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

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Introduction

Title XIX of the federal Social Security Act authorizes the U.S. Department of Health and Human Services (DHHS) to provide financial assistance to states to fund health care services for people with limited resources. The program is commonly referred to as medical assistance (MA) or Medicaid. The Department of Health Services (DHS) administers Wisconsin's MA program under a framework of state and federal laws, and in conformity with the state plan it submits to the DHHS Centers for Medicare and Medicaid Services (CMS).

The 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 these federal matching funds. Each state's FMAP is calculated annually under a formula that compares a three-year average of the state's per capita income to national per capita income. In state fiscal year 2012-13, Wisconsin's standard FMAP is approximately 60%, although costs related to certain services and certain enrollees can qualify for higher federal matching rates.

The state also receives federal assistance for MA administrative costs. The typical federal matching rate for these costs is 50%, but as with benefit expenditures, that rate can vary depending upon the nature of the activity.

Wisconsin's MA program has grown more complex over time as the state has opted to provide services and to cover individuals beyond the levels mandated by federal law. These program expansions have been authorized by state legislation and implemented through waiver agreements between the state and DHHS. Examples of current MA-related waiver programs include several home- and community-based long-term care programs (including Family Care), SeniorCare, and the BadgerCare Plus Core Plan.

Despite this multiplicity of subprograms, Wisconsin MA can be viewed in terms of its two primary components. The first, called "EBD MA," provides elderly, blind, and disabled individuals traditional MA services such as physician services, inpatient and outpatient hospital services, and nursing home care. Some EBD MA recipients also receive non-traditional long-term care services under Family Care and other home- and community-based waiver programs. The second primary component of the MA program, BadgerCare Plus, provides coverage to low-income children, their parents, pregnant women, and in the case of the Core Plan, childless adults.

Table 1 shows benefit expenditures under Wisconsin's MA program for fiscal years 2007-08 through 2011-12, by fund source. The expenditure figures in Table 1 incorporate several offsetting items. The largest of these offsetting

items are the rebates received from drug manufacturers whose prescription drugs the program purchases on behalf of MA participants. Once received, those rebates are used to proportionately reduce the amount of GPR and FED needed to fund MA benefit expenditures. The rebates are not classified as PR in Table 1. A similar accounting treatment is applied to amounts collected as a result of provider audits and amounts recovered from other payment sources such as participants' other insurance coverage.

The funding sources for the net MA benefit expenditures shown in Table 1 include state general purpose revenues (GPR), federal MA matching funds (FED), segregated revenues from the MA trust fund, the hospital assessment fund, the critical access hospital fund (SEG), and several program revenue (PR) sources. Several of those PR sources, including contributions counties make to support Family Care, and funds the University of Wisconsin transfers to DHS to support services provided to MA recipients at UW Hospital, are used in lieu of GPR to fund the non-federal share of those MA expenditures. Several other PR sources shown in Table 1, such as amounts the Department obtains through its estate recovery efforts, and premiums paid by certain MA participants, are used to proportionately reduce the GPR and FED otherwise needed to fund MA expenditures in general.

Benefit expenditures for the SeniorCare prescription drug program are shown separately in Table 1. Unlike MA, the SeniorCare expenditures reflect drug manufacturer rebates as PR.

More detailed information about expenditure and enrollment trends in the MA and MA-related programs, including SeniorCare, is provided in subsequent chapters.

Table 1: Net Benefit Expenditures for MA/BC Plus and SeniorCare, by Fund Source Fiscal Years 2007-08 through 2011-12

	2007-08	2008-09	2009-10	2010-11	2011-12
MA/BC Plus					
GPR	$1,756,424,200	$1,102,495,600	$1,285,958,000	$1,446,356,000	$1,863,950,600
FED	2,905,844,900	3,878,779,400	4,675,132,000	4,960,883,300	3,979,299,400
PR	76,391,100	88,044,800	99,959,300	108,010,200	112,650,600
SEG	212,060,700	875,533,100	635,098,700	666,488,300	641,254,500
Total	$4,950,720,900	$5,944,852,900	$6,696,148,000	$7,181,737,800	$6,597,155,100
SeniorCare					
GPR	$38,797,300	$33,983,200	$18,273,100	$20,407,200	$21,200,200
FED	33,476,700	50,696,300	16,741,000	23,130,600	15,382,300
PR	54,780,900	40,033,800	79,682,300	64,348,800	51,614,800
Total	$127,054,900	$124,713,300	$114,696,400	$107,886,600	$88,197,300

CHAPTER 1

BADGERCARE PLUS AND RELATED PROGRAMS

This chapter provides an overview of BadgerCare Plus and several related programs such as the BadgerCare Plus Core Plan, BadgerCare Plus Basic, Well Woman MA, Children Come First, and Wraparound Milwaukee. Additional information about these programs, including comprehensive descriptions of their respective eligibility requirements and benefits, is available at the Department's website, www.dhs.wisconsin.gov, and the BadgerCare Plus eligibility handbook at www.emhandbooks.wi.gov/bcplus/.

BadgerCare Plus -- Eligibility

Subject to the requirements discussed below, the following individuals are eligible for coverage under BadgerCare Plus:

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

To receive services under BadgerCare Plus, individuals from the above groups must satisfy the following non-financial criteria.

First, they must be a Wisconsin resident, a requirement generally satisfied if they are physically present 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. Federal law prescribes the documents states can accept as proof of citizenship or qualified alien status for these purposes. 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. Moreo-

ver, 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 "Crowd-out" Rules

BadgerCare Plus has provisions designed to limit some applicants' eligibility for benefits if they have access to or coverage under employer-sponsored insurance. These "crowd-out" rules (so called because they are intended to reduce the crowding out of employer-based coverage by public coverage) vary depending upon the individual.

For most BadgerCare Plus enrollees, the term "employer-sponsored insurance" for these purposes means health insurance offered by a current employer of an adult family member living in the applicant's household for which the employer pays at least 80% of the premium, or health insurance offered through the Wisconsin state employee health plan. Individuals who have either had past access to, or currently have access to or coverage under such a plan may not be eligible for BadgerCare Plus.

"Past access" refers to situations where a family member could have enrolled in an employer-sponsored plan that was available to them, but did not. In those circumstances, any person in the household who could have been covered under that 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 the plan, or the applicant had coverage under different health insurance.

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

A person who is currently covered by employer-sponsored insurance is not eligible for BadgerCare Plus. In addition, individuals who drop their employer-sponsored coverage (for in-

stance, by voluntarily leaving their job) cannot enroll in BadgerCare Plus for three months thereafter. If a person drops their employer-sponsored coverage but continues to have access to that coverage, they will be subject to the "current access" rules described above.

There are several major exceptions to these "crowd-out" rules. First, they do not generally apply to individuals if their family income is at or below 150% of the federal poverty level (FPL).[1] Second, effective July 1, 2012, they do not apply to children under age one if their family's income is at or below 300% of the FPL, nor do they apply to children ages one through five if their family's income is at or below 185% of the FPL. Third, some groups such as youths exiting out-of-home care are exempt from the "other insurance" rules altogether. Pregnant women are generally exempt from the program's past access, current access, and current coverage rules.

In addition, a different set of crowd-out rules apply to non-pregnant, non-disabled parents and caretakers with family incomes greater than 133% of the FPL. These adults are not eligible for BadgerCare Plus if they had past access to, or have current access to or coverage under employer-sponsored insurance where the employee's share of the premium for employee-only coverage does not exceed 9.5% of family income. The revised crowd-out rules for these adults went into effect July 1, 2012, but only when a new application or program request is submitted, new employment is reported, or a renewal for coverage is submitted. Individuals who participate in BadgerCare Plus through "Transitional MA" (discussed below) are not subject to the program's crowd-out rules, regardless of their income.

DHS implemented these new crowd-out rules for non-pregnant, non-disabled adults by using a process authorized in the 2011-13 biennial budget act (Act 32). That process temporarily allows DHS to implement certain changes to the MA program, even if they conflict with existing MA-related state statutes, provided the changes are approved by the Legislature's Joint Committee on Finance (JFC) and, where necessary, CMS. DHS used this same process to change several other aspects of the program for non-pregnant, non-disabled adults with incomes greater than 133% of the FPL, including premiums and retroactive eligibility.

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 these 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. 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 definition, some income sources are excluded, including all court-ordered support an applicant is obligated to pay for the support or maintenance of another person.

Beginning January 1, 2014, the Patient Protection and Affordable Care Act ("ACA") will require state MA programs to use Modified Adjusted Gross Income, or "MAGI", to determine MA eligibility for most non-elderly, non-disabled

[1] Appendix 1 shows the 2012 FPL by family size and identifies several percentages of the FPL relevant for MA eligibility purposes. The 2013 Poverty Guidelines are expected to be published in the Federal Register in January or February, 2013.

individuals for whom income is an eligibility factor. Under MAGI, states will not be allowed to apply any type of expense, block, or income disregard when determining MA eligibility for these individuals. That contrasts with the current latitude states have to develop their own income-counting rules. In addition, for those individuals whom states will be required to use MAGI, the ACA imposes a 5% income disregard, which, all things being equal, will effectively increase existing income eligibility thresholds by five percentage points. It is difficult at this time to estimate exactly how the ACA's MAGI requirements will impact Wisconsin's MA program beginning January 2014.

Once an applicant's countable income is calculated, the following limits apply when determining if they are eligible for BadgerCare Plus:

- *No Maximum Income Limit*: Children under age 19 and youths exiting out-of-home care are income-eligible at all levels, though children in families with incomes greater than 200% of the FPL may be required to pay premiums.

- *300% of the FPL:* Pregnant women with incomes less than 300% of the FPL are income-eligible for BadgerCare Plus. Pregnant women with higher incomes can also qualify if they meet a deductible equal to the amount by which their income exceeds 300% of the FPL.

- *200% of the FPL:* Parents and caretaker relatives of children under age 19 are income-eligible for BadgerCare Plus if their family income does not exceed 200% of the FPL, though non-pregnant, non-disabled adults with family incomes greater than 133% of the FPL may be required to pay premiums. Parents and caretakers with self-employment income are income-eligible if their family income after deducting depreciation does not exceed 200% of the FPL.

Owing to the manner in which these thresholds are established, some family members might qualify for BadgerCare Plus while others might not. For example, if a family comprised 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 up to 300% of the FPL) are income-eligible, but the father is not.

An exception to these income eligibility thresholds (and to some of the program's other rules) applies to individuals who qualify for Transitional MA. Under Transitional MA (also called "income extensions"), BadgerCare Plus recipients in families with income less than 100% of the FPL remain income eligible for coverage for specified periods if their income increases, even if their higher income would make them ineligible for MA coverage. When the additional income is earned income, the Transitional MA period is twelve months. When the additional income comes from child support the Transitional MA period is four months. Individuals in Transitional MA remain eligible for coverage under the standard plan and are exempt from the program's crowd-out rules. They are also exempt from the program's premium requirements unless they are non-pregnant, non-disabled adults with family incomes greater than 133% of the FPL, in which case they are subject to the same premiums as other BadgerCare Plus parents and caretakers at those income levels.

Special Eligibility Rules

Express Enrollment. BadgerCare Plus has several eligibility rules targeted specifically for pregnant women and children. Through express enrollment (also called presumptive eligibility), pregnant women with family incomes at or below 300% of the FPL and children at the following ages and incomes (less than age one with family incomes at or below 300% of the FPL, ages one through five with family incomes at or below 185% of the FPL, and over age five with family incomes at or below 150% of the FPL) can temporarily enroll in BadgerCare Plus based on a

preliminary eligibility determination. They then have until the last day of the month following the month in which their preliminary eligibility determination was made to apply for BadgerCare Plus. If they apply within that period, their presumptive eligibility continues until a county or state eligibility worker determines whether they are eligible for the program. If they do not apply within that period, their presumptive eligibility ends. During her period of presumptive eligibility, a pregnant woman is eligible for ambulatory prenatal care only. During a child's period of presumptive eligibility, the child is eligible for full benefits under the BadgerCare Plus standard plan.

Pregnant Women. Once a pregnant woman is determined to be eligible for BadgerCare Plus, she retains her eligibility, at a minimum, through the end of the month in which the 60th day after the end of her pregnancy occurs.

Continuously Eligible Newborns. Children whose natural mothers were determined to be eligible for BadgerCare Plus or certain other MA-related programs on the date of delivery remain eligible for BadgerCare Plus from the date they are born through the end of the month in which they turn one year old. During that period, the child receives coverage under the standard plan or the benchmark plan, depending upon which plan the mother was enrolled in at the time of delivery. Continuously eligible newborns are exempt from the program's other insurance crowd-out rules and its citizenship and identity documentation requirements.

Retroactive Eligibility. Under the program's retroactive eligibility rules, pregnant women with family incomes at or below 300% of the FPL and children at the following ages and incomes (less than age one with family incomes at or below 300% of the FPL, between ages one and five with family incomes at or below 185% of the FPL, and over age five with family incomes at or below 150% of the FPL) can obtain coverage for services provided during the three months prior to their application for BadgerCare Plus if they met the program's eligibility requirements during that period. Beginning July 1, 2012, non-pregnant, non-disabled adults are also eligible for retroactive benefits, but only if their family income does not exceed 133% of the FPL. Prior to that date, such adults were eligible for retroactive benefits if their income did not exceed 150% of the FPL.

Premiums

Depending upon their family income and other factors, some individuals are required to pay monthly premiums to obtain coverage under BadgerCare Plus.

Children: Generally speaking, families with incomes greater than 200% of the FPL must pay premiums for their children to participate in the program. Table 2 shows the monthly premiums a family at various income levels must pay for each child enrolled in BadgerCare Plus as of July 1, 2012. For families with incomes at or below 300% of the FPL, total premiums for children in the family are capped at 5% of countable income.

Table 2: BadgerCare Plus Premiums for Children, by Family Income, as of July 1, 2012

Family Income As % of FPL	Monthly $ Premium per Child
200% or Below	$0
>200% to 210%	10
210% to 220%	10
220% to 230%	10
230% to 240%	15
240% to 250%	23
250% to 260%	34
260% to 270%	44
270% to 280%	55
280% to 290%	68
290% to 300%	82
300% or Greater	98

Non-Pregnant, Non-Disabled Adults: Effective July 1, 2012, non-pregnant, non-disabled

adults with family incomes greater than 133% of the FPL must pay premiums under BadgerCare Plus. Prior to that date, such adults paid premiums only if their income exceeded 150% of the FPL. This new requirement also extends to non-pregnant, non-disabled adults with incomes greater than 133% of the FPL in the Core Plan and Transitional MA. Prior to July 1, 2012, Core Plan and Transitional MA participants did not pay premiums. Table 3 shows the revised premiums for these adults in a three-person family at various income levels, as of July 1, 2012. Adults in different-sized families would pay different premiums because the FPL varies with family size. Unlike the individual premiums for children in Table 2, the premiums for adults shown in Table 3 represent the total premiums that would apply, in the aggregate, to all premium-paying adults in the family.

Table 3: Premiums for Non-Pregnant, Non-Disabled Adults in BadgerCare Plus, the Core Plan, and Transitional MA in a Three-Person Family, by Family Income, as of July 1, 2012

Family Income As % of FPL	Monthly Premium For All Adults in the Family as % of Family Income	Monthly $ Premium for All Adults in Family
133% or Below	0.00%	$0
134% to 139%	3.00	63 to 67
140% to 149%	3.50	78 to 84
150% to 159%	4.00	95 to 102
160% to 169%	4.50	115 to 122
170% to 179%	4.90	133 to 141
180% to 189%	5.40	155 to 163
190% to 199%	5.80	175 to 185
200% to 209%	6.30	200 to 210
210% to 219%	6.70	224 to 234
220% to 229%	7.00	245 to 256
230% to 239%	7.40	271 to 282
240% to 249%	7.70	294 to 306
250% to 259%	8.10	322 to 335
260% to 269%	8.30	343 to 356
270% to 279%	8.60	369 to 383
280% to 289%	8.90	396 to 410
290% to 299%	9.20	424 to 439
300% or Greater	9.50	453 and Up

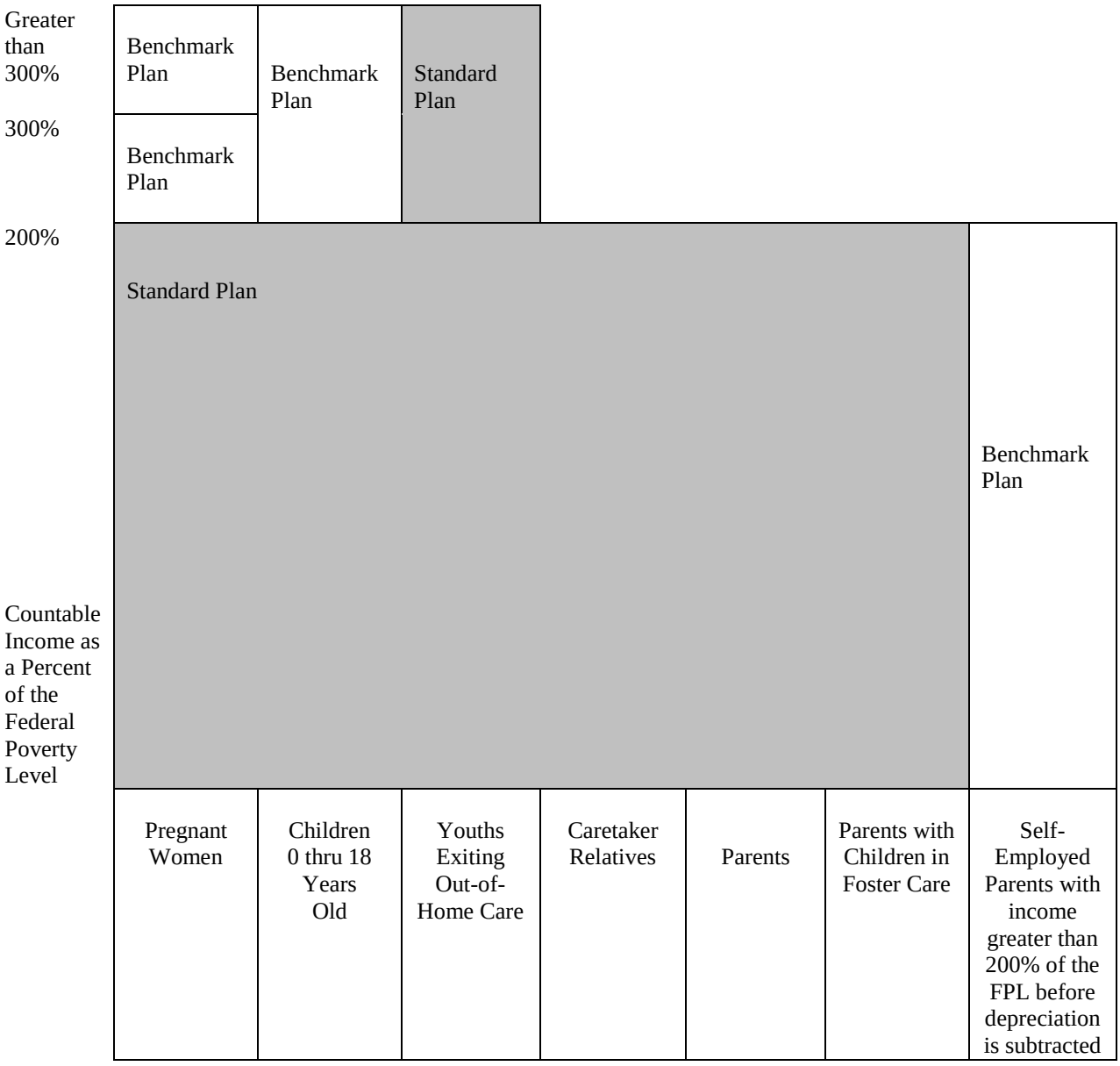
The following people are exempt from having to pay premiums under BadgerCare Plus: (a) children in families with incomes not greater than 200% of the FPL, children in Transitional MA, and children in families with income greater than 200% of the FPL if their parents are in Transitional MA and paying premiums; (b) adults with family incomes not greater than 133% of the FPL; (c) pregnant women; (d) tribal members, children and grandchildren of tribal members, and anyone eligible to receive Indian Health Services; (e) children under one year of age whose mothers were eligible for and receiving medical assistance on the date the child was born; (f) adults enrolled in BadgerCare Plus who are blind or disabled; and (g) youths exiting out-of-home care. Given the scope of these exceptions, a significant majority of BadgerCare Plus participants are not required to pay premiums under current program rules.

