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Medical Assistance, BadgerCare Plus, SeniorCare, and Related Programs

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Introduction

Title XIX of the federal Social Security Act authorizes the U.S. Department of Health and Human Services (DHHS) to financially assist states in providing health care services to people with limited resources. This program is commonly referred to as medical assistance (MA), Medicaid, or Title 19.

Wisconsin's MA program is authorized under Chapter 49 of the state statutes and is administered by the Division of Health Care Access and Accountability (DHCAA) in the Department of Health Services (DHS). DHS administers the program under state and federal law, and in conformity with the MA plan it provides to the DHHS Centers for Medicare and Medicaid Services (CMS). The state periodically amends its MA plan to reflect changes in law and policy, with all such amendments subject to CMS review and approval.

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

States receive federal matching payments to help pay for these covered services and for program administration. The federal medical assistance percentage (FMAP) is the portion of the total payment for covered services supported by federal matching funds. Each state's FMAP is calculated annually under a formula that compares a three-year average of the state's per capita income to national per capita income. The minimum FMAP for any state is 50%. In federal fiscal year 2008-09 (October 1, 2008 through September 30, 2009), Wisconsin's FMAP is 59.38%, which for state budgeting purposes converts to an FMAP of 58.94% for state fiscal year 2008-09. Most MA administrative costs are funded on a 50% state / 50% federal basis.

In recent years, Wisconsin's MA program has grown increasingly complex, partly due to agreements between the state and DHHS that waive certain aspects of federal MA law, thereby enabling the state to expand coverage. Examples of current waiver programs include the state's home- and community-based long-term care programs (including the community options waiver program, the community integration program, and the long-term care children's waiver program), the family planning waiver program, and SeniorCare, Wisconsin's program to assist elderly individuals purchase drugs.

2007 Wisconsin Act 20 (the 2007-09 biennial budget act) ushered in further changes to the state's MA program by authorizing DHS to implement BadgerCare Plus. On February 1, 2008, the state began enrolling individuals in the new BadgerCare Plus program.

With the implementation of BadgerCare Plus, Wisconsin's medical assistance program can now be viewed as two broad but distinct programs. The first, now referred to simply as "MA," provides coverage for elderly, blind, and disabled individuals under a series of subprograms such as EBD MA, Family Care, and the home- and community-based waivers. The second, BadgerCare Plus, provides

coverage primarily to low-income children, their families, and pregnant women.

Table 1 shows total state benefit expenditures under Wisconsin's MA and BadgerCare Plus programs for state fiscal years 2005-06, 2006-07 and 2007-08, by funding source. Benefit expenditures for the SeniorCare prescription drug program are shown separately. The revenue sources used to fund the benefit expenditures reflected in Table 1 include state general purpose revenue (GPR), segregated revenue from the MA trust fund (SEG), program revenue from various sources (PR), and federal MA matching funds (FED).

Table 1: State Benefit Expenditures for MA/BadgerCare Plus and SeniorCare, By Fund Source, State Fiscal Years 2005-06, 2006-07 and 2007-08

	2005-06	2006-07	2007-08	% of Total Benefits, 2005-06 through 2007-08
MA/BC+				
GPR	$1,361,482,100	$1,766,425,600	$1,756,424,200	35%
FED	2,706,452,000	2,774,287,400	2,905,844,900	59
PR	7,295,000	9,336,300	45,468,400	1
SEG	359,935,500	127,253,200	212,060,700	5
Total	$4,435,164,600	$4,677,302,500	$4,919,798,200	100%
SeniorCare				
GPR	$44,364,400	$45,668,300	$38,797,300	31%
FED	45,700,200	41,875,500	33,476,700	30
PR	50,639,800	53,198,000	54,780,900	39
Total	$140,704,400	$140,741,800	$127,054,900	100%

CHAPTER 1

BADGERCARE PLUS AND RELATED PROGRAMS

Beginning February 1, 2008, BadgerCare Plus replaced the programs previously known as Family Medicaid and BadgerCare. This chapter discusses the eligibility criteria and the delivery of health care services under BadgerCare Plus, as well as several other MA-related programs including the family planning waiver, Well Woman MA, the Children Come First and Wraparound Milwaukee programs, and the MA coverage provided to foster children. The chapter also briefly describes the anticipated expansion of MA services to childless adults, scheduled to begin in early 2009.

BadgerCare Plus -- Eligibility

Subject to the non-financial and financial requirements discussed below, the following individuals are eligible for health care coverage under BadgerCare Plus:

- Children under 19 years of age;

- Parents and caretaker relatives of children under 19 years of age;

- Pregnant women;

- Young adults up to age 21 who were in out-of-home care (such as foster care) on their 18th birthday; and

- Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care.

Non-Financial Eligibility Criteria

Individuals from the above-listed eligibility groups must, with limited exceptions, satisfy the following non-financial criteria to participate in BadgerCare Plus. First, they must be a Wisconsin resident, a requirement generally satisfied if they live in Wisconsin and express their intent to remain living in Wisconsin. Inmates of public institutions are not eligible, with the exception that inmates who are pregnant women may enroll in the BadgerCare Plus prenatal program.

Second, the individual must be a U.S. citizen (or a U.S. national or qualified alien) and must be able to document their status. Regulations developed by CMS pursuant to the Deficit Reduction Act of 2005 prescribe the documents states can accept as proof of citizenship or qualified alien status. Those documentation requirements first applied to MA eligibility determinations made on or after July 1, 2006. Persons applying for or receiving emergency MA benefits or BadgerCare Plus prenatal benefits are exempt from these documentation requirements, as are individuals who currently receive Medicare, SSI, or SSDI benefits.

Third, the individual must cooperate in establishing medical support and third-party liability for medical expenses. Medical support refers to the obligation a parent has to pay for his or her child's medical care, either through health insurance or through direct payment of medical expenses. An example of the member's duty to cooperate in this regard is their obligation to help establish the paternity of any child born out of wedlock for whom coverage under BadgerCare Plus is received.

Third-party liability refers to situations where a party other than the BadgerCare Plus program or the member is obligated to pay the member's medical expenses, such as when a member has

coverage under a private health insurance plan. Members are required to provide to the program information about their private health insurance coverage. As the payer of last resort, BadgerCare Plus only pays for covered services not covered by the member's other health insurance. Moreover, some individuals with employer-sponsored health insurance are not eligible for coverage under BadgerCare Plus due to the program's "other insurance" rules discussed below.

Third-party liability also exists when a member becomes entitled to a settlement related to injuries for which BadgerCare Plus paid part or all of the resulting medical expenses. In those circumstances, the member must advise the state of their claim before they settle their case, and must assign to the state that portion of the settlement needed to reimburse BadgerCare Plus for the medical expenses it paid.

Fourth, the individual must provide a social security number or apply for a number if they do not have one. Several groups, such as continuously eligible newborns, pre-adoptive infants living in a foster home, non-qualifying immigrants receiving emergency services, and women applying for the BadgerCare Plus prenatal program are exempt from this requirement, as are individuals who belong to a recognized religious sect that conscientiously opposes applying for or using a social security number.

Fifth, and related to all of the program's other eligibility criteria, is the member's ongoing duty to cooperate with requests to verify information relevant to their participation in BadgerCare Plus, such as their social security number, citizenship and identity, immigration status, pregnancy, income, and access to other health insurance coverage.

"Other Insurance" Eligibility Rules

BadgerCare Plus has eligibility provisions designed to limit some applicants' ability to switch their health insurance coverage from an employer-sponsored plan to BadgerCare Plus. For these purposes, the term "employer-sponsored insurance" means health insurance offered by a current employer of an adult family member living in the applicant's household for which the employer pays at least 80% of the premium, or health insurance offered through the Wisconsin state employee health plan. These "other insurance" provisions (also referred to as "crowd out" rules because they are intended to reduce the crowding out of employer-based coverage by public coverage) apply to individuals who either had past access to, have current access to, or have current coverage under an employer-sponsored health insurance plan.

"Past access" refers to situations where a family member could have enrolled in an employer-sponsored insurance plan that was available to them, but did not. In those circumstances, any person in the household that could have been covered under that private plan is not eligible for BadgerCare Plus for twelve months from the date the employer-sponsored insurance would have begun. Several "good cause" reasons can excuse an applicant's not enrolling in an employer-sponsored plan to which they had past access. Those reasons include instances where the family member's employment ended, the employer discontinued its health insurance plan, or the applicant had coverage under a different health insurance plan.

"Current access" refers to situations where the individual currently has access to an employer-sponsored health plan, but is not enrolled. It also refers to those circumstances where household members could be covered under that private plan in the three calendar months following any of the following events: (a) the BadgerCare Plus application filing date; (b) the BadgerCare Plus member's annual review month; or (c) the employed family member's employment start date. Unlike past access, there are no good cause reasons for not enrolling in an employer-sponsored health plan to which the individual currently has access.

A person currently covered by employer-sponsored health insurance is not eligible for

BadgerCare Plus. In addition, individuals who had employer-sponsored coverage but dropped it for other than good cause reasons cannot enroll in BadgerCare Plus for three calendar months following the month in which they dropped their private coverage.

There are several important exceptions to these "other insurance" rules. First, the rules only apply to individuals with family income greater than 150% of the federal poverty level (FPL).[1] Second, children under age 19 with family income greater than 150% of the FPL can qualify for BadgerCare Plus by meeting a deductible, even if they have access to or coverage under a different health insurance plan. That deductible is calculated for a six-month period and equals the amount by which the child's family income exceeds 150% of the FPL. The child meets their deductible by the family incurring medical expenses equal to or greater than the deductible amount or by prepaying the deductible. Third, some groups such as continuously eligible newborns and youths exiting out-of-home care are exempt from the "other insurance" rules altogether. Pregnant women, other than those in the BadgerCare Plus prenatal program, are also exempt from the past access, current access, and current coverage elements of the "other insurance" rules, but are subject to eligibility rules regarding dropped insurance coverage.

Health Insurance Premium Payment Program

The health insurance premium payment (HIPP) program is available to certain individuals and families who qualify for coverage under BadgerCare Plus but for whom the state determines it is more cost-effective to help them buy into their employer-sponsored health plan. The following individuals are eligible for HIPP: (a) children and parents with incomes at or below 150% of the FPL; (b) children and parents with income greater than 150% of the FPL where the employer pays less than 80% of the premium; and (c) pregnant women with incomes up to 300% of the FPL. Some farm and other self-employed families and members with self-funded insurance plans can also qualify for HIPP. For persons participating in HIPP, the program pays their share of the premium for their private coverage, plus any coinsurance and deductibles. HIPP also pays for any BadgerCare Plus-covered services not covered by the HIPP participant's private plan.

Special Eligibility Rules

BadgerCare Plus has several eligibility rules targeted specifically for pregnant women and newborn children. Through express enrollment, for instance, pregnant women with income up to 300% of the FPL can temporarily enroll in BadgerCare Plus for the period beginning with their application date and running through the end of the following month. During that period of temporary enrollment, and while their application for full benefits is being processed, a pregnant woman can receive pregnancy-related outpatient and pharmacy services. (Under a similar express enrollment process, children under age 19 who are U.S. citizens and who have family income at or below 150% of the FPL can also temporarily enroll in BadgerCare Plus for up to two months while their application is processed.) Pregnant women can also have their BadgerCare Plus eligibility backdated to the first of the month up to three months prior to the month of their application. Finally, pregnant women retain their BadgerCare Plus eligibility, at a minimum, through the end of the month in which the 60th day after the end of their pregnancy occurs.

As for newborn children, they remain eligible for BadgerCare Plus from the date they are born through the end of the month in which they turn one year old if they continuously live with their natural mother and the natural mother was determined to have been eligible for MA coverage with

[1] Appendix 1 shows the 2008 FPL by family size and identifies several percentages of the FPL that are relevant for EBD MA, BadgerCare Plus, and SeniorCare eligibility purposes.

full benefits, or BadgerCare Plus or MA emergency services. When these circumstances hold, the newborn child receives coverage under the standard plan or the benchmark plan, depending upon which plan the mother was enrolled in at the time of the baby's birth. Newborn children are also exempt from the program's "other insurance" eligibility provisions, and from its citizenship and identity documentation requirements.

Financial Eligibility Criteria

Income (but not assets) is also a factor in determining eligibility for BadgerCare Plus. The first step in calculating an applicant's income for program eligibility purposes is to identify their BadgerCare Plus test group. Broadly speaking, a BadgerCare Plus test group includes the individuals who live in the applicant's household and whose income and needs are considered when determining financial eligibility for BadgerCare Plus. Depending upon an applicant's particular circumstances, their BadgerCare Plus test group can include children under age 19, parents, co-parents, spouses, caretaker relatives, and other "essential" persons.

Once the test group is established, the available income of its members is counted to determine whether an applicant is eligible for BadgerCare Plus. For these purposes, income is deemed "available" if it is actually available, the person has a legal interest in it, and they have the legal ability to make it available for support and maintenance. From this broad definition, a number of possible income sources are excluded, including all court-ordered support a BadgerCare Plus applicant or member is obligated to pay for the support or maintenance of another person is deducted in determining income.

When the applicant's countable income is calculated, the following income limits apply to determine if they are eligible for BadgerCare Plus:

- *No Maximum Income Limit*: Children under age 19 and youths exiting out-of-home care.

- *300% of the FPL*. Pregnant women. Note that pregnant women with income greater than 300% of the FPL can qualify for BadgerCare Plus if they meet a deductible equal to the amount by which their income exceeds 300% of the FPL. They can satisfy this deductible by either incurring medical expenses or prepaying the deductible amount.

- *200% of the FPL*. Parents and caretaker relatives of children under age 19. Parents and caretakers with self-employment income are income-eligible for BadgerCare Plus if their family income after deducting depreciation does not exceed 200% of the FPL.

By virtue of the manner in which these income thresholds are established, some family members might qualify for coverage under BadgerCare Plus while others might not. For example, if a family that consists of a pregnant woman, her husband, and a five-year old child has income equal to 250% of the FPL, the child (eligible at any income level) and the pregnant mother (eligible because her family income is less than 300% of the FPL) are income-eligible for coverage, but the father is not.

A limited exception to the program's income eligibility rules exists for individuals who were enrolled in Family MA or BadgerCare when BadgerCare Plus was implemented, but who were deemed ineligible for BadgerCare Plus solely due to excess income. These persons, referred to as "transitional grandfathered individuals," can receive coverage under BadgerCare Plus for up to 18 months following that program's implementation, provided they pay the premium formerly required of them under Family MA or BadgerCare and they continue to meet all the non-financial eligibility criteria of BadgerCare Plus.

Coverage under BadgerCare Plus: The Standard Plan and the Benchmark Plan

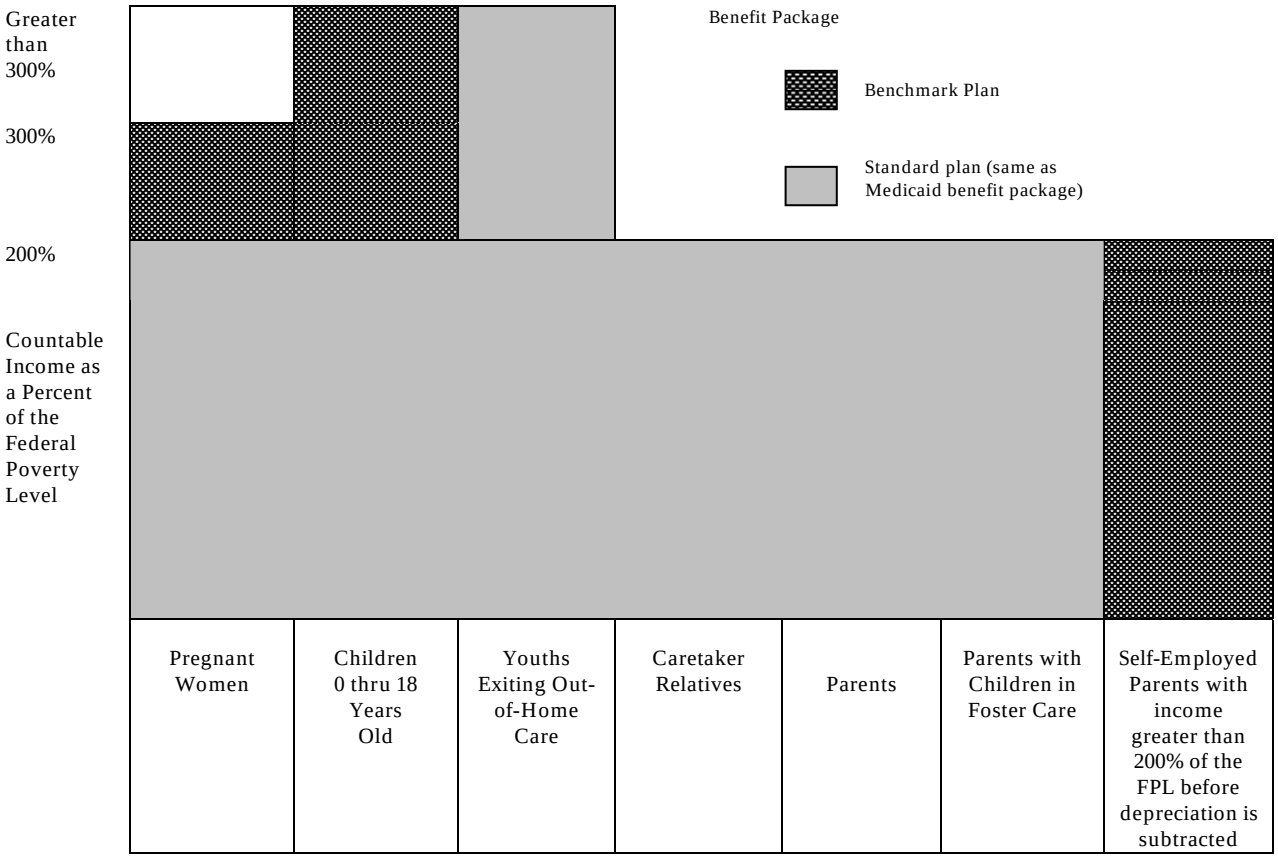
BadgerCare Plus offers two comprehensive benefit plans; the standard plan, and the more limited benchmark plan. The plan a particular mem-

ber participates in depends on their eligibility group and their income. This is illustrated in Figure 1, which shows that virtually all BadgerCare Plus members with income less than or equal to 200% of the FPL, as well as youths exiting out-of-home care (regardless of their income) receive coverage under the standard plan. Participants in the benchmark plan include pregnant women with income greater than 200% but less than 300% of the FPL, children up to 19 years of age with family income greater than 200% of the FPL, and self-employed parents and caretaker relatives of children under age 19 whose income is greater than 200% of the FPL before subtracting depreciation.

As of June 2008, 550,880 individuals, or approximately 98% of the total BadgerCare Plus enrollment, were enrolled in the standard plan, which provides the same coverage most MA and BadgerCare recipients received prior to the implementation of BadgerCare Plus. Those health care services are defined in Chapter 49 of the Wisconsin statutes and are described in greater detail in Chapter 3 of this paper.

Chapter 49 of the statutes also defines the benefits provided under the benchmark plan. Those benefits are more limited than the coverage provided under the standard plan. Appendix 2 summarizes and compares the services covered under the standard plan and the benchmark plan.

Figure 1: BadgerCare Plus Eligibility and Benefits, by Group



The two benefit plans also differ with respect to copayments. A copayment is the dollar amount a member is responsible for paying to the provider in exchange for health care services. As Appendix 2 indicates, copayments under the benchmark plan are higher than the nominal copayments required under the standard plan. Health care providers cannot refuse services to a standard plan enrollee for failing to satisfy a copayment, but participants in the benchmark plan can be denied services if they do not pay a copayment in advance. Several groups are exempt from the program's copayment requirements. Those groups include, but are not limited to children under age 19 with family income up to 100% of the FPL, and most pregnant women.

Premiums

The following individuals must pay a premium to obtain health insurance coverage under BadgerCare Plus:

- Children in families with income over 200% of the FPL;

- Parents, stepparents, and caretaker relatives with income from 150% through 200% of the FPL;

- Self-employed parents, stepparents and caretaker relatives with income over 200% of the FPL (subject to the depreciation rules described above); and

- Transitional grandfathered individuals who were paying a premium under the former BadgerCare program prior to the start of Badger-Care Plus.

Other individuals are exempt from the program's premium requirements. They include the following:

- Pregnant women ages 19 and above;

- Pregnant women up to age 19 in families with income at or below 300% of the FPL;

- Youths exiting out-of-home care;

- Children who have met a BadgerCare Plus deductible (for the remaining deductible period);

- Children and caretaker relatives who remain eligible for a period after their countable household income increases above 100% of the FPL, either due to an increase in earned income, an increase in child support income, or both;

- Most children in families with income at or below 300% of the FPL who are verified members of an American Indian Tribe or an Alaskan Native; and

- Continuously eligible newborns.

Additional details regarding the premiums under BadgerCare Plus, as well as other program information is available in the BadgerCare Plus Eligibility Handbook, accessible online at http://dhs.wisconsin.gov/badgercareplus.

Subject to the rules identified above, Table 2 shows the individual monthly premiums under BadgerCare Plus for children, and parents and adult caretakers with children, by income level. Different premiums, not shown in Table 2, can apply to certain families with self-employment income.

Note that Table 2 shows individual premiums for BadgerCare Plus members. Under program rules, these individual premiums are added together to arrive at the total premiums for a family. With limited exceptions, families with income at or below 300% of the FPL are not required to pay premiums which in the aggregate exceed 5% of their family income.

The following examples illustrate how BadgerCare Plus premiums are calculated using Table 2:

Table 2: BadgerCare Plus Premiums -- Individual Monthly Premiums for Children and Adult Caretakers (Effective January 1, 2009)

Percentage of FPL	Each Child	Each Parent or Adult Caretaker
150% or below	$0.00	$0.00
>150% to 160%	0.00	10.00
>160% to 170%	0.00	29.00
>170% to 180%	0.00	73.00
>180% to 190%	0.00	130.00
>190% to 200%	0.00	201.00
200%	10.00	286.00
>200% to 210%	10.00	Not Eligible
>210% to 220%	10.00	Not Eligible
>220% to 230%	10.00	Not Eligible
>230% to 240%	15.00	Not Eligible
>240% to 250%	23.00	Not Eligible
>250% to 260%	31.00	Not Eligible
>260% to 270%	41.00	Not Eligible
>270% to 280%	52.00	Not Eligible
>280% to 290%	63.00	Not Eligible
>290% to 300%	76.00	Not Eligible
300% or Greater	90.74	Not Eligible

Example 1. A family with countable income between 210% and 220% of the FPL, with two adults and three children would pay a monthly premium of $30 (3 x $10). The children would be enrolled in BadgerCare Plus, and the adults would not be eligible for coverage.

Example 2. A family with countable income between 280% and 290% of the FPL, with two adults, one of whom is pregnant, and one child, would pay $63 per month for coverage of the child, $0 for the pregnant adult, and the other adult would not be eligible for coverage.

Example 3. A family with countable income between 170% and 180% of the FPL, with one adult and two children would pay $73 per month for coverage of the adult and $0 for the two children.

Delivery of Health Care Services Under Badger-Care Plus: Fee-for-Service and Managed Care

Health care services under BadgerCare Plus are provided either on a fee-for-service basis or through a managed care organization. Under a fee-for-service arrangement, members obtain services through participating health care providers. Those providers, in turn, submit claims to the BadgerCare Plus program for each covered service they provide, and they are reimbursed for those services at the rates established by DHS.

Under a managed care arrangement, the state pays a health maintenance organization (HMO) a monthly capitation payment for each BadgerCare Plus member enrolled with that HMO. In return for those monthly capitation payments, the HMO, through its provider network, provides comprehensive health services to its enrolled members. HMOs are reimbursed for most of the services they provide through these capitation payments, although a few services such as certain neonatal intensive care unit (NICU) costs, costs incurred for ventilator-assisted patients, and pharmacy costs, are reimbursed outside of the standard capitation payment. If enrollees use more services or more costly services than projected when the capitation rates were established, the HMO may incur a loss. If enrollees use fewer or less costly services than anticipated, the HMO may realize greater-than-expected profit. In this way, the HMOs, rather than the state, assume the financial risks associated with their members' use of most MA services.

BadgerCare Plus members enrolled in HMOs receive most of the program's covered services through their HMO and its network of providers. Until recently, this was also true with respect to prescription drugs. Effective February 2008, however, prescription drug services have been "carved out" of the capitation payments the state makes to HMOs for BadgerCare Plus members. As a result, BadgerCare Plus members enrolled in HMOs now obtain their prescription drugs through an MA-certified pharmacist on a fee-for-service basis. The pharmacist in turn bills the MA program for those services. The only exceptions are participants in the PACE and Family Care Partnership programs, who continue to receive prescription drugs and related services through

their managed care program.

HMOs have the option of covering dental and chiropractic services. Those that provide those services receive higher capitation payments. BadgerCare Plus members enrolled in HMOs that do not cover those services are entitled to receive them from MA-certified providers on a fee-for-service basis.

HMOs are responsible for providing family planning services to their BadgerCare Plus members, but, under federal law, members can elect to obtain those services from their provider of choice, whether or not that provider participates in the member's HMO. If the member selects that option, those family planning services are reimbursed on a fee-for-service basis.

HMOs do not currently serve BadgerCare Plus members in all areas of the state. Where HMO coverage does not exist, BadgerCare Plus members receive covered health care services on a fee-for-service basis. In some parts of the state, only one HMO offers services to BadgerCare Plus members. Under federal law, states typically cannot require MA recipients to enroll in an HMO unless the recipient has a choice of at least two HMOs. CMS has, however, approved an amendment to Wisconsin's MA plan that permits DHS to require certain BadgerCare Plus members in eligible rural counties to enroll in an HMO, even if only one HMO is participating in the program.

DHS has implemented measures designed to increase the number of MA recipients who receive services through managed care organizations. Those measures include providing financial incentives to HMOs to increase the number of MA recipients they accept and to expand their coverage to new areas of the state. These incentives reflect an intentional strategy on the part of Wisconsin's MA program, the belief being that an increased emphasis on managed care will provide more coordinated, higher quality care to members while controlling program costs. The emphasis on managed care is reflected in Table 3, which shows the increase in HMO enrollment for Family MA and BadgerCare (prior to February 2008) and BadgerCare Plus (beginning February 2008) during the past four years. The June 2008 HMO enrollment of 431,835 members constituted approximately 77% of total BadgerCare Plus enrollment (561,430) as of that date.

Table 3: HMO Enrollment for Family MA and BadgerCare (June 2005, 2006, and 2007) and BadgerCare Plus (June 2008)

June, 2005	353,748
June, 2006	373,357
June, 2007	369,256
June, 2008	431,835

Table 4 identifies the HMOs that were providing services to BadgerCare Plus members in June 2008. Effective December 1, 2008, HMOs were providing coverage to BadgerCare Plus members in 68 of Wisconsin's 72 counties. In 57 of those counties, BadgerCare Plus members were required to enroll in an HMO, and in eight other counties HMO enrollment was mandatory in some zip codes and voluntary (or only fee-for-service) in other zip codes. The remaining counties ranged from 100% voluntary HMO (1), to a mix of voluntary HMO and fee-for service (2), to 100%

Table 4: HMOs Providing Coverage to BadgerCare Plus Members, June 2008

HMO	BadgerCare Plus Enrollees as of June, 2008
Abri Health Plan	11,920
Children's Community Health Plan	15,810
Compcare	36,457
Dean Health Plan	21,121
GHC of Eau Claire	22,026
GHC of South Central Wisconsin	3,961
Health Tradition Health Plan	7,121
Managed Health Services	75,697
Mercy Care Health Plan	11,165
Network Health Plan	42,261
Security Health Plan	28,022
United Healthcare of WI	151,100
Unity Health Plan	5,174
Total Enrollment	431,835

fee-for-service (4). Appendix 3 shows the distribution of HMO coverage for the BadgerCare Plus program effective December 1, 2008.

