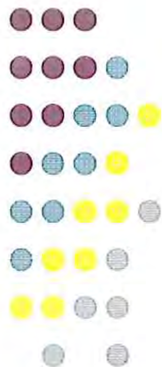

Informational Paper 44

Medical Assistance, BadgerCare Plus, SeniorCare, and Related Programs

Wisconsin Legislative Fiscal Bureau
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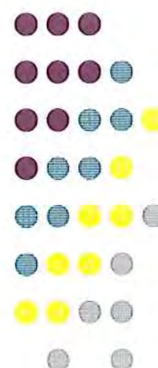

Medical Assistance, BadgerCare Plus, SeniorCare, and Related Programs

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Medical Assistance, BadgerCare Plus, SeniorCare, and Related Programs

Introduction

Title XIX of the federal Social Security Act authorizes the U.S. Department of Health and Human Services (DHHS) to provide financial assistance to states to fund 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. All such amendments are 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 funds to help pay for these covered services. 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. In recent years, Wisconsin's FMAP has been approximately 60%. The American Recovery and Reinvestment Act of 2009 (ARRA) and related federal legislation, however, increased Wisconsin's FMAP for the period October 1, 2008, through June 30, 2011. In state fiscal year 2009-10, for example, Wisconsin's FMAP was approximately 70%. On July 1, 2011, the state's FMAP is currently scheduled to revert to a more "normal" rate of approximately 60%.

The state also receives federal assistance for the administrative costs associated with the MA program. Generally speaking, federal matching funds cover 50% of those administrative costs.

During the past decade, Wisconsin's MA program has grown increasingly complex. This is due, in part, to agreements between the state and DHHS that waived aspects of federal MA law, thereby enabling the state to expand coverage. Examples of current waiver programs are 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), SeniorCare, and Family Care.

2007 Wisconsin Act 20 ushered in further changes to the state's MA program by authorizing DHS to implement BadgerCare Plus, which consolidated and replaced the programs formerly known as Family MA, Healthy Start, and BadgerCare. Act 20 also directed DHS to seek a waiver for the BadgerCare Plus Core Plan, a new program designed to provide health care benefits to adults who do not have dependent children and whose incomes do not exceed 200% of the federal

poverty level (FPL).

With implementation of BadgerCare Plus, Wisconsin's medical assistance program can be viewed as two broad but distinct programs. The first, now referred to simply as "MA" or "EBD 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 (including the BadgerCare Plus Core Plan), provides coverage to low-income children, their families, pregnant women, and low-income childless adults.

Table 1 shows benefit expenditures for Wisconsin's MA and BadgerCare Plus programs for state fiscal years 2005-06 through 2009-10, by funding source. The figures in the table reflect total MA benefit expenditures net of several offsetting revenue sources, such as rebates Wisconsin receives from drug manufacturers that supply prescription drugs to program enrollees.

Benefit expenditures for the SeniorCare prescription drug program are shown separately. Unlike the expenditures for the MA and BadgerCare Plus programs, the SeniorCare expenditures in Table 1 include the rebate revenues received from drug manufacturers (shown in the table as PR, or program revenue).

The revenue sources used to fund the benefit expenditures shown in Table 1 include state general purpose revenue (GPR), segregated revenue (SEG) from the MA trust fund and the hospital assessment fund (the latter beginning in state fiscal year 2008-09), program revenue from various sources (PR), and federal MA matching funds (FED). Additional information about these funding sources, as well as the program's expenditure and enrollment trends, is provided in Chapters 8 and 9.

Table 1: Benefit Expenditures for MA/BadgerCare Plus and SeniorCare, by Fund Source, State Fiscal Years 2005-06 through 2009-10

	2005-06	2006-07	2007-08	2008-09	2009-10	% of Total Benefits, 2005-06 Thru 2009-10
MA/BC+						
GPR	$1,361,482,100	$1,766,425,600	$1,756,424,200	$1,102,495,700	$1,285,958,100	27%
FED	2,706,452,000	2,774,287,400	2,905,844,900	3,878,779,300	4,675,132,000	64
PR	7,295,000	9,336,300	45,468,400	64,459,100	66,941,000	1
SEG	359,935,500	127,253,200	212,060,700	875,533,100	635,098,700	8
Total	$4,435,164,600	$4,677,302,500	$4,919,798,200	$5,921,267,200	$6,663,129,800	100%
SeniorCare						
GPR	$44,364,400	$45,668,300	$38,797,300	$33,983,200	$18,273,100	28%
FED	45,700,200	41,875,500	33,476,700	50,696,300	16,741,000	29
PR	50,639,800	53,198,000	54,780,900	40,033,800	79,682,300	43
Total	$140,704,400	$140,741,800	$127,054,900	$124,713,300	$114,696,400	100%

CHAPTER 1

BADGERCARE PLUS AND RELATED PROGRAMS

Beginning February 1, 2008, BadgerCare Plus replaced the programs previously known as Family Medicaid, Healthy Start, and BadgerCare. This chapter discusses the eligibility criteria and the delivery of health care services under BadgerCare Plus, as well as several related programs such as the family planning waiver, Well Woman MA, the Children Come First and Wraparound Milwaukee programs, and the MA coverage provided to foster children. It also describes the BadgerCare Plus Core Plan and the BadgerCare Plus Basic Plan. The chapter concludes with a brief summary of the recent federal healthcare reform legislation and its potential impact on the state's MA program.

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 eligibility groups listed above must, with limited exceptions, satisfy the following non-financial criteria to enroll 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.

Second, they 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. 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 foster care, adoption assistance, Medicare, supplemental security income (SSI) benefits, or Social Security disability insurance (SSDI) benefits.

Third, they 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 the obligation to help establish the paternity of any child born out of wedlock who is covered by BadgerCare Plus.

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 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 who could have been covered under that employer-sponsored 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 applicant currently has access to an employer-sponsored health plan, but is not enrolled. It also refers to circumstances where the individual could be covered under an employer-sponsored 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 that coverage. Thus, if a person with employer-sponsored insurance voluntarily quits his or her job in May, they are not eligible for BadgerCare Plus until September.

There are several important exceptions to these "other insurance" rules. First, they 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 an employer-sponsored 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 that deductible if the family incurs 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 when the employer pays 80% or more of the premium. 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, a pregnant woman with income up to 300% of the FPL can temporarily enroll in BadgerCare Plus for the period beginning with her application date and running through the end of the following month. During that period of temporary enrollment, and while her 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, depending upon their family's income, 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 their natural mother was deter-

[1] Appendix 1 shows the 2010 FPL by family size and identifies several percentages of the FPL that are relevant for EBD MA, BadgerCare Plus, and SeniorCare eligibility purposes.

mined to have been eligible for BadgerCare Plus, other full-benefit MA coverage, BadgerCare Plus or MA emergency services, or the BadgerCare Plus prenatal plan. 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. Continuously eligible newborn children are exempt from the program's "other insurance" provisions, and from its citizenship and identity documentation requirements, until the next eligibility review after the child turns one year of age.

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 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.

When an applicant's countable income is calculated, the following 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.

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 member 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 incomes 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-

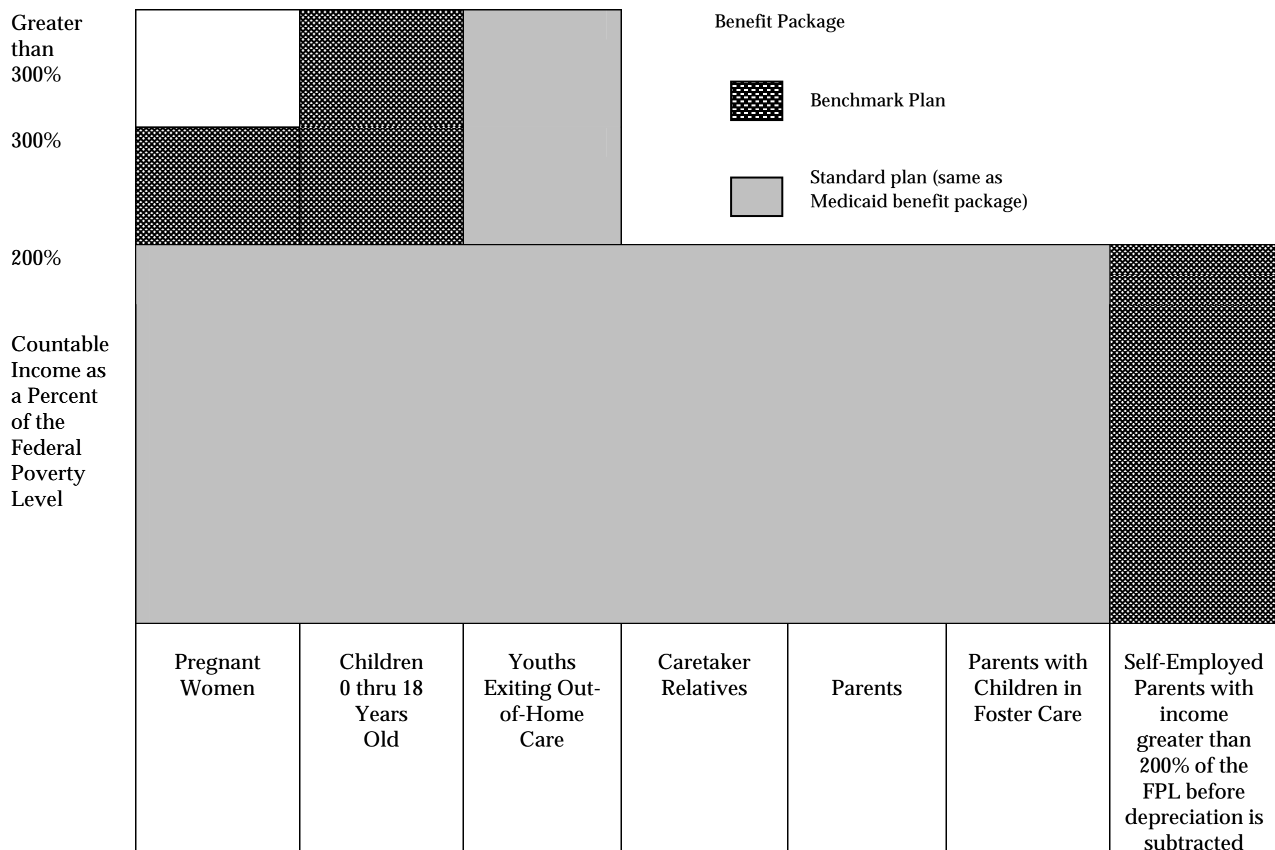
employed parents and caretaker relatives of children under age 19 whose income is greater than 200% of the FPL before subtracting depreciation.

As of June 2010, nearly 98% of all BadgerCare Plus recipients (excluding Core Plan enrollees, for whom a separate benefit plan applies) 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 in the Wisconsin Administrative Rules (DHS 107). They are described at greater length 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.

Premiums

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 shown in Appendix 2, 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.

Figure 1: BadgerCare Plus Eligibility and Benefits, by Group



Generally speaking, children in families with income over 200% of the FPL, and parents and caretaker relatives with income from 150% through 200% of the FPL, must pay premiums in order to obtain coverage under BadgerCare 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 (referred to as BadgerCare Plus "extension" groups);

- 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://emhandbooks.wi.gov/bcplus/.

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 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.

Table 2: BadgerCare Plus Premiums -- Individual Monthly Premiums for Children and Adult Caretakers (As of January, 2011)

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	27.00
>170% to 180%	0.00	68.00
>180% to 190%	0.00	122.00
>190% to 200%	0.00	188.00
200%	0.00	268.00
>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%	34.00	Not Eligible
>260% to 270%	44.00	Not Eligible
>270% to 280%	55.00	Not Eligible
>280% to 290%	68.00	Not Eligible
>290% to 300%	82.00	Not Eligible
300% or Greater	97.53	Not Eligible

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

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 because family income exceeds 200% of the FPL.

Example 2: A family with countable income between 280% and 290% of the FPL, with two adults, one of who is pregnant, and one child, would pay $68 per month for coverage of the child, and $0 for the pregnant adult. The other adult would not be eligible for coverage.

Example 3: A family with countable income between 180% and 190% of the FPL, with one adult and two children would pay $122 per month for coverage of the adult and $0 for the two children.

Delivery of Health Care Services Under BadgerCare 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 covered services through MA-certified health care providers. Those providers, in turn, submit claims to the BadgerCare Plus program for the services they provide, and are reimbursed 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 (part of which reflects reimbursement for administrative services) the HMO, through its provider network, provides comprehensive health services to its enrolled members. Generally speaking, 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 HMO, rather than the state, assumes some of the financial risk 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. In some cases, however, covered services are provided to the HMO member on a fee-for-service basis. The most notable such service, perhaps, is the program's prescription drug benefit, which was "carved out" of the HMO capitation payments in 2008. Other examples include prenatal care coordination, targeted case management services, school-based services, the crisis intervention benefit, community support program services, and common carrier transportation services (except in Milwaukee County, where HMOs currently provide that benefit).

In most areas of the state, HMOs have the option of covering dental and chiropractic services; those that do 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. In DHS service regions 5 and 6 (which include Southeast Wisconsin and Milwaukee County), participating HMOs provide the program's dental benefit, and reimbursement for those services is included in the HMO's medical and dental base capitation rate.

HMOs are also 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 currently serve BadgerCare Plus members in virtually all Wisconsin counties. Where two or more HMOs participate, BadgerCare Plus members can be required to enroll in an HMO, though they generally have the option to select their HMO. If they do not make a selection, they will be automatically enrolled in an HMO. Under federal law, states typically cannot require MA recipients to enroll in an HMO unless 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. In those areas where HMO coverage does not exist, BadgerCare Plus members receive covered health care services on a fee-for-service basis. As of September 2010, approximately 80% of all BadgerCare Plus recipients, including Core Plan

recipients, were enrolled in HMOs.

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 adequacy and accessibility of health care services, payment procedures, billing, enrollment, and grievances and appeals.

The contract also identifies the capitation rates HMOs receive for serving BadgerCare Plus participants. 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 are not eligible for federal MA matching funds.

Capitation rates vary across the six DHS rate regions throughout the state, and within each region rates vary depending upon each 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.

Working with its contracted actuary, DHS establishes BadgerCare Plus capitation rates by analyzing prior years' encounter data submitted by the HMOs, pricing that encounter data by applying the Department's fee-for-service rates, and then making adjustments to reflect projected utilization trends and changes in applicable law or policy. The base capitation rates are also subject to an adjustment using the Chronic Disability Payment System (CDPS), which adjusts payments to HMOs to reflect cost differences attributable to their members' health conditions.

Table 3 shows per member/per month HMO capitation rates in DHS rate regions 1, 2, 3, and 4 for calendar year 2010. Those regions are located as follows: Region 1 (North); Region 2 (Northeast); Region 3 (West Central); and Region 4 (Madison and Southwest). The indicated rates are for enrollment in the BadgerCare Plus standard plan, and assume the HMO provides medical, dental, and chiropractic services. Note that for pregnant women enrolled in BadgerCare Plus, the state makes an additional "kick payment" to the HMO when the woman gives birth. This kick payment, which is designed to compensate HMOs for providing those birth-related services, is a separate cash payment made to the HMO in addition to the standard monthly capitation rate.

Table 3: 2010 Monthly Capitation Rates for BadgerCare Plus Standard Plan (Excluding Maternity-Related Services) DHS Regions 1 Thru 4

Age Range	Gender	Region 1	Region 2	Region 3	Region 4
Age 0	All	$287.14	$307.46	$252.82	$285.86
Ages 1-5	All	68.71	59.86	59.22	64.57
Ages 6-14	All	65.64	54.72	53.42	61.91
Ages 15-20	Female	127.02	113.6	114.05	112.32
Ages 15-20	Male	76.74	69.88	73.29	84.01
Ages 21-34	Female	184.42	174.55	168.32	170.77
Ages 21-34	Male	115.80	107.17	117.09	126.73
Ages 35-44	Female	230.60	252.26	235.03	229.54
Ages 35-44	Male	170.19	201.42	148.29	187.51
Ages 45 & Over	Female	323.30	306.28	283.63	312.75
Ages 45 & Over	Male	227.12	323.46	233.88	191.93
Maternity Kick Payment		$4,698.00	$4,081.00	$4,108.00	$4,447.00

In regions 1 through 4, the base capitation rates are the same for all of the HMOs that serve BadgerCare Plus members in that region (subject to the CDPS adjustment). In regions 5 and 6, the base capitation rates vary slightly, depending upon the HMO. This difference reflects changes resulting from the Department's ForwardHealth Rate Reform Project, which stemmed from a provision in 2009 Act 28 that required DHS to realize approximately $630 million in savings in the MA program during the 2009-11 biennium. As part of that project, DHS issued a request for proposal (RFP) for HMOs to serve BadgerCare Plus recipients in Southeast Wisconsin, including Milwaukee County (DHS regions 5 and 6). The resulting contract between the Department and the four selected HMOs (United Healthcare of Wisconsin, Abri Health Plan, Children's Community Health Plan, and Community Connect Health Plan) contains a number of unique provisions, particularly with respect to quality performance standards. For instance, under the new contracts, DHS will withhold 3.25% of each HMO's full capitation rate in calendar year 2011, subject to the HMO meeting a series of performance criteria in areas such as diabetes testing, blood lead testing, childhood immunizations, asthma management, tobacco cessation, emergency department utilization, and dental utilization. (In regions 1 through 4 there is a pay-for-performance withhold of 1.0% in calendar year 2011.)

Table 4 shows the calendar year 2010 monthly capitation rates for providing medical, dental, and chiropractic services under the standard plan for each of the four HMOs selected through the Department's Southeast Wisconsin RFP process. The

Table 4: 2010 Monthly Capitation Rates BadgerCare Plus Standard Plan (Excluding Maternity Related Services) DHS Regions 5 and 6

Age Range	Gender	United Healthcare of Wisconsin	Abri Health Plan	Children's Community Health Plan	Community Connect Health Plan
Region 5					
Age 0	All	$254.07	$255.35	$255.36	$258.86
Ages 1-5	All	70.41	71.69	71.70	75.20
Ages 6-14	All	60.39	61.67	61.68	65.18
Ages 15-20	Female	106.22	107.50	107.51	111.01
Ages 15-20	Male	80.10	81.38	81.39	84.89
Ages 21-34	Female	170.06	171.34	171.35	174.85
Ages 21-34	Male	122.71	123.99	124.00	127.50
Ages 35-44	Female	228.63	229.91	229.92	233.42
Ages 35-44	Male	173.39	174.67	174.68	178.18
Ages 45 & Over	Female	263.22	264.50	264.51	268.01
Ages 45 & Over	Male	227.59	228.87	228.88	232.38
Maternity Kick Payment (no administrative allowance)		$3,659.71	$3,659.71	$3,659.71	$3,659.71
Region 6					
Age 0	All	$326.09	$327.37	$327.38	$330.88
Ages 1-5	All	82.98	84.26	84.27	87.70
Ages 6-14	All	60.74	62.02	62.03	65.53
Ages 15-20	Female	107.56	108.84	108.85	112.35
Ages 15-20	Male	72.51	73.79	73.80	77.30
Ages 21-34	Female	164.58	165.86	165.87	169.37
Ages 21-34	Male	115.38	116.66	116.67	120.17
Ages 35-44	Female	224.13	225.41	225.52	228.92
Ages 35-44	Male	174.63	175.91	175.92	179.42
Ages 45 & Over	Female	291.79	293.07	293.08	296.58
Ages 45 & Over	Male	294.67	295.95	295.96	299.46
Maternity Kick Payment (no administrative allowance)		$4,596.43	$4,596.43	$4,596.43	$4,596.43

differences between the HMOs' respective capitation rates reflect slightly different rates of reimbursement for administrative costs, per the plans' responses to the RFP.

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 goal of the family planning waiver program is to provide individuals with information and services to assist them in preventing pregnancy and to prevent sexually transmitted diseases (STDs). In keeping with Act 28, which authorized DHS to seek approval from CMS to expand the then-existing program to include males, the program was recently expanded to cover both females and males ages 15 through 44 in families with countable incomes less than 200% of the FPL who are U.S. citizens or qualified immigrants and who are not eligible for BadgerCare Plus without a premium. If the applicant is under age 19 and lives with one or both of his or her parents, the parents' income is not counted in determining the applicant's eligibility for benefits.

Depending upon the enrollee, covered services can 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. As of September 2010, there were approximately 54,000 people enrolled in the family planning waiver program. Program expenditures in 2009-10 were $27.9 million (all funds), of which approximately 85% was funded with federal matching dollars.

Under the Patient Protection and Affordable Care Act (the PPACA, or the 2010 federal healthcare legislation), states can amend their MA plans to provide family planning services to non-pregnant individuals who are not otherwise eligible for MA and whose incomes do not exceed the highest income eligibility level that applies to pregnant women under that plan (in Wisconsin that level is 300% of the FPL). Wisconsin submitted a state plan amendment that would allow it to exercise this option, and in anticipation of receiving CMS approval, began offering those services in November 2010. CMS subsequently approved that proposed amendment, effectively eliminating the rationale for maintaining a separate family planning waiver program.