Restrictive Re-enrollment Period. BadgerCare Plus participants who fail to pay a premium when due, or who request that their coverage be terminated, are subject to a restrictive re-enrollment period (RRP). During the RRP, the individual cannot re-enroll in BadgerCare Plus. For children the RRP is six months, and for non-pregnant, non-disabled adults with incomes greater than 133% of the FPL the RRP is twelve months (adults with lower incomes do not pay premiums). The RRP does not begin until a 60-day grace period has elapsed, during which the individual can return to good standing by paying premiums that are in arrears. There are several limited "good cause" exceptions for failing to pay a BadgerCare Plus premium.

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

Individuals who satisfy the non-financial and financial requirements outlined above are eligible for benefits under the standard plan or 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

Figure 1: BadgerCare Plus Eligibility and Benefits, by Group



BadgerCare Plus recipients with incomes up to 200% of the FPL, as well as youths exiting out-of-home care at all income levels, receive coverage under the standard plan. In contrast, the benchmark plan serves pregnant women with incomes 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 September 2012, most BadgerCare Plus recipients (approximately 97%) were receiving benefits under the standard plan. That figure does not include participants in the Core Plan or Basic Plan (described below), for whom different, more

limited benefit plans apply.

The services covered by the standard and benchmark plans are described in Chapter 49 of the Wisconsin statutes and the Wisconsin Administrative Rules (DHS 107). They also reflect federal MA law, which requires state MA programs to cover many basic services (such as physician and hospital services), while making coverage of other services optional. In practice, Wisconsin's MA program covers all of those optional services, including prescription drugs, physical therapy, personal care, and chiropractic services.

The various BadgerCare Plus coverage plans also differ with respect to copayments. A copayment is the dollar amount a recipient (as opposed to their insurance plan) is responsible for paying to the provider in exchange for services. Copayments under the standard plan are nominal (typically $0.50 to $3.00 per service, if any), whereas copayments under the other plans can be higher, depending on the service. 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, including children in families with incomes less than 100% of the FPL and most pregnant women, are exempt from the program's copayment requirements. Appendix 2 compares the coverage currently available to MA recipients under the standard plan, benchmark plan, Core Plan, and Basic Plan, as well as the applicable copayments.

Delivery of Health Care Services under BC 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. In a fee-for-service arrangement, members obtain services through MA-certified health care providers who, in turn, submit claims directly to the program and are reimbursed at the fee-for-service rates established by DHS.

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

As indicated, BadgerCare Plus participants enrolled in HMOs receive most of the program's covered services through their HMO and its network of providers. In some cases, however, those HMO enrollees obtain covered services on a fee-for-service basis. For instance, all BadgerCare Plus participants, including those enrolled in HMOs, access the program's prescription drug benefit on a fee-for-service basis.

As of September, 2012, approximately 86% of all BadgerCare Plus participants (including Core Plan participants) were enrolled in one of the 17 HMOs participating in the program throughout the state. In areas where two or more HMOs participate, individuals can be required to enroll in an HMO, though they generally have the option to select their HMO. If the participant does not make a selection, they will be automatically enrolled in an HMO. Under federal law, states typically cannot require MA recipients to enroll in an HMO unless they have a choice of at least two HMOs. CMS has, however, approved an amendment to Wisconsin's MA plan that permits DHS to require certain BadgerCare Plus participants in eligible rural counties to enroll in an HMO even if only one HMO is participating in the program.

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

The contract also identifies the capitation rates DHS pays these HMOs for serving BadgerCare Plus participants. Federal regulations require MA capitation rates to 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. The rates also vary within each region depending upon the member's age, gender, the plan in which they participate, and whether the HMO also provides chiropractic and/or dental services.

Working with its contracted actuary, DHS adjusts BadgerCare Plus capitation rates each calendar year by analyzing prior years' encounter data submitted by the HMOs, pricing that encounter data at the Department's fee-for-service rates, and then making adjustments to reflect projected utilization trends and changes in applicable law and policy. Table 4 shows the calendar year 2012 per member/per month capitation rates in DHS rate regions 1 (North), 2 (Northeast), 3 (West Central), and 4 (Madison and Southwest) for the all-services BadgerCare Plus standard plan. The indicated rates include a 14% administrative component paid to the HMO. Note that for pregnant women, 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. In calendar year 2012 those kick payments ranged from $4,237 in Region 2 to $6,117 in Region 1.

In Regions 1 through 4, the base capitation rates are the same for all HMOs that serve BadgerCare Plus members in that region (subject to certain HMO-specific chronicity adjustments). In Regions 5 and 6 (Southeast Wisconsin including Milwaukee County), the base capitation rates vary slightly among HMOs. This reflects the fact

Table 4: Monthly Capitation Rates for BC Plus Standard Plan (Excluding Maternity-Related Services) DHS Regions 1 Thru 4 Calendar Year 2012

Age Range	Gender	Region 1	Region 2	Region 3	Region 4
Age 0	All	$343.89	$283.83	$289.15	$268.59
Ages 1-5	All	90.77	62.59	74.32	68.20
Ages 6-14	All	76.05	55.49	64.56	64.19
Ages 15-20	Female	146.30	112.24	119.16	110.74
Ages 15-20	Male	98.38	76.32	80.32	82.01
Ages 21-34	Female	209.61	160.19	180.08	167.77
Ages 21-34	Male	138.41	109.10	115.99	117.40
Ages 35-44	Female	248.22	211.03	219.31	210.30
Ages 35-44	Male	170.39	144.37	147.25	141.54
Ages 45 & Over	Female	297.76	271.18	264.03	242.00
Ages 45 & Over	Male	211.33	231.69	205.16	230.78
Maternity Kick Payment		$6,117.43	$4,236.91	$4,777.77	$4,970.31

that the HMOs serving BadgerCare Plus recipients in those regions were selected under a competitive bid process. The resulting contract between DHS and the four selected HMOs (United Healthcare of Wisconsin, Molina Healthcare, 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 HMO contracts for Regions 5 and 6, DHS withholds 3.25% of each HMO's full capitation rate, subject to the HMO meeting performance requirements in such areas as diabetes testing, blood lead testing, childhood immunizations, asthma management, tobacco cessation, emergency department utilization, and dental utilization (in Regions 1 through 4 the current pay-for-performance withhold is 1.5%).

Table 5 shows the monthly capitation rates for the BadgerCare Plus standard plan, by HMO, that were in effect in DHS Regions 5 and 6 in calendar year 2012. Note that while UnitedHealthcare of Wisconsin (UHC) is included among the HMOs in Table 5, that HMO notified DHS that it would no longer serve BadgerCare Plus recipients in Regions 5 and 6 beginning November 1, 2012. At the time of that announcement, UHC was by far the largest BadgerCare Plus HMO in those regions, serving approximately 174,000

Table 5: Monthly Capitation Rates BC Plus Standard Plan (Excluding Maternity Related Services) DHS Regions 5 and 6, Calendar Year 2012

Age Range	Gender	United Healthcare of Wisconsin	Molina	Children's Community Health Plan	Community Connect Health Plan
Region 5					
Age 0	All	$258.71	$260.04	$260.06	$263.68
Ages 1-5	All	63.74	65.08	65.09	68.71
Ages 6-14	All	61.23	62.56	62.57	66.20
Ages 15-20	Female	99.01	100.34	100.35	103.98
Ages 15-20	Male	74.68	76.02	76.03	79.65
Ages 21-34	Female	143.55	144.88	144.89	148.52
Ages 21-34	Male	101.99	103.32	103.33	106.96
Ages 35-44	Female	194.45	195.78	195.79	199.42
Ages 35-44	Male	147.41	148.74	148.75	152.37
Ages 45 & Over	Female	228.09	229.42	229.43	233.06
Ages 45 & Over	Male	190.63	191.96	191.97	195.60
Maternity Kick Payment		$3,804.56	$3,804.56	$3,804.56	$3,804.56
Region 6					
Age 0	All	$313.49	$314.81	$314.82	$318.41
Ages 1-5	All	77.71	79.03	79.04	82.63
Ages 6-14	All	64.04	65.36	65.37	68.96
Ages 15-20	Female	98.67	99.98	99.99	103.59
Ages 15-20	Male	70.08	71.40	71.41	75.00
Ages 21-34	Female	145.23	146.55	146.56	150.15
Ages 21-34	Male	106.34	107.66	107.67	111.26
Ages 35-44	Female	205.95	207.27	207.28	210.87
Ages 35-44	Male	154.46	155.78	155.79	159.38
Ages 45 & Over	Female	286.09	287.41	287.42	291.01
Ages 45 & Over	Male	206.98	208.30	208.31	211.90
Maternity Kick Payment		$4,209.26	$4,209.26	$4,209.26	$4,209.26

BadgerCare Plus participants. As of the date of this paper, DHS indicates that it is working to transition the BadgerCare Plus recipients who had been enrolled with UHC into the remaining HMOs in those regions.

BadgerCare Plus Core Plan

The 2007-09 biennial budget act authorized DHS to request a waiver from CMS to allow the state's MA program to provide services to non-elderly adults who do not have dependent children and whose incomes do not exceed 200% of the FPL. Federal law has traditionally not required state MA programs to cover these individuals, often referred to simply as "childless adults." The resulting waiver program, called the BadgerCare Plus Core Plan, has a more limited benefit package (see Appendix 2), and more rigorous crowd-out rules, than BadgerCare Plus.

DHS began providing services to Core Plan enrollees in January, 2009. Most of the initial participants had previously been enrolled in Milwaukee County's general assistance medical program (GAMP). The Core Plan was expanded statewide in July, 2009.

Demand for the new program quickly exceeded all budget projections and threatened to cause DHS to exceed the budget neutrality limits established in its waiver agreement with CMS. DHS responded by limiting enrollment to applications received on or before October 9, 2009. Core Plan enrollment has since declined dramatically, falling from a peak of 65,300 in January, 2010 to 22,300 by September, 2012. As of January 1, 2013, the Core Plan enrollment cap remained in place.

Until recently, Core Plan enrollees were required to pay only a $60 annual enrollment fee to participate in the program. They were not required to pay premiums. Starting July 1, 2012, non-pregnant, non-disabled Core Plan enrollees with incomes greater than 133% of the FPL must pay premiums comparable to those paid by non-pregnant, non-disabled adults in BadgerCare Plus, as shown in Table 3. The current Core Plan waiver agreement expires on December 31, 2013.

BadgerCare Plus Basic Plan

When DHS capped Core Plan enrollment, it established a waitlist for people who wanted to join that program but had submitted their application after the October 9, 2009 deadline. For these waitlisted individuals, 2009 Wisconsin Act 219 authorized DHS to create the BadgerCare Plus Basic Plan. Under that legislation, people on the waitlist who satisfied all of the Core Plan's eligibility requirements were eligible to enroll in the Basic Plan. The Basic Plan is not a medical assistance program and it is not subject to federal or state MA laws. Moreover, it was intended to be financed wholly by the premiums paid by plan participants (with supplemental funding provided, as needed, through a federal grant).

DHS began providing coverage to Basic Plan participants in July 2010. Monthly premiums were initially set at $130. Enrollment in the program peaked in April 2011 at approximately 6,000 participants.

DHS is required to submit quarterly reports to the Joint Committee on Finance regarding the Basic Plan's financial condition and enrollment. In the report dated April 1, 2011, DHS indicated that program costs were exceeding revenues generated by the $130 monthly premiums. DHS responded by increasing premiums to $200 a month and capping program enrollment. DHS has since increased monthly premiums to $325 while maintaining the enrollment cap. As a result, Basic Plan enrollment had fallen to approximately 1,800 individuals as of September 2012.

Under current law, the Basic Plan terminates on January 1, 2014, meaning the plan cannot pay for services provided after December 31, 2013.

Table 6: Average Monthly Enrollment in BadgerCare Plus, Core, and Basic, Fiscal Year 2011-12

BC Plus Children	477,500
BC Plus Parents/Caretakers	264,200
Pregnant Women	20,800
BC Plus Total	762,500
BC Plus Core Plan	28,900
BC Plus Basic Plan	3,000

Table 6 shows the average monthly enrollment in BadgerCare Plus, as well as the Core and Basic Plans, during fiscal year 2011-12. Additional enrollment and expenditure information for these and the state's other MA-related programs is provided in Chapters 8 and 9.

Other Non-EBD MA Programs

Family Planning Only Services Program. The goal of the family planning only services program is to prevent unplanned pregnancies and sexually transmitted diseases (STDs). Both males and females are eligible for the program if they meet the following criteria: (a) they are a U.S. citizen or have proof of immigration status; (b) they are at least fifteen years old; (c) they are not otherwise receiving services under the BadgerCare Plus standard plan, benchmark plan, or EBD MA; and (d) their family income does not exceed 300% of the FPL. For minors, their parents' income is not counted. The program has an express enrollment feature similar to that available to pregnant women and children under BadgerCare Plus. The family planning only services program, which is now incorporated into the state MA plan, is the successor (with modifications) to the previous family planning waiver program.

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

As of September 2012 there were approximately 72,000 people enrolled in the family planning only services program. In addition, 7,400 Core Plan participants also received family planning services through the program. Expenditures in 2011-12 were $29.8 million, of which approximately 87% were funded with federal matching dollars.

Prenatal Program. Pregnant women who meet the other eligibility requirements for BadgerCare Plus but who do not qualify because they are inmates of public institutions or are non-qualifying immigrants may receive prenatal services under the BadgerCare Plus prenatal program. Covered services include prenatal care, doctor and clinic visits, prescription drugs (including prenatal drugs), labor, and delivery. Coverage under the 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 the pregnancy ends. As of September 2012 there were approximately 1,550 women enrolled in the prenatal program. Total expenditures in 2011-12 were approximately $25.9 million.

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 qualify, these individuals must meet the typical BadgerCare Plus eligibility criteria (except the citizenship and social security number requirements), and their income cannot exceed the following limits:

Pregnant women and newborns up to age 1: 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 begins when the individual first receives treatment for the emergency and ends when the condition is no longer an emergency.

Pregnant women who are non-qualifying immigrants are eligible for emergency services up to one calendar month before their due date, through the end of the calendar month in which the 60th day after the end of her pregnancy occurs. DHS estimates that during 2011-12, the MA program spent approximately $0.6 million on emergency services for these women. 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.

Wisconsin Well Woman 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 only services program, 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 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. There were approximately 880 women enrolled in the program as of September 2012. All-funds expenditures in 2011-12 were $13.8 million, of which approximately 72% were funded with federal matching funds.

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. In calendar year 2012, the state MA program paid a monthly capitation payment of $1,649 per CCF enrollee, with Dane County providing additional funding. In fiscal year 2011-12, average monthly enrollment in CCF was approximately 122 children, and the capitation payments made by the state totaled $2.6 million.

Milwaukee County’s Children and Adolescent Treatment Center operates the WM program. In calendar year 2012, the Wisconsin MA program

paid a monthly capitation rate of $1,979 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 2011-12, average monthly enrollment in the WM program was approximately 853 children, and the capitation payments made by the state totaled $20.0 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 MA, regardless of whether the state receives federal Title IV-E matching funds for their maintenance payments. As of September 2012, approximately 8,260 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 September 2012 there were approximately 9,470 such children enrolled in the MA program.

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 (ACA), which has potentially wide-ranging impacts on private health insurance markets and MA programs in Wisconsin and the rest of the country. The law has been the subject of ongoing political and policy debate. In addition, two of its principal features, the individual insurance mandate and the Medicaid expansion, were the subject of the U.S. Supreme Court's June 2012 decision in *National Federation of Independent Business v. Sebelius (NFIB).*

A comprehensive assessment of the ACA's potential impact hinges in large measure upon state and federal policy decisions that are pending as of the date of this paper. The purpose of the following paragraphs, therefore, is to briefly summarize several of the ACA's major provisions.