Federal regulations require that HMO capitation rates be "actuarially sound," meaning they must be established in accordance with generally accepted actuarial principles and practices, be appropriate for the population to be covered and the services provided, and be 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.

The base HMO capitation rates for the BadgerCare Plus program vary across six rate regions. Within those regions, capitation rates vary depending on the member's age, gender, whether they participate in the standard plan or the benchmark plan, and whether the HMO provides chiropractic and/or dental services. Starting in calendar year 2008, the base capitation rates will be adjusted using the Chronic Disability Payment System (CDPS). The CDPS is used to adjust payments to HMOs to reflect cost differences attributable to their members' health conditions. The impact related to CDPS adjustment is being phased in at 25% in calendar year 2008, 50% in calendar year 2009, 75% in calendar 2010, and 100% in calendar year 2011. Table 5 shows per member/per month HMO capitation rates in each of the six regions for calendar year 2008. Those regions are located as follows: Region 1 (North); Region 2 (Northeast); Region 3 (West Central); Region 4 (Madison and Southwest); Region 5 (Southeast); and Region 6 (Milwaukee County). The rates indicated are for enrollment in the standard plan, and assume the HMO provides dental and chiropractic services. As of June 2008, virtually all BadgerCare Plus members enrolled in HMOs were participating in the standard plan. Separate capitation rates apply to pregnant women.

The relationship between the state's MA program and participating HMOs is governed by federal and state regulations, and by the contracts between DHS and those HMOs. The current model contract sets forth in detail the parties' respective duties regarding the delivery of health care services to BadgerCare Plus members, including payment procedures, covered services, billing, enrollment, and grievances and appeals. Two particularly important subject areas addressed in regulation and contract are the accessibility and quality of the health care services HMOs provide to their BadgerCare Plus enrollees.

Accessibility. Federal regulations require states to ensure that each HMO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide

Table 5: Calendar Year 2008 All-Service Base Capitation Rates for the BadgerCare Plus Standard Plan by Age, Gender, and Rate Region

		Rate Region					
Age Range	Gender	1	2	3	4	5	6
Age 0-1	All	$305.51	$302.36	$272.97	$290.89	$336.36	$351.88
Ages 1-5	All	70.44	66.55	62.90	67.91	73.55	77.12
Ages 6-14	All	59.34	53.39	52.95	57.89	58.57	61.56
Ages 15-20	Female	179.44	172.32	160.27	171.91	190.75	199.57
Ages 15-20	Male	74.84	69.95	66.82	72.23	76.72	80.35
Ages 21-34	Female	241.95	232.87	216.12	231.12	257.66	260.09
Ages 21-34	Male	118.30	111.18	105.64	113.16	122.37	127.48
Ages 35-44	Female	257.69	247.74	230.18	245.72	273.87	285.62
Ages 35-44	Male	174.40	165.88	155.76	166.25	182.88	190.38
Ages 45 & older	Female	315.75	304.07	282.04	301.32	336.37	351.08
Ages 45 & older	Male	271.54	261.00	242.54	259.34	288.67	301.38

adequate access to all services covered under the contract. The current contract between DHS and participating HMOs reflects those regulations by requiring each HMO to provide medical care to its BadgerCare Plus enrollees that is "as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to non-enrolled BadgerCare Plus . . . members within the area served by the HMO." To ensure that level of services, the contract requires HMOs, when establishing their network of providers, to consider the following: (a) the anticipated BadgerCare Plus enrollment; (b) the expected utilization of services, considering enrollee characteristics and health care needs; (c) the number and type of providers (in terms of training experience and specialization) needed to furnish the required services; (d) the number of network providers not accepting new patients; and (e) the geographic location of providers and enrollees, distance, travel time, normal means of transportation used by enrollees and whether provider locations are accessible to enrollees with disabilities.

In some cases, the contract establishes specific accessibility requirements. For example, if an HMO agrees to provide dental services, it must have a dental provider within a 35-mile distance from any enrollee residing in the HMO service area, or no further than the distance for non-enrolled members residing in the service area. In meeting that requirement, the HMO must take into consideration whether the dentist accepts new patients and whether full or part-time coverage is available. The same requirements hold for mental health and substance abuse services. For primary care providers, HMOs must have a certified primary care provider within a 20-mile distance from any enrollee in their service area. If there is no such provider, the travel distance for the BadgerCare Plus member shall be no more than for a non- enrolled member. In other cases, the accessibility requirements are stated more generally, as in the contract's requirement that the HMO provide female enrollees with direct access to a woman's health specialist within the network for covered women's routine and preventive health care services.

*Quality***.** Federal regulations also require states to have a written strategy for assessing and improving the quality of managed care services provided by all HMOs. 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' contracts with HMOs must require that each HMO have an ongoing quality assessment and performance improvement (QAPI) program for services furnished to enrollees.

The state's current contract with HMOs reflects these mandates by requiring participating HMOs to establish a QAPI program that, among other things, includes the following elements: (a) monitoring and evaluation of clinical care on an ongoing basis; (b) health promotion and disease prevention services; (c) provider selection (credentialing) and periodic evaluation (recredentialing); (d) enrollee feedback on quality improvement; (e) maintaining medical records in an organized manner that permits effective patient care while addressing such issues as patient confidentiality, organization and completeness, tracking, accuracy, legibility, and safeguards against loss, destruction, or unauthorized use; (f) utilization management; (g) dental services quality improvement (for those HMOs that cover dental services); and (h) accreditation by recognized accrediting bodies.

The current contract also requires each HMO to conduct QAPI performance improvement projects in at least two priority areas. HMOs must focus one of their PIPs on a pay-for-performance area for improvement. Plans can choose other study topics based on the Department’s priority areas. The clinical priority areas listed in the current contract include the following: (a) HealthCheck; (b) tobacco cessation; (c) blood lead testing; (d) healthy birth outcomes; (e) diabetic management; (f) asthma management; and (g) childhood obesity. Non-clinical priority areas identified in the contract are SSI case management, access to and availability of

services, member satisfaction with HMO customer services, and satisfaction with services for enrollees with special health care needs or cultural competency of the HMO and its providers.

External Quality Review Organization and Quality of Care Audits. DHS 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. DHS uses this information to work with HMOs to improve care in those areas where concerns are identified.

Healthcare Effectiveness Data and Information Set (HEDIS). During 2008, DHS began using HEDIS as the basis for assessing quality of care provided to Medicaid and BadgerCare Plus members. HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to help health care payers and consumers assess a managed care organization's performance. HEDIS includes 70 measures across eight domains of care:

- Effectiveness of care
- Access / Availability of care
- Satisfaction with experience of care
- Use of services
- Costs of care
- Health plan descriptive information
- Health plan stability
- Informed health care choices.

Effectiveness of care measures are the most commonly used measures and are the basis for the DHS 2009 Pay for Performance measures.

HMO Report Cards. For the past seven years DHCAA has published an HMO report card that has been included in the enrollee handbook. This report card is designed to provide consumer-friendly representations of each HMO's performance that can be used by BadgerCare Plus members. The report card rates 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 consumer satisfaction measures (customer service, getting needed advice, health plan, and health care). The 2008 report card will focus on pay for performance HEDIS indicators.

Pay for Performance. DHCAA has implemented a multi-year Pay-for-Performance (P4P) program that is intended to leverage its purchasing power and improve the health and health care of its members by establishing financial incentives for HMOs. The primary goal of P4P is to improve the performance of the health care delivery system as well as improving the health and health care outcomes of Medicaid members. DHCAA believes P4P will foster greater health plan and provider accountability for the care provided to the MA population by tying financial incentives to performance.

Limited Benefit Programs

In addition to the comprehensive services offered to most BadgerCare Plus and EBD MA recipients, the state has several limited benefit programs. These programs include the family planning waiver, the prenatal program, and the provision of emergency services.

Family Planning Waiver. The family planning waiver program serves women ages 15 through 44 in families with countable income less than 200% of the FPL who are U.S. citizens or qualified immigrants and who are not enrolled in BadgerCare Plus without a premium. The goal of the program is to provide women with information and services to assist them in preventing pregnancy and to pre-

vent sexually transmitted diseases (STDs). Covered services include contraceptive services and supplies, natural family planning supplies, family planning pharmacy visits, Pap tests, tubal ligations, tests and treatment for STDs, and routine preventive services if they are related to family planning. Women can receive services under the program only in conjunction with contraception services. As of June 2008, approximately 48,800 women were enrolled in the family planning waiver program.

To qualify for benefits, the woman must meet the BadgerCare Plus non-financial criteria, except the "other insurance" rules and the medical support and third party liability requirements (unless she is applying for or receiving BadgerCare Plus coverage for a child for whom she is a caretaker relative.) If a woman under age 19 who lives with one or both of her parents applies for coverage under the program, her parents' income is not counted in determining her eligibility for benefits.

Pre-Natal Program. Pregnant women who meet the financial and nonfinancial eligibility requirements of BadgerCare Plus, but who do not qualify for coverage because they are inmates of public institutions or non-qualifying immigrants, may receive prenatal services under the BadgerCare Plus prenatal program. These services include prenatal care, doctor and clinic visits, prescription drugs (including prenatal drugs), and labor and delivery. Women enrolled in the prenatal program must pay a premium if their countable income is greater than 200% of the FPL. They are not eligible if they have access to an employer-sponsored health insurance plan for which the employer pays 80% or more of the premium, nor if they currently have, or within the preceding three months had coverage under such a plan. Coverage under the prenatal program begins the first day of the month in which a valid application is received and the applicant's pregnancy is verified, and continues through the end of the month after delivery.

Emergency Services. BadgerCare Plus provides coverage for emergency services to documented immigrants who have not been in the United States for five years or more, and for undocumented immigrants. To be eligible for BadgerCare Plus emergency services, immigrants must meet the standard BadgerCare Plus eligibility criteria (except the citizenship and social security number requirements), and their income cannot exceed the following limits:

Pregnant women and newborns up to age 1: 250% of the FPL;

Children ages 1-5: 185% of the FPL;

Children ages 6-18: 150% of the FPL;

Youths exiting out-of-home care: No maximum income; and

Parents and caretaker relatives: 130% of the FPL.

For these purposes, an "emergency" is defined as a medical condition, including labor and delivery, that shows acute symptoms of sufficient severity, including severe pain, such that the lack of immediate medical treatment could result in serious jeopardy of the patient's health, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part. Coverage for emergency services begins at the time the individual first receives treatment for the emergency and ends when the condition is no longer an emergency.

Pregnant women who are non-qualifying immigrants are eligible for emergency services up to one calendar month before their due date, through the end of the calendar month in which occurs the 60th day after the end of their pregnancy. A child born to a mother covered under BadgerCare Plus emergency services is eligible for BadgerCare Plus as a continuously eligible newborn if they satisfy all other eligibility conditions.

Other MA-Related Programs

Wisconsin Well Women Care (Care for Women Diagnosed with Cervical or Breast Cancer). Women who receive a health screening under the Wisconsin well woman program (WWWP) or the Family Planning Waiver (FPW) and who are diagnosed with breast or cervical cancer may be eligible for well woman care under BadgerCare Plus. To qualify for coverage, a woman must satisfy the following requirements:

- Meet general BadgerCare Plus non-financial requirements;
- Be at least 35 years of age, but under age 65;
- Have been screened for breast or cervical cancer by the WWWP or as a FPW member;
- Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, and need treatment for the condition;
- Not be eligible for BadgerCare Plus or EBD MA; and
- Not have private or public coverage for breast or cervical cancer treatment.

Women who are eligible for well women care under BadgerCare Plus are eligible for all services provided under the standard plan. In addition, if the health care provider who conducts the health screening is a certified MA provider, a woman may be eligible for presumptive eligibility, which provides immediate eligibility beginning on the date of the diagnosis and extends through the last day of the following calendar month. To remain eligible for services following the presumptive eligibility period, the woman must apply at the local income maintenance agency. As of June 2008, approximately 470 women were enrolled in Wisconsin well woman care.

Children Come First and Wraparound Milwaukee. The Children Come First (CCF) and Wraparound Milwaukee (WM) programs provide community-based mental health and substance abuse services to children with severe emotional disorders. 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, 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.

Under CCF, DHS contracts with Dane County to arrange services for program clients. For the contract period February 1, 2008 to June 30, 2009, the state MA program paid a monthly capitation payment of $1,642 per CCF enrollee, with Dane County providing additional funding for the services provided. In calendar year 2007, CCF served 241 children.

Milwaukee County's Children and Adolescent Treatment Center operates the WM program. In 2007-08, the Wisconsin MA program paid a monthly capitation rate of $1,661 per WM enrollee, with Milwaukee County and the DHS Bureau of Milwaukee Child Welfare contributing funds to pay for the costs not covered by MA. In calendar year 2007, WM served 961 children.

Foster Children and Children in Subsidized Adoptions. Children placed in private foster care settings and children living in state foster homes are eligible for health care coverage under MA,

regardless of whether the state receives federal Title IV-E matching funds for their maintenance payments. As of June 2008, approximately 6,200 such foster children were receiving MA benefits.

Children with special needs for whom adoption assistance agreements are in effect and children adopted under state-established agreements are also eligible for MA. As of June 2008, approximately 14,400 such children were enrolled in the state's MA program.

BadgerCare Plus Core Plan for Childless Adults. The 2007-09 biennial budget act authorized DHS to request a waiver from CMS that would allow the state's MA program to provide limited health care services to childless adults ages 19 through 64 who have incomes up to 200% of the FPL and who are not eligible for any other MA, Medicare, or SCHIP program. In late 2008, CMS granted preliminary approval.

While final rules for the new program were not established as of the date of this paper, DHS has preliminarily indicated that the new program will be called the BadgerCare Plus Core Plan for Childless Adults, and that participants will be required to pay an annual application fee of $60 or $75, depending upon the HMO they select. To be eligible, participants must not have been covered by private health insurance nor had access to employer-sponsored health insurance for the previous twelve months. The Core Plan will cover a more limited range of services than either the BadgerCare Plus standard plan or benchmark plan.

DHS's current stated intention is to implement the Core Plan for childless adults in early 2009. Individuals enrolled in the Milwaukee County general assistance medical program (GAMP) and the other participating counties' general assistance medical programs will automatically be enrolled in the Core Plan effective January 1, 2009. The timeframe for expanding the program beyond these initial enrollees has not yet been established.

CHAPTER 2

MA ELIGIBILITY FOR ELDERLY, BLIND AND DISABLED INDIVIDUALS

In addition to the state's BadgerCare Plus program discussed in the previous chapter, the other major component of the Wisconsin MA program is the services provided to elderly, blind, and disabled individuals. As of June 30, 2008, approximately 180,900 of these individuals were receiving benefits under the state's MA program. This chapter describes the eligibility requirements relating to this program, commonly referred to as EBD MA or Wisconsin Medicaid.

This chapter also provides information relating to individuals participating in EBD MA who are eligible for both Medicare and Medicaid, commonly referred to as "dual eligibles." The MA "card services" available to all EBD MA and BadgerCare Plus enrollees are discussed in Chapter 3. The Medicaid-funded programs that are particularly targeted to individuals who qualify for EBD MA, including the home- and community-based long-term care waiver program, and Family Care, are discussed in more detail in Chapter 4.

Nonfinancial Eligibility Requirements

In order to be eligible for EBD MA, an individual must meet the following nonfinancial eligibility requirements:

- Be at least 65 years old, blind, or disabled;
- Be a state resident;
- Be a U.S. citizen or qualifying immigrant;
- Cooperate with medical support liability;
- Provide a social security number, or apply for a social security number; and
- Pay any required premium or other cost-sharing amount.

For purposes of determining eligibility, a disability is defined as an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Substantial gainful employment is defined as gross income equal to or greater than $900 per month.

A blind individual is a person whose vision is no better than 20/200 or who has a limited visual field of 20 degrees or less with the best corrective eyeglasses.

All disability and blindness determinations are made by the DHS Disability Determination Bureau, which uses the same disability standards to determine eligibility for EBD MA, the supplemental security income (SSI) benefits, and social security disability payments.

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

Financial Eligibility Requirements

In order to be eligible for EBD MA, individuals must meet certain financial criteria, including an asset and income test.

Assets

The asset limit for all EBD-related MA is $2,000

for an individual and $3,000 for a married couple. Most types of assets that are available to an individual that can be converted to cash are counted, including (but not limited to) funds in bank accounts, certificates of deposit, stocks, bonds, life insurance policies, and cash. Some assets are generally not counted, including the individual's home, certain burial assets, clothing, a vehicle used for transportation, and other personal items.

However, the methods the Medicaid program uses to determine countable assets for the purpose of determining program eligibility are complex due to the wide variety of assets individuals may own, and because some assets may be shared by an individual and his or her spouse. Additional information regarding how the Medicaid program counts assets is available in DHS's *Medicaid Eligibility Handbook*, which can be accessed at http://www.emhandbooks.wi.gov/meh-ebd.

Income

The income limit for EBD-related Medicaid is determined by making several calculations to determine an individual's countable income. The starting point for these calculations is an individual's gross income, which includes both earned and unearned income. The following discussion describes the criteria the MA program uses to determine an individual's income eligibility for EBD MA.

Deductions from Gross Income. First, several types of income are subtracted from an applicant's monthly gross income to calculate the applicant's countable income. These subtractions include:

• An earned income deduction equal to $65 plus one-half of the individual's monthly earned income;

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

• Income the individual receives under an approved self-support plan, such as income a blind or disabled individual receives that will be used for training or purchasing equipment necessary for self support.

• Support payments an applicant or member makes to another person outside of the household for the purpose of supporting and maintaining that person;

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

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

• A standard MA credit of $20.

Compare Countable Income with EBD MA Limits. Once an applicant's countable income is determined, his or her counted income is compared with two income limits -- the categorically needy limit and, if necessary, the medically needy limit. The categorically needy income limit equals an income amount plus a shelter cost component, while the medically needy income limit only has an income component.

Table 6 identifies the asset and income eligibility limits for categorically needy and medically needy EBD MA as of January 1, 2009. The income and asset limits shown in the table reflect countable income and assets.

Table 6: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category (Calendar Year 2009)

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
1	$2,000	$758[1]
2	3,000	1,143[2]

[1] Assumes that person has actual shelter costs of at least $225.
[2] Assumes that the family has actual shelter costs of at least $337.

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
1	$2,000	$592
2	3,000	592

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 $109,560. (The federal minimum spousal asset share amount is $21,912.) 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 $583 per month for each qualifying dependent).

Family Size	Asset Limit	Maximum Monthly Income
2	See Text	$2,739

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	$867	$1,167	All Medicare premiums, coinsurance and deductibles.
SLMB	$4,000	$6,000	$1,040	$1,400	Part B premium.
SLMB+	$4,000	$6,000	$1,170	$1,575	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 $854 and $2,022 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
1	$2,000	$2,022

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
1	$15,000	$2,167
2	15,000	2,917

Note: Income and asset limits are applied after various exclusions and deductions. The elderly 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.

*Medicaid Deductible***.** If an applicant's countable income exceeds the medically needy income limit shown in Table 6, he or she may become eligible for coverage for all MA-eligible services provided in a six-month period after the applicant pays out-of-pocket expenses that equal the applicant's deductible. The applicant's deductible is calculated by: (a) determining the monthly amount by which the individual's counted income exceeds the medically needy income limit ($591.67 per month); and (b) multiplying the amount by six (to reflect the six-month period for which MA coverage is provided). The applicant can choose to begin the deductible period as early as three months prior to the month of application, and as late as the month of application. However, an applicant cannot choose a deductible period that includes a month in which, if the applicant had applied, the applicant would have been ineligible due to excess assets.

SSI-Related Eligibility

A significant segment of the EBD Medicaid population qualifies under SSI-related Medicaid. SSI-related Medicaid refers to Medicaid coverage provided to individuals who qualify for EBD Medicaid because they receive cash benefits under the supplemental security income (SSI) program, or meet requirements relating to the SSI program. These recipients qualify for EBD Medicaid by meeting all of the nonfinancial eligibility requirements described above, an asset limit, and one of two income limits -- the categorically needy income limit or the medically needy income limit. However, individuals with countable income that exceeds both the categorically and medically needy income limits may still qualify for SSI-related Medicaid coverage by meeting a deductible.

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

Federal law requires state MA programs to provide coverage for several groups of individuals who were previously eligible for SSI, but no longer receive monthly SSI payments. For instance, states must provide 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 these individuals if they need MA coverage to continue employment and their earnings are not sufficient to provide the equivalent of SSI MA and attendant care benefits these individuals 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.

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

EBD MA Programs

While all EBD MA-eligible individuals have access to certain covered services (the "card

services" described in Chapter 3), the MA program includes several programs in which the EBD Medicaid population may participate. These programs, excluding the home and community-based waiver programs discussed in Chapter 4, are discussed below.

SSI Managed Care. Under federal rules, states may require MA recipients to enroll in managed care plans, subject to certain limitations and exceptions. For example, states may not require the following groups to be enrolled in managed care plans: (a) dually-eligible MA recipients (MA recipients who are also eligible for Medicare); (b) most Native Americans who are members of federally recognized tribes; and (c) certain groups of children who are under the age of 19, including children who are eligible for SSI, and children who are in foster care or other out-of-home placement.

In areas where SSI managed care is implemented, DHS only requires EBD MA recipients who meet all of the following criteria to enroll in managed care programs: (a) are age 19 or older; (b) are eligible for MA under SSI or SSI-related criteria due to a disability; (c) are not living in an institution or a nursing home; (d) are not participating in a home- or community-based waiver program; and (e) are not enrolled in Family Care and PACE or Family Care Partnership. Individuals who may, but are not required, to enroll in HMOs include individuals who are dually eligible for MA and Medicare, and individuals participating in the MA purchase plan (MAPP). Currently, DHS is expanding the program on a county-by-county basis with the cooperation of local governments and participating HMOs.

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

As of July 1, 2008, 34 counties were offering SSI managed care options. Appendix 4 provides a complete list of participating counties, along with enrollment and total 2007-08 capitation payments made to HMOs. Six different HMOs have contracted with DHS to provide managed care services to EBD MA enrollees, which as of July 1, 2008, totaled 24,308 individuals. Table 7 provides a list of participating HMOs and the corresponding enrollment served by each participant as of June 30, 2008. In addition to current enrollees, DHS estimates that some people will choose to opt-out of the program (return to fee-for-service), and several others will be exempted from being required to participate in the counties where SSI managed care is available. Further, at any given time, several additional individuals are engaged in the SSI managed care enrollment process (as of October, 2008, approximately 1,000 individuals were estimated to be engaged in the enrollment

Table 7: HMOs Providing Coverage to SSI Managed Care Members as of June 30, 2008

HMO	Enrollment as of June 30, 2008
Abri Health Plan	1,775
GHC of Eau Claire	694
I-CARE	8,193
Managed Health Services	4,764
Network Health Plan	2,650
UnitedHealthcare of WI	6,232
Total	24,308

process, including those who had received notification of eligibility but had not yet completed enrollment, and those within the window for opting-out, as described below).

Under the SSI managed care program, enrollees have access to all of the covered services discussed in Chapter 3. In addition, enrollees receive a complete assessment of medical and social needs, a care plan for medical and social services, assistance from a health care coordinator, and transportation to and from appointments and covered services.

The provision of these required services is outlined in the annual contract between DHS and participating HMOs, which is similar to the contract between the state and HMOs that serve the BadgerCare Plus population. At a minimum, HMOs are required to provide care coordination and case management services at no cost to SSI managed care enrollees. To meet this requirement, HMOs employ care coordinators to assess the medical, behavioral health, and social needs of recipients and develop comprehensive case plans with enrollees and their providers. DHS requires that all care plans: (a) include appropriate medical and social services; (b) be consistent with the primary care provider's treatment plan and medical diagnosis; (c) be member-centric; (d) reflect the principles of recovery; and (e) be culturally sensitive. In addition, enrollees must have the opportunity to participate and contribute during development of the care plan. Furthermore, all HMOs are required to offer a basic minimum set of services to all enrollees similar to those offered to BadgerCare Plus individuals.

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

In 2008, the MA program paid SSI managed care providers capitation rates that are determined based on medical status, Medicare coverage, and eight actuarially determined age and gender cells that reflect different risk-adjusted rates. The result is a 34-cell rate structure. The SSI managed care program also enrolls SSI eligible individuals who qualify for Medicaid benefits under the Medicaid Purchase Plan (MAPP). A single rate cell structure has been established for Medicaid-only and other Medicare-eligible MAPP enrollees because the limited number of participants does not allow for the calculation of credible age and gender adjusted rate cells.

DHS may also pay a special incentive to HMOs that encourages greater participation in SSI managed care by increasing net enrollment in managed care plans in areas that are significantly below enrollment capacity, only offer fee-for-service options or only have voluntary rather than mandatory enrollment in managed care plans.

The regionally determined capitation rates in effect during 2008 are shown in Table 8. Approximately $184.0 million (all funds) was expended in 2007-08 to support SSI managed care capitation payments throughout the state.

Table 8: SSI Managed Care Average Monthly Capitation Rates by Region and Eligibility Category (Calendar Year 2008)

Eligibility Category	Gender	Region 1	2	3	4	5	6
SSI Medicaid Only							
19-29	Male	$366.42	$328.04	$309.66	$328.16	$402.55	$480.55
19-29	Female	436.20	391.59	368.63	390.66	479.21	571.72
30-39	Male	474.58	426.05	401.07	425.04	521.39	621.87
30-39	Female	469.78	421.74	397.01	420.74	516.11	615.60
40-64	Male	609.80	547.44	515.34	546.14	669.93	798.53
40-64	Female	616.54	553.49	521.03	552.18	677.34	807.34
65+	Male	475.23	426.63	401.62	425.62	522.10	622.72
65+	Female	586.12	526.18	495.32	524.93	643.92	767.59
SSI Dual Eligible							
19-29	Male	$131.72	$138.47	$121.09	$129.41	$171.92	$204.53
19-29	Female	127.43	133.96	117.14	125.19	166.31	197.92
30-39	Male	111.34	117.05	102.36	109.39	145.32	173.17
30-39	Female	113.13	118.93	104.00	111.14	147.66	175.92
40-64	Male	137.65	144.71	126.54	135.23	179.66	213.65
40-64	Female	153.01	160.85	140.66	150.32	199.70	237.28
65+	Male	203.51	213.94	187.08	199.93	265.61	315.00
65+	Female	220.90	232.22	203.07	217.01	288.31	341.76
SSI Related Medicaid Only							
19-29	Male	$883.77	$745.90	$659.02	$725.40	$926.52	$680.48
19-29	Female	652.76	550.93	486.76	535.79	684.34	503.08
30-39	Male	1,160.40	979.39	865.31	952.46	1,216.54	892.91
30-39	Female	902.38	761.62	672.90	740.68	946.03	694.77
40-64	Male	1,914.01	1,615.43	1,427.27	1,571.03	2,006.60	1,471.61
40-64	Female	1,312.98	1,108.16	979.08	1,077.70	1,376.49	1,010.07
65+	Male	464.89	392.37	346.66	381.58	487.37	358.81
65+	Female	501.59	423.34	374.03	411.70	525.85	386.99
SSI Related Dual Eligible							
19-29	Male	$114.05	$111.43	$98.78	$114.16	$132.63	$164.18
19-29	Female	135.83	132.70	117.65	135.96	157.96	195.19
30-39	Male	173.18	169.19	149.99	173.34	201.39	248.36
30-39	Female	181.28	177.11	157.01	181.45	210.81	259.89
40-64	Male	180.39	176.24	156.24	180.55	209.77	258.62
40-64	Female	181.85	177.66	157.50	182.02	211.47	260.70
65+	Male	185.94	181.66	161.04	186.11	216.22	266.52
65+	Female	174.79	170.76	151.39	174.95	203.26	250.65
MAPP--MA Only	All	898.02	898.02	898.20	898.02	898.02	899.84
MAPP--Dual Eligible	All	164.87	164.87	164.87	164.87	166.69	166.69

*Note: All capitation rates represent the standard plan, including dental and chiropractic services.