Prenatal 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 because they are 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 coverage, 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. During the first nine months of calendar year 2010, the prenatal program's monthly enrollment averaged approximately 1,990 women.

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 lim-

its:

Pregnant women and newborns up to age 1: 300% 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: 200% 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 when 60 days have passed since their pregnancy ended. 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, or who are enrolled in the Family Planning Waiver, the BadgerCare Plus Benchmark Plan, or the BadgerCare Plus Core Plan, and who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix, are eligible for services under the Wisconsin well woman MA program if they are found to be in need of treatment for those conditions and they do not have other insurance that would cover that treatment. The program does not have separate income eligibility tests because eligibility for services is gained through one of the gatepost programs listed above.

Women who qualify for coverage are eligible for the full range of benefits on a fee-for-service basis provided under the BadgerCare Plus Standard Plan. During 2009-10, the program's average monthly enrollment was 645, and total program expenditures were approximately $11.2 million (all funds), of which federal matching funds constituted 72%.

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. During calendar year 2010, the state MA program paid a monthly capitation payment of $2,137 per CCF enrollee, with Dane County providing additional funding for the services provided. During state fiscal year 2009-10, the average monthly enrollment

in the CCF program was approximately 137 children, and the total (all funds) capitation payments made by the state were $3.5 million.

Milwaukee County's Children and Adolescent Treatment Center operates the WM program. In calendar year 2010, the Wisconsin MA program paid a monthly capitation rate of $1,770 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 state fiscal year 2009-10, the average monthly enrollment in the WM program was approximately 839 children, and the total (all funds) capitation payments made by the state were $17.8 million.

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 2010, approximately 7,100 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, 2010, approximately 10,200 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 (received in late 2008) that would allow the state's MA program to provide health care services to adults under age 65 who do not have dependent children and whose incomes are less than 200% of the FPL. Other eligibility rules require that the applicant not be eligible for any other full-benefit MA program, and that they not have had access to health insurance through a current employer during the preceding 12 months (subject to certain good cause exceptions). In addition, applicants must pay an annual enrollment fee of $60 and they must obtain a comprehensive physical exam within the first twelve-month certification period.

The Core Plan offers more limited healthcare coverage than either the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan. DHS began providing services to Core Plan enrollees in January, 2009. Most of the initial enrollees had previously been enrolled in Milwaukee County's general assistance medical program (GAMP). The Core Plan was expanded statewide in July, 2009.

Demand for the new program far exceeded initial budget projections. For instance, during state fiscal year 2009-10, the program's average monthly enrollment of approximately 56,000 individuals was more than twice the level projected for budgeting purposes. Among other things, that higher-than-budgeted enrollment threatened to cause DHS to exceed the budget neutrality limits established in its waiver agreement with CMS. Under those provisions, federal support for Core Plan expenditures is limited to the amount of federal money the state is allocated each year for disproportionate share hospital (DSH) payments. In addition, the state received a grant from the federal Health Resources and Services Administration (HRSA) of $10 million per year for five years beginning in 2009 which can also be used to support Core Plan expenditures. To the extent Core Plan expenditures exceed these federal funding sources they must be funded 100% by GPR.

DHS responded to these enrollment and funding pressures by imposing an enrollment cap for Core Plan applications received after October 9, 2009. The program's enrollment has steadily declined in the wake of that cap, falling from 65,300 in January, 2010, to 50,300 in October, 2010. Based on current cost projections, DHS estimates that Core Plan enrollment of approximately 50,000 individuals is sustainable under the budget neutrality provisions of the CMS waiver agreement.

To date, Core Plan expenditures have significantly exceeded the amounts budgeted in 2009 Act 28. For example, Act 28 budgeted $85.2 million (all funds) for Core Plan benefits in state fiscal year

2009-10. Actual expenditures that year (prior to any adjustments for drug rebates and other potential offsets) were approximately $158.5 million (all funds).

The Core Plan Waitlist and BadgerCare Plus Basic. At the time DHS imposed its Core Plan enrollment cap, it also established a waitlist for individuals who wanted to enroll in that program. As of October, 2010, 82,300 people were on the Core Plan waitlist.

To partially address the demand for healthcare services of individuals on the waitlist, 2009 Wisconsin Act 219 authorized DHS to create the BadgerCare Plus Basic Plan. Under that legislation, individuals on the Core Plan waitlist who satisfy all of the Core Plan's eligibility requirements can enroll in the Basic Plan. The BadgerCare Plus Basic Plan is not a medical assistance program. It is not subject to federal or state MA laws. Moreover, it is intended to be financed wholly by the premiums paid by plan participants (an exception being that $1 million of the federal HRSA grant noted above has been earmarked by DHS as a reserve against Basic Plan costs). Currently, the plan's monthly premium is $130 per month, with discounts available if premiums are paid in advance. Act 219 allows DHS to adjust those premiums in order to pay covered benefits and to maintain the fiscal soundness of the plan.

DHS began providing coverage to Basic Plan participants in July, 2010. As of December 14, 2010, approximately 5,100 people were enrolled in the program.

Act 219 specified that DHS could not set a deductible for inpatient and nonemergency outpatient services under the Basic Plan that exceeded $7,500 in an enrollment year. The act also specified that the Basic Plan's benefits could not exceed the benefits covered under the Core Plan. Beyond that, Act 219 gave DHS wide latitude to establish the scope of coverage, expressly exempting the Basic Plan from the coverage mandates that typically apply to commercial coverage sold in the state.

The Basic Plan is scheduled to terminate on January 1, 2014, meaning that the plan cannot pay for services provided after December 31, 2013. As discussed below, that date coincides with the date by which the state is required to have a fully operational health benefit exchange under the recently enacted federal healthcare reform legislation.

Appendix 2 compares coverage provided under four plans offered under Wisconsin's MA program as of September, 2010 -- the BadgerCare Plus standard plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

Potential Impact of Federal Healthcare Legislation on Wisconsin's MA Program

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). Along with the Health Care and Education Reconciliation Act of 2010, the PPACA contains many provisions that affect private health insurance markets and state MA programs. Some of these changes have already gone into effect, while others are scheduled to be phased in over time.

Private Insurance Provisions. The PPACA implemented many changes to the private insurance market, including eliminating preexisting condition exclusion periods, prohibiting lifetime or annual limits on the dollar value of benefits, and generally prohibiting the rescission of coverage once an individual is enrolled. The PPACA also requires states to establish, no later than January 1, 2014, a health benefit exchange that facilitates the purchase of qualified health plans by individuals. If a state does not establish an exchange, or has not made sufficient progress towards doing so by 2013, the PPACA directs the HHS Secretary to establish and operate an exchange in the state.

The PPACA also includes an individual insurance mandate beginning in 2014. That mandate requires most individuals to maintain "minimum essential health insurance coverage." Individuals

who do not comply with that mandate are subject to tax penalties to be phased in from 2014 to 2016. To help individuals obtain the mandated health insurance coverage, the PPACA provides premium tax credits and cost-sharing subsidies for individuals in families with income between 100% and 400% of the FPL. These tax credits and subsidies will only be available to individuals who purchase insurance through the state's health benefit exchange.

MA Provisions. The PPACA will also directly affect Wisconsin's MA program. The following paragraphs provide a brief synopsis of several of the act's most significant MA-related provisions.

Maintenance of Effort Requirement. The PPACA contains a maintenance of effort (MOE) requirement that prevents states (at the risk of losing their federal MA matching funds) from having MA eligibility standards, methodologies, or procedures under their state MA plan, or under any waiver to that plan, that are more restrictive than those that were in effect as of March 23, 2010. For adults, this MOE requirement remains in effect until the Health and Human Services (HHS) Secretary determines that a health benefit exchange established by the state is fully operational (presumed date of January 1, 2014). For children under age 19, the MOE requirement runs through September 30, 2019.

There is a limited exception to this MOE requirement for nonpregnant, nondisabled adults who are eligible for MA under the state plan or a waiver of the plan and whose incomes exceed 133% of the FPL. During the period January 1, 2011, through December 31, 2013, the MOE requirement can be waived for these individuals if the state certifies to the HHS Secretary that the state has a budget deficit during the fiscal year in which the certification is made, or that the state is projected to have a budget deficit in the succeeding fiscal year. As noted, both BadgerCare Plus and the BadgerCare Plus Core Plan currently provide coverage to nonpregnant, nondisabled adults with incomes greater than 133% of the FPL. To date, CMS has not issued regulations or guidance regarding the application of this MOE exception.

New Mandatory Coverage Group. Beginning January 1, 2014, the PPACA will require state MA programs to cover non-elderly individuals with family incomes up to 133% of the FPL. The coverage provided to these individuals must consist of "benchmark" or "benchmark equivalent" coverage, as defined in federal law. For many states, this new eligibility requirement will represent a significant expansion of their current MA programs. In Wisconsin, BadgerCare Plus and the BadgerCare Plus Core Plan already provide coverage to many nonelderly adults with incomes up to 200% of the FPL (although an enrollment cap is currently in place for Core Plan services).

Enhanced FMAP for "Newly Eligible" Individuals. The PPACA defines a "newly eligible" individual as a person who meets all of the following criteria: (1) is not pregnant; (2) is age 19 (or higher if the state has elected) through 64; (3) is not entitled to or enrolled for benefits under Medicare Parts A or B; (4) has income not greater than 133% of the FPL; and (5) on December 1, 2009, was not eligible under the state plan or under a waiver of the state plan, or is eligible but not enrolled (or is on a waiting list) under the state plan or a waiver of the state plan that has a capped or limited enrollment that is full, for full MA benefits, for benchmark coverage, or for benchmark equivalent coverage. For these "newly eligible" individuals, the PPACA provides states an enhanced FMAP. For calendar quarters in 2014 through 2016, that enhanced FMAP is 100%. From 2017 through 2020 that FMAP decreases to 90%, where it remains thereafter.

DHS has indicated that Core Plan enrollees (and individuals on the Core Plan waitlist) with incomes not greater than 133% of the FPL will be deemed "newly eligible" individuals under the PPACA because the Core Plan benefit package is less comprehensive than full MA benefits, benchmark coverage, or benchmark equivalent coverage.

If that is in fact the case, the state will be entitled to the PPACA's enhanced FMAP for these individuals beginning in 2014. Currently, the state receives its standard FMAP of approximately 60% for services provided to those individuals under the Core Plan.

Increased Federal Support for the Children's Health Insurance Program (CHIP). The PPACA extends the current reauthorization for the CHIP program for two years, through September 30, 2015. From October 1, 2015, through September 30, 2019, the PPACA increases the FMAP for children who are eligible for a state's CHIP program by 23 percentage points. Wisconsin currently receives an enhanced FMAP of approximately 72% for children enrolled in BadgerCare Plus whose service costs are funded through CHIP. The PPACA will increase that FMAP to approximately 95% for the four-year period beginning October 1, 2015.

State Options for Coverage of Adults under Age 65 in Families with Incomes Greater than 133% of the FPL. For children under age 19, the PPACA requires Wisconsin to maintain its current MA eligibility standards through September 30, 2019. However, the state will have several options with respect to the coverage of non-elderly adults with incomes above 133% of the FPL once the HHS Secretary determines that the state's health benefit exchange is fully operational. Those options include, but are not necessarily limited to, the following.

First, the state could continue to cover these adults under BadgerCare Plus and the BadgerCare Plus Core Plan, and continue to receive its standard FMAP for providing those services.

Second, the state could discontinue MA coverage for these adults, thereby enabling them to seek coverage through plans offered in the newly-established health benefit exchange. By virtue of their incomes (133% to 200% of the FPL), these individuals would be eligible for the premium tax credits and cost-sharing reductions provided in the PPACA.

Third, the state could establish a basic health coverage plan for individuals who are under age 65 and who have incomes between 133% and 200% of the FPL. Under the PPACA, this basic health coverage plan would have to meet certain minimum coverage requirements. If the state elects this option, the federal government will provide to the state an amount that is equal to 95% of the premium tax credits and cost-sharing reductions these individuals would have received in any given fiscal year had they enrolled in qualified health plans through the exchange.

It is anticipated that additional federal rulemaking and guidance over the next several years will clarify the details of these and other MA-related provisions in the PPACA.

CHAPTER 2

MA ELIGIBILITY FOR ELDERLY, BLIND AND DISABLED INDIVIDUALS

In addition to funding services for individuals and families under the state's BadgerCare Plus program, the MA program funds services for elderly, blind, and disabled individuals and several other groups. DHS refers to this component of the program as EBD MA, or Wisconsin Medicaid. EBD MA includes the following subprograms and benefit plans:

- SSI-related Medicaid;
- Institutional Long-Term Care;
- The MA Purchase Plan (MAPP);
- Family Care;
- Home- and Community-Based Waivers Long-Term Care;
- Partnership Long-Term Care;
- Program for All-Inclusive Care for the Elderly (PACE);
- The Katie Beckett Program;
- MA Coverage for Individuals with Tuberculosis;
- Medicare Premium Assistance Programs;
- Emergency Medicaid; and
- Wisconsin Well-Woman Medicaid.

SeniorCare, which is also part of EBD MA, is budgeted as a separate program. For the purposes of this chapter, it is not considered part of EBD MA.

An individual may meet eligibility requirements for both BadgerCare Plus and one or more of the EBD MA subprograms. In these cases, the individual is enrolled in the program that offers the best benefit plan and the lowest cost-share to the family or individual. As of July 1, 2010, approximately 188,200 individuals were enrolled in EBD MA subprograms other than SeniorCare.

This chapter describes general eligibility requirements for EBD MA, as well as eligibility for most of the EBD Medicaid subprograms, including SSI-related Medicaid, eligibility for institutional long-term care, MAPP, the Katie Beckett program and the Medicare premium assistance programs. Several of the subprograms are discussed in other chapters, including Family Care (Chapter 5), the home- and community-based waiver programs (Chapter 4), and SeniorCare (Chapter 7).

Nonfinancial Eligibility Requirements

In order to be eligible for most of the EBD MA subprograms, 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;
- Cooperate with third party 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. As of July 1, 2010, substantial gainful employment was defined as gross income equal to or greater than $1,000 per month for non-blind individuals and $1,640 per month for blind individuals.

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.

General Financial Eligibility Requirements

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

Assets

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

The methods the Medicaid program uses to determine countable assets for the purpose of determining program eligibility are complex due to the wide variety of assets individuals may own, and because some assets may be shared by an individual and his or her spouse. Additional information regarding how the Medicaid program counts assets is available in 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 monthly income. The starting point for these calculations is an individual's gross monthly income, which includes both earned and unearned income.

Step 1 -- Deductions from Gross Income. First, several types of income may be subtracted from an applicant's monthly gross income to calculate the applicant's countable income. These subtractions include:

- For individuals with income from a job, a 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.

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

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

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

• Medical and remedial expenses. These expenses 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.

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

• A standard Medicaid credit of $20.

Step 2 -- Compare Countable Income with EBD MA Limits. Once an applicant's countable income is determined, his or her counted income is compared with two monthly income limits -- one that is used for single individuals, and the second for married individuals In 2010, the income limit for individuals was $533.11, plus actual shelter costs (up to $224.67), for a total of $757.78. The income limit for an individual who was married was $806.05, plus actual shelter costs of up to $337, for a total of $1,143.05.

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

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 in 2010); and (b) multiplying that 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

Many EBD Medicaid recipients qualify for the standard MA benefits plan because they receive cash benefits under the supplemental security income (SSI) program, or meet requirements relating to the SSI program. States may enter into agreements with the Social Security Administration, which administers to the SSI program, to provide all SSI recipients with MA eligibility, eliminating the need for individuals to apply for both programs separately.

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."

Medicaid Eligibility for Individuals Who Require Long-Term Care Services

Under federal law, states may provide MA coverage to residents of institutional facilities (nursing facilities, hospitals and other medical institutions) and individuals who live in their own homes but participate in the community-based waiver programs, under a special institutional income rule. This rule permits individuals who are not eligible for SSI and have income that does not exceed 300% of the maximum monthly federal SSI payment amount to be automatically eligible for MA coverage without meeting the Medicaid deductible. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level ($674 per month x 3.0 = $2,022 per month in 2010).

Income Eligibility for Institutional Medicaid. There are two ways an individual can meet the income eligibility standard to qualify for MA-funded care in skilled nursing facilities, intermediate care facilities, institutions for mental diseases and hospitals ("Institutional Medicaid"). First, the individual can meet the standard by having monthly gross income that is less than 300% of the income standard described above ($2,022 in 2010).

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

MA recipients who qualify for MA-funded institutional care 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.

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

The level of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of initial institutionalization or request for 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 2010). 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. Consider a couple whose combined countable resources are $120,000 at the initial period of continuous institutionalization. The spousal share, which is equal to one-half of the couple's countable resources, is $60,000. After a period of time, the institutionalized spouse applies for 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 ($50,000); would be deducted from the combined countable resources at the time of application, resulting in an unprotected resource amount of $30,000 ($90,000 minus $60,000). 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 whose income exceeds the limits may still qualify for MA if they meet a Medi-

caid deductible described previously.

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 2010. 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 ($1,821 per month in 2010); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the federal minimum amount ($546.38 per month in 2010). Since the FPL is usually adjusted each year to reflect increases in the cost of living, the federal minimum is usually increased each year. If the state establishes an income allowance that is below the federal maximum, the state must establish an excess shelter allowance.

Wisconsin establishes its income allowance between the federally-established minimum and maximum amounts. Specifically, in 2010, the income allowance was the lesser of: (a) $2,739 per month; or (b) $2,428.33 plus an "excess shelter allowance," which is for shelter expenses above $728.50 per month. Shelter expenses include the community spouse's expenses for rent, mortgage principal and interest payments, taxes and insurance for a principal place of residence, maintenance fees if the community spouse lives in a condominium or cooperative, and a standard utility allowance, as calculated under the FoodShare program. In addition, Wisconsin currently permits the institutionalized spouse to transfer up to $607 per month for each qualifying dependent family member living with the community spouse.

The federal Deficit Reduction Act of 2005 (DRA) clarified that transfers of resources from the institutionalized spouse to the community spouse under these circumstances must follow the "income first" method. Under the "income first" method, the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet the minimum monthly maintenance needs allowance. Any remaining income is then applied to the institutionalized spouse's cost of care. Under this method, the assets of the institutionalized spouse (including annuities or other income-producing assets) can only be transferred to the community spouse if such a transfer would not cause the community spouse's income to exceed the state-approved monthly maintenance needs allowance. Otherwise, they remain attributed to the institutionalized spouse and must be used towards care costs. This option generally requires a couple to deplete a larger share of their assets before becoming eligible for 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 (between $854 and $2,022 per month in 2010) 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 2010, 200% of the FPL for a two-person family was $2,428 per month. If a community spouse has shelter costs of $839 per month, the excess shelter costs equal $110

per month ($839 - $729 = $110). In this case, the maximum monthly income allocation is $2,538 ($2,428 + $110 = $2,538). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,538 per month to determine the spousal income allocation amount ($2,338). If the institutionalized spouse's income is $3,600, the institutionalized spouse’s nursing home liability amount would be $1,217 per month [$3,600 (the institutionalized spouse's income) - $2,338 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,217].

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 *Medicaid 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. Since October 1, 2009, assets are no longer counted for disabled or institutionalized children. This effectively eliminates the possibility of divestment in child Medicaid cases.

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. For divestments that occurred before January 1, 2009, states are 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 ($6,216 in 2010). The penalty period began on the date of the transfer.

For example, if a person made a transfer of $50,000 one year before applying for MA, and the transfer occurred before January 1, 2009, the penalty period for the applicant would total 8 months ($50,000/$6,216 per month = 8.04 months, rounded down). Since the penalty period began on the date of the transfer (in this example, 12 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.

New divestment rules went into effect January 1, 2009. The look back period for divestments occurring after January 1, 2009 is 36 months until January 1, 2012, 37 to 57 months from January 1, 2012 to December 31, 2013, and 60 months after January 1, 2014. These look back periods apply to both trust and non-trust divestments. For divestments transferred on or after January 1, 2009, the penalty period is calculated by dividing the amount of the transfer by the average daily private pay rate of nursing homes ($204.35 in 2010). The penalty period begins on the date that the individual applies for Medicaid services is institutionalized and meets all other eligibility requirements. If the individual is a current Medicaid recipient, the penalty period begins the first day of the month in which the divestment occurred.

Using the previous example, and assuming the transfer occurred after January 1, 2009, a person transferring $50,000 one year before applying for MA would generate a penalty period of 244 days ($50,000/$204.35 per day = 244.68 days, rounded down). 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 example, the MA program would not pay for long-term care services for the individual until 244 days 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 or their community spouse 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. The limit does not apply if a spouse, minor or disabled child resides in the home.