Private Insurance Provisions. The ACA 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 ACA also requires states to establish, no later than January 1, 2014, a health benefit exchange that facilitates the purchase of private health plans by individuals and small businesses. If a state does not establish an exchange, or has not made sufficient progress towards doing so by January 1, 2013, the ACA directs the HHS Secretary to establish and operate a federally-facilitated exchange in the state. All health plans sold through an exchange (and all MA benchmark plans) will be required to cover a minimum set of benefits.

On November 16, 2012, Governor Walker announced that Wisconsin would not establish a state-operated exchange under the ACA. As a result, the federal government will establish a federally-facilitated exchange, with coverage starting on January 1, 2014.

The ACA also includes an individual insurance mandate beginning in 2014. That mandate requires most individuals to maintain "minimum essential health insurance coverage" such as private health insurance or coverage under Medicaid. 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 ACA provides premium tax credits for individuals in families with income between 100% and 400% of the FPL. Additional cost-sharing reductions are available for individuals with household incomes below 250% of the FPL. These tax credits and cost-sharing reductions will only be available to individuals who purchase insurance through the state's health benefit exchange.

MA Provisions of the ACA. Among its many MA-related provisions, the ACA stands to impact MA eligibility standards and federal reimbursement rates. Several of the more significant such provisions are described below.

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

There is a limited exception to this MOE requirement for non-pregnant, non-disabled adults whose income exceeds 133% of the FPL. From January 1, 2011, through December 31, 2013, the MOE requirement for these individuals can be waived if a state certifies to DHHS that it has a budget deficit. Governor Walker invoked this limited exception in late 2011. In its acknowledgment of that certification, DHHS indicated that the ACA's MOE requirement would not apply to non-pregnant, non-disabled adults in Wisconsin with incomes greater than 133% of the FPL during the period January 1, 2012, through June 30, 2013, whereupon a new deficit certification would be required. Non-application of the MOE may have set the stage for DHS to eliminate MA coverage for these adults altogether. Instead, the Department and CMS, with JFC approval under the 2011 Act 32 process outlined above, negotiated the more limited changes to the program's crowd-out rules, premiums, restrictive re-enrollment periods, and retroactive eligibility that went into effect July 1, 2012.

Medicaid Expansion. As enacted, the ACA required state MA programs, at the risk of losing their federal MA matching funds, to cover virtually all non-elderly individuals with family incomes up to 133% of the FPL beginning January 1, 2014. This new mandatory eligibility requirement was referred to as the ACA's "Medicaid expansion."

Enhanced FMAP for "Newly Eligible" Individuals. The ACA provides states an enhanced FMAP to help cover the costs of individuals who would be "newly eligible" under the Medicaid expansion. For these purposes, a "newly eligible" individual is a non-pregnant, non-elderly adult who is not entitled to or enrolled for benefits under Medicare Parts A or B, has income not greater than 133% of the FPL, and who, as of December 1, 2009, was not eligible under the state plan or under a waiver of the state plan for full MA benefits, benchmark coverage, or benchmark equivalent coverage, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

For these "newly eligible" individuals, the ACA provides an enhanced FMAP of 100% in 2014 through 2016. From 2017 through 2020, that FMAP gradually declines to 90%, where it remains thereafter. A slightly lower, but still enhanced FMAP is available starting in 2014 for childless adults with incomes not greater than 133% of the FPL in "expansion states" which, on the date of the ACA's enactment, offered certain health benefits coverage to both parents and childless adults whose incomes were at least 100% of the FPL.

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

Other MA Eligibility Changes. The ACA raises the mandatory MA income eligibility threshold for children ages six through 18 from 100% to 133% of the FPL, and requires states to cover young adults exiting foster care up to age 26. Both changes go into effect January 1, 2014.

NFIB. The *NFIB* decision addressed two of the ACA's main provisions -- the individual insurance mandate and the Medicaid expansion. The Court upheld the former as a permissible exercise of Congress's taxing powers under the Constitution. As to the latter, the Court's decision effectively makes the ACA's Medicaid expansion optional rather than mandatory. States that implement the expansion will be eligible for the enhanced federal matching rates provided in the ACA. States that do not implement the expansion will not receive that additional federal funding, but neither will they risk losing all federal funding for their existing MA programs.

Following *NFIB*, a state's decision to implement the now-optional Medicaid expansion may depend in part on its current MA program. For instance, a number of states' current MA eligibility standards for parents are well below 100% of the FPL. In addition, many of those same states do not provide MA coverage to childless adults. For these states, the ACA's Medicaid expansion would dramatically reshape their existing MA programs.

In Wisconsin, the current income eligibility standards for children and parents under BadgerCare Plus are already higher than what the ACA will require starting January 1, 2014. Consequently, the ACA's now-optional Medicaid expansion in Wisconsin relates most directly to the state's childless adult population. As noted, some childless adults with family incomes less than 200% of the FPL (approximately 22,300 individuals as of September 2012) currently receive benefits under the Core Plan. By all estimates, however, those enrollees represent a relatively small portion of the childless adults who could become eligible for MA coverage under an expansion up to 133% of the FPL.

The decision whether to expand MA coverage to all childless adults with incomes up to 133% of the FPL in 2014 will require weighing the state's future costs against the benefits of extending MA to a larger segment of the state's adult population. Many other fiscal and policy considerations may also factor into that analysis.

The ACA also gives the state several options with respect to MA coverage for parents and caretaker relatives once the MOE requirement expires. They include, but are not limited to the following: (a) maintain current eligibility standards under BadgerCare Plus (and continue to receive the standard federal matching rate); (b) reduce income eligibility levels, thereby allowing some of these adults (those with incomes between 100% and 400% of the FPL) to obtain coverage through a health benefit exchange and receive premium assistance tax credits and, where applicable, other cost-sharing reductions; or (c) establish a basic health plan in lieu of MA coverage for individuals under age 65 with incomes between 133% and 200% of the FPL. Under this final option, the federal government would provide to the state an amount equal to 95% of the premium assistance tax credits and cost-sharing reductions these individuals would have received had they enrolled in qualified health plans through the exchange.

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. EBD MA includes the following subprograms and benefit plans:

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

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, 2012, approximately 202,600 individuals were enrolled in EBD MA subprograms.

This chapter describes general eligibility requirements for EBD MA, as well as eligibility for most of the EBD Medicaid subprograms. Several other EBD MA subprograms are also discussed in other chapters, including Family Care (Chapter 5), and the home- and community-based waiver programs (Chapter 4).

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 January 1, 2013, substantial gainful employment was defined as gross income equal to or greater than $1,040 per month for non-blind individuals and $1,740 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.wisconsin.gov/mehebd/meh.htm.

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:

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

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

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

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

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

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

- Depreciation and business losses from self-employment.

- Medical and remedial expenses. 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 2013, the income limit for individuals is $557.11, plus actual shelter costs (up to $236.67), for a total of $793.78. The income limit for an individual who is married is $842.72, plus actual shelter costs of up to $355.33, for a total of $1,198.05.

*Medicaid Deductible***.** If an individual does not qualify for MA coverage only 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. 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 2013); 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. In calendar year 2013, the federal SSI income limit is $710 per month and the asset limit is $2,000 for an individual. For couples, the income limit is $1,066 per month and the asset limit is $3,000. States may enter into agreements with the Social Security Administration, which administers the SSI program, to provide all SSI recipients with 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 ($710 per month x 3.0 = $2,130 per month in 2013).

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 ($2,130 in 2013).

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

stitution's payment rate, the individual is responsible for paying the entire MA rate, but is able to keep any remaining income. SSI recipients do not have a 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 minimum and maximum limits ($23,184 to $115,920 in calendar year 2013). Both federal limits are adjusted annually, based on changes in the consumer price index. Most states allow the community spouse to keep the maximum level, regardless of what the couple's total assets are.

Wisconsin has set its spousal asset protection level at the greater of: (a) $50,000; or (b) 50% of the couple's resources, up to the federal maximum of $115,920. 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 improvement, vehicle repair or replacement, clothing or other household expenses.

The following example illustrates how the asset test is currently applied in Wisconsin. Consider a couple whose combined countable resources are $120,000 at the 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 Medicaid 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 for calendar year 2013 to either $2,898 per month or $2,521.67 per month plus any shelter costs greater than $756.50. Similar to the asset limit, this limit is adjusted annually by the change in the consumer price index. Additional income may also be transferred to provide for certain dependent family members living with the community spouse or if ordered by a court.

Under federal law, the minimum amount of income that states must allow to be transferred to the community spouse is an amount that would bring the community spouse's total income up to the sum of: (a) 150% of the FPL for a family of two; and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the federal minimum amount. Since the FPL is 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. In 2013, the income allowance is the lesser of: (a) $2,898 per month; or (b) $2,521.67 plus an "excess shelter allowance," which is for shelter expenses above $756.50 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 $630 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 $890 and $2,130 per month in 2013) 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 2012, 200% of the FPL for a two-person family was $2,521.67 per month. If a community spouse has shelter costs of $866 per month, the excess shelter costs equal $110 per month ($866 - $756 = $110). In this case, the maximum monthly income allocation is $2,631 ($2,521 + $110 = $2,631). If the community spouse receives $200 per month as income that is in the name of the community spouse, the amount is subtracted from $2,631 per month to determine the spousal income allocation amount ($2,431). If the institutionalized spouse's income is $3,600, the institutionalized spouse's nursing home liability amount would be $1,124 per month [$3,600 (the institutionalized spouse's income) - $2,431 (the spousal income allocation) - $45 (the institutionalized spouse's personal needs allowance) = $1,124].

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*.

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

Under specified circumstances, resource transfers to certain family members are permitted without adversely affecting 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 considered 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 ($6,554 in 2012). The penalty period begins 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 7 months ($50,000/$6,554 per month = 7.63 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.

The look back period for divestments occurring after January 1, 2009 is 36 months until January 1, 2012, 37 to 59 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 ($215.48 in 2012). 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 232 days ($50,000/$215.48 per day = 232.04 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 232 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 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. 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 on or after January 1, 2009. Once DHS verifies that these benefits have been paid, an individual is able to protect a corresponding amount of personal assets that equals the cash value of the insurance benefits. These protected assets are added to the $2,000 standard asset limit, as well as the protections offered under spousal impoverishment rules to determine the total value of an individual's assets that are protected.

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, 2012, seven HMOs provided managed care to approximately 34,000 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 2011-12 capitation payments made to HMOs.

Under the SSI managed care program, enrol-

lees 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 enrollee's current provider for the first 60 days of enrollment, or until the first of the month following the completion of the individual's assessment and care plan. Second, the HMO must honor fee-for-service prior authorizations at the level approved for 60 days or until the month following the HMO's completion of the assessment and care plan. Third, the HMO must assist members who wish to change HMOs or return to fee-for-service arrangements by making appropriate referrals and transferring records to the new providers.

In 2012, 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. Medicare pays for many of the services Medicare eligible individuals receive, leaving fewer services to be covered in the MA capitation rate for these individuals. 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 2012 are shown in Table 7. Approximately $206.7 million (all funds) was expended in 2011-12 to support SSI managed care capitation payments throughout the state. That amount includes hospital access payments DHS made to SSI HMOs.

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.

Table 7: SSI Managed Care
Average Monthly Capitation Rates by Region and Eligibility Category
Calendar Year 2012

Eligibility Category	Gender	Region 1	2	3	4	5	6
SSI Medicaid Only							
19-29	Female	$515.82	$567.92	$520.57	$549.19	$408.46	$620.90
19-29	Male	377.26	489.12	266.38	404.72	260.20	556.53
30-39	Female	578.14	504.98	432.12	511.06	418.70	684.20
30-39	Male	465.62	611.80	488.84	468.12	423.35	548.08
40-64	Female	651.85	661.74	599.11	535.32	638.09	907.01
40-64	Male	658.07	609.11	579.61	598.95	676.99	855.17
65+	Female	723.59	1,029.20	688.50	511.16	116.72	925.17
65+	Male	1,360.91	1,238.00	170.98	206.21	454.24	782.46
SSI Dual Eligible							
19-29	Female	$158.23	$157.26	$88.13	$241.47	$65.31	$206.76
19-29	Male	109.44	101.57	82.09	162.55	50.64	174.30
30-39	Female	166.42	139.49	103.72	131.58	118.51	202.82
30-39	Male	69.16	101.67	66.48	145.32	101.06	166.51
40-64	Female	209.82	168.23	124.17	126.04	140.09	361.98
40-64	Male	177.04	162.70	98.47	142.36	153.64	288.59
65+	Female	311.86	299.44	163.78	152.97	110.03	365.96
65+	Male	303.48	321.32	139.05	140.57	78.67	281.78
SSI- Related Medicaid Only							
19-29	Female	$700.76	$789.12	$1,712.01	$602.98	$191.04	$349.65
19-29	Male	1,065.04	292.08	349.52	634.49	279.40	713.32
30-39	Female	692.88	765.64	372.98	736.18	335.98	391.27
30-39	Male	1,895.61	1,005.95	1,448.19	534.26	757.88	530.02
40-64	Female	1,104.94	1,045.51	1,015.72	1,203.93	820.75	1,029.17
40-64	Male	1,191.41	1,596.65	1,684.22	1,669.85	1,192.96	1,341.69
65+	Female	684.82	956.57	682.92	373.26	386.02	641.75
65+	Male	1,019.11	1,052.14	825.72	584.87	230.32	674.05
SSI-Related Dual Eligible							
19-29	Female	$150.26	$127.40	$74.74	$132.24	$83.71	$112.37
19-29	Male	77.18	58.71	48.78	55.91	159.11	210.65
30-39	Female	128.23	155.21	78.65	97.17	84.18	218.75
30-39	Male	110.33	81.60	145.45	111.49	34.76	202.50
40-64	Female	154.88	127.79	104.79	128.31	124.31	359.25
40-64	Male	117.34	102.75	123.95	131.49	116.04	263.48
65+	Female	155.85	207.25	113.22	121.20	84.73	244.81
65+	Male	120.63	150.98	156.19	104.84	69.16	162.66

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

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 independence accounts.

An individual is eligible to participate in MAPP if: (a) their family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL; (b) their countable assets under MA financial eligibility rules do not exceed $15,000; (c) they have a disability, under SSI standards (disregarding one's ability to work); (d) they are engaged in gainful employment or is participating in a vocational program that is approved by DHS; and (e) they are at least 18 years old.

Individuals enrolled in MAPP pay a monthly premium if their individual gross monthly income, before deductions or exclusions, exceeds 150% of the FPL for their family size. The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the following deductions: (a) standard living allowance ($801 per month in calendar year 2012); (b) impairment-related work expenses; (c) out-of-pocket medical and remedial expenses; and (d) a cost of living adjustment disregard. The part of the premium based on earned income is equal to 3% of earned income. If the deductions for unearned income are greater than unearned income, any remaining deductions can be applied to earned income before the 3% premium rate is applied.

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 $1,481 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 tuberculosis. As of July 1, 2012, there were 214 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 the child's medical expenses. However, if a child was institutionalized for longer than a month, the child was no longer considered to be a member of the parent's household and only the child's own financial resources were considered available for medical expenses.

These restrictions resulted in children remaining institutionalized, even though their medical care could be provided at home. In 1982, federal 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 are eligible under the Katie Beckett

provision and participate in the children's long-term care support home and community-based MA-waiver program (CLTS). As of June, 2012, there were approximately 5,100 children who qualified for MA by meeting these eligibility criteria.

Individuals Eligible for Both Medicare and Medicaid -- Dual Eligibles

The federal Medicare program provides health care coverage for people who are 65 years of age or older, certain disabled individuals who are under the age of 65, and persons of all ages with end-stage renal disease (people who require dialysis or a kidney transplant). The program provides several types of health care coverage. Part A covers hospital care, non-custodial care in a skilled nursing facility following an inpatient hospital stay, hospice care, and home health services. Part B covers physician services, lab and x-ray services, durable medical equipment, and certain outpatient services. Part C, also known as Medicare Advantage, is an alternative to Parts A and B, and in some cases Part D, in which Medicare enrollees choose to receive the same services through a private health plan of their choosing, rather than through the fee-for-service system used in Part A and Part B. Part D refers to Medicare outpatient drug coverage, which is discussed in greater detail in Chapter 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 2013, the monthly premium for Part A coverage is $441 for people who are not otherwise eligible for premium-free hospital insurance and who have less than 30 quarters of Medicare-covered employment, and $243 per month for people who have 30 to 39 quarters of Medicare-covered employment.

All persons who enroll in Medicare Part A may enroll in Medicare Part B by paying a monthly premium. In calendar year 2013, individuals and married couples with annual incomes less than $85,000 and $170,000, respectively, pay individual monthly premiums of $104.90.

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

In 2013, Medicare Part A pays for all covered Part A services in a benefit period, except a deductible of $1,184 during the first 60 days of a hospital stay and coinsurance amounts for hospital stays that last beyond 60 days but not more than 150 days ($296 per day for days 61 through 90 and $592 per day for days 91 through 150). For care provided in a skilled nursing facility, the coinsurance amount is $148 per day for days 21 through 100 each benefit period.

In 2013, Medicare Part B pays for all covered Part B services in the benefit period except a deductible of $147 per year and a cost share of 20% of the Medicare-approved amount for services after the $147 deductible is met. The cost share for outpatient mental health is 40% of the Medicare-approved amount after the deductible. Pro-

viders 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 that Receive Assistance with Medicare Cost-Sharing Requirements***.** Beginning in 1968, Congress 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 $6,940 for an individual and $10,410 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, copayments, and deductible for both Medicare Part A and Part B coverage.