In 2009, DHS implemented a multi-year Pay-for-Performance (P4P) program that is intended to leverage its purchasing power and improve the health and health care of its members by establishing financial incentives for HMOs. The primary goal of P4P is to improve the performance of the health care delivery system as well as improving the health and health care outcomes of Medicaid members. DHCAA believes P4P will foster greater health plan and provider accountability for the care provided to the MA population by tying financial incentives to performance.

MA Purchase Plan. The Medicaid Purchase Plan (MAPP) permits individuals with a disability who are working or want to work to become eligible or remain eligible for Medicaid, since the program has higher income limits than SSI-related Medicaid. The goal of this program is to remove financial disincentives to work. The program also allows an individual to accumulate savings from earned income in an independence account. To be eligible for the program, an individual must:

- Meet general Medicaid non-financial requirements;
- Be at least 18 years of age;
- Be disabled, as determined by the Disability Determination Bureau; and
- Be working in a paid position or participating in a health and employment counseling program.

An individual is eligible to participate in MAPP if: (a) the individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL ($2,167 for an individual in 2008); (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 DHS; and (e) the individual is at least 18 years old.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL ($1,300 for an individual in 2008). 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 ($740 per month in calendar year 2008); (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.

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; (f) services designed to encourage individuals to take their medications; and (g) services that are necessary as a result of side effects of medications prescribed to treat tuberculosis. As of July 1, 2008, there were 151 individuals enrolled in MA under these criteria.

Medicaid for Individuals Who Require Long-Term Care Services

In addition to those outlined above, additional eligibility criteria may apply to individuals who reside in nursing homes and/or who participate in one of several long-term care programs offered through the Medicaid program, such as the home- and community-based waiver programs or Family Care. Furthermore, policies intended to provide financial protection for spouses of individuals who require long-term care services (spousal impoverishment protections), and to prevent individuals from transferring income and/or assets for the purpose of meeting Medicaid eligibility requirements (divestment) affect eligibility for Medicaid-funded long-term care services.

Special Income Eligibility. Under federal law, states may provide MA coverage to residents of institutional facilities (nursing facilities, hospitals and residential facilities) and individuals who live in their own homes but participate in the community-based waiver programs, under a special institutional income rule. This rule permits individuals who are not categorically eligible for SSI and have income between 100% and 300% of the maximum

monthly federal SSI payment amount to be automatically eligible for MA coverage without "spending down" to the medically needy standards. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($2,022 per month in 2009).

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. The MA recipient's share of these costs is referred to as the recipient's patient liability.

Allowable deductions under the special institutional income rule include: (a) for institutionalized enrollees, $45 per month, and between $854 and $2,022 per month in 2009 for community-based waiver recipients as a personal maintenance allowance; (b) a transfer of income to a spouse that is the lesser of $2,739 or $2,333 plus an excess shelter allowance (defined as expenses that exceed $700) and a transfer of $583 for each dependent family member living in the community; and (c) medical costs not covered by MA.

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.

These restrictions resulted in children remaining 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, however a parental fee may be assessed to help offset the costs of providing services for children that participate in the child long-term care support MA-waiver program (CLTS).

Additional Requirements Affecting Eligibility

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

Spousal Impoverishment. Spousal impoverishment protections refer to features of the 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, trust funds, or plots), household furnishings and clothing or other personal items.

The level of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or request for home- and community-based waiver benefits. Federal law allows states discretion in establishing the asset protection level within maximum and minimum limits ($21,912 to $109,560 in calendar year 2009). Both federal limits are adjusted annually, based on changes in the consumer price index.

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

The following example illustrates how the asset test is currently applied in Wisconsin. A couple's combined countable resources at the beginning of the initial period of continuous institutionalization is $120,000. The spousal share, which is equal to one-half of the couple's countable resources, is $60,000. After a period of time, the institutionalized spouse applies for MA. By the time the institutionalized person applies for MA, the couple's combined countable resources have been reduced to $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 at the beginning of the initial period of institutionalization ($60,000); or (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.

Individuals and couples whose income exceeds the limits identified in Table 6 may qualify for MA if they meet an MA deductible. Their deductible obligation is based on the amount of their income that exceeds the medically needy income limit, extended over a six-month period. This period may begin as early as three months prior to the month of application, and as late as the month of application. However, an applicant may not choose a deductible period that includes a month in which, if he or she had applied, the applicant would have been ineligible due to excess assets.

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 $2,739 per month for calendar year 2009. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index. Additional income may also be transferred to provide for certain dependent family members living with the community spouse 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 for a family of two; 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 ($2,333 per month for a couple in 2008); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed the state's standard (shelter costs in excess of $700 per month for calendar year 2008). In addition, Wisconsin currently permits the institutionalized spouse to transfer up to $583 per month for each qualifying dependent family member living with the community spouse.

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

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 ($854 and $2,022 per month in 2009) 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 2008, 200% of the FPL for a two-person family was $2,333 per month. If a community spouse has shelter costs of $810 per month, the excess shelter costs equal $110 per month ($810 - $700 = $110). In this case, the maximum monthly income allocation is $2,443 ($2,333 + $110 = $2,443). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,443 per month to determine the spousal income allocation amount ($2,243). If the institutionalized spouse's income is $3,600, the institutionalized spouse's nursing home liability amount would be $1,312 per month [$3,600 (the institutionalized spouse's income) - $2,243 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,312].

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 for other long-term care services by disposing of assets or income for less than market value for the purpose of becoming eligible for MA. The following discussion provides a brief summary of state divestment rules implemented by DHS. A full description of the state divestment rules can be found in the state's *Medical Eligibility Handbook.*

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

Divestment rules also include: (a) limiting individuals' ability to use annuities to become eligible for 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, DHS 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.

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 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 individual demonstrates that: (a) the individual intended to dispose of the assets either at fair market value or for other valuable consideration; (b) the assets were transferred exclusively for a purpose other than to qualify for 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 for 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. Until recently, states were required to review the assets of all long-term care MA applicants for a period of 36 months before the date the applicant applied for MA, or 60 months if the applicant's assets were included as part of a trust. This period is commonly referred to as the "look back" period. If an eligibility worker determined that an individual transferred resources any time during the look back period, a penalty period would be calculated. The penalty period establishes the amount of time that the person would be ineligible for MA-funded long-term care costs. The length of the penalty period is calculated by dividing the amount of the transfer by the monthly private pay rate of nursing homes ($6,259 in 2008). The penalty period began on the date of the transfer.

For example, under the prior divestment standard, if a person made a transfer of $100,000 two years before applying for MA, the penalty period for the applicant would total 15 months ($100,000 / $6,259 per month = 15.9 months, rounded down). Since the penalty period began on the date of the transfer (in this example, 24 months before the person applied for MA), the penalty period would be over by the time the individual applied for MA. Hence, the applicant would not be penalized for making this transfer. This divestment standard will continue to apply to all transfers that occur before February 8, 2006.

Under the provisions of the DRA, several new divestment policies were mandated that make divestment rules more restrictive. 2007 Wisconsin Act 20 formally adopted all of the new provisions outlined in the DRA, which became effective January 2009. First, for new transfers, the look back period was extended to five years for all income and assets disposed of by the applicant, regardless of the type of assets transferred. Second, the start date of the penalty period was changed to the first day of the month during or after which the assets were transferred for less than fair market value, or the date on which the individual is eligible for MA and would otherwise be receiving institutional-level care, whichever is later. Third, current law mandates that DHS no longer round down when calculating the penalty period, and must impose penalties for partial months.

Using the previous example, and applying the current legal provisions regarding divestment, a person transferring $100,000 two years before applying for MA would generate a 15.9-month penalty period. Furthermore, the penalty period now begins on the date the person is determined to be eligible for MA and would be receiving care in a nursing home, or services under a home- and community-based waiver program, based on an approved application for such care. Under this ex-

ample, the MA program would not pay for long-term care services for the individual until 15.9 months after the person applies and is determined to be eligible for MA-funded long-term care services. If an individual is already enrolled in MA but is not receiving long-term care services, the penalty period would begin when the individual is approved to receive long-term care services.

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

Under the new rules mandated by the DRA, individuals may also be disqualified from MA eligibility if the equity in their home and the land used and operated in connection with the home exceeds a certain value. Federal rules establish this threshold at $500,000. However, states that submit a state plan amendment may increase this amount to $750,000. Wisconsin has elected to adopt this higher threshold.

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

As with the changes made to regulations regarding the look pack period and penalty calculation, all these provisions mandated by the DRA apply to transactions occurring after February 8, 2006.

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

Dual Eligibility for Medicaid and Medicare

The federal Medicare program (Title 18 of the Social Security Act) provides health care coverage for people who are 65 years of age or older, certain disabled individuals who are under the age of 65, and persons of all ages with end-stage renal disease (people who require dialysis or a kidney transplant). The program provides several types of

health care coverage. Part A covers hospital, non-custodial care in a skilled nursing facility following an inpatient hospital stay, hospice care, and home health services. Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Part C refers to Medicare Advantage plans, which are private health plans available to Medicare enrollees that offer benefits that supplement the basic benefits offered under Part A and Part B. Part D refers to Medicare outpatient drug coverage, which is discussed in greater detail in Chapter 6.

Medicare Part A and B Cost-Sharing. After reaching age 65, most individuals are entitled to coverage under Medicare Part A and do not pay a monthly premium for this coverage because they or their spouse have 40 or more quarters of Medicare-covered employment. For individuals that do not meet the 40 quarter requirement, Medicare coverage can still be obtained by paying a premium. In 2008, the monthly premium for Part A coverage was $423 for people who were not otherwise eligible for premium-free hospital insurance and who had less than 30 quarters of Medicare-covered employment, and $233 per month for people who had 30 to 39 quarters of Medicare-covered employment.

All persons who enroll in Medicare Part A may enroll in Medicare Part B by paying a monthly premium. In calendar year 2009, individuals with annual income less than $85,000 and married couples with annual income less than $170,000 paid a monthly premium of $96.40.

Individuals that receive Medicare Part A and B services may be subject to certain deductible and coinsurance requirements based on the length of the benefit period for which services are received. A "benefit period" is a period of consecutive days during which medical benefits for covered services are available to the individual. The benefit period is renewed when an individual has not been in a hospital or skilled nursing facility for 60 days. Under Part A, the maximum benefit period is 60 full days of hospitalization, plus 30 days during which the individual pays coinsurance. An individual may also utilize up to 60 additional benefit days drawn from their lifetime reserve. Lifetime reserve days are not renewable, however. For a skilled nursing facility, the maximum benefit period is 100 days, with coinsurance requirements for days 21 through 100. In 2008, Medicare Part A paid for all covered Part A services in a benefit period, except a deductible of $1,024 during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days but not more than 150 days ($256 per day for days 61 through 90 and $512 per day for days 91 through 150). For care provided in a skilled nursing facility, the coinsurance amount was $128 per day for days 21 through 100 each benefit period.

In 2008, Medicare Part B paid for all covered Part B services in the benefit period except a deductible of $135 per year and a cost share of 20% of the Medicare-approved amount for services after the $135 deductible is met. Providers must accept Medicare rates as full payment for any services provided to a Medicare enrollee.

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

Dual Eligibles with Full Benefits. Some dual eligibles are eligible for full MA coverage. For these individuals, the Medicare health care coverage they receive is supplemented by services offered by the state's MA program. For example, following an inpatient hospital stay, an individual may require care in a skilled nursing facility. In this example, the Medicare program would pay for the covered Medicare services the individual receives, such as the first 100 days of care in the skilled nursing facility, but the MA program would pay for all MA covered services that are not covered under Medi-

care, including the days of care in the facility that exceed 100 days, and any deductibles, premiums and coinsurance. In these cases, the MA coverage the individual receives "wraps around" the more limited coverage available under Medicare.

*Dual Eligibles that Receive Assistance with Medicare Cost-Sharing Requirements***.** Beginning in 1968, Congress has enacted several programs, now collectively referred to as Medicare savings programs (MSPs), to help low-income Medicare recipients who do not qualify for full MA benefits pay for Medicare's cost-sharing requirements. Federal law defines several groups of individuals who may participate in the MSPs, and specifies the benefits to which these individuals are entitled. These groups are described below.

1. *Qualified Medicare Beneficiaries (QMBs).* QMBs are individuals who are entitled to Medicare Part A services whose income does not exceed 100% of the FPL, and whose resources do not exceed 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 purchase Part A coverage by paying a monthly premium. For QMBs, MA pays any required Medicare premium, coinsurance and deductible for both Medicare Part A and Part B coverage. QMBs pay copayments required of other MA recipients.

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

2. *Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs).* A more limited MA benefit is provided to specified low-income Medicare beneficiaries (SLMBs) and qualifying individuals (QIs). SLMBs and QIs are individuals who are enrolled in Medicare Part A and have income that is at least 100% but less than 120% of the FPL (SLMBs) or is at least 120% but less than 135% of the FPL (QIs). State MA programs are required to pay Medicare Part B premiums for these two groups. The MA program does not pay other premiums, deductibles or copayments for these groups.

While the MA program pays the same benefit (the Medicare Part B premium) on behalf of SLMBs and QIs, the source of funding for this benefit varies. The Medicare cost sharing funded by the state MA program for QMBs and SLMBs is funded as an MA service cost, which permits the state to claim federal matching funds for these costs. In contrast, CMS allocates sum certain amounts of federal funds to each state to fund Medicare Part B premiums for QIs. Consequently, these costs are 100% federally-funded. Further, unlike the assistance provided to QMBs and SLMBs, the state's obligation to fund Medicare Part B premiums for QIs is limited to the federal funding allocation the state receives for that purpose.

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

Medicare Crossover Claims. Medicare crossover claims are claims submitted to the state's MA program for services provided to dual eligibles that are covered under Medicare that require MA payment for deductibles and coinsurance (dual eligibles with full benefits and QMBs). WPS Health Insurance (the firm with which CMS contracts to administer the Medicare Part B benefit in Wisconsin) automatically forwards claims to the

MA program in cases where: (a) the provider's Medicare provider number is on file with the MA program; (b) WPS has a crossover agreement with the MA program; (c) WPS has identified that the service was provided to a dual-eligible; and (d) the claim is for a recipient who is not enrolled in a Medicare Advantage plan (Medicare Part C). Other crossover claims are submitted by health care providers, including claims for services provided to dual eligibles enrolled in Medicare Advantage plans and claims that were initially submitted by WPS that were not processed by the MA program within 30 days.

State law limits MA reimbursement for coinsurance and copayment for Medicare Part B services. The total payment a health care provider receives as reimbursement for a Medicare Part B service may not exceed the Medicare-allowed amount for that services. The MA reimbursement to providers is the lesser of: (a) the Medicare-allowed amount less any amount paid from other sources; or (b) the Medicaid-allowed amount less any amount paid from other sources.

Medicare Part C (Medicare Advantage Plans)

Individuals who are enrolled in Medicare Part A and Part B may enroll in a Medicare Advantage plan, which is required to provide at least the Medicare benefit care package, but may also offer additional covered benefits, including some benefits commonly offered by Medicare supplemental policies. Medicare Advantage plans include managed care plans, preferred provider organization plans, private fee-for-service plans, and specialty plans. CMS purchases private health plans on behalf of individuals who qualify for, and wish to participate in Medicare Advantage. All Medicare Advantage plans must meet minimum state and federal requirements for licensure, offered benefits, access to providers, quality of care, and reporting. Each Medicare Advantage plan has an annual election period that begins November 15 and continues through December 31, during which Medicare recipients may enroll in, or disenroll from any Medicare Advantage plan for the following calendar year. In addition, each plan has an open enrollment period from January 1 through March 31 during which a Medicare recipient can disenroll from their Medicare Advantage plan, either to opt out of Medicare Part C (and return to coverage provided under Part A and B), or switch from one Medicare Advantage plan to another plan of the same type.

CHAPTER 3

SERVICES AND PROVIDER REIMBURSEMENT

State and federal law define the health care services covered by Wisconsin's MA, BadgerCare Plus, and MA-related programs. The level of services covered by these programs can vary substantially. For instance, participants in limited benefit programs such as the family planning waiver and SeniorCare receive a relatively narrow range of services, while individuals in the home- and community-based long-term care programs described in Chapter 4 receive services beyond those typically available to most MA enrollees.

Despite these variations, all EBD MA enrollees, and virtually all BadgerCare Plus enrollees, are entitled to the core set of comprehensive services offered under the BadgerCare Plus Standard Plan. Those services, described in Chapter 1 and summarized in Appendix 2, are commonly referred to as MA "card services." This chapter provides additional information regarding MA card services, as well as a brief description of how MA-certified providers are reimbursed for providing these services.[2]

Medical Necessity and Other Service Limitations

State and federal law place limits on the services covered by the MA program. Perhaps the primary such limitation is the requirement that all services provided under MA must be "medically necessary." A medically necessary service is one that is required to prevent, identify, or treat a recipient's illness, injury, or disability and that meets all of the following standards:

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

The requirement that services be medically necessary is a general limitation under the MA program, as is the common requirement that MA services be prescribed by a certified physician. Other more specific examples are the dollar, numeric, or duration limits the MA program

[2] As noted in Chapter 1, a relatively small number of BadgerCare Plus enrollees currently obtain coverage under the more limited BadgerCare Plus benchmark plan.

imposes on otherwise covered services. For example, while the card services available to EBD MA and BadgerCare Plus participants include nurse-midwife services, that coverage extends only through the sixth week of postpartum care.

Often, the limitations for a particular covered service work in conjunction with the program's prior authorization rules. For example, Wisconsin's MA program covers up to $500 or 15 hours of non-hospital outpatient psychotherapy services, whichever limit is reached first. Services beyond that limit are covered only if prior authorization is obtained from DHS. Wisconsin administrative rules contain numerous examples of services that require prior authorization to be eligible for MA reimbursement. MA pays providers for services that require prior authorization only if prior authorization is approved by qualified medical professionals and staff according to criteria established by DHS, and 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.

Provider Reimbursement Rules

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 procedures relating to the utilization of, and the payment for care and services must be adequate to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy and quality of care.

Federal law also contains requirements specific to certain types of services. One such 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.

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

When an MA participant receives covered services on a fee-for-service basis, the provider bills the MA program directly, and is generally reimbursed at the lesser of their usual and customary charges or the DHS fee-for-service rate. The current fee-for-service reimbursement rates under Wisconsin's MA program are published on the DHS website.

If, however, an MA participant is enrolled in a managed care organization such as an HMO, provider reimbursement typically flows through the HMO (in the form of monthly capitation payments from the MA program) to the individual provider. The actual reimbursement individual providers receive from the HMO may differ from the fee-for-service rates established by DHS, depending on the

contract between the provider and the HMO.

The balance of this chapter describes several of the major categories of MA card services available to enrollees under the state's EBD MA and BadgerCare Plus programs.

Nursing Homes

Under the MA program, nursing homes are categorized into three groups: (1) nursing facilities, which consist of skilled nursing facilities (SNFs) 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.

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 II 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.

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 individuals who are mentally retarded. 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) governance and management; (2) client protections; (3) facility staffing; (4) active treatment services; (5) client behavior and facility practices; (6) health care services; (7) physical environment; and (8) dietetic services.

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 order for an MA recipient to receive services in an 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 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 costs of care for these individuals.

Regardless of the type of facility, federal law also requires that long-term care facilities protect and promote the residents' rights, including the rights 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.

As of August 2008, there were 399 licensed nursing homes listed with DHS, with a total of 37,700 licensed beds available. Of these nursing homes, 396 were skilled nursing facilities, two were ICFs, and one was an IMD. Approximately 84 percent of these facilities were privately owned and operated (35 percent nonprofit and 48 percent for-profit) while the remaining 16 percent were owned and operated by a government entity, including the state, counties, municipalities and tribes. On average, 88.8% of licensed nursing home beds were occupied and 61.5% of nursing home residents were supported by MA in 2007.

In addition to nursing homes, there were also 18 ICFs-MR in the state as of August 2008, with a total of 1,147 licensed beds. These totals include the three state centers for people with developmental disabilities. Table 9 summarizes the number of long-term care institutions in the state as of August, 2008, organized by type of ownership.

Table 9: Nursing Home Facilities, by Ownership Type, As of August 2008

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	141	18,070
Non-Profit	196	12,986
Government	62	6,644
Total	399	37,700
ICF-MR		
For-Profit	3	68
Non-Profit	3	225
Government	11	854
Total	17	1,147

Reimbursement of Nursing Homes Other than State Facilities. In 2007-08, MA fee-for-service expenditures for nursing home care, excluding care provided at the state centers for people with developmental disabilities and state veterans homes, totaled $757.9 million (all funds) representing approximately 16% of gross MA expenditures in that year. Fee-for-service nursing home care is expected to continue to decline in the future as more individuals enroll in the state's Family Care program (see Chapter 4).

Under state law, DHS is required to reimburse

nursing homes for fee-for-service care provided to MA recipients according to a prospective payment system that 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 each of these facilities.

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

Under MA nursing home reimbursement methods, DHS considers five cost centers when developing facility-specific nursing home rates. These cost centers include: (1) direct care; (2) support services; (3) property tax and municipal services; (4) property acquisitions; and (5) provider incentives.

Previously, these cost centers played a greater role in determining the distribution of funding between nursing homes. Facilities could expect to be reimbursed up to their actual expenditure, provided that it did not exceed the targeted cost. From this perspective, high-cost homes were penalized if they exceeded the targeted rates for these cost centers, since their reimbursements would be less than their costs. However, as funding provided for nursing home reimbursement has lagged behind industry cost growth and inflation, the disparity between average actual nursing home costs and targeted rates set for cost centers has increased. DHS staff estimates that as many as 87% of the state's nursing homes report expenditures that exceed set direct care price targets for the various cost centers. From this perspective, calculating reimbursements based on these targets has become less useful as a means of providing goals for nursing homes to limit expenditures.

Direct Care. Under current statute, DHS is required to establish payment for allowable direct care nursing services and direct care supplies and services. Allowable expenses are limited to expenses incurred by the nursing facility related solely to patient care, including all necessary and proper expenses which are appropriate in developing and maintaining the operating of the nursing home facility and services. 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.

DHS staff has determined a base direct care target rate applied uniformly to all facilities by calculating and combining the direct care nursing services allowance and the direct care supplies and services allowance. The direct care target rate calculated by DHS takes into account actual direct care costs for a sample of all facilities in the state, adjusted for inflation. Costs used in the calculation are obtained from annual cost reports submitted by nursing facilities to DHS and reflect the actual cost incurred by these facilities to provide services to residents. This base rate is then adjusted to reflect a facility's average acuity case mix index and labor cost index. This price-based calculation is derived from recent RUGS III resident classification methodology adopted by CMS to determine case-mix adjustment factors.

Separate rates are calculated for services provided to persons with developmental disabilities and for services provided to other individuals. In certain circumstances DHS may also 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.

In addition, DHS pays a higher rate 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 2008-09, the AIDS/ARC rate is $150 per patient day and the ventilator-dependent rate is $475 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 (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.

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, adjusted for inflation, up to a maximum amount. Tax exempt facilities may also receive a per patient day property tax allowance for the costs of certain municipal services, including those services which are financed through the municipalities' property tax and are provided without leveraging a separate service fee for the service.

For 2008-09, the payment to a facility for property taxes or municipal service fees is 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 property insurance, lease costs, land improvements, buildings, fixed and movable equipment, and other long-term physical assets. The statutes require that the capital payments be based on a replacement value for the facility, as determined by a commercial estimator that is paid for by the facility.

For 2008-09, DHS limits the allowed value to no more than $75,900 per bed. Facilities that have received Departmental approval for an innovative

construction and total replacement after July 1, 2008, are subject to a limit of $135,000 per bed.

Provider Incentives. The MA program pays certain qualifying nursing homes incentive payments, which are specified in the annual nursing home reimbursement formula. In 2008-09, nursing homes can receive five types of incentive payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 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 $2.70 per patient day for facilities with more than 50 beds and from $1.30 to $4.20 per patient day for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA / Medicare increases). A separate incentive payment is available for facilities located within the City of Milwaukee that ranges from $1.45 per patient day to $4.60 per patient day.

Second, a nursing facility with a high percentage of MA / Medicare residents (65% 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 as a result of renovation. 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 need to acquire bariatric moveable equipment during the cost reporting period to serve obese patients. This incentive allows nursing facilities to partially recoup the cost of providing services to this particular population of patients. During 2008-09, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease arrangements do not generally qualify for the incentive.

Fourth, an MA access incentive is provided to nursing facilities at a rate of $3.69 per patient day and to ICFs-MR at a rate of $23.31 per patient day.

Fifth, a $10 per day incentive is provided to facilities receiving approval for innovative capital construction .

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 managed care organization (MCO) 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. The statutes permit DHS to budget up to $37.1 million each fiscal year to support supplemental payments to these facilities to offset operating deficits.

In order to distribute these supplemental funds, DHS currently determines: (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); and (4) the non-direct care operating deficit (the difference between the projected overall operating deficit and the projected direct care operating deficit).

If the funding budgeted for supplemental payments is not sufficient to support each qualifying facility's eligible direct care operating deficit (EDCD), DHS then calculates an EDCD per MA day by dividing the amount of available supplemental funds by the total number of MA patient days for all facilities, factoring in the limits of each facility's EDCD. This per day amount would then be paid for each MA day, up to the amount of each qualifying facility's EDCD amount. In 2007-08 the rate used to allocate the supplemental payments was approximately $23.89 per patient day.

2005 Wisconsin Act 107 also created a permanent mechanism by which additional funding may be available through the nursing home certified public expenditure (CPE) program to provide additional supplemental payments. Specifically, Act 107 requires DHS, in each year, to distribute all federal MA moneys the state receives as matching funds to operating deficits incurred by county- and municipally-operated nursing homes that were not anticipated and budgeted as revenue in the biennial budget act for the fiscal year in which it is received, to increase supplemental payments to county and municipally-operated nursing homes.

In 2007-08, $37.1 million in supplemental payments were made to county-operated facilities and to Family Care MCOs. An additional $17.6 million was distributed by the state as a CPE supplemental payment. After accounting for all supplemental payments, counties had unreimbursed Medicaid expenses of approximately $84.6 million. Appendix 5 identifies actual supplemental MA payments to county- and municipally-operated nursing homes by county and payments made to Family Care MCOs from 2003-04 through 2007-08.

Reimbursement for State Facilities. MA payments for care provided at the state centers for the developmentally disabled and the Veterans Homes at King and Union Grove are determined by DHS separately from the methods established for all other nursing facilities. The state centers are paid based on actual costs, which coincide with the upper limit as the RUGS system under Medicare does not establish rates for developmentally disabled care levels. 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. The Veterans Homes are paid the upper limit, which are equal to the RUGS rate under Medicare and could be higher than actual costs. Table 10 summarizes the total MA fee-for-service nursing home payments, by facility type, made by the state during each of the last three state fiscal years.

Table 10: Total MA Fee-For-Service Payments to Nursing Facilities

Facility Type	2005-06	2006-07	2007-08
Non-state Facilities	$847,160,100	$795,016,600	$757,919,800
State DD Centers	119,392,300	121,920,800	123,638,200
Veterans Homes	36,809,200	28,964,200	30,640,600
Total	$1,003,361,600	$945,901,600	$912,198,600

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

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 and 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,

DHS distributes $10,583,800 GPR each fiscal year to assist counties in supporting residents of IMDs and individuals relocated from IMDs to community-based treatment programs. A portion of these funds are available annually 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. For purposes of the MA program, an inpatient is defined as a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who receives or is expected to receive room, board, and professional services in the institution for a period of 24 hours or longer. Inpatient hospital services are defined 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 or dentist. Inpatient hospital services must be provided at facilities that meet the following criteria:

- 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 meets federal 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 applies to inpatient services provided at most acute care hospitals in the state, as well as major border status hospitals located outside the state. The DRG system is not used to reimburse rehabilitation hospitals, state Institutes for Mental Disease (IMDs), or psychiatric hospitals, all of which are reimbursed on a per diem basis.

Under the DRG payment system, an inpatient hospital stay is classified into one DRG, the classification of which is based on the major diagnostic categories developed by the federal Medicare program. Each DRG is assigned a weight based on the relative resource consumption associated with that patient's particular diagnosis. Those weights are determined from an analysis of past services provided by hospitals, the claim charges for those services, and the relative cost of those services. Then a hospital-specific cost factor is applied to the standard DRG to determine the actual payment rate paid to a particular hospital. Those hospital-specific cost factors are based on an analysis of cost report data submitted by hospitals, and are adjusted to reflect the particular hospital's case mix, based on its historical MA claims data. The resulting reimbursement to hospitals for inpatient services is the standard DRG weight adjusted to reflect a particular hospital's costs. A uniform budget adjustment factor is also applied to each in-state hospital's rate to assure compliance with the DHS budget.

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

In addition, the DRG system is not used to reimburse health care providers such as physicians, psychiatrists, psychologists, dentists, chiropractors, or anesthesia assistants for the professional services they provide to hospital inpatients. Those professional services must be billed separately by the provider. The same is true for such services as

pharmacy for take home drugs on the date of discharge, durable medical equipment and supplies for non-hospital use, specialized medical vehicle transport, and ambulance service.

Supplemental Hospital Payments. Some hospitals are eligible for enhanced reimbursement from the state's MA program. As described below, these augmented reimbursements can be based on the types of patients or geographic areas these hospitals serve, or on other factors identified in the state's MA plan.

Disproportionate Share Hospitals. Certain qualifying hospitals are eligible for supplemental reimbursements called "disproportionate share adjustment" payments, or DSH payments. Hospitals can qualify for DSH payments if they have an MA utilization rate of at least one percent and they meet at least one of the following criteria: (1) their 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 in the state that receive MA reimbursement; or (2) they have a "low-income utilization rate" of more than 25%. In addition, the hospital must have at least two obstetricians who have staff privileges and who have agreed to participate in the MA program. Under these criteria, 29 hospitals in Wisconsin received DSH adjustments to their DRG rates totaling approximately $10 million (all funds) in 2007-08.

Another type of DSH payment goes to hospitals that meet the 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. In addition to the general DSH criteria stated above, 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. The hospital must also have met those criteria during the current rate year as well as during the year July 1, 1995 through June 30, 1996. DHS pays up to $4,748,000 (all funds) annually to hospitals that meet the definition of an EACH. Since the creation of this DSH payment in 1991, the only hospital that has qualified is Aurora Sinai Medical Center.

A third category of DSH payment is the General Assistance DSH allowance, or GA-DSH. This is a separate DSH allotment for areas covered by an Indigent Care Agreement (ICA). The ICA must be between a hospital and a general assistance medical program (GAMP) in the ICA area, which is defined as being within reasonable geographic proximity to the hospital. In 2007-08, DHS made DSH payments to seven hospitals in Milwaukee County under that county's GAMP. Those payments totaled $60.4 million ($6.9 million GPR, $35 million FED, and $18.5 million PR). The PR source of funding for these payments is an intergovernmental transfer (IGT) payment Milwaukee County makes to DHS which is used to partially support the state share of the general relief supplemental payments.

Rural Hospital Adjustment. A rural hospital can 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; and

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

The amount of the DRG rate adjustment for qualifying rural hospitals is based on the particular hospital's MA utilization rate, calculated by dividing the hospital's total MA inpatient days by its total inpatient days. By statute, rural hospital adjustments, in the aggregate, are limited to $2,256,000 (all funds) annually.

Critical Access Hospitals. DHS reimburses hospitals that are certified as critical access hospitals (CAHs) at the lower of their allowable costs or charges for the services provided to MA recipients. A CAH is a hospital that has no more than 25 inpatient beds used for acute inpatient care or as "swing beds" (beds used for skilled nursing facility-level care), that provides inpatient care for no more than an average stay of 96 hours per patient, and that provides emergency care 24 hours per day. In addition, the hospital must meet one of the following criteria: (a) be located outside of a metropolitan statistical area (MSA), not be classified as an urban hospital, and not be among a group of hospitals that have been redesignated to an adjacent urban area; or (b) be located within an MSA but be treated as being located in a rural area. The hospital must also be more than a 35-mile drive from another hospital or certified by DHS as a necessary provider of health care services to residents in the area.

DHS makes interim payments to CAHs as they submit claims throughout the year. Once DHS receives a final cost report, it makes a final payment adjustment to ensure that each CAH is paid its allowable costs. CAHs are not eligible for supplemental payments or other payment adjustments, since their reimbursement is limited to their allowable costs. In state fiscal year 2008, there were 59 CAHs in Wisconsin. Those hospitals received reimbursements of approximately $21,269,200 million (all funds) for both inpatient and outpatient services provided to MA patients.

Direct Medical Education Payments. Adjustments for direct graduate medical education (GME) costs are added to certain hospitals' base DRG rates to partially reimburse those 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. The GME adjustment varies by hospital, since the calculation is dependent on case mix and utilization. In 2007-08, 19 hospitals received direct GME adjustments totaling $11,453,000 million (all funds).

Capital Reimbursement. Allowable capital costs are added to a hospital's base DRG rate. Allowable costs are determined based on the inpatient costs attributable to MA recipients compared with total inpatient revenues.

Pediatric Inpatient Supplement. DHS 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 be an acute care hospital located in Wisconsin, and 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 2007-08, this calculation is based on a hospital's inpatient days in the hospital's fiscal year that ends in calendar year 2006. Days for neonatal intensive care units are not included in this determination. The pediatric supplement, in the aggregate, is limited to $2.0 million annually.

Payments to Hospitals Outside of Wisconsin. Hospitals outside of Wisconsin that provide inpatient services to Wisconsin MA recipients can be reimbursed for those services. The method DHS uses to calculate these payments 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.

Minor border status hospitals (non-Wisconsin hospital that are not major border status hospitals) and out-of-state hospitals are reimbursed under a DRG payment methodology, with payments based on a standard DRG base rate without adjustments for hospital-specific differences. These hospitals can, however, request an administrative adjustment to their payment that would consider such differences. They are also eligible for disproportionate share adjustments and cost outlier claims.

Outpatient Services. Federal MA law defines an outpatient as a patient of an organized medical facility or distinct part of that facility who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remained in the facility past midnight. An outpatient hospital service means a preventive, diagnostic, therapeutic, rehabilitative, or palliative service that is furnished to an outpatient under the direction of a physician or dentist and that is furnished at a state-licensed hospital that meets the requirements for participation in Medicare as a hospital.

The Wisconsin MA program reimburses hospitals for the outpatient services they provide to fee-for-service MA participants at an interim rate per visit, with a subsequent retrospective final settlement. Interim payments are based on the lesser of the hospital's rate per outpatient visit (based on the hospital's historical costs, adjusted for inflation, then multiplied by a budget neutrality factor applied to maintain payments within the federal upper payment limit and the state's available budgeted funding) or the hospital's hold-harmless rate per visit (based on what the MA program would have paid the hospital for an outpatient visit on June 30, 2001). The final settlement is based on the hospital's reimbursable costs, which are the lesser of the following: (a) its "calculated gross rate amount" (defined as the hospital's rate per outpatient visit including amounts for appropriate administrative adjustments, or its "hold-harmless" rate, multiplied by the number of outpatient visits incurred by the hospital for Wisconsin MA recipients during the settlement period; (b) its total allowed charges; (c) its gross laboratory-fee-limited ceiling; or (d) its allowed outpatient costs. Within this reimbursement framework are a number of exceptions and possible administrative adjustments.

Payments to all out-of-state hospitals for outpatient hospital services are paid at the average percentage of allowed outpatient charges paid to in-state hospitals. Reimbursement for diagnostic laboratory services will be the lower of the MA program's laboratory fee schedule or the hospital's charges for laboratory services rendered. Payments to out-of-state hospitals that are not designated as border status, whether those services are inpatient or outpatient, are limited to emergency services or services that were authorized in advance by the Wisconsin MA program.

Other Services

Physician and Clinic Services. Physicians' services include 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. As noted, many of these services, while otherwise reimbursable, may be subject to the prior authorization and / or limitations identified in Wisconsin administrative rules.

Physician services (for fee-for-service MA recipients), as well as the other services described

below, are generally reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by DHS. The DHS fee schedule includes higher rates for certain services provided to MA recipients in areas of the state designated as health professional shortage areas (HPSAs). There are currently 52 HPSAs in Wisconsin. These HPSAs are classified by zip code and therefore may exist within different areas of a single county, or they may include areas in several different counties. HPSA-enhanced payment rates apply if the provider is located in an HPSA and/or the recipient resides in an HPSA. Primary care providers and emergency care providers eligible for the enhanced HPSA reimbursement include physicians with specialties of general practice, obstetrics and gynecology, family practice, internal medicine, or pediatrics. Other eligible providers include physician assistants, nurse practitioners, and nurse midwives. The standard HPSA enhancement for primary care services is 120% of the rates paid for the same services in non-HPSAs of the state. The HPSA enhancement for obstetric and gynecological services is 150%. HealthCheck services, described below, are not eligible for the enhanced HPSA reimbursement.

Early and Periodic Screening, Diagnostic and Treatment Services (HealthCheck). These federally mandated services, which in Wisconsin are referred to as "HealthCheck," provide comprehensive screenings to MA recipients under age 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 patient 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 regulations require state MA plans to establish a periodicity schedule for these screening services that is consistent with reasonable standards of medical and dental practice. Wisconsin's program has established a periodicity schedule for determining screening intervals and age appropriate procedures that limits the number of comprehensive screenings during a continuous 12-month period as follows: birth to first birthday, six screenings; first birthday to second birthday, three screenings; second birthday to third birthday, two screenings; and third birthday to twenty-first birthday, one screening.

Federal law also 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 a state'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. RHCs are eligible for cost-based reimbursement (based on their reasonable costs determined using Medicare cost prin-

ciples) for the RHC services they provide to MA enrollees. For services other than RHC services that are nonetheless covered by MA, RHCs are eligible for MA fee-for-service reimbursement. According to a current CMS survey, there are 47 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. As required by federal law, DHS reimburses FQHCs for 100% of their reasonable costs of providing services to MA recipients. This reimbursement requirement recognizes that FQHCs serve a disproportionate share of the state's MA, Medicare, and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. In 2007-08, DHS expended approximately $74.6 million (all funds) to reimburse FQHCs for the services they provided to MA recipients.

Indian Health Service. Some MA services are provided to Native Americans through Indian Health Services (IHS) and tribe-owned facilities. MA state plans must provide that an IHS facility, meeting state requirements for MA participation, be accepted as an MA provider on the same basis as any other qualified provider. Under federal law, a facility operated by IHS or in an IHS-owned or leased facility operated by a tribe or tribal organization is 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 federal matching rate.

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

Skilled Nursing Services. A recipient is eligible for skilled nursing services delivered in the home if they are provided under a plan of care that requires less than eight hours of direct, skilled nursing services in a 24-hour period, the recipient does not reside in a hospital or nursing facility, and the recipient requires a considerable and taxing effort to leave the residence or cannot reasonably obtain services outside the residence. These services are provided exclusively by registered nurses (RNs) and licensed practical nurses (LPNs). 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.

*Private-Duty Nursing Services***.** A recipient is eligible for private duty nursing services if they require eight or more hours of direct skilled nursing services in a 24-hour period, they do not reside in a hospital or nursing facility, and they have a written plan of care specifying the medical necessity for these services. Only LPNs and RNs can provide these services. All providers must receive prior authorization before providing these services to MA recipients.

Under the private duty nursing benefit, RNs and LPNs may provide certain services to ventilator-dependent recipients, such as tracheostomy care, oxygen therapy, and operation of ventilators. A recipient must have been hospitalized for at least 30 consecutive days for a respiratory condition, must be dependent on a ventilator for at least six hours per day, and must be served in their home to qualify for this benefit. These respiratory care services require prior authorization.

Home Health Therapy Services. Wisconsin's MA program covers medically necessary skilled physical therapy, occupational therapy, and speech and language pathology services. The physical therapists, occupational therapists, and speech-language pathologists that provide these services may be employed by the home health agency, by an agency under contract with the home health agency, or they may be independent providers under contract with the home health agency. A therapy evaluation must be completed before a therapy plan of care is provided for the recipient.

Home Health Aide Services. These services include medically oriented tasks, assistance with activities of daily living when provided in conjunction with medically oriented tasks, and incidental household tasks required to facilitate treatment of a recipient's medical condition or to maintain their health. To be eligible for reimbursement under MA, an RN must determine that the medically oriented tasks cannot be safely delegated to a personal care worker who has not received special training in performing tasks for the specific individual. Examples of these tasks include simple dressing changes and taking vital signs.

Personal Care Services. Personal care services are medically oriented activities related to assisting recipients with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services are provided under the written orders of a physician and are performed by a personal care worker under the plan and supervision of a registered nurse. 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 for any recipient to receive more than 250 hours of personal care services in a calendar year, and for all personal care hours provided to a recipient that is also receiving private-duty nursing or respiratory care services.

Laboratory and X-Ray Services. Professional and technical diagnostic services covered under Wisconsin's MA program include laboratory services provided by a certified physician or under a physician's supervision, laboratory services prescribed by a physician and provided by an independent certified laboratory, and x-ray services prescribed by a physician and provided by, or under the general supervision of a certified physician.

Family Planning Services and Supplies. MA recipients may receive family planning services that are prescribed by a physician and furnished, directed, or supervised by a physician, registered nurse, nurse practitioner, licensed practical nurse, or nurse midwife. Covered services include physical examinations and health histories, office visits, laboratory services, counseling services, the provision of contraceptives and supplies, and prescribing medication for specific treatments. 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.

Nurse-Midwifery Services. Covered services provided by a certified nurse-midwife include the care of mothers and their babies through the maternity cycle, including pregnancy, labor, normal childbirth, and six weeks of postpartum care.

Dental Services. Wisconsin's MA program covers the following categories of dental services when the services are provided by or under the supervision of a dentist: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) orthodontics; (i) adjunctive general services; (j) palliative emergency services; (k) general anesthesia, intravenous conscious sedation, nitrous oxide, and non-intravenous conscious sedation. The program also covers various services provided by a dental hygienist, including

but not limited to oral screening and preliminary examinations, prophylaxis, pit and fissure sealants, and periodontal maintenance. Wisconsin administrative rules establish a number of limitations and prior authorization requirements pertaining to the dental services covered by the MA program.

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

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

Ambulance transportation services may be covered if a recipient is suffering from an illness or injury which contraindicates transportation by other means, but only when provided under the following conditions: (a) for emergency care, when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition; or (b) for non-emergency care, if authorized in writing by a physician, physician assistant, nurse midwife, or nurse practitioner and the recipient has a significant medical condition or need for medical monitoring that cannot be provided by a common carrier, private motor vehicle, or SMV.

SMVs may be used to transport MA recipients who a physician, physician assistant, nurse midwife, or nurse practitioner has determined is indefinitely disabled or legally blind. An "indefinite disability" is defined 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 recipient from using common carrier transportation reliably or safely. Recipients who have not been declared legally blind or indefinitely disabled can also be transported by SMVs if they have documentation from one of the health professionals identified above that describes why the use of an SMV, rather than a common carrier or a private vehicle, is necessary. Furthermore, the MA program only provides reimbursement for SMV transportation if the transportation is to a location at which the recipient receives an MA-covered service on that day.

Ambulance and SMV providers are paid a base rate and other applicable rates, such as mileage and waiting time, where applicable. 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 other MA recipients. 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.

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

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

Speech and Language Pathology Services. 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 are eligible for reimbursement under MA. Covered services include evaluation procedures and speech treatments. Prior authorization is required for all 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.

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

Medical supplies are disposable, consumable, expendable, or nondurable medically necessary supplies that have a very limited life expectancy. Examples include catheters, syringes and continence supplies. Medical supplies ordered for a patient in a hospital or nursing home are considered part of the institution's cost and may not be billed directly to the MA program by the provider. DME and medical supplies provided to a hospital inpatient to take home on the date of discharge are reimbursed as part of the inpatient hospital services.

DME includes medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment, and prostheses. A physician, podiatrist, nurse practitioner, or chiropractor must prescribe all DME services, including purchases, rental, and repairs. The item must be necessary and reasonable for treating an illness or injury, or for improving the function of a malformed body part. In cases where DHS determines that a piece of equipment will only be needed on a short-term basis, equipment is rented, rather than purchased, for the client.

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

Mental Health and Substance Abuse Services. Several types of mental health, and alcohol and other drug abuse (AODA) services are covered by Wisconsin's MA program. Those services include inpatient hospital mental health and AODA services provided in an institution for mental disease (IMD). Those inpatient services are described in Chapter 2.

The MA program also covers certain outpatient and day treatment mental health and AODA services, provided those services are prescribed by a physician and provided by a certified provider.

Mental health and AODA outpatient services are covered up to $500 or 15 hours, whichever limit is reached first, per recipient per calendar year. Services beyond those amounts require prior authorization.

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.

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

The MA program also covers certain pharmaceutical care services through incentive-based payments where pharmacies may receive an enhanced dispensing fee if they provide services that achieve positive patient outcomes, such as increasing patient compliance or preventing potential adverse drug reactions.

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

Reimbursement Rate. DHS reimburses pharmacists and physicians for drugs they provide to MA recipients by paying them to dispense the drug, and for the product itself.

For most single source brand name drugs, pharmacies are paid a dispensing fee of $3.44 per prescription, plus the average wholesale price (AWP) of the drug minus 14%. Manufacturers report the AWP of drugs to commercial publishers, such as First DataBank, which sells that information to government entities such as Wisconsin's MA program, private insurers, and other drug purchases.

For generic drugs and multi-source brand name drugs, pharmacies are paid a dispensing fee of $3.94 per prescription, plus the maximum allowable cost (MAC) of the drug, as determined by DHS. CMS provides DHS with lists of generic drugs that are available from at least three companies, and for each of these drugs, an MAC recommendation. In addition, DHS maintains its own MAC list that is updated quarterly and that is based on prices for which the drugs are readily available through wholesalers in Wisconsin.

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 recipients or providers, which may require an intervention by DHS if the prescribing activity is deemed inappropriate.

Wisconsin's MA program uses "automatic generic substitution" to ensure that MA recipients receive the generic version of a drug when appropriate. Under this policy, the MA program automatically reimburses a pharmacy for the generic

equivalent of a drug when such a drug is available, even if a brand-name drug is prescribed by a physician. The MA program 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 DHS 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 typically limited to antacids, analgesics, insulins, contraceptives, cough preparations, ophthalmic lubricants, and iron supplements for pregnant women.

Another method DHS uses to help contain MA drug costs includes the development of a preferred drug list (PDL), based on a review of the relative clinical effectiveness and cost of products within therapeutic classes. Appendix 6 identifies the classes of drugs comprising Wisconsin's preferred drug list as of December 2008.

In February 2008, DHS consolidated the MA prescription drug benefit into a totally fee-for-service model in order to reduce program costs and increase the amount of rebate revenue the state collects to offset MA-funded drug costs. Previous to that date, MA recipients enrolled in a managed care organization received their covered drugs through their HMO, which was reimbursed for those prescription drug services through the capitation payments it received from the state. Now, only participants in the PACE and Family Care Partnership receive prescription drugs and related services through their managed care program.

Medicare Prescription Drug Benefit and MA Recipients. Beginning January 1, 2006, Medicare beneficiaries can obtain outpatient prescription drug coverage under a benefit authorized in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. This new benefit is commonly referred to as Medicare Part D. Medicare beneficiaries who also have full MA benefits are referred to as "dual eligibles." These individuals are automatically enrolled in Medicare Part D, and state MA programs no longer cover their prescription drug benefits. Chapter 6 of this paper provides additional information on Medicare Part D and the state's SeniorCare prescription drug program.

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 the following : (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. Reimbursement by the state MA program is equal to the federal share of the lesser of the maximum allowable fee, as established by DHS, or the billed amount.

Community-Based Psychosocial Services. Community-based psychosocial services, sometimes referred to as comprehensive community services (CCS), are available to MA recipients with mental health or substance abuse conditions, as a county-funded service. Counties must elect to pro-

vide the services and provide the state's share of the costs of the benefit. In order to receive services, 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 recipients and their families gain access to, coordinate, and monitor necessary medical, social, educational, vocational, and other services covered by MA and other programs. People who are over age 64, are diagnosed with Alzheimer's disease or other dementia, or are members of one or more of the following target populations are eligible for case management services under MA: (a) developmentally disabled; (b) chronically mentally ill, age 21 or older; (d) alcoholic or drug dependent; (e) physically or sensory disabled; (f) under age 21 and severely emotionally disturbed; (g) HIV positive; (h) children enrolled in the Birth-to-Three program; (i) children with asthma; (j) individuals infected with tuberculosis; (k) women age 45 through 64; and (l) families with children at risk of serious physical, mental, or emotional dysfunction, including lead poisoning, risk of maltreatment, involvement with the juvenile justice system, or where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.

Case management providers are required to perform a written comprehensive assessment of a person's abilities, deficits and needs. Following the assessment, providers develop a case plan to address the needs of the client, and provide ongoing monitoring and service coordination.

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, DHS administers a targeted case management program that assigns high-cost MA recipients to case managers contracted by DHS 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. Covered 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. Inpatient hospital services necessary for pain control, symptom management, and respite purposes are also covered, but the aggregate number of inpatient days eligible for MA reimbursement is limited to 20% of the aggregate total number of hospice care days provided to all MA recipients enrolled in the hospice during the year. Inpatient days for persons with AIDS are not included in this calculation and are not subject to this limitation.

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

Podiatry Services. Covered podiatry services are provided by a certified podiatrist and are medically necessary for the diagnosis and treatment of the feet and ankles. 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 recipient has certain conditions and is under the active care of a physician.

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 MA-eligible women who are at high risk for adverse pregnancy outcomes, as determined through the use of a risk assessment tool developed by DHS. Covered services include outreach, administration of the initial risk assessment, care planning, ongoing care coordination and monitoring, health education, and nutrition counseling. Similar services, such as child care coordination services, are available to MA-eligible children through age six in Milwaukee County.

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

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

To be eligible for reimbursement under the MA program, a school-based service must be "medically necessary" as generally defined under the program, and the service must satisfy the following additional criteria: (a) it must identify, treat, manage or address a medical problem or a mental, emotional or physical disability; (b) it must be identified in an individualized education plan (IEP); (c) it must be necessary for a recipient to benefit from special education; and (d) it must be referred or prescribed by a physician or advanced practice nurse, where appropriate, or a psycholo-

gist, where appropriate. Parental consent is required in order for a child to receive the special education and related services defined in an IEP. Separate parental consent is not required, however, in order for the school-based services provider to seek reimbursement from the state's MA program.

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

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

CHAPTER 4

COMMUNITY-BASED LONG-TERM CARE PROGRAMS

Introduction

Individuals who meet the functional and financial eligibility criteria to qualify for MA benefits may also receive either community-based or institutional long-term care services. During the past two decades, the state has 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 about where to live and the long-term care services they receive.

Under the MA home- and community-based waiver programs, participants have access to services in addition to services available to all MA recipients. These services are intended to enable MA recipients to remain in their homes or live in other non-institutional settings. 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 by the state and by county agencies for community-based waiver services determines how many people will receive waiver services. Consequently, there are often waiting lists for services under these programs, and, for some individuals, nursing homes or intermediate care facilities for the mentally retarded (ICFs-MR) remain the only long-term care option immediately available to them. However, with the continued expansion of the Family Care program, which creates an entitlement to home- and community-based services, many of these waiting lists are being eliminated throughout the state.

In recent years, Wisconsin has increasingly implemented managed care programs to try to increase access to community-based long-term care and control spending on long-term care services provided to individuals throughout the state. The Family Care program, the program for all-inclusive care for the elderly (PACE), and the Family Care Partnership (FCP) program all 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 in a growing number of counties throughout the state.

In Wisconsin, the provision of long-term care services represented approximately 46% of the state's MA budget in 2007-08. The state spent over $2.3 billion (all funds) to provide long-term care services to Wisconsin residents, including approximately $950 million (43%) on fee-for-service institutional care, and almost $1.4 billion (57%) on community-based long-term care services and Family Care capitation payments, as shown in Table 11.

Table 11: All Funds Expenditures for Selected Long-Term Care Services (Fiscal Year 2007-08)

Program / Service	Amount
MA Waiver Services, excluding COP-W	$527,218,000
COP and COP-W Services	131,774,100
Family Care Capitation Payments*	324,563,400
PACE / FCP Payments	138,487,500
MA Fee-for-Service Home Care Services	275,083,100
Total**	$1,397,126,100
Total FFS Institutional Care ***	$952,719,700
All Long-Term Care	$2,349,845,800

*Includes capitation payments for nursing home care funded by MCOs.
**Excludes encumbrances.
***MA fee-for-service payments to all nursing homes, including state facilities.

The rest of this chapter provides a description of the state's various home- and community-based waiver programs.

Home- and Community-Based Waiver Services

The U.S. Centers for Medicare and Medicaid 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 7 to this paper provides a list of waiver services currently available under the CIP IA, CIP IB, BIW, CLTS, COP-W and CIP-II waiver programs.

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, nursing home care, and Family 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 funding allocated in state and county budgets. As a result, eligible individuals can be, and often are, placed on waiting lists for these programs until funding becomes available. However, as the Family Care program (described below) continues to expand statewide, replacing many of these waiver programs, waiting lists for MA home and community-based services are being eliminated since Family Care creates an entitlement to these services.

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 does not exceed the costs which would have been incurred for the same group of individuals had the waiver not been granted. States must also provide assurances that safeguards are in place to protect the health and welfare of waiver participants, that providers are qualified, and that service plans address participant needs.

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 currently set well above the projected number of individuals to be served. Waivers are granted for an initial period of three years, while waiver renewals are usually authorized for five-year periods.

Under several different federal MA home- and community-based waivers, Wisconsin operates seven federal waiver 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. Adult

individuals who have a developmental disability are served under one federal waiver that encompasses two state programs; the community integration programs, CIP IA and CIP IB. The brain injury waiver (BIW) operates under a single, separate waiver. The children's long-term support (CLTS) program is authorized under three separate federal waivers. Intensive in-home services for children with a congenital development disorder, such as autism, Asperger syndrome or Pervasive Developmental Disorder, not otherwise specified, are provided within the CLTS waivers. Starting in 2007, the Department has also secured an agreement with CMS to implement the community opportunities recovery program (COR), targeting services to adults who have co-occurring mental and physical health conditions. Finally, as of July 1, 2008 DHS is authorized to provide home and community based long-term care services under two self-directed support (IRIS) waiver programs as an alternative to Family Care waivers.

DHS 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 the other waiver programs, allocations are based on the number of slots designated for a county and the daily reimbursement rate. All state contributions are supplemented with federal matching funds. In 2007-08, the state and federal responsibility for MA funding allocations was approximately 41 percent and 59 percent, respectively. Counties may also obtain additional federal MA matching funds for waiver-covered services supported by county funds. Appendix 8 lists the calendar year 2008 county allocations of GPR funding budgeted for the various 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 (See Chapter 2 for a detailed discussion of MA eligibility criteria). For instance, states may provide nursing home and MA waiver services to individuals with income between 100% to 300% of the applicable 2008 SSI payment level (up to $1,911 per month in 2008). 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 2008, under the MA waiver programs, the personal needs allowance ranges from $817 to $1,911 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. The rest of this section describes the various MA waiver programs.

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 people with developmental disabilities (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. When an individual is relocated, funding for the state centers is reduced by the daily allowance and is reallocated to fund the CIP IA slot.

For the 2007-08 fiscal year, DHS 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 2007-08, approximately $95.7 million was budgeted to support CIP IA services, including approximately $13.0 million of federal matching funds from county contributions.

As of December 31, 2007, there were 1,325 individuals participating in the CIP IA program.

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 people with developmental disabilities. 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. DHS allocates new, state-funded slots that do not result from a bed closure to counties based on need. DHS usually provides slots created by bed closings to the county in which the facility is located.