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 back period and penalty calculation, all these provisions mandated by the DRA apply in Wisconsin to transactions occurring on or after January 1, 2009.

Wisconsin Long-Term Care Insurance Partnership. Beginning January 1, 2009, individuals that purchase a qualifying long-term care insurance policy may 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.

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).

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, 2010, six HMOs provided managed care to approximately 30,400 SSI-related MA recipients in all or part of 58 counties. Appendix 3 provides a complete list of participating counties, along with enrollment and total 2009-10 capitation payments made to HMOs. Table 5 provides a list of participating HMOs and the corresponding enrollment served by each participant as of July 1, 2010.

Table 5: HMOs Providing Coverage to SSI Managed Care Members as of July 1, 2010

HMO	Enrollment as of July 1, 2010
Abri Health Plan	1,715
GHC of Eau Claire County	1,886
I-CARE	8,911
Managed Health Services	5,380
Network Health Plan	2,670
UnitedHealthcare of WI	9,882
Total	30,444

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. 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 enrol-

lee'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 2010, the MA program paid SSI managed care organizations 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 2010 are shown in Table 6. Approximately $199.4 million (all funds) was expended in 2009-10 to support SSI managed care capitation payments throughout the state.

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. DHS 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.

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 ($2,256 for an individual in 2010); (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 vocational program that is approved 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 ($1,354 for an individual in 2010). 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 ($777 per month in calendar year 2010); (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.

Table 6: SSI Managed Care Average Monthly Capitation Rates by Region and Eligibility Category (Calendar Year 2010)

Eligibility Category	Gender	Region 1	2	3	4	5	6
SSI Medicaid Only							
19-29	Male	$356.78	$391.08	$286.42	$349.34	$411.40	$427.71
19-29	Female	524.72	433.20	463.20	420.51	453.36	543.12
30-39	Male	471.85	496.34	386.72	600.72	513.62	496.70
30-39	Female	499.79	475.07	512.78	490.05	656.01	606.36
40-64	Male	627.43	627.55	493.87	602.56	619.16	837.47
40-64	Female	605.31	605.73	577.22	575.65	751.09	942.47
65+	Male	429.05	589.64	248.12	207.83	1,407.75	756.70
65+	Female	689.78	623.50	751.54	489.61	947.64	730.75
SSI Dual Eligible							
19-29	Male	$105.28	$76.24	$72.63	$119.34	$125.87	$86.75
19-29	Female	151.50	82.61	96.33	154.24	115.06	202.91
30-39	Male	98.49	64.11	60.04	129.84	79.82	194.13
30-39	Female	114.55	123.86	97.11	116.03	173.54	207.04
40-64	Male	114.69	145.05	128.80	130.14	156.31	282.02
40-64	Female	149.11	152.11	126.66	152.01	188.08	340.25
65+	Male	174.79	252.87	191.93	139.72	244.59	274.74
65+	Female	213.30	292.69	215.86	187.16	195.25	284.91
SSI- Related Medicaid Only							
19-29	Male	$713.88	$619.45	$1,135.05	$690.43	$746.46	$614.03
19-29	Female	740.15	353.32	1,176.79	591.09	472.13	574.13
30-39	Male	2,113.98	489.74	755.65	577.50	684.52	484.57
30-39	Female	686.64	1,030.63	551.52	839.27	886.33	727.79
40-64	Male	2,115.04	1,908.89	1,493.36	1,866.51	1,774.62	1,126.39
40-64	Female	1,383.88	1,209.09	1,051.92	1,503.83	1,305.01	1,121.28
65+	Male	819.97	929.98	705.21	383.13	440.22	773.42
65+	Female	766.80	1015.57	858.22	416.84	433.53	670.93
SSI-Related Dual Eligible							
19-29	Male	$84.75	$74.93	$48.49	$108.22	$53.78	$159.67
19-29	Female	160.93	324.03	166.82	109.79	163.58	184.79
30-39	Male	78.39	109.01	124.52	144.13	126.94	194.76
30-39	Female	128.97	118.75	128.29	180.34	190.02	205.36
40-64	Male	160.43	163.96	111.76	167.06	141.60	226.92
40-64	Female	161.04	123.08	134.38	157.42	164.21	275.68
65+	Male	150.91	180.55	161.08	152.17	110.97	211.42
65+	Female	174.78	181.47	146.25	158.69	122.54	205.34

*Note: All capitation rates include medical, dental and chiropractic services.

People with Tuberculosis. An individual who is infected with tuberculosis (TB), but who is not blind, disabled or over the age of 65 may be eligible to receive certain MA-funded services if he or she has countable assets of $2,000 or less and gross income of up to $1,433 per month. For these individuals, MA coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services and services provided by federally-qualified health centers; (e) case management services; (f) services designed to encourage individuals to take their medications; and (g) services that are necessary as a result of side effects of medications prescribed to treat tubercu-

losis. As of July 1, 2010, there were 179 individuals enrolled in MA that met these criteria.

The Katie Beckett Provision. Historically, federal MA income and resource guidelines presented eligibility barriers for disabled children who could receive needed care in their homes. In the past, if a child under the age of 21 was living at home, the income and resources of the child's parents were automatically considered available for 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," named after Katie Beckett, a child who was ventilator-dependent and institutionalized and was unable to receive care in her home not for 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 19 who: (1) would be eligible for MA if they were in a hospital or nursing facility; (2) require a level of care typically provided in a hospital nursing facility; (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 liability may be assessed to help offset the costs of providing services for children who participate in the children's long-term care support home and community-based MA-waiver program (CLTS).

Individuals Eligible for Both Medicare and Medicaid -- Dual Eligibles

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 care, non-custodial care in a skilled nursing facility following an inpatient hospital stay, hospice care, and home health services. Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Part C 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 7.

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 2010, the monthly premium for Part A coverage was $461 for people who were not otherwise eligible for premium-free hospital insurance and who had less than 30 quarters of Medicare-covered employment, and $254 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 2010, Medicare Part B monthly premiums varied by participant enrollment dates. Individuals and married couples that enrolled prior to January 1, 2010, with annual incomes less than $85,000 and $170,000, respectively, paid a monthly premium of $96.40. The same par-

ticipants would pay a monthly premium of $110.50 if they enrolled after January 1, 2010.

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 2010, Medicare Part A paid for all covered Part A services in a benefit period, except a deductible of $1,100 during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days but not more than 150 days ($275 per day for days 61 through 90 and $550 per day for days 91 through 150). For care provided in a skilled nursing facility, the coinsurance amount was $133.50 per day for days 21 through 100 each benefit period.

In 2010, Medicare Part B paid for all covered Part B services in the benefit period except a deductible of $155 per year and a cost share of 20% of the Medicare-approved amount for services after the $155 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 Medicare, 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 Beneficiary (QMB).* QMB participants are individuals who are entitled to Medicare Part A services whose income does not exceed 100% of the FPL, and whose resources do not exceed a resource limit of $6,680 for an individual and $10,020 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 QMB participants, MA pays any required Medicare premium, coinsurance and deductible for both Medicare Part A and Part B coverage. QMB participants 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 QMB participants 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 Beneficiary (SLMB) and Specified Low-Income Medicare Beneficiary Plus (SLMB+).* A more limited MA benefit is provided to individuals eligible for the specified low-income Medicare beneficiary (SLMB) and specified low-income Medicare beneficiaries plus (SLMB+) program. SLMB and SLMB+ participants are individuals who are enrolled in Medicare Part A and have income that is at least 100% but less than 120% of the FPL (SLMB) or is at least 120% but less than 135% of the FPL (SLMB+). The resource limits for SLMB and SLMB+ are the same as those for QMB. State 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 SLMB and SLMB+, participants the source of funding for this benefit varies. The Medicare cost sharing funded by the state MA program for QMB and SLMB participants 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 SLMB+ participants. Consequently, these costs are 100% federally-funded. Further, unlike the assistance provided to QMB and SLMB participants, the state's obligation to fund Medicare Part B premiums for SLMB+ participants is limited to the federal funding allocation the state receives for that purpose.

3. *Qualified Disabled and Working Individual (QDWI).* Under federal law, a disabled Medicare recipient who works and who previously qualified for Medicare due to a disability, but who lost eligibility for Medicare because of 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 QMB participants). 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 service. 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 man-

aged 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.

Table 7 summarizes the asset and income eligibility limits for categorically needy and medically needy EBD MA as of January 1, 2011. The income and asset limits shown in the table reflect countable income and assets.

Table 7: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category (as of January 1, 2011)

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 $607 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	$6,680	$10,020	$903	$1,214	Medicare Part A and B premiums, coinsurance and deductibles.
SLMB	$6,680	$10,020	$1,083	$1,457	Part B premium.
SLMB+	$6,680	$10,020	$1,218	$1,639	Part B premium.

SPECIAL INCOME LIMIT

- Individuals who are not categorically eligible for MA with income not exceeding 300% of the monthly federal SSI payment level and who are residents of institutional facilities or participating in a community-based 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 an approved vocational 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	$2,256
2	15,000	3,035

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

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 (excluding Core Plan enrollees, for whom a separate set of benefits apply), 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

[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.

duration limits the MA program imposes on otherwise covered services. Often those limitations work in conjunction with the program's prior authorization rules. For example, the BadgerCare Plus Standard Plan provides full coverage (subject to nominal co-payments) for physical therapy services, subject to the requirement that such services provided to an MA recipient in excess of 35 treatment days per spell of illness require prior authorization. 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.

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. Unless otherwise indicated, the discussion does not include the more limited range of benefits provided to enrollees in the BadgerCare Plus benchmark plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

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 the following: (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 three months; (d) the assessment is a reflection of each resident's plan of care; and (e) the assessments are coordinated with any state-required pre-admission screening to avoid duplication of assessments. In addition, nursing facilities may not admit a person who is mentally ill or mentally retarded unless a pre-admission 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 the provision of health or rehabilitation services. In addition, ICFs-MR must meet certain conditions relating to: (1) governance and management; (2) client protections; (3) facility staffing; (4) active treatment services; (5) client behavior and facility practices; (6) health care services; (7) physical environment; and (8) dietetic services.

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, 2010, there were 382 licensed nursing homes in the state, with a total of 36,359 licensed beds. Approximately 84% of these facilities were privately owned and operated (36% non-profit and 48% for-profit) while the remaining 16% were owned and operated by a government entity, including the state, counties, municipalities and tribes. On average, 86.5% of licensed nursing home beds were occupied, and 59% were occupied by MA-funded residents.

In addition to nursing homes, there were 15 ICFs-MR in the state as of August, 2010, with a total of 1,024 licensed beds. These totals include the three state centers for people with developmental disabilities. Table 8 shows the number of long-term care institutions in the state as of August, 2010, by type of ownership.

Reimbursement of Non-state Nursing Home Facilities. In 2009-10, 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 $871.3 million (all funds) representing approximately 12.8% of gross MA expenditures in that year. Fee-for-service nursing home care is expected to continue to decrease in the future as more individuals enroll in the state's Family Care program (see Chapter 5).

Table 8: Nursing Home Facilities, by Ownership Type, (August, 2010)

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	183	18,050
Non-Profit	137	13,215
Government	62	5,094
Total	382	36,359
ICF-MR		
For-Profit	1	12
Non-Profit	2	155
Government	12	857
Total	15	1,024

Under state law, DHS is required to reimburse nursing homes for fee-for-service care provided to MA recipients according to a prospective payment system that DHS must update annually. The payment system must include 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 must include factors that: (a) incorporate acuity measurements under the most recent resource

utilization groupings (RUGs) resident classification methodology adopted by CMS to determine case-mix adjustment factors; (b) determine the average case-mix index for each MA-supported nursing facility 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, in state fiscal year 2009-10, as many as 78% 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. 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 operation 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 determines a base direct care target rate using the actual direct care costs of facilities in the state, adjusting for inflation, statutory funding, and the relative costs of labor. Costs used in the calculation are obtained from annual cost reports submitted by nursing facilities to DHS and reflect the actual cost incurred by these facilities to provide services to residents. This base rate is then adjusted to reflect a facility's average acuity case mix index and labor cost index. This price-based calculation is derived from recent RUGS 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 2010-11, 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 tax-paying facilities, the statutes direct that the payment be made for the amount of the previous calendar year's tax or the amount of municipal service costs, adjusted for inflation, up to a maximum amount. Tax exempt facilities may also receive a per patient day property tax allowance for the costs of certain municipal services, including those services which are financed through the municipalities' property tax and are provided without leveraging a separate service fee for the service.

For 2010-11, 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 0.7% for real estate taxes and municipal fees.

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

For 2010-11, 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 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 2010-11, nursing homes can receive six types of incentive payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 70% or more of MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $1.50 per patient day to $2.70 per patient day for facilities with more than 50 beds and from $1.50 to $4.20 per patient day for facilities with 50 or fewer beds (the rate increases as the percentage of patient days that are MA/Medicare increases). A separate incentive payment is available for facilities located within the City of Milwaukee that ranges from $1.65 per patient day to $4.60 per patient day.

Second, a nursing facility 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 2010-11, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease arrangements do not generally qualify for the incentive.

Fourth, an MA access incentive is provided to nursing facilities at a rate of $9.65 per patient day and to ICFs-MR at a rate of $28.42 per patient day.

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

Sixth, a behavior incentive provides additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties. Each facility is assessed so as to calculate a Behavior/Cognitive Impairment Score which is then multiplied by a supplement base to determine the Behavior/Cognitive Impairment Incentive. In 2010-11, the Behavior/Cognitive Impairment supplement base was $0.12.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for: direct care, support services, the property tax components, plus the property allowance. In 2009-10, the average MA payment rate, including the resident's share, to nursing homes was $141.77 per day. Ancillary services and materials are specifically identified and billed separately to the MA program, often by an independent provider of the service. The special allowances for government-operated facilities represent supplemental MA payments to facilities that are described in the following paragraphs.

County Supplemental 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 $38 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 operating costs per patient day and MA payments per day); (2) the projected direct care operating deficit (the difference between allowable direct care 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 2009-10 the rate used to allocate the supplemental payments was approximately $28.59 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 munici-

pally-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 2009-10, $38.1 million in supplemental payments were made to county-operated facilities and to Family Care MCOs. An additional $10.3 million was distributed by the state as a CPE supplemental payment. After accounting for all supplemental payments, counties had unreimbursed Medicaid expenses of approximately $75.7 million. Appendix 4 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 2009-10.

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, because the RUGS system under Medicare does not establish rates for care levels that apply to the developmentally disabled. 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 9 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 9: Total MA Fee-For-Service Payments to Nursing Facilities

Facility Type	2007-08	2008-09	2009-10
Non-state Facilities	$757,919,800	$822,994,800	$871,349,300
State DD Centers	123,638,200	91,951,100	148,092,800
Veterans Homes	30,640,600	34,111,000	38,151,000
Total	$912,198,600	$949,056,900	$1,057,593,100

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 $10,628,000 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 institutions for mental diseases (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, 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.

Those DRG weights are then multiplied by a hospital-specific DRG base rate in order to determine the amount a particular hospital will be paid by the MA program for an inpatient stay. The following is a simplified description of how those hospital-specific DRG base rates are calculated. First, DHS establishes a uniform "standard DRG group rate" for the state fiscal year, based on the MA program's budget for DRG hospitals and projected inpatient utilization and case mix for that year. That standard DRG group rate is adjusted to reflect the fact that critical access hospitals (CAHs) are provided 100% cost-based reimbursement for the services they provide to MA recipients. The standard DRG group rate is then converted to a hospital-specific DRG base rate by making adjustments for a series of factors, including the following: (a) a wage index applicable to the hospital's geographic location; (b) an add-on for allowable capital costs; (c) partial reimbursement for the hospital's direct graduate medical education costs; and (d) an increase for hospitals that qualify for a rural hospital adjustment (limited, in the aggregate, to $5 million annually).

While the DRG system is used to reimburse hospitals for most fee-for-service inpatient services, there are exceptions for some AIDS patient care, ventilator patient care, unusual cases and brain injury cases, all of which may be billed on a per diem rate or as negotiated with DHS. Hospitals can also receive an "outlier" payment in addition to their standard DRG-based payment for 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, this augmented reimbursement 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 Hospital Payments. Under federal law, states are eligible for federal MA

matching funds to provide supplemental reimbursement to hospitals which serve relatively high numbers of MA recipients and/or low income patients. Until recently, Wisconsin committed significant portions of its annual allotment of this disproportionate share hospital (DSH) funding to augment the DRG-based rates paid to certain qualifying hospitals, and to help support the Milwaukee County general assistance medical program (GAMP). With the statewide expansion of the BadgerCare Plus Core Plan in July, 2009, the state now uses virtually all of its federal DSH allotment (approximately $97 million in federal fiscal year 2009-10) to support Core Plan expenditures.

Most of the remaining DSH funding in that year was used to provide supplemental funding for 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, 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, the only hospital that has qualified is Aurora Sinai Medical Center. Starting with state fiscal year 2011, this EACH payment will no longer be counted against the state's DSH allotment, thereby freeing up additional federal funding to support the BadgerCare Plus Core Plan.

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 and is not located in a CMS-defined metropolitan statistical area (MSA);

- 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 $5,000,000 (all funds) annually.

In addition, 2009 Wisconsin Act 28 authorized DHS to make payments to each independent, rural hospital that is located in a county that borders another state, and which is not a critical access hospital, of $300,000 in 2009-10 and $400,000 in 2010-11. This provision is an extension of similar provisions in Act 2 and Act 28 which, in conjunction with the implementation of a new hospital assessment (described in more detail in Chapter 8), provided one-time supplemental payments to independent rural hospitals in 2008-09 totaling $1,750,000. Two rural hospitals (the Bay Area Medical Center in Marinette and the Monroe Clinic in Monroe) received supplemental payments under these provisions.

Critical Access Hospitals. A critical access hospital (CAH) is a hospital that has no more than 25 inpatient beds used for acute inpatient care or as "swing beds" (beds used for skilled nursing facility-level care), that provides inpatient care for no more than an average stay of 96 hours per patient, and that provides emergency care 24 hours per day. In

addition, the hospital must meet 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. While the latter certification process is no longer available, hospitals that obtained CAH certification by being designated a necessary provider prior to January 1, 2006 can retain their CAH certification even if they do not satisfy the 35-mile distance requirement. There are currently 59 CAHs in Wisconsin.

Historically, CAHs have been eligible for reimbursement of 100% of the allowable costs they incur to serve MA recipients. As part of its initial plan to achieve the unspecified MA spending reductions required of it during the 2009-11 biennium (approximately $630 million (all funds)), DHS proposed reducing CAH reimbursement to 90%, and in fact implemented that reduction for the first six months of calendar year 2010.

To avert that cut going forward, 2009 Wisconsin Act 190 established a new assessment on CAH gross inpatient revenues beginning July 1, 2010. The CAH assessment mechanism in Act 190 is similar to that in 2009 Wisconsin Act 2, which authorized an assessment on most of the state's other hospitals (CAHs were excluded from the original Act 2 hospital assessment, as were IMDs). The revenues from the CAH assessment, along with corresponding federal MA matching funds, are intended to restore (and in some cases augment) the reimbursement CAHs receive for serving MA recipients. A portion of the CAH assessment revenues are also earmarked to help fund a loan assistance program and a new rural physician residency assistance program, both of which are administered by the University of Wisconsin.

Additional information regarding the Act 2 hospital assessment and the Act 190 CAH assessment is provided in Chapter 8. That chapter also describes a new assessment imposed on ambulatory surgical centers beginning in fiscal year 2009-10 as part of Act 28.

Level I Adult Trauma Centers. Act 2 authorized DHS to make an annual payment not to exceed $8 million, beginning in state fiscal year 2009-10, to hospitals in the state that satisfy the criteria established by the American College of Surgeons for classification as a Level I adult trauma center. This payment is to be funded by proceeds of the hospital assessment established under Act 2, and by federal MA matching funds. UW Hospital and Clinics and Froedert Memorial Lutheran Hospital are currently the only hospitals in the state that meet the criteria for this payment. Act 2 also authorized DHS to make an additional payment of up to $3 million to UW Hospital and Clinics, beginning in 2009-10, for care that is not otherwise compensated.

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.

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 age 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. 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 $750,000 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 hospitals 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). The final settlement is based on the hospital's reimbursable costs, which is 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, 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 non-CAH 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. Physician 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), which can apply to primary care, dental, and mental health service providers. 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.

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, although they may be subject to applicable prior authorization requirements.

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

enrollees. For services other than RHC services that are nonetheless covered by MA, RHCs are eligible for MA fee-for-service reimbursement. There are currently 52 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. There are currently 16 FQHCs in Wisconsin.

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.

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 a home health agency, by an agency under contract with the home health agency, or they may be independent providers under contract with the home health agency. A therapy evaluation must be completed before a therapy plan of care is provided for the recipient.

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

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. These services supplement the care families and other health professionals are able to provide. Only home health agencies that meet Medicare conditions of participation and independent nurses may provide these services. All providers must receive prior authorization before providing these services to MA recipients.