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+ participants are referred to as Qualifying Individuals (QIs) in federal law. SLMB and SLMB+ participants are individuals who are enrolled in Medicare Part A and have income that is at least 100% but less than 120% of the FPL (SLMB) or is at least 120% but less than 135% of the FPL (SLMB+). The resource limits for SLMB and SLMB+ are the same as those for QMB. State MA programs are required to only pay Medicare Part B premiums for these two 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 without a set limit. In contrast, CMS allocates sum certain amounts of federal funds to each state to fund Medicare Part B premiums for SLMB+ participants. Consequently, these costs are 100% federally-funded. Further, unlike the assistance provided to QMB and SLMB participants, the state's obligation to fund Medicare Part B premiums for SLMB+ participants is limited to the federal funding allocation the state receives for that purpose.

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

ual does not otherwise qualify for MA assistance, MA will pay for the individual's Medicare Part A premiums.

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

For most full benefit dual eligibles, Medicare covers eligible services up to Medicare cost-sharing and service limitations. Any costs not covered by Medicare are covered first by other supplemental coverage the person may have and last by MA. MA is always the last payer. Supplemental coverage, sometimes referred to as Medigap coverage, is private insurance a Medicare recipient may purchase to cover the cost of Medicare Part A and B cost-sharing. Supplemental plans are not available to Part C participants. For services under Part B and inpatient hospital services under Part A, MA payments are limited to an amount no greater than the allowable charge under MA less the direct Medicare payment the provider receives.

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 is said to "wrap around" the more limited coverage available under Medicare.

Medicare Crossover Claims. Medicare cross-over 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). 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 firm has identified that the service was provided to a dual-eligible; and (b) the claim is for a recipient who is not enrolled in a Medicare Advantage plan (Medicare Part C). Other crossover claims are submitted by health care providers, including claims for services provided to dual eligibles enrolled in Medicare Advantage plans and claims that were initially submitted by the firm that were not processed by the MA program within 30 days.

On September 27, 2012, CMS announced that National Government Services, Inc. (NGS), Wisconsin's current Part A administrator, would begin to administer Part B as well. Wisconsin Physicians Service Insurance Corporation (WPS) previously had the Part B contract. WPS has protested the contract award and as of this writing CMS' contract with NGS is on hold.

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

Medicare Part C (Medicare Advantage Plans)

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

All Medicare Advantage plans must meet minimum state and federal requirements for licensure, offered benefits, access to providers, quality of care, and reporting. Each Medicare Advantage plan has an annual election period that begins 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 8 summarizes the asset and income eligibility limits for categorically needy and medically needy EBD MA as of January 1, 2013. The income and asset limits shown in the table reflect countable income and assets.

Table 8: Income and Asset Eligibility Criteria for MA by Group and Eligibility Category
As of January 1, 2013

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	$793[1]
2	3,000	1,198[2]

[1] Assumes that person has actual shelter costs of at least $237.
[2] Assumes that the family has actual shelter costs of at least $355.

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 $115,920. In each case, the institutionalized spouse may retain $2,000 in assets. In addition to the assets retained by the community spouse, part of the institutional spouse's income may be transferred to the community spouse to provide income for the community spouse and any dependents living with the community spouse (an additional $630 per month for each qualifying dependent).

Family Size	Asset Limit	Maximum Monthly Income
2	See Text	$2,898

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. Couple	Benefits Paid
QMB	$7,080	$10,620	$100% of FPL	Medicare Part A and B premiums, coinsurance and deductibles.
SLMB	$7,080	$10,620	100-<120% of FPL	Part B premium.
SLMB+	$7,080	$10,620	120-<135% of FPL	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 $890 and $2,130 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	$2,130

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	250% of FPL
2	15,000	250% of FPL

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

CHAPTER 3

SERVICES AND PROVIDER REIMBURSEMENT

State and federal law define the services covered by Wisconsin's EBD MA, BadgerCare Plus, and other MA-related programs. The scope of services varies substantially across those programs. For instance, participants in limited benefit programs such as the family planning only services program 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 traditionally available to most MA enrollees.

Despite these variations, all full-benefit EBD MA enrollees and virtually all BadgerCare Plus enrollees are entitled to the services offered under the BadgerCare Plus Standard Plan. Those services 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.

Medical Necessity and Other Service Limitations

State and federal law place limits on the services covered by the MA program. Perhaps the primary limitation is the requirement that those services 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. More specific limitations include the dollar, numeric, or duration limits the MA program imposes on otherwise covered services. Often those limitations work in conjunction with the program's prior authorization rules. For example,

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

Provider Reimbursement Rules

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

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

When an MA recipient 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 program's current fee-for-service reimbursement rates are published on the DHS website.

When an MA recipient 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 the individual provider receives under a managed care arrangement is established in their contract with the HMO. Those contractual reimbursement rates may or may not be the same as the DHS fee-for-service rates.

Appendix 2 provides a list of the MA card services covered by the BadgerCare Plus Standard Plan and the other BadgerCare Plus service plans. The balance of this chapter provides additional information about some of the services covered by the Standard Plan.

Nursing Homes, ICFs-ID, and IMDs

This section describes services and MA reimbursement for three types of providers: (1) nursing facilities, which consist of skilled nursing facilities (SNFs) and intermediate care facilities (ICFs); (2) intermediate care facilities for persons with an intellectual disability (ICFs-ID) (formerly 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 preadmission screening to avoid duplication of assessments. In addition, nursing facilities may not admit a person who is mentally ill or intellectually disabled unless a pre-admission screening and annual resident review (PASARR) determines 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. 2011 Wisconsin Act 126 replaced "mentally retarded" and "mental retardation" with "intellectual disability" in state statutes. Act 126 retitled ICFs-MR as ICFs-ID. However, federal law continues to refer to these facilities as ICFs-MR.

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 prevents states from claiming federal MA matching funds for IMD services 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 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 June, 2012, there were 398 licensed nursing homes in the state, with a total of 35,718 licensed beds. Approximately 86% of these facilities were privately owned and operated (31% nonprofit and 54% for-profit) while the remaining 14% were owned and operated by a government entity, including the state, counties, municipalities and tribes. In 2011, an average of 83.7% of licensed nursing home beds were occupied, and 55.2% were occupied by MA-funded residents.

In addition to nursing homes, there were 10 ICFs-ID in the state as of June, 2012, with a total of 341 licensed beds. These totals do not include the three state centers for people with developmental disabilities. Table 9 shows the number of long-term care institutions in the state as of June, 2012, by type of ownership.

Reimbursement of Non-State Nursing Home Facilities. In 2011-12, MA fee-for-service expenditures for nursing home care and ICFs-ID, excluding care provided at the state centers for people with developmental disabilities and state veterans homes, totaled $773.3 million (all funds) representing approximately 11.8% 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.

Table 9: Nursing Home Facilities, by Ownership Type, June, 2012

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For-Profit	217	19,448
Non-Profit	124	10,369
Government	57	5,901
Total	398	35,718
ICF-ID		
For-Profit	1	11
Non-Profit	2	115
Government	7	215
Total	10	341

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) de-

termine 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 independently established and regularly updated by health care providers, based on the diagnosed care needs of each facility's residents. As a result, nursing facilities that serve higher-needs individuals will be compensated at a higher rate than facilities that serve lower-needs individuals, reflecting the higher cost of providing services to these individuals.

Under MA nursing home reimbursement methods, DHS considers five cost centers when developing facility-specific nursing home rates. These cost centers include: (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 targeted rates set for cost centers have covered a smaller percentage of average actual nursing home costs. DHS staff estimate that 45% of facilities experienced direct care costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives. However, when Medicaid costs across all cost centers are considered, 94% reported total costs that were greater than the total fee for service rate, largely due to significant deficits in the support services cost center.

Direct Care. DHS is required to establish payment for allowable direct care nursing services and direct care supplies and services. 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, developmental disability professional nursing, resident living staff, feeding staff, nurse's assistants, nurse aide training and training supplies. Direct care supplies and services include personal comfort supplies; medical supplies; over-the-counter drugs; and the non-billable services of a ward clerk, activity person, recreation person, social workers, volunteer coordinator, certain teachers or vocational counselors, religious persons, therapy aides, and counselors on resident living.

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, such as for the provision of services to individuals who require supplemental skilled care due to complex medical conditions, or require specialized psychiatric rehabilitation services. 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 2012-13, the AIDS/ARC rate is $150 per patient day and the ventilator-dependent rate is $550 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 2012-13, 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 2012-13, DHS limits the allowed replacement 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 2012-13, 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, based on the ratio of private rooms to total licensed beds. Facilities with 15% or more of their beds in private rooms can receive a per patient day incentive equal to $1.00 multiplied by the percentage of private beds. Facilities that have replaced all of their rooms since July 1, 2000, and have 90% or more of their beds in private rooms can receive an incentive per patient day equal to $2.00 multiplied by the percentage of private beds. To receive either incentive payment, 65% of the facilities total patient days must come from MA and Medicare patients. Facilities can only receive one private room incentive payment.

Third, an incentive payment is provided to facilities that need to acquire bariatric moveable equipment during the cost reporting period to serve obese patients. This incentive allows nursing facilities to partially recoup the cost of providing services to this particular population of patients. During 2012-13, nursing facilities can receive an incentive of up to 50 percent of the total cost of bariatric equipment purchased during the cost reporting period. Lease arrangements do not generally qualify for the incentive.

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

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

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 2012-13, the Behavior/Cognitive Impairment supplement base was $0.29.

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 2011-12, the average MA payment rate, including the resident's share, to nursing homes varied by county, from $132.02 to $169.81 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 Payment. 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 are eligible to apply for supplemental MA funding. The statutes permit DHS to provide up to $39.1 million each fiscal year to support supplemental payments to these facilities to offset operating deficits.

In order to distribute these supplemental

funds, DHS currently determines: (1) the projected overall operating deficits (OAOD) for each county and municipal home (the difference between allowable operating costs per patient day and MA payments per day); (2) the projected direct care operating deficit (DCOD) (the difference between allowable direct care costs per patient day and MA payments per day); (3) the eligible direct care deficit (EDCD) for each county and municipal home (the lesser of the OAOD and the DCOD); and (4) the projected non-direct care deficit (the difference between the projected overall operating deficit and the eligible direct care deficit).

If the funding budgeted for supplemental payments is not sufficient to support each qualifying facility's eligible direct care operating deficit (EDCD), DHS then calculates an EDCD per MA day by dividing the amount of available supplemental funds by the total number of MA patient days for all facilities, factoring in the limits of each facility's EDCD. This per day amount would then be paid for each MA day, up to the amount of each qualifying facility's EDCD amount. Any funds in excess of all facilities' EDCD will be allocated based on the MA patient days with an adjustment for each facility's non-direct care deficits. In 2011-12 the rate used to allocate the supplemental payments was approximately $31.96 per patient day.

Certified Public Expenditure Supplement. 2005 Wisconsin Act 107 created a permanent mechanism by which additional funding may be available through the nursing home certified public expenditure (CPE) program to provide additional supplemental payments. In every biennial budget, DHS budgets the amount of federal revenues it expects to receive as the federal match for the operating losses of municipally owned nursing homes in each of the next two years. In many cases the nursing homes incurred the losses multiple years earlier. If the amount of federal revenues received in a fiscal year exceeds the amount of revenues budgeted in that same year, all revenues in excess of the budgeted amount are disbursed among the municipal nursing homes. No federal revenue is disbursed to municipal nursing homes when the revenues are less than the budgeted amount.

In 2011-12, $39.1 million in supplemental payments were made to county-operated facilities and to Family Care MCOs. DHS distributed an additional $5.5 million as a CPE supplemental payment. After accounting for all supplemental payments, counties had unreimbursed Medicaid expenses of approximately $67.2 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 2005-06 through 2011-12.

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 individuals with developmental disabilities. 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. DHS pays the state Veterans Homes MA payment rates equal to the "Medicare Upper Limit" (the rates Medicare would pay, based on the acuity of the resident population), which may exceed the Veterans Homes' actual costs of caring for its MA-eligible residents. Table 10 summarizes the total MA fee-for-service nursing home payments, by facility type, made by the state during each of the last three state fiscal years.

Managed Care Capitation Payments. Nursing facilities receive payment for services they provide to MA recipients participating in the

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

Facility Type	2009-10	2010-11	2011-12
Non-State Facilities	$871,349,300	$811,857,600	$773,310,600
State DD Centers	148,092,800	112,531,900	127,446,400
Veterans Homes	38,151,000	31,736,800	45,535,700
Total	$1,057,593,100	$956,126,300	$946,292,700

state's long-term care managed care programs (Family Care, PACE and the Family Care Partnership programs). The rates paid to nursing facilities to cover the costs of services provided to these individuals are included in the capitation payments paid to managed care organizations.

State Supplement for IMD Nursing Homes. Although federal law does not permit states to claim 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, in 2011-12 DHS distributed $9,565,200 GPR 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 a utilization review plan that meets federal requirements in effect that is applicable to all MA patients.

Under Wisconsin's MA program, payment for most fee-for-service inpatient hospital services is based on a prospective payment system known as the diagnosis-related group (DRG) system. The DRG system applies to inpatient services provided at most acute care hospitals in the state. It 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 a DRG based on the major diagnostic categories developed by the Medicare program. Each DRG is assigned a

weight based on the relative resource consumption associated with a particular diagnosis. Those weights are determined from an analysis of past MA 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 for in-state hospitals. 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 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. For rate year 2012, the state DRG base rate is $3,211.

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

While the DRG system is used to reimburse hospitals for most fee-for-service inpatient services, there are exceptions for some AIDS patient care, ventilator patient care, 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 inpatient stays where the costs exceed the applicable "trimpoint" amount.

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

The DRG system is not used to reimburse individual professionals such as physicians, psychiatrists, psychologists, dentists, chiropractors, or anesthesia assistants for the services they provide to hospital inpatients. Those professional services must be billed separately by 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.

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

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, and whether or not the patient remained in the facility past midnight. An outpatient hospital service is a preventive, diagnostic, therapeutic, rehabilitative, or palliative service that is furnished to an outpatient under the direction of a physician or dentist at a state-licensed hospital that meets the requirements for participation in Medicare as a hospital.

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

The following is an abbreviated summary of the methodology DHS currently uses to establish fee-for-service outpatient reimbursement rates for in-state non-critical access hospitals under the MA program. First, DHS establishes an average cost per visit based on the hospital's historical audited cost reports. In that calculation, capital costs applicable to outpatient services provided to MA recipients are limited to no more than 8% of the total outpatient cost. Second, an inflation adjustment is made to that historical average cost figure. Third, the Department establishes a prospective rate per outpatient visit by multiplying the hospital's average inflated cost per visit by a budget neutrality factor to maintain costs within federal upper payment limits and within the funding available for outpatient hospital services in the upcoming state fiscal year. For rate year 2012, that budget neutrality factor was 31.72%. Finally, that prospective per-visit payment is subject to a retroactive settlement for diagnostic laboratory tests provided in outpatient visits such that the total reimbursement for those tests does not exceed the sum of what the program would have paid under the Department's fee-for-service rate schedule.

Payments to all out-of-state hospitals for outpatient hospital services, including border status hospitals, are paid at the average percentage of allowed outpatient charges paid to in-state non-CAH hospitals. Reimbursement for diagnostic laboratory services will be the lower of the MA program's laboratory fee schedule or the hospital's charges for those services.

Going forward, DHS has indicated that fee-for-service outpatient rates will be developed using an Enhanced Ambulatory Patient Grouping (EAPG) methodology beginning April 1, 2013. Additional information regarding the EAPG methodology and its possible impact on fee-for-service outpatient rates is not currently available.

Hospital Assessment Access Payments. In addition to the reimbursement policies outlined above, most Wisconsin hospitals (except psychiatric hospitals and IMDs) also receive "access" payments for serving MA recipients. These hospital access payments are funded by the hospital assessment created in 2009 Wisconsin Act 2, along with federal MA matching funds. The current hospital access payment for each inpatient discharge (for dates of discharge starting July 1, 2012) is $3,608. The hospital access payment for each outpatient visit (for dates of services starting July 1, 2012) is $309. Depending upon whether the MA recipient is a fee-for-service enrollee or an HMO enrollee, these access payments are made either directly to the hospital or are passed on to the hospital through the HMO. More information regarding the Act 2 hospital assessment is provided in Chapter 8.

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 re-designated 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. The "necessary provider" certification process is no longer available, but 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 58 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 MA spending reductions required during the 2009-11 biennium, DHS proposed reducing CAH reimbursement to 90%, and implemented that reduction for the first six months of calendar year 2010.

To avert that payment reduction 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 which applies to most of the state's other hospitals (CAHs were excluded from the original hospital assessment). 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. The current CAH access payment for inpatient hospital stays (for dates of discharge starting July 1, 2012) is $901, and the current CAH access payment for outpatient visits (for dates of service starting July 1, 2012) is $31. A portion of the CAH assessment revenues are also earmarked to help fund a loan assistance program and a rural physician residency assistance program, both of which are administered by the University of Wisconsin. More information about the CAH assessment is provided in Chapter 8.

Hospital Pay-for Performance. Beginning in fiscal year 2012-13, DHS implemented a hospital pay-for-performance program that applies to fee-for-service inpatient and outpatient hospital claims. Under this program, 1.5% of a hospital's total fee-for-service claims payments will be withheld, subject to being earned back based on performance in areas such as 30-day hospital readmission rates, asthma care for children, surgical infections, and healthcare personnel influenza vaccinations. In addition to earning back the 1.5% withhold, hospitals can also earn a bonus payment of up to 1.5% of their total hospital fee-for-service claims payments, funded entirely by performance withholds by other hospitals.

DHS also maintains a second pay-for-performance program totaling $5 million annually for acute care hospitals, children's hospitals, and rehabilitation hospitals located in Wisconsin. These hospitals can receive payments under this program if they meet performance measures on a range of factors, including perinatal care, prevention of surgical infections, and consumer assessments. The funding source for this pay-for-performance program is the Act 2 hospital assessment.

Supplemental Hospital Payments. Some hospitals are eligible for additional payments from the MA program based on the patients or geographic areas they 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 that 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). That changed with the statewide expansion of the Core Plan in July 2009. Since that time, DHS uses federal DSH funding (to the extent it continues to claim those matching funds) almost exclusively to support Core Plan expenditures.