In 2007-08, the maximum average per day allowance for state reimbursement under CIP IB was $49.67, although DHS 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 $177.40 per day). In 2007-08, approximately $218.5 million (all funds) was budgeted for the CIP IB waiver program. In addition to these state-funded slots, Wisconsin also claims federal matching funds for individuals for whom counties elect to provide the state match with county funds. In calendar year 2007, counties contributed approximately $91.9 million in county funds.

Effective January 1, 2008, state funding provided to counties for both CIP IA and CIP IB services is now treated as an allocation to counties. Counties can use the total available funding to serve as many individuals as possible regardless of the number of slots allocated. State funding allocations are still based on the reimbursement rate, number of allocated slots and total number of days in the contract year. In addition, counties are not able to transfer funds between waiver programs.

As of December 31, 2007, there were 11,377 individuals participating in the CIP IB program.

Relocation Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-MR. In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services in ICFs-MR and nursing homes, other than the state centers for people with developmental disabilities.

The change was intended to increase access to community-based, long-term care services for individuals with developmental disabilities by allowing counties access to funding which had been previously designated solely for institutional care, and to instead use those funds to support noninstitutional services for these individuals (referred to as "the money follows the person"), as long as total program costs for institutional and community services could be managed within the same allowable funding limit. Act 33 also provided funding for phase-down payments to ICFs-MR that agreed to reduce the number of their licensed beds.

As of January 1, 2005, 1,398 individuals with developmental disabilities resided in ICFs-MR and nursing homes in Wisconsin, other than the state centers. This population is considered to be the target population for the community relocation initiative. As of December 31, 2007, 540 of these individuals had relocated from institutions to alternative community-based residential settings.

Under the relocation initiative, DHS establishes a global budget to provide services to all individuals eligible for the program, including individuals located in either an institutional or community setting. Counties are then responsible for managing the cost of providing services to these individuals within the approved budget amounts established by the state. If actual costs exceed the budgeted allotment, counties are then responsible for making up the difference. Care provided by institutional facilities is still billed to the state, however, DHS then reduces the amount of funding available for providing community-based services by a corresponding amount.

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 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 funding of MA recipients who receive CIP II services may not exceed the annual CIP II allocation.

For 2007-08, the maximum daily reimbursement rate available to counties serving CIP II clients is $41.86. However, 2003 Wisconsin Act 33 authorized DHS 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.

The authority of the Department to relocate MA-eligible individuals from nursing homes to the community and provide services under CIP II was expanded somewhat under 2005 Act 25. That act authorized DHS to pay counties an enhanced rate (up to the actual cost of the plan) for services provided to individuals relocated to the community, provided that the number of individuals relocated under the provision did not exceed the number of nursing home beds that are delicensed as part of plans submitted by nursing homes and approved by DHS. Further, the aggregate cost of serving these individuals in the community is required to be less than the estimated cost of serving those individuals in a nursing home. Participation in the relocation initiative remains voluntary. If an individual relocated under this initiative receives services for at least 180 days before leaving the program, the county would retain the funding allocated to provide services to the individual under CIP II, and would be allowed to use these funds to provide services to eligible individuals who may be on the county's waiting list for services, but not yet residing in a nursing home.

Current law also authorizes DHS to pay an enhanced rate of $85 per person per day for CIP II services provided to up to 150 individuals who meet the MA level of care requirements for

nursing home care, but who are diverted from imminent entry into nursing homes on or after July 27, 2005. The act requires DHS to develop criteria for determining when individuals meet this standard, and directs the Department to include considerations for the immanent loss of current living arrangements and the risk of a long-term nursing home stay. The act also allows DHS to submit a request to the Joint Committee on Finance under a passive review process to increase the number of persons served above 150, should it become likely that the number of individuals eligible to benefit from this provision may exceed the statutory cap. As of June 30, 2008, DHS requested and received authority to pay the enhanced rate for an additional 300 individuals, bringing the total number of individuals funded at the enhanced rate to 450.

In 2007-08, approximately $96.1 million (all funds) was budgeted to support CIP II services. In addition, counties also contributed additional funds that were used to obtain federal matching funds. In calendar year 2007, counties contributed approximately $924,400 towards the CIP II program. At the end of calendar year 2007, 3,255 individuals were receiving MA services under CIP II.

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. In 2007-08, the maximum reimbursement rate was $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. In 2007-08 a total of 217 state funded slots were approved for funding. 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 DHS 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.

In 2007-08, the total amount budgeted to provide BIW services was approximately $18.9 million, including $3.8 million received as federal matching funds to contributions made by counties. Counties have the option of funding additional slots with county contributions if desired. In calendar year 2007, counties contributed $2.4 million to provide BIW services. As of June 30, 2008, there were 265 individuals enrolled in the BIW waiver program.

Children's Long-Term Support (CLTS) 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 CLTS 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. In order to be eligible to participate in the CLTS 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 2008, the child's income not exceed $1,809 per month and countable assets not exceed $2,000. Children with greater income and/or assets may become eligible for MA by "spending down" to the CLTS 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 based on annual income and family size. Fees are assessed for families with income equal to or greater than 330% of the federal poverty level (FPL), beginning at one percent of the service plan costs and increasing up to a maximum of 41% of service costs for families with incomes over 1580% of the FPL. County support, service coordination, and administrative costs are excluded for purposes of calculating the fee. Families may request a fee recalculation if they experience a dramatic change in income, and may either deduct a disability allowance of either the standard $3,300 from their adjusted gross income or their actual allowable medical deduction reported on their income taxes from the previous calendar year, whichever is greater.

The services provided under the CLTS 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 CLTS waiver supports services that are not available under the other waivers, including intensive in-home treatment services for children diagnosed with a congenital developmental disorder, such as autism, Asperger Syndrome or Pervasive Development Disorder, NOS and specialized medical and therapeutic supplies. In addition to receiving waiver services, CLTS enrollees have access to all MA-covered card services. As with other MA waiver programs, DHS 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 CLTS on a waiting list for an adult waiver slot.

Funding for the CLTS waiver program is based on the allocation of a certain number of waiver slots, which 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. The daily reimbursement rate paid to counties to provide services (excluding intensive in-home treatment services) is $30.60. For children in crisis the daily rate was $48.42 in 2009. Total funding is then determined by multiplying the total number of approved slots by the current reimbursement rate. In 2007-08, 143 CLTS waiver slots were approved for funding. In addition to these base slots, 2007 Wisconsin Act 20 provided an additional $2.0 million in GPR funding, combined with federal matching funds, to create additional slots throughout the state.

Once funding has been allocated, counties then

have the authority to serve as many individuals as available funds will allow. As shown in Table 12, as of June 30, 2008, 3,107 children were enrolled in the CLTS waiver program. An additional 3,919 children were on the CLTS waiting list, including 392 waiting for intensive in-home treatment services.

Table 12: CLTS Waiver Enrollment as of June 30, 2008

	Enrollment	Waiting List
Autism Services	1,819	392
Other CLTS Services	1,288	3,527
Total	3,107	3,919

Intensive In-Home Treatment Services. 2003 Wisconsin Act 33 also created an intensive in-home treatment services 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 treatment 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 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 treatment 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 intensive in-home 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 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 CLTS waivers.

The state began providing intensive in-home treatment services under the CLTS waivers on January 1, 2004. When the in-home treatment benefit became available under the waivers, the responsibility for administering the intensive in-home 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 treatment services, a child must have a verified congenital development disorder, such as autism, Asperger Disorder or Pervasive Development Disorder, not otherwise specified (PDD-NOS). The vast majority of children eligible to receive intensive in-home treatment 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 intensive in-home 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. As of July 1, 2008, approximately 636 children were receiving intensive in-home treatment services, while 1,183 children were receiving ongoing treatment services.

Participants at the intensive level may receive 20 to 35 hours per week of intensive in-home treatment 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 treatment services based on an established weekly rate and the number of hours specified in each participant's individual service plan. In addition, counties are reimbursed for the

cost of case management, and are permitted to claim up to 7% of direct service and case management costs to support administrative expenses. At the post-intensive level (ongoing services), counties receive $30.60 per participant per day to support all benefit and administrative costs.

Community Opportunities Recovery Waiver. Under 2005 Act 25, DHS was directed to seek a waiver from CMS to provide services under a new home and community-based program for persons with a dual diagnosis of mental health and physical health conditions currently residing in an institutional setting. The community opportunities recovery waiver (COR), approved by CMS, offers adult persons with serious mental illness and co-occurring physical disabilities a choice of relocating from a nursing home to the community. Services available through the COR program include the same services available under other existing MA waiver programs. DHS estimates that a total of 500 individuals in the state would qualify and benefit from the new program.

Individuals enrolled in the COR program must meet the following criteria to be eligible for services:

- reside in a nursing home;
- have a serious mental illness;
- have a physical medical condition, or be elderly (over age 65);
- have a nursing home level of care as determined by the long-term care functional screen; and
- meet the Medicaid home- and community-based waiver financial and non-financial criteria.

Enrollment in the COR program, which became effective July 1, 2007, will be gradually phased in over a multi-year period. In accordance with the timeline set by CMS, DHS estimates that 50 individuals will be enrolled by the end of the first year, 150 by the end of the second year, and 250 by the end of the third year.

Services provided to individuals enrolled in the COR program include a mix of care management and recovery focused services. Each individual will receive a comprehensive assessment to develop an individual care plan that includes mental health and physical health community-based services. In 2007-08, the state reimbursement rate for services provided through the COR program was $114 per person per day.

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 the 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. DHS limits the average expenditure per COP-W client to $41.86 per day, which is the same limit as under CIP II.

Approximately $82.3 million was expended to support COP-W services in calendar year 2007, including $0.5 million contributed by counties.

Include, Respect, I Self-Direct Program (IRIS)

As a condition for federal authority to expand the Family Care managed care program statewide, the Centers for Medicare and Medicaid Services (CMS) required the state to offer a fee-for-service alternative to managed care in order to provide individuals with sufficient choice in obtaining long-term care services. The IRIS program is a self-directed support waiver under the MA home and

community-based services waiver authority where individuals are given the ability to self-direct their own care and manage an individual designated budget amount. Under the self-directed supports option, participants have greater control over how services are received and who provides these services. IRIS is only available in counties where Family Care services are also available.

The IRIS program consists of two major components. First, an independent consulting agency (ICA) is responsible for assisting individuals in selecting a consultant that will work with the individual to develop a support plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must insure the individual will be healthy and safe. The ICA also maintains a 24-hour call center that provides immediate access to IRIS participants who may need assistance in resolving any unanticipated and urgent issues. DHS has contracted with The Management Group to provide these services. Second, a financial services agency (FSA) assures that all services are paid according to an individual's plan and assist enrollees in managing all fiscal requirements such as payment to providers and assuring that employment and tax regulations are met. The FSA also provides training and support to help individuals with financial accountability and processes all payments to service providers. DHS has contracted with Milwaukee Center for Independence (MCFI) to serve as the fiscal agent for all individuals enrolled in IRIS throughout the state.

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

The services available under the IRIS program are the same as the services allowed by the other home and community-based waiver programs. In addition, IRIS also allows enrollees to receive customized goods and service, which are services, support or goods that enhance the individual's opportunity to achieve outcomes related to living arrangements, relationships, community inclusion, work and functional or medical status. To qualify as a customized good and service the service, support or good must meet the following four criteria:

- is designed to meet the participant's functional, vocational, medical or social needs and also advances the desired outcomes specified in the individual service plan;

- is documented in the individual service plan;

- is not prohibited by federal and state statutes; and

- is not available through another source and is not experimental in nature.

In addition to meeting all of these criteria, the service, support or good must also meet at least one of the following:

- maintain or increase the participant's safety in the home or community environment;

- decrease or prevent increased dependence on other MA-funded services;

- maintain or increase the participant's functioning related to the disability; or

- maintain or increase the participant's access to or presence in the community.

Individuals participating in the IRIS program are given an annual budget, based upon their functional needs and a comparison to people with comparable needs within the managed care programs. The individual then develops an individual support plan. Once the plan is reviewed and ap-

proved by the ICA, the person may use funds from his/her individual budget to obtain the services they need on a fee-for-service basis. Individuals receiving IRIS services may reside, on a short-term basis, in any living arrangement (CBRF, adult family home, RCAC, etc.) as long as it is not a nursing home or other institutional facility. Individuals are not permitted to use any of their individual budget amount to pay for room and board. Further, IRIS enrollees may use their individual budget to pay caregivers, including family members, friends and members of their community, to provide services. Enrollees work with an ICA consultant to develop an appropriate care plan that fits their individual budget. The budget amount determined by DHS is based on results from the individual's long-term care functional screen. The estimated costs for the services included in the plan are based on the average Family Care capitation rates (discussed in detail in the next section). Once the care plan and budget have been determined, the FSA then assists enrollees in managing the payments for services received. Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed.

Long-Term Care Managed Care Programs

Family Care

The Family Care program is a comprehensive long-term care program that was created to improve 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, individuals with physical disabilities, and individuals with developmental disabilities, operates under four federal waivers. Approximately $324.5 million was expended on the Family Care program in 2007-08 for capitated payments to managed care organizations (MCOs). Funding provided to support aging and disability resource centers (ADRCs) is budgeted by calendar year, and is expected to total approximately $29.6 million (all funds) for 2008.

The Family Care program consists of two major components. First, ADRCs provide information, assessments, eligibility determinations and other preliminary services. Second, MCOs 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. These services are primarily designed to provide long-term care to individuals in the community rather than an institutional setting such as a nursing facility; however, Family Care is also available to eligible individuals residing in a nursing home or other institutional facility. Examples of services MCOs 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 and primary care services, such as hospital and physician services, are not part of the monthly capitation rate MCOs receive. These costs are billed to MA on a fee-for-services basis.

As of December 31, 2008, 22 counties were operating ADRCs that served a single county, while 16 additional counties were served by six multi-county ADRCs collaboratively. At the same time, MCOs operated in 26 counties. Appendix 9 illustrates each of these ADRCs and MCOs, by county. All of the MCOs, with the exception of Milwaukee County provide services to individuals who are elderly, developmentally disabled, and physically disabled. The Milwaukee County MCO currently serves only the elderly population. As part of the effort to expand Family Care statewide, additional counties are also engaged in the planning process and anticipate operating ADRCs and MCOs in

2009.

2007 Wisconsin Act 20 authorized the expansion of Family Care services statewide, in all counties that choose to participate in the program. The approval of the Joint Committee on Finance under a 14-day passive review process is now required before DHS can approve any expansion of the Family Care program to areas where, in the aggregate, more than 29% of the population that is eligible for the Family Care benefit reside. Since this threshold has already been reached, this provision effectively requires that all future expansions must be approved by the Committee. The proposal submitted by DHS, in writing, must include a description of the contract, an estimate of the fiscal impact that demonstrates the addition will be cost neutral, and documentation demonstrating county consent. If the Committee objects to any submitted proposal, it must then act by holding a formal hearing within 59 working days following the date of notification, otherwise the expansion proposal is deemed approved.

2005 Wisconsin Act 386 also expanded requirements directing DHS to conduct ongoing evaluations of the long-term care system, including the review of client access to services, client choice of living and service options, quality of care, and cost effectiveness. These provisions also apply to other managed care programs for long-term care services.

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 than 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 nursing home 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 non-nursing home level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others; or

c. The person is not functionally eligible under either a. or b. above, but submits an application for the Family Care benefit within 36 months after the date on which this benefit first became available in his or her county of residence, and 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 DHS, 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) was already receiving the family care benefit on October 27, 2007, and would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHS 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 DHS rules.

Initially, some individuals who were not eligible for MA were enrolled in Family Care. However, these individuals were not entitled to receive the Family Care benefit, funding for services to non-MA eligible enrollees was limited,

and the state did not receive federal MA matching funds to partially support services to these individuals. 2007 Wisconsin Act 20 permitted DHS to maintain Family Care eligibility for non-MA eligible individuals who were enrolled in the program as of the effective date of the act, but specified that these individuals were not entitled to Family Care coverage. In addition, the act specified that only individuals who met MA eligibility requirements were entitled to the Family Care benefit. By July 1, 2008, all non-MA recipients who previously had received services under the Family Care benefit were disenrolled, and only individuals who met MA eligibility requirements were receiving Family Care services.

MA eligible Family Care enrollees are subject to the same cost-sharing requirements that apply to individuals who participate in the MA community-based waiver programs.

Aging and Disability Resource Centers. ADRCs are meant to be a gateway for all individuals in the state in need of long-term care services, providing "one-stop shopping" for information, assessments, functional 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 ADRCs provide. ADRCs are the principle source of information about Family Care, IRIS, and other MA benefits.

All ADRCs must provide the following services:

- Information, referral services, and assistance at convenient hours;
- A determination of functional eligibility for the Family Care and IRIS benefit;
- Prevention and early intervention services;
- Benefits counseling;
- Long-term care options counseling;
- Timely referrals to the income maintenance agency that is responsible for determining financial eligibility and cost sharing for individuals interested in enrolling in a MCO;
- Assistance in enrolling in a MCO, if desired;
- Assessment of risk for individuals on a waiting list and assistance in securing MA fee-for-service and other available programs while waiting for the Family Care benefit;
- Transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system;
- Information about access to SSI, MA and FoodShare; and
- Assurance of prompt responses to emergency calls, 24 hours a day.

ADRCs must provide all of their services, including conducting functional screens, functional eligibility determinations and individual counseling, free-of-charge.

Managed Care Organizations. MCOs contract directly with DHS to provide a comprehensive network of long-term care services either directly by MCO employees or through contracts negotiated with other providers. Under current law, DHS may contract with: (a) a long-term care district; (b) a governing body of a tribe or band or the Great Lakes inter-tribal council; (c) a county; or (d) a private organization that has no significant connection to an entity that operates a resource center in establishing a MCO. Regardless of the type of entity, however, all MCOs must ensure the following:

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

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

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

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

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

As of December 2008, there were eight MCOs operating throughout the state.

Funding. The two entities that provide direct services under Family Care -- ADRCs and MCOs -- are reimbursed under two different funding mechanisms.

ADRCs. The ADRC contract assigns responsibilities to each ADRC. The contract allows each ADRC to be reimbursed for its costs in carrying out these required functions, subject to an upper reimbursement limit. Funding is budgeted based on the estimated size of the population to be served in each area and is calculated based on the amount of time required to respond to inquires for various groups of consumers by ADRC employees. If actual costs exceed this limit, the ADRC is responsible for those costs. Thus, the ADRC assumes some financial risk in carrying out its functions. As an incentive to test new methods to improve an individual's functioning, ADRCs 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 13 lists the contract amounts (state general purpose funds only) for the ADRCs for calendar year 2008, as well as any prevention grants awarded for that calendar year. In calendar year 2008, the costs of operating ADRCs is estimated to total approximately $29.6 million (all funds). Because ADRCs services are also available to non-MA eligible individuals, federal cost sharing is limited and varies by the amount of time actually spent serving MA eligible individuals. As a result, the federal reimbursement level can fluctuate from month to month based on actual encounter experience. During 2007-08, the average

Table 13: ADRC Contract Amount s (Calendar Year 2008)

ADRC	Contract Amount	Prevention Grants
Barron	$294,175	$84,378
Brown	1,461,309	114,178
Calumet, Outagamie, Waupaca	1,635,266	
Chippewa	300,459	
Columbia	341,457	
Dodge	346,898	
Dunn	164,577	
Eau Claire	175,924	
Fond du Lac	708,564	
Forest	173,921	
Green	69,724	
Southwest Wisconsin-South (Green, Grant, Iowa, Lafayette)	552,096	98,910
Jackson	111,029	
Jefferson	219,401	
Kenosha	1,107,976	55,445
La Crosse	371,451	
Western Wisconsin (La Crosse, Jackson, Monroe, Vernon)	834,582	
Manitowoc	521,885	
Marathon & Wood	1,318,887	91,300
Milwaukee	2,777,521	98,140
Ozaukee	520,576	
Pierce	152,898	
Portage	524,382	118,473
Racine	1,373,713	
Richland	127,242	53,047
Southwest Wisconsin (Richland, Sauk, Juneau, Crawford)	592,913	
Sheboygan	763,719	
St. Croix	197,978	
Trempealeau	312,132	56,997
Washington	686,584	
Waukesha	1,639,087	
Waushara, Green Lake and Marquette	538,306	
Total	$20,916,632	$770,868

federal reimbursement rate for ADRC costs was approximately 24 percent.

*MCOs***.** MCOs receive a monthly capitation rate paid by the state that represents the average cost calculated across all members of each respective MCO. Average costs reflect the case mix risk based on individuals' level of functional eligibility, labor costs and administrative costs. Two different capitation rates are paid to each MCO, including: (1) a nursing home rate, for enrollees that meet a nursing home level of care standard; and (2) a non-nursing home rate, for enrollees with a lower level of care need. Capitation rates differ by MCO to reflect different acuity of people served by each respective MCO and the costs associated with variation in acuity.

The calendar year 2008 rates at the nursing home level vary from a low of $2,221 per month to a high of $2,957 per month. The non-nursing home rate ranges from $656 per month to $725 per month.

In 2007-08, payments to MCOs totaled approximately $324.5 million. Table 14 summarizes the capitation rates, enrollment and capitation payments by MCO for 2007-08.

Table 14: MCO Capitation Rates, Enrollments and Expenditures

MCO	Cap. Rates CY 2008	Enroll. 6/30/2008	2007-08 Cap. Pmts.
Care Wisconsin	$2,845	603	$1,296,400
CHP	3,245	119	77,200
Community Care	2,768	2,704	48,690,100
Community Care of Central WI	2,750	960	27,391,800
Fond Du Lac County MCO	2,324	1,012	27,407,600
Lacrosse Co MCO	2,238	1,826	45,330,500
Milwaukee Co. Dept. on Aging	2,221	6,499	164,545,300
Southwest Family Care Alliance.	2,450	366	9,824,700
Total		14,089	$324,563,600

Note: Capitation rates are at the nursing home level of care.

Administration. DHS 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 ADRCs and MCOs establish procedures under which an individual who applies for or receives the Family Care benefit may register a complaint or grievance and procedures for resolving complaints and grievances; (d) developing criteria to assign priority equitably for persons waiting to enroll in Family Care; and (e) ensuring that each MCO is financially viable through maintenance of sound business practices.

For any county or tribe in which the Family Care program is offered, 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 ADRC and the MCO, including recommendations to the county board (or other governing board or tribe) and to DHS;

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

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

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

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

f. Advise MCOs 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 MCOs;

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

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 developmental 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 ADRC and MCOs and make recommendations, as appropriate, on the interaction between the resource center and MCOs 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 DHS 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 October, 2005, APS Health Care, Inc. completed a second independent assessment evaluation of the access to, quality, and cost effectiveness of the Family Care program in calendar years 2003 and 2004. The following conclusions were identified in the report:

Access. Similar to the initial study, results showed overall improvement in access to long-term care services and supports in Family Care counties. Among the specific findings identified in the report: (1) provider networks had increased; (2) functional assessments had improved; (3) enrollment had been streamlined; and (4) disenrollment tracking was more detailed. Recommendations for areas of improvement included: (1) improve communication and coordination between ADRCs and MCOs; (2) improve outreach to attract individuals before health or functioning deteriorates to point where they can no longer stay in the community; (3) clarifying expectations of nursing staff in coordinating non-covered services, such as primary and acute care; and (4) DHS should work with MCOs to develop alternatives to very high cost developmentally disabled cases.

Quality. Overall, the independent assessment found that the quality of long-term care services continued to increase in counties implementing the Family Care program. In particular, the study noted that waiting lists for services had been eliminated, achievement of member outcomes remained high and each MCO had improved its cost-effectiveness. Some of the key recommenda-

tions for improvement outlined in the study included: (1) clarify the definition of choice and the distinction between outcomes and desire for services for all members; (2) provide training for care managers focusing on person-centeredness and cost management; (3) facilitate regular communication between care managers to share experiences; (4) develop a joint outcome-type tool for assessing member progress towards individual long-term care goals; and (5) develop an approach for sharing best practices among MCOs.

Cost Effectiveness. In order to evaluate the cost-effectiveness of the Family Care program, APS reviewed service utilization and expenditure data for Family Care participants and compared data to similar groups of MA recipients that did not participate in Family Care but had the same characteristics and service needs as Family Care participants. Service utilization was analyzed at both the individual and county level.

The results of the study showed that Family Care participants had lower total costs and long-term care costs compared to the non-Family Care comparison group. In particular, Family Care participants exhibited lower rates of institutionalization, illness burden and functional impairment. Specifically, the assessment found that total MA costs for Family Care participants outside of the Milwaukee County area were, on average, $452 less per month than comparable counterparts receiving services under MA but not enrolled in the Family Care Program. In Milwaukee County, the savings from the Family Care program was much less but still positive, costing, on average, $55 less per member per month compared to the comparison group. The average cost savings in the non-Milwaukee counties represents the average cost savings of serving all three Family Care target groups: frail elderly, developmentally disabled and physically disabled. While services provided to each separate group were all more cost-effective under Family Care, the amount of savings differed significantly across each respective group. Finally, the study concluded that the total long-term care costs of Family Care participants rose at a slower rate than among the comparison group.

PACE/Family Care Partnership Program

The program for all-inclusive care for the elderly (PACE) and the Family Care Partnership program (formerly called Wisconsin Partnership Program) 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. Enrollment in the PACE program is currently only available for elderly individuals (defined as 55 or older), while Family Care Partnership (FCP) is available to both elderly and disabled individuals. Both programs are designed to 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 FCP. First, PACE requires enrollees to attend a day health center on a regular basis in order to receive many services. In contrast, FCP 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 FCP attempts to retain the client's current primary physician by recruiting that physician to the FCP organization. PACE programs serve only elderly individuals, while the FCP also serves individuals with physical disabilities.

There is currently one PACE site (Community Care Health Plan (CCHP) in Milwaukee) and thirteen counties with FCP services provided by three different providers (CCHP in Milwaukee, Racine, and Kenosha Counties, Care Wisconsin in Columbia, Dane, Dodge, Jefferson, and Sauk Counties, and Partnership Health Plan (PHP) in Dunn, Chippewa, Pierce, St. Croix and Eau Claire Counties.) A fourth provider, Health Plan for Community Living (HPCL), discontinued participation in the WPP program as of May 2008.

The MA capitation rates DHS pays to provide services vary by site. In 2008, these capitation rates ranged from $2,775 for elderly persons at Care Wisconsin (formerly ElderCare) in Columbia, Dane and Dodge Counties to $4,731 for persons with developmental disabilities at the Health Plan for Community Living (formerly Community Living Alliance) in Dane County. The Department is in the process of revising the MA capitation rates for this program to align them with the methods used by the Family Care program when the types of services overlap. Table 15 lists the range of capitation rates, enrollment, and actual expenditures for each of the PACE/FCP sites. Capitation rates vary by target group (developmentally disabled, elderly or physically disabled) and type of nursing facility (SNF/ICF versus ISN). In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services.

Table 15: PACE/FCP Capitation Rates, Enrollments and Expenditures (All Funds)

Site	Calendar Year 2008 Rates	06/30/08 Enrollment	2007-08 Expenditures
CCHP	$2,831 to $3,757	1,114	$40,342,300
Care WI	$2,775 to $3,643	1,030	27,565,900
HPCL	$3,857 to $4,731	0	15,172,500
PHP	$2,924 to $4,573	1,549	55,406,800
Total		3,693	$138,487,500

Community Options Program (Non-Waiver)

The non-waiver community options program is a 100% GPR-supported program that counties use 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 -- individuals with early stages of Alzheimer's disease who do not require a skilled nursing facility level of care and 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 DHS 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 2008, DHS used $37,1600 as the average cost of nursing home care for a six-month period ($6,193 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 DHS; 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 DHS or the CBRF consists entirely of independent apartments.

Of the $58.5 million GPR expended for COP services in calendar year 2007, counties expended $7.4 million to provide services not covered under the MA waiver programs, $13.1 million for individuals not eligible for the MA waiver program, $32.2 million to support locally-matched CIP IB slots and waiver costs in excess of the state maximum reimbursement rate for MA waiver programs, and $5.8 million to support assessments, case plans, and other expenditures.

The number of individuals eligible for COP funding often exceeds available funding for the program, creating the need to maintain waiting lists. Table 16 presents information on the number of individuals on waiting lists for COP services in each year from 1996 through 2007. Of the 13,206 individuals on waiting lists as of December 31, 2007, 442 (3.3%) were residing in an institution, 9,261 (70.1%) were receiving no public long-term care funding, and 3,503 (22.9%) were receiving some public long-term care funding but not COP or waiver funding. While the expansion of Family Care has reduced waiting list for MA home and community-based long-term care services, the waiting list for COP services has continued to increase.

Table 16: Number of Individuals on Waiting Lists for MA Waiver Programs*

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
2004	12,969
2005	11,583
2006	11,845
2007	13,206

*As of December 31 of each year.
**The Family Care benefit became available in 2001.

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. DHS is required to determine what constitutes a "significant number" of people for each county.

DHS 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. DHS may grant variances to the "significant numbers" requirement on a county-by-county basis.

Table 17 presents statewide information on the number of people served in each COP client group on December 31, 2007, 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 17: Total Number of Person Served with COP and COP-W Funds by Disability Group (December 31, 2007)

	Number	Actual Percent	"Significant Numbers" Percentages
Elderly*	4,545	45.7%	57.0%
Developmentally disabled	2,657	26.7	14.0
Physically disabled	1,927	19.54	6.6
Seriously mentally ill	779	7.8	6.6
Chemically dependent and others	38	0.4	0.0
Total	9,946	100.0%	84.2%

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

CHAPTER 5

ADMINISTRATION

State law assigns DHS numerous responsibilities relating to the administration of the MA program. Those duties 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, DHS must ensure that the MA program complies with the state's MA plan and with federal law and policy. DHS meets these responsibilities, in part, by contracting with third parties (private and public), and by working with counties and tribal governing bodies.

MA Administrative Contracts. DHS contracts with outside entities to provide a range of MA-related administrative services that include claims processing, reviewing prior authorization requests, conducting utilization reviews, and identifying overpayments to providers. Many of these services are provided by the state's current MA fiscal agent, Electronic Data Systems, Inc. (EDS). The rest are provided either by other private entities such as MetaStar, PriceWaterhouse Coopers, Automated Health Systems, Inc. (AHS), and Deloitte, or by state agencies such as the Department of Administration's Division of Hearings and Appeals.

In 2007-08, DHS spent approximately $105 million ($36 million GPR and $69 million FED) for contracted administrative services for the EBD MA, BadgerCare Plus, SeniorCare, FoodShare, and other related programs. DHS refers to these costs collectively as "MA and FoodShare Administration." Table 18 summarizes those contracting costs by funding source. Note that Table 18 does not include costs related to the income maintenance (IM) administrative responsibilities that are performed by counties and tribes and financed by a combination of GPR, FED, and county-provided funds. Those IM administration activities are described later in this chapter.

Table 18: MA and FoodShare Administrative Costs, Fiscal Year 2007-08

	GPR	FED	Total
Fiscal Agent Services	$12,774,800	$43,267,300	$56,042,100
Major External Contracts	2,338,900	2,886,200	5,225,100
Inter- and Intra-agency	2,508,200	2,768,300	5,276,500
CARES	16,863,200	18,445,200	35,308,400
Other DHS Contracts	1,539,700	1,649,100	3,188,800
Total	$36,024,800	$69,016,100	$105,040,900

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the state's MA program and several related programs. Those services include processing claims, distributing MA eligibility cards, reviewing prior authorization requests, managing pharmacy point-of-sale systems, collecting BadgerCare Plus premiums, coordinating benefits, and developing and supporting information systems.

In 2007-08, approximately $28.6 million of the total fiscal agent service costs of $56 million related to the design and implementation of ForwardHealth interChange, a web-based information system that replaced the MA program's previous Medicaid Management Information System (MMIS). ForwardHealth interChange is designed to allow MA providers and DHS trading partners more and better ways to verify member enrollment, submit electronic claims, make claims adjustments, and submit prior authorization requests. ForwardHealth interChange is designed and supported by EDS. Of the approximately $28.6 million DHS paid for services related to ForwardHealth

interChange in 2007-08, nearly 90% was financed through federal matching funds.

Major External Contracts. In addition to EDS, DHS contracts with several other private entities for MA-related administrative services. Several of the more significant external contracts are with MetaStar, PriceWaterhouse Coopers, and AHS.

Federal law requires states to develop a utilization review plan and provisions for the external review of certain facilities. To help meet these requirements, DHS contracts with MetaStar and other entities to provide certain services, including managed care and medical record quality reviews, hospital audits, best practices seminars, performance improvement projects, encounter validity audits, and other peer reviews. In 2007-08, DHS paid MetaStar approximately $1,071,500 (all funds) to provide these services. Because MetaStar operates as an external quality review organization (EQRO), 75% of these costs are funded with federal matching funds.

PriceWaterhouse Coopers provides actuarial services to the state's MA program and related programs. In 2007-08, DHS paid PriceWaterhouse $1,429,800 (all funds) for those services.

DHS currently contracts with AHS to provide outreach and enrollment counseling services to BadgerCare Plus members who enroll in HMOs. Those services are provided through a call center located in Milwaukee County. In 2007-08, DHS paid AHS approximately $2,993,400 (all funds) to support services provided under the HMO enrollment contract.

Interagency and Intra-agency Agreements. The MA program also receives administrative services from other state agencies and from other divisions within DHS itself. Primary among the interagency services are the MA and FoodShare administrative hearings conducted by the Department of Administration's Division of Hearings and Appeals. In 2007-08, DHS paid that Division approximately $2,085,800 (all funds) for costs related to those administrative hearings.

Professionals with the Disability Determination Bureau of the DHS Division of Health Care Access and Accountability determine whether an individual has an illness, injury, or condition that meets the legal definition of disability as defined under the Social Security Act. Such determinations can be a factor in establishing whether that individual qualifies for benefits under such programs as SSDI, SSI, MA, the Katie Beckett program, and the Medicaid Purchase Plan. In 2007-08, DHS incurred costs of approximately $1,997,600 (all funds) for disability determinations related to the MA program.

CARES. The client assistance for reemployment and economic support (CARES) system assists state and county staff in making eligibility determinations and maintaining case information for such programs as BadgerCare Plus, SeniorCare, Family Care, FoodShare, the SSI Caretaker Supplement, TANF/W-2, and Child Care Assistance. The first five of these programs, administered by DHS, accounted for approximately 90% of CARES cases in fiscal year 2008. The other two programs are administered by the Department of Children and Families (DCF).

CARES is a mainframe system that was first implemented in January 1994, and has been changed as additional programs were added or program needs changed. With the transfer of the FoodShare program from DWD to DHS in July 2002, DHS assumed responsibility for the primary programs supported by CARES. The state contracts with Deloitte, which is responsible for programming and maintaining the daily operations of the system. DHS also purchases services from the Department of Administration's Division of Enterprise Technology (DET), DWD, and DCF to connect and support IM workers and other CARES users.

CARES costs are allocated across the programs it supports in both DHS and DCF. CARES-related costs in 2007-08 totaled approximately $40.1 million (all funds), the great majority of which

($36.5 million) were funded through DHS due to the preponderance of DHS-administered programs that use the system. A substantial portion of the total CARES expenditures in 2007-08 ($13.7 million) were paid to Deloitte for programming, analysis, and maintenance tasks of the CARES system. An additional $16.9 million (all funds) was paid to DET for computer-related services.

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

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

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

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

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

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

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 DHS to perform eligibility functions for MA, BadgerCare Plus, and FoodShare. DHS also contracts with tribes for these functions. In addition, DHS 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.

In calendar year 2007, DHS allocated approximately $54.6 million (all funds) to counties and tribes to support these income maintenance activities. This allocation consists of the base income maintenance administrative allocation (IMAA) of $46 million and several supplemental allocations. DHS allocates IMAA funding to counties on a calendar year basis and to tribes on a federal fiscal year basis. Funding for other IM functions, including funeral and cemetery aids, MA transportation, and public assistance fraud programs (both program integrity and investigations) are provided as separate allocations and amendments to the IM contract. The IMAA and supplemental allocations for calendar years 2006 and 2007 are shown in Appendix 10.

Each program, for example the FoodShare program, is required to support its proportional share of income maintenance program costs. Since 2003, CMS has required that DHS use a random moment sampling methodology to determine each program's proportional share of the IM costs. Each program supports its share with GPR, federal funds, local funds, or some combination of these sources.

Counties and tribes are not required to provide local funding for IM activities, but most do. This funding is called local non-reimbursable expenditures. In 2007, 69 counties and three tribes used local non-reimbursable expenditures to support their IM activities. Appendix 11 lists local non-reimbursable expenditures by counties and tribes for IM activities in calendar years 2006 and 2007, and the amount each entity provided. Combining the IMAA and supplemental allocations shown in Appendix 10 with the local non-reimbursable expenditures shown in Appendix 11 sums to a total of $101.6 million that counties and tribes expended to conduct IM activities in calendar year 2007. Those total expenditures included $27.3 million GPR, $50.8 million in matching federal funds, and $23.5 million in local funds. The federal funding amount includes federal funding that is matched to both the state GPR and the local non-reimbursable expenditures.

Audits and Coordination of Benefits

Federal law requires states to employ mechanisms designed to ensure that their MA programs pay only the proper amount for legitimate claims, and to ensure that other resources (such as a recipient's other health insurance coverage) are used before MA pays for services. DHS efforts in this regard include its audit and coordination of benefit activities.

As a condition of receiving federal MA matching funds, states are required to audit the financial records of hospitals, clinics, pharmacies, and other entities that provide services to MA recipients. Under state law, DHS is authorized to audit all claims filed by MA service providers, and as part of that audit to request of the provider medical records of MA recipients. These audits are conducted in order to ensure that providers are properly billing the state's MA program for MA-covered services, and to ensure that providers are properly documenting those claims. When the audits reveal improper billings or other problems, the MA program can recover previously made payments.

In 2007-08, the Bureau of Health Care Program Integrity within DHS conducted approximately 1,800 MA provider audits. Those audits included relatively limited "desk audits," which are generally limited to a single issue, to more intensive au-

dits where an audit team conducts an on-site investigation of a provider's records. The Bureau also performs follow-up audits where appropriate. As a result of these audits and other related activities, DHS recovered approximately $6.8 million in 2007-08.

As noted, federal law also 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. DHS 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. For example, Wisconsin law requires the use of other health insurance benefits, such as Medicare, commercial health insurance, and settlements resulting from subrogation (injury, medical malpractice, product liability) to defray the costs incurred by MA. Any COB savings generated by states are shared with the federal government in the same proportion as each state's MA benefits expenditures. Examples of other resources for COB include individuals who have either voluntarily accepted or been assigned legal responsibility for the health care of one or more MA recipients, worker's compensation carriers, absent parents or other entities providing medical child support, and estates.

The identification of COB resources is a shared responsibility of 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 DHS Division of Health Care Access and Accountability. 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 a recipient's MA card, before billing MA.

DHS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available by requiring the service provider to obtain reimbursement from those sources. In 2007-08, DHS estimates these efforts enabled the MA program to avoid over $1.1 billion in costs, $670.6 million relating to claims where the MA recipient had Medicare coverage, and $434.4 million where the recipient had or was suspected of having other non-Medicare health insurance coverage. Note that the latter amount does not include claims where the other insurance carrier paid the provider's bill in full and the MA program was never billed for the services.

A second COB method, referred to as "post-payment recovery," is where the state initially pays provider claims then attempts to recover those payments from other potentially liable sources. In 2007-08, these post-payment recoveries included recoveries stemming from other health insurance coverage, ($7.7 million), subrogation ($2.0 million), medical support liability ($16.1 million), and other post-payment recoveries ($18.5 million). In addition to these amounts, DHS "estate recovery" activities, discussed in more detail later in this chapter, generated post-payment recoveries of $17.9 million in 2007-08.

A third COB method is called "provider-based billing," where the state initially uses MA funds to pay provider claims, but then retroactively identifies health insurance coverage that requires documentation, for example, a physician's plan of care, prescriptions or discharge notes. When that occurs, a bill is produced for the provider to use to bill the health insurer. The provider has 120 days to collect payment from the insurer and refund the MA payment. If the provider does not refund the MA payment within 120 days, the MA payment is automatically recouped from the provider through a claims adjustment. In 2007-08, provider-based bill COB activities benefited the MA program by approximately $6.2 million.

Estate Recovery Program

DHS uses the estate recovery process to offset MA program costs. Under the estate recovery program, the state recovers from the estates of deceased MA recipients 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. DHS 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, DHS must notify the recipient in writing of its intention and advise the recipient that they have a right to a hearing on whether the necessary conditions have been satisfied.

DHS can also place other claims against a recipient's estate. A claim on the estate may not be paid if a spouse, or a child under age 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 satisfied through available liquid assets. DHS cannot enforce that lien, however, if the recipient has a spouse, or a child who is under age 21, blind or disabled. DHS 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 DHS 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.

In addition to placing liens, certain transfers of assets may trigger a review by the DHS. When a probate case is filed relating to an MA recipient's estate, DHS may review the action and file a claim to recover care-related costs under the estate recovery program. Currently, Wisconsin Circuit Court records are available online through the consolidated court automation program (CCAP), allowing the DHS to monitor when an estate is in probate.

However, under 2005 Wisconsin Act 206, a new mechanism for the non-probate transfer of real

property at the death of the property owner was created. Under that act, an interest in real property that is solely owned, owned by spouses as survivorship marital property, or owned by two or more persons as joint tenants may be transferred without probate to a designated transfer-on-death (TOD) beneficiary on the death of the sole owner or the last to die of multiple owners. Since the TOD beneficiary has no interest in the property while the owner is alive, the provision does not affect the recipient's eligibility while they are alive. However, upon his/her death, DHS is not able to file a claim or collect against these assets, thus impacting the State's ability to recover these assets previously owned by the MA recipient.

CHAPTER 6

SENIORCARE AND MEDICARE PART D

Introduction

Wisconsin's SeniorCare program and the federal Medicare Part D program both provide prescription drug benefits to elderly Wisconsin residents. This chapter gives an overview of the eligibility factors, benefit design, and funding sources for these programs.

SeniorCare

SeniorCare was created as part of 2001 Wisconsin Act 16 to help Wisconsin residents age 65 or older purchase prescription drugs. DHS began paying program benefits on September 1, 2002, after CMS gave its approval to operate a portion of the SeniorCare program as a five-year demonstration project pursuant to a waiver of federal MA law (thereby qualifying a portion of the program's benefits for federal matching funds). That original five-year waiver period has since been extended through December 31, 2009.

Eligibility. Most Wisconsin residents age 65 or older who pay a $30 annual enrollment fee are eligible for SeniorCare. The exceptions are people who are already eligible for full MA benefits (including coverage for prescription drugs), people who are not U.S. citizens and whose immigration status would make them ineligible for MA, and inmates of public institutions. Individuals who have other prescription drug coverage are eligible to participate in SeniorCare, but the program only pays for that portion of the eligible costs that are not payable from other sources.

Cost-Sharing Requirements. In addition to the $30 annual enrollment fee, SeniorCare has deductible and copayment requirements.

Deductibles. A SeniorCare participant's deductible is based on the income of their fiscal test group. The fiscal test group consists of the participant and a married participant's spouse if the spouses reside together. The spouse's income is not included, however, if the spouse is eligible for SSI or the spouses live 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 also included, and it is determined by deducting estimated business expenses, losses and depreciation from gross self-employment income. Income from sources that under federal law are exempt when determining MA eligibility is also exempt for purposes of SeniorCare.

If the income of the applicant's fiscal test group is less than 160% of the federal poverty level (FPL), the applicant does not have to pay a deductible.[3] For these participants, SeniorCare pays the cost of all covered prescription drugs, subject to the copayment requirements described below.

If the income of the applicant's fiscal test group is greater than 160% of the FPL but not greater than 200% of the FPL, their deductible is $500. For these participants, SeniorCare pays the cost of all covered prescription drugs, subject to the required copayments, after this $500 deductible is met.

If the income of the applicant's fiscal test group is greater than 200% of the FPL, their deductible is $850. SeniorCare pays the cost of all covered prescription drugs for these participants, subject to the required copayments, after the $850 deductible

[3] See Appendix 1 for the 2008 FPL by family size.

is met. Note, however, that if the applicant has fiscal test group income greater than 240% of the FPL, they must satisfy certain "spend down" rules before they receive program benefits. Those "spend down" rules are discussed below.

In those cases where the fiscal test group consists of two spouses, each spouse has their own deductible requirement. Prescription drug purchases only apply toward the deductible of the spouse for which they are prescribed.

During the period in which a participant is meeting their SeniorCare deductible, they can purchase prescription drugs at the discounted program payment rate. It is estimated that on average, this discount is equal to 28% of the retail price, although the actual discount varies according to the drug purchased. The participating pharmacy absorbs this discount. The ability of SeniorCare participants to purchase drugs at a discounted rate while they are meeting their deductible is referred to as the program's "deductible benefit." This benefit is available to participants with income not greater than 240% of the FPL, and to higher-income participants once they satisfy the "spend-down" requirement described below. During the period of the deductible benefit, DHS keeps a record of the prescription drug purchases made by the participant, and notifies participating pharmacists when the enrollee has satisfied their deductible.

As noted, SeniorCare participants with income greater than 240% of the FPL must "spend-down" in order to receive the deductible benefit. They do this by incurring prescription drug costs in an amount equal to the difference between their income and 240% of the FPL. For married couples with both spouses participating in the program, purchases of prescription drugs for either spouse count towards their spend-down requirement. During the spend-down period, pharmacies cannot charge these SeniorCare participants more than the retail price of the drug. Once they satisfy their spend-down amount, participants are eligible for the "deductible benefit" until they satisfy their $850 deductible. After the $850 deductible is met, SeniorCare pays the cost of all covered prescription drugs, subject to the required copayments

Copayments. After they have satisfied the program's deductible requirements, participants pay a copayment for each prescription drug they purchase under SeniorCare. 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.

The rules pertaining to income, deductibles, spend-down, and copayments are reflected in the four "participation levels" DHS has designated for SeniorCare recipients:

Level 1. Individuals with income at or below 160% of the FPL are enrolled in SeniorCare Level 1. There is no deductible or spenddown requirement for these individuals. They only pay copayments for covered prescription drugs they purchase under the program.

Level 2a. Individuals with income above 160% but not greater than 200% of the FPL are enrolled in SeniorCare Level 2a. These individuals pay a $500 annual deductible. Once Level 2a participants meet that deductible, they only pay copayments for covered prescription drugs they purchase under the program.

Level 2b. Individuals with income above 200% but not greater than 240% of the FPL are enrolled in SeniorCare Level 2b. These individuals pay an $850 annual deductible. Once Level 2b participants meet that deductible, they only pay copayments for covered prescription drugs they purchase under the program.

Level 3. Spend-down. Individuals with income above 240% of the FPL are enrolled in SeniorCare Level 3. These individuals must first meet their spend-down requirement, then satisfy an $850 annual deductible. Once Level 3 participants meet both those requirements, they only pay copay-

ments for covered prescription drugs they purchase under the program.

Table 19 shows SeniorCare's month-end enrollment as of November 2008, by participation level.

Table 19: SeniorCare Enrollment, by Participation Level, November 2008

Level 1 (≤ 160% FPL)	39,575
Level 2a (> 160% to ≤ 200% FPL)	20,059
Level 2b (> 200% to ≤ 240% FPL)	11,795
Level 3 (> 240% FPL)	14,449
Total	85,878

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

The amount of the reimbursement equals the lesser of the pharmacy's usual and customary charge or the SeniorCare reimbursement rate (which is equal to the MA rate for the same drug plus 5%), 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 28% of pharmacies' usual and customary charges. A provider's usual and customary charge represents the amount the provider customarily charges to individuals and other parties. 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.

DHS 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. 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. For a recipient participating in the waiver program, the drugs covered are identical to the drugs covered under MA (all of which are produced by manufacturers who have entered into a rebate agreement with DHS in conjunction with the state's MA program.) For individuals not in the waiver program, SeniorCare only covers drugs produced by manufacturers that have signed a separate rebate agreement with the state. In practice, the lists of covered drugs are virtually identical.

DHS 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. DHS requires a pharmacy to receive prior authorization for some drugs, including certain stimulants, nutritional supplements, and selected other drugs that have been demonstrated to entail substantial cost and utilization problems under the MA program. In most cases, pharmacists submit requests for prior authorization electronically and receive responses in real time. In some cases, however, 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. Where prior authorization is required but not obtained before a prescription is provided, the program may not reimburse the provider except in the case of an emergency.

Generic Substitution. SeniorCare automatically reimburses a pharmacy for the generic equivalent of a drug whenever the generic equivalent is available, unless the pharmacy receives prior authorization to use the brand name drug. Pharmacies must obtain information from prescribers indicating why the brand name drug is medically necessary and submit this information to DHS with the 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. To receive payment for pharmaceutical care services, a pharmacist must meet all basic requirements of federal and state laws 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 and preventing potential adverse drug reactions.

SeniorCare pays pharmacists for pharmaceutical care services only if they are provided while the participant 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 state's SeniorCare waiver agreement with CMS, 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 agreement, 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 not in the waiver. Most pharmaceutical manufacturers that participate in the MA rebate program have signed a separate SeniorCare rebate agreement. The amount of the rebate paid by a manufacturer that has signed a separate SeniorCare agreement is the same as the MA rebate.

Rebate revenue received from pharmaceutical manufacturers is deposited in a program revenue appropriation and is budgeted to offset GPR and federal MA funds proportionately. In 2007-08, DHS received approximately $54.8 million in revenue from rebates paid by pharmaceutical manufacturers for drugs purchased under the program.

Funding. SeniorCare benefits are funded with GPR, federal MA matching funds and program revenue from the manufacturer rebates described above. Rebates paid by pharmaceutical manufacturers for recipients with income up to 200% of the FPL 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 DHS 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, DHS is not required to pay pharmacies for any drugs purchased by recipients, pharmacies are not prohibited from charging SeniorCare recipients more than the SeniorCare payment rate, and manufacturers whose drugs are covered under the program are not required to pay rebates for drugs purchased by recipients.

The CMS Waiver. On July 1, 2002, DHS received the necessary waiver approvals from CMS to operate a portion of SeniorCare as a five-year demonstration project. That original five-year period was scheduled to end on June 30, 2007, but has since been extended through December 31, 2009. Under the terms of the waiver, DHS 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 and are not eligible for federal matching funds. Table 20 identifies benefits expenditures by funding source for state fiscal years 2005-06 through 2007-08.

Table 20: SeniorCare Benefit Expenditures, by Source (SFYs 2005-06 through 2007-08)

	2005-06	2006-07	2007-08
GPR	$44,364,400	$45,668,300	$38,797,300
FED	45,700,200	41,875,500	33,476,700
PR*	50,639,800	53,198,000	54,780,900
Total	$140,704,400	$140,741,800	$127,054,900

*Manufacturer rebates

SeniorCare administrative costs are funded from a combination of program revenue generated by the $30 enrollment fee, GPR, and federal MA matching funds. In 2007-08, these administrative costs totaled approximately $5 million (all funds).

Medicare Part D

Since January 1, 2006, Medicare beneficiaries have been able to obtain outpatient prescription drug coverage under the Medicare Part D program. Authorized in the Medicare Prescription Drug, Improvement and Modernization Act (MMA), Medicare Part D drug benefits are delivered by federally approved private entities called stand-alone prescription drug plans (PDPs), and Medicare Advantage prescription drug plans (MA-PD plans). The MMA provides a model standard benefit plan, but competing plans can and do offer a variety of alternative and enhanced coverage options. Most enrollees pay monthly premiums, deductibles, and copayments, the amounts of which vary depending on which plan they select. Medicare Part D also has a low-income subsidy (LIS) program that helps certain enrollees meet those out-of-pocket expenses.

Eligibility. Medicare is a government health insurance program administered by CMS. Most U.S. citizens age 65 and older, people under age 65 with certain disabilities, and people with end-stage renal disease, are eligible for coverage under the program. Medicare has four parts. Medicare Part A provides hospital insurance that includes inpatient care in hospitals, nursing homes, skilled nursing facilities, and critical care access hospitals, but does not include long-term care or custodial care. Most Part A enrollees are not required to pay a premium to receive those benefits. Medicare Part B provides supplementary medical insurance that covers such services as medically necessary doctor visits, outpatient care, and other services not covered by Medicare Part A. Unlike Part A, most people are required to pay a premium to participate in Medicare Part B. Medicare Part C combines the benefits available under Medicare Parts A and B, and does so through private health insurance plans referred to as Medicare Advantage Plans. In most cases,

these Medicare Advantage Plans also include the Medicare Part D prescription drug coverage. Additional information about Medicare Parts A, B, and C is provided in Chapter 2 of this paper.

Medicare Part D is the prescription drug benefit program established in the MMA. People are eligible to participate in Medicare Part D if they are entitled to Medicare Part A or they are enrolled in Medicare Part B. Generally speaking, participation in Medicare Part D is voluntary, although some individuals such as "dual eligibles" (individuals who are eligible for coverage under both the Medicare and Medicaid programs) are automatically enrolled in a Medicare Part D plan.

Enrollment. The annual open enrollment period for Medicare Part D runs from November 15 through December 31, with enrollment in the selected plan effective January 1 of the following year. Enrollees who become newly eligible for Part D benefits during the course of the year, for instance by aging into the program, can enroll at any time during an initial enrollment period that begins three months before the month in which they turn 65 and ends three months after their birthday.

Special enrollment rules apply to dual eligibles and other individuals participating in the LIS program. For their initial enrollment in the Part D program, these individuals can choose their own drug plan or, failing that, be automatically enrolled in a randomly selected benchmark plan. Benchmark plans are drug plans that offer basic Medicare Part D coverage for a monthly premium at or below a regional benchmark level. The benchmark monthly premium for Wisconsin in 2009 is $38.15.

If a person is eligible for Medicare Part D but does not enroll in a plan when they are first eligible to join, and there is a period of 63 continuous days or more during which they do not have "creditable prescription drug coverage" (defined as coverage that is at least equivalent to the standard Part D coverage), they face a permanent penalty equal to 1% of the national average monthly premium for each month they delay enrollment. In Wisconsin, the state's SeniorCare program is considered "creditable prescription drug coverage" for these purposes. Other prescription drug coverage, such as that offered by companies to their retirees, can also qualify as creditable coverage, depending upon the benefits offered.

Coverage under Medicare Part D. The MMA defines the standard coverage available under Part D in terms of drugs covered and benefit structure. Regarding the former, Part D plans must cover at least two drugs in every therapeutic category of prescription drugs, as well as all or substantially all drugs in six categories (antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and anticancer). Excluded from coverage are barbiturates, benzodiazepines, prescription vitamins and minerals, and drugs prescribed for weight gain or loss, cosmetic purposes or hair growth, fertility, anorexia, and relief of symptoms of colds. Subject to these limitations, Medicare Part D plans can and do establish their own formularies.

With respect to benefit structure, the Part D "model plan" for 2009 consists of the following elements: (a) an annual deductible of $295; (b) a coinsurance requirement of 25% of the initial coverage limit of $2,700; and (c) 100% catastrophic coverage (subject to copayments of $2.40 for generic drugs and $6.00 for brand name drugs, or 5% of retail price, whichever is greater) that begins after the enrollee incurs total out-of-pocket prescription drug costs of $4,350. As this description implies, there is a coverage gap in the standard coverage structure that begins after the enrollee has purchased covered prescription drugs totaling $2,700 (with accompanying out-of-pocket costs of $896) that continues until the enrollee has purchased covered prescription drugs totaling $6,155. During this $3,455 coverage gap, also referred to as the Medicare Part D "donut hole," the enrollee is responsible for 100% of prescription drug costs. Beyond the donut hole, Medicare Part D covers 100% of the enrollee's covered prescription drugs, subject

to the copayments described above.

Part D drug plans are not required to offer the model plan. Instead, PDPs and MA-PDs offer a variety of plans that have different benefit structures. For example, some plans offer enrollees a lower (or no) deductible, a lower initial coverage limit, and/or coverage for prescriptions written in the donut hole. As might be expected, monthly premiums vary according to the particular plan's benefits.

According to the Henry J. Kaiser Family Foundation (Kaiser), there are 53 PDPs providing Medicare Part D coverage to Wisconsin residents in 2009, with the monthly premiums for those plans ranging from $13.70 to $102.70. Kaiser also reports that eight companies are offering Medicare Advantage prescription drug plans to Wisconsin residents in 2009. Approximately 430,310 Wisconsin residents were enrolled in PDPs or MA-PDs in 2008.

Low-Income Subsidy. Medicare Part D provides financial assistance to certain enrollees, with the level of assistance varying depending upon the type of beneficiary and their income and assets. The first category of LIS beneficiaries are full-benefit dual eligibles. These individuals do not pay a Part D premium or deductible (assuming they enroll in a benchmark plan) and their copayments vary with their income. Those with income at or below 100% of the federal poverty level (FPL) pay a $1.10 copayment for generic drugs and a $3.20 copayment for brand name drugs, but do not have any copayments after paying annual out-of-pocket drug costs of $4,350. Dual eligibles with income greater than 100% of the FPL pay copayments of $2.40 for generics and $6.00 for brand names, up to the maximum out-of-pocket limit of $4,350. Dual eligibles who are institutionalized do not have any copayments.

The second category of LIS beneficiaries are partial-benefit dual eligibles, which include participants in a Medicare Savings Program and SSI beneficiaries. These individuals do not pay a Part D premium or deductible. Their copayments are $2.40 for generics and $6.00 for brand names, up to total annual out-of-pocket drug spending of $4,350, beyond which they do not have copayments.

Full-benefit dual eligibles and partial-benefit dual eligibles both automatically qualify for the LIS program and do not need to file an application.

The third group of LIS beneficiaries include non-dual eligibles with income below 135% of the FPL and assets less than or equal to $8,100 (single) or $12,910 (married). These individuals do not pay a premium or a deductible, and their copayments are $2.40/$6.00 up to the out-of-pocket threshold of $4,350, beyond which they do not have copayments.

The fourth group of LIS beneficiaries are non-dual eligibles with income from 135% to 149% of the FPL and assets between $8,100 and $12,510 (single) or $12,910 and $25,010 (married). These individuals pay a premium based on a sliding scale, and a $60 deductible, after which they pay 15% of their drug costs up to the maximum out-of-pocket threshold of $4,350, beyond which their copayments are $2.40/$6.00. Unlike dual eligibles, individuals in the third and fourth LIS groups must apply in order to receive the subsidy.

Funding. The Medicare Part D benefit is supported by enrollee premiums (designed to cover approximately 25.5% of the program's costs) and payments from the federal government's general fund. States also contribute to the Medicare Part D program through a "clawback" mechanism designed to recognize that with the implementation of Medicare Part D, state MA programs no longer reimburse pharmacies for most prescription drugs purchased by dual eligibles. The amount of the clawback payment is based on a declining percentage of the 2003 calendar year non-federal share of prescription drug costs under state MA programs paid for dual eligibles, inflated to the current year. The percentage began at 90% in calendar year 2006 and is set to decrease to 75% during the following 10 years. For state fiscal year 2007-08, DHS estimates the Wisconsin MA program made clawback

payments to CMS of approximately $139.7 million.

SeniorCare and Medicare Part D. Since the Medicare D program was created in January 2006, many elderly Wisconsin residents are eligible for prescription drug benefits under both that program and SeniorCare. Coincident with the implementation of Medicare Part D, SeniorCare enrollment increased, perhaps due to enrollees' desire to enroll in a prescription drug plan with creditable coverage and thereby avoid the Medicare Part D's late enrollment penalty. During both 2007 and 2008, however, SeniorCare enrollment declined. As of November 2008, the program's total enrollment was approximately 85,900, down from over 100,000 in 2006. DHS attributes this decline to individuals' increased familiarity with the Part D program. In addition, for those seniors who qualify for Part D's LIS program, there may be an incentive to enroll in Part D rather than SeniorCare.

CHAPTER 7

FUNDING SOURCES

This chapter provides additional information about the revenue sources used to finance benefits under Wisconsin's MA program.

Funding Sources for the Wisconsin MA Program.

The majority of benefits provided under the state's MA and MA-related programs are funded either by general purpose revenues (GPR) or federal MA matching funds (FED). As Table 1 on page 2 of this paper indicates, GPR (35%) and FED (59%) combined funded approximately 94% of total MA benefit expenditures during the three state fiscal years 2005-06 through 2007-08.

In addition to GPR, Wisconsin uses other revenues to finance the non-federal share of MA benefit expenditures. Under federal law, MA benefit expenditures funded by these other revenue sources qualify as the state's share of MA expenditures and are eligible for federal MA matching funds, provided the revenues are generated and applied in a manner consistent with federal regulations. Examples of these other revenue sources include the following:

- Broad-based health care-related taxes (including licensing fees, provider assessments, or other mandatory payments) if those taxes relate to health care items or services, are uniformly imposed throughout the jurisdiction, and do not violate "hold harmless" rules set forth in federal law;

- Intergovernmental transfers (IGTs), which are funds that are either directly appropriated to the MA program from local units of government or that are transferred to the MA program from local units of government, and that are under the administrative control of the MA program (provided those transferred funds are not federal funds that cannot be used to match other federal funds); and

- Certified public expenditures (CPEs), which are funds contributed by local units of governments and which the local unit of government certifies were spent to provide services to eligible individuals receiving MA or in administration of the state MA plan.

State Medical Assistance Trust Fund

Revenues from the funding sources listed above, as well other assets, are deposited into the medical assistance trust fund (MATF), a separate, nonlapsible trust fund created in 2001 Wisconsin Act 16 and used to support the costs of the state's MA program. The following discussion briefly describes the revenues and other assets that constitute the MATF.

Nursing Home Bed Assessment. The state established a provider assessment on nursing home beds in 1991-92. The nursing home assessment is an amount per licensed nursing home bed and applies to all nursing home beds, including state facilities, and beds occupied by Medicare beneficiaries. In 2007-08, the monthly assessment per bed is $75 for nursing facilities. In addition, the state also implements a separate bed assessment on all ICF-MR beds in the state. 2007 Wisconsin Act 20 changed the method of determining the assessment for ICFs-MR. Instead of applying a flat fee, the monthly assessment for ICFs-MR is calculated by multiplying the total gross annual revenues of all ICFs-MR in the state by 5.5% (the maximum allowable federal rate),

then dividing by the total number of licensed beds in the state, and finally dividing by 12 months to determine the monthly assessment rate. In 2007-08 the average monthly assessment rate for ICF-MRs was $521 per bed.

The revenues generated from the nursing home bed assessment are deposited in the MATF. In 2007-08, those revenues totaled approximately $41.7 million.

Although federal rules prohibit states from implementing any hold- harmless provisions that would directly tie MA reimbursement levels to the amount of the tax paid by any individual provider, most nursing homes benefit from the assessment because the state has used assessment revenue and the federal matching funds, 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 November, 2008, only 19 of the 399 licensed nursing homes in the state were not certified to serve MA-funded residents. 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.

Nursing Home Certified Public Expenditure Program. After CMS imposed restrictions on the amounts states could claim under the former IGT program and began phasing out payments (the program officially ended in 2004-05), DHS determined that larger reimbursement claims could be made using the operating losses incurred by nursing homes owned and operated by local governments. As a result, DHS requested and received CMS approval to create a CPE program under which the state receives federal MA matching funds based on unreimbursed costs county and local government facilities incur to provide nursing home care to MA recipients. All revenue the state collects under this nursing home CPE program is deposited to the MATF.

2005 Wisconsin Act 107 requires DHS to distribute any federal matching funds generated by the nursing home CPE program that exceed the amount of funds the state anticipates and budgets as revenue in the biennial budget and are received in the current fiscal year. DHS currently distributes these funds, when available, as additional supplemental payments to nursing homes owned and operated by local governments.

Hospital Certified Public Expenditure Program. Under a separate CPE program applicable to UW hospital, DHS is authorized to submit a claim for federal matching funds in an amount equal to the MA deficit UW hospital incurs to provide unreimbursed services to MA recipients. In 2007-08, this CPE program generated $15.4 million in federal matching funds that were deposited to the MATF.

UW Intergovernmental Transfer Program. 2007 Wisconsin Act 20 requires the University of Wisconsin System to annually transfer $15 million of program revenue from its general operations appropriation to the MATF beginning in state fiscal year 2007-08 and continuing through state fiscal year 2010-11. These funds represent a portion of the federal MA matching funds generated by the supplemental MA reimbursement rates paid to UW physicians for services they provide to MA recipients.

HealthCheck Screenings Certified Public Expenditure Program. In state fiscal year 2004-05, the state began claiming federal MA matching funds for HealthCheck screenings provided to children in residential care centers RCCs), the costs of which were paid in the first instance by counties through a combination of community aids, youth aids, and local tax levies. In 2007-08, $7.5 million in federal matching funds associated with these costs were deposited into the MATF.

Table 21: Medical Assistance Trust Fund(Fiscal Years 2005-06 through 2008-09)

	2005-06	Actual 2006-07	2007-08	Estimated 2008-09
Beginning Balance	$1,171,900	-$25,745,300	$2,405,500	$273,600
Revenue				
Nursing Home Bed Assessment	$30,580,000	$27,759,000	$41,747,500	$42,237,600
Nursing Home CPE	0	89,980,700	56,975,400	37,000,000
HealthCheck Screenings CPE	16,602,300	7,640,600	7,500,000	10,000,000
Hospital CPE	0	0	15,357,800	7,804,800
UW Hospital IGT	0	0	15,000,000	15,000,000
Interest on MATF Cash Balance	-977,200	-160,200	1,848,100	1,000,000
Assets Transferred from Other Funds				
Injured Patients and Families Compensation Fund	0	0	71,500,000	128,500,000
Permanent Endowment Fund	0	0	0	309,000,000
Transportation Fund / General Fund*	286,813,200	25,383,900	0	0
Income Augmentation Funds	0	4,800,000	0	0
Total Funds Available	$334,190,200	$129,658,700	$212,334,300	$550,816,000
MA Benefit Expenditures	$359,935,500	$127,253,200	$212,060,700	$550,816,000*
Reserved For Future Benefit Expenditures	0	0	0	0
Closing MATF Balance	-$25,745,300	$2,405,500	$273,600	$0

* Assumes expenditure authority will be increased by $31.8 million in 2008-09.

In addition to the revenues described above, the Wisconsin Legislature has periodically authorized the transfer of assets from other state funds to the MATF. In recent years, assets from the following state funds have been transferred to the MATF and used to support MA expenditures: (a) the Injured Patients and Families Compensation Fund ($71.5 million in 2007-08 and $128.5 million in 2008-09); (b) the Permanent Endowment Fund ($309 million in 2008-09); and (c) the state's General Fund ($286,813,200 in 2005-06) and $25,383,900 in 2006-07).[4] In addition, $4,800,000 of income augmentation funds (federal MA matching funds identified and claimed by the state with the help of a third-party consultant) were used to help fund the MA program in 2006-07. Table 21 shows the MATF's revenues, expenditures, and balances for fiscal years 2005-06, 2006-07, and 2007-08, and current projections for fiscal year 2008-09.

Other Revenues Used To Support MA Expenditures

In addition to GPR, FED, and the assets deposited into the MATF, the state uses, and/or claims for federal matching purposes, several other revenue sources to support its MA program. As described below, some of these other revenues are based on MA expenditures made by local and county governments. Federal law allows Wisconsin to claim those local expenditures as the state's share of MA benefit expenditures, and thereby to obtain federal matching funds. Depending upon the expenditures at issue, the local and county governments retain some, all, or none of the associated federal MA matching funds.

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 2007, counties and tribes contributed approximately $107.9 million under the MA waiver programs, generating approximately $149.0 million in additional federal matching funds.

[4] 2005 Wisconsin Act 25 as initially passed by the Legislature would have transferred $268.1 million from the state transportation fund to the MATF. Governor Doyle vetoed that transfer, and directed $427 million be transferred from the transportation fund to the general fund during the 2005-07 biennium, of which $235.4 million was transferred from the general fund to the MATF in 2005-06. 2005 Wisconsin Act 211 subsequently transferred an additional $51.4 million in 2005-06 and $25.4 million in 2006-07 from the general fund to the MATF.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide the state's match for the school-based health services described in Chapter 3. In 2007-08, the federal matching dollars associated with those school-based services and claimed by the state totaled $42.1 million, of which 60% was distributed to the provider school districts and CESAs, and 40% was credited to the state's general fund.

Case Management Services, Community-Based Psychosocial Services, Community Support Programs. The state's share of the costs for these services, as explained in Chapter 3, are paid either by counties or by local service agencies, which in turn receive all of the associated federal matching dollars claimed by the state. In 2007-08, those federal matching dollars totaled approximately $69.2 million.

Milwaukee County General Assistance Medical Program IGT. In 2007-08, Milwaukee County provided $18,450,600 to DHS 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). DHS claimed federal matching dollars of $35 million on the combination of those IGT funds and $6.9 million GPR, which were used to make supplemental payments to seven hospitals in Milwaukee County.

Tribal Gaming Revenue. DHS is budgeted $825,000 annually from revenue the state receives from tribes from gaming proceeds to fund the state's share of MA payments to tribal FQHCs.

Hospital Assessment. Current law requires DHS to assess hospitals a total of $1.5 million annually, with each hospital's assessment proportional to its share of total gross private pay revenues all hospitals received in the previous fiscal year. All revenue from the current hospital assessment is credited to a program revenue appropriation and used to support MA benefits.

Drug Manufacturer Rebates and BadgerCare Plus Premiums. In addition to the revenue sources outlined above, the state also receives money from other sources that it uses to reduce the net amount of state and federal funding needed to support MA benefits. These other sources include the audit and COB activities described in Chapter 5, as well as amounts received from drug manufacturers and premiums paid by BadgerCare Plus members.

Under federal law, a drug manufacturer must enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services in order for states to receive federal MA matching funds for outpatient drugs dispensed to MA patients. According to CMS, approximately 550 pharmaceutical companies currently participate in the MA drug rebate program. In 2007-08, Wisconsin's MA program received drug manufacturer rebates totaling $102.8 million. That rebate revenue is used to offset, proportionately, the GPR and FED required to fund MA benefits.

As described in Chapter 1, DHS collects premiums from certain BadgerCare Plus members. In 2007-08, those premiums totaled $9.3 million, which were used to offset the GPR and FED required to fund program benefits.

CHAPTER 8

MA BENEFIT EXPENDITURE TRENDS

Table 22 provides information on net benefit expenditures under the state MA program (including the former Family MA, Healthy Start, and BadgerCare programs through January 31, 2008, and the BadgerCare Plus program effective February 1, 2008), SeniorCare, and Family Care, by funding source, for the five-year period 2003-04 through 2007-08. The expenditures reflected in Table 22 are net of various revenues, collections, and recoveries DHS uses to offset benefit costs, including manufacturer drug rebates, estate recovery activities, premiums paid by MA recipients, and amounts recovered from other responsible third parties. As a result, the totals in Table 22 represent the net costs incurred by the state (by funding source) to provide MA benefits to eligible enrollees.

Expenditures by Type of Service

Table 23 provides information on total payments to MA service providers by major service category for 2007-08. As Table 23 indicates, spending for long-term care services, including institutional services provided in nursing homes and the state centers, as well as community-based services provided under various waiver programs, accounted for approximately 43.6% of total payments to MA service providers in 2007-08. Acute care services, including inpatient and outpatient hospital and payments to various non-institutional providers, accounted for the remaining 56.4% of provider payments.

Table 22: MA/BadgerCare Plus, Family Care, and SeniorCare Net Benefit Expenditures (Fiscal Years 2003-04 through 2007-08)

	2003-04	2004-05	2005-06	2006-07	2007-08
MA/BC +					
GPR	$686,052,900	$1,588,565,100	$1,261,825,100	$1,650,195,500	$1,616,972,700
FED	2,604,919,500	2,599,563,500	2,573,309,700	2 ,624,193,000	2,720,950,000
PR	7,342,600	9,343,900	7,295,000	9,336,300	39,714,800
SEG	734,952,700	10,286,800	359,935,500	127,253,200	212,060,700
Subtotal	$4,033,267,700	$4,207,759,300	$4,202,365,300	$4,410,978,000	$4,589,698,200
SeniorCare					
GPR	$38,211,000	$45,383,400	$44,364,400	$45,668,300	$38,797,300
FED	41,548,200	45,062,900	45,700,200	41,875,500	33,476,700
PR	31,178,100	39,351,300	50,639,800	53,198,000	54,780,900
Subtotal	$110,937,300	$129,797,600	$140,704,400	$140,741,800	$127,054,900
Family Care					
GPR	$78,618,700	$72,659,800	$99,657,000	$116,230,100	$139,451,500
FED	120,269,300	98,387,900	133,142,300	150,094,400	184,894,900
PR	0	0	0	0	5,753,600
Subtotal	$198,888,000	$171,047,700	$232,799,300	$266,324,500	$330,100,000
Total Expenditures					
GPR	$802,882,600	$1,706,608,300	$1,405,846,500	$1,812,093,900	$1,795,221,500
FED	2,766,737,000	2,743,014,300	2,752,152,200	2,816,162,900	2,939,321,600
PR	38,520,700	48,695,200	57,934,800	62,534,300	100,249,300
SEG	734,952,700	10,286,800	359,935,500	127,253,200	212,060,700
Total	$4,343,093,000	$4,508,604,600	$4,575,869,000	$4,818,044,300	$5,046,853,100

Table 23: MA Provider Payments, by Type of Service Category (Fiscal Year 2007-08)

	Provider Payments	% of Total
Long-Term Care Services		
Fee-for-Service Institutional Services-Long-Term Care		
Nursing Homes, ICFs, ICFs-MR	$835,656,000	16.4%
State Centers	117,063,700	2.3
Subtotal	$952,719,700	18.7%
Fee-for-Service Community-Based Services		
CIP IA	$95,726,400	1.9%
CIP IB	262,566,900	5.1
COP-waiver	25,693,900	0.5
CIP II	98,976,400	1.9
Brain Injury	18,516,200	0.4
CLTS / Autism	48,986,600	1.0
COR	2,445,500	0.0
Personal Care	184,318,700	3.6
Home Health	64,076,700	1.3
Hospice	26,687,700	0.5
Subtotal	$827,995,000	16.2%
Managed Care Capitation Payments, Long-Term Care		
Family Care Capitation Payments	$307,651,300	6.0%
PACE / Partnership Capitation Payments	137,416,600	2.7
Subtotal	$445,067,900	8.7%
Total Long-Term Care Services	$2,225,782,600	43.6%
Acute Care Services		
Fee-for-Service Institutional Services, Acute Care		
Inpatient Hospital	$409,651,600	8.0%
Outpatient Hospital	85,054,700	1.7
Subtotal	$494,706,300	9.7%
Fee-for-Service Non-Institutional Providers, Acute Care		
Drugs	$466,282,400	9.1%
Physicians and clinics	157,237,000	3.1
County Matched Services	134,038,400	2.6
DME / DMS	39,596,200	0.8
Outpatient Mental Health	43,745,400	0.9
FQHCs	74,634,000	1.5
Laboratory and X-Ray	35,609,200	0.7
School-Based Services	42,060,000	0.8
Other Care	16,292,500	0.3
Dental	29,617,800	0.6
Common Carrier Transportation	27,659,000	0.5
SMV Transportation	17,481,900	0.3
Healthcheck	4,737,000	0.1
Therapies	17,433,000	0.3
Ambulance	13,962,400	0.3
Family Planning	29,058,500	0.6
Rural Health Clinics	5,759,500	0.1
Vision	4,529,500	0.1
Chiropractic	7,711,400	0.2
Prenatal Care Coordination	2,765,300	0.1
Subtotal	$1,170,210,400	22.9%
Medicare Payments, Acute Care		
Medicare Buy-in Premiums	$128,469,100	2.5%
Medicare Crossovers-Part B	47,847,300	0.9
Medicare Crossovers-Part A	51,676,400	1.0
Subtotal	$227,992,800	4.5%
Managed Care Capitation Payments, Acute Care		
SSI	$182,055,800	3.6%
BadgerCare Plus	788,401,400	15.4
Milwaukee Wrap-around	14,462,300	0.3
Subtotal	$984,919,500	19.3%
Total Acute Care Services	$2,877,829,000	56.4%
Total Provider Payments	$5,103,611,600*	100%

* Reflects total payments to providers before adjusting for drug manufacturer rebates, MA recipient premiums, and other cost offsets recovered and / or collected by the state.

Fee-For-Service versus Managed Care

Table 24 shows the breakdown of total provider payments in 2007-08 between fee-for-service providers and managed care capitation payments. As indicated, managed care capitation payments represented approximately 28% of total provider payments in 2007-08. That percentage has increased in recent years (for instance, in 2005-06, managed care capitation payments represented approximately 23% of total provider payments), consistent with the Department's emphasis on the managed care delivery system.

Table 24: Fee-for-Service Provider Payments, Managed Care Capitation Payments, and Medicare Payments (Fiscal Year 2007-08)

	Amount	% of Total
Fee-for-Service		
Institutional Services, Long-Term Care	$952,719,700	19%
Community-Based Service	827,995,000	6
Institutional Services, Acute Care	494,706,300	1
Non-institutional Providers, Acute Care	1,170,210,400	23
Subtotal	$3,445,631,400	68%
Managed Care Capital Payments		
Long-Term Care	$445,067,900	9%
Acute Care	984,919,500	19
Subtotal	$1,429,987,400	28%
Medicare Payments	$227,992,800	4%
Total MA Provider Payments	$5,103,611,600	100%

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2008 Federal Poverty Guidelines

Annual

No. in Family	100%	133%	150%	185%	200%	240%	300%
One	$10,400	$13,832	$15,600	$19,240	$20,800	$24,960	$31,200
Two	14,000	18,620	21,000	25,900	28,000	33,600	42,000
Three	17,600	23,408	26,400	32,560	35,200	42,240	52,800
Four	21,200	28,196	31,800	39,220	42,400	50,880	63,600
Five	24,800	32,984	37,200	45,880	49,600	59,520	74,400
Six	28,400	37,772	42,600	52,540	56,800	68,160	85,200
Seven	32,000	42,560	48,000	59,200	64,000	76,800	96,000
Eight	35,600	47,348	53,400	65,860	71,200	85,440	106,800
Each Additional	$3,600	$4,788	$5,400	$6,660	$7,200	$8,640	$10,800

Monthly

No. in Family	100%	133%	150%	185%	200%	240%	300%
One	$867	$1,153	$1,300	$1,603	$1,733	$2,080	$2,600
Two	1,167	1,552	1,750	2,158	2,333	2,800	3,500
Three	1,467	1,951	2,200	2,713	2,933	3,520	4,400
Four	1,767	2,350	2,650	3,268	3,533	4,240	5,300
Five	2,067	2,749	3,100	3,823	4,133	4,960	6,200
Six	2,367	3,148	3,550	4,378	4,733	5,680	7,100
Seven	2,667	3,547	4,000	4,933	5,333	6,400	8,000
Eight	2,967	3,946	4,450	5,488	5,933	7,120	8,900
Each Additional	$300	$399	$450	$555	$600	$720	$900

APPENDIX 2

Standard and Benchmark Plans

Services	BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Drugs	Comprehensive drug benefit with coverage of generic prescription drugs, brand prescription drugs and some over-the-counter (OTC) drugs. Co-payments: $0.50 for OTC Drugs $1.00 for generic drugs $3.00 for prescription drugs Co-payments are limited to $12.00 per member, per provider, per month. OTCs are excluded from this $12.00 maximum.	Generic drug-only formulary with a few generic OTC drugs. Member will be automatically enrolled in the Badger Rx Gold plan, administered by Navitus, which provides for a discount on the cost of drugs. Copayment of $5 with no limits.
Physician Visits	Full coverage, including laboratory and radiology. Copayments of $0.50 to $3.00 per service, limited to $30 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. Copayment of $15 per visit. No copayment for emergency services, anesthesia, or clozapine management.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems. No copayment.	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems. No copayment.
Inpatient Hospital	Full coverage. Copayment of $3 per day, capped at $75 per stay.	Full coverage with the following dollar amount limits per enrollment year: $6,300 for stays in a general acute care hospital for substance abuse, and $7,000 for stays in an IMD for substance abuse treatment. Hospital stays for mental health and substance abuse services have a 30-day limit. Copayment of $100 per stay for medical stays and $50 per stay for mental health and/or substance abuse treatment.
Outpatient Hospital	Full coverage. Copayment of $3 per visit.	Full coverage. Copayment of $15 per visit.
Emergency Room (ER)	Full coverage. No copayment	Full coverage. Copayment of $60 copayment (waived if member is admitted to hospital).
Nursing Home	Full coverage. No copayment.	Full coverage for stays at skilled nursing homes, limited to 30 days per enrollment year. No copayment.

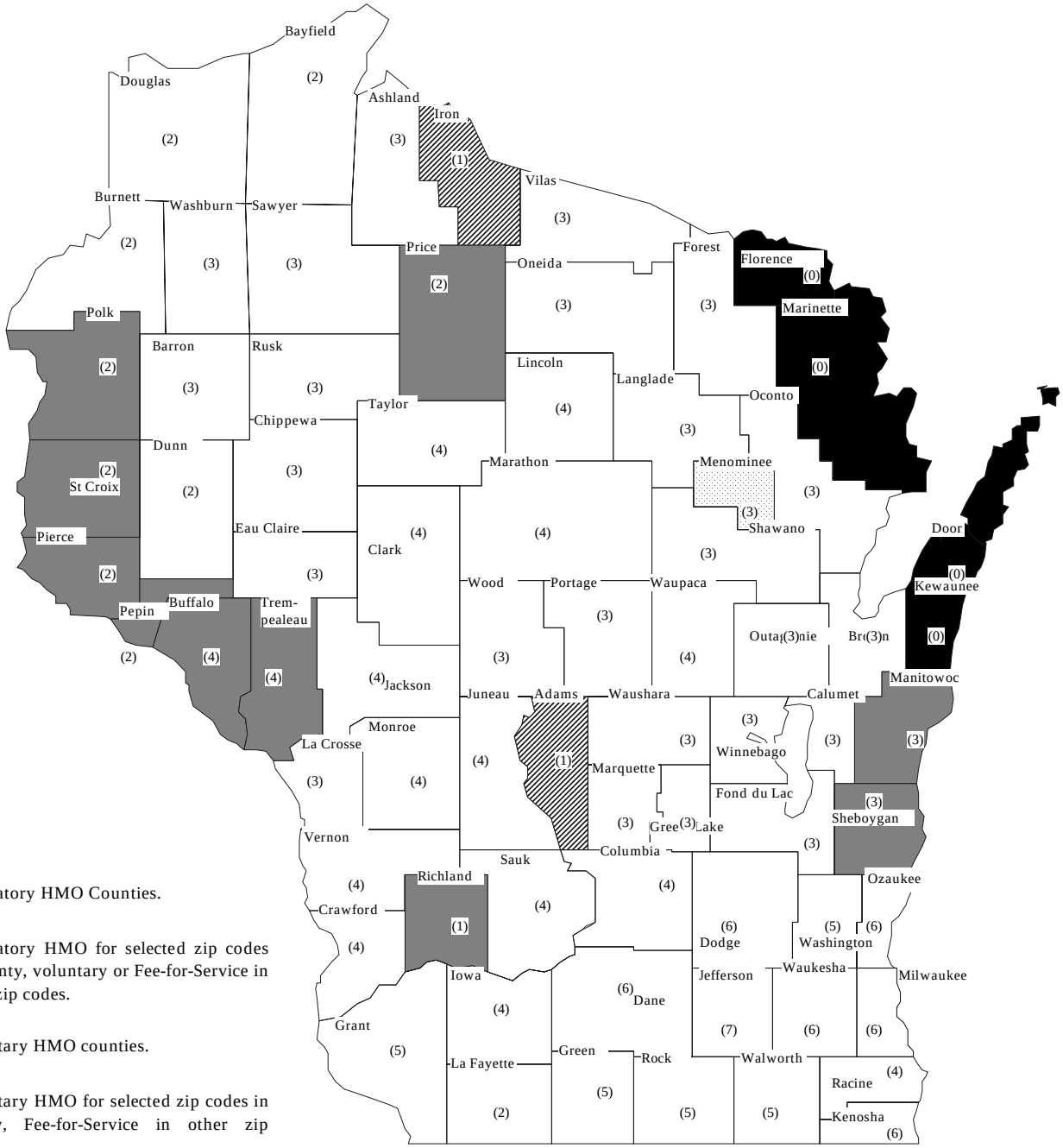
Services	BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage. Copayment of $0.50 to $3.00 per service. Copayment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).	Full coverage, limited to 20 visits per therapy discipline per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation (which do not count towards the 20 PT visit limit). Copayment of $15 per visit.
Durable Medical Equipment (DME)	Full coverage. Copayment of $0.50 to $3.00 per item. Rental items not subject to a copayment.	Full coverage up to $2,500 per enrollment year. Copayment of $5 per item. Rental items are not subject to a copayment but do count towards $2,500 annual limit.
Disposable Medical Supplies (DMS)	Full coverage. Copayment of $0.50 per item.	Coverage of syringes, diabetic pens and DMS that is required with use of a DME item. No copayment.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). Copayment of $0.50 to $3.00 per service, limited to the first 15 hours or $500 of services, provided per calendar year. Copayment not required when services provided in hospital setting.	Coverage of this service is based upon coverage in the Wisconsin State Employees' Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, child/adolescent mental health day treatment, and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program (CSP), comprehensive community services (CCS), outpatient services in the home and community for adults, and substance abuse residential treatment. Mental health services have no dollar maximum. Substance abuse services are limited to a $7,000. Costs of mental health services, including inpatient stays, apply to that overall limit. Also, separate dollar limits apply to the following specific substance abuse services: (a) $4,500 for outpatient substance abuse services including $2,700 for outpatient services (including narcotic treatment) for substance abuse day treatment; and (b) $6,300 for inpatient hospital stays in a general acute care hospital. Copayments of $10 to $15 per visit for all outpatient services, as follows: $10 per day for all day treatment services; $15 per visit for narcotic treatment services (no copayment for lab tests); $15 per visit for outpatient mental health diagnostic interview exam, psychotherapy, individual or group (no copayment for electroconvulsive therapy and pharmacological management). $15 per outpatient substance abuse services.

Services	BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Home Health	Full coverage of private duty nursing, home health care, and personal care. No copayment.	Full coverage of home health services, limited to 60 visits per enrollment year. Private duty and personal care are not covered. Copayment of $15 per visit.
Transportation	Full coverage of emergency and non-emergency transportation to and from a certified provider for a Medicaid covered service. Copayments as follows: $2 per trip for non-emergency ambulance services; $1 per trip for transportation by SMV; and no copayment for transportation by common carrier or for emergency ambulance.	Coverage limited to emergency transportation by ambulance. Copayment of $50 per trip.
Health Screenings for Children	Full coverage of HealthCheck screenings and other service for individuals under age 21. Copayment of $1 per screening for 18, 19 and 20 year olds only.	Full coverage of HealthCheck screenings (but not HealthCheck "other" services or interpedic services for individuals under age 21. No copayments.
Dental	Full coverage. Copayment of $0.50 to $3.00 per service.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions for both pregnant women and children. Coverage limited to $750 per enrollment year. Copayment of $200 for all services except preventive and diagnostic. Cost sharing equal to 50% of allowable fee on all services.
Hearing Services	Full coverage. $50 to $3 per procedure. No co-payment for hearing aid batteries.	Limited coverage of services provided by an audiologist. Hearing aids, hearing aid batteries, cochlear implants and bone anchored hearing devices are not covered. $15 per procedure, regardless of the number of procedures performed during one visit.
Routine Vision	Full coverage including coverage of eyeglasses. Copayment of $0.50 to $3.00 per service.	One eye exam every two years, with refraction. Copayment of $15 per visit.
Smoking Cessation Services	Coverage includes prescription and over-the-counter tobacco cessation products. Copayments as provided under drug benefit.	Coverage includes prescription and over-the-counter tobacco cessation products. Copayments as provided under drug benefit.
Hospice	Full coverage. No copayment.	Full coverage, limited to 360 days per lifetime. Copayment of $2 per day.
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization. No copayment.	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization. No copayment.
Chiropractic Services	Full coverage. Copayment of $0.50 to $3.00 per service.	Full coverage. Copayment of $15 per visit.

Services	BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Podiatry Services	Full coverage. Copayment of $0.50 to $3.00 per service, limited to $30 per provider per calendar year.	Full coverage. Copayment of $15 per visit.

APPENDIX 3

BadgerCare Plus HMO Participation
Contract Period February, 2008, - December, 2009



Mandatory HMO Counties.

Mandatory HMO for selected zip codes in county, voluntary or Fee-for-Service in other zip codes.

Voluntary HMO counties.

Voluntary HMO for selected zip codes in county, Fee-for-Service in other zip codes.

Fee-for-Service counties (HMOs do not participate).

Mandatory Counties	*57*
Mandatory - Partial Counties	*8*
Voluntary Counties	*1*
Voluntary - Fee-for-Service Counties	*2*
Fee-for-Service Counties	*4*

APPENDIX 4

SSI Managed Care by County for FY 2007-08

County	MA Only	Dual Eligibles	Total Enrollment	Total MCO Payments
Brown	1,050	24	1,074	$4,665,726
Buffalo	17	2	19	145,421
Calumet	71	0	71	276,316
Clark	145	0	145	91,630
Dodge	11	1	12	136,858
Fond du Lac	243	12	255	1,783,142
Green Lake	64	0	64	79,667
Jackson	62	7	69	430,970
Jefferson	81	2	83	517,872
Kenosha	737	136	873	7,052,933
LaCrosse	319	23	342	2,197,368
Langlade	146	2	148	146,064
Manitowoc	216	9	225	1,521,676
Marathon	261	3	264	217,716
Marquette	62	0	62	87,334
Milwaukee	12,071	3,903	15,974	134,592,608
Monroe	132	11	143	875,467
Oconto	124	1	125	159,270
Outagamie	513	13	526	1,966,123
Ozaukee	68	4	72	728,774
Racine	785	67	852	9,057,908
Rock	392	26	418	3,035,488
Shawano	173	2	175	175,445
Sheboygan	356	6	362	2,691,572
Taylor	63	0	63	55,060
Trempealeau	48	6	54	312,786
Vernon	58	2	60	363,131
Washington	148	6	154	1,574,588
Waukesha	468	86	554	4,326,505
Waupaca	157	2	159	581,400
Waushara	119	0	119	143,746
Winnebago	542	17	559	3,986,295
Wood	50	0	50	26,464
Total	19,752	4,373	24,125	$184,003,324

APPENDIX 5

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

County	2003-04	2004-05	2005-06	2006-07	2007-08
Barron	$0	$35,639	$225,257	260,279	348,911
Brown	1,159,618	1,584,938	962,382	804,579	494,862
Calumet	338,918	496,508	456,671	447,481	216,588
Clark	1,602,784	1,787,467	1,120,334	1,125,853	1,272,522
Columbia	944,514	760,766	566,934	603,726	741,026
Dane	915,877	1,108,725	700,298	697,231	855,541
Dodge	2,267,534	2,734,072	1,563,848	1,488,884	1,709,935
Dunn	1,418,132	1,276,169	895,958	882,931	918,271
Eau Claire				17,049	1,015
Fond du Lac	1,458,460	1,723,733	1,139,941	1,018,463	898,647
Grant	533,468	1,281,742	827,053	790,945	917,578
Green	974,966	984,850	699,604	717,589	795,798
Iowa	590,888	370,286	290,820	340,945	411,509
Jackson	997,124	884,744	543,457	455,537	
Jefferson	1,015,589	1,282,639	723,478	741,174	796,109
Kenosha	1,137,460	1,159,677	651,378	725,604	811,833
Kewaunee	84,873	67,173	261,032	295,982	333,245
La Crosse	2,768,550	3,006,042	2,117,188	1,751,103	1,828,967
Lafayette	687,182	619,180	416,067	395,067	473,761
Lincoln	1,191,191	877,628	1,032,199	1,083,243	1,283,228
Manitowoc	1,107,916	1,422,574	890,083	871,045	624,838
Marathon	2,363,553	2,675,897	1,824,701	1,950,520	2,212,014
Milwaukee	1,218,707	1,219,772	1,144,149	1,140,820	1,136,977
Monroe	878,946	821,846	538,753	547,835	648,926
Outagamie	1,506,765	1,980,000	1,259,592	1,193,131	1,320,029
Ozaukee	1,506,765	1,548,583	998,739	1,111,116	1,305,978
Pierce	89,529	162,035	154,381	106,938	164,577
Polk	842,016	854,788	549,689	560,325	696,721
Portage	844,949	836,565	492,949	346,628	400,742
Racine	1,551,082	1,885,074	1,210,116	1,238,156	1,331,906
Richland	667,515	713,451	488,345	334,617	386,994
Rock	1,429,499	1,941,618	1,145,300	1,170,524	1,093,437
Rusk	686,908	772,113	537,860	451,291	400,635
Sauk	982,352	1,033,120	677,396	618,526	619,700
Shawano	556,289	365,965	618,474	617,319	560,244
Sheboygan	3,896,457	4,066,825	2,461,374	2,478,267	973,903
St. Croix	706,752	746,024	552,553	511,910	562,763
Trempealeau	855,227	1,023,548	865,164	918,976	962,257
Vernon	613,127	620,841	600,448	725,904	728,982
Walworth	1,835,734	2,202,321	1,102,493	839,634	901,400
Washington	1,684,032	1,665,383	1,077,785	1,098,709	1,180,160
Waupaca	607,836	763,275	446,113	428,018	344,421
Winnebago	1,765,279	2,159,490	1,411,333	1,435,220	1,456,339
Wood	1,144,846	1,250,062	858,311	921,773	984,634
Subtotal	$49,429,209	$54,773,148	$37,100,000	$36,260,867	$36,107,923
Family Care Awards	670,791	0	0	839,133	992,077
Total payments	$50,100,000	$54,773,148	$37,100,000	$37,100,000	$37,100,000

APPENDIX 6

Classes of Drugs Comprising Wisconsin's Preferred Drug List as of December, 2008

Acne Agents
Alzheimer's Agents
Analgesics, Narcotics
Androgenic Agents
Angiotensin Modulators

Angiotensin Modulators/CCB Combinations
Angiotensin / Anesthetics, Topical
Antibiotics, GI
Antibiotics, Vaginal
Anticoagulants, Injectables

Anticonvulsants
Antidepressants, Other
Antidepressants, SSRI
Antiemetics, Oral
Antifungals, Oral

Antifungals, Topical
Antihistamines, Nonsedating
Antimigraine, Triptans
Antiparasitics, Topical
Antiparkinson's Agents

Antipsychotics, Atypical
Antivirals, Influenza
Antivirals, Other
Antivirals, Topical
Agents for BPH

Beta Blockers
Bladder Relaxant Preparations
Bone Resorption Suppression
Bronchodilators, Anticholinergic
Bronchodilators, Beta Agonists

Calcium Channel Blocking Agents
Cephalosporin and Related Agents
Cytokine and CAM Antagonists
Erythropoiesis Stimulating Proteins
Fluoroquinolones

Glucocorticoids, Inhaled

Growth Hormone
Hepatitis B Agents
Hepatitis C Agents
Hypoglycemics, Adjunct Therapy

Hypoglycemics, Insulins
Hypoglycemics, Meglitinides
Hypoglycemics, Thiazolidinediones
Intranasal Rhinitis Agents
Leukotriene Modifiers

Lipotropics, Bile Acid Sequestrants
Lipotropics, Fibric Acid
Lipotropics, Other
Lipotropics, Statins
Macrolides/Ketolides

Multiple Sclerosis Agents
NSAIDs
Ophthalmics, Allergic Conjunctivitis
Ophthalmics, Antibacterial
Ophthalmics, Glaucoma Agents

Ophhthalmics, NSAIDS
Otics, Fluoroquinolones
Pancreatic Enzymes
Phosphate Binders
Platelet Aggregation Inhibitors

Proton Pump Inhibitors
Sedative Hypnotics
Skelatal Muscle Relaxants
Steroids, Topical Low
Steroids, Topical Medium

Steroids, Topical High
Steroids, Topical Very High
Stimulants and Related Agents
Topical, Anti-Infectives
Topical Immunomodulators

Ulcerative Colitis

APPENDIX 7

Medical Assistance Waiver Services*

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

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Adaptive aids include devices, controls or appliances which enable individuals to increase their ability to perform activities of daily living independently.	Yes	Yes	Yes	Yes
Adult day care provides social or health-supportive services for part of a day in a group setting.	Yes	Yes	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 no more than four residents by a person whose lives in the home.	Yes	Yes	Yes	Yes
Care management includes the planning and coordination of an individual's program plan, along with advocacy and defense services, outreach, and referral.	Yes	Yes	Yes	Yes
Children's foster care includes supplementary intensive supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs (including personal care provision beyond those age activities expected for a child, skilled tasks, monitoring of complex medical needs, and comprehensive behavioral intervention plans).	Yes	Yes	Yes	No
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	Yes	No	No
Consumer and family directed supports are designed to assist children and their families to build, strengthen, and maintain informal networks of community supports. Specific supports may include adaptive and communication aids, consumer education, counseling, daily living skills training, day services, foster care, home modification, respite care, supportive home care, and supported employment.	No	No	Yes	No
Consumer training and education help a person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.	Yes	Yes	Yes	No
Counseling and therapeutic services provide treatment oriented services for a personal, social, behavioral, mental or alcohol or drug abuse disorder.	Yes	Yes	Yes	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

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Day services include activities to enhance social development.	Yes	Yes	Yes	Yes
Financial management services include the services of a fiscal intermediary for those receiving consumer-directed services to ensure that appropriate compensation is paid to providers of services, and provision of assistance managing personal funds for those unable to manage their money themselves.	Yes	Yes	Yes	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
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.	Yes	Yes	No	Yes
Housing counseling provides assistance in acquiring housing in the community, where ownership or rental of housing is separate from service provision.	Yes	Yes	Yes	Yes
Housing start up provides assistance in establishing housing arrangements in the community after relocation from an institution, including security deposits, furnishings, and household equipment.	Yes	Yes	Yes	No
Intensive in-home autism services are one-on-one behavioral modification therapy services for children **with** autism disorder, Asperger's disorder, or pervasive developmental disorder.	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.	Yes	Yes	Yes	Yes
Personal emergency response systems (PERS) are community-based electronic communications devices activated by the consumer in the event of a physical, emotional or environmental emergency.	Yes	Yes	Yes	Yes
Pre-vocational services include teaching and activities related to concepts to prepare an individual for paid or unpaid employment such as work directions and routines, mobility training, interpersonal skills development and transportation to and from work.	Yes	Yes	No	No
Relocation related utilities and housing start-up provide assistance for certain relocation costs for individuals that move from an institution to an alternative community living arrangement, including establishment of utility services, or person-specific services, supports or goods used in preparation of the relocation.	No	No	No	Yes

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
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
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.	Yes	Yes	Yes	Yes
Specialized transportation are services to improve access to needed community services and the ability to perform tasks independently.	Yes	Yes	Yes	Yes
Vocational futures planning provide consumer directed, team based comprehensive employment services to help individuals obtain, maintain or advance in employment.	No	No	No	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 people with developmental disabilities (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 8

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2008

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Adams	$278,678	$175,698	$98,349	$81,783	$67,703	$107,832
Ashland	347,137	337,468	285,597	0	94,726	273,823
Barron	462,486	310,856	245,166	81,783	601,404	496,304
Bayfield	277,400	195,778	220,648	81,783	168,416	124,946
Brown	2,529,142	1,887,441	1,343,727	109,044	5,866,940	1,346,070
Buffalo	239,093	153,225	79,092	27,261	144,263	246,107
Burnett	244,298	159,089	50,736	27,261	71,761	277,609
Calumet	267,468	164,557	123,005	54,522	157,973	123,205
Chippewa	658,367	362,145	354,676	81,783	580,157	944,750
Clark	482,730	336,932	196,176	0	589,723	380,444
Columbia	705,610	503,265	330,834	109,044	365,638	286,090
Crawford	265,287	153,872	260,622	0	188,064	164,627
Dane	5,140,635	3,013,000	2,639,190	463,439	2,640,446	2,122,431
Dodge	621,875	366,202	277,864	218,089	742,211	346,367
Door	228,463	120,233	156,627	54,522	155,823	114,951
Douglas	864,519	457,022	1,037,969	54,522	582,794	418,307
Dunn	396,048	274,437	182,065	0	591,721	444,356
Eau Claire	948,351	637,856	120,742	27,261	672,252	1,642,938
Florence	85,954	49,195	13207	0	86,522	18,931
Fond du Lac	564,513	0	0	0	0	0
Forest-Oneida-Vilas	0	0	0	136,305	1,161,718	533,561
Forest	187,158	90,850	92,680	0	0	0
Grant-Iowa	225,589	120,294	56,850	81,783	365,956	392,711
Grant	616,661	327,871	589,135	0	0	0
Green	395,084	195,426	563,589	81,783	179,204	232,628
Green Lake	145,926	104,762	69,714	0	75,225	266,856
Iron	131,960	88,768	44,996	0	97,166	0
Jackson	270,647	198,471	421,799	0	255,913	219,603
Jefferson	595,577	344,248	872,609	272,611	2,441,701	333,040
Juneau	287,882	210,631	199,582	81,783	324,781	289,119
Kenosha	557,810	0	0	0	0	0
Kewaunee	231,660	227,733	118,106	27,261	139,248	215,211
La Crosse	478,315	0	0	0	0	0
Lafayette	217,792	151,413	63,458	0	45,135	46,798
Langlade	322,268	135,408	119,761	0	0	0
Lincoln's 51.437 Board	247,683	201,927	0	109,044	299,281	415,429
Lincoln-Langlade- Marathon	0	0	120,403	109,044	1,150,163	980,947
Lincoln	0	0	190,115	0	0	0
Manitowoc	803,362	558,597	1,314,095	136,305	1,626,330	452,232
Marathon	1,144,784	1,139,769	354,658	0	0	0

APPENDIX 8 (continued)

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2008

County	COP	COP-W	CIP II	BIW	CIP IB	CIP IA
Marinette	$484,285	$340,181	$357,179	$109,044	$345,952	$209,153
Marquette	157,544	161,802	161,305	0	136,947	97,837
Menominee	156,328	100,104	88,146	0	30,090	0
Milwaukee	8,527,073	3,066,288	2,649,726	845,095	7,872,468	5,565,665
Monroe	430,595	231,934	456,733	81,783	337,645	492,137
Oconto	337,492	180,025	86,589	109,044	191,451	272,459
Oneida	397,107	154,640	475,950	0	0	0
Outagamie	1,300,259	980,940	474,325	109,044	1,476,883	1,093,323
Ozaukee	483,913	368,593	425,479	54,522	315,592	468,891
Pepin	146,266	64,513	157,031	0	141,941	84,660
Pierce	390,181	171,638	127,085	54,522	563,895	326,527
Polk	452,745	302,216	139,979	54,522	118,911	494,183
Portage	210,952	0	0	0	45,135	37,862
Price	271,976	229,552	239,140	0	234,861	229,447
Racine	748,647	0	0	0	0	0
Richland	123,310	0	0	0	0	0
Rock's 51.437 Board	846,835	0	0	136,305	1,760,173	723,480
Rock	1,159,159	1,169,290	2,117,348	0	0	0
Rusk	201,816	222,714	164,037	81,783	115,517	209,607
St. Croix	426,064	297,906	580,522	218,089	332,011	530,986
Sauk	458,501	367,709	712,708	181,740	588,492	209,305
Sawyer	238,601	148,249	137,913	54,522	89,386	235,960
Shawano	391,547	498,567	380,106	27,261	234,198	426,408
Sheboygan	1,237,477	685,880	1,290,529	136,305	1,861,068	543,859
Taylor	216,717	164,802	94,048	54,522	219,842	329,859
Trempealeau	543,480	410,797	224,537	0	291,245	372,417
Vernon	210,429	233,987	83,690	27,261	294,891	215,968
Vilas	263,319	231,440	383,907	0	0	0
Walworth	685,394	563,369	703,748	109,044	276,951	380,898
Washburn	260,389	248,602	397,432	0	210,716	75,725
Washington	664,063	433,432	627,066	190,828	453,639	566,123
Waukesha	3,570,467	1,918,697	1,043,059	354,394	1,095,572	1,281,273
Waupaca	606,889	359,328	457,098	81,783	860,813	196,734
Waushara	233,782	328,017	417,177	0	72,267	80,874
Winnebago	1,702,672	1,090,279	1,323,966	163,566	1,011,526	1,114,829
Wood	777,848	541,282	821,556	81,783	1,021,861	686,829
Total	$51,782,334	$30,021,212	$31,006,956	$5,824,778	$45,132,297	$31,811,501

APPENDIX 9

Family Care Participation by County
December, 2008

County	ADRC	MCO
Barron	x	
Brown	x	
Calumet*	x	
Chippewa	x	x
Columbia	x	x
Dodge	x	x
Dunn	x	x
Eau Claire	x	x
Fond du Lac	x	x
Forest	x	
Green*	x	
Green Lake*	x	x
Jackson*	x	x
Jefferson	x	x
Juneau*	x	
Kenosha	x	x
La Crosse*	x	x
Manitowoc	x	
Marathon*	x	x
Marquette*	x	x
Milwaukee	x	x
Monroe*	x	
Outagamie*	x	
Ozaukee	x	x
Pierce	x	x
Portage	x	x
Racine	x	x
Richland*	x	x
Sauk*	x	x
Sheboygan	x	x
St. Croix	x	x
Trempealeau	x	
Vernon*	x	x
Washington	x	x
Waukesha	x	x
Waupaca*	x	
Waushara*	x	x
Wood*	x	

*Counties operate ADRC jointly with other counties.

APPENDIX 10

Income Maintenance Administrative Allocations and Supplemental Allocations*
Calendar Years 2006 and 2007

County	2006	2007
Adams	$251,181	$260,395
Ashland	326,711	335,051
Barron	569,488	593,711
Bayfield	183,866	189,995
Brown	1,506,650	1,582,211
Buffalo	163,606	168,568
Burnett	211,725	217,960
Calumet	206,005	210,523
Chippewa	570,667	580,936
Clark	314,109	325,379
Columbia	371,055	380,709
Crawford	212,014	213,515
Dane	2,448,780	2,556,169
Dodge	572,736	585,253
Door	218,476	227,012
Douglas	574,493	588,058
Dunn	363,660	381,961
Eau Claire	851,521	893,159
Florence	164,537	163,458
Fond du Lac	875,701	906,498
Forest	166,967	170,569
Grant	426,113	441,885
Green	279,375	298,545
Green Lake	174,088	179,694
Iowa	181,604	180,930
Iron	162,857	164,433
Jackson	237,020	247,221
Jefferson	519,529	536,278
Juneau	266,202	270,944
Kenosha	1,564,519	1,564,053
Kewaunee	168,386	167,913
La Crosse	1,160,552	1,183,394
Lafayette	163,313	166,641
Langlade	288,057	296,658
Lincoln	279,182	293,731
Manitowoc	622,660	635,078
Marathon	952,383	986,018
Marinette	455,485	468,811
Marquette	165,148	168,386
Milwaukee	16,553,268	17,073,248
Monroe	411,357	423,913
Oconto	289,124	296,497
Oneida	404,667	418,765
Outagamie	749,532	779,089
Ozaukee	276,756	286,721
Pepin	$167,673	$164,808
Pierce	210,290	225,839
Polk	395,791	409,550
Portage	626,859	648,013
Price	270,156	275,141
Racine	1,729,022	1,847,472
Richland	244,242	253,960
Rock	1,563,883	1,631,677
Rusk	242,062	245,730
St. Croix	355,174	379,312
Sauk	462,256	466,192
Sawyer	276,454	281,935
Shawano	370,771	370,255
Sheboygan	741,572	765,131
Taylor	247,692	250,430
Trempealeau	319,210	330,061
Vernon	281,928	291,010
Vilas	176,825	180,742
Walworth	600,571	626,874
Washburn	225,647	236,261
Washington	554,979	574,069
Waukesha	1,258,817	1,289,044
Waupaca	550,853	567,296
Waushara	237,253	246,301
Winnebago	1,056,615	1,092,346
Wood	738,074	754,131
Menominee	161,992	165,029
County Totals	$51,951,797	$53,628,545
Tribes		
Bad River	$161,500	$162,651
Lac du Flambeau	162,971	164,598
Oneida Tribe	162,389	167,210
Potawatomi Tribe	98,203	98,473
Red Cliff	161,697	162,642
Sokaogon	98,205	98,841
Stockbridge Munsee	98,151	98,531
Tribal Totals	$943,116	$952,946
Statewide Totals	$52,894,913	$54,581,491

*These allocations do not include additional funds DHS provides to counties for other IM functions.

APPENDIX 11

Local Overmatch Expenditures for Income Maintenance Activities
Calendar Years 2006 and 2007

County	2006	2007
Adams	$10,008	$2,171
Ashland	9,933	15,999
Barron	179,755	204,216
Bayfield	67,144	43,646
Brown	722,054	777,108
Buffalo	39,597	52,938
Burnett	91,585	92,455
Calumet	66,843	73,864
Chippewa	183,502	275,134
Clark	0	0
Columbia	169,455	168,063
Crawford	104,810	101,012
Dane	1,831,117	1,802,375
Dodge	254,789	329,682
Door	116,956	187,523
Douglas	284,795	238,445
Dunn	232,005	235,713
Eau Claire	366,327	472,311
Florence	0	0
Fond du Lac	664,057	778,150
Forest	21,972	0
Grant	46,779	72,892
Green	54,951	52,892
Green Lake	39,940	40,775
Iowa	129,389	102,260
Iron	44,328	58,995
Jackson	126,153	138,806
Jefferson	228,653	293,167
Juneau	71,824	96,754
Kenosha	3,283,395	3,723,122
Kewaunee	3,679	8,111
La Crosse	98,721	68,829
Lafayette	45,988	39,660
Langlade	64,491	94,961
Lincoln	90,645	92,604
Manitowoc	192,538	292,802
Marathon	451,012	447,041
Marinette	333,045	369,595
Marquette	13,926	30,078
Milwaukee	2,487,444	3,559,823
Monroe	158,962	159,208
Oconto	145,998	150,418
Oneida	18,736	63,689
Outagamie	751,251	828,501
Ozaukee	$212,487	$230,821
Pepin	42,702	47,535
Pierce	51,326	99,583
Polk	245,300	240,683
Portage	288,793	293,875
Price	94,598	69,184
Racine	898,825	926,394
Richland	30,159	22,180
Rock	586,674	638,680
Rusk	46,471	42,965
St Croix	218,575	201,462
Sauk	58,034	40,858
Sawyer	43,136	47,075
Shawano	82,868	138,360
Sheboygan	231,770	301,583
Taylor	57,674	67,532
Trempealeau	86,907	81,849
Vernon	87,427	134,478
Vilas	53,780	83,419
Walworth	304,902	369,809
Washburn	76,629	58,971
Washington	284,203	330,466
Waukesha	688,125	939,044
Waupaca	220,323	239,835
Waushara	129,729	153,364
Winnebago	616,625	770,311
Wood	345,797	351,814
Menominee	0	3,798
County Totals	$20,382,391	$23,562,716
Tribes		
Bad River	$0	$0
Lac du Flambeau	0	0
Oneida Tribe	4,131	37,903
Potawatomi Tribe	0	2,324
Red Cliff	13,227	0
Sokaogon	0	0
Stockbridge Munsee	0	2,188
Tribal Totals	$17,358	$42,415
Statewide Totals	$20,399,749	$23,605,131