Private duty nursing services to recipients authorized for private party duty nursing may include respiratory care services that are provided within the scope of nursing practice.

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 that 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. In some counties, the county contracts with an HMO to provide common carrier services, in which case the HMO generally bills the county for the services, and the county submits a reimbursement claim to the state MA program. In counties with this arrangement, common carrier costs have been treated as MA administrative costs, rather than MA benefit expenditures, and as such have been eligible for the lower federal matching rate (50%) associated with administrative costs. In Milwaukee County, DHS contracts directly with HMOs to provide common carrier services, and DHS reimburses those HMOs for common carrier services in the monthly capitation rates which are eligible for federal matching funds at the higher FMAP rate.

As part of Act 28, DHS was directed to hire an entity to serve as an MA transportation manager, the goal being to realize savings in the program. The proposal seeks to achieve those savings in two ways. First, it is expected that the transportation manager will increase efficiency and reduce fraud in the delivery of SMV services to MA recipients. Second, it is anticipated that through better report-

ing capabilities, the transportation manager will enable the state to claim all common carrier costs as MA benefit expenditures, rather than MA administrative costs. DHS expects the transportation manager selected through the RFP process to begin providing services to the MA program on July 1, 2011.

Chiropractor Services. The MA program covers manual manipulations of the spine to treat a suluxation (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 described in Appendix 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. Wisconsin administrative rule DHS 107.13 sets forth in detail the range of services covered by these aspects of the program, as well as the prior authorization requirements and other applicable limitations.

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.

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 regularly updates its own MAC list 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 ge-

neric 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.

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 7 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 at least 65 years of age, 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-3 program; (i) children with asthma; (j) individuals infected with tuberculosis; (k) women age 45 through age 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 psychologist, where appropriate. Parental consent is required in order for a child to receive the special education and related services defined in an IEP.

Separate parental consent is not required, however, in order for the school-based services provider to seek reimbursement from the state's MA program.

Schools provide the 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 -- WAIVER PROGRAMS

Introduction

Wisconsin's MA program offers home-and community-based long-term care services to qualifying individuals over the age of 65 and people with physical and developmental disabilities. Since the state has been able to offer these services by requesting CMS to waive provisions of federal law, the programs under which these services are provided are commonly referred to as the state's "waiver" programs.

This chapter provides a description of the state's various fee-for-service home- and community-based waiver programs. Chapter 5 provides a description of the state's Family Care and other related managed care programs.

Wisconsin operates six 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. Adults with developmental disabilities 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 (PDD-NOS), are provided within the CLTS waivers. Finally, 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.

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.

Under the community-based waiver provisions of federal MA law, states may offer medical and support services to certain groups of MA recipients. In particular, community-based waiver services are designed to provide a cost-effective alternative to institutional care that may not otherwise be available to MA recipients. For example, medical support and social services generally excluded from traditional 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 5 to this paper provides a list of long-term care services currently available under the various home and community based programs.

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 through the

current fee-for-service programs 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 in the next chapter) 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 the Family Care benefit, which may include these services..

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

Non-Financial Criteria. Individuals must meet nursing home level of care requirements in order to qualify for the state's long-term care waiver programs. 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, as described in Chapter 2, are also applicable to the MA home- and community-based waiver programs. For instance, states may provide nursing home and MA waiver services to individuals with income between 100% to 300% of the applicable 2010 SSI payment level (up to $2,022 per month in 2010). 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 2010, under the MA waiver programs, the personal needs allowance ranges from $854 to $2,022 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 these costs.

Funding

DHS allocates the funding budgeted for each waiver program to participating counties on a calendar year basis. Counties in which the Family Care benefit is available do not receive funding allocations for waiver services. The state contributions are supplemented with federal matching funds. In 2009-10, the state and federal responsibility for MA funding allocations (not including the enhanced federal matching funds provided as part of the federal economic stimulus package) was approximately 40 percent and 60 percent, respectively. Counties may also obtain additional federal MA matching funds for waiver-covered services supported by county funds. Appendix 6 lists the calendar year 2010 county allocations of GPR funding budgeted for these various MA waiver services and services funded under COP.

The rest of this chapter describes each of the 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 funding to finance the services in the community. If the CIP IA participant dies, the county retains the CIP IA funding to support 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.

Prior to 2009-10, DHS provided counties a maximum average per day allowance. These per diem amounts are shown in Table 10. Beginning fiscal year 2009-10, the state provides the funding needed to meet the individual's care plan in the community.

Table 10: Rates for CIPs IA Regular Slots Prior to 2009-10

Per Diem Amounts	From:	To:
$125.00	Prior to	7/1/1995
153.00	7/1/1995	6/30/1997
184.00	7/1/1997	6/30/2000
190.00	7/1/2000	6/30/2001
200.00	7/1/2001	6/30/2002
225.00	7/1/2002	6/30/2003
325.00	7/1/2003	6/30/2004
325.00	7/1/2004	6/30/2009

For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed with federal matching funds for approximately 60% of the excess costs, as long as overall expenditures for these services are below the maximum permitted under the waiver.

As of December 31, 2009, there were 833 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 2009-10, 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 $198 per day in 2010). 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.

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, 2009, there were 7,215 individuals participating in the CIP IB program.

ICF-MR Restructuring Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-MR. In addition, the act transferred from the state to counties the responsibility for the nonfederal 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.

Individuals at a developmental disability level of care are the target population for the restructuring initiative. From January 1, 2005 to June 30, 2009, 653 individuals at a developmental disability level of care had been successfully relocated from ICFs-MR and nursing homes, other than state centers, 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 calendar year 2010, 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 individual care 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.

2005 Act 25 originally limited the number of individuals that could receive an enhanced reimbursement rate to 150 individuals, but allowed 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. 2009 Act 277 removed this statutory cap, thereby giving DHS greater discretion to pro-

vide an enhanced reimbursement rate for a greater number of individuals within the total MA funding appropriated by the Legislature.

At the end of calendar year 2009, 3,663 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 calendar year 2010, 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. Currently, a total of 217 state funded slots are 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 calendar year 2009, 215 individuals received services under the 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 2010, the child's income not exceed $2,022 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. 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 2010. Total funding is then determined by multiplying the total number of approved slots by the current reimbursement rate. In 2009-10, funding was sufficient for an average monthly number of 806 waiver slots.

Once funding has been allocated, counties then have the authority to serve as many individuals as available funds will allow. As shown in Table 11, as of June 30, 2010, 4,582 children were enrolled in the CLTS waiver program. An additional 2,663 children were on the CLTS waiting list, including 269 waiting for intensive in-home treatment and on-going services.

Table 11: CLTS Waiver Enrollment as of June 30, 2010

	Enrollment	Waiting List
Autism Services	2,288	269
Other CLTS Services	2,294	2,394
Total	4,582	2,663

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 June 30, 2010, approximately 889 children were receiving intensive in-home treatment services, while 1,399 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 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.

As of December 31, 2009, there were 3,814 individuals enrolled in the COP waiver program.

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 an 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 2010, DHS used $38,172 as the average six-month cost of nursing home care for adults and $162,607 for children.

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 $45.8 million GPR expended for COP services in calendar year 2009, counties expended

$4.7 million to provide services to waiver participants that are not covered under the MA waiver programs, $13.3 million for individuals not eligible for the MA waiver program, $24.3 million to support locally-matched CIP IB slots and waiver costs in excess of the state maximum reimbursement rate for MA waiver programs, and $3.6 million to support assessments, case plans, and other expenditures. Statewide, per person COP spending cannot exceed the average per person GPR cost of nursing home care. In calendar year 2010, per person per month COP spending cannot exceed $1,620.84.

The number of individuals eligible for COP funding often exceeds available funding for the program, creating the need to maintain waiting lists. Table 12 presents information on the number of individuals on waiting lists for COP services in each year from 1996 through 2009. Of the 5,246 individuals on waiting lists as of December 31, 2009, 99 (1.9%) were residing in an institution, 3,594 (68.5%) were receiving no public long-term care funding, and 1,553 (29.6%) were receiving some public long-term care funding but not COP or waiver funding. While the expansion of Family Care has reduced waiting lists for MA home and community-based long-term care services, the waiting list for COP services continued to increase.

Table 12: 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
2008	10,321
2009	5,246

*As of December 31 of each year.
**The Family Care benefit became available in five counties in 2001 and broader expansion began in 2007. Information after 2000 only includes non-Family Care counties.

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 13 presents statewide information on the number of people served in each COP client group on December 31, 2009, 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 13: Total Number of Person Served with COP and COP-W Funds by Disability Group (December 31, 2009)

	Number	Actual Percent	"Significant Numbers" Percentages
Elderly*	1,975	33.3%	57.0%
Developmentally disabled	1,958	33.0	14.0
Physically disabled	1,071	18.0	6.6
Seriously mentally ill	924	15.6	6.6
Chemically dependent and others	6	0.1	0.0
Total	5,934	100.0%	84.2%

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

Restricted Use of COP Funds for CIP I. Another policy was established in 2004 limiting the amount of COP funds counties can use as the non-federal share for CIP I waiver participants. Under this policy, counties can use up to 25% of their COP funding for CIP I matching. Counties that were using more than 25% of their COP funding for CIP I match in 2003 are able to maintain but not exceed funding CIP I at their 2003 levels.

CHAPTER 5

FAMILY CARE AND RELATED PROGRAMS

Introduction

Under the Family Care program, managed care organizations (MCOs) provide long-term care services to three target populations of MA recipients--elderly individuals, individuals with developmental disabilities, and individuals with physical disabilities. Although the program is not yet operating in all Wisconsin counties, the program has expanded to additional areas of the state during the past several years, replacing the MA waiver programs that formerly provided community-based long-term care services to these populations. In counties where the Family Care benefit is offered, individuals that do not wish to enroll in Family Care have the option of participating in the state's self-directed supports long-term care program, called IRIS, which is the fee-for-service alternative to Family Care.

Eligibility

Individuals must meet functional and financial eligibility standards to enroll in Family Care. An individual who meets these standards is entitled to receive Family Care services no later than 36 months after the Family Care benefit becomes available in the county.

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:

- 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, or assistance or supervision; or

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

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

Financial Eligibility. Individuals must meet certain financial criteria, including an asset and income test. The asset limit is $2,000 for an individual and $3,000 for a married couple. The income limit is based on an individual's countable income and may not exceed $758 per month ($1,143 for married couples) for individuals that are deemed categorically needy or $592 per month for individuals that are deemed medically needy.

Provisions of MA law relating to eligibility for

institutional care are also applicable to the Family Care program. For example, an individual is financially eligible for Family Care if his or her income is no greater than 300% of the applicable SSI payment level (up to $2,022 per month in 2010). The same spousal impoverishment protections also apply to spouses that receive services through the Family Care program. Further, individuals receiving services through the Family Care program may retain a greater amount of income for rent, food, and other living expenses under the personal needs allowance. In 2010, the personal needs allowance ranges from $854 to $2,022 per month. Table 14 shows the current financial eligibility thresholds applicable to individuals qualifying for the Family Care program.

Table 14: Financial Eligibility Thresholds

	Maximum Income		Asset Test	
	Individual	Married	Individual	Married
Categorically Needy	$758	$1,143	$2,000	$3,000
Medically Needy	592	592	2,000	3,000
Institutional	2,022	2,022	2,000	3,000

Aging and Disability Resource Centers (ADRCs)

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

The contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating ADRCs. State funding to support ADRCs is allocated based on the estimated size of the population served in each area and estimates of the amount of time required to carry out the ADRC functions. If actual costs exceed this limit, the ADRC is responsible for those costs. The current funding model DHS uses provides $487,300 per 1% of the population residing in the county where an ADRC is located. DHS provides funding to support ADRCs on a calendar year basis. Because ADRCs provide services to, and respond to, inquiries from individuals and their families regardless of MA eligibility, federal cost sharing for their operation is limited to the amount that can be documented as supporting services for MA-eligible individuals. Currently, DHS estimates that approximately 28% of ADRC expenditures are eligible for federal MA administrative matching funds.

Table 15 shows funding amounts allocated to ADRCs and the amount budgeted in Act 28 (the 2009-11 biennial budget act) for ADRC operations. As of June 30, 2010, 57 counties and two tribes were being served by an ADRC.

Table 15: State Funding Allocations for ADRCs
Fiscal Years 2003-04 through 2010-11

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	Act 28 Budgeted 2010-11
GPR	$8,774,600	$8,774,300	$8,768,600	$8,768,600	$8,830,300	$22,607,000	$29,173,900	$32,239,600
FED	1,859,200	2,235,800	2,117,100	4,188,000	4,733,200	10,399,100	11,140,000	12,385,000
Total	$10,633,800	$11,010,100	$10,885,700	$12,956,600	$13,563,500	$33,006,100	$40,313,900	$44,624,600

Managed Care Organizations (MCOs)

Long-term care services available through the Family Care program are provided by MCOs, which receive monthly capitation payments to support these services. Individuals who enroll in MCOs to receive the Family Care benefit have access to a broad range of services, including services provided under the other MA home- and community-based waiver programs, long-term care MA card services, and nursing home services. Appendix 7 lists the MA waiver services currently available to individuals receiving the Family Care benefit. Table 16 shows the ten Family Care services with the highest expenditure levels in calendar year 2009. In addition to long-term care services, card services that may be provided through the MCO include (but are not limited to) care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit.

Table 16: Family Care Service Expenditures Calendar Year 2009

Service	Expenditures	Percent of Expenditures
CBRF, AFH, RCAC	$345,775,054	43.6%
Supportive Home Care	119,281,116	15.0
Case Management	98,434,248	12.4
Nursing Home/ICF-MR	62,202,910	7.8
Home Health/Skilled Nursing	28,470,942	3.6
Day Center Services Treatment	23,717,558	3.0
Pre-Vocational/Sheltered Workshop	23,421,531	2.9
Transportation	21,147,617	2.7
Equipment and Supplies	17,645,399	2.2
Adult Day Care	11,902,123	1.5
All Other Services	41,968,659	5.3
Total	$793,967,159	

Each MCO develops and manages a comprehensive network of long-term care services and supports, either through contracts with providers, or by providing care directly through its employees. MCOs contract directly with DHS. 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 an ADRC in establishing an ADRC. Regardless of the type of entity, however, all MCOs must ensure the following:

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

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

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

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

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

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

ciated with variation in acuity. Current federal law requires all capitation rates paid by the state to MCOs be actuarially sound. Capitation rates are reviewed and updated annually by DHS and are also reviewed by an independent third party, PricewaterhouseCoopers, LLP, to ensure that all calculated rates are actuarially sound, as required under federal MA law. Table 17 shows the calendar year 2010 capitation rates paid to MCOs participating in the Family Care program. Capitation rates vary based on MCO and region. These regions and the service areas for each MCO, as of August 1, 2010, are shown in Appendix 8.

Table 17: MCO Capitation Rates -- Calendar Year 2010

MCO	Nursing Home Rate	Non-Nursing Home Rate
Creative Care Options of Fond du Lac County	$2,627.26	$672.17
Western Wisconsin Cares	2,783.16	626.79
Milwaukee County Department on Aging	2,689.44	665.06
Community Care of Central Wisconsin	3,040.86	655.41
Southwest Family Care Alliance	2,885.37	681.08
Community Care, Inc. (Kenosha/Racine)	3,225.14	641.96
Community Care, Inc. (Milwaukee)	3,542.05	641.96
Community Care, Inc. (Teal Region)	3,113.71	641.96
Community Care, Inc. (Pink Region)	3,481.36	641.96
Care Wisconsin	3,305.44	672.17
Community Health Partnership	3,391.34	672.17
Northern Bridges	3,087.75	672.17

Table 18 shows the historical funding amounts for capitation rates paid to MCOs and the amount budgeted in 2009 Act 28.

During the first five years Family Care services are available in a county, the county's' contributions to the costs of the program can decrease, based on a formula established in 2007 Wisconsin Act 20. This provision specifies that the county's contribution is reduced to the lower of its base amount (defined as the actual amount spent to provide long-term care services in calendar year 2006) or 22% of its calendar year 2006 basic community aid. Appendix 9 shows how the required county contributions changes for each county during the first five years the county participates in the program.

Statewide Expansion. 2007 Wisconsin Act 20 authorized DHS to expand the Family Care program statewide, in all counties that choose to participate in the program. Current law requires DHS to notify the Joint Committee on Finance, under a 14-day passive review process, if DHS proposes to contract with entities to administer the Family Care benefit in geographic areas in which, in the aggregate, resides more than 29 percent of the state population that is eligible for the Family Care benefit. Since the benefit is currently available to more than 29 percent of the state population that is eligible, DHS submits all proposed expansions to the Joint Committee on Finance. Among the items DHS must submit prior to contracting with an MCO is an "estimate of the fiscal impact of the proposed addition that demonstrates that the addition will be cost neutral, including startup, transitional and ongoing operational costs and of any proposed county contribution." 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.

Appendix 10 lists each ADRC and the counties

Table 18: Family Care Benefit Expenditures -- Payments to MCOs Fiscal Year 2004-05 through 2010-11

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	Act 28 Budgeted 2010-11
GPR	$75,920,900	$102,517,600	$116,288,100	$135,766,300	$182,453,600	$223,149,600	$447,005,300
FED	98,387,900	133,142,300	150,094,400	184,894,900	373,595,900	628,912,800	942,258,300
PR	0	0	0	5,753,600	27,724,600	42,249,300	62,795,800
Total	$174.308.800	$235.659.900	$266.382.500	$326.414.800	$583.774.100	$894.311.700	$1.452.059.400

the ADRC serves.

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

During the expansion process, MCOs enroll participants in the current home and community-based waiver programs first, followed by individuals on waiting lists for these services, individuals supported by MA in the community who may have unmet long-term care needs, and individuals who are not currently enrolled in MA. MA-eligible individuals receiving institutional care who choose to relocate to the community may enroll in Family Care at any time because the MA costs to support an individual in the community are generally less than the costs in an institution. Contracts between the MCO and DHS include specific ceilings on the number of individuals an MCO may enroll during the initial expansion of Family Care into a county. As a result, MCOs are not permitted to exceed the enrollment projections prepared by DHS.

Funding for the expansion of the Family Care program is supported with: (a) additional state and federal MA funding provided as part of the state budget process; (b) reallocations of base funds that support MA fee-for-service payments and MA waiver services; and (c) county funds, including community aids and revenue from the county tax levy. In the short-run, Family Care expansion generally results in cost savings to the state. These program savings reflect the impact of a gradual phase-in of enrollment, collection of county contributions, and projected savings that accrue from providing long-term care services to individuals through managed car, rather than on a fee-for-service basis.

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

DHS is also charged with establishing regional long-term care advisory committees to fulfill the following duties:

- Evaluate the performance of MCOs and ADRCs in the region;

- Monitor grievances and appeals to MCOs;

- Review utilization of long-term care services;

- Identify any gaps in services and develop strategies to address them;

- Annually report to DHS on significant achievements and problems.

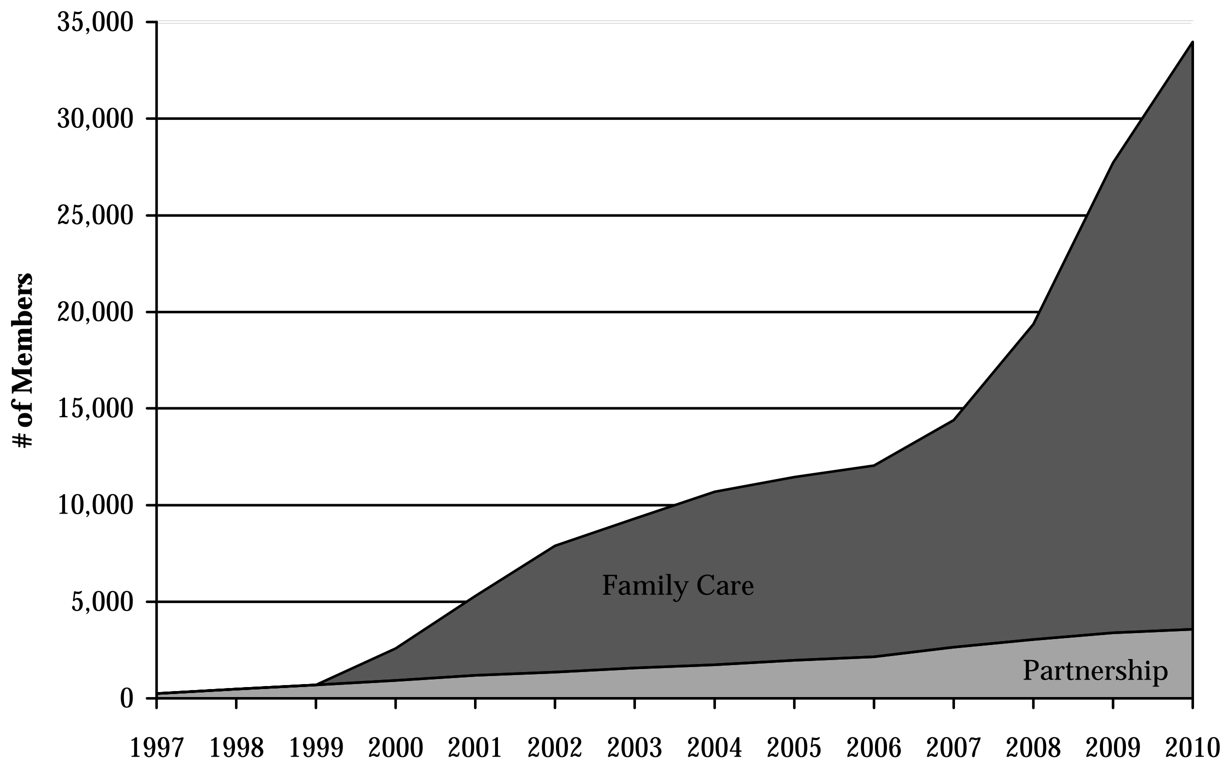
Family Care Expansion and Enrollment

1999 Wisconsin Act 9 initiated the Family Care benefit in five pilot counties. Fond du Lac, La Crosse, Milwaukee, and Portage Counties began offering Family Care in 2000. Richland County began in 2001. Enrollment in these five counties increased from approximately 4,107 participants in 2001 to 9,478 participants by 2006. As of August 2010, 55 counties offered Family Care with a total of 30,397 enrollees. Table 19 and Chart 1 show the growth in Family Care enrollment from 1997 to 2010.

Table 19: Wisconsin Family Care and Partnership Program (Number of Members Enrolled as of September 30 of Each Year)

	Partnership	Family Care	Number of Counties
1997	252		
1998	482		
1999	689		
2000	917	1,676	4
2001	1,188	4,107	5
2002	1,352	6,537	5
2003	1,563	7,746	5
2004	1,745	8,946	5
2005	1,977	9,478	5
2006	2,159	9,897	5
2007	2,657	11,738	7
2008	3,052	16,310	28
2009	3,393	24,324	51
2010	3,635	30,963	55

Chart 1: Wisconsin Family Care and Partnership Enrollment (1997 to 2010)



PACE/Family Care Partnership Program

The state offers two additional long-term care managed care programs besides Family Care. The program for all-inclusive care for the elderly (PACE) and the Family Care partnership (FCP) 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 limited to elderly individuals, ages 55 and older, while both elderly and disabled individuals may enroll in FCP. These voluntary programs are available to people that are eligible for both MA and Medicare (dual eligibles).

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' home, 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 attempt to retain the client's current primary physician by recruiting that physician to the FCP network. Finally, as noted above, PACE programs serve only elderly individuals, while the FCP also serves individuals with developmental and physical disabilities.

There are currently two PACE sites (Community Care Health Plan (CCHP) in Milwaukee and Waukesha), and eighteen counties with FCP services provided by four different providers: (a) CCHP in Kenosha, Milwaukee, Racine, Outagamie, Ozaukee, Washington, Waukesha, and Waupaca Counties; (b) Care Wisconsin in Columbia, Dane, Dodge, Jefferson, and Sauk Counties; (c) Independent Care, Inc. in Milwaukee County, and (d) Partnership Health Plan (PHP) in Chippewa, Dunn, Eau Claire, Pierce, and St. Croix Counties.

Similar to the Family Care program, the state's MA program makes capitation payments to PACE and Partnership MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on an individuals' level of functional eligibility, labor costs and administrative costs. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services. Table 20 lists the calendar year 2010 MA capitation rates paid to MCOs participating in the PACE and Family Care Partnership programs. Table 21 shows Partnership and PACE service expenditures in calendar year 2009.

Table 20: PACE and Family Care Partnership Monthly Capitation Rates -- Calendar Year 2010

MCO	2010 Capitation Rate
Community Care Health Plan: PACE	$2,957.54
Community Care Health Plan: FCP Milwaukee	3,089.13
Community Care Health Plan: FCP Racine/Kenosha/Ozaukee/Washington/Waukesha	3,233.60
Community Care Health Plan: FCP Calumet/Outagamie/Waupaca	3,377.88
Partnership Health Plan	3,638.02
Care Wisconsin	3,202.90
iCare	3,150.52

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

As a condition for federal authority to expand the Family Care managed care program statewide, 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 a 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

Table 21: Long-Term Care and Acute Care Service Expenditures in Family Care Partnership and PACE in 2009

	Expenditures	% of Total
Long-Term Care Services		
Case Management	$37,292,432	16.9%
Nursing Home/ICF-MR	17,189,700	7.8
CBRF, AFH, GH	16,883,790	7.6
Personal Care	15,484,508	7.0
Other LTC Services	14,353,600	6.5
Equipment and Supplies	8,336,684	3.8
Transportation	8,233,918	3.7
Adult Day Care/Day Center	5,262,906	2.4
Supportive Home Care	5,125,121	2.3
Home Health/Skilled Nursing	2,576,712	1.2
Meals	1,082,064	0.5
Consumer Directed Supports	152,431	0.1
Recreational Activities	208,500	0.1
Respite	192,406	0.1
Total LTC Services	$132,374,772	59.9%
Acute Care Services		
Inpatient Hospital	$25,341,867	11.5%
Medications	24,003,418	10.9
E&M Care (Office calls, NH, Hospital Visits)	17,420,928	7.9
Physician/other Medical Services	9,710,460	4.4
Physician Surgery	4,019,500	1.8
Physician Radiology	2,388,020	1.1
Dental	2,029,293	0.9
Physician Pathology and Lab	1,615,912	0.7
MH and AODA Outpatient Therapy	1,087,016	0.5
Nutrition Intervention	616,160	0.3
Anesthesia	277,575	0.1
ER	235,818	0.1
Total Acute Care Services	$88,745,967	40.1%
Total Acute & LTC Services	$221,120,739	100.0%

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 ensure 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 assists 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 not as broad as the services provided through the Family Care program. Like Family Care, IRIS covers home- and community-based waiver services, but unlike Family Care, IRIS does not cover MA long-term card services, such as therapies, personal care, and nursing home care. IRIS 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 be: (a) designed to meet the participant's functional, vocational, medical or social needs and also advances the desired outcomes specified in the individual service plan; (b) documented in the individual service plan; (c) not prohibited by federal and state statutes; and (d) 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: (a) maintain or increase the participant's safety in the home or community environment; (b) decrease or prevent increased dependence on other MA-funded service: (c) maintain or increase the participant's functioning related to the disability; or (d) 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 on 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 approved by the ICA, the person may use funds from his/her individual budget to obtain the services needed on a fee-for-service basis. Individuals receiving IRIS services may reside, on a short-term basis, in any living arrangement, such as a CBRF, adult family home or a RCAC, 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. 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. Table 22 shows the ten largest types of IRIS services costs in calendar year 2009.

Table 22: Ten Highest IRIS Service Expenditures in 2009

Service	Expenditures	Percent of Expenditures
Supportive Home Care	$6,838,751	55.4%
CBRF, AFH, RCAC	1,023,847	8.3
Customized Goods and Services	974,418	7.9
Respite Care	696,040	5.6
Day Center Services Treatment	498,066	4.0
Transportation	499,734	4.0
Equipment and Supplies	392,766	3.2
Counseling and Therapeutic Resources	243,710	2.0
Home Modifications	251,852	2.0
Prevocational	234,010	1.9
All Other Services	685,978	5.7
Total	$12,339,171	100.0%

CHAPTER 6

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, HP (formerly EDS). The rest are provided either by other private entities such as PriceWaterhouse Coopers (PwC), Public Consulting Group (PCG), Automated Health Systems, Inc. (AHS), and Deloitte, or by state agencies such as the Department of Administration's Division of Hearings and Appeals, and Division of Enterprise Technology.

In 2009-10, DHS spent approximately $110.8 million ($47.2 million GPR and $63.6 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 23 summarizes those contracting costs by funding source. Note that Table 23 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 23: MA and FoodShare Administrative Costs, Fiscal Year 2009-10

	GPR	FED	Total
Fiscal Agent Services	$13,853,100	$28,323,600	$42,176,700
Enrollment Services Ctr. & Enrollment Broker	5,818,300	5,804,600	11,622,900
Major External Contracts	1,327,200	1,832,900	3,160,100
Inter- and Intra-agency	2,632,600	3,268,300	5,900,900
FoodShare (EBT)	1,293,700	1,293,700	2,587,400
CARES	21,945,500	22,892,100	44,837,500
Other Payments	300,100	193,400	493,500
Total	$47,170,500	$63,608,600	$110,779,100

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, member and provider enrollment, reviewing prior authorization requests, pharmacy services, customer service, federal and state reporting, program integrity requirements, coordination of benefits, managed care enrollment, and developing and supporting information systems. The contractual arrangement with HP, established in 2008, consists of a monthly flat fee for Medicaid management information systems services and base fiscal agent services. In 2009-10, that flat fee totaled $31 million (all funds). Additional services provided by HP that have been added to the base contract since 2008 are billed separately. Those services include, but are not limited to, pharmacy benefit manager activities, employer verification of health insurance coverage of program applicants, prior authorization services,

HMO contract monitoring, and MMIS system changes and supports required to implement the Department's ForwardHealth Rate Reform initiatives and several changes in federal law. Combined, reimbursement to HP for providing these additional services totaled approximately $11.2 million (all funds).

Beginning October 1, 2010, HP also performs all of the contracted services related to the Department's Enrollment Services Center (ESC). Prior to that date, ESC activities were performed by AHS. The ESC was developed as part of the state's BadgerCare Plus Core Plan expansion, and it performs all application processing, customer service, and maintenance activities for the FoodShare, BadgerCare Plus Core, and BadgerCare Plus Basic plans for adults without dependent children statewide. By performing these duties, the ESC reduces the workload demands on the counties' income maintenance agencies.

AHS currently serves as the Department's HMO enrollment broker, which encompasses 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 2009-10, costs associated with the ESC and the HMO enrollment broker totaled $11.6 million (all funds).

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

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 2009-10, DHS paid MetaStar approximately $1.3 million (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.

PwC provides actuarial services to the state's MA program and related programs. In 2009-10, DHS paid PwC $687,000 (all funds) for those services.

PCG provides a range of revenue maximization and consulting services to DHS, particularly in the areas of rate-setting for MA service providers, maximization of recovery, collections, federal revenue and cost avoidance activities. In 2009-10, DHS paid PCG $864,400 (all funds) for these and other services.

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, FoodShare, and SSI administrative hearings conducted by the Department of Administration's Division of Hearings and Appeals. In 2009-10, DHS paid that Division approximately $2,105,400 (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 2009-10, DHS incurred costs of approximately $1,528,400 (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 determina-

tions 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 92% of CARES cases in 2009-10. 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 hardware hosting, network, and mainframe 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. Total CARES-related costs in 2009-10 were approximately $49.2 million (all funds). DHS supported the majority of those costs ($44.8 million) due to the preponderance of DHS-administered programs that utilize the system. A substantial portion of the total CARES-related expenditures ($16.0 million) was paid to Deloitte for programming, analysis, and maintenance tasks of the CARES system. An additional $25.7 million (all funds) was paid to DET for computer hardware and network-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 (TJC) for determining whether an institution meets most program requirements. In Wisconsin, TJC surveys most hospitals and DHS survey activity is limited to: (a) a sample to validate the reviews by TJC; (b) investigation of violations of program requirements; and (c) initial surveys of those hospitals that are not surveyed by TJC; and (d) investigation of complaints by citizens, the media, and others.

For Wisconsin nursing homes and assisted living facilities, the Division of Quality Assurance in DHS performs 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 resident health, welfare and safety. When a conditional license is issued, a written plan of correction is developed and a time schedule for correcting the deficiencies is established. DHS is also permitted to place a monitor or request the appointment of a receiver for a facility in certain circumstances in order to ensure that adequate care is being provided. When a facility is placed under receivership, DHS assumes the operation of the facility until residents can be relocated to another institutional facility or

to the community.

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

Income Maintenance Administration

Income maintenance (IM) refers to the eligibility determination and management functions associated with several federal and state programs. Under state law, DHS may contract with county human and social service departments 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.

DHS allocates funds to counties and tribes to support these income maintenance activities. This allocation consists of the base income maintenance administrative allocation (IMAA) 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.

Each 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 nearly all do. In 2009, 70 counties and one tribe used local funds to support their IM activities. Appendix 11 lists the total expenditures, by county and tribe, for IM activities in calendar years 2008 and 2009, and the funding sources that supported those expenditures. The indicated amounts include the IMMA as well as several supplemental allocations, including estate recovery amounts distributed to counties. In calendar year 2009, for example, counties and tribes spent approximately $111.8 million to conduct IM activities. Of that total, local funds (provided by the counties and tribes) totaled $26.8 million, with the remaining $85 million funded by a combination of GPR ($29 million) and federal matching funds ($56 million). The FED includes federal funding that is matched to both the state GPR and the local contributions.

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

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

Act 28 provided one-time funding in 2009-10 of $14 million ($7 million GPR and $7 million FED) to DHS to facilitate that transfer of authority. Act 15 obligated Milwaukee County to contribute $2.7 million in 2009 for the operation of IM programs in the county. For each year after 2009, Act 15 requires Milwaukee County to increase its annual contribution by the percentage increase in annual wage and benefit costs paid with respect to county employees performing services in conjunction with the state's administration of those IM activities.

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 2009-10, the Bureau of Health Care Program Integrity within DHS conducted approximately 1085 MA provider audits. Those audits included relatively limited "desk audits," which are generally limited to a single issue, to more intensive audits 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 $3.8 million in 2009-10.

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 2009-10, DHS estimates these efforts enabled the MA program to avoid over $632.8 million in costs, $448.1 million relating to claims where the MA recipient had Medicare coverage, and $184.7 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 2009-10, these post-payment recoveries included recoveries stemming from other health insurance coverage ($7.5 million), subrogation ($6.7 million), medical support liability ($16 million), and other post-payment recoveries ($24.2 million). In addition to these amounts, DHS "estate recovery" activities, discussed in more detail later in this chapter, generated post-payment recoveries of $17.0 million (all funds) in 2009-10.

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 2009-10, provider-based billing COB activities benefited the MA program by approximately $310,000.

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 or hospital. 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 re-

cipient'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. The heir or beneficiary of the deceased member's estate 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 7

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 that portion of the program's benefits for federal matching funds). That original five-year waiver period has since been extended through December 31, 2012.

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 meet 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 2010 FPL by family size.

is met. Note, however, that if the income of the applicant's fiscal test group is 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 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. 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 incomes not greater than 240% of the FPL, and to higher-income participants once they satisfy the "spend-down" requirement described below. While participants are meeting their deductible, DHS keeps a record of their prescription drug purchases and notifies participating pharmacists when the enrollee has satisfied their deductible. Only purchases of prescription drugs covered under the SeniorCare program count towards meeting the participant's 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. Only purchases of prescription drugs covered by the SeniorCare program count towards meeting this 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 an $850 deductible. After that $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 obtain 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 incomes 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 obtain under the program.

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

Level 2b. Individuals with incomes above 200% but not greater than 240% of the FPL are enrolled in SeniorCare Level 2b. These individuals must meet an $850 annual deductible. Once Level 2b participants meet that deductible, they only pay copayments for covered prescription drugs they obtain 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 satisfy their spend-down requirement, then they must meet an $850 annual deductible. Once Level 3 participants meet both those requirements, they only pay co-

payments for covered prescription drugs they obtain under the program.

Table 24 shows SeniorCare's month-end enrollment as of June 2010, by participation level.

Table 24: SeniorCare Enrollment, by Participation Level, June 2010

Level	Enrollment
Level 1 (160% FPL)	40,037
Level 2a (>160% to 200% FPL)	21,158
Level 2b (>200% to 240% FPL)	11,802
Level 3 (>240% FPL)	16,356
Total	89,353

Reimbursement to Pharmacies. As a condition of participating in the state's MA program, pharmacies must also agree to participate in SeniorCare. DHS reimburses pharmacies for drugs acquired by SeniorCare participants 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 reimbursement paid to pharmacies is 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 a dispensing fee. For single-source brand name drugs, that reimbursement rate is typically equal to the average wholesale price (AWP) less 14%, plus a dispensing fee of $3.44. For multi-source brand name drugs and generics, the reimbursement rate is equal to the drug's maximum allowable cost (MAC) plus a dispensing fee of $3.94. 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.

Covered Drugs and Limitations. The list of drugs covered for a SeniorCare recipient depends on whether the recipient's income is 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 for the two groups 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 request 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.

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 the program's GPR and federal MA funding requirements.

Funding. SeniorCare benefits are funded with GPR, federal MA matching funds (for expenditures pertaining to participants with incomes not greater than 200% of the FPL), 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, the program's costs are partially offset by participant cost-sharing and by payments from third parties that are also liable for prescription drug costs for SeniorCare participants, 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 the GPR budgeted for the program, it must continue to accept applications and determine eligibility for program participation and 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.

SeniorCare administrative costs are funded from a combination of program revenue generated by the $30 enrollment fee, GPR, and federal MA

matching funds. In 2009-10, these administrative costs totaled approximately $5.3 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. These Medicare Advantage Plans can also offer additional benefits, including 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 the month they turn 65.

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 2010 is $38.20.

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 "cred-

itable 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 the drugs that are covered and the structure of that coverage. 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 "standard benefit" for 2010 consists of the following elements: (a) an annual deductible of $310; (b) a coinsurance requirement of 25% of the initial coverage limit of $2,830; and (c) 100% catastrophic coverage (subject to copayments of $2.50 for generic drugs and $6.30 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 $4,550. 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 $2,830 (with accompanying out-of-pocket costs of $940) that continues until the enrollee has purchased covered prescription drugs totaling $6,440. During this $3,610 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 standard benefit 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), 48 PDPs provided Medicare Part D coverage to Wisconsin residents in 2010, with the monthly premiums for those plans ranging from $16.80 to $99.80. The weighted average monthly premium for those 48 PDPs was $42.97. In addition, a number of Medicare Advantage plans offering Part D benefits are available to Wisconsin residents. Wisconsin's Office of the Commissioner of Insurance (OCI) prepared a report dated November 2009 entitled Medicare Advantage Plans in Wisconsin, which lists those Medicare Advantage Plans (the list reflects plans that responded to an OCI questionnaire). A copy of that report, which describes the coverage and premiums associated with those various plans, is available at the OCI website, oci.wi.gov. Kaiser reports that as of February 2009, 309,376 Wisconsin residents had creditable prescription drug coverage through standalone PDPs, and an additional 151,356 Wisconsin residents obtained that coverage through MA-PDs.

Low-Income Subsidy. Medicare Part D provides financial assistance to some of its enrollees, with the level of assistance varying depending upon the type of beneficiary and their income and assets. The first category of LIS beneficiaries is full-benefit dual eligibles. These individuals do not pay a Part D premium or a deductible (assuming they enroll in a benchmark plan) and their copayments vary with their income. Those with income at or below 100% of the FPL pay a $1.10 copayment for generic drugs and a $3.30 copayment for brand name drugs, but do not have any copayments after paying annual out-of-pocket drug costs of $4,550. Dual eligibles with income greater than 100% of the FPL pay copayments of $2.50 for generics and $6.30 for brand names, up to the maximum out-of-pocket

limit of $4,550. Full- benefit dual eligibles who are institutionalized do not have any copayments.

The second category of LIS beneficiaries is partial-benefit dual eligibles, which include participants in a Medicare Savings Program and SSI beneficiaries with Medicare but without Medicaid coverage. These individuals do not pay a Part D premium or deductible, again assuming they enroll in a benchmark plan. Their copayments are $2.50/$6.30, up to total annual out-of-pocket drug spending of $4,550, 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 includes non-dual eligibles with incomes less than 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 if they enroll in a benchmark plan, and their copayments are $2.50/$6.30 up to the out-of-pocket threshold of $4,550, beyond which they do not have copayments.

The fourth group of LIS beneficiaries is non-dual eligibles with incomes from 135% to 149% of the FPL and assets below $12,510 (single) or $25,010 (married). These individuals pay a premium based on a sliding scale, and a $63 deductible, after which they pay 15% of their drug costs up to the maximum out-of-pocket threshold of $4,550. Beyond that limit, they face copayments of $2.50/$6.30. 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 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. In state fiscal year 2009-10, the Wisconsin MA program made clawback payments to CMS of approximately $114.9 million.

Medicare Part D and Federal Health Care Reform. As noted, Part D participants currently face a "donut hole" in the program's standard benefit plan for prescription drugs they purchase after they exceed their initial coverage limit ($2,830) but before they reach the program's catastrophic coverage ($6,440). The PPACA includes several provisions intended to gradually phase out that coverage gap. First, in 2010, Part D recipients who are enrolled in a PDP or an MA-PD and whose prescription drug purchases exceed their initial coverage limit are eligible for a $250 rebate, paid directly to them by the Medicare program. Second, beginning in 2011, Part D enrollees will begin to see ever-growing discounts to the brand-name and generic drugs they purchase in the coverage gap, such that by 2020, enrollees will be responsible for 25% of the costs of those drugs (rather than the 100% they are currently responsible for under the Part D standard benefit plan).

SeniorCare Enrollment and Spending Trends

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 late enrollment penalty. Following that initial increase, SeniorCare enrollment has returned to levels more consistent with the program's historical experience. This is reflected in Table 25, which shows SeniorCare enrollment of as June for

Table 25: SeniorCare Fiscal Year-End Enrollment (2004-2010)

2004	90,211
2005	87,088
2006	110,939
2007	97,037
2008	90,014
2009	86,615
2010	89,353

each year during the period 2004 (the program's first full fiscal year ended June 2004) through 2010.

Table 26 shows total benefit expenditures under the SeniorCare program for that same seven-year period. The table shows those expenditures by funding source. The "PR" column in the table reflects the drug manufacturer rebates described earlier in this chapter.

Table 26: SeniorCare Benefit Expenditures, By Funding Source, State Fiscal Years 2003-4 thru 2009-10

	GPR	FED	PR	Total
2003-04	$38,211,000	$41,548,200	$31,178,100	$110,937,300
2004-05	45,383,400	45,062,900	39,351,300	129,797,600
2005-06	44,364,400	45,700,200	50,639,800	140,704,400
2006-07	45,668,300	41,875,500	53,198,000	140,741,800
2007-08	38,797,300	33,476,700	54,780,900	127,054,900
2008-09	33,983,200	50,696,300	40,033,800	124,713,300
2019-10	18,273,100	16,741,000	79,682,300	114,696,400

CHAPTER 8

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

Services provided under the state's MA and MA-related programs are funded primarily with general purpose revenues (GPR) and federal MA matching funds (FED). As Table 1 on page 2 of this paper indicates, GPR (27%) and FED (64%) combined funded approximately 91% of total net MA benefit expenditures during the five state fiscal years 2005-06 through 2009-10. The FED component of the state's overall MA funding portfolio increased significantly in recent years due to the American Recovery and Reinvestment Act of 2009 (ARRA) and related legislation which temporarily increased the state's FMAP from October 1, 2008, through June 30, 2011. For instance, in fiscal year 2009-10, the state's FMAP was slightly over 70%, compared to a more "normal" rate of 60%. Under current law, Wisconsin's FMAP will revert to approximately 60%, beginning July 1, 2011.

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 can 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. Table 27 shows the revenues deposited to and the expenditures made from the MATF during state fiscal years 2008-09, 2009-10, and 2010-11.

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. 2009 Wisconsin Act 28 increased the monthly

Table 27: Medical Assistance Trust Fund (Fiscal Years 2008-09 through 2010-11)

	Actual 2008-09	Actual 2009-10	Projected 2010-11
Beginning Balance	$273,600	$479,700	$497,400
Revenues			
Nursing Home Intergovernmental Transfer	$47,151,300	$56,712,000	$48,884,000
Nursing Home Bed Assessment	42,173,500	72,659,500	80,879,000
Transfer from the Hospital Assessment Fund	154,068,900	202,018,700	203,452,800
Transfer from the Critical Access Hospital Fund	0	0	5,218,700
Ambulatory Surgical Center Assessment	0	15,921,000	16,600,000
Interest	1,275,600	-288,600	-231,600
Additional Federal Matching Dollars under ARRA Related to County-Supported MA Expenditures	0	37,775,400	19,068,600
Required Lapse to General Fund	-8,200,000	-7,021,400	-7,021,400
Hospital CPE/DSH	11,189,100	5,928,700	0
Transfer from Injured Patients Compensation Fund	128,500,000	0	0
Endowment Fund	309,000,000	50,000,000	50,000,000
Transfer from UW Related to UW Physicians Intergovernmental Transfer	15,000,000	23,800,000	25,000,000
HealthCheck Other RCCs	9,744,700	7,000,000	12,800,000
Total Revenues	$709,903,100	$464,505,300	$454,650,100
Expenditures	$709,697,000	$464,487,600	$447,946,000
Ending Balance	$479,700	$497,400	$7,201,500

assessment from $75 in 2007-08 to $150 per month in 2009-10, and to $170 per month in 2010-11. In addition, the state collects a separate bed assessment on all ICF-MR beds in the state. The ICFs-MR assessment 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. Under this formula, the ICF-MR assessment rate per bed increased to $638 in 2008-09, to $701 in 2009-10, and to $770 in 2010-11.

The revenues generated from the nursing home bed assessment are deposited in the MATF. In 2009-10, those revenues totaled approximately $72.7 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. 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 nurs-

ing 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 received in the current fiscal year and generated by the nursing home CPE program in excess of the amount set in the biennial budget. DHS currently distributes these funds, when available, as additional supplemental payments to nursing homes owned and operated by local governments.

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 2009-10, this CPE program generated $5,928,700 in federal matching funds that were deposited to the MATF.

UW Intergovernmental Transfer Program. 2007 Wisconsin Act 20 required 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. Act 28 increased the amount of the required transfers in 2009-10 and 2010-11 to $23,800,000 and $25,000,000, respectively. 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 2009-10, $7.0 million in federal matching funds associated with these costs were deposited into the MATF.

Hospital Assessment. 2009 Wisconsin Act 2 (Act 2) authorized DHS to collect an assessment from most hospitals in the state (several types of hospitals, including critical access hospitals and institutions for mental disease, were excluded from the assessment). The hospital assessment is based on a uniform percentage of each eligible hospital's gross patient revenues. The aggregate amount of each year's assessment is established in statute. Revenues collected from the hospital assessment are initially deposited into the hospital assessment fund, a newly created segregated fund. From that fund, a portion of the assessment revenues (along with federal matching dollars) are used to increase the reimbursement hospitals receive for providing inpatient and outpatient services to MA recipients. The total amount of additional reimbursement hospitals receive through the assessment mechanism, in the aggregate, is also established in statute.

For MA recipients served on a fee-for-service basis, hospitals receive this increased reimbursement directly through the Department's fee-for-service hospital rates. For MA recipients enrolled in managed care organizations, DHS makes monthly "hospital access" payments to each HMO based on how many of their enrollees are MA recipients. The HMO, in turn, is required to distribute 100% of those access payments to eligible hospitals based on the number of inpatient stays and outpatient visits those hospitals provided to the HMO's MA enrollees during the preceding month. Assessment revenues that remain in the hospital assessment fund after DHS makes these additional payments to hospitals and HMOs are transferred to the MATF where they are used to support MA services in general (thereby reducing the amount of GPR that would otherwise be required to fund those services).

Act 2 initially set the total amount of the hospital assessment for 2008-09 at $275,445,100. 2009 Wisconsin Act 28 subsequently increased that amount to $335,945,100. Act 28 also established the hospital assessment levels for 2009-10 and 2010-11 ($378,694,500 and $414,507,300, respectively). Table 28 shows the actual cash flows associated with the hospital assessment for state fiscal years 2008-09 and 2009-10. As the table indicates, timing issues related to the collection and payment of assessment revenues during the final quarter of the state fiscal year push some of those payments into the following state fiscal year.

Critical Access Hospital Assessment. State law defines a critical access hospital (CAH) by referencing federal law, which specifies that a CAH must be located in an area outside of a metropolitan statistical area (or be located in a rural area of an urban county), be located more than a 35-mile drive from another hospital, and maintain no more than a total of 25 beds to be used exclusively for acute inpatient care. Before January 1, 2006, a hospital could also be certified as a CAH if the state designated it as a necessary provider of health care services to residents in the area. While this latter certification is no longer available, hospitals that obtained CAH status by being designated necessary service providers prior to January 1, 2006 can retain their CAH certification even if they do not satisfy the 35-mile distance requirement. There are currently 59 CAHs in Wisconsin.

Act 28 included a provision that required DHS to achieve approximately $630 million in savings (all funds) in the MA program during the 2009-11 biennium. As part of its initial plan to realize those savings, DHS proposed reducing the reimbursement CAHs received for treating MA recipients from 100% of those hospitals' allowable costs to 90% of their allowable costs, and in fact implemented that reduction for the first six months of calendar year 2010. In part to avert that reduction going forward, 2009 Wisconsin Act 190 (Act 190) established a new assessment on CAHs. The revenues generated by the CAH assessment, along with federal matching dollars, are intended to restore (and in some cases, augment) the reimbursement these hospitals receive for serving MA recipients. In addition, a portion of the assessment revenues ($1,000,000) is earmarked to help fund a loan assistance program and a new rural physician residency assistance program administered by the University of Wisconsin.

The CAH assessment created in Act 190 is similar to the mechanism used for the larger hospital assessment, except that the CAH assessment is

Table 28: Use of Hospital Assessment Revenues, SFYs 2008-09 and 2009-10

	Actual 2008-09	Actual 2009-10
Assessment Revenue	$335,945,100	$378,694,500
Assessment Revenues Paid to Hospitals	$165,836,100	$170,611,100
Assessment Revenues Transferred to MATF	154,839,200	203,028,800
Assessment Revenues Paid or Transferred	$320,675,300	$373,639,900
Additional Hospital Payments Required by Act 28 (assess. rev. plus FED)	$581,723,100	$613,966,400
Total Additional Hospital Payments made in 2008-09	$550,767,500	$0
Additional 2008-09 Hospital Payments made in 2009-10	$0	$30,955,600
Additional Hospital Payments made in 2009-10	0	544,708,000
Total Additional Hospital Payments made in SFY 2009-10	$0	$575,663,600
Additional 2009-10 Hospital Payments to be made in 2010-11	$0	$69,258,400

based on gross inpatient revenues (rather than total gross patient revenues) and that the total amount of the CAH assessment is not set in statute, but instead is a function of the uniform percentage used to collect the larger hospital assessment.

In 2010-11, it is estimated that the CAH assessment will generate revenues of approximately $10,579,500, a portion of which, when combined with federal matching funds, will be used to make $17,152,200 in additional MA reimbursement payments to CAHs. The remaining assessment revenues will be used for the UW items or transferred to the MATF to support MA benefit expenditures.

Ambulatory Surgical Center Assessment. Act 28 also established a new assessment on ambulatory surgical centers. Federal regulations define an ambulatory surgical center (ASC) to mean any distinct entity that operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. Those regulations also require, among other things, that the entity have an agreement with the federal Centers for Medicare and Medicaid Services (CMS) to participate in Medicare as an ASC.

Act 28 authorized the Wisconsin Department of Revenue (DOR) to collect an assessment on the gross patient revenues of ASCs located in Wisconsin consistent with federal regulations pertaining to provider assessments (said regulations typically limit provider assessments to 5.5% of the applicable patient revenue stream). In 2009-10, DOR collected and transferred to the MATF approximately $15,921,000 in ASC assessment revenues. That amount is net of a 0.5% allowance to DOR for its costs to collect and administer the assessment. The net ASC assessment revenues transferred to the MATF, along with federal matching dollars, are used to support increased reimbursement to ASCs under the state's MA program and to support other MA benefit expenditures.

Additional Federal Matching Funds Generated by County-Supported MA Services. As noted, ARRA temporarily increased the state's FMAP, thereby generating additional federal matching dollars to support MA service costs. In some instances, counties or other units of local government provide the state share of the costs associated with providing those services. Typically, the state claims federal matching funds stemming from those local expenditures, and in turn disburses all or a portion of those federal dollars back to the local governmental units.

Act 28 contained a provision requiring that with respect to several of those locally-supported MA services, if the services were provided prior to January 1, 2011, the state would retain the additional federal matching funds resulting from ARRA's higher FMAPs (rather than disbursing those dollars to the local governmental unit). Act 28 assumed those additional federal dollars would total approximately $37,775,400 for 2008-09 and 2009-10, and approximately $19.1 million in 2010-11.

Other Assets Transferred to the MATF. Periodically, the Legislature has authorized the transfer of assets from other state funds to the MATF to support MA benefits expenditures. In recent years, this practice has included transfers from the state's general fund ($51,364,200 in 2005-06 and $25,383,900 in 2006-07), the transportation fund ($235,449,000 in 2005-06), the permanent endowment fund ($309 million in 2008-09, and $50 million annually beginning in 2009-10); and (c) the injured patients and families compensation fund ($71,500,000 in 2007-08 and $128,500,000 in 2008-09). Regarding the latter, the Wisconsin Supreme Court ruled in July 2010 that the transfer of assets from the injured patients and families compensation fund to the MATF was an unconstitutional taking of property without just compensation, and remanded the case with instructions to the circuit court to issue an order requiring DOA to replace the transferred assets, together with lost interest and earnings.

Other Revenues Used To Support MA Expenditures

In addition to GPR, FED, and the revenues and other 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 they incur in providing home- and community-based waiver services that exceed their state allocations. In fiscal year 2009-10, counties and tribes contributed approximately $74.2 million under the MA waiver programs (including regular COP funding used for waivers), which generated approximately $111.4 million in additional federal matching funds.

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 2009-10, the federal matching dollars associated with those school-based services and claimed by the state totaled $50.8 million, of which approximately $26 million was distributed to the provider school districts and CESAs, and $24.8 million 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 2009-10, those federal matching dollars (including the dollars generated by ARRA's higher FMAPs) totaled approximately $104.1 million.

Milwaukee County General Assistance Medical Program IGT. Until recently, Milwaukee County provided funds to DHS through an IGT program and the state in turn used those dollars to leverage federal matching funds that were used to help support expenditures made through the county's general assistance medical program (GAMP). With the introduction of the BadgerCare Plus Core Plan in January 2009 (the initial enrollees in which were primarily former GAMP participants), Milwaukee County discontinued its GAMP program. The county has, however, continued to provide funding to the state that is now used to support Core Plan expenditures. In 2009-10, Milwaukee County provided $6,799,400 to the state for that purpose.

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.

Drug Manufacturer Rebates and BadgerCare Plus Premiums. In addition to the revenue sources outlined above, the state 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 6, 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. During the 2007-09 biennium, prescription drug costs for most MA recipients were "carved out" of the capitation rates managed care organizations receive for serving those enrollees. The prescription drug benefit for most MA enrollees is now provided on a fee-for-service. A primary reason DHS instituted this change was because at that time, the state was not eligible for these drug manufacturer rebates if the

benefit was paid through managed care capitation rates. Carving the prescription drug benefit out of capitation rates contributed to the large increase in drug rebate revenues the state received in 2009-10 ($239.6 million) compared to 2008-09 ($164.5 million). These drug rebates are 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 2009-10, those premiums totaled $18.1 million, which were used to offset the GPR and FED required to fund program benefits.

CHAPTER 9

MA EXPENDITURE AND CASELOAD TRENDS

Table 29 provides information on net benefit expenditures under the state MA and MA-related program, by funding source, for the five-year period 2005-06 through 2009-10. The expenditures shown in Table 29 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 29 represent the net costs incurred by the state (by funding source) to provide MA benefits to eligible enrollees. An exception is SeniorCare, where the PR amounts shown in the table do include the drug manufacturer rebates applicable to that program.

The table shows how the relative contributions made by the funding sources that support MA benefit expenditures have changed in recent years. Reliance on segregated revenues (SEG) generally increased as a result of the additional revenues generated by provider assessments (such as the new hospital assessment), and from the transfer of assets from other state funds such as the Injured Patients and Families Compensation Fund and the Permanent Endowment Fund. Federal revenues (FED) also increased in 2008-09 and 2009-10, mainly due to the higher FMAPs provided to states

Table 29: MA/BadgerCare Plus, Family Care, and SeniorCare Net Benefit Expenditures (Fiscal Years 2005-06 through 2009-10)

	2005-06	2006-07	2007-08	2008-09	2009-10
MA/BC +					
GPR	$1,261,825,100	$1,650,195,500	$1,616,972,700	$917,566,400	$1,063,201,000
FED	2,573,309,700	2,624,193,000	2,720,950,000	3,505,183,500	4,047,155,000
PR	7,295,000	9,336,300	39,714,800	36,734,500	24,691,700
SEG	359,935,500	127,253,200	212,060,700	875,533,100	635,098,700
Subtotal	$4,202,365,300	$4,410,978,000	$4,589,698,200	$5,335,017,500	$5,770,146,400
SeniorCare					
GPR	$44,364,400	$45,668,300	$38,797,300	$33,983,200	$18,273,100
FED	45,700,200	41,875,500	33,476,700	50,696,300	16,741,000
PR	50,639,800	53,198,000	54,780,900	40,033,800	79,682,300
Subtotal	$140,704,400	$140,741,800	$127,054,900	$124,713,300	$114,696,400
Family Care					
GPR	$99,657,000	$116,230,100	$139,451,500	$184,929,300	$222,757,100
FED	133,142,300	150,094,400	184,894,900	373,595,900	627,977,100
PR	0	0	5,753,600	27,724,600	42,249,300
Subtotal	$232,799,300	$266,324,500	$330,100,000	$586,249,800	$892,983,500
Total Expenditures					
GPR	$1,405,846,500	$1,812,093,900	$1,795,221,500	$1,136,478,900	$1,304,231,200
FED	2,752,152,200	2,816,162,900	2,939,321,600	3,929,475,700	4,691,873,100
PR	57,934,800	62,534,300	100,249,300	104,492,900	146,623,300
SEG	359,935,500	127,253,200	212,060,700	875,533,100	635,098,700
Total	$4,575,869,000	$4,818,044,300	$5,046,853,100	$6,045,980,600	$6,777,826,300
% Increase Over Prior Year	1.5%	5.3%	4.7%	19.8%	12.1%

under the American Recovery and Reinvestment Act of 2009.

As Table 29 also indicates, MA benefit expenditures increased significantly over the past five years, with the largest increases occurring in 2008-09 and 2009-10. Two major factors contributed to those increases. First, 2009 Wisconsin Act 2 created the aforementioned hospital assessment. As explained in greater detail in Chapter 3, a portion of the revenues generated by that new assessment, along with federal MA matching funds, were used to increase the reimbursement most hospitals received for providing services to MA recipients. In 2008-09 and 2009-10, the additional reimbursement paid to hospitals as a result of that new assessment mechanism was approximately $550.7 million (all funds) and $575.7 million (all funds), respectively.

Second, segments of the MA program have experienced large enrollment increases during the past several years. Those trends are shown in Table 30, which summarizes the average monthly enrollment for various MA and MA-related programs and eligibility groups. In some cases, as with the BadgerCare Plus Core Plan, enrollment grew as a result of the state's decision to expand coverage.

In the case of BadgerCare Plus, the large enrollment increases resulted in part from a program expansion, coupled with simplified enrollment processes and outreach efforts. In December, 2010, the state received a bonus payment of $23.1 million from the federal government under the Children's Health Insurance Program Reauthorization legislation in recognition of the state's efforts to streamline its enrollment and renewal process and by documenting a significant increase in the number of children enrolled in BadgerCare Plus.

The recent economic downturn also contributed to the large increase in BadgerCare Plus enrollment

Table 30: Average Monthly Enrollment By MA and MA-Related Program Groups, by State Fiscal Year

	State Fiscal Year				
	2005-06	2006-07	2007-08	2008-09	2009-10
Family Assistance/BadgerCare Plus*	491,355	491,604	526,865	588,994	686,105
BadgerCare Core Plan	N/A	N/A	N/A	12,398	50,627
EBD Medical Assistance and Limited Benefits Programs					
Full MA Benefits					
SSI and SSI-Related Populations	116,900	115,600	115,509	115,012	115,749
Individuals in Institutions	23,646	22,594	21,636	21,419	21,071
Individuals Enrolled in MA Waiver Programs	19,867	21,136	23,430	27,685	32,647
Individuals Enrolled in the Medical Assistance Purchase Plan (MAPP)	9,545	10,707	12,058	13,458	15,380
All Other EBD Groups	299	341	268	177	220
Subtotal	170,257	170,378	172,900	177,753	185,067
Limited MA Benefits					
Medicare Savings Program	5,542	8,322	10,459	11,964	13,462
Family Planning Waiver Program	56,013	53,925	50,759	47,375	48,460
Senior Care	93,364	104,869	93,559	87,816	87,693
Subtotal	154,919	167,115	154,776	147,154	149,616
Other MA Related Populations	20,586	20,434	21,082	21,808	23,452
Total MA and MA-Related Enrollment	837,117	849,532	875,624	948,107	1,094,866

* BadgerCare Plus began on February 1, 2008. For periods prior to that date, figures reflect enrollment in the programs formerly referred to as Family MA, Healthy Start, and BadgerCare.
Source: DHS Forward Health Website. Actual program enrollment may be slightly greater due to enrollees added retroactively.

through higher unemployment, lower income, and reduced access to employer-sponsored health insurance, all of which are factors in determining eligibility for the program.

Note that beginning in fiscal year 2007-08, the state began the phased-in statewide expansion of the Family Care program. Family Care enrollment is not shown separately in Table 30. Instead, Family Care enrollees are reflected in the enrollment figures for "Individuals in Institutions" or "Individuals Enrolled in MA Waiver Programs."

MA Benefit Expenditures: Managed Care Capitation Payments, Fee-For-Service, and Medicare Payments

As described in preceding chapters, MA recipients receive program benefits either on a fee-for-service basis or through a managed care organization such as an HMO. Table 31 shows total net MA benefit expenditures in 2009-10 broken out as follows: (a) total capitation payments made to the various managed care organizations that serve MA recipients; and (b) the twelve service categories that account for the largest share of fee-for-service expenditures. Note that the expenditure totals for the individual fee-for-service categories reflect only those services that are provided on a fee-for-service basis. They do not reflect the portion of the capitation rates the state pays managed care organizations for delivering those services. For example, all MA recipients who receive MA card services are eligible for inpatient hospital services. In 2009-10, the state paid $486 million (all funds) for inpatient

Table 31: Net MA Benefit Expenditures, Managed Care Capitation Payments and Twelve Largest Fee-For-Service Expenditure Categories, SFY 2009-10

	Expenditures	% of Net Total
Managed Care		
BadgerCare Plus MCO Payments	$1,326,299,900	19.9%
Family Care MCO Payments	894,270,200	13.4
SSI Managed Care MCO Payments	235,112,500	3.5
PACE Partnership MCO Payments	173,151,600	2.6
Childless Adults (does not include FFS costs for Core plan enrollees)	63,133,300	0.9
Wraparound Milwaukee/Children Come First (Dane County)	20,921,000	0.3
Total Managed Care Payments	$2,712,888,500	40.7%
Fee for Service		
FFS Nursing Homes (inc. Vets Homes)	$909,500,300	13.6%
Prescription Drugs	569,213,500	8.5
FFS Inpatient Hospital	486,081,800	7.3
Waivers	350,647,200	5.3
FFS MA Card Home Care	275,096,400	4.1
Medicare	272,926,500	4.1
FFS Physicians/Clinics	209,589,400	3.1
Federal Funds from County-Local Match	182,423,200	2.7
FFS Outpatient Hospital	163,499,200	2.5
FFS DD Centers	148,092,800	2.2
FQHCs	129,118,000	1.9
Clawback (100% GPR)	126,301,400	1.9
Total Fee for Service	$3,822,489,700	57.4%
Total: Cap payments and Top Twelve FFS Categories	$6,535,378,200	98.1%
All Other Expenditures	460,298,800	6.9
Less: Collections, Rebates, Premiums, etc.	-332,547,100	-5.0
Net Total*	$6,663,129,900	100.0%

* Does not Include SeniorCare expenditures

hospital services delivered on a fee-for-service basis. HMO enrollees also received inpatient hospital services. Reimbursement for those inpatient hospital services is embedded in the monthly capitation rates paid to those enrollees' HMOs.

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2010 Federal Poverty Guidelines

Number in Family	100%	133%	150%	185%	200%	240%	300%
Annual							
One	$10,830	$14,404	$16,245	$20,036	$21,660	$25,992	$32,490
Two	14,570	19,378	21,855	26,955	29,140	34,968	43,710
Three	18,310	24,352	27,465	33,874	36,620	43,944	54,930
Four	22,050	29,327	33,075	40,793	44,100	52,920	66,150
Five	25,790	34,301	38,685	47,712	51,580	61,896	77,370
Six	29,530	39,275	44,295	54,631	59,060	70,872	88,590
Seven	33,270	44,249	49,905	61,550	66,540	79,848	99,810
Eight	37,010	49,223	55,515	68,469	74,020	88,824	111,030
Monthly							
One	$903	$1,200	$1,354	$1,670	$1,805	$2,166	$2,708
Two	1,214	1,615	1,821	2,246	2,428	2,914	3,643
Three	1,526	2,029	2,289	2,823	3,052	3,662	4,578
Four	1,838	2,444	2,756	3,399	3,675	4,410	5,513
Five	2,149	2,858	3,224	3,976	4,298	5,158	6,448
Six	2,461	3,273	3,691	4,553	4,922	5,906	7,383
Seven	2,773	3,687	4,159	5,129	5,545	6,654	8,318
Eight	3,084	4,102	4,626	5,706	6,168	7,402	9,253

APPENDIX 2

BadgerCare Plus and Wisconsin Medicaid Covered Services Comparison Chart

The covered services information in the following chart is provided as general information. Providers should refer to their service-specific publications and the Forward Health Online Handbook for detailed information on covered and noncovered services and prior authorizations (PA) information.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.	Coverage of certain surgical and related services. Limited to five visits per enrollment year. $60.00 copayment per service.
Chiropractic	Full Coverage. $0.50 to $3.00 copayment per service.	Full Coverage. $15 copayment per visit.	Full Coverage. $0.50 to $3.00 copayment per service.	Full Coverage. Initial visits and chiropractic manipulative treatments are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. $10.00 copayment per visit.
Dental	Full Coverage. $0.50 to $3.00 copayment per service.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and surgical procedures for pregnant women and children. Coverage limited to $750.00 per enrollment year. A $200.00 deductible applies to all services except preventive and diagnostic. Cost-sharing equal to 50 percent of allowable fee on all services.	Coverage limited to certain emergency services. No copayment.	Coverage limited to certain emergency services. $10.00 copayment per visit.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
		Pregnant women are exempt from deductible and cost-sharing requirements for dental services.		
Disposable Medical Supplies (DMS)	Full Coverage. $0.50 to $3.00 copayment per service and $0.50 per prescription for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DMS). $0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of DMS. $0.50 to $3.00 copayment per service. $0.50 per prescription for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of DMS. Up to $5.00 copayment per priced unit for most DMS. $0.50 per prescription for diabetic supplies do not count towards the member's limit of 10 prescriptions per calendar month.
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Copayments are as follows: • $0.50 for OTC drugs. • $1.50 for generic drugs. • $3.50 for brand name drugs. Copayments are limited to $12.00 per member, per provider, per month. Over-the-counter drugs are excluded from this $12.00 maximum.	Generic-only formulary drug benefit with a few generic OTC drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. $5.00 copayment with no upper limits.	Generic-only formulary drug benefit with a limited number of OTC drugs. Some brand name drugs are covered. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. Up to $4.00 copayment for generic drugs and up to $8.00 for brand name drugs with a $24.00 copayment limit per month, per provider.	Generic-only formulary drug benefit with a limited number of OTC drugs. Humalog, Humalog Mix, Lantus, Tamiflu, and Relenza are the only brand name drugs covered. Prescriptions are limited to 10 per calendar month. There is up to a $5.00 copayment per prescription with no upper limit. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions.
Durable Medical Equipment (DME)	Full coverage. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment.	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants.	Full coverage up to $2,500.00 per enrollment year. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 annual limit.	Full coverage up to $500.00 per enrollment year. Up to $10.00 copayment per item. Copayment for blood glucose meters is $0.50 per prescription. Rental items are not subject to copayment but count toward the $500.00 annual limit.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
		Hearing aid repairs are subject to the $2,500.00 enrollment year limit.		
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.	Full coverage. No copayment.	Full coverage. No copayment.	Full coverage. End-stage renal disease providers who bill ESRD services as an ESRD facility are not subject to the outpatient hospital limits. $10.00 copayment per visit.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. $1.00 copayment per screening for members 18, 19, and 20 years of age.	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. $1.00 copayment per screening for members 18, 19, and 20 years of age.	Not applicable.	Not applicable.
Hearing Services	Full coverage. $0.50 to $3.00 copayment per procedure. No copayment for hearing aid batteries.	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.	No coverage.	No coverage.
Home Care Services (Home Health, Private Duty Nursing PDN], and Personal Care)	Full coverage of PDN, home health, and personal care services. No copayment.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.	Coverage of home health services for 30 days following an inpatient stay if discharge from the hospital is contingent on the provision of follow-up home health services. Coverage is limited to 100 visits within the 30-day post-hospitalization period. No copayment.	No coverage.
Hospice	Full coverage. No copayment.	Full coverage, up to 360 days per lifetime. No copayment.	Full coverage. No copayment.	Full coverage. No copayment.
Inpatient Hospital	Full coverage. $3.00 copayment per day with a $75.00 cap per stay.	Full coverage. Copayments are as follows: • $100.00 stay for medical stays.	Full coverage (not including inpatient psychiatric stays in either an Institute for Mental Disease (IMD) or the psychiatric ward of an acute	Full coverage for the first inpatient stay with authorization (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
		• $50.00 copayment per stay for mental health and/or substance abuse treatment.	care hospital and inpatient substance abuse treatment). $3.00 copayment per day for members with income up to 100 percent of the Federal Poverty Level (FPL) with a $75.00 cap per stay. $100.00 copayment per stay for members with income from 100 percent to 200 percent of the FPL. There is a $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services for all income levels.	care hospital and inpatient stays for transplant services). If the first stay is a transfer, both providers are required to have authorization. Subsequent impatient stays are subject to the $7,500.00 deductible per enrollment year for inpatient and outpatient hospital services (excluding emergency room). Reimbursement for per diem facility stays will be capped at the length of 14 days. Outlier costs are hospital access payments are not included in the reimbursement rate. There is a $100.00 copayment per covered stay for nondeductible impatient hospital stays.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3.00 copayment per service, limited to the first 15 hours of $825.00 of services, whichever comes first, provided per calendar year. Copayment not required when services are provided in a hospital setting.	Coverage of this service is based on the Wisconsin State Employee Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), adult mental health day treatment for adults, substance abuse day treatment, and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program, comprehensive community services, outpatient mental health services in the home and community for adults, community recovery services, and substance abuse residential treatment. $10.00 to $15.00 copayment per visit for all outpatient hospital services: • $10.00 per day for all day treatment services. • $15.00 per visit for narcotic treatment services (no copayment for lab tests).	Coverage limited to services provided by a psychiatrist under the physician services benefits. $0.50 to $3.00 copayment per service, limited $30.00 per provider, per enrollment year.	Coverage limited to services provided by a psychiatrist under the physician services benefit. Certain covered services by psychiatrists are counted toward the combined 10-visit limit. The combined 10-visit limit applies to certain visits provide by the following providers: • Chiropractors. • Nurse practitioners. • optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
		• $15.00 per visit for outpatient mental health diagnostic interview exam, psychotherapy - individual or group (no copayment for electroconvulsive therapy and pharmacological management). • $15.00 per visit for outpatient substance abuse services.		
Nursing Home Services	Full coverage. No copayment.	Full coverage. No copayment.	No coverage.	No coverage.
Outpatient Hospital -- Emergency Room	Full coverage. No copayment.	Full coverage. $60.00 copayment per visit (waived if the member is admitted to a hospital).	Full coverage. No copayment for members with income up to 100 percent of the FPL. $60.00 copayment per visit for members with income from 100 percent to 200 percent of the FPL (waived if the member is admitted to a hospital.	Full coverage, limited to five visits per enrollment year. $60.00 copayment per visit (waived if the member is admitted to a hospital).
Outpatient Hospital	Full coverage. $3.00 copayment per visit.	Full coverage. $15.00 copayment per visit.	Full coverage. Outpatient mental health and substance abuse treatment services are not covered. $3.00 copayment per visit for members with income up to 100 percent of the FPL. $15.00 copayment per visit for members with income from the 100 percent to 200 percent of the FPL. $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services for all income levels.	Full coverage for the first five outpatient non-emergency room visits with authorization. Subsequent visits covered after the first five outpatient visits are subject to the $7,500.00 deductible per enrollment year for inpatient and outpatient hospital services (excluding emergency room). After the deductible is reached, full coverage of outpatient hospital services. Payment will not include outliers. There is a $60.00 copayment per visit for nondeductible visits.
Physical Therapy (PT), Occupational Therapy, and	Full coverage. $0.50 to $3.00 copayment per service.	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment	Full coverage, limited to 20 visits per therapy discipline, per enrollment year.	Full coverage, limited to 10 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
Speech and Language Pathology (SLP)	Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).	year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.	(Cardiac rehabilitation visits count towards the 20-visit limit for PT.) $0.50 to $3.00 copayment per service. Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one enrollment year (copayment limits calculated separately for each discipline).	towards the 10-visit limit for PT.) $10.00 copayment per visit.
Physician	Full coverage, including laboratory and radiology. $0.50-$3.00 copayment per service, limited to $30.00 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $0.50-$3.00 copayment per service, limited to $30.00 per provider per enrollment year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology although certain visits are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. Transplants and transplant-related services are not covered. Provider-administered drugs are not covered. There is a $10.00 copayment per visit.
Podiatry	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year.	Full coverage. $15.00 copayment per visit.	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per enrollment year.	Full coverage, although certain visits are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • optometrists.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
				• Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. There is a $10.00 copayment per visit.
Prenatal/ Maternity Care	Full coverage, including Prenatal Care Coordination (PNCC), and preventative mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Full coverage, including PNCC, and preventative mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Not applicable.	Not applicable.
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver (FPW).	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver (FPW).
Routine Vision	Full coverage including coverage of eyeglasses. $0.50 to $3.00 copayment per service.	One eye exam per enrollment year, with refraction. $15.00 copayment per visit.	No coverage.	No coverage.
Transportation - - Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $2.00 copayment for non-emergency ambulance trips. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.	Coverage limited to emergency transportation by ambulance. No copayment.	Coverage limited to emergency transportation by ambulance. No copayment.

Note: The covered services information in this chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services and PA information.

APPENDIX 3

SSI Managed Care Enrollment by County for FY 2009-10

County	MA Only	Dual Eligibles	Total Enrollment	Total Capitation Payments
Ashland	52	2	54	$347,893
Bayfield	18	1	19	144,434
Brown	1,212	196	1,408	8,721,990
Buffalo	24	9	33	141,681
Burnett	33	1	34	226,462
Calumet	69	16	85	502,006
Clark	63	8	71	345,625
Columbia	53	6	59	323,669
Crawford	28	6	34	181,747
Dodge	13	3	16	83,966
Douglas	165	5	170	1,138,339
Fond du Lac	267	54	321	1,917,672
Grant	105	6	111	649,937
Green	46	4	50	316,877
Green Lake	58	7	65	373,013
Iowa	29	2	31	190,355
Jackson	58	14	72	358,723
Jefferson	82	8	90	486,791
Juneau	94	8	102	556,064
Kenosha	813	265	1,078	6,403,825
Kewaunee	15	2	17	102,261
La Crosse	363	89	452	2,271,920
Lafayette	27	2	29	159,232
Langlade	109	16	125	806,851
Lincoln	54	2	56	352,320
Manitowoc	237	39	276	1,630,637
Marathon	405	42	447	2,891,408
Marquette	37	7	44	241,055
Milwaukee	13,069	4,995	18,064	129,890,363
Monroe	137	27	164	837,231
Oconto	140	24	164	970,597
Oneida	87	4	91	562,283
Outagamie	528	100	628	3,578,900
Ozaukee	69	15	84	498,461
Pepin	4	1	5	26,593
Polk	31	1	32	217,686
Portage	69	3	72	428,750
Racine	1,012	230	1,242	7,764,010
Richland	46	2	48	290,774
Rock	414	77	491	2,771,214

APPENDIX 3 (continued)

SSI Managed Care Enrollment by County for FY 2009-10

County	MA Only	Dual Eligibles	Total Enrollment	Total Capitation Payments
St. Croix	29	1	30	$203,478
Sauk	71	4	75	430,001
Sawyer	28	1	29	189,627
Shawano	144	22	166	1,136,738
Sheboygan	420	49	469	3,345,655
Taylor	29	6	35	200,296
Trempealeau	55	11	66	308,896
Vernon	71	7	78	396,178
Vilas	38	3	41	259,548
Walworth	45	3	48	347,104
Washburn	51	2	53	375,764
Washington	167	33	200	1,271,402
Waukesha	524	172	696	3,967,097
Waupaca	175	25	200	1,218,085
Waushara	110	16	126	684,605
Winnebago	602	116	718	4,297,314
Wood	182	20	202	1,038,646
Menominee	1	0	1	596
Total	22,853	6,764	29,617	$199,403,887

APPENDIX 4

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

County	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
Barron	$0	$35,639	$225,257	$260,279	$348,911	$598,184	$485,346
Brown	1,159,618	1,584,938	962,382	804,579	494,862	647,647	582,588
Calumet	338,918	496,508	456,671	447,481	216,588	158,825	52,546
Clark	1,602,784	1,787,467	1,120,334	1,125,853	1,272,522	1,823,697	1,561,458
Columbia	944,514	760,766	566,934	603,726	741,026	1,023,601	833,273
Dane	915,877	1,108,725	700,298	697,231	855,541	1,253,381	1,017,664
Dodge	2,267,534	2,734,072	1,563,848	1,488,884	1,709,935	2,292,131	1,718,519
Dunn	1,418,132	1,276,169	895,958	882,931	918,271	982,599	704,314
Eau Claire				17,049	1,015	3,582	
Fond du Lac	1,458,460	1,723,733	1,139,941	1,018,463	898,647	1,238,415	923,610
Grant	533,468	1,281,742	827,053	790,945	917,578	1,139,872	1,087,818
Green	974,966	984,850	699,604	717,589	795,798	1,156,187	979,785
Iowa	590,888	370,286	290,820	340,945	411,509	570,524	435,304
Jackson	997,124	884,744	543,457	455,537			
Jefferson	1,015,589	1,282,639	723,478	741,174	796,109	1,158,965	867,407
Kenosha	1,137,460	1,159,677	651,378	725,604	811,833	1,123,651	827,184
Kewaunee	84,873	67,173	261,032	295,982	333,245	380,127	296,933
La Crosse	2,768,550	3,006,042	2,117,188	1,751,103	1,828,967	2,417,384	1,965,088
Lafayette	687,182	619,180	416,067	395,067	473,761	606,255	504,372
Lincoln	1,191,191	877,628	1,032,199	1,083,243	1,283,228	1,465,296	1,492,934
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	3,019,262	2,258,168
Milwaukee	1,218,707	1,219,772	1,144,149	1,140,820	1,136,977	1,541,768	1,232,672
Monroe	878,946	821,846	538,753	547,835	648,926	882,558	728,585
Outagamie	1,506,765	1,980,000	1,259,592	1,193,131	1,320,029	1,853,282	1,435,187
Ozaukee	1,506,765	1,548,583	998,739	1,111,116	1,305,978	1,874,013	1,472,522
Pierce	89,529	162,035	154,381	106,938	164,577		25,643
Polk	842,016	854,788	549,689	560,325	696,721	728,594	649,033
Portage	844,949	836,565	492,949	346,628	400,742	542,501	403,143
Racine	1,551,082	1,885,074	1,210,116	1,238,156	1,331,906	1,844,600	1,335,015
Richland	667,515	713,451	488,345	334,617	386,994	477,630	425,270
Rock	1,429,499	1,941,618	1,145,300	1,170,524	1,093,437	1,475,410	1,175,353
Rusk	686,908	772,113	537,860	451,291	400,635	497,011	439,249
Sauk	982,352	1,033,120	677,396	618,526	619,700	746,160	683,674
Shawano	556,289	365,965	618,474	617,319	560,244	797,170	439,278
Sheboygan	3,896,457	4,066,825	2,461,374	2,478,267	973,903	1,312,031	1,147,909
St. Croix	706,752	746,024	552,553	511,910	562,763	554,238	501,170
Trempealeau	855,227	1,023,548	865,164	918,976	962,257	967,021	611,485
Vernon	613,127	620,841	600,448	725,904	728,982	832,976	746,216
Walworth	1,835,734	2,202,321	1,102,493	839,634	901,400	1,243,172	946,052
Washington	1,684,032	1,665,383	1,077,785	1,098,709	1,180,160	1,463,916	1,259,687
Waupaca	607,836	763,275	446,113	428,018	344,421	422,459	336,820
Winnebago	1,765,279	2,159,490	1,411,333	1,435,220	1,456,339	1,816,266	1,433,872
Wood	1,144,846	1,250,062	858,311	921,773	984,634	1,265,049	972,953
Subtotal	$49,429,209	$54,773,148	$37,100,000	$36,260,867	$36,107,923	$46,197,409	$36,995,100
Family Care Awards	$670,791	$0	$0	$839,133	$992,077	$1,200,000	$1,104,900
Total Payments	$50,100,000	$54,773,148	$37,100,000	$37,100,000	$37,100,000	$47,397,409	$38,100,000

APPENDIX 5

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 6

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2010

County	COP	COP-W	CIP II	CIP 1A	CIP 1B	BIW
Adams	$275,891	$179,393	$352,053	$150,358	$64,761	$52,153
Ashland	22,348	0	0	0	0	0
Barron	123,994	0	0	0	0	0
Bayfield	39,613	0	0	0	0	0
Brown	2,503,851	1,878,382	2,955,457	1,339,022	6,262,055	104,305
Buffalo	71,440	0	0	0	0	0
Burnett	54,475	0	0	0	0	0
Calumet	264,793	0	0	0	0	0
Chippewa	101,918	0	0	0	0	0
Clark	183,133	0	0	0	0	0
Columbia	118,514	0	0	0	0	0
Crawford	113,766	0	0	0	0	0
Dane	5,089,229	2,982,870	3,499,230	2,104,418	2,659,237	443,298
Dodge	95,539	0	0	0	0	0
Door	226,178	131,006	368,293	109,955	311,722	52,153
Douglas	110,247	0	0	0	0	0
Dunn	88,642	0	0	0	0	0
Eau Claire	548,425	0	0	0	0	0
Florence	85,094	48,703	41,434	18,109	74,135	0
Fond du Lac	558,868	0	0	0	0	0
Forest	185,286	99,272	202,371	0	0	0
Forest-Vilas-Oneida	0	0	0	512,043	1,274,427	130,382
Grant-Iowa	223,333	29,775	35,003	115,843	102,733	25,719
Grant	610,494	81,150	263,521	0	0	0
Green	87,217	0	0	0	0	0
Green Lake	22,443	0	0	0	0	0
Iron	8,730	0	0	0	0	0
Jackson	90,055	0	0	0	0	0
Jefferson	152,115	0	0	0	0	0
Juneau	85,085	0	0	0	0	0
Kewaunee	229,343	231,988	300,874	205,858	133,196	64,416
Kenosha	582,233	0	0	0	0	0
La Crosse	473,532	0	0	0	0	0
Lafayette	12,375	0	0	0	0	0
Langlade	319,045	134,054	196,235	0	0	0
Lincoln-Langlade-Marathon	352,963	0	0	123,978	339,814	78,229
Lincoln's 51.437 Board	0	0	0	451,007	278,378	104,305
Lincoln	245,206	199,908	401,537	0	0	0
Manitowoc	795,328	138,255	603,217	106,663	425,882	32,149
Marinette	479,442	353,420	674,907	200,063	343,753	78,229
Marquette	24,675	0	0	0	0	0
Menominee	154,765	99,103	103,334	0	145,857	0
Milwaukee	3,251,887	948,648	2,603,558	1,999,326	2,553,969	283,482
Monroe	174,167	0	0	0	0	0
Oconto	334,117	178,225	498,921	260,618	208,350	104,305

APPENDIX 6 (continued)

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2010

County	COP	COP-W	CIP II	CIP 1A	CIP 1B	BIW
Oneida	$393,136	$153,094	$558,425	$0	$0	$0
Outagamie	1,287,256	283,243	274,588	332,491	421,194	18,575
Ozaukee	79,565	0	0	0	0	0
Pepin	24,955	0	0	0	0	0
Pierce	115,459	0	0	0	0	0
Polk	178,865	0	0	0	0	0
Portage	208,842	0	0	0	0	0
Price	74,026	0	0	0	0	0
Racine	878,816	0	0	0	0	0
Richland	122,077	0	0	0	0	0
Rock	1,147,567	1,157,597	2,558,739	0	0	0
Rock's 51.437 Board	838,367	0	0	694,304	1,844,003	160,804
Rusk	156,035	0	0	0	0	0
St. Croix	400,758	0	0	0	0	0
Sauk	170,767	0	0	0	0	0
Sawyer	42,849	0	0	0	0	0
Shawano	387,632	493,581	756,691	409,212	596,564	26,076
Sheboygan	251,094	0	0	0	0	0
Taylor	214,550	177,526	238,874	316,557	210,286	52,153
Trempealeau	94,162	0	0	0	0	0
Vernon	34,668	0	0	0	0	0
Vilas	260,686	266,294	577,977	0	0	0
Walworth	226,164	23,240	86,673	22,623	9,529	16,860
Washburn	73,181	0	0	0	0	0
Washington	124,834	0	0	0	0	0
Waukesha	398,581	0	0	0	0	0
Waupaca	600,820	182,853	320,486	116,022	381,896	64,298
Waushara	77,571	0	0	0	0	0
Winnebago	1,685,645	539,688	1,654,432	549,103	477,573	77,157
Wood	175,481	0	0	0	0	0
Total All Counties	$30,294,205	$10,991,268	$20,126,830	$10,137,573	$19,119,314	$1,969,048
Onedia Tribe	$110,302	$79,109	$12,722			
Menominee Tribe	0	0	12,031			
Total Tribes	$110,302	$79,109	$24,753			
Total Counties and Tribes	$30,404,507	$11,070,377	$20,151,583	$10,137,573	$19,119,314	$1,969,048

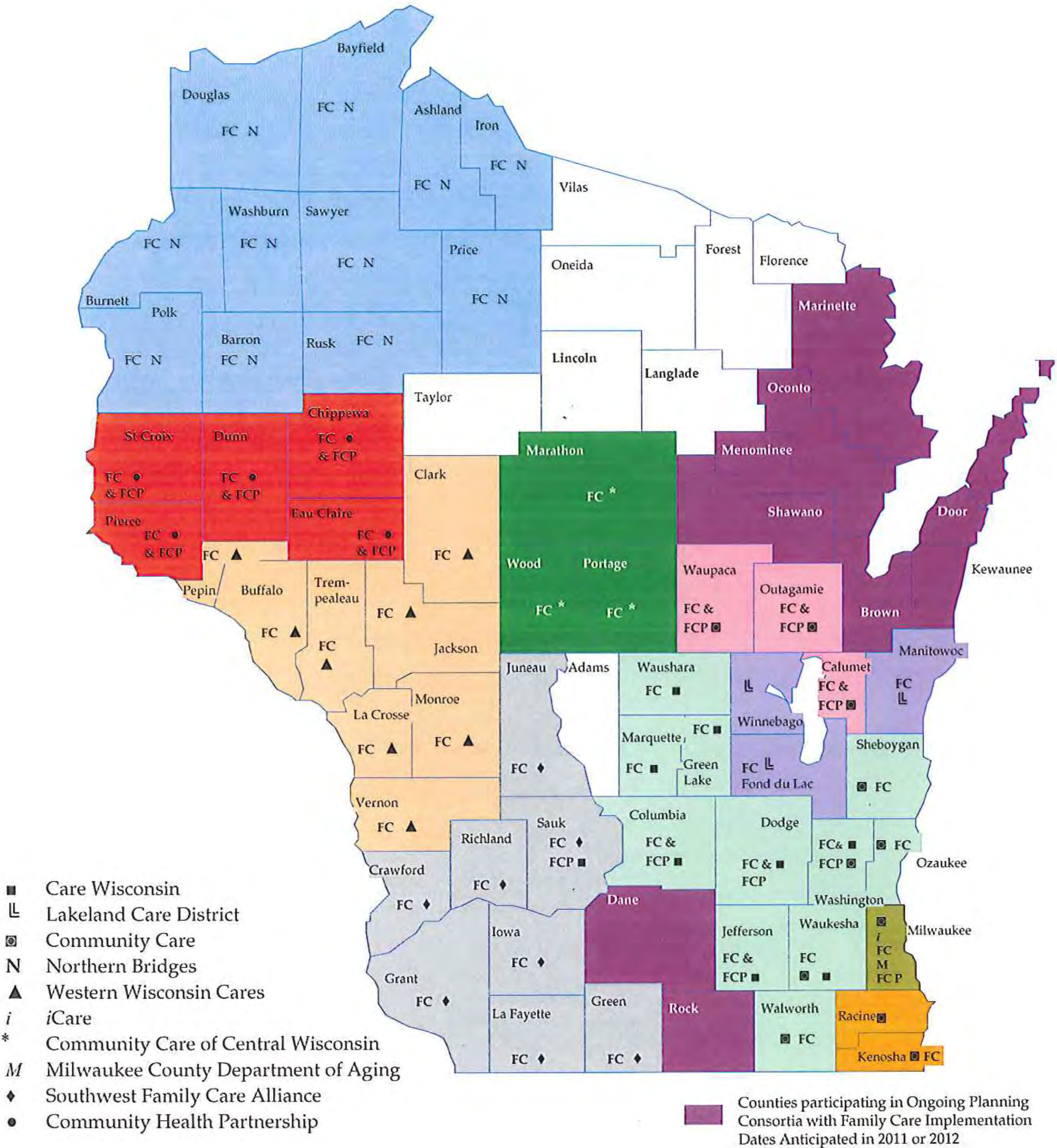
APPENDIX 7

Covered Items and Services under the Family Care Benefit

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings)
- Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Community Support Program
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)
- Home Health
- Home Modifications
- Housing Counseling
- Meals: home delivered
- Medical Supplies
- Mental Health Day Treatment Services (in all settings)
- Mental Health Services, except those provided by a physician or on an inpatient basis
- Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation
- (ICF/MR) and Institution for Mental Disease
- Nursing Services (including respiratory care, intermittent and private duty nursing) and Nursing Services
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System Services
- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Relocation Services
- Residential Services: Certified Residential Care Apartment Complex (RCAC), Community-Based
- Residential Facility (CBRF), Adult Family Home
- Respite Care (for care givers and members in non-institutional and institutional settings)
- Specialized Medical Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except
- Ambulance and transportation by common carrier) and non-Medicaid covered

APPENDIX 8

Family Care County Participation and MCO Regions
August 2010



APPENDIX 9

Family Care County Contributions

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

APPENDIX 9 (continued)

Family Care County Contributions

County	Year 1	Year 2	Year 3	Year 4	Year 5
Milwaukee - Disabled	$8,305,873	$8,305,873	$8,305,873	$8,305,873	$8,305,873
Milwaukee - Elderly	0	0	0	0	0
Monroe	698,862	627,909	556,955	486,001	415,047
Oconto	1,630,558	1,297,842	965,126	632,410	299,694
Oneida	408,381	388,801	369,220	349,639	330,059
Outagamie	2,987,511	2,590,951	2,194,390	1,797,829	1,401,268
Ozaukee	2,190,999	1,787,157	1,383,315	979,473	575,631
Pepin	119,713	119,713	119,713	119,713	119,713
Pierce	334,319	327,681	321,042	314,404	307,765
Polk	610,810	562,210	513,611	465,011	416,412
Portage	0	0	0	0	0
Price	395,635	343,621	291,607	239,594	187,580
Racine	1,106,213	1,106,213	1,106,213	1,106,213	1,106,213
Richland	0	0	0	0	0
Rock	3,559,579	3,176,381	2,793,183	2,409,985	2,026,787
Rusk	366,768	335,435	304,103	272,770	241,438
Sauk	1,274,226	1,083,382	892,537	701,693	510,849
Sawyer	87,961	87,961	87,961	87,961	87,961
Shawano	638,774	569,301	499,829	430,356	360,883
Sheboygan	2,330,950	2,024,301	1,717,652	1,411,003	1,104,354
St. Croix	2,669,902	2,096,428	1,522,954	949,480	376,005
Taylor	160,621	160,621	160,621	160,621	160,621
Trempealeau	481,156	447,178	413,199	379,221	345,242
Vernon	527,913	476,513	425,114	373,714	322,315
Vilas	195,240	194,822	194,403	193,984	193,565
Walworth	1,390,495	1,230,275	1,070,054	909,833	749,612
Washburn	578,294	483,286	388,277	293,268	198,260
Washington	2,713,307	2,226,815	1,740,324	1,253,833	767,341
Waukesha	4,379,582	3,910,841	3,442,100	2,973,359	2,504,618
Waupaca	1,397,312	1,156,849	916,386	675,922	435,459
Waushara	419,444	373,579	327,714	281,848	235,983
Winnebago	5,501,277	4,524,614	3,547,950	2,571,287	1,594,624
Wood	1,096,804	1,024,548	952,293	880,038	807,783
Total	$97,084,091	$84,319,482	$71,554,873	$58,790,263	$46,025,654

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

APPENDIX 10

Family Care Counties by ADRC
As of June 30, 2010

ADRC	County
ADRC of the North	Ashland Bayfield Iron Price Sawyer
ADRC of Barron, Rusk & Washburn Counties	Barron Rusk Washburn
ADRC of Brown County	Brown
ADRC of Buffalo, Clark & Pepin Counties	Buffalo Clark Pepin
ADRC of Northwest Wisconsin	Burnett Polk
ADRC of Calumet, Outagamie & Waupaca Counties	Calumet Outagamie Waupaca
ADRC of Chippewa County	Chippewa
ADRC of Columbia County	Columbia
ADRC of Southwest Wisconsin - North	Crawford Juneau Richland Sauk
ADRC of Dodge County	Dodge
ADRC of Douglas County	Douglas
ADRC of Dunn County	Dunn
ADRC of Eau Claire County	Eau Claire
ADRC of Fond du Lac County	Fond du Lac
ADRC of Forest County	Forest
ADRC of Southwest Wisconsin - South	Grant Green Iowa Lafayette
ADRC of Green Lake, Marquette & Waushara Counties	Green Lake Marquette Waushara
ADRC of Western Wisconsin	Jackson La Crosse Monroe Vernon
ADRC of Jefferson County	Jefferson
ADRC of Kenosha County	Kenosha
ADRC of Manitowoc County	Manitowoc
ADRC of Central Wisconsin	Marathon Wood
Aging Resource Center (ARC) of Milwaukee County	Milwaukee
Disability Resource Center (DRC) of Milwaukee County	Milwaukee
ADRC of Ozaukee County	Ozaukee
ADRC of Pierce County	Pierce
ADRC of Portage County	Portage
ADRC of Racine County	Racine
ADRC of Sheboygan County	Sheboygan
ADRC of St. Croix County	St. Croix
ADRC of Trempealeau County	Trempealeau
Aging & Disability Resource Center of Walworth County	Walworth
ADRC of Washington County	Washington
ADRC of Waukesha County	Waukesha
ADRC of Winnebago County	Winnebago

APPENDIX 11

Income Maintenance (IM) Administrative Allocations and Supplemental Allocations
Calendar Years 2008 and 2009

	CY 2008			CY 2009		
County Name	State and Federal IM Funding	Local IM Funding	Total IM Funding	State and Federal IM Funding	Local IM Funding	Total IM Funding
Adams	$272,183	$5,525	$277,708	$298,261	$5,508	$303,769
Ashland	356,656	18,611	375,267	374,631	10,215	384,846
Barron	834,395	228,214	1,062,609	832,349	183,219	1,015,568
Bayfield	255,209	66,348	321,557	288,037	88,508	376,545
Brown	2,500,376	915,538	3,415,914	2,584,445	796,424	3,380,869
Buffalo	223,874	49,217	273,091	234,839	55,550	290,389
Burnett	321,019	96,210	417,229	333,083	97,595	430,678
Calumet	315,752	103,620	419,372	347,993	111,979	459,972
Chippewa	855,061	264,725	1,119,786	883,520	227,150	1,110,670
Clark	372,993	45,704	418,697	388,562	38,865	427,427
Columbia	638,734	249,258	887,992	710,546	288,404	998,950
Crawford	389,651	173,027	562,678	406,732	180,871	587,603
Dane	4,976,920	2,399,862	7,376,782	4,907,560	2,023,523	6,931,083
Dodge	943,409	356,660	1,300,069	1,041,614	383,979	1,425,593
Door	404,169	179,076	583,245	424,012	175,052	599,064
Douglas	881,206	286,937	1,168,143	909,742	263,538	1,173,280
Dunn	659,592	277,511	937,103	822,289	395,353	1,217,642
Eau Claire	1,479,393	577,768	2,057,161	1,638,308	649,775	2,288,083
Florence	161,189	-	161,189	150,843	0	150,843
Fond du Lac	1,758,544	830,324	2,588,868	1,832,991	854,873	2,687,864
Forest	203,859	36,185	240,044	181,993	3,697	185,690
Grant	517,395	73,154	590,549	547,131	70,617	617,748
Green	394,104	105,628	499,732	412,314	88,906	501,220
Green Lake	225,521	48,115	273,636	265,461	68,681	334,142
Iowa	295,878	114,276	410,154	328,951	120,929	449,880
Iron	212,227	44,271	256,498	229,526	55,240	284,766
Jackson	397,245	157,688	554,933	410,588	157,729	568,317
Jefferson	987,422	444,020	1,431,442	993,134	399,799	1,392,933
Juneau	377,862	100,291	478,153	348,278	48,203	396,481
Kenosha	5,726,262	4,147,607	9,873,869	6,420,248	4,629,856	11,050,104
Kewaunee	188,447	15,608	204,055	223,192	39,898	263,090
La Crosse	1,312,925	122,952	1,435,877	1,337,448	50,159	1,387,607
Lafayette	224,750	56,247	280,997	222,229	40,927	263,156
Langlade	396,278	100,402	496,680	414,084	81,199	495,283
Lincoln	428,148	130,241	558,389	413,067	90,402	503,469

APPENDIX 11 (continued)

Income Maintenance (IM) Administrative Allocations and Supplemental Allocations Calendar Years 2008 and 2009

	CY 2008			CY 2009		
County Name	State and Federal IM Funding	Local IM Funding	Total IM Funding	State and Federal IM Funding	Local IM Funding	Total IM Funding
Manitowoc	$994,444	$353,407	$1,347,851	$1,102,715	$388,855	$1,491,570
Marathon	1,549,976	556,386	2,106,362	1,580,767	477,815	2,058,582
Marinette	851,986	372,021	1,224,007	930,001	408,749	1,338,750
Marquette	247,449	78,917	326,366	340,951	155,552	496,503
Menominee	158,164	0	158,164	176,590	0	176,590
Milwaukee	19,398,363	2,385,488	21,783,851	19,634,814	2,731,698	22,366,512
Monroe	663,051	242,349	905,400	726,960	265,623	992,583
Oconto	476,012	177,782	653,794	464,342	135,729	600,071
Oneida	518,853	102,901	621,754	543,563	90,594	634,157
Outagamie	1,749,055	962,508	2,711,563	1,867,860	990,187	2,858,047
Ozaukee	561,560	276,097	837,657	594,513	282,902	877,415
Pepin	216,703	49,560	266,263	217,324	38,155	255,479
Pierce	392,245	170,550	562,795	471,246	235,058	706,304
Polk	559,814	160,585	720,399	595,441	159,229	754,670
Portage	953,158	298,436	1,251,594	975,500	268,944	1,244,444
Price	353,849	82,084	435,933	351,274	63,595	414,869
Racine	2,936,523	1,153,185	4,089,708	3,055,526	1,020,362	4,075,888
Richland	267,440	9,007	276,447	288,698	8,835	297,533
Rock	2,444,181	803,837	3,248,018	2,649,033	809,406	3,458,439
Rusk	314,285	65,850	380,135	308,772	37,746	346,518
St Croix	651,212	274,688	925,900	682,313	271,503	953,816
Sauk	549,902	75,962	625,864	567,622	45,961	613,583
Sawyer	358,689	74,775	433,464	424,076	109,371	533,447
Shawano	511,836	136,353	648,189	503,939	99,744	603,683
Sheboygan	1,117,970	331,718	1,449,688	1,227,373	358,880	1,586,253
Taylor	335,845	76,981	412,826	345,619	73,708	419,327
Trempealeau	431,707	96,421	528,128	455,066	104,276	559,342
Vernon	402,714	114,137	516,851	479,704	164,856	644,560
Vilas	253,496	70,805	324,301	276,279	75,919	352,198
Walworth	1,108,882	482,768	1,591,650	1,244,246	527,558	1,771,804
Washburn	330,378	96,972	427,350	338,604	81,928	420,532
Washington	958,731	386,813	1,345,544	1,053,523	414,754	1,468,277
Waukesha	2,512,134	1,201,724	3,713,858	2,779,315	1,384,861	4,164,176
Waupaca	883,048	309,705	1,192,753	957,801	340,713	1,298,514
Waushara	420,912	176,149	597,061	462,257	192,982	655,239
Winnebago	1,899,788	801,965	2,701,753	1,976,164	761,831	2,737,995
Wood	1,111,732	353,376	1,465,108	1,252,010	418,113	1,670,123
County Totals	$79,934,735	$26,183,082	$106,117,817	$84,059,802	$26,772,615	$110,832,417

APPENDIX 11 (continued)

Income Maintenance (IM) Administrative Allocations and Supplemental Allocations Calendar Years 2008 and 2009

	CY 2008			CY 2009		
County Name	State and Federal IM Funding	Local IM Funding	Total IM Funding	State and Federal IM Funding	Local IM Funding	Total IM Funding
Bad River	$161,159	$0	$161,159	$156,854	$0	$156,854
Lac du Flambeau	161,814	0	161,814	141,132	0	141,132
Oneida Tribe	234,446	44,569	279,015	161,156	0	161,156
Potawatomi Tribe	98,074	150	98,224	98,086	262	98,348
Red Cliff	160,979	2	160,981	163,195	0	163,195
Sokaogon	98,085	0	98,085	99,727	0	99,727
Stockbridge Munsee	99,600	0	99,600	99,430	0	99430
Tribe Totals	$1,014,157	$44,721	$1,058,878	$919,580	$262	$919,842
Statewide Totals	$80,948,892	$26,227,803	$107,176,695	$84,979,382	$26,772,877	$111,752,259