EACH Payments. Hospitals that meet the definition of an essential access city hospital (EACH) are eligible for a supplemental payment under the MA program. An EACH is an acute care 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. In 2011-12, two hospitals received a supplemental EACH payment: Aurora Sinai Medical Center ($2,997,700) and Wheaton Franciscan-St. Joseph Hospital ($999,200).

Rural Hospital Adjustment. Under the Department's inpatient state hospital plan, DHS is authorized to make lump sum rural adjustment payments of $300,000 each to hospitals which are classified as rural under the Medicare wage index but which are not eligible for the rural hospital percentage adjustment to their DRG rate. In 2011-12, DHS made lump sum supplemental payments to rural hospitals totaling $1.2 million under this provision.

In addition, 2011 Wisconsin Act 32 authorized DHS to make a payment of $300,000 annually to a hospital that: (a) is located in a city that has a municipal border that is also a state border; (b) has an MA recipient case mix that consists of at least 25 percent of residents from a border state; (c) is located in a city with a poverty level, as determined from the 2000 U.S. Census, that is greater than 5 percent; and (d) is located in a city with a population of less than 15,000. In 2011-12, the only hospital that met these criteria and received the $300,000 supplemental payment was the Bay Area Medical Center in Marinette.

Level I Adult Trauma Centers. State law authorizes DHS to make annual payments not to exceed $8 million in the aggregate to hospitals that satisfy the criteria established by the American College of Surgeons for classification as a Level I adult trauma center. These payments are funded by proceeds of the hospital assessment and by federal MA matching funds. UW Hospital and Clinics and Froedert Memorial Lutheran Hospital are currently the only hospitals that receive these supplemental payments.

Supplemental Payment for Uncompensated Care. Beginning in fiscal year 2009-10, DHS is required to make a supplemental payment of $3 million annually to UW Hospital and Clinics for care that is not otherwise compensated.

Pediatric Inpatient Supplement. DHS makes supplemental payments to acute care hospitals that have inpatient days in the hospital's acute care and intensive care pediatric units that exceed 12,000 days in the second calendar year preceding the hospital's current fiscal year. Days for neonatal intensive care units are not included in that determination. The pediatric supplement, in the aggregate, is limited to $2.0 million annually. In 2011-12, UW Hospital and Clinics and Children's Hospital of Wisconsin received supplemental payments under this provision.

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 supervision of a physician. As noted, many of these services may be subject to the prior authorization and/or limitations identified in Wisconsin administrative rules.

Physician services (when provided on a fee-for-service basis), are typically reimbursed at the lesser of the provider's usual and customary charge or the fee-for-service rates established by DHS. If the MA recipient is an HMO enrollee, however, the physician's reimbursement is determined by the physician's individual contract with the HMO.

The DHS fee schedule includes higher rates for certain services provided by primary care and emergency medicine providers in areas of the state designated as health professional shortage areas (HPSAs). These HPSAs are classified by zip code and enhanced payments are available 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" services, provide comprehensive screenings to MA recipients under age 21. HealthCheck screening examinations are distinguished from other preventive health services under MA because they include a significant health education component, a schedule for periodic examinations, detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the patient is appropriately referred for care.

Each comprehensive HealthCheck screen is to include the following components: (1) a comprehensive health and developmental history (including preventive health education); (2) a comprehensive unclothed physical examination; (3) an appropriate vision screening; (4) an appropriate hearing screening; (5) dental 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 screenings that is consistent with reasonable standards of medical and dental practice. Wisconsin's periodicity schedule limits the number of comprehensive screenings during a continuous 12-month period as follows: (a) birth to first birthday, six screenings; (b) first birthday to second birthday, three screenings; (c) second birthday to third birthday, two screenings; and (d) third birthday to twenty-first birthday, one screening.

Federal law also requires states to provide MA coverage for 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 53 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. As required by federal law, DHS reimburses FQHCs for 100% of the reasonable costs of providing services to MA recipients. This reimbursement requirement recognizes that FQHCs serve a disproportionate share of the state's MA, Medicare, and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 18 FQHCs in Wisconsin.

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

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 home health aide tasks include administration of medications and activities of daily living, such as personal hygiene, in cases where the person's condition has worsened when assistance was provided on a previous occasion.

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

Home health agencies, independent living centers, Wisconsin tribes and bands, certain county departments, and freestanding personal care agencies can be 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 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 a clinic, hospital or 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 other MA services, most family planning services receive a 90% federal match.

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) limited orthodontics; (i) adjunctive general services; (j) palliative emergency services; and (k) general anesthesia, intravenous conscious sedation, nitrous oxide, and non-intravenous conscious sedation. The program also covers various services provided by dental hygienists, including oral screening and preliminary examinations, prophylaxis, pit and fissure sealants, and periodontal maintenance. 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.

Until recently, common carrier services were coordinated by the individual counties and tribes. The MA program reimbursed these entities for their common carrier services based on the cost reports they submitted to DHS. SMV services, on the other hand, were provided by DHS on a fee-for-service basis.

This changed in July 2011 due to a provision in the 2009-11 biennial budget act that directed DHS to hire an entity to manage non-emergency medical transportation (NEMT) services on a statewide basis. A primary goal of this require-

ment was to realize program savings by: (a) increasing efficiency and reducing fraud in the delivery of those NEMT services; and (b) enabling the state to claim higher federal MA matching rates for common carrier costs based on the improved recording-keeping capabilities of the transportation manager.

The 2009-11 state budget assumed the statewide NEMT manager would be in place by January 1, 2010, but delays pushed that date out. Following an RFP/competitive bid process, the NEMT manager contract was awarded to Logisticare Solutions LLC. The original term of the contract was July 1, 2011, through June 30, 2014, with an option by mutual agreement to renew for two additional one-year periods. Under that contract, DHS made capitation payments to Logisticare based on monthly MA enrollment figures in the areas served. A second contract covering NEMT services in six southeast Wisconsin counties, including Milwaukee County, was subsequently awarded to Logisticare through a separate RFP process. The original term of that second contract was September 1, 2012, through June 30, 2014, with an option for two additional one-year renewal periods at the parties' mutual agreement.

By letters dated November 16, 2012, Logisticare served notice to DHS that it was terminating both contracts effective February 17, 2013. In its notice of termination letters, Logisticare stated that the utilization of NEMT services by Wisconsin MA recipients under the contracts was significantly greater than anticipated, and that the Department's failure to provide adequate utilization data during the RFP process limited Logisticare's ability to meaningfully model the program. DHS has since indicated that it intends to rewrite and issue a new RFP for NEMT services.

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

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

Speech and Language Pathology Services. 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.

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

Medical supplies are disposable, consumable, expendable, or nondurable medically necessary supplies that have a very limited life expectancy. Examples include catheters, syringes and incontinence supplies. Medical supplies ordered for a patient in a hospital or nursing home are consid-

ered 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 the 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.

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. The MA program typically pays pharmacies the lesser of a drug's estimated acquisition cost (EAC) or the usual and customary amount the pharmacy bills private pay clients for the drug. The EAC is established according to the type of drug, as follows: (a) the wholesale acquisition cost (WAC) plus 2.0 percent for most brand name drugs; (b) the state maximum allowed cost (SMAC) for multi-sourced branded and generic drugs; (c) an expanded maximum allowed cost (EMAC) for drugs without a SMAC or WAC rate on file; or (d) the WAC minus 3.8% for single-source generic drugs without a SMAC rate on file.

When a drug is on the SMAC list (updated monthly to reflect the prices for which drugs are readily available through wholesalers in Wisconsin) the program pays the generic price unless the prescriber indicates that the brand name drug is medically necessary, in which case prior authorization is required. In all cases, the amount the state pays the pharmacy is reduced by the co-payments paid by program participants.

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

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

Covered Drugs and Limitations. Wisconsin MA has an open drug formulary. This means that a prescription drug is covered if it meets all the following criteria: (a) it is approved by the FDA; (b) the manufacturer has signed a rebate agreement with CMS, and a separate rebate agreement with the state where necessary; and (c) the manufacturer has reported data and prices to First DataBank.

The program also maintains a preferred drug list (PDL) and a supplemental rebate program. Based on the drug's therapeutic significance and cost effectiveness, supplemental rebates are negotiated with the manufacturer and PDL recommendations are made to the Wisconsin Medicaid Prior Authorization Advisory Committee. That committee is composed of physicians, pharmacists, advocates, and consumers. Drugs that are part of the PDL may be designated by the Advisory Committee as either preferred or non-preferred. Non-preferred drugs require prior authorization. Not all drugs are on the PDL.

Maintenance of the PDL, the SMAC list, and generic substitution are several of the strategies DHS uses to control prescription drug costs in the MA program. Other tools include the use of prospective and retrospective drug utilization reviews, prior authorization requirements for certain drugs and/or certain situations, diagnosis restrictions, and the exclusion of certain drugs that are deemed experimental or lacking medically accepted indications. Many of these strategies are facilitated by the Department's pharmacy point-of-sale electronic claims management system which, among other things, enables pharmacies to submit real-time claims that are screened against the program's eligibility records and the participant's medical and prescription history.

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.

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 rebate revenues. Prior to that time, MA recipients enrolled in a managed care organ-

ization received their covered drugs through their HMO, which was reimbursed for those prescription drug services through the capitation payments it received from the state.

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 benefit is referred to as Medicare Part D. Medicare beneficiaries who also have full MA benefits (dual eligibles) are automatically enrolled in Medicare Part D, and the state MA program no longer covers 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 non-federal share of these service costs. 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 Recovery Services (CRS). Effective January, 2010, DHS received approval to offer community recovery services (CRS) to individuals with severe and persistent mental illness. The CRS benefit includes community living supportive services, supported employment, and peer supports. These services are only available in counties that choose to provide them and that provide the non-federal share of the costs. To be eligible for CRS, individuals must meet all of the following criteria: (a) be eligible for elderly, blind, or disabled MA or the BadgerCare Plus standard plan; (b) have countable income at or below 150% of the federal poverty level; (c) reside at home or in the community; (d) meet CRS functional eligibility requirements; and (e) have a DHS-approved service plan.

Under the ACA, services provided through the CRS benefit would have needed to be extended statewide. DHS subsequently submitted a state plan amendment in November 2011 to establish a benchmark plan that would maintain the program's character as a geographically-targeted benefit.

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 provide the services and provide the non-federal share of the costs. 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. The services must be provided by qualified private, nonprofit agencies or qualified public agencies. Payment 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 non-federal share 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.

DHS also 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. Recipients must receive these 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 non-federal share of these costs, whereas case management agencies must provide the non-federal 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. Care coordination services are also available to certain MA-eligible children through age six in Milwaukee County and through age two in the City of Racine.

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 only covered by Wisconsin's MA program 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, the program 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 (HCBW) programs. Chapter 5 provides a description of the state's other waiver programs, including Family Care, the IRIS (Include, Respect, I Self-direct) program, the Program for All-Inclusive Care for the Elderly (PACE), and Family Care Partnership. Family Care and IRIS currently provide services to adults in 57 counties and 15 counties continue to serve adults through fee-for-service HCBW programs. All counties provide services to children through fee-for-service HCBW programs.

Wisconsin operates six federal waiver programs that are intended to reduce the number of individuals receiving long-term care services in nursing homes or institutions. Adults with physical disabilities and elderly individuals 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. Wisconsin's 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. DHS also provides counties with GPR funding through the community options program (COP-Regular) for community-based long-term care related costs. Counties can use COP-Regular funds as the non-federal share for additional MA eligible services for individuals in other HCBW programs or to pay the full amount of costs not eligible for federal MA matching funds.

In order to obtain a federal MA home- and community-based services waiver from CMS, a state must demonstrate that the projected average per member cost for individuals receiving services under a waiver does not exceed the costs 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 support-

ive 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, Family Care, and IRIS 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) has expanded, it has replaced the adult waiver programs in the areas of expansion and all adults eligible for MA home and community-based services become entitled to those services without the need for waiting lists.

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 up to 300% of the applicable SSI payment level. 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 2013, under the MA waiver programs, the personal needs allowance ranges from $890 to $2,130 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 COP-W, CIP IA and IB, CIP II, COP-Regular, BIW, or for waiver services provided to individuals over age 18 in the CLTS program.

Funding allocations for the waiver programs were originally based on a waiver reimbursement rate per individual, number of allocated slots, and total number of days in the contract year. Currently, slots in the various programs are based on a combination of the historical budget allocations, the addition of the care plan costs for new program enrollees, and in some cases the rate DHS associates with a new slot. DHS makes some adjustments when an individual moves between counties.

For most of the waivers' existence, counties could only serve one person for every waiver slot they were allocated. Beginning with CIP IB and

BIW in 2008 and CLTS in 2009, DHS allowed counties to treat their state waiver funding as an allocation and use the total available funding to serve as many individuals as possible. For CIP IA and the BIW, while funding may be treated as an allocation, a county may not serve more people than the number of slots awarded. Counties may serve fewer people in order to adjust for increased costs per person. Counties have been able to treat COP-W funding as an allocation since its inception. Counties are reimbursed fully by the state for allowable expenses for each program up to the county's funding allocation.

The state contributions are supplemented with federal matching funds. In 2011-12, the state and federal responsibility for MA funding allocations 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 2012 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 cost of the individual's community care plan under CIP IA and is reallocated to fund the CIP IA slot.

Prior to 2009-10, DHS provided counties a maximum average per day allowance. Since fiscal year 2009-10, the state provides the funding needed to meet the individual's care plan in the community. In calendar year 2011, there were 265 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-ID other than the state centers for people with developmental disabilities.

In 2011-12, 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-ID (approximately $215 per day in 2012). In addition to these state-funds, Wisconsin also claims federal matching funds for individuals for whom counties provide the state match. In calendar year 2011, there were 3,127 individuals participating in the CIP IB program.

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

needs of the individual.

In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services in ICFs-ID and nursing homes, other than the state centers 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, as long as total program costs for institutional and community services could be managed within the same allowable funding limit. Act 33 also provided funding for phase-down payments to ICFs-ID that agreed to reduce their number of licensed beds.

Individuals at a developmental disability level of care are the target population for the restructuring initiative. From January 1, 2005, to June 30, 2011, 744 individuals at a developmental disability level of care had been successfully relocated from ICFs-ID 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.

Counties are reimbursed fully by the state for expenses for each CIP II participant up to the county's state funding allocation. For calendar year 2012, the daily reimbursement rate to counties serving CIP II and COP-W clients is $41.86 per person, unless a variance is granted by the Department to exceed the average $41.86.

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. Two initiatives under the CIP II umbrella, the Community Relocation Initiative (CRI) and the Nursing Home Diversion program (NH Diversion), were authorized in the 2005-07 biennial budget and implemented in 2006. Participation in the relocation initiative (CIP II - CRI) is voluntary. If an individual relocated under CIP II - CRI receives services for at least 180 days before leaving the program, the county retains the funding allocated to provide services to the other eligible individuals who may be on the county's waiting list for services, but not yet residing in a nursing home.

The NH Diversion program is directed to those individuals who were on the county's waitlist for services and were determined to be at higher risk of entry to a nursing home. These individuals are allocated a "slot." Costs for these individuals may not exceed $85 per day. If an individual leaves the NH Diversion program, the county may retain the slot to serve another individual who meets the high risk criteria. In calendar year 2011, 1,894 individuals received MA services under CIP II, CIP II - CRI, and the CIP II - NH Diversion program.

Community Options Waiver Program. The community options waiver program (COP-W)

provides services to elders and persons with physical disabilities who would otherwise receive care in a nursing facility.

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

In calendar year 2011, 1,556 individuals received services in the COP waiver program.

Brain Injury Waiver (BIW). Individuals who are substantially disabled 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 2012, the maximum reimbursement rate was $180 per day. 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, such as CIP II, did not provide sufficient funding to meet the needs of this group. 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 2011, 96 individuals received services under the program.

Children's Long-Term Support (CLTS) Waivers Program. 2003 Wisconsin Act 33 provided funding to support a MA waiver program, operating under three MA home- and community-based waivers, that provides MA services to children with long-term care needs and a single entry point for eligibility determinations in each county.

The CLTS waiver seeks to improve access to services, choice, coordination of care, quality, and financing of long-term care services for children with physical, 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. The impairment must be characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services that result in eligibility for MA if the child (1) is in a hospital or nursing facility, (2) requires a level of care typically provided in a hospital nursing facility, (3) can appropriately receive care outside of the facility, and (4) can receive care outside of an institution that costs not more than the estimated cost of institutional care.

The financial eligibility criteria require that in 2013, the child's income not exceed $2,130 per month and, for those aged 18 and over, countable assets not exceed $2,000. Children with greater income and/or assets may become eligible for 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 significant 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. However, some of the services that are necessary for adults, such as home-delivered meals, housing counseling, adult day care, and services provided by adult family homes, residential care apartment complexes (RCACs), and community-based residential facilities (CBRFs), are not available to children under the waivers. The CLTS waiver also supports services that are not available under other waivers, including specialized medical and therapeutic supplies. In addition to receiving waiver services, CLTS participants have access to all MA-covered card services.

DHS provides each county with a funding allocation to provide CLTS services. Counties must serve children on a first-come, first-served basis, so long as funds are available, and may serve as many children as their allocation allows.

Counties may serve additional children by supplying the local match to obtain the federal financial participation on these services. Children applying for state-matched funding must meet the functional level of care requirement and be determined disabled by the DDB. Children applying for county-matched funding need only meet the functional level of care requirements. Once funding has been allocated, counties then have the authority to serve as many individuals as available funds will allow. As of June 30, 2012, 5,096 children were receiving services under the CLTS waiver.

Similar to other MA waiver programs, counties may establish waiting lists for services when the funding provided by the state is not sufficient to provide services to all eligible individuals. As of June 30, 2012, 2,653 children were on the CLTS waiting list, including 424 waiting for autism treatment services. Children may continue receiving services under the waiver until they reach the age of 22 (as long they continue to be eligible for MA), after which they would need to receive some services under an adult waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 22 years of age, although counties can prevent a disruption in services by placing children already receiving services under CLTS on waiting lists for adult waiver slots.

As shown in Table 11, as of June 30, 2012, 5,096 children were enrolled in the CLTS waiver program. An additional 2,653 children were on the CLTS waiting list, including 424 waiting for intensive treatment and on-going services.

Table 11: CLTS Waiver Enrollment as of June 30, 2012

	Enrollment	Waiting List
Autism Services	2,300	424
Other CLTS Services	2,796	2,229
Total	5,096	2,653

Autism Treatment Services. 2003 Wisconsin Act 33 created the intensive in-home treatment services benefit for children with autism spectrum disorders. In 2011, the Department began to phase out the intensive in-home treatment

program and created two distinct levels of intensive service -- the Early Intensive Behavioral Intervention (EIBI) service and the Consultative Behavioral Intervention (CBI) service -- to reflect the most recent research into the benefits of early intervention. The services remain fundamentally the same in the two programs, but children in the EIBI service receive 30 to 40 hours of face-to-face treatment and children in the CBI service receive 10 to 20 hours of face-to-face treatment.

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

The state began providing autism treatment services under the CLTS waivers on January 1, 2004. When this benefit became available under the waivers, responsibility for administering it was transferred from the state to counties. Counties conduct assessments, establish individual service plans (ISPs), and perform quality assurance activities for each participant.

In order to qualify for autism treatment services, a child must have a verified diagnosis of autism, Asperger's Disorder or Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). This requirement is in addition to all other CLTS Waiver eligibility criteria.

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

Children who have received intensive autism treatment services, EIBI or CBI, for at least 12 of the past 18 months are eligible to receive ongoing CLTS Waiver services. Ongoing services must be identified in the ISP, and may include any services allowable under the waiver in which the child is enrolled, including respite and adaptive aids, but do not focus on direct treatment. As of June 30, 2012, 738 children were receiving intensive autism services, while 1,562 children were receiving ongoing autism services.

The waitlist for intensive autism services is managed at the state level and functions on a slot-based system. When a slot becomes available the slot goes to the next child on the statewide waitlist. The child's county and provider meet with the child to determine the number of hours of treatment the child will need each week. The county receives the corresponding rate for that level of treatment. The annual amount for the intensive services is added to the county's contract at the end of the year. Once the child leaves the program, the funding for the slot is returned to the state and is used to fund autism services for other children.

Counties are permitted to claim up to 7% of direct service and case management costs to support administrative expenses in both the CLTS waiver and the autism treatment program.

Counties are allocated $30.60 per day to serve children receiving ongoing services. Counties have the choice to limit services for each child to $30.60 per day or, based on the children's service plans, to provide some children with more or less

than $30.60 per day as long as the total average cost per child is no more than $30.60 per day. When a child ages out of ongoing autism services, the county retains the funding to serve other children in need of those services.

Community Options Program (Non-Waiver)

The non-waiver community options program is a 100% GPR-supported program. Counties can use COP-Regular funds as the non-federal share for additional MA eligible services provided to individuals in other HCBW programs or to pay the full costs of services not eligible for federal MA matching funds. Counties also use this funding as the local match to fund services for additional waiver enrollees or to draw down federal matching funds on MA allowable 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. The first are individuals with early stages of Alzheimer's disease who do not require a skilled nursing facility level of care. The second are individuals with chronic mental illness who would be likely to require long-term care or repeated hospitalization if they did not receive long-term, community support services.

Before becoming eligible for COP services, an individual must be a resident of Wisconsin for at least six months and have a long-term care need that is defined as lasting a year or more.

Counties may not use COP funds to support waiver allowable services for 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 and the individual's projected income, after certain exclusions, over the next six months, with the average cost of nursing home care for six months. If the sum of assets and income is less than the cost of nursing home care, the individual is financially eligible for COP services. In 2012, DHS used $39,324 as the average six-month cost of nursing home care for adults and $169,585 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, in some instances participants can exclude more assets and income than would normally be allowed in MA. Although COP is not part of MA, MA spousal impoverishment and divestment provisions apply.

Services. In general, counties use COP funds to: (1) provide pre-relocation funding; (2) purchase services that cannot be funded under the waivers and to provide services to individuals who are not eligible for the waivers; and (3) sup-

plement state funding for the non-federal share of payments for the services provided under the MA waiver programs.

COP funds may be used to develop assessments and case plans for non-MA as well as MA-eligible applicants. They may also be used to develop 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 move from an institution. However, for individuals in an MA waiver, these types of transitional expenses must be billed to the MA waiver program if they were incurred within 180 days of the individual's move.

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

Of the $26.8 million GPR expended for COP services in calendar year 2011, counties expended $2.8 million to provide services to waiver participants that are not covered under the MA waiver programs, $13.2 million for individuals not eligible for the MA waiver program, $8.7 million to support locally-matched services and waiver costs in excess of the state maximum reimbursement rate for MA waiver programs, and $2.1 million to support assessments, case plans, and other expenditures.

Table 12 presents the percentage of total COP-Regular expenditures by eligibility group in calendar year 2011. Statewide, per person COP spending cannot exceed the average per person GPR cost of nursing home care. In calendar year 2011, per person per month COP spending could not exceed $1,649.68.

Table 12: Percentage of Total COP-Regular Expenditures by Eligibility Group (Calendar year 2011)

Severely Mentally Ill	52.9%
Developmentally Disabled	26.4
Elderly	15.2
Physically Disabled	5.0
Chemically Dependent and Others	0.5
Total	100.0%

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

The number of individuals eligible for COP funding often exceeds available funding for the program, creating the need to maintain waiting lists.

Table 13 presents information on the number of individuals on waiting lists for COP services in each year from 1996 through 2011. Of the 4,072 individuals on waiting lists as of December 31, 2011, 123 (3%) were residing in an institution, 2,891 (71%) were receiving no public long-term care funding, and 1,058 (26%) 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 for individuals not eligible for managed long-term care, such as persons with mental or AODA diagnoses and children.

Table 13: Number of Individuals on Waiting Lists for COP Services*

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
2010	3,962
2011	4,072

*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 children and adults for the non-Family Care counties and eligible COP participants in the Family Care counties (persons with mental health/AODA and children).

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, adults with developmental disabilities, and adults 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 county-administered 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 with long-term care needs who want community-based care but 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 (Include, Respect, I Self-Direct). IRIS 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 his or her county of residence.

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 EBD MA's asset and income test to be eligible for the Family Care benefit. As described in Chapter 2, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income limit is based on an individual's countable

income and, in 2013, may not exceed $794 per month ($1,198 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 $2,130 per month in 2013). 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 2013, the personal needs allowance ranges from $890 to $2,130 per month.

Aging and Disability Resource Centers (ADRCs)

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

The contract between an ADRC and DHS assigns responsibilities to each ADRC and allows the ADRC to be reimbursed for its costs in carrying out these required functions. Counties are not expected to contribute to the cost of operating 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 14 shows ADRC expenditures for fiscal years 2005-06 through 2011-12. The growth in expenditures shown in Table 14 is primarily due to the increase in the number of ADRCs operating during this period. As of January, 2012, 28 counties and tribes were independently operating resource centers, while 50 counties and tribes operated 13 additional regional ADRCs collaboratively.

Table 14: ADRC Expenditures
Fiscal Years 2005-06 through 2011-12

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
GPR	$7,510,600	$9,631,400	$7,077,000	$20,210,800	$25,035,900	$27,069,600	$32,869,200
FED	1,314,300	3,788,000	4,738,300	9,992,400	16,394,100	21,476,000	23,757,900
Total	$8,824,900	$13,419,400	$11,815,300	$30,203,200	$41,430,000	$48,545,600	$56,627,100

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 15 shows the 10 Family Care services with the highest expenditure levels in calendar year 2010. 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 15: Family Care Service Expenditures Calendar Year 2010

Service	Expenditures	% of Total
Non-NH Residential Care	$378,240,100	38.9%
Supported Home Care	151,801,500	15.6
Case Management	125,289,400	12.9
Nursing Home/ICF-ID	93,834,500	9.7
Day Center Treatment	44,243,600	4.6
Home Health/Skilled Nursing	39,743,500	4.1
Prevocational	30,852,700	3.2
Transportation	27,710,300	2.9
DME and Supplies	21,888,800	2.3
Adult Day Care	12,022,600	1.2
All Other Services	46,036,200	4.7
Total	$971,663,200	100.0%

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 or is establishing an ADRC. Regardless of the type of entity, however, all MCOs must ensure the following:

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

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

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

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

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

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

tive costs. Capitation rates differ by MCO to reflect differences in acuity of people served by each respective MCO and the costs associated with variation in acuity.

Federal law requires that all capitation rates be actuarially sound. The MCO capitation rates are reviewed and updated annually. DHS contracts with an independent third party, PricewaterhouseCoopers, LLP, to calculate the rates and ensure that all rates are actuarially sound.

Table 16 shows the calendar year 2012 capitation rates DHS paid to MCOs for their Family Care enrollees. Capitation rates vary based on MCO and region. These regions and the service areas for each MCO, as of August 1, 2012, are shown in Appendix 8.

Table 16: MCO Monthly Capitation Rates Calendar Year 2012

MCO	Nursing Home Rate	Non-Nursing Home Rate
Care Wisconsin	$3,394.98	$559.74
Community Care of Central Wisconsin	3,132.85	564.19
Community Care, Inc. (Kenosha/Racine)	3,205.36	578.35
Community Care, Inc. (Milwaukee)	3,453.93	578.35
Community Care, Inc. (Southeast)	3,142.02	578.35
Community Care, Inc. (Northeast)	3,133.58	578.35
Community Health Partnership	3,729.25	559.74
Lakeland Care District	3,305.87	580.62
Milwaukee County CMO	2,747.96	543.70
Northern Bridges	2,933.88	559.74
Southwest Family Care Alliance	2,954.78	540.96
Western Wisconsin Cares	2,850.54	557.13

In January 2013, Southwest Family Care Alliance replaced Community Health Partnership as the Family Care MCO in Chippewa, Dunn, Eau Claire, Pierce, and St. Croix Counties. Community Health Partnership served approximately 1,203 Family Care and 1,548 Family Care Partnership enrollees as of June 1, 2012.

During the first five years Family Care services are available in a county, the county's contributions to the costs of the program are determined by a formula established in 2007 Wisconsin Act 20. A county's contribution is based on whether the actual amount the county spent to provide long-term care services in calendar year 2006 was greater than or less than 22% of the county's basic community aids allocation in 2006. If the county's long-term care expenditures were less than 22% of its basic community aids allocation, the county's ongoing contribution is set at its 2006 long-term care expenditure level. If the county's long-term care expenditures were greater than 22% of its basic community allocation, the county's Family Care contribution equals its 2006 level for the first year and then decreases for the next four years by 25% of the difference between its long- term care expenditure level and 22% of its basic community aids allocation. The county's ongoing contribution is then set at 22% of the county 2006 basic community aids allocation. Appendix 9 shows how the required county contribution 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. Under current law, if DHS proposes to contract with entities to administer the Family Care benefit in new geographic areas, it must first submit the proposed contract to the Joint Committee on Finance (JFC). In addition to the contract, DHS must also submit the following items to JFC prior to contracting with an MCO: (1) an estimate of the fiscal impact of the proposed expansion; (2) documentation that each county affected by the proposal consents to the administration of the Family Care benefit in the county; (3) each county's Family Care contribution; and (4) each county's proposal for how they will use any county expenditure savings that result from the Family Care benefit being available in their county. The fiscal estimate must demonstrate that the expansion will be cost neutral, including startup, transitional and ongoing operational costs, and any proposed county con-

tribution. DHS may only enter into the proposed contract if the JFC approves the contract.

Prior to the enactment of 2011 Wisconsin Act 127, the Department's notification to JFC was part of a passive review process, in which DHS could contract with an organization to provide the Family Care benefit in additional areas of the state if the Committee did not schedule a meeting to review the proposal within 14 days after receiving a notice of the Department's intent to expand the program. The Department could also implement its proposed expansion if the JFC failed to act within 59 working days of the Department's notification.

Appendix 10 lists each ADRC and the counties each 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 into Family Care 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.

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

Due to the general aging of Wisconsin's population, many more people are expected to be eligible for and need nursing home and home and community based services in the future. Since Family Care is expected to be less expensive on a per person basis than either nursing homes or the other waiver programs, Family Care is expected to be a less expensive model for meeting in-

creased demand for long-term care services in the future.

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.

Table 17: Family Care and Partnership Program Enrollment, As of September 30

	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
2011	3,857	33,257	57
2012*	3,935	34,119	57

*Number of Members Enrolled as of May 31, 2012

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 June 2012, 57 counties offered Family Care with a total of 34,119 enrollees. Table 17 shows the growth in Family Care enrollment from 1997 to 2012.

PACE/Family Care Partnership Program

In addition to Family Care, the state offers two additional long-term care managed care programs. 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 attempts 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 operated by Community Care Health Plan (CCHP) that serve individuals in Fond du Lac, Milwaukee, Monroe, Washington and Waukesha Counties.

Three providers offer FCP services in 19 other counties: (a) CCHP in Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Washington, Waukesha, and Waupaca Counties; (b) Care Wisconsin in Columbia, Dane, Dodge, Jefferson, and Sauk Counties; and (c) Independent Care, Inc. in Kenosha, Milwaukee, and Racine Counties.

As mentioned earlier, in January 2013, Southwest Family Care Alliance replaced Community Health Partnership, which managed the Partnership Health Plan in Chippewa, Dunn, Eau Claire, Pierce, and St. Croix Counties. Southwest Family Care Alliance will only be providing the Family Care benefit, the Family Care Partnership benefit will no longer be offered in these 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 individual's 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 18 lists the calendar year 2012 MA capitation rates paid to MCOs participating in the PACE and Family Care Partnership programs. Table 19 shows Partnership and PACE service expenditures in calendar year 2010.

Table 18: PACE and Family Care Partnership Monthly Capitation Rates -- Calendar Year 2012

MCO	2012 Capitation Rate
Community Care Health Plan: PACE	$3,150.30
Community Care Health Plan: FCP Milwaukee	3,799.71
Community Care Health Plan: FCP Kenosha/Racine	3,639.95
Community Care Health Plan: FCP Southeast	3,471.85
Community Care Health Plan: FCP Northeast	3,415.02
Partnership Health Plan	3,529.70
Care Wisconsin	3,449.71
Independent Care, Inc.	3,124.40

Table 19: Long-Term Care and Acute Care Service Expenditures in Family Care Partnership and PACE -- Calendar Year 2010

	Expenditures	% of Total
Long-Term Care Services		
Non-NH Residential Care	$31,894,800	12.9%
Case Management	30,851,600	12.5
Nursing Home	21,865,800	8.9
Personal/Supportive Home Care	20,324,300	8.2
Other LTC Services	13,033,200	5.3
DME & Supplies	10,250,800	4.2
Transportation	8,320,300	3.4
Adult Day Care/Day Center	7,554,100	3.1
Physical Med. & Rehab (PT, OT)	3,433,800	1.4
Home Health/Skilled Nursing	2,592,300	1.0
Prevocational	1,808,000	0.7
Meals	1,015,200	0.4
Respite	333,400	0.1
Health Club Fitness/Exercise	119,300	0.0
Total LTC Services	$153,396,900	62.1%
Acute Care Services		
Inpatient Hospital	$32,018,800	13.0%
Medications	28,049,300	11.4
Evaluation & Management Visits	12,531,700	5.1
Other Physician Services	5,100,900	2.1
Physician Surgery	4,607,600	1.9
Physician Radiology	2,726,500	1.1
Physician Pathology & Lab	2,327,800	0.9
Dialysis	1,939,200	0.8
Dental	1,754,300	0.7
Cardiopulmonary Therapy	1,053,200	0.4
Mental Health & AODA	668,000	0.3
Nutrition Intervention	419,300	0.2
Emergency Room Visits	360,800	0.1
Total Acute Care Services	$93,557,400	37.9%
Total Acute & LTC Services	$246,954,300	100.0%

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

CMS requires 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 authori-

ty where individuals may self-direct their 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.

DHS contracts with two agencies to administer the IRIS program. First, DHS contracts with The Management Group to serve as the IRIS program's independent consulting agency (ICA). The ICA is responsible for assisting individuals in selecting a consultant that will work with the individual to develop a support plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must 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.

Second, DHS contracts with the Milwaukee Center for Independence to serve as the IRIS program's statewide financial services agency (FSA). The FSA assures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements, such as paying providers and assuring that employment and tax regulations are met. The FSA also provides training and support to help individuals with financial accountability and processes all payments to service providers.

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

The services available under the IRIS program are limited to the home and community-based services not available through MA card services. This differs from Family Care, which covers all long-term care services, including those otherwise available through MA card services. IRIS does not cover MA long-term card services, such as therapies, personal care, and nursing home care. Instead, IRIS recipients continue to receive these services through their MA card. Although provided as an MA card service, IRIS enrollees have the option of self-directing their personal care services with the help of the ICA.

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

Individuals participating in the IRIS program are given an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person may use funds from his/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 20 shows the ten largest types of IRIS services costs in calendar year 2010.

Table 20: Ten Highest IRIS Service Expenditures Calendar Year 2010

Service	Expenditures	% of Total
Supportive Home Care	$33,832,900	56.3%
Non-NH Residential Care	6,213,600	10.3
Home Health/Skilled Nursing	3,926,000	6.5
Respite Care	2,757,600	4.6
Customized Goods and Services	2,444,000	4.1
Transportation	2,444,300	4.1
Adult Day Care	2,334,400	3.9
Day Center Treatment	1,291,800	2.2
Prevocational	1,155,200	1.9
Supported Employment	753,400	1.3
All Other Services	2,918,200	4.9
Total	$60,071,400	100.0%

2011 Wisconsin Act 32 Enrollment Cap

2011 Wisconsin Act 32, the 2011-13 biennial budget act, established an enrollment cap for the Family Care, PACE, Family Care Partnership, and IRIS programs for the period July 1, 2011, through June 30, 2013. During this period, the total enrollment in each ADRC service region for these long-term care programs could not exceed the number of individuals enrolled in these programs on June 30, 2011.

Act 32 provided a limited exception to the enrollment cap for certain individuals who relocated from institutions if any of the following applied: (a) the individual resided at the facility for at least 90 days; (b) the facility closed or relocated residents; (c) the facility was no longer licensed to operate in the state; or (d) the individual relocated due to an emergency, as determined by DHS.

Act 32 reduced MA benefits funding by approximately $265.5 million ($105.9 million GPR and $159.6 million FED) in the 2011-13 biennium to reflect: (a) an estimate of savings that would result from implementing the general enrollment cap (-$115.9 million GPR and -$174.9 million FED); and (b) additional one-time funding to support long-term care services for individuals who were on waiting lists for these programs and who were in urgent need of long-term care services, as determined by DHS ($10 million GPR and $15.2 million FED).

In addition, Act 32 prohibited DHS from expanding these long-term care programs to any new county unless DHS determined that these programs were more cost-effective than the coun-

ty's current long-term care service system. DHS implemented the enrollment cap on July 1, 2011.

Notwithstanding the Act 32 enrollment cap, some individuals were enrolled in these programs after July 1, 2011. This was due, in part, to an increase in the number of applications DHS received in the months immediately prior to the effective date of the enrollment cap and a subsequent lag in applicant processing times. Within guidelines described above, 614 individuals that previously lived in institutions were permitted to enroll in these long-term care programs. In addition, approximately 102 individuals were enrolled in these programs and received services funded from the "urgent needs" funding provided in Act 32, for total expenditures of approximately $765,000. In addition, 3,055 individuals were able to enroll as other individuals left these programs.

On December 13, 2011, CMS notified DHS that states could not implement changes to state waiver programs without first receiving approval from CMS. CMS directed the Department to enroll into the Family Care, PACE, Partnership and IRIS programs any individuals that would have been entitled to services under these programs if the enrollment cap had not been put in place.

2011 Wisconsin Act 127 repealed the Act 32 provisions relating to the enrollment cap, effective April 3, 2012.

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 agencies), 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, Hewlett-Packard (HP). 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 Consulting, or by state agencies such as the Department of Administration's Division of Hearings and Appeals, and Division of Enterprise Technology.

In 2011-12, DHS spent approximately $149.1 million (all funds) 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 21 summarizes those contracting costs by funding source. Note that Table 21 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 funds. Those IM administration activities are described later in this chapter.

Fiscal Agent Services. The MA fiscal agent provides administrative services that support the

Table 21: MA and FoodShare Contracted Administrative Costs, Fiscal Year 2011-12

	GPR/PR	FED	Total
Fiscal Agent Services	$18,014,400	$40,265,600	$58,280,000
Enrollment Services Center	8,893,600	8,557,900	17,451,500
Central Data Processing Unit	872,300	972,800	1,845,100
Enrollment Broker	1,365,900	1,285,500	2,651,400
Major External Contracts	3,782,900	3,082,900	6,865,800
Inter/Intra-Agency Contracts	2,357,200	2,786,900	5,144,100
FoodShare (EBT)	1,666,800	1,666,800	3,333,600
CARES	27,114,900	26,303,200	53,418,100
Other Payments	59,100	59,100	118,200
Total	$64,127,100	$84,980,700	$149,107,700

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 (MMIS) services and base fiscal agent services. In 2011-12, the sum of these flat fees totaled $32.3 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 $58.3 million (all funds) in 2011-12.

HP also performed all of the contracted services related to the Department's Enrollment Services Center (ESC). The ESC was developed as part of the state's BadgerCare Plus Core Plan expansion, and, until 2012, performed 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 reduced the workload demands on the counties' income maintenance agencies. As part of changes to the state's income maintenance program enacted in 2011 Act 32, DHS began transitioning cases from the ESC to counties and Milwaukee Enrollment Services (MilES) in October, 2011. Consequently, HP no longer performs this function.

AHS currently serves as the Department's HMO enrollment broker, which provides 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 2011-12, costs associated with the HMO enrollment broker totaled $2.7 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 2011-12, DHS paid MetaStar approximately $1.6 million (all funds) to provide these services and to fund an audit of MA payments to HMOs for maternity-related costs. 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 2011-12, DHS paid PwC $504,200 (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 2011-12, DHS paid PCG $4.4 million (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 2011-12, DHS paid that Division approximately $2.1 million (all funds) for costs related to those administrative hearings.

Staff in 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 2011-12, DHS incurred costs of approximately $1.8 million (all funds) for disability determinations related to the MA program.

CARES. The client assistance for reemployment and economic support (CARES) system assists state and county staff in making eligibility determinations and maintaining case information for such programs as BadgerCare Plus, SeniorCare, Family Care, FoodShare, the SSI Caretaker Supplement, TANF/W-2, and Child Care Assistance (Wisconsin Shares) . The first five of these programs, administered by DHS, accounted for approximately 92% of CARES cases in 2011-12. 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 Consulting, 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. In 2011-12, DHS costs relating to CARES totaled approximately $53.4 million ($22.7 million GPR, $4.4 million PR, and $26.3 million FED).

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 res-

idential facilities or adult family homes. State law requires DHS to survey RCACs at least once every three years.

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

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

*Licensing and Certification Revenues***.** DHS currently collects revenue to support its regulation function by charging facilities a flat certification fee or a fixed amount per licensed bed that varies by the type of facility. 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, including MA, FoodShare Wisconsin, and Wisconsin's program that funds cemetery, funeral and burial expenses for indigent individuals. Prior to calendar year 2012, DHS contracted with each county to perform these activities.

2011 Wisconsin Act 32 (the 2011-13 biennial budget act) included provisions that required counties, other than Milwaukee County, to form up to 10 multi-county consortia to administer IM programs. DHS was directed to administer IM programs in Milwaukee County as a single-county consortium. Act 32 specified that if a county chose not to participate in a multi-county consortium, or DHS determines that a multi-county consortium does not satisfy DHS performance requirements, DHS must assume responsibility for administering IM programs in the county or the geographical area of the multi-county consortium, either by contracting with another multi-county consortium or by providing these services directly However, if DHS assumes this responsibility, the affected counties are required to pay DHS the amount that the county expended for these services in calendar year 2009.

Beginning in 2012, each contract with a multi-county consortium must provide that the multi-county consortium is responsible for:

- Operating a maintaining a call center;
- Conducting application processing and eligibility determinations;
- Conducting ongoing case management; and
- Providing lobby services.

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

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

Finally, each contract must provide that DHS will reimburse each multi-county consortium for services provided under the contract on a risk-adjusted caseload basis.

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

- Providing IM worker training;
- Performing 2nd-party reviews;
- Administering the funeral and burial expense program for indigent individuals;
- Providing information technology and licenses for call centers that are operated by multi-county consortia;
- Maintaining the CARES system;
- Contracting with multi-county consortia and tribes, including establishing performance requirements;
- Monitoring contracts with multi-county consortia and tribes, including compliance with performance standards and federal and other reporting requirements; and
- Operating a centralized document processing unit.

In 2012, there were 10 multi-county consortia. In addition, Menominee tribe served Menominee tribal members and individuals in that county. Milwaukee County's IM programs were administered by DHS staff, which included some individuals that were previously employed by Milwaukee County. Table 22 shows the counties that participated in each consortium in 2012.

*County Contributions***.** Prior to the formation of multi-county consortia, most counties had contributed local funds to partially support their income maintenance activities. These county contributions are referred to as "local overmatch." In 2011, 71 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 2010 and 2011, and the funding sources that supported those expenditures. In calendar year 2011, counties and tribes spent approximately $90.9 million to conduct IM activities. Of that total, local funds (provided by the counties and tribes) totaled $28.5 million, with the remaining $62.3 million funded by a combination of GPR ($16.8 million) and federal matching funds ($45.5 million). The FED includes federal funding that is matched to both the state GPR and the local contributions.

Act 32 required each county, other than Milwaukee County, in calendar years 2012 and 2013, to contribute funds to the county's consortia for the administration of IM programs in an amount that is at least equal to the amount the county expended for these purposes in 2009. In order to resolve a dispute between DHS and Kenosha County regarding that county's local overmatch in 2009, Act 32 specified that Kenosha County's minimum contribution for these two years is $673,000.

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,

Table 22. Income Maintenance Multi-County consortia (Calendar Year 2012)

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

*Denotes Lead Agency

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

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

Table 23: Funding Budgeted for Income Maintenance Activities
Fiscal Year 2012-13

Centralized Services	GPR/County	FED	Total
Staff	$2,757,100	$2,757,100	$5,514,200
Document Processing Unit	2,093,000	2,093,000	4,186,000
Call Center Licenses	2,150,000	2,150,000	4,300,000
CARES Infrastructure	2,500,000	2,500,000	5,000,000
Subtotal	$9,500,100	$9,500,100	$19,000,200
Milwaukee Enrollment Services	$14,500,700	$14,500,700	$29,001,400
Allocations to County Consortia and Tribes			
State IM Contracts to Counties and Tribes	$13,624,500	$13,624,600	$27,249,100
County Maintenance of Effort and Federal Match	20,084,050	20,084,050	40,168,100
Subtotal	$33,708,550	$33,708,650	$67,417,200
Fraud Prevention and Investigation			
State Staff and Contracts	$750,000	$750,000	$1,500,000
Contracts to Counties and Tribes	250,000	250,000	500,000
Subtotal	$1,000,000	$1,000,000	$2,000,000
Grand Total	$58,709,350	$58,709,450	$117,418,800

Table 23 identifies the total funding budgeted in Act 32 for IM functions in 2012-13.

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

Fraud Prevention and Investigations

DHS and its contracted entities are responsible for fraud prevention and investigations relating to the MA and FoodShare programs. These activities are conducted by a combination of federal, state, county, and contracted staff, pursuant to state and federal laws. Further, the state Department of Justice operates a Medicaid Fraud Control and Elder Abuse Unit, which investigates and prosecutes fraud perpetrated by providers against the MA program, and crimes committed against vulnerable adults in nursing homes and other facilities.

The DHS, Office of the Inspector General (OIG) has the primary responsibility for conducting fraud prevention and audit activities for the MA and FoodShare programs. OIG was created in October, 2011, when the Department combined staff from the former Bureau of Program Integrity with other DHS staff that had been performing these activities into a single unit, and attached OIG to the DHS Secretary's office.

2011 Act 32 increased base funding for DHS by $2,000,000 ($1,000,0000 GPR and $1,000,000 FED), beginning in 2012-13, to support: (a) 19.00 additional positions in DHS to conduct program integrity functions ($1,330,000); (b) the restoration of base funding that had been deleted in the previous biennial

budget for DHS to allocate to counties and tribes to support local fraud prevention and investigation activities ($500,000); and (c) an increase in funding available to support contracted program integrity activities ($170,000).

In March, 2012, the Joint Committee on Finance approved the administration's request to reallocate funding DHS had previously used to contract for fraud prevention activities, together with the additional funding that had been provided in Act 32 for contracted services, to instead support additional state positions for OIG, beginning in 2012-13 for this purpose. As a result of these actions, there are currently 106.13 authorized full-time equivalent positions in OIG. This staff works to detect and investigate fraud committed by MA providers, retailers that participate in the FoodShare program, and individuals enrolled in these programs.

OIG is responsible for administering the fraud prevention and investigation program (FPIP) for the MA, and FoodShare programs. For calendar year 2012, DHS allocated $500,000 (all funds) to counties and tribes to fund these activities. DHS provided each county and tribe the option of either: (a) taking the lead or participating as part of a FPIP consortium; or (b) managing these activities independently for their own county or tribe. For agencies that elect the first option, DHS allocated to each county and tribe an amount that is based on each agency's percentage of the statewide income maintenance caseload (excluding the caseload for which Milwaukee Enrollment Services (MilES) is responsible). Counties and tribes that choose the second option receive only federal MA matching funds, based on the funding they provide for these efforts.

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

The current program is based on general guidelines developed by DHS in January, 2011. These guidelines include:

- An emphasis on fraud prevention over fraud detection;

- An emphasis on the administrative disqualification process over criminal adjudication;

- A requirement that the FPIP is cost neutral such that total program costs do not exceed total program savings as measured by future savings, claims established and sanctions. Each FPIP project is to establish a savings-to-cost ratio target of 5:1;

- Investigations must be categorized as either "pre-certification" or "post-certification" to conform to federal reporting requirements;

- DHS will monitor FPIP performance relative to the cost-benefit ratio, timeliness of completions, and the number of investigations completed; and

- FPIP staff must enter all data related to fraud investigation activities into CARES.

Audits of Providers 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 medical records of MA recipients from providers. 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 2011-12, DHS conducted 1,245 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. DHS also performs follow-up audits where appropriate. As a result of these audits and other related activities, DHS recovered approximately $2.8 million in 2011-12.

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 local IM 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 before MA if health insurance or Medicare is indicated on a recipient's MA card.

DHS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available by requiring the service provider to obtain reimbursement from those sources. In 2011-12, DHS estimates these efforts enabled the MA program to avoid over $266 million in costs, $111.5 million relating to claims where the MA recipient had Medicare coverage, and $154.5 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 2011-12, these post-payment recoveries included recoveries stemming from other health insurance coverage ($4.3 million), casualty ($3.1 million), medical support liability ($19.5 million), and other post-payment recoveries ($63.2 million). In addition to these amounts, DHS "estate recovery" activities, discussed in more detail later in this chapter, generated post-payment recoveries of $24.7 million (all funds) in 2011-12.

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 2011-12, provider-based billing COB activities benefited the MA program by approximately $7.4 million.

Estate Recovery Program

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

The estate recovery program attempts to recover MA costs by: (a) placing a lien against a home; (b) filing claims in a recipient's estate; (c) affidavits; and (d) voluntary recoveries. DHS may place a lien 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 recipient's estate. A claim on the estate may not be paid if a spouse, or a child under age 21, blind or disabled, survives the recipient. 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 consortia and tribal governing body participation in the estate recovery program is limited to the collection and transmittal of certain information to DHS including homestead property, legal descriptions of property, and notices of death. Each consortia 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 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 health care-related costs under the estate recovery program. Currently, Wisconsin Circuit Court records are available online through the consolidated court automation program (CCAP), allowing DHS to monitor when an estate is in probate.

However, under 2005 Wisconsin Act 206, a 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.

Eligibility Determinations and the Federal Affordable Care Act

The federal Affordable Care Act requires all states to make changes to their MA eligibility criteria and eligibility systems by January 1, 2014. Two significant changes are described below.

First, to ensure coordination of health care coverage between state MA programs and health plans offered through new health insurance exchanges, states must adopt a uniform method of counting income by using modified adjusted gross income (MAGI) as the basis for their MA income eligibility determinations. MAGI is defined as adjusted gross income, as determined for federal income tax purposes, plus any foreign income or tax-exempt interest that a taxpayer receives. Currently, states use different methods of counting income in making MA eligibility determinations, generally by excluding certain types of income. MAGI will also be used in determining eligibility for premium credits for health plans purchased through benefit exchanges. In addition, states currently have some discretion in determining how a family's size is determined, and which family members' income is counted. Beginning in 2014, for MA eligibility purposes, an individual's family size will be

based on the number of personal exemptions an individual claims on his or her tax return.

Second, states must provide a process for individuals to apply for, or renew their MA eligibility through a website that enrolls individuals in either MA, the children's health insurance program or a plan offered through the exchange, regardless of the program for which the individual initially applied. These eligibility determination systems will interface with a federal data system hub, which is an electronic service that states will use to verify certain information from federal agencies. Federal MA matching funds will support 90% of the costs of development and installation of these enhanced eligibility determination systems until December 15, 2015.

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 ages 65 and older purchase prescription drugs. DHS began paying benefits on September 1, 2002, after CMS granted a waiver of federal MA law that allows the state to claim federal matching funds for a portion of the program's benefit costs. The current SeniorCare waiver expires December 31, 2012. DHS has formally applied to extend that waiver through December 31, 2015. As of the date of this writing, a final determination from CMS regarding that extension had not been received.

Eligibility. Most Wisconsin residents age 65 and older are eligible for SeniorCare. The exceptions are people who are already eligible for full MA benefits, people who are not U.S. citizens or qualified immigrants, and inmates of public institutions. Individuals who have other prescription drug coverage such as Medicare Part D can participate in SeniorCare, but the program only pays for that portion of their eligible prescription drug costs that are not payable from those other sources.

Cost-Sharing Requirements. In addition to an annual enrollment fee of $30, SeniorCare has the following cost-sharing 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 their spouse if they 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 prospective income for the 12 calendar months starting with the month of application. Self-employment income is also included, with allowed deductions for business expenses, losses, and depreciation. 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), they do not have a deductible. For these participants, SeniorCare pays the cost of all covered prescription drugs, subject only 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 annual deductible is $500. For these participants, SeniorCare pays the cost of all covered prescription drugs, subject to the required copayments, after they satisfy the $500 deductible.

If the income of the applicant's fiscal test group is greater than 200% of the FPL, their annual deductible is $850. SeniorCare pays the cost of all covered prescription drugs for these participants, subject to the required copayments, after they satisfy the $850 deductible. Note, however, that if the applicant's fiscal test group has income greater than 240% of the FPL, they must satisfy

the program's "spend down" rules before they are eligible for benefits. Those "spend down" rules are discussed below.

When 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. This 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 their "spend-down" requirement. 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" 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 SeniorCare count toward this spend-down requirement. During the spend-down period, pharmacies cannot charge SeniorCare participants more than the retail price of the drug. Once they satisfy their spend-down amount, participants are eligible for the "deductible benefit" while they satisfy their $850 deductible. After they meet that deductible, SeniorCare pays the cost of their covered prescription drugs, subject to the required copayments

Copayments. After they satisfy their deductible, if any, participants pay a copayment for each prescription drug they obtain under SeniorCare. The copayment is $5 for each generic drug prescription and $15 for each brand-name drug prescription. The state's payment to the pharmacy is reduced by the amount of the copayment.

These 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. These participants do not have deductibles or spenddown requirements. They only pay the required 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 participants must meet a $500 annual deductible. Once they meet that deductible, they pay the required 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 participants must meet an $850 annual deductible. Once they meet that deductible, they pay the required copayments for covered prescription drugs they obtain under the program.

Level 3. Individuals with income above 240% of the FPL are enrolled in SeniorCare Level 3. These participants must first satisfy their spend-down requirement then meet an $850 annual deductible. Once Level 3 participants satisfy both those requirements, they pay the required copayments for covered prescription drugs they obtain under the program.

Table 24 shows SeniorCare enrollment as of

September 2012, by participation level.

Table 24: SeniorCare Enrollment, by Participation Level, September 2012

Level 1 (≤160% FPL)	35,400
Level 2a (>160% to ≤ 200% FPL)	18,600
Level 2b (>200% to ≤240% FPL)	10,400
Level 3 (>240% FPL)	21,300
Total Enrollment	85,700

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

SeniorCare typically pays pharmacies the lesser of a drug's estimated acquisition cost (EAC) or the usual and customary amount the pharmacy bills private pay clients for the drug. The EAC is established according to the type of drug, as follows: (a) the wholesale acquisition cost (WAC) plus 2.0 percent for most brand name drugs; (b) the state maximum allowed cost (SMAC) for multi-sourced branded and generic drugs; (c) an expanded maximum allowed cost (EMAC) for drugs without a SMAC or WAC rate on file; or (d) the WAC minus 3.8% for single-source generic drugs without a SMAC rate on file.

When a drug is on the SMAC list (updated monthly to reflect the prices for which drugs are readily available through wholesalers in Wisconsin) the program pays the generic price unless the prescriber indicates that the brand name drug is medically necessary, in which case prior authorization is required. In all cases, the amount the state pays the pharmacy is reduced by the copayments paid by program participants.

In addition to reimbursing pharmacies for their product costs, the program pays pharmacies a dispensing fee for each SeniorCare prescription they fill. The dispensing fee is $3.44 for brand name drugs and $3.94 for generic drugs. The pharmacy can receive higher fees if they have to compound or repackage drugs. Pharmacies can also receive reimbursement for providing certain types of Medication Therapy Management services for the participant. This care must go beyond the basic activities required by state and federal standards, and must result in a positive outcome for both the participant and the program. Examples include increasing patient compliance, preventing potential adverse drug reactions, or a scheduled consultation with the pharmacist to review the patient's drug therapy regimen.

Covered Drugs and Limitations. SeniorCare, like the state's larger MA program, has an open drug formulary. This means that a prescription drug is covered if it meets all the following criteria: (a) it is approved by the FDA; (b) the manufacturer has signed a rebate agreement with CMS, and a separate rebate agreement with the state where necessary; and (c) the manufacturer has reported data and prices to First DataBank.

The SeniorCare and MA programs also maintain a preferred drug list (PDL) and a supplemental rebate program. Based on the drug's therapeutic significance and cost effectiveness, supplemental rebates are negotiated with the manufacturer and PDL recommendations are made to the Wisconsin Medicaid Prior Authorization Advisory Committee. That committee is composed of physicians, pharmacists, advocates, and consumers. Drugs that are part of the PDL may be designated by the Advisory Committee as either preferred or non-preferred. Non-preferred drugs require prior authorization. Not all drugs are part of the PDL.

Maintenance of the PDL, the SMAC list, and generic substitution are several of the strategies DHS uses to control prescription drug costs in the SeniorCare and MA programs. Other tools in-

clude the use of prospective and retrospective drug utilization reviews, prior authorization requirements for certain drugs and/or certain situations, diagnosis restrictions, and the exclusion of certain drugs that are deemed experimental or lacking medically accepted indications. Many of these strategies are facilitated by the Department's pharmacy point-of-sale electronic claims management system which, among other things, enables pharmacies to submit real-time claims that are screened against the program's eligibility records and the participant's medical and prescription history.

Funding. SeniorCare benefits (net of participant cost-sharing and payments from other sources such as some participants' Medicare Part D coverage) are funded with state GPR, federal MA matching funds (for expenditures associated with participants in the waiver program), and drug manufacturer rebates.

GPR funding for benefits is budgeted in a sum certain appropriation. Under current law, if DHS exhausts the GPR budgeted for the program, it must continue to accept applications, determine eligibility, and notify applicants that program benefits are conditioned on the availability of funding. For any period in which funding is completely expended, DHS is not required to pay pharmacies for any drugs purchased by recipients. In that event, pharmacies can charge 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.

Federal matching funds help offset benefit costs for those participants in the SeniorCare waiver program, i.e., individuals with incomes less than 200% of the FPL. That federal funding is based on the state's federal medical assistance percentage (FMAP), which in state fiscal year 2012-13 is approximately 60%.

Rebate revenue received from pharmaceutical manufacturers is deposited into a program revenue appropriation. For costs associated with participants in the waiver program, these program revenues offset state and federal expenditures proportionately. For costs associated with participants not in the waiver program, the rebate revenues are applied solely against GPR.

SeniorCare administrative costs are funded from a combination of program revenue generated by the $30 enrollment fee, GPR, and federal MA matching 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 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 October 15 through early December, 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 Part D enrollment, these individuals can choose their own drug plan or, failing that, be automatically enrolled in a randomly selected benchmark plan. Benchmark plans offer basic Medicare Part D coverage for a monthly premium at or below a regional benchmark level. The benchmark monthly premium for Wisconsin in 2013 is $38.25.

If a person does not enroll for Medicare Part D when they become eligible, and there is a period of 63 or more continuous days 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 SeniorCare program is considered "creditable prescription drug coverage" for these purposes. Other prescription drug coverage, such as that offered by companies to their retirees, can also qualify as creditable coverage, depending upon the benefits offered.

Coverage under Medicare Part D. The MMA defines the standard coverage available under Part D in terms of 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 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.

As for benefit structure, the Part D "standard benefit" for 2013 consists of the following: (a) an annual deductible of $325; (b) a coinsurance requirement of 25% of the initial coverage limit of $2,970; and (c) 100% catastrophic coverage (subject to copayments of $2.65 for generic/preferred multi-source drugs and $6.60 for other 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 $4,750. As this description implies, there is a gap in the

standard coverage structure that begins after the enrollee has purchased covered prescription drugs totaling $2,970 (with accompanying out-of-pocket costs of $986) and continues until the enrollee has purchased covered prescription drugs totaling $6,734. This $3,764 coverage gap ($6,734 catastrophic coverage threshold minus the $2,970 initial coverage limit) is called the Medicare Part D "donut hole."

As originally enacted, the standard Medicare Part D benefit required enrollees to pay 100% of the cost of prescription drugs purchased in the donut hole. The Patient Protection and Affordable Care Act (ACA) gradually reduces enrollee cost-sharing in the donut hole from 100% in 2010 to 25% by 2020 for both brand name drugs and generic drugs. In 2013, enrollees will pay 47.5% of the cost of brand name drugs and 79% of the cost of generic drugs they purchase in the donut hole.

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), 29 PDPs were offering Medicare Part D coverage to Wisconsin residents in 2012, with monthly premiums ranging from $15.10 to $114.70. A number of MA-PDs were also providing Part D coverage to state residents during this period. According to Kaiser, in February 2010, 303,600 Wisconsin residents were obtaining Part D coverage through PDPs and 178,500 state residents were obtaining Part D coverage through MA-PDs.

Low-Income Subsidy. Medicare Part D provides financial assistance to some of its enrollees. The amount of assistance varies with the type of beneficiary, their income, and their assets. Most people who qualify for the full Medicare Part D low-income subsidy (LIS) are full-benefit duals, meaning they are eligible for Medicare and full-benefits under Medicaid. Full-benefit duals do not pay a Part D premium or a deductible (assuming they enroll in a benchmark plan). In 2013, those with incomes at or below 100% of the FPL will pay a $1.15 copayment for generic/preferred multi-source drugs and a $3.50 copayment for other drugs, but do not have any copayments after paying annual out-of-pocket drug costs of $4,750. Full-benefit duals with incomes greater than 100% of the FPL pay copayments of $2.65 for generics/preferred multi-source drugs and $6.60 for brand names, up to the maximum out-of-pocket limit of $4,750. Institutionalized full-benefit duals do not have copayments.

Limited-benefit duals (QMBs, SLMBs, and QIs) who are eligible for Medicare and whose limited income and resources entitle them to Medicare cost-sharing assistance under Medicaid, Medicare beneficiaries who receive SSI, and other individuals with incomes less than 135% of the FPL and limited resources can qualify for the same Part D low-income subsidies as full-benefit duals with incomes greater than 100% of the FPL. In 2013, individuals in these groups do not pay Part D premiums or deductibles, and pay copayments of $2.65/$6.60 up to the maximum out-of-pocket limit of $4,750.

Finally, some other individuals with incomes less than 150% of the FPL and limited resources can qualify for partial subsidies under the Part D LIS program. In 2013, these individuals pay income-based sliding-scale premiums and a $66 deductible. After satisfying their deductible, they pay 15% of their drug costs up to the maximum out-of-pocket threshold of $4,750, beyond which they pay copayments of $2.65/$6.60.

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 clawback payment is based on a declining percentage of the 2003 calendar year non-federal share of prescription drug costs state MA programs paid for dual eligibles, inflated to the current year. The percentage began at 90% in 2006 and is set to decrease to 75% during the following 10 years. In fiscal year 2011-12, the Wisconsin MA program made clawback payments to CMS of approximately $171.0 million.

SeniorCare Enrollment and Spending Trends. After Medicare Part D began offering prescription drug coverage in January 2006, enrollment in SeniorCare increased, perhaps due to seniors' desire to enroll in a prescription drug plan with creditable coverage and thereby avoid any Medicare Part D late enrollment penalty. In more recent years, SeniorCare enrollment has returned to levels more consistent with the program's earlier experience. Table 25 shows the program's average monthly enrollment in state fiscal years 2006-07 through 2011-12.

Table 25: SeniorCare Average Monthly Enrolment, Fiscal Years 2006-07 through 2011-12

2006-07	104,420
2007-08	93,337
2008-09	87,823
2009-10	87,693
2010-11	89,403
2011-12	87,693

Table 26 shows total benefit expenditures under the SeniorCare program for that same six-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 Fiscal Years 2006-07 through 2011-12

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
GPR	$45,668,300	$38,797,300	$33,983,200	$18,273,100	$20,407,200	$21,200,200
FED	41,875,500	33,476,700	50,696,300	16,741,000	23,130,600	15,382,300
PR	53,198,000	54,780,900	40,033,800	79,682,300	64,348,800	51,614,800
Total	$140,741,800	$127,054,900	$124,713,300	$114,696,400	$107,886,600	$88,197,300

CHAPTER 8

FUNDING SOURCES

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

Funding Sources for the Wisconsin MA Program

Table 1 on page 2 of this paper shows the relative contribution of the various funding sources that support MA benefit expenditures. As that table indicates, federal matching funds (FED) constitute by far the single largest funding source for Wisconsin's MA program. Those federal funds are provided in the form of a matching rate based on the state's federal medical assistance percentage, or FMAP. Each state's FMAP is adjusted annually based on a formula in federal law that compares the state's per capita income to national per capita income. Under that formula, Wisconsin's standard FMAP has tended to be around 60%, meaning that federal matching funds have typically supported approximately sixty cents of each dollar the MA program spends on benefits costs.

The federal government has, on occasion, temporarily increased states' FMAPs during periods of economic recession. This most recently occurred under the American Recovery and Reinvestment Act of 2009 (ARRA), which increased Wisconsin's FMAP during the period October 1, 2008 through June 30, 2011. The additional FED Wisconsin received as a result of ARRA's enhanced FMAPs temporarily reduced the amount of state funding that otherwise would have been needed to support the large MA enrollment increases that occurred during that period.

Effective July 1, 2011, Wisconsin's standard FMAP reverted to a more typical rate of approximately 60%. The resulting reduction in FED (relative to what the state had been temporarily receiving under ARRA) was one of the primary reasons GPR spending for the MA program increased by approximately $420 million in 2011-12 compared to the prior year, even as total MA expenditures declined. See Chapter 9 for more information on MA expenditure and enrollment trends.

Wisconsin's standard FMAP for 2012-13 is 59.94%, meaning that federal matching funds will finance 59.94% of most eligible MA benefit costs. Higher FMAPs can and do apply to some enrollees (such as children whose benefits are funded through the Children's Health Insurance Program) and for some healthcare services (such as family planning services).

In order to claim federal matching dollars, the MA program must provide the non-federal spending match. In Wisconsin, as in other states, that non-federal share is funded both by GPR and non-GPR sources. Examples of non-GPR funding sources include the following:

- Broad-based healthcare-related taxes (licensing fees, provider assessments, or other mandatory payments) that relate to healthcare 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 pro-

gram (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 these and several other non-GPR sources are deposited into the medical assistance trust fund (MATF). The MATF is a separate, non-lapsible trust fund used to help 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 2010-11, 2011-12, and projected revenues and expenditures for 2012-13.

Nursing Home and ICF-ID Bed Assessment. The state established a provider assessment on nursing home beds in 1991-92. The assessment is currently $170 per month per licensed nursing

Table 27: Medical Assistance Trust Fund
Fiscal Years 2010-11 through 2012-13

	Actual 2010-11	Actual 2011-12	Projected 2012-13
Beginning Balance	**$497,400**	**$4,970,900**	**$10,046,100**
Revenues			
Transfer from Other Funds			
Hospital Assessment Fund	$202,312,000	$146,834,800	$139,220,500
Critical Access Hospital Fund	6,172,100	4,908,800	3,150,900
Permanent Endowment Fund	50,000,000	50,000,000	50,000,000
Provider Taxes Deposited Directly to MA Trust Fund			
Nursing Home/ICF-ID Bed Assessment	$80,723,700	$79,980,000	$79,401,100
Ambulatory Surgical Center Assessment	16,600,000	16,618,100	16,600,000
Federal MA Funds Deposited to MA Trust Fund			
Wisconsin Medicaid Cost Reporting	$0	$0	$15,738,900
HealthCheck-Eligible Services Provided by Residential Care Centers	9,500,000	7,870,900	7,000,000
Nursing Home Certified Public Expenditure Program	53,477,200	54,388,200	48,884,000
Hospital Certified Public Expenditure Program	8,883,900	6,589,200	5,400,000
Claims for County-Supported Services During Period of Enhanced Federal Match	6,645,100	0	0
Claims for Services Provided by UW Physicians Transferred from UW System	25,000,000	16,721,400	17,000,000
Revenue Reductions			
Interest to the General Fund	-$204,100	-$50,300	-$231,600
Required Transfer to the General Fund	-7,021,400	0	0
Net Revenue	$452,088,500	$383,861,100	$382,163,800
Expenditures	$447,615,000	$378,785,900	$392,209,900
Ending Balance	$4,970,900	$10,046,100	$0

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 assessment from $75 in 2007-08 to $150 per month in 2009-10, and to $170 per month in 2010-11. Provisions included in the 2009-11 and 2011-13 budget acts exempted the nursing homes operated by the Department of Veterans Affairs from paying the nursing home bed assessment.

In addition, the state collects a bed assessment on all ICF-ID beds in the state. The ICFs-ID assessment is calculated by multiplying the total gross annual revenues of all ICFs-ID 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. Under this formula, the ICF-ID monthly assessment rate per bed was $638 in 2008-09, $701 in 2009-10, $770 in 2010-11, $840 in 2011-12, and $910 in 2012-13.

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. However, the current method DHS uses to reimburse nursing homes for the care they provide to MA recipients includes a component that is intended to offset, in the aggregate, the total estimated costs nursing homes incur to pay the nursing home assessment.

All revenues generated from the nursing home and ICF-ID bed assessment are deposited in the MATF. In 2011-12, those revenues totaled approximately $80.0 million. The state has used revenues from the nursing home bed assessment and associated federal matching funds, in part, to fund rate increases for nursing homes and to replace GPR funding for general MA benefits costs with SEG revenues from the assessment.

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 ended in 2004-05), DHS determined that larger reimbursement claims could be made using the operating losses incurred by nursing homes owned and operated by local governments. As a result, DHS requested and received CMS approval to create a CPE program, under which the state receives federal MA matching funds based on unreimbursed costs county and local government facilities incur to provide nursing home care to MA recipients. All federal revenue the state collects under this nursing home CPE program is deposited to the MATF. In 2011-12, those revenues totaled $54.4 million.

For federal matching funds generated by the nursing home CPE, provisions enacted in 2005 Wisconsin Act 107 require DHS to distribute any funds that the state receives in a fiscal year that are in excess of the amount set in the biennial budget for that same fiscal year. DHS currently distributes these funds, when available, as additional supplemental payments to nursing homes owned and operated by local governments. In 2011-12, the excess CPE payment was $5,504,200.

Hospital Certified Public Expenditure Program. Under a separate CPE program, DHS is authorized to submit a claim for federal matching funds in an amount equal to the deficit UW hospital incurs to provide services to MA recipients. In 2011-12, this CPE program generated $6.6 million in federal matching funds that were deposited to the MATF.

UW Intergovernmental Transfer Program. State law requires the UW System to transfer no more than $20,338,500 annually in program revenue from its general operations appropriation to the MATF. In 2011-12, the amount transferred under this provision was $16.7 million. These funds represent a portion of the federal MA matching funds generated by the supplemental MA reimbursement rates paid to UW physicians

for services they provide to MA recipients. The non-federal share of those supplemental reimbursement payments is funded by the UW through an IGT payment to the MA program.

RCC HealthCheck Services Certified Public Expenditure Program. In fiscal year 2004-05, the state began claiming federal MA matching funds for HealthCheck services 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 2011-12, $7.9 million in federal matching funds associated with these costs were deposited into the MATF.

Hospital Assessment. 2009 Wisconsin 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). Similar to the nursing home assessment, the hospital assessment was created to increase MA payment rates to hospitals and to replace GPR funding previously budgeted for MