region 11 (Dane County)	126.41	4.34	0.59	131.34
Region 12 (Eau Claire)	124.54	6.02	2.12	132.68
Region 13 (Kenosha)	138.21	6.98	0.24	145.43
Region 14 (Waukesha)	146.53	6.33	0.64	153.50
Healthy Start Pregnant Women				
Region 1 (Duluth / Superior)	$622.40	$6.33	$1.07	$629.80
Region 2 (Wausau / Rhinelander)	594.31	3.40	1.32	599.03
Region 3 (Green Bay)	587.12	3.48	0.62	591.22
Region 4 (Twin Cities)	590.88	6.56	1.65	599.09
Region 5 (Marshfield / Steven Pt)	607.58	3.82	1.23	612.63
Region 6 (Appleton / Oshkosh)	585.20	4.65	0.67	590.52
Region 7 (La Crosse)	592.64	5.08	1.23	598.95
Region 8 (Madison / South Central)	612.58	4.85	0.62	618.05
Region 9 (Southeast)	599.59	3.38	0.57	603.54
Region 10 (Milwaukee County)	720.56	1.95	0.21	722.72
Region 11 (Dane County)	655.60	2.60	0.44	658.64
Region 12 (Eau Claire)	715.82	3.07	1.88	720.77
Region 13 (Kenosha)	663.02	4.83	0.15	668.00
Region 14 (Waukesha)	611.77	4.05	0.29	616.11
BadgerCare				
Region 1 (Duluth / Superior)	$140.48	$6.46	$1.02	$136.49
Region 2 (Wausau / Rhinelander)	145.23	6.12	0.98	152.33
Region 3 (Green Bay)	141.07	6.47	0.85	148.39
Region 4 (Twin Cities)	133.45	7.98	1.78	143.21
Region 5 (Marshfield / Steven Pt)	138.97	6.64	0.90	146.51
Region 6 (Appleton / Oshkosh)	129.64	6.10	0.91	136.65
Region 7 (La Crosse)	120.98	6.00	1.10	128.08
Region 8 (Madison / South Central)	135.95	6.48	0.50	142.93
Region 9 (Southeast)	139.53	6.01	0.47	146.01
Region 10 (Milwaukee County)	145.15	5.49	0.15	150.79
Region 11 (Dane County)	134.76	4.60	0.60	139.96
Region 12 (Eau Claire)	136.19	6.59	2.30	145.08
Region 13 (Kenosha)	143.54	7.28	0.25	151.07
Region 14 (Waukesha)	162.37	7.02	0.73	170.12

whether the providers are accepting new patients and where full or part-time coverage is available.

Quality. Federal regulations require states to have a written strategy for assessing and improving the quality of managed care services provided by all HMOs and must periodically review the effectiveness of that strategy and update it as

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

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

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

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

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

Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS). DHFS tracks quality improvement through MEDDIC-MS, a set of standardized criteria for the uniform measurement of health care services provided to MA and BadgerCare recipients who are enrolled in managed care. The system uses validated encounter data, reported by HMOs, to measure HMOs' performance against several quality standards, including inpatient hospital services and emergency room use by asthma patients, blood lead toxicity screenings for children, preventive dental services, diabetes care, childhood immunization, mammography screenings, and maternity care. Using these data, in February, 2004, DHFS released reports

comparing HMO performance in aggregate, and by HMO. With limited exceptions, these data do not compare performance among the HMOs with providers serving MA and BadgerCare recipients under fee-for-service, since the population served under fee-for-service is not comparable to the population served in managed care.

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

Consumer Satisfaction Survey. DHFS conducts a survey of HMO enrollees using a standardized survey, CAHPS (consumer assessment of health plans), with some state-specific modifications. This survey measures enrollees' assessment of the quality of care provided by HMOs. In December, 2003, DHFS published a report on the results of the survey, which indicates at least 80% of enrollees were satisfied on seven key indicators. HMOs performance was highest in the "getting needed care" and "helpful clinic office staff" indicators. Lowest performance was indicated for "quality of HMO" and "HMO customer service" indicators.

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

HealthCheck Screenings. The state's contracts with HMOs provide a financial incentive for HMOs to conduct HealthCheck screenings. Each HMO must report to DHFS the number of HealthCheck screens that it provides for MA- and BadgerCare-eligible children enrolled in the HMO. If an HMO fails to screen at least 80% of the number of expected screens, as calculated according to the contract, DHFS penalizes the HMO by recouping MA payments from the HMO. For calendar year 2001, the most recent year for which information is available, the state recouped approximately $1.7 million from HMOs that failed to meet the 80% standard. DHFS expects to recover a similar amount based on the HealthCheck screens HMOs conducted in calendar year 2002.

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

Promotion of Accreditation Programs. DHFS en-

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

Other Managed Care Programs

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

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

Under CCF, DHFS contracts with Dane County, which in turn, contracts with CCF Managed Care, Inc., a limited service health organization, to arrange services for program clients. In calendar year 2004, the total capitation rate was approximately $3,485 per child per month, of which, approximately $1,540 was paid by MA and the remainder was paid by Dane County. The amount paid by MA reflects an estimate of the amount MA would have paid for services to these children if, instead, they received services under the MA fee-for-service system. As of November, 2004, 110 children were enrolled in CCF.

Milwaukee County's Children and Adolescent Treatment Center operates the Wraparound Milwaukee program. MA pays a monthly capitation rate of $1,557 to support the cost of MA services to children participating in the program. Milwaukee County and the DHFS Bureau of Milwaukee Child Welfare contribute funds to pay for those costs not covered by MA or for costs of children not eligible for MA. As of November, 2004, 496 children were enrolled in the Wraparound Milwaukee program.

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

health care, including physical and behavioral health services, to children in out-of-home care in Milwaukee County.

DHFS issued a request-for-proposal in July, 2004 to select an MCO that would serve children under the project. In January, 2005, DHFS will award a contract to an MCO that was chosen as part of a competitive procurement process. Enrollment is expected to begin in May, 2005.

In 2004-05, capitation payments are expected to range from $200 to $600 per child per month depending on the age of the child and whether he or she is in foster care, kinship care, or subsidized adoption. However, these rates may be revised based on negotiations with CMS and the MCO.

CHAPTER 4

COMMUNITY-BASED LONG-TERM CARE PROGRAMS

Introduction

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

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

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

In 2003-04, the state spent approximately $2.1 billion (all funds) to provide long-term care services to Wisconsin residents, including approximately $1.1 billion (52%) on institutional care, and $1.0 billion (48%) on community-based long-term care services, as shown in Table 9.

Table 9: Expenditures for Selected Long-Term Care Services -- Fiscal Year 2003-04 (All Funds)

Program / Service	Amount
MA Waivers, excluding COP-W	$346,257,100
COP and COP-W	144,527,600
Family Care Capitation Payments*	198,888,000
I-Care	57,066,900
PACE / Partnership	80,496,000
MA Card Home Care	193,080,400
Total**	$1,020,316,000
Total Institutional Care ***	$1,115,200,000
All Long-Term Care	$2,135,516,000

*Includes Non-MA capitation payments
**Excludes encumbrances
***Including the State Centers and the Veterans Homes

Long-Term Care Managed Care Programs

Family Care

The Family Care program is a comprehensive long-term care program that was created to im-

prove the quality of long-term care services individuals receive, provide individuals with more choices and greater access to services, and to be a cost-effective system for delivering long-term care services. The program, which provides comprehensive services to elderly, physically disabled, and developmentally disabled individuals, operates under four federal waivers. Approximately $209.5 million was expended on the Family Care program in 2003-04.

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

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

Currently, nine counties operate resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau), while five counties operate CMOs (Fond du Lac, La Crosse, Milwaukee, Portage and Richland). Four of the CMOs (Fond du Lac, La Crosse, Portage, and Richland) provide services to individuals who are elderly, developmentally disabled, and physically disabled. The Milwaukee County CMO serves only the elderly population.

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

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

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

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

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

c. The person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the

date that the Family Care benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by DHFS, funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county.

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

The deductions and allowances for non-MA Family Care are more generous than under MA so that individuals who are not eligible for MA may still be eligible for Family Care. For example, Family Care allows a deduction for countable assets of either $9,000 (for nursing home, CBRF, or adult family home residents), or $12,000 (for individuals who reside in their own home or in residential care apartment complexes (RCACs), compared to the $2,000 or $3,000 exclusion under MA. In addition, Family Care provides a monthly deduction for earned income that is equal to the first $200 of earned income plus two-thirds of earned income in excess of $200, whereas MA allows a deduction of $65 plus one-half of earned income in excess of $65. Family Care also allows a slightly higher personal needs allowance of $65 per month for individuals in nursing homes, CBRFs, and adult family homes, compared to $45 per month allowed for other MA nursing home residents. The personal needs allowance for individuals in their own home or in an RCAC is a minimum of $759 and a maximum of $1,737 per month in 2005 (the same as for MA waiver participants).

The Family Care benefit is not an entitlement for non-MA eligible persons and the provision of services is limited by program funding. Services provided to non-MA eligible participants are supported entirely by GPR funds. Beginning May 1, 2003, DHFS instructed CMOs to no longer enroll most non-MA eligible applicants until further notice. As of June 30, 2004, 170 (1.9%) of the 8,900 Family Care enrollees were not eligible for MA.

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

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

Resource centers must provide the following services:

- Information, referral services, and assistance at convenient hours;
- A determination of functional eligibility for the Family Care benefit;
- Prevention and early intervention services;
- Benefits counseling;
- A determination of financial eligibility and cost sharing for an individual who is seeking long-

term care services;

- Long-term care options counseling;

- Assistance in enrolling in a CMO, if desired;

- Equitable assignment of waiting list priorities for the non-MA eligible Family Care population;

- Assessment of risk for individuals on a waiting list and development of an interim plan of care;

- Transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system;

- Access to SSI, MA and FoodShare; and

- Assurance of prompt responses to emergency calls, 24 hours a day.

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

Funding

Two separate entities provide direct services under Family Care. First, resource centers provide the preliminary services of providing information, screening, eligibility determinations and enrollment. Second, CMOs develop an individualized service plan and provide long-term care services under the Family Care benefit. Resource centers are reimbursed under a different mechanism than are CMOs.

Resource Centers. The resource center contract assigns responsibilities to each resource center. The contract allows a resource center to be reimbursed for its costs in carrying out these required functions, subject to an upper reimbursement limit. If actual costs exceed this limit, the resource center is responsible for those costs. Thus, the resource center assumes some financial risk in carrying out its functions. As an incentive to test new methods to improve long-term care, resource centers can also apply for "prevention grants" to test programs aimed at preventing conditions, such as improper nutrition, that contribute to a decline in functional ability. Table 10 lists the maximum contract amounts for the nine resource centers for calendar year 2005. In 2003-04, the costs of operating resource centers totaled approximately $8.8 million.

Table 10: Resource Centers -- Maximum Calendar Year 2005 Contract Amounts (All Funds)

County	Contract Amount	Prevention Grant
Fond du Lac	$792,400	$0
Jackson	287,300	0
Kenosha	1,081,500	147,400
La Crosse	1,071,900	52,000
Marathon	885,400	145,300
Milwaukee	3,386,800	249,000
Portage	617,600	99,900
Richland	320,900	0
Trempealeau	328,900	68,600
Total	$8,772,700	$762,200

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

The calendar year 2005 rates at the comprehensive level vary from a low of $1,829 per month in La Crosse County to a high of $2,321 per month in

Portage County. The intermediate rate is the same for all five CMOs -- $691 per month.

In 2003-04, payments to CMOs totaled approximately $198.9 million, including $6.0 million to support non-MA eligible individuals. Table 11 summarizes the capitation rates, enrollment and MA cost estimates by county for 2004-05.

Table 11: CMO Capitation Rates, Enrollments and Budgeted Expenditures

County	Comprehensive Rates CY 2005	November, 2004 Enrollment	2004-05 Budget (All Funds)
Fond du Lac	$2,121	959	$23,497,200
La Crosse	1,829	1,598	36,880,600
Portage	2,321	760	26,625,300
Milwaukee	2,055	5,446	122,237,100
Richland	2,140	293	8,760,900
Total		9,056	$218,001,100

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

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

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

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

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

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

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

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

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

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

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

opmental disabilities;

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

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

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

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

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

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

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

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

Access. (1) The long-term care functional screen is an accurate and reliable instrument for assessing eligibility; (2) the use of independent, third-party "enrollment consultants" to ensure individuals fully understand the Family Care program and eligibility for other long-term services is valuable; (3) a major accomplishment of the program was elimination of wait lists in the CMO counties by the end of calendar year 2002; (4) access monitoring activities need to be strengthened; (5) CMOs appear to meet requirements for health services availability, accessibility, adequacy, and access performance standards; (6) the number of providers participating in the MA program may have increased; (7) reliance on emergency room utilization did not significantly change over time; (8) the frequency of visits to physicians and hospital lengths of stay decreased; and (9) DHFS must continue developing strategies to better track and understand reasons for disenrollments.

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

Cost Effectiveness. In order to evaluate the cost-effectiveness of the Family Care program, APS reviewed service utilization and expenditure data: (a) for Family Care participants before and after they enrolled; (b) for Family Care participants and compared data to similar groups of MA recipients that

did not participate in Family Care; and (c) at the county level and at the individual level.

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

Independent Care Program

Since 1994, the independent care (I-Care) program has provided coordinated medical and social services for SSI-related MA enrollees ages 18 and older in Milwaukee County. Under the program, care coordinators assess the medical, behavioral health and social needs of recipients and develop case plans with enrollees and their providers. Individuals enrolled in I-Care receive certain benefits that are not available to MA recipients who receive services on a fee-for-service basis, including ongoing care coordination services, exemption from copayments, more convenient access to transportation, and access to certain non-standard services.

In 2004, the MA program paid I-Care under a 32-cell rate structure. The rates reflect risk-adjusted rates for enrollee age and gender. The age and gender adjusted rates are based on a four-cell rate structure that is sensitive to cost variances based on an enrollee's eligibility group and Medicare status. In 2004, the MA program paid I-Care a base capitation rate of $827 per month for MA-only eligible individuals enrolled in the program who received SSI cash payments, $529 per month for Medicare-eligible individuals who received SSI cash payments, $1,143 per month for MA-only eligible individuals who did not receive SSI cash payments, and $522 per month for Medicare-eligible individuals who did not receive SSI cash assistance. In calendar year 2004, the average base capitation rate was $716 per month. As of November, 2004, there were 6,116 individuals enrolled in the program. Approximately $56.3 million (all funds) is budgeted to support I-Care capitation payments in 2004-05.

PACE/Wisconsin Partnership Program

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

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

individuals, while the WPP also serves individuals with physical disabilities.

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

The MA capitation rates DHFS pays to provide services vary by site. In 2004, these capitation rates ranged from $2,722 for elderly persons at ElderCare in Dane County to $5,375 for persons with developmental disabilities at the Community Living Alliance in Dane County. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services. The MA capitation rate reflects an estimated 5% savings from the average fee-for-service equivalent for nursing home care. Table 12 lists the range of capitation rates, enrollment, and actual expenditures for each of the PACE/WPP sites.

Table 12: PACE/WPP Capitation Rates, Enrollments and Expenditures

Site	Calendar Year 2004 Rates	Nov., 2004 Enrollment	2003-04* Expenditures
CCO	$2,989 to $4,811	830	$29,791,900
Elder Care	$2,722 to $4,015	479	15,736,700
CLA	$4,546 to $5,375	283	15,315,000
CHP	$2,739 to $5,274	599	19,497,300
Total		2,191	$80,340,900

*All funds amounts

SSI Managed Care Expansion

2003 Wisconsin Act 33 reduced MA benefits funding to reflect projected savings that would result from requiring certain adults who are eligible for supplemental security income to enroll in managed care plans, beginning in January, 2004. Under this initiative, individuals who are eligible for both MA and Medicare ("dual eligibles") would not be required to enroll, but could enroll at their option. Individuals enrolled in Family Care, the MA community-based waiver programs and the community support program could not enroll.

In trying to address some of the concerns raised by advocacy groups, DHFS did not implement the Act 33 proposal. Instead, in its 2005-07 budget request, DHFS proposes to implement a more limited proposal that would include pilot projects in Milwaukee County, Dane County, Southeastern Wisconsin and La Crosse County, the Fox River Valley area, and areas served by the Marshfield Clinic. Expansion would begin in Milwaukee and Dane Counties in April, 2005; at the Marshfield Clinic in July, 2005; in Southeastern Wisconsin and La Crosse County in January, 2006; and in the Fox River Valley area in April, 2006.

Home- and Community-Based Waiver Services

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

Under the community-based waiver provisions of federal MA law, states may offer medical and support services to certain groups of MA recipients. Community-based waiver services provide a cost-effective alternative to institutional care that may not otherwise be available to MA recipients. Medical support and social services generally excluded from MA coverage can be offered to waiver

participants, including supportive home care services, home modifications, adaptive aids, specialized transportation services, adult day care, and supportive services in community-based residential facilities, as well as any other services requested by the state and approved by CMS. Appendix V to this paper provides a list of waiver services available under CIP IA, CIP IB, BIW, CLTC, COP-W and CIP-II.

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

Unlike MA card services and nursing home care, which are entitlements to all individuals who qualify for such services, the amount of MA community-based waiver services available to qualifying individuals is limited by state and county budgets. As a result, eligible individuals can be, and often are, placed on waiting lists for these programs. Table 13 presents information on the number of individuals on waiting lists for COP and MA waiver services in each year from 1996 through 2003. Of the 10,143 individuals on waiting lists as of December 31, 2003, 622 (6%) were residing in an institution, 6,704 (66%) were receiving no public long-term care funding, and 2,817 (28%) were receiving some public long-term care funding but not COP or waiver funding.

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

Table 13: Number of Individuals on County COP and MA Waiver Program Waiting Lists*

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

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

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

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

operates under a single, separate waiver. Finally, the children's long-term care (CLTC) and intensive in-home autism programs are authorized under three separate federal waivers.

DHFS allocates the funding budgeted for each waiver program to counties on a calendar year basis. The state-supported COP and COP-waiver allocations are based on the prior calendar year's awards. These base allocations are adjusted only when there is a change in the total amount of funding appropriated by the Legislature for these programs. Under CIP II, allocations are based on the number of slots designated for a county and the daily rate. The allocations for the other MA waivers are based on the most recent caseload information and the actual county costs per day in calendar year 2003, inflated to 2005. Counties may obtain federal MA matching funds for eligible services supported by county funds. Appendix VI lists 2005 county allocations of GPR funding budgeted for MA waiver services and services funded under COP.

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

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

*Financial Criteria***.** Several provisions of MA law relating to eligibility for institutional care are also applicable to the MA home- and community-based waiver programs. For instance, states may provide nursing home and MA waiver services to individuals with income between 100% to 300% of the applicable 2005 SSI payment level (up to $1,737 per month in 2005). The same spousal impoverishment protections apply to spouses that receive services in a nursing home or under the MA home- and community-based waiver programs. However, individuals who qualify under the special income limit and receive services in the community may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance than individuals who reside in nursing homes. In 2005, under the MA waiver programs, the personal needs allowance ranges from $759 to $1,737 per month, whereas nursing home residents may retain $45 per month. The personal needs allowance is larger, in part, because room and board costs are not an allowable benefit under the MA waiver programs, and participants must use their personal needs allowance to support this cost.

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

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

For the 2004-05 fiscal year, DHFS provides counties a maximum average per day allowance of $125 for each person relocated from the centers before July 1, 1995, $153 for relocations that occurred between July 1, 1995 and June 30, 1997, $225 for individuals placed between July 1, 2002 and June 30, 2003, and $325 for persons placed on or after July 1, 2003. For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed with federal matching funds for approximately 58% of the excess costs, as long as

overall expenditures for theses services are below the maximum permitted under the waiver. In calendar year 2003, approximately $74.6 million was expended to support CIP IA services, including approximately $6.2 million of county funds.

The average cost of serving residents at the three state centers was $466.52 per day in 2003, compared to $257.24 per day for individuals enrolled in CIP IA when MA card services expenditures are included.

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

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

In 2004-05, the maximum average per day allowance for state reimbursement under CIP IB is $49.67, although DHFS pays a higher rate for placements from facilities that close or have on file a Department-approved plan for significant downsizing. The state claims federal matching funds for county costs that exceed the state payment rates up to a maximum of the average cost of care in an ICF-MR (approximately $181.65 per day). As of July 1, 2004 there were 2,671 state-funded and 6,873 locally-supported individuals participating in CIP IB. In addition to these state-matched slots, Wisconsin claims federal funding for individuals for whom counties elect to provide the state match with county funds. In calendar year 2003, approximately $283.3 million was expended to support CIP IB services; including $87.2 million of county funds.

The average cost of serving individuals with developmental disabilities in ICFs-MR other than the state centers was $181.65 per day in 2003. By comparison, the average actual cost to serve a person under CIP IB was $131.77 per day, when costs for MA card services are included. As of July 1, 2004, 10,678 individuals were participating in CIP IA and CIP IB.

CIP IA and CIP IB participants may participate in the self-determination project. The project was created in 1998 under a three-year Robert Wood Johnson Foundation grant to expand consumer choice and control for individuals with developmental disabilities in three Wisconsin counties (La Crosse, Winnebago, and Dane Counties). Under the initiative, participants are part of a person-centered team that is responsible for identifying the care needs of the individual and how those needs will be met by: (a) identifying the enrollee's goals and establishing a method to attain those goals; (b) adhering to the constraints of a care budget established for the individual; (c) strengthening social supports and using community resources; and (d) establishing processes and supports to meet the needs identified in a consumer-directed service plan. The project allows participants to have greater choice in determining what services will be provided and who will provide those services, while technical functions, such as payroll-related duties are designated to fiscal intermediaries. As of July 1, 2004, 82 CIP IA and 834 CIP IB enrollees were participating in this option.

Community Integration Program -- CIP II. CIP II participants are individuals who are either over the age of 65 years or physically disabled who are relocated or diverted from nursing homes. CIP II funding is based on actual and anticipated nursing home bed closures. The Legislature may create

new CIP II slots without the requirement that a nursing home bed be closed. However, under state statutes, the number of MA recipients who receive CIP II services at any time may not exceed the number of MA beds that are closed.

For 2004-05, the maximum daily reimbursement rate available to counties serving CIP II clients is $41.86. However, 2003 Wisconsin Act 33 authorized DHFS to provide counties enhanced reimbursement for CIP II services provided to individuals who are relocated to the community after July 24, 2003, if the nursing home bed that was occupied by the individual is delicensed upon relocation. Similar to other MA waiver programs, counties can receive federal matching funds for costs in excess of this maximum. Since the costs of care for individual service plans vary, counties are expected to support a combination of high cost and low cost participants.

In calendar year 2003, approximately $50.8 million was expended to support CIP II services, including $0.2 million of county funds. At the end of calendar year 2003, 3,640 individuals were receiving MA services under CIP II. DHFS usually distributes new CIP II slots to the county in which the facility with the closed bed is located.

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

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

On July 1, 2004, the program was serving 315 individuals. In calendar year 2003, approximately $17.8 million was expended for BIW services, including $1.2 million of county funds.

Children's Long-Term Care (CLTC) Program. 2003 Wisconsin Act 33 provided funding to support a new MA waiver program, operating under three MA home- and community-based waivers, that provides children with long-term care needs MA services and a single entry point for eligibility determinations in each county. These waivers include: (a) the children's developmental disability waiver for children who meet the ICF-MR level of care; (b) the children's mental health waiver for children who meet the psychiatric hospital or severe emotional disturbance level of care; and (c) the children with physical disabilities waiver for children with hospital, intensive skilled nursing, skilled nursing, and intermediate care facility levels of care.

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

2003 Wisconsin Act 33 provided $821,800 in 2004-05 to support waiver services to individuals participating in the CLTC program. These waiver slots have been allocated to several counties across the state. Counties are also permitted to create waiver slots by supplying the local match to obtain federal matching funds to support these services.

As of October, 2004, there were 120 locally-matched CLTC slots.

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

The financial eligibility criteria require that, in 2005, the child's income may not exceed $1,737 per month and countable assets may not exceed $2,000. Children who have income and/or assets that exceed these limits may become eligible for MA by "spending down" to the CLTC income and asset criteria.

Although, the income of the parents of the child is not considered for determining eligibility for MA, families may be required to contribute to the cost of services. DHFS is currently developing parental cost share criteria.

The services provided under the CLTC waiver are similar to those available under other MA home- and community-based waivers. Some of the services that are necessary for adults, such as home-delivered meals, housing counseling, and adult day care, adult family home, residential care apartment complex, and community-based residential facility services, are not available to children under the waivers. Similarly, the CLTC waiver supports services that are not available under the other waivers, including intensive in-home autism services and specialized medical and therapeutic supplies. DHFS paid counties an average daily rate of $48.42 to provide waiver services in 2004. In addition to receiving waiver services, CLTC enrollees have access to all MA-covered card services. As with other MA waiver programs, DHFS allocates funding to counties on a calendar year basis based on each county's estimated expenditures.

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

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

Until January 1, 2004, in-home autism services were provided as a fee-for-service benefit under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. However, in June of 2000, the U.S. Department of Health and Human Services (HHS) notified the state that in-home autism services offered under the EPSDT benefit would no longer be eligible for federal MA matching funds. HHS later indicated that the appropriate

method for claiming federal financial participation for intensive in-home autism services is through a section 1915 (c) home- and community-based waiver. As a result, the administration developed a proposal to recreate the benefit as a service available under the CLTC waivers.

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

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

Services may be provided at either the intensive or ongoing level. Children are eligible for in-home autism services at the intensive level for up to three years as long as they begin receiving services by the time they are eight years old. Services are available at the ongoing level until the individual reaches 16 years of age. As of September 15, 2004 637 children were receiving intensive in-home autism services, while 607 children were receiving ongoing autism services.

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

Funding is provided to counties to support intensive in-home autism services based on an established weekly rate and the number of hours specified in each participant's individual service plan. In addition, counties receive funding to support approximately one hour per week of case management services per recipient and are permitted to claim up to 7% of direct service and case management costs to support administrative expenses. At the post-intensive level, counties receive $31 per participant per day to support all benefit and administrative costs.

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

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

The average cost of care for participants in the COP-W and CIP II programs was $73.16 per day in calendar year 2003, while the average cost for MA nursing home recipients was $110.44 per day. This comparison includes not only direct costs, but other costs such as MA card costs for hospital care and other services and SSI costs. In calendar year 2003, 9,003 individuals received services under COP-W. Approximately $93.5 million was expended to support COP-W services in calendar year 2003, including $4.7 million in county funds.

Community Options Program (Non-Waiver)

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

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

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

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

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

3. Be a current resident of a nursing home who is eligible for MA and who is identified as a person for whom community care is appropriate;

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

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

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

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

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

The formula used by DHFS to implement this six-month spend down provision compares the sum of the individual's assets, after certain

exclusions, and the individual's projected income over the next six months, after certain exclusions, with the average cost of nursing home care for six months. If the sum of assets and income is less than the cost of nursing home care, the individual is financially eligible for COP services. In 2004, DHFS used $30,890 as the average cost of nursing home care for a six-month period ($5,148 per month).

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

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

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

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

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

Services. In general, counties use COP funds to supplement funding for MA waiver clients in three areas: (1) to provide pre-relocation funding; (2) to purchase services that cannot be funded under the waivers and to provide services to individuals who are not eligible for the waivers; and (3) to supplement funding provided under the MA waiver programs.

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

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

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

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

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

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

(3) No state funds may be used for care

provided in a CBRF facility that is larger than 20 beds unless a variance is granted by DHFS or the CBRF consists entirely of independent apartments.

Of the $57.4 million GPR expended for COP services in calendar year 2003, counties expended $8.5 million to provide services not covered under the MA waiver programs, $13.2 million for individuals not eligible for the MA waiver program, $30.2 million to support locally-matched CIP IB slots and waiver costs in excess of the state maximum reimbursement rate for MA waiver programs, and $5.5 million to support assessments, case plans, and other expenditures.

Program Restrictions

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

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

Table 14 presents statewide information on the number of people served in each COP client group on December 31, 2003, and compares the percentage of individuals served in each client group to the "significant numbers" percentages. For purposes of compliance with the "significant numbers" requirement, clients served with COP and COP-W funds are counted on December 31st of each year. To provide counties with the flexibility to exceed the "significant numbers" percentages, the total of the percentages is less than 100%.

Table 14: Total Number of Person Served with COP and COP-W Funds by Disability Group as of December 31, 2003

	Number	Actual Percent	"Significant Numbers" Percentages
Elderly*	7,003	49.6%	57.0%
Developmentally disabled	3,327	23.6	14.0
Physically disabled	2,861	20.2	6.6
Seriously mentally ill	881	6.2	6.6
Chemically dependent and others	53	0.4	0.0
Total	14,125	100.0%	84.2%

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

CHAPTER 5

FUNDING SOURCES

In 2004-05, federal MA matching funds support approximately 58.3% of the cost of most MA services. The state's share of these costs is estimated to be approximately $1,749 million. Most of the state's share of these costs is funded with GPR ($1,488 million GPR or 85.1%).

Wisconsin uses several funding sources, in addition to GPR, to support the state's share of MA costs. These include MA-eligible costs paid by local governments (including county nursing homes), provider assessments, and tribal gaming revenues. The state also uses some licensing and certification fee revenues to support MA administrative activities.

Table 15 identifies the non-GPR funding sources the state uses to fund the state's share of MA benefits costs in the 2003-05 biennium.

Table 15: Non-GPR Sources of the State's Share of MA Benefits Costs, 2003-05 Biennium

	2003-04 Actual	2004-05 Estimate
Provider Assessments		
Nursing Home Assessment*	$48,603,900	$47,523,500
Hospital Assessment	1,500,000	1,500,000
Local Government Revenues		
County Nursing Home IGT	52,785,900	46,111,400
Other	167,646,900	165,267,800
Tribal Gaming Revenue	825,000	825,000
Total	$271,361,700	$261,227,700

*Includes $14.3 million in 2003-04 and $13.8 million in 2004-05 from the nursing home bed assessment that is deposited to the state's general fund.

In addition to the funding sources identified in Table 15, 2003 Wisconsin Act 318 reduced GPR funding that had previously been budgeted for state aid programs and increased GPR funding by a corresponding amount to support the state's share of MA costs. This change enabled the state to increase federal MA matching funds for MA-eligible services provided by counties.

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

The following other types of revenue may be used as the state share:

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

- Certain provider-related donations that are made directly or indirectly to the state or local gov-

ernment by a health care provider or a similar entity.

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

- Local government revenues used to fund the state's share of certain MA costs.

However, federal law places some restrictions on these provisions, including:

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

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

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

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

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

Nursing Homes. The state established a provider assessment on nursing homes in 1991-92. Currently, the nursing home assessment is an amount per licensed nursing home bed and applies to all nursing home beds, including those in the state centers for the developmentally disabled, the state veterans homes, and beds occupied by Medicare beneficiaries. In 2004-05, the monthly rate per bed is $75 for nursing facilities and $445 for ICFs-MR. Prior to passage of 2003 Wisconsin Act 33, the nursing home bed tax was only applied to occupied nursing home beds and beds at the state centers, the veterans homes, and beds occupied by Medicare recipients were exempt from the assessment.

The revenues generated from the nursing home assessment are deposited, in part, in the medical assistance trust fund (MATF). In 2003-04, the nursing home bed assessment generated approximately $48.6 million -- $34.3 million of which was deposited in the MATF and $14.3 million of which was deposited in the general fund. These assessment revenues may be used to claim federal MA matching funds as long as the payments are made for allowable services and the payments to providers do not exceed the Medicare upper payment limit.

Although federal rules prohibit any hold harmless provisions that directly tie MA reimbursement levels to the amount of the tax paid by the provider, most nursing homes benefit from the assessment because the assessment revenue and the federal matching funds have been used, in part, to fund rate increases for nursing homes. Non-MA residents may benefit to some degree if higher MA provider rates result in less cost-shifting to private-pay patients. Nursing homes with few or no MA-funded residents do not benefit significantly from higher MA provider rates. However, many nursing homes have a large number of residents supported by MA. As of August 1, 2004, only 18 of the 442 licensed nursing homes in the state were not certified to serve MA-funded residents. On December 31, 2003, approximately 64% of Wisconsin nursing home residents used MA as their primary source of payment for services. For private pay residents, a nursing home may elect to include the assessment in their bill, either in the overall rate or as a separate, billable amount.

Hospital Assessment. Current law requires Wisconsin hospitals to pay a $1.5 million annual assessment, which is used to fund the state's share of MA benefits costs. The total revenue collected from the assessment is set at $1.5 million annually and

distributed among licensed hospitals, based on each hospital's gross private-pay patient revenues. Funding from the assessment is deposited in a PR appropriation in DHFS.

Licensing and Certification Revenues. DHFS currently collects revenue to support its regulation function by charging facilities a flat certification fee or a fixed amount per licensed bed that varies by the type of facility. For instance, nursing homes are required to pay $6 per licensed bed annually, while other inpatient health care facilities, such as hospitals, pay $18 per licensed bed. Licensing and support service revenues currently support health facility plan and rule development activities, facility accreditation, capital construction and remodeling plan reviews, technical assistance, and associated licensing and support costs. Facility accreditation, technical assistance, and licensing and support costs are eligible for federal matching funds under MA. In 2003-04, approximately $355,300 in licensing and certification revenues were used support MA-allowable costs, generating $495,900 in federal matching funds.

Donations. Under federal law, the following provider-related donations may be used as the state match to claim federal funding: (a) bona fide provider-related donations which are donations made to the state or local government that have no direct or indirect relationship to MA payments to the health care providers or related entities; and (b) donations made by health care facilities to support the direct costs of governmental employees who are located at these facilities and who determine individuals' eligibility for MA and conduct outreach activities. There are no limitations on the amount of bona fide provider-related donations that may be used as the state match under MA; however, donations for outstationed eligibility workers is limited to 10% of the state's MA administrative costs.

Nursing Home Intergovernmental Transfer Program. Wisconsin first began claiming federal MA funds under the nursing home intergovernmental transfer program (IGT) in 1985-86. Currently, the state claims federal MA funds based on the difference between what the state actually pays to nursing homes and what would be paid to these nursing homes under Medicare payment principals. The net federal revenue the state receives under the IGT program is deposited to the MATF, which is used to support a portion of the state's share of MA benefits costs.

Table 16 identifies the amount of federal MA matching funds the state has received under the nursing home IGT program from 1992-93 thru 2003-04 and projected revenues in 2004-05.

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

Fiscal Year	Amount
1992-93	$18.6
1993-94	42.5
1994-95	67.5
1995-96	63.2
1996-97	118.5
1997-98	94.1
1998-99	95.4
1999-00	105.0
2000-01	372.8
2001-02	351.7
2002-03	322.5
2003-04	52.8
2004-05 (est.)	46.1

Nursing home IGT revenues decreased from $322.5 million in 2002-03 to $52.8 million in 2003-04 and will continue to decrease in future years. The decrease occurred because the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services, or CMS) issued a regulation relating to the upper payment limit (UPL) that narrowed the Medicare UPL provision that states used to maximize the receipt of federal MA reimbursement. The new rule established an additional Medicare UPL test that is applied separately to non-state, public nursing facilities that prohibits the use of any difference between the federal UPL and the actual payments to private

facilities to claim excess funds in order to support higher payments to county and municipal facilities. Previously, the UPL test was applied in aggregate to each group of nursing homes so that the test was applied to privately owned (profit and nonprofit) nursing homes and county- and municipally-owned nursing homes as a group. Transitional provisions included under this rule permitted states to gradually comply with these new requirements over several years. Wisconsin, along with Nebraska and Pennsylvania, were permitted to phase-out the excess payments made in 1999-00 by increments of 15% each year, beginning in 2003-04 and continuing until the excess payments are completely phased-out by 2009-10. In addition, the transitional provisions allowed Wisconsin to claim higher IGT revenues through 2002-03.

MA Trust Fund. The MATF was created by 2001 Act 16 as a separate, nonlapsible trust fund where all federal matching funds based on nursing home and local government intergovernmental transfer would be deposited. During the 2001-03 biennium, only nursing home IGT revenues were deposited in the MATF. However, due to provisions in 2003 Wisconsin Acts 33 and 129, beginning in 2003-04, revenue from additional sources are deposited to the MATF, including: (a) IGT claims for non-institutional services; (b) nursing home bed assessment revenues; (c) IGT claims for community-based waiver services; and (d) bond refinancing revenues.

As in the 2001-03 biennium, segregated revenues budgeted in the 2003-05 biennium from the MATF will support supplemental MA payments to nursing homes, as well as other MA benefits costs.

Table 17 presents information on MA trust fund revenues, expenditures and balances for the 2003-05 biennium, based on the DHFS 2005-07 budget request. The Legislature will likely address this projected shortfall prior to passage of the 2005-07 biennial budget act.

Table 17: MA Trust Fund Fund Condition (2003-05 Biennium)

	2003-04 Actual	2004-05 DHFS Estimate
Opening Balance	**$327,329,500**	**-$195,642,400**
Revenues		
2003 WI Act 129 (Bond Refinancing Proceeds)	$123,500,000	$0
Current Nursing Home IGT Claims	52,785,900	$46,111,400
Nursing Facility Provider Assessment	34,303,900	33,723,500
Interest Earnings	1,487,700	-2,543,400
Revenue Total	$212,077,500	$77,291,500
Total Available	**$539,407,000**	**-$118,350,900**
Expenditures		
MA and BadgerCare Benefits	$734,952,700	$27,329,400
Other	96,700	25,300
Expenditure Total	$735,049,400	$27,354,700
Closing Balance	**-$195,642,400**	**-$145,705,600**

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

Counties provide the largest share of local government revenue, but school districts also contribute a portion of the state's share of MA benefits costs. Table 18 identifies the estimated amount of local government revenue used to fund MA benefits costs in the 2003-05 biennium.

MA Waivers. Counties retain federal MA matching funds the state claims for costs counties incur in providing home- and community-based waiver services that exceed their state allocations In calendar year 2003, counties and tribes contributed approximately $100.4 million under the MA waiver programs, generating approximately $159.8 million in federal matching funds. As of July 1, 2004, there were 6,873 CIP IB locally-supported slots.

Non-Institutional Services Provided by Counties. There are several MA non-institutional services for which the counties are required to provide the state match. No GPR funding is budgeted to sup-

Table 18: Estimated Local Funds Used to Match Federal MA Funds -- 2003-05 Biennium*

	2003-04*			2004-05**		
	Local	FED	Total	Local	FED	Total
Waiver Services***	$100,373,100	$159,795,600	$260,168,700	$100,373,100	$140,575,300	$240,948,400
Non-Institutional Services						
Community Support Program	14,618,400	23,272,800	37,891,200	14,580,500	20,420,400	35,000,900
Case Management Services	12,100,600	19,264,300	31,364,900	14,007,300	19,617,600	33,624,900
Crisis Intervention Services	4,638,800	7,385,000	12,023,800	4,941,600	6,920,900	11,862,500
Other	53,600	85,300	138,900	242,900	340,200	583,100
CSDRB	10,225,100	16,278,600	26,503,700	0	0	0
School-Based Services	20,977,300	33,396,200	54,373,500	24,323,000	34,065,100	58,388,100
Milwaukee County IGT GAMP Payment	4,660,000	7,418,800	12,078,800	6,799,400	10,824,800	17,624,200
Total	$167,646,900	$266,896,600	$434,543,500	$165,267,800	$232,764,300	$398,032,100

*Based on actual federal funding claimed in 2003-04
**Estimated
***Represents actual local expenditures in calendar year 2003

port the state's share of the costs of these services. County boards must elect to provide these services and provide the state's share of funding. Any federal MA matching funds received for these services are passed through directly to the counties as provider of these services. These services include community support program services, case management services, and crisis intervention services.

Community Services Deficit Reduction Benefit. Through 2003-04, counties and municipalities that provide MA services could claim federal MA matching funds, through the community services deficit reduction benefit (CSDRB) to support their costs of providing certain MA-covered services that are not fully reimbursed under the rates established in the MA maximum fee schedule. Services eligible for federal MA matching funds under this benefit include: (a) EPSDT; (b) home health; (c) family planning; (d) physical, occupational, and speech therapy; (e) mental health and substance abuse day treatment and outpatient services; (f) nursing services; (g) personal care; (h) community support program; (i) community-based psychosocial services; (j) respiratory care for ventilator-dependent individuals; (k) case management; (l) prenatal care and child care coordination; and (m) mental health crisis intervention services.

Some of the services included under this benefit include services for which GPR is budgeted to fund the state's share of payment, and providers other than counties or municipalities also provide the service. However, CSDRB is only available to counties and other local governments that provide these services, since these entities are subunits of the state.

Under provisions of 2003 Wisconsin Act 318, federal MA matching funds under CSDRB are not available in 2004-05 through 2006-07 due to the availability of MA supplemental payments to counties.

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

Milwaukee County General Assistance Medical Program IGT. In 2003-04, Milwaukee County was authorized to provide $4,660,000 to DHFS through an IGT to support the state's share of payments to hospitals in Milwaukee County as reimbursement for services provided by the hospitals and originally paid under Milwaukee County's general assistance medical program (GAMP). These hospitals then reimburse Milwaukee County for any pay-

ments under GAMP. The amount Milwaukee County is authorized to provide increases to $6,799,400, beginning in 2004-05.

Tribal Gaming Revenue. Currently, the Department of Administration (DOA) transfers $825,000 annually from revenue the state receives from tribes from gaming proceeds, to DHFS to fund the state's share of MA payments to tribal FQHCs. This revenue is deposited in a DHFS PR appropriation.

Table 19: MA Payment Adjustments Budgeted in 2003 Acts 33 and 318

	2003-04		
	GPR	FED	Total
Ambulance Services	$4,158,500	$5,841,500	$10,000,000
School-Based Services	8,524,900	11,975,100	20,500,000
Various County-Provided Services	0	0	0
Total	$12,683,400	$17,816,600	$30,500,000

	2004-05		
	GPR	FED	Total
Ambulance Services	$4,162,800	$5,837,200	$10,000,000
School-Based Services	8,533,600	11,966,400	20,500,000
Various County-Provided Services	50,183,100	70,275,700	120,458,800
Total	$62,879,500	$88,079,300	$150,958,800

Supplemental Payments and State Aid Reductions under Acts 33 and 318. 2003 Wisconsin Acts 33 and 318 reduced GPR funding for two state aid programs (shared revenue and community aids) and anticipated lapses from a third GPR-funded program (school aids) as part of proposals to increase MA claiming for certain services provided by local governments.

The GPR reductions in shared revenue ($10 million annually) and the anticipated lapse from school aids ($20.5 million annually) were included in Act 33. The GPR community aids reduction ($103.5 million in 2004-05) was included in Act 318 and affects 2004 and 2005 community aids allocations only.

These state aid payment reductions and lapses were intended to be replaced by MA payment adjustments for ambulance services provided by municipalities, school-based services provided by school districts, and various non-institutional services provided by counties. Therefore, local governments do not receive a net increase in funding as a result of these provisions. The GPR reductions to the state aid programs were used to fund the state's share of the new payment adjustments, and the remainder was used to offset increases in GPR budgeted in the MA benefits appropriation to fund base MA benefits. Table 19 identifies the estimated amount of funding budgeted for payment adjustments in 2003-04 and 2004-05 under Acts 33 and 318.

The payment adjustments to counties for various non-institutional services are also intended to replace payments to counties that were previously made under CSDRB (an estimated $17 million in 2004-05). The new payment adjustments are intended to fully reimburse local government providers for MA-covered services, including costs that were previously claimed under CSDRB. As a result, Act 318 eliminates counties' option to claim federal MA matching funds under CSDRB, in 2004-05 through 2006-07, since counties will receive full MA reimbursement with the new payments.

CHAPTER 6

ADMINISTRATION

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

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

MA Contracts. DHFS contracts with private firms to provide several administrative services, including processing claims, reviewing prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Most of these services are provided under a contract with the current MA fiscal agent, Electronic Data Systems, Inc. (EDS). In 2003-04, DHFS expended approximately $161.5 million ($67.0 million GPR and PR and $94.5 million FED) to supported contracted services for the MA, BadgerCare, Food Share, chronic disease, and supplemental security income (SSI) caretaker supplement programs. Table 20 summarizes these contracting costs in 2003-04, by funding source.

Table 20: MA, BadgerCare, Senior Care, and Related Programs Administrative Contract Costs -- Fiscal Year 2003-04

	GPR / PR	FED	Total
Fiscal Agent Services	$17,130,600	$38,388,200	$55,518,800
Peer Review Organizations	310,100	856,800	1,166,900
HMO Enrollment Assistance	1,104,800	1,137,700	2,242,500
CARES	14,813,800	17,090,500	31,904,300
Other DHFS Contracts	3,014,700	6,418,100	9,432,800
Income Maintenance -- Eligibility Determinations*	30,622,900	30,622,900	61,245,800
Total	$66,996,900	$94,514,200	$161,511,100

*Estimated

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

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the state's MA program and several related programs. In 2003-04, DHFS paid EDS approximately $55.5 million for services EDS provided for these programs. Of this amount, approximately $20.6 million (37%) supported claims processing services. DHFS first entered into an agreement with EDS to provide fiscal agent services in 1991.

Under the current fiscal agent contract, EDS provides a variety of services, including: processing claims, distributing MA eligibility cards, reviewing prior authorization requests, managing pharmacy point-of-sale systems, collecting BadgerCare premiums, coordinating benefits, and maintaining MMIS.

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

In 1981, DHFS first entered into an agreement with MetaStar to provide several surveillance and utilization control activities for the state's MA program. Under the current contract, MetaStar conducts managed care and medical record quality reviews, hospital audits, best practices seminars, performance improvement projects, encounter validity audits, and other peer reviews. In 2003-04, DHFS paid MetaStar approximately $1.2 million to provide these services. Because MetaStar operates as an external quality review organization (EQRO), 75% of these costs are funded with federal matching funds.

HMO Enrollment Contract. DHFS currently contracts with Automated Health Systems, Inc. to provide outreach and enrollment counseling services to AFDC, Healthy Start, and BadgerCare recipients that enroll in HMO plans. These services are provided through a call center located in Milwaukee County. In 2003-04, DHFS expended approximately $2.2 million to support services provided under the HMO enrollment contract.

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

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

Each state is required to establish methods for identifying and investigating cases of potential fraud and abuse. These cases include providers billing for services not covered under MA or billing for services that were not provided. Federal funding supports approximately 75% of the costs of supporting Wisconsin's MA fraud control units (MFCUs), which are located in the Department of Justice. The MFCUs also investigate and prosecute cased of abuse and neglect in health care facilities. In 2003-04, $995,300 ($223,900 GPR and $771,400 FED) was expended to support 11.0 positions to conduct these investigations.

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

Both Medicare and MA use state certification agencies to determine institutional providers' compliance with program standards. For hospital certification, both Medicare and MA rely on the findings of the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) for determining whether an institution meets most pro-

gram requirements. In Wisconsin, JCAHCO surveys most hospitals and DHFS survey activity is limited to: (a) a sample to validate the reviews by JCAHCO; (b) investigate violations of program requirements; and (c) initial surveys of those hospitals that are not surveyed by the JCAHCO. For Wisconsin nursing homes and assisted living facilities, the Bureau of Quality Assurance in DHFS performs regular surveys that serve as the basis for Medicare and MA certification and state licensure. Under federal law, DHFS is required to survey each nursing home at least once every 15 months and survey all nursing homes, on average, every 12 months. Federal law does not specify how frequently assisted living facilities must be surveyed, and Wisconsin's administrative code only specifies survey frequency requirements for residential care apartment complexes (RCACs) -- not for community-based residential facilities or adult family homes. State law requires DHFS to survey RCACs at least once every three years.

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

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

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

Income Maintenance Administration

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

IM Administrative Funding. In calendar year 2004, DHFS allocated approximately $54.6 million, including approximately $26.2 million GPR, to counties and tribes to support the base administrative costs of determining eligibility for the IM programs. Each IM program is required under federal law to support its proportional share of the program costs. Each program's share has previously been determined by each program's caseload rela-

tive to the total IM caseload. Since 2003, the federal government has required that DHFS use a random moment sampling methodology to determine each program's proportional share of the IM costs. Each program supports its share with GPR, federal funds, local funds, or some combination of these sources.

DHFS allocates IM funding to counties on a calendar year basis. These contracts include funding for counties to perform the base IM functions, which include eligibility determinations for MA, BadgerCare, FoodShare, and caretaker supplement. Funding for other IM functions, including funeral and cemetery aids, MA transportation, public assistance fraud program (both program integrity and investigations) are provided as separate allocations and amendments to the IM contract.

Currently, DHFS does not allocate state and federal IM funding to counties based on a single formula. Instead, DHFS allocates funding for IM contracts each year under different methodologies. Since 2002, funding has been allocated to counties based on each county's unduplicated number of FoodShare and MA cases at a point in time. Agencies with 200 or fewer cases received a base allocation of $97,600; agencies with 201 to 499 cases received a base allocation of $160,644; and agencies with 500 or more cases received the remaining available funding. Because 2003 Wisconsin Act 33 reduced funding for IM contracts, DHFS reduced 2004 calendar year contract allocations for agencies with 500 or more cases by at least 8.2% from their calendar year 2003 allocations. However, in 2004, DHFS allocated an additional $4,000,000 (all funds) to IM agencies for eligibility determination costs resulting from caseload increases. These funds were allocated to agencies with 500 or more cases based on the agencies' share of the state's unduplicated FoodShare and MA cases on November 29, 2003.

Calendar year 2005 IM allocations were based on the 2004 allocations of the base funding (not including the supplemental funding). County allocation amounts for 2003, 2004, and 2005 are listed in Appendix VII.

Local Agency Overmatch Funds. Local agencies (county and tribes) are not required to provide local funding for IM activities. However, many counties use other funds, in addition to their state allocations, to support these activities. This funding is called overmatch. In 2003, 13 counties and six tribes did not contribute local funds for IM activities, but 30 counties contributed more than 15% of the total costs of the county's IM program. In 2003, counties expended approximately $84.1 million to conduct IM activities, which included $28.2 million GPR, $43.7 million in federal funds, and $13.5 million in local funds. When counties provide funding for IM activities, when applicable, federal matching funding can be claimed for those activities, which is passed from DHFS to the county. Therefore, the federal funding amount includes federal funding that is matched to both the state GPR and local funds. In 2003, the local funding accounted for about 16% of the total expenditures in that year.

Appendix VIII identifies the local agencies that provided overmatch funding for IM activities in 2001, 2002, and 2003, and the amount each agency provided.

CARES. The statewide automated client assistance for reemployment and economic support (CARES) eligibility system provides the basis for an integrated application and review process for IM programs. DHFS and the Department of Workforce Development (DWD) jointly administer the CARES system, since both departments have programs that are supported with CARES. There are approximately 5,000 public and private users of CARES through the state, supporting the FoodShare, MA, child care, and Wisconsin Works (W-2) programs. CARES is a mainframe system that was first implemented in January, 1994, and has been maintained and changed as additional programs were added or program needs changed. With the

transfer of the FoodShare program from DWD to DHFS in July, 2002, DHFS assumed responsibility for the primary programs supported by CARES. The state contracts with Deloitte, which is responsible for programming and development and the daily operations of the system. DHFS purchases services from DWD to connect and support IM workers and other CARES users.

CARES costs are allocated across the programs that are supported by the system, in both DHFS and DWD. The total cost of CARES incurred in 2003-04 was $41.2 million, of which DHFS' share was $32.5 million. DHFS is budgeted approximately $29.8 million ($13.5 million GPR, $14.4 million FED, and $1.9 million PR) in 2004-05 to support CARES. The federal funding is available from several sources, including MA, FoodShare, child care, and temporary assistance for needy families (TANF) funding.

IM Caseload and Workload. IM caseloads have increased during each of the last several years. As Figure 1 shows, the increase in caseloads statewide has largely been due to increases in caseloads in non-Milwaukee counties. The caseload numbers shown in the figure includes unduplicated cases for child care, FoodShare, MA, and W2. MA cases comprise the largest number of total cases. In October, 2004, there were approximately 336,200 unduplicated IM cases statewide, including 95,400 cases in Milwaukee County and 240,800 cases in the rest of the state.

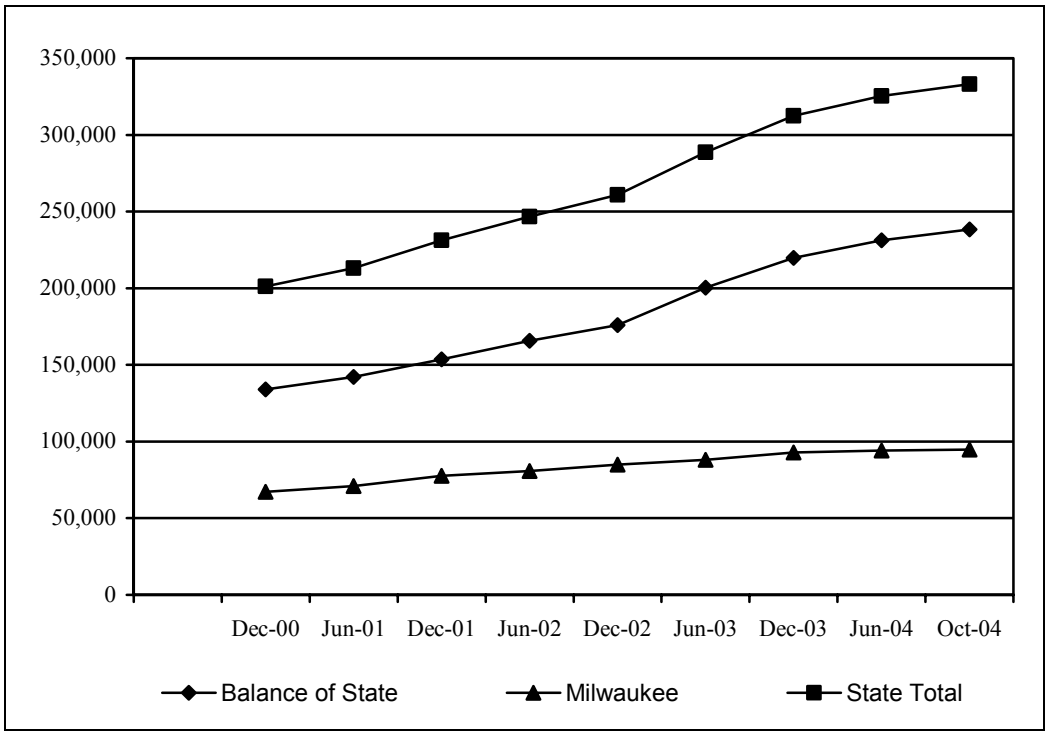
Workload Reduction Efforts. As the number of cases have increased, DHFS and IM agencies have implemented systems and policy changes that have reduced the workload for IM agencies. Workload is determined by looking at the caseload and the case mix in each agency and statewide. Funding in 2003 Wisconsin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

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

Coordination of Benefits

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

Figure 1: Unduplicated IM Caseload December, 2000, thru October, 2004



expenditures.

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

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

DHFS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available, by requiring the service provider to obtain reimbursement from other liable sources. A second method is "postpayment recovery," where the state initially pays provider claims, then attempts to recover payments from liable sources. Finally, there is "provider-based billing." Under this method, the state initially uses MA funds to pay provider claims. It then identifies retroactive health insurance coverage that requires documentation (for example, a physician's plan of care, prescriptions or discharge notes), and a bill is produced for the

provider to use to bill the health insurer. The provider has 120 days to collect payment from the insurer and refund the MA payment. If the provider does not refund the MA payment within 120 days, the MA payment is automatically recouped from the provider through a claims adjustment.

Table 21 summarizes all coordination of benefits savings the MA program achieved in 2003-04 and funds received through estate recovery.

Table 21: Coordination of Benefits and Estate Recovery Payments -- Fiscal Year 2003-04

Category	Cost Avoidance	Postpayment Recoveries	Claims Adjustments
Medicare	$843,392,400		
Other Health Insurance	323,515,000*	$13,120,900	
Subrogation		2,227,200	
Provider-Based Bills		223,900	$8,163,900
Medical Support Liability		17,763,900	
Estate Recovery		16,772,700	
Miscellaneous		11,048,400	
Total	$1,166,907,400	$61,157,000	$8,163,900
Grand Total			$1,236,228,300

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

Estate Recovery Program

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

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

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

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

Property considered to be the home of the MA recipient that is being transferred by an affidavit is subject to a lien if the state's claim cannot be satis-

fied through available liquid assets. However, the lien may not be enforced as long as a spouse or child who is under the age of 21, blind, or disabled exists. DHFS may also send an affidavit to an heir who claims or transfers certain funds to recover any funds remaining after burial and estate administration costs have been paid.

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

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

CHAPTER 7

BADGERCARE

Introduction

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

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

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

Individuals in families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before family members are no longer eligible for the program. Table 22 identifies the initial income eligibility levels for BadgerCare and the ongoing income eligibility limits based on the 2004 FPL.

Table 22: BadgerCare Eligibility -- Maximum Countable Monthly Income (Based on 2004 FPL)

Family Size	Initial Eligibility 185% of FPL	Ongoing Eligibility 200% of FPL
1	$1,435	$1,552
2	1,926	2,082
3	2,416	2,612
4	2,906	3,142
5	3,396	3,672
6	3,867	4,202

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

Families with incomes above 150% of the FPL must pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 5% of the family's income. Table 23 provides a schedule of the minimum and maximum premiums a family would be required to pay based a range of countable income, using the 2004 FPL.

Table 23: BadgerCare Premium Schedule (Based on 2004 Federal Poverty Level)

Family Size	Monthly Income		Monthly Premium	
	Minimum	Maximum	Minimum	Maximum
1	$1,164	$1,552	$50	$75
2	1,561	2,082	75	100
3	1,959	2,612	75	125
4	2,356	3,142	100	150
5	2,754	3,672	125	175
6	3,151	4,202	150	200

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

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

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

Based on provisions included in 2003 Wisconsin Act 33, effective May 10, 2004, as a condition of eligibility, each member of a family who is employed is required to verify from his or her employer: (a) his or her earnings; (b) whether his or her employer provides health care coverage for which the family is eligible; and (c) the amount that the employer pays, if any, toward the cost of that coverage, excluding any deductibles or copayments required under the coverage. Before May 10, 2004, DHFS contacted BadgerCare recipients' employers to verify earnings and insurance information after these individuals were determined eligible.

Services. BadgerCare recipients are eligible to receive all of the services that are available to MA recipients. Approximately 70% of BadgerCare recipients are enrolled in HMOs. Average capitation costs for BadgerCare clients are generally higher than AFDC-related and Healthy Start MA capitation costs because the BadgerCare population is generally older and more costly to serve than low-income families enrolled in MA. As with MA capitation rates, the actual amount paid to an HMO for an enrollee is based on the enrollee's age, gender and area of residence.

Funding. In the 2003-05 biennium, BadgerCare is funded with GPR, federal funding available under MA and SCHIP, and premiums paid by some recipients. Table 24 identifies actual expenditures for services to BadgerCare recipients, by fund source, from 1999-00 through 2003-04 and funding budgeted for the program in 2004-05.

Federal MA matching funds support approximately 58% of the costs of services for adults in families with income at or below 100% of the FPL. SCHIP funding supports approximately 71% of the costs of services for children and all other adults enrolled in BadgerCare. It is estimated that federal SCHIP and MA funds will support approximately 64% of total BadgerCare costs in 2004-05.

Table 24: BadgerCare Expenditures ($ in thousands)

	GPR	FED	SEG	PR	Total
1999-00	$21,920.3	$35,697.6	$0.0	$758.2	$58,376.1
2000-01	46,164.6	81,449.4	0.0	1,410.6	129,024.6
2001-02	43,774.5	92,371.7	549.2	4,447.7	141,143.1
2002-03	60,814.9	124,538.4	966.8	4,113.5	190,433.6
2003-04	64,767.3	134,732.1	0.0	6,145.3	205,644.7
2004-05*	68,336.8	139,268.4	0.0	8,954.3	216,559.5

* Budgeted

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

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

Table 25: BadgerCare Enrollment --November, 2004

Income Range Based On the % of FPL	Adults	Children	Total	% of Total
No More than 100%	25,803	n/a*	25,803	27.4%
Greater than 100% but No More than 150%	29,087	23,780	52,867	56.1
Greater than 150% but No More than 185%	7,391	5,841	13,232	14.0
Greater than 185% but No More than 200%	1,183	1,172	2,355	2.5
Total	63,464	30,793	94,257	100.0%

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

Enrollment. As of November, 2004, 94,257 people were enrolled in BadgerCare, including 63,464 adults and 30,793 children. Approximately 83% of BadgerCare recipients were in families that had countable income less than 150% of the FPL and therefore these families did not pay monthly premiums. Table 25 identifies enrollment in BadgerCare as of November, 2004, by income.

Table 26 shows the number of BadgerCare recipients at the end of each quarter, beginning in September, 1999 through September, 2004. As shown in the table, enrollment in BadgerCare grew rapidly in its first year, then steadily for the next several years. Beginning in 2003, enrollment growth began to slow, and recently has been decreasing. The recent decreases might be due to provisions in Act 33 that: (a) increased the monthly premiums paid by families with income above 150% of the FPL, from 3% to 5% of the family's income, effective January 1, 2004; and (b) required applicants to verify information on employer health insurance.

Table 26: BadgerCare Enrollment by Quarter -- September, 1999 through September, 2004

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

CHAPTER 8

SENIORCARE

Introduction

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

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

Each applicant becomes eligible for SeniorCare on the first day of the month after the date DHFS receives a completed application and determines that the person is eligible. Once they are enrolled in the program, SeniorCare recipients must re-enroll and pay the enrollment fee every 12 months to remain eligible for SeniorCare benefits. As of November, 2004, approximately 87,800 individuals were enrolled in SeniorCare.

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

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

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

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

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

Types of Cost-Sharing Requirements. In addition to paying the enrollment fee, which is required of all recipients as a condition of eligibility, recipients share in the cost of the program by paying copayments and meeting deductible and spenddown requirements.

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

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

Deductible. Some SeniorCare recipients pay a $500 or $850 annual deductible, depending on their income, before SeniorCare pays for drugs they purchase. Recipients receive a discount for drugs they purchase during the deductible period. This discount equals the difference between the retail price of the drug and the rate at which SeniorCare reimburses pharmacies. It is estimated that, on average, this rate equals 18% of the retail price of drugs purchased, although the actual discount per drug varies significantly. The amount of the discount is absorbed by the pharmacy. SeniorCare does not reimburse the pharmacy for the value of this discount. Once a recipient meets the deductible requirement, he or she is only responsible for making the required copayments.

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

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

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

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

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

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

Level 2b - $850 Deductible. Individuals with income above 200% of the FPL but no more than

240% of the FPL are enrolled in SeniorCare at Level 2b. These individuals pay the $850 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

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

Table 27 identifies the number of individuals enrolled in SeniorCare, by participation level, as of November, 2004.

Table 27: SeniorCare Enrollment by Participation Level - November, 2004

Level 1 (≤160% FPL)	50,743
Level 2a (>160% to ≤200% FPL)	20,723
Level 2b (>200% to ≤240% FPL)	12,481
Level 3 (> 240% FPL)	3,829
Total	87,776

Table 28 identifies the various annual income levels that determine SeniorCare participation, based on the 2004 FPL.

Table 28: SeniorCare Income Levels (Based on the 2004 FPL)

% of the FPL	One Person	Two People
160%	$14,896	$19,984
200%	18,620	24,980
240%	22,344	29,976

The amount each recipient saves by participating in SeniorCare depends on the participation level in which the individual is enrolled and the individual's total drug costs. On average, Level 1 recipients save the most and Level 3 recipients save the least, due to the different cost-sharing requirements that apply at different levels. Table 29 identifies the average savings per recipient by participant level based, on allowed costs in 2003-04. Average savings is defined as the difference between the amount a recipient would have paid if they were required to pay the pharmacy's usual and customary charge for drugs covered under the program and what the recipient actually paid in copayments, deductible and spenddown requirements.

Table 29: Average Recipient Savings in 2003-04

Level 1	$1,205
Level 2a	909
Level 2b	825
Level 3	465
All Levels	1,013

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

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

Reimbursement to Pharmacies. As a condition of participating in MA, pharmacies must participate in SeniorCare. DHFS reimburses pharmacies for purchases made by SeniorCare recipients only when the recipient is responsible for copayments. DHFS does not reimburse pharmacies for drugs purchased during an recipient's deductible or spenddown phase.

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

It is estimated that the SeniorCare reimbursement rate currently equals, on average, approximately 82% of a pharmacy's usual and customary charge. A provider's usual and customary charge represents the amount the provider customarily charges to individuals and other parties for the same product. This amount is typically referred to as the retail price of the product, and usually does not include discounts that providers give to certain purchasers. If an individual has other prescription drug coverage, payment to the pharmacy totals the amount not covered by the other coverage, up to the amount payable under SeniorCare.

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

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

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

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

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

In most cases, pharmacists submit requests for prior authorization electronically and receive responses in real time. However, in some cases, pharmacists may be required to submit a paper

prior authorization request, particularly where documentation of the medical necessity of the prescription is required for approval.

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

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

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

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

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

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

Most pharmaceutical manufacturers that participate in the MA rebate program have signed a separate SeniorCare rebate agreement. It is estimated that payments for drugs produced by manufacturers that have signed the SeniorCare rebate agreement represent over 94 percent of costs for drugs covered for the waiver recipients, based on an analysis of claims paid from April, 2003, through June, 2003. Drugs produced by manufacturers that did not sign a separate SeniorCare rebate agreement are not covered for those recipients not included in the waiver.

Revenue received from pharmaceutical manufacturers is deposited in a PR appropriation and is budgeted to offset GPR and federal MA funds proportionately. In 2003-04, DHFS received approximately $28.6 million in revenue from rebates paid by pharmaceutical manufacturers for drugs purchased under the program from September 1, 2002, through December, 2003.

through December, 2003.

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

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

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

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

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

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

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

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

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

Table 30 identifies the amounts expended for SeniorCare benefits, by source, in 2002-03 and 2003-04, and the amounts budgeted for the SeniorCare benefits in 2004-05.

Table 30: SeniorCare Benefits Costs, by Source (Fiscal Year 2002-03 through 2004-05)

	2002-03 Actual	2003-04 Actual	2004-05 Budgeted
GPR	$25,424,500	$38,211,000	$39,324,400
FED	28,829,600	41,548,200	36,251,900
PR	6,807,500	31,178,100	30,534,800
Total	$61,061,600	$110,937,300	$106,111,100

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

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

SeniorCare administrative costs are funded from a combination of program revenue available from the $30 enrollment fee, GPR, and federal MA matching funds. In 2003-04, DHFS received approximately $3.4 million in enrollment fee revenue. In addition, $1,620,400 ($875,300 GPR and $745,100 FED) was budgeted in 2003-04 to fund SeniorCare administrative costs, including costs of DHFS staff, CARES and MMIS, costs to operate the central application processing operation at EDS, outreach activities and customer service functions.

Medicare Drug Benefit. Beginning January 1, 2006, Medicare beneficiaries will have the option of having their prescription drugs covered under a new Medicare benefit authorized in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108 – 173). The Act will significantly affect how states fund drug coverage for individuals enrolled in both MA and Medicare. However, the Act does not directly address the issue of drug coverage for individuals participating in MA waiver programs such as the SeniorCare waiver.

Under the Act, generally, beginning in January, 2006, MA recipients that are eligible for full MA benefits and are also eligible for Medicare ("full benefit dual eligibles") will begin receiving prescription drug benefits under Medicare. Federal MA matching funds will not be provided to support prescription drug coverage to these individuals once the Medicare benefit becomes available, except that federal MA matching funds will be provided for MA coverage of those drugs that are excluded from coverage under the Medicare benefit, such as over-the-counter drugs and sedative drugs.

However, SeniorCare recipients participating in the waiver are not full benefit dual eligibles, since they only receive drug coverage under the waiver,

not all MA services. The Act does not address the issue of whether federal MA matching funds will be available for drug coverage for these individuals once the Medicare benefit is available in 2006.

In July, 2004, the U.S. Government Accountability Office (GAO) released a report criticizing the assumptions used to approve the SeniorCare waiver and indicated that it is not likely to meet its budget neutrality requirements. The report criticized DHHS for not adequately ensuring that the waivers will be budget neutral and not effectively monitoring such waivers. The report does not address whether states like Wisconsin will exceed the expenditure caps established under the current waiver agreements, but rather, whether the caps themselves are likely to ensure budget neutrality to the federal government.

At this time, it is not clear how the availability of the new Medicare benefit in 2006 and the concerns raised in the GAO report will affect any negotiations to renew the SeniorCare waiver before it expires in July, 2007.

The Act indicates that state pharmacy assistance programs, programs which are entirely funded with state funds, can provide wraparound coverage for the Medicare benefit, meaning that the state can cover those drugs not covered under the Medicare benefit, and/or contribute towards an individual's cost-sharing requirements under the Medicare benefit. In Wisconsin, this appears to be an option for SeniorCare recipients that are not in the waiver, (those with income above 200% of the FPL).

Current law requires DHFS to submit a report to the Legislature that contains an analysis of the differences between the new federal Medicare prescription drug benefit and SeniorCare and provide recommendations concerning alignment, if any, of the differences. DHFS indicates that the release of this report will coincide with the Governor’s 2005-07 biennial budget submission.

CHAPTER 9

TRENDS IN PROGRAM FUNDING AND PARTICIPATION

Table 31 provides annual information on MA, BadgerCare, SeniorCare, and Family Care benefits expenditures, by source, for 1999-00 through 2003-04. The expenditure amounts listed in this table differ from those in Table 32 because Table 31 represents total MA, BadgerCare, and SeniorCare expenditures as recorded in the state's accounting system (WISMART), whereas Table 32 excludes

Table 31: MA, BadgerCare, Family Care, and Senior Care Benefit Expenditures

	1999-00	2000-01	2001-02	2002-03	2003-04
MA					
GPR*	$1,009,205,800	$1,028,746,700	$1,081,650,700	$1,030,625,100	$662,378,100
FED	1,831,257,300	1,912,720,500	2,048,356,500	2,279,530,000	2,515,383,400
PR	18,758,000	18,416,400	23,545,600	22,119,200	24,008,700
SEG	0	0	154,918,300	361,522,700	734,952,700
Subtotal	$2,859,221,100	$2,959,883,600	$3,308,471,100	$3,693,797,000	$3,936,723,000
BadgerCare					
GPR	$21,920,300	$46,164,600	$43,774,500	$60,814,900	$64,767,300
FED	35,697,600	81,449,400	92,371,700	124,538,400	134,732,100
PR	758,200	1,410,600	4,447,700	4,113,500	6,145,300
SEG	0	0	549,200	966,800	0
Subtotal	$58,376,100	$129,024,600	$141,143,100	$190,433,600	$205,644,700
SeniorCare					
GPR	$0	$0	$0	$25,424,500	$38,211,000
FED	0	0	0	26,892,600	41,548,200
PR	0	0	0	6,807,500	31,178,100
Subtotal	$0	$0	$0	$59,124,600	$110,937,300
Family Care**					
GPR	$2,874,500	$14,255,100	$25,783,300	$48,026,000	$72,647,500
FED	4,099,100	32,470,900	57,937,600	87,895,200	120,269,300
Subtotal	$6,973,600	$46,726,000	$83,720,900	$135,921,200	$192,916,800
Total -- All Programs					
GPR	$1,034,000,600	$1,089,166,400	$1,151,208,500	$1,164,890,500	$838,003,900
FED	1,871,054,000	2,026,640,800	2,198,665,800	2,518,856,200	2,811,933,000
PR	19,516,200	19,827,000	27,993,300	33,040,200	61,332,100
SEG	0	0	155,467,500	362,489,500	734,952,700
All Funds	$2,924,570,800	$3,135,634,200	$3,533,335,100	$4,079,276,400	$4,446,221,700
Percentage Increase		7.2%	12.7%	15.5%	9.0%

*Excludes encumbrances incurred under COP-W

**Excludes expenditures from an appropriation that, in the past, supported a portion of non-MA benefits costs, resource center costs, and a portion of MA benefits costs.

expenditures not attributable to a specific claim. Services provided under the home- and community-based waiver programs account for more than half of the difference between these two tables.

Expenditures by Type of Recipient

Table 32 provides information on the average monthly number of recipients in each major eligibility group and program expenditures for the 1994-95 through 2003-04 fiscal years. The AFDC, Healthy Start, BadgerCare, non-MA SeniorCare, non-MA Family Care, Family Planning Waiver, some MA home-and community-based waiver, and other recipients are combined in the "low-income families and others" group. For each year, information is provided on the average monthly number of recipients in each group and that group's percentage of total MA, BadgerCare, SeniorCare, and Family Care recipients. Corresponding information on expenditures for each group is also provided, along with the annual average cost per recipient.

The information for fiscal year 2003-04 is shown graphically in Figures 2 and 3. Although low-income families and others represented 70.9% of all MA, BadgerCare, and SeniorCare recipients in 2003-04, they accounted for only 29.4% of all MA, BadgerCare, and SeniorCare expenditures. In contrast, the elderly, who represented 13.8% of all recipients, accounted for 28.6% of all expenditures. Disabled MA recipients represented only 15.3% of the total number of recipients, but accounted for 42.0% of all expenditures in 2003-2004. As shown in Table 31, the average annual cost per recipient in each group in 2003-04 was as follows: (a) elderly, $9,978; (b) disabled, $13,224; and (c) low-income families and others; $1,989. The creation of SeniorCare accounts for the significant increase in elderly recipients and the dramatic decrease in average costs per elderly recipient, beginning in 2002-03.

Expenditures by Type of Service

Figure 4 provides information on MA funding, by major service category, for the 2003-04 year. The table shows that spending for institutional services, including services provided by nursing homes and the state centers for the developmentally disabled, accounted for 26.4% of total spending in 2003-04. In contrast, community-based long term care services accounted for 15.0% of total spending and managed care payments, including payments made under long-term care programs such as Family Care CMOs, PACE, WPP, and I-Care, accounted for 21.0% of total expenditures. Acute care spending represented 33.8% of gross expenditures.

Figure 5 shows MA fee-for-service spending in 2003-04 for the five largest acute care services categories. Inpatient hospital and drug expenditures represented 22.7% and 39.4%, respectively, of fee-for-service acute care expenditures.

A summary of MA benefit expenditures in 2003-04 is provided in Table 33. Table 34 shows how the composition of expenditures has changed from 1999-00 to 2003-04. The service categories identified in Table 33 have been collapsed in Table 34 to highlight historical trends in major service areas. Tables 33 and 34 do not represent a complete picture of MA expenditures, since certain expenditures, such as supplemental payments to nursing homes, and various offsets to program expenditures, are not included. Unlike Table 32, Tables 33 and 34 include expenditures for services provided under the home- and community-based waiver programs.

Table 34 indicates several trends over the five-year period. First, total payments for institutional, long-term care have increased slowly, at an average annual rate of 1.8%, payments for community-based long-term care have increased at a much higher rate, an average annual rate of 6.4%. Second, managed care payments have grown rapidly (23.6% average annual rate) while payments for fee-for-service non-institutional services have increased an average of 9.9% annually during this period. Total payments to providers have increased at an average annual rate of 8.6% over 1999-00 thru 2003-04.

Table 32: MA, BadgerCare, and SeniorCare Expenditures and Recipients, by Eligibility Group

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Elderly										
Total Expenditures	$767,127,000	$788,708,200	$794,906,000	$808,754,400	$823,386,200	$850,746,300	$871,232,400	$933,113,700	$1,014,210,400	$1,086,198,400
Percent of Total	36.3%	37.3%	36.6%	36.9%	36.3%	33.9%	31.6%	29.9%	28.9%	28.6%
Average No. of Recipients	53,024	50,625	48,935	47,335	45,674	44,629	43,515	42,954	88,105	108,859
Percent of Total	10.7%	10.6%	10.9%	11.5%	11.3%	9.8%	8.6%	7.6%	12.7%	13.8%
Average Cost / Recipient	$14,468	$15,579	$16,244	$17,086	$18,027	$19,063	$20,022	$21,724	$11,511	$9,978
Blind/Disabled										
Total Expenditures	$809,407,500	$808,043,000	$854,798,400	$909,117,600	$950,205,200	$1,073,025,700	$1,164,579,300	$1,317,853,600	$1,474,370,700	$1,595,877,500
Percent of Total	38.3%	38.2%	39.4%	41.5%	41.9%	42.7%	42.3%	42.3%	42.0%	42.0%
Average No. of Recipients	103,709	106,687	107,807	107,867	107,126	106,853	107,272	110,227	115,545	120,681
Percent of Total	20.9%	22.3%	24.0%	26.3%	26.5%	23.4%	21.2%	19.6%	16.7%	15.3%
Average Cost / Recipient	$7,805	$7,574	$7,929	$8,428	$8,870	$10,042	$10,856	$11,956	$12,760	$13,224
Low-Income Families & Others										
Total Expenditures	$538,410,300	$518,488,800	$521,102,000	$473,783,500	$492,713,300	$586,790,600	$720,312,600	$864,988,000	$1,022,465,500	$1,114,862,900
Percent of Total	25.5%	24.5%	24.0%	21.6%	21.7%	23.4%	26.1%	27.8%	29.1%	29.4%
Average No. of Recipients	338,478	321,744	291,666	255,053	251,098	304,354	355,731	410,575	487,884	560,613
Percent of Total	68.4%	67.2%	65.0%	62.2%	62.2%	66.8%	70.2%	72.8%	70.6%	70.9%
Average Cost / Recipients	$1,591	$1,611	$1,787	$1,858	$1,962	$1,928	$2,025	$2,107	$2,096	$1,989
Total Expenditures	$2,114,944,800	$2,115,240,000	$2,170,806,400	$2,191,655,500	$2,266,304,700	$2,510,562,600	$2,756,124,300	$3,115,955,300	$3,511,046,600	$3,796,938,800
Total Average No. of Recipients	495,211	479,056	448,408	410,255	403,898	455,836	506,518	563,756	691,534	790,153

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

FIGURE 2

Average Monthly MA, BadgerCare, and SeniorCare Recipients by Group
Fiscal Year 2003-04

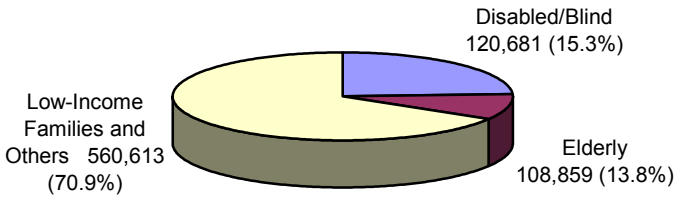


FIGURE 3

Total MA, BadgerCare, and SeniorCare Expenditures by Group
Fiscal Year 2003-04
($ In Millions)

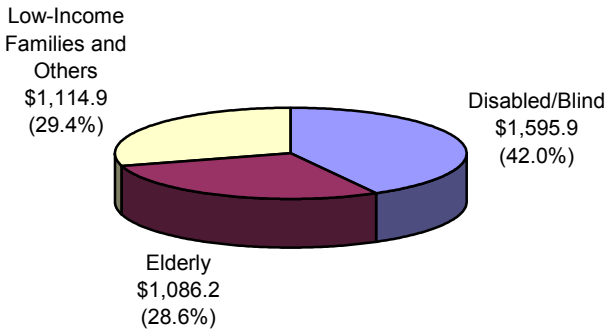


FIGURE 4

Selected Services as a Percent of Gross MA Expenditures
Fiscal Year 2003-04

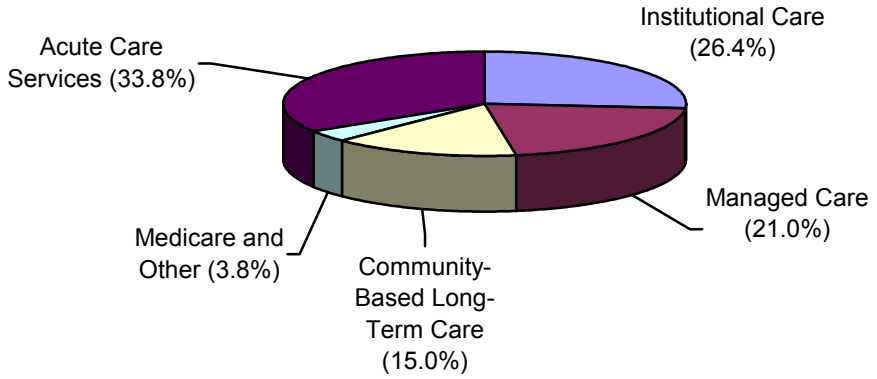


FIGURE 5

Fee-for-Service Expenditures for Acute Care Services
Fiscal Year 2003-04

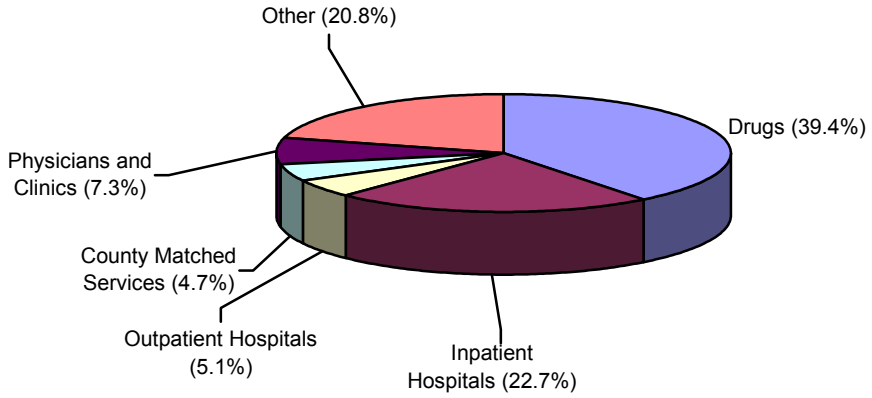


Table 33: MA Benefit Expenditures, by Service Category -- Fiscal Year 2003-04

Long-Term Care Services		
Institutional Services		
Nursing Homes - SNF	$826,962,400	19.6%
Nursing Homes - ICF	51,522,100	1.2
Nursing Homes - ICFs-MR	93,675,800	2.2
State Centers	143,039,700	3.4
Subtotal	$1,115,200,000	26.4%
Community-Based Services		
CIP IA	$67,747,800	1.6%
CIP IB	193,430,600	4.6
COP-Waiver*	97,057,000	2.3
CIP II	53,429,800	1.3
CSLA	616,800	0.0
Brain Injury	18,068,800	0.4
Autism / Children's Long-Term Care	12,963,300	0.3
Personal Care	123,040,100	2.9
Respiratory Care Services	21,197,700	0.5
Home Health	16,874,400	0.4
Private Duty Nursing	17,688,300	0.4
Hospice	14,254,700	0.3
Subtotal	$636,369,300	15.0%
Total Long-Term Care Services	$1,751,569,300	41.4%
Acute Care Services		
Institutional Fee-for-Service Providers		
Inpatient Hospital	$323,285,700	7.7%
Outpatient Hospital	72,228,300	1.7
Outpatient Hospital-Psychiatric	8,561,800	0.2
Subtotal	$404,075,800	9.6%
Non-Institutional Fee-for-Service Providers		
Drugs	$560,630,800	13.3%
Physicians and Clinics	104,007,400	2.5
County Matched Services	66,286,000	1.6
DME / DMS	35,505,300	0.8
Outpatient Mental Health	35,228,300	0.8
FQHCs	32,221,700	0.8
Laboratory and X-Ray	24,465,400	0.6
School Based Services	23,176,500	0.5
Other Care	22,964,900	0.5
Dental	22,533,200	0.5
SMV Transportation	19,397,000	0.5
Healthcheck	17,269,400	0.4
Therapies	16,799,800	0.4
Ambulance	16,315,900	0.4
Family Planning	6,944,300	0.2
Rural Health Clinics	5,284,600	0.1
Vision	4,140,600	0.1
Chiropractic	3,413,900	0.1
Prenatal Care Coordination	2,501,200	0.1
Subtotal	$1,019,086,200	24.2%
Total Acute Care Services	$1,423,162,000	33.8%
Managed Care		
Capitation Payments**	$874,514,200	20.7%
Supplemental Payments	12,620,800	0.3
Subtotal	887,135,000	21.0%
Other Provider Payments		
Medicare Buy-in Premiums	$75,899,700	1.8%
Medicare Crossovers - Part B	46,420,900	1.1
Medicare Crossovers - Part A	40,093,600	0.9
Subtotal	$162,414,200	3.8%
Total Provider Payments* **	$4,224,280,500	100.0%

*Includes an estimate of the GPR expended outside of the MA benefits appropriations to support COP-W

**Includes payments to HMOs for low-income families and payments to Family Care CMOs, PACE / WPP, and I-Care

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

Table 34: Major MA Expenditure Categories -- Fiscal Years 1999-00 through 2003-04

Service Type	Expenditures 1999-00	2000-01	2001-02	2002-03	2003-04*	Percent Change Over Previous Year 2000-01	2001-02	2002-03	2003-04	Ave. Annual Percentage Change
Long-Term Care Services										
Institutional Services										
Nursing Homes	$906,281,500	$916,181,100	$980,578,200	$990,587,000	$972,160,300	1.09%	7.03%	1.02%	-1.86%	1.8%
State Centers	135,932,400	115,304,000	126,885,800	123,875,900	143,039,700	-15.18	10.04	-2.37	15.47	2.0
Subtotal	$1,042,213,900	$1,031,485,100	$1,107,464,000	$1,114,462,900	$1,115,200,000	-1.03%	7.37%	0.63%	0.07%	1.8%
Community-Based Services										
MA Waivers**	$360,117,400	$355,360,900	$356,107,400	$409,893,900	$443,314,100	-1.32%	0.21%	15.10%	8.15%	5.5%
Personal Care	74,380,800	100,427,700	104,476,400	113,096,200	123,040,100	35.02	4.03	8.25	8.79	14.0
Private Duty Nursing	15,005,900	14,874,200	15,203,700	17,622,900	17,688,300	-0.88	2.22	15.91	0.37	4.4
Other Home Care	49,259,500	51,530,300	52,628,800	52,016,600	52,326,800	4.61	2.13	-1.16	0.60	1.5
Subtotal	$498,763,600	$522,193,100	$528,416,300	$592,629,600	$636,369,300	4.70%	1.19%	12.15%	7.38%	6.4%
Total Long-Term Care Services	$1,540,977,500	$1,553,678,200	$1,635,880,300	$1,707,092,500	$1,751,569,300	0.82%	5.29%	4.35%	2.61%	3.3%
Acute Care Services										
Institutional Fee-for-Service										
Inpatient Hospital	$270,613,700	$297,828,400	$333,197,900	$332,029,100	$323,285,700	10.06%	11.88%	-0.35%	-2.63%	4.7%
Outpatient Hospital	55,267,900	58,663,600	69,602,400	75,647,100	80,790,100	6.14	18.65	8.68	6.80	10.1
Subtotal	$325,881,600	$356,492,000	$402,800,300	$407,676,200	$404,075,800	9.39%	12.99%	1.21%	-0.88%	5.7%
Non-Institutional Fee-for-Service										
Physicians and Clinics	63,184,200	72,401,200	78,703,500	85,194,600	104,007,400	14.59%	8.70%	8.25%	22.08%	13.4%
Outpatient Mental Health	35,205,200	40,625,400	47,813,300	57,185,400	35,228,300	15.40	17.69	19.60	-38.40	3.6
Drugs	336,515,300	373,633,500	432,476,000	494,714,400	560,630,800	11.03	15.75	14.39	13.32	13.6
DME/DMS	32,187,500	33,970,100	37,766,700	37,233,600	35,505,300	5.54	11.18	-1.41	-4.64	2.7
SMV Transport and Ambulance	28,886,400	26,767,200	26,280,200	25,942,600	35,712,900	-7.34	-1.82	-1.28	37.66	6.8
Dental	19,645,600	21,601,600	23,717,300	21,032,100	22,533,200	9.96	9.79	-11.32	7.14	3.9
Other Care	135,912,100	157,102,900	183,639,900	193,066,300	225,468,300	15.59	16.89	5.13	16.78	13.6
Subtotal	$651,536,300	$726,101,900	$830,396,900	$914,369,000	$1,019,086,200	11.44%	14.36%	10.11%	11.45%	11.8%
Total Acute Care Services	$977,417,900	$1,082,593,900	$1,233,197,200	$1,322,045,200	$1,423,162,000	10.76%	13.91%	7.20%	7.65%	9.9%
Managed Care Payments* **	$394,389,300	$523,590,900	$681,842,400	$657,888,600	$887,135,000	32.76%	30.22%	-3.51%	34.85%	23.6%
Medicare Premiums and Payments	$131,260,600	$131,946,100	$149,951,400	$162,216,700	$162,414,200	0.52%	13.65%	8.18%	0.12%	5.6%
Total Provider Payments** **	$3,044,045,300	$3,291,809,100	$3,700,871,300	$3,849,243,000	$4,224,280,500	8.14%	12.43%	4.01%	9.74%	8.6%

*DHFS accelerated payments to take advantage of the enhanced FFP rate available in 2003-04.

**Includes an estimate of the GPR expended outside of the MA benefits appropriations to support COP-W and excludes encumbrances

***Includes payments to HMOs for low-income families and payments to Family Care CMOs, PACE/WPP, and I-Care

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

APPENDIX I

Allocation of Supplemental MA Payments to County- and Municipally-Operated Nursing Homes in 2003-04

County	Total Supplemental Payment Award
Brown	1,159,618
Calumet	338,918
Clark	1,602,784
Columbia	944,514
Dane	915,877
Dodge	2,267,534
Dunn	1,418,132
Fond du Lac	1,458,460
Grant	533,468
Green	974,966
Iowa	590,888
Jackson	997,124
Jefferson	1,015,589
Kenosha	1,137,460
Kewaunee	84,873
La Crosse	2,768,550
Lafayette	687,182
Lincoln	1,191,191
Manitowoc	1,107,916
Marathon	2,363,553
Milwaukee	1,218,707
Monroe	878,946
Outagamie	1,506,765
Ozaukee	1,506,765
Pierce	89,529
Polk	842,016
Portage	844,949
Racine	1,551,082
Richland	667,515
Rock	1,429,499
Rusk	686,908
Sauk	982,352
Shawano	556,289
Sheboygan	3,896,457
St. Croix	706,752
Trempealeau	855,227
Vernon	613,127
Walworth	1,835,734
Washington	1,684,032
Waupaca	607,836
Winnebago	1,765,279
Wood	1,144,846
Subtotal	49,429,209
Family Care awards	670,791
Total payments	$50,100,000

APPENDIX II

Planned Phase-In of Classes of Drugs Comprising Wisconsin's Preferred Drug List as of December, 2004

Therapeutic Class	Date PA Required
Angiotensin II Receptor Blockers	Nov. 01, 2004
Antimigrant Agents, Triptans	Nov. 01, 2004
Bone Resorption Suppression and Related Agents	Nov. 15, 2004
Glucocoricoids, Inhaled	Nov. 15, 2004
Lipotropics, Statins	Nov. 15, 2004
Intranasal Rhinitis Agents	Nov. 29, 2004
Lipotropics, Other	Nov. 29, 2004
NSAIDS	Dec. 13, 2004
Beta Blockers	Jan. 05, 2005
Calcium Channel Blockers	Jan. 05, 2005
NSAIDs -- Prevacid Naprapac Only	Jan. 05, 2005
Otics, Antibiotics	Jan. 05, 2005
Antifungals, Oral	Jan. 19, 2005
Antivirals, Influenza	Jan. 19, 2005
Antivirals, Other	Jan. 19, 2005
Cephalosporins and Related Antibiotics	Jan. 19, 2005
Fluoroquinolones	Jan. 19, 2005
Macrolides / Ketolides	Jan. 19, 2005
Proton Pump Inhibitors	Feb. 2, 2005

Therapeutic Classes for Which Prior Authorization is Not Required

Leukotriene Modifiers
Hypoglycemics, Thiazolidinediones
Ace Inhibitors / CCB Combinations
Topical Immunomodulators
Lipotropics, Statins (Vytorin only)

"PA" = Prior Authorization

APPENDIX III

Drug Categories Requiring Prior Authorization
As of December, 2004

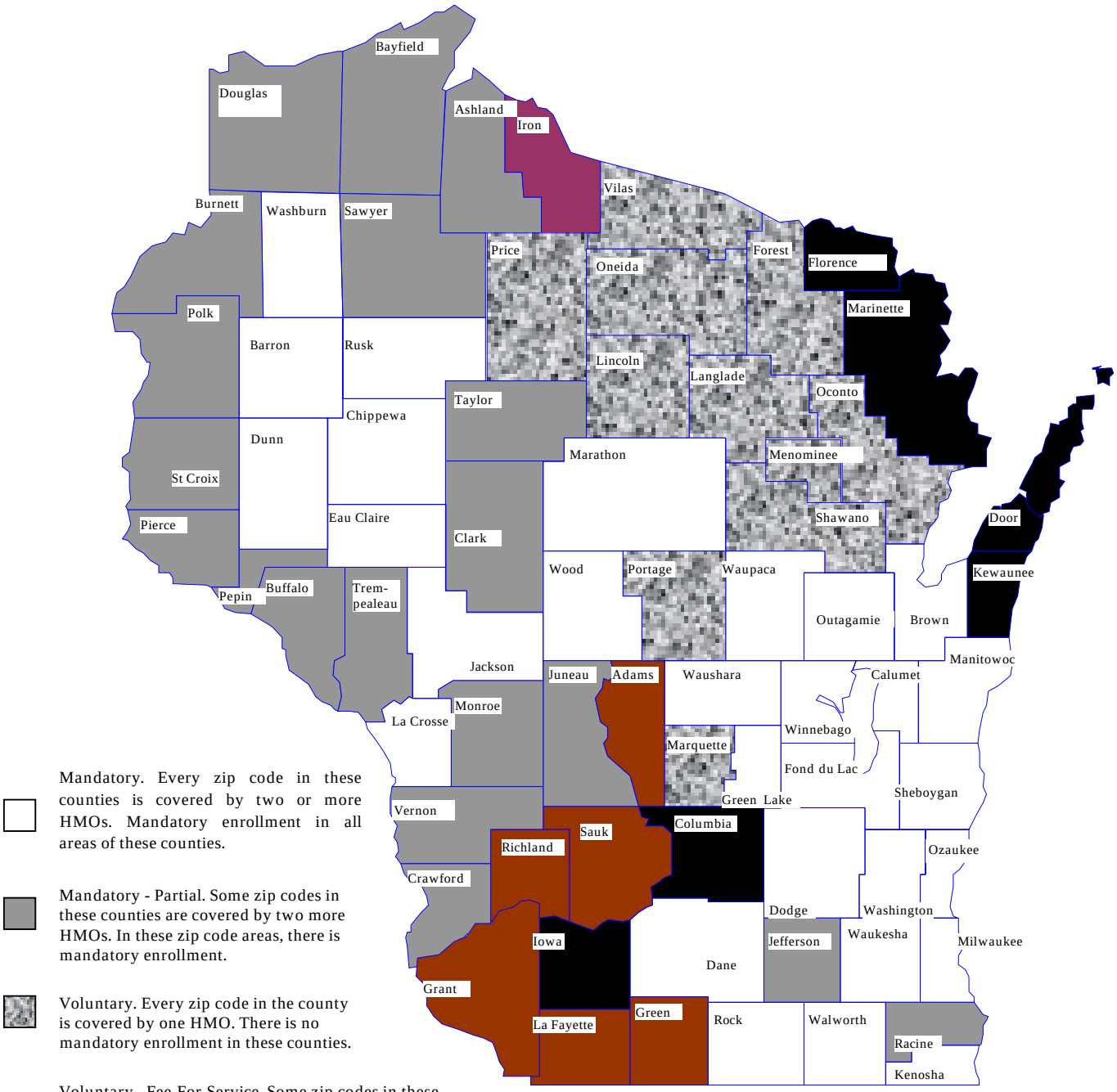
.

Drug Category

Alitretinoin Gel
Angiotension Converting Enzyme (ACE) Inhibitor Drugs
Alpha-1 Proteinase Inhibitor Drugs
C-III and C-IV Stimulants
Cholesterol Lowing Drugs (Statins)
Enteral Nutrition Products
Fertility Enhancement Drugs
Human Growth Hormone
Impotence Treatment Drugs
Nonsedating Antihistamine Drugs
Non-Steroidal Anti-Imflammatory Drugs
Proton Pump Inhibitors (PPI) Drugs
Selective Serotonin Reuptake Inhibitor (SSRI) Drugs
Unlisted or Investigational Drugs
Weight Loss Agents

APPENDIX IV

HMO Enrollment Status for MA and BadgerCare Recipients
As of October, 2004



Mandatory. Every zip code in these counties is covered by two or more HMOs. Mandatory enrollment in all areas of these counties.

Mandatory - Partial. Some zip codes in these counties are covered by two more HMOs. In these zip code areas, there is mandatory enrollment.

Voluntary. Every zip code in the county is covered by one HMO. There is no mandatory enrollment in these counties.

Voluntary - Fee-For-Service. Some zip codes in these counties are covered by one HMO, the rest are not covered by an HMO. Consequently, there is no mandatory enrollment in these counties.

Fee-For-Service. No HMOs participate in these counties.

APPENDIX V

Medical Assistance Waiver Services*

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

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

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

Service	CIP IA CIP IB	BIW	CLTC	COP-W CIP II
Supportive home care are services to maintain individuals in independent or supervised living situations.	Yes	Yes	Yes	Yes
Specialized medical and therapeutic supplies are items and devices that are necessary to maintain the child's health, manage a medical or physical condition, or improve functioning or enhance independence.	No	No	Yes	No
Specialized transportation are services to improve access to needed community services and the ability to perform tasks independently.	Yes	Yes	Yes	Yes

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

Note: CIP IA and CIP IB funds services for individuals who are relocated from the state centers for the developmentally disabled (CIP IA) and individuals who are relocated or diverted from other intermediate care facilities for the mentally retarded (CIP IB). The brain injury waiver (BIW) program funds services to individuals with brain injuries who require post acute rehabilitation institutional care. The children's long-term care (CLTC) waiver program provides services to children with developmental disabilities, physical disabilities, and who meet the psychiatric hospital or severe emotional disturbance level of care. The community options waiver program (COP-W) and the community integration program (CIP II) provide community based services for elderly and physically disabled individuals.

APPENDIX VI

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2005

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Adams	$278,678	$175,698	$37,641	$80,929	$66,996	$106,707
Ashland	347,137	337,468	62,735	0	85,079	270,963
Barron	462,486	310,856	81,556	80,929	537,782	344,998
Bayfield	277,400	195,778	94,103	80,929	104,216	122,999
Brown	2,529,142	1,887,441	501,881	107,906	1,511,135	1,002,324
Buffalo	239,093	153,225	75,282	26,976	59,552	97,415
Burnett	244,298	159,089	43,914	26,976	22,332	83,777
Calumet	267,468	164,557	25,094	53,953	148,880	37,467
Chippewa	658,367	362,145	81,556	80,929	215,876	691,346
Clark	482,730	336,932	100,376	0	394,532	279,056
Columbia	705,610	503,265	62,735	107,906	248,768	283,103
Crawford	265,287	153,872	232,120	0	186,100	162,908
Dane	5,140,635	3,013,000	2,013,799	377,670	2,469,636	1,808,020
Dodge	621,875	366,202	125,470	242,788	264,366	294,043
Door	228,463	120,233	25,094	53,953	96,772	76,073
Douglas	864,519	457,022	803,010	53,953	478,235	219,108
Dunn	396,048	274,437	106,650		178,804	293,593
Eau Claire	948,351	637,856	75,282	53,953	260,540	1,187,412
Florence	85,954	49,195	0	0	37,220	18,734
Fond du La	564,513	0	0	0	59,712	
Forest, Oneida, Vilas	0	0	0	80,929	596,320	381,866
Forest	187,158	90,850	75,282	0	0	
Grant-Iowa	225,589	120,294	50,188	80,929	316,507	291,195
Grant	616,661	327,871	439,146	0	0	0
Green	395,084	195,426	445,420	80,929	95,375	230,199
Green Lake	145,926	104,762	18,821	0	66,996	228,375
Iowa	0	0	0	0	0	
Iron	131,960	88,768	31,368	0	37,220	
Jackson	270,647	198,471	388,958	0	200,988	168,603
Jefferson	595,577	344,248	677,540	242,788	1,183,838	232,147
Juneau	287,882	210,631	106,650	80,929	132,824	139,978
Kenosha	1,694,698	1,512,670	583,437	134,882	602,796	668,116
Kewaunee	231,660	227,733	43,914	26,976	130,350	212,964
LaCrosse	478,315	0	0	0	44,664	48,408
Lafayette	217,792	151,413	62,735	0	44,664	46,310
Langlade	322,268	135,408	106,650	0	0	0
Lincoln, Langlade, Marathon	0	0	125,470	107,906	714,623	629,750
Lincoln	247,683	201,927	150,565	80,929	193,544	167,554
Manitowoc	803,362	558,597	878,292	80,929	334,980	301,387
Marathon	1,144,784	1,139,769	87,829	0	55,972	0

APPENDIX VI (continued)

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2005

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Marinette	$484,285	$340,181	$56,462	$134,882	$157,320	$206,969
Marquette	157,544	161,802	163,111	0	73,353	96,815
Menominee	156,328	100,104	37,641	0	29,776	
Milwaukee	8,527,073	3,066,288	1,731,490	998,128	5,652,537	4,679,510
Monroe	430,595	231,934	301,129	80,929	133,992	243,461
Oconto	337,492	180,025	50,188	107,906	133,992	172,199
Oneida	397,107	154,640	420,325	0	0	
Outagamie	1,300,259	980,940	307,402	134,882	476,416	581,492
Ozaukee	483,913	368,593	75,282	53,953	127,699	366,580
Pepin	146,266	64,513	94,103	0	44,664	111,353
Pierce	390,181	171,638	106,650	53,953	483,860	225,703
Polk	452,745	302,216	94,103	26,976	90,137	354,135
Portage	210,952	0	0	0	66,996	11,830
Price	271,976	229,552	69,009	26,976	113,289	129,637
Racine	2,379,729	982,332	746,548	134,882	437,250	1,223,381
Richland	123,310	0	0	0	44,664	0
Rock	2,005,994	1,169,290	1,894,602	134,882	565,435	715,924
Rusk	201,816	222,714	112,923	80,929	44,664	158,711
St. Croix	426,064	297,906	313,676	215,811	282,872	330,611
Sauk	458,501	367,709	545,796	179,966	364,756	207,119
Sawyer	238,601	148,249	81,556	53,953	68,033	184,788
Shawano	391,547	498,567	43,914	0	89,328	192,881
Sheboygan	1,237,477	685,880	978,668	107,906	635,317	392,057
Taylor	216,717	164,802	50,188	53,953	148,880	254,025
Trempealeau	543,480	410,797	138,017	0	119,104	271,113
Vernon	210,429	233,987	25,094	26,976	208,432	116,298
Vilas	263,319	231,440	150,565	0		
Walworth	685,394	563,369	577,164	107,906	194,630	328,213
Washburn	260,389	248,602	31,368	0	79,152	74,935
Washington	664,063	433,432	257,214	215,811	342,095	560,210
Waukesha	3,570,467	1,918,697	495,608	377,670	540,464	1,267,892
Waupaca	606,889	359,328	338,770	26,976	119,104	194,680
Waushara	233,782	328,017	319,949	0	59,552	80,030
Winnebago	1,702,672	1,090,279	652,446	188,835	384,738	713,526
Wood	777,848	541,282	476,787	80,929	295,288	630,948
Total	$54,550,304	$32,516,214	$20,558,311	$6,033,846	$24,785,983	$26,203,924

APPENDIX VII

Income Maintenance Base Allocations*
2003 through 2005

County / Tribe	2003	2004	2005	County / Tribe	2003	2004	2005
Adams	$293,707	$264,710	$246,714	Marquette	$175,072	$172,100	$160,644
Ashland	382,148	344,552	321,004	Menominee	160,644	160,644	160,644
Bad River	97,600	97,600	160,644	Milwaukee	18,253,941	17,043,820	15,829,372
Barron	663,236	606,214	557,118	Monroe	473,795	429,724	397,988
Bayfield	215,419	193,740	180,952	Oconto	327,640	301,682	278,042
Brown	1,592,268	1,595,690	1,461,434	Oneida	467,383	427,075	393,047
Buffalo	176,676	169,700	160,644	Oneida Tribe	160,644	167,714	160,644
Burnett	244,008	220,143	204,967	Outagamie	777,327	778,375	713,455
Calumet	224,503	214,781	198,813	Ozaukee	298,516	284,292	263,620
Chippewa	649,341	591,343	548,323	Pepin	160,644	160,644	160,644
Clark	364,246	331,389	306,325	Pierce	245,077	228,885	205,865
Columbia	408,867	387,087	358,583	Polk	447,076	407,240	375,544
Crawford	231,183	213,190	198,438	Portage	609,797	600,209	548,885
Dane	2,603,063	2,591,566	2,389,174	Potawatomi	97,600	97,600	97,600
Dodge	649,609	592,008	547,948	Price	307,868	277,029	258,609
Door	240,802	230,774	212,486	Racine	1,841,293	1,820,851	1,679,267
Douglas	665,907	604,702	559,362	Red Cliff	160,644	160,644	160,644
Dunn	398,981	388,120	356,148	Richland	249,352	232,099	216,607
Eau Claire	926,154	907,697	835,461	Rock	1,663,342	1,659,380	1,526,668
Florence	160,644	160,644	160,644	Rusk	279,812	251,126	235,042
Fond du Lac	882,869	851,385	789,009	Sauk	505,324	476,287	440,623
Forest	168,927	170,372	160,644	Sawyer	321,495	290,372	270,056
Grant	488,224	446,548	410,108	Shawano	394,439	377,943	349,967
Green	315,616	292,212	271,300	Sheboygan	778,931	775,019	714,927
Green Lake	200,456	180,155	168,383	Sokaogon	97,600	97,600	97,600
Iowa	202,326	182,494	169,954	St. Croix	375,468	380,424	344,616
Iron	160,644	168,450	160,644	Stockbridge-Munsee	97,600	97,600	97,600
Jackson	270,193	243,706	226,962	Taylor	286,225	257,201	240,429
Jefferson	548,877	542,389	501,309	Trempealeau	363,444	327,349	305,293
Juneau	288,897	277,804	257,064	Vernon	324,968	293,077	272,973
Kenosha	1,598,414	1,597,847	1,467,075	Vilas	205,800	185,872	172,872
Kewaunee	170,263	171,084	160,644	Walworth	630,638	634,483	578,819
La Crosse	1,139,642	1,079,829	990,361	Washburn	261,910	239,540	221,664
Lac du Flambeau	160,644	160,644	160,644	Washington	585,215	580,056	537,128
Lafayette	160,644	170,268	160,644	Waukesha	1,348,053	1,308,628	1,209,508
Langlade	332,984	302,647	279,707	Waupaca	621,553	570,618	530,154
Lincoln	326,037	296,667	273,871	Waushara	276,606	249,093	232,349
Manitowoc	648,540	642,818	595,250	Winnebago	1,104,640	1,098,173	1,013,873
Marathon	1,022,878	1,005,217	921,433	Wood	837,446	763,840	707,532
Marinette	512,271	477,023	441,559				
				Total	$57,362,530	$54,629,517	$50,692,561

*These allocations do not include additional funds DHFS provides to counties for other IM functions.

APPENDIX VIII

Local Overmatch Expenditures for Income Maintenance Activities for 2001 through 2003

County / Tribe	2001	2002	2003
Adams	$12,043	$40,220	$69,173
Ashland	1,106	0	2,279
Bad River	0	0	0
Barron	0	1,911	35,523
Bayfield	7,276	41,828	16,678
Brown	94,630	325,148	440,701
Buffalo	21,271	0	0
Burnett	5,190	4,902	26,492
Calumet	0	592	2,989
Chippewa	0	18,811	0
Clark	0	0	0
Columbia	0	91,080	125,319
Crawford	1,828	20,986	39,361
Dane	1,915,966	1,635,801	1,509,388
Dodge	103,616	66,425	102,430
Door	77,174	33,976	55,850
Douglas	0	20,592	1,179
Dunn	54,309	103,370	149,373
Eau Claire	0	204,611	239,997
Florence	8,650	0	0
Fond du Lac	105,613	174,802	436,236
Forest	8,660	5,708	5,649
Grant	0	0	0
Green	0	0	0
Green Lake	8,802	0	6,369
Iowa	0	33,053	54,539
Iron	9,129	1,935	11,068
Jackson	5,399	60,724	60,346
Jefferson	99,227	153,997	276,104
Juneau	0	65,930	69,229
Kenosha	1,771,313	2,215,855	3,013,226
Kewaunee	12,916	0	0
Lac du Flambeau	0	0	0
LaCrosse	0	0	0
Lafayette	16,164	24,920	29,155
Langlade	39,728	63,749	9,896
Lincoln	0	0	10,442
Manitowoc	0	20,996	86,526
Marathon	454,099	262,854	251,188
Marinette	164,608	167,982	326,011
Marquette	$6,656	$7,342	$619
Menominee	0	7,455	3,652
Milwaukee	799,611	2,154,104	1,622,726
Monroe	88,039	63,466	73,990
Oconto	86,663	114,472	78,584
Oneida	3,218	0	0
Oneida Tribe	4,009	0	0
Outagamie	33,416	448,304	581,190
Ozaukee	15,828	44,536	77,260
Pepin	15,288	0	0
Pierce	0	290	55,130
Polk	17,677	22,036	29,472
Portage	74,696	94,950	171,300
Potawatomi Tribe	N.A.	N.A.	0
Price	52,059	50,096	9,846
Racine	367,018	569,891	727,617
Red Cliff	6,115	0	238
Richland	49,735	33,172	43,975
Rock	0	207,458	132,602
Rusk	0	0	6,961
Sauk	16,783	0	0
Sawyer	44,015	0	0
Shawano	113,209	160,473	120,994
Sheboygan	80,264	0	31,386
Sokaogon	0	0	0
St. Croix	50,184	105,895	120,891
Stockbridge Munsee	203	0	0
Taylor	0	8,452	18,348
Trempealeau	0	0	0
Vernon	0	16,526	40,161
Vilas	30,204	36,555	18,806
Walworth	94,467	181,077	169,964
Washburn	0	3,803	30,416
Washington	3,288	107,592	156,020
Waukesha	298,135	505,356	799,816
Waupaca	143,388	147,204	176,101
Waushara	49,260	85,094	94,288
Winnebago	124,132	200,217	381,258
Wood	295,199	403,509	242,566
Total	$7,961,476	$11,642,083	$13,478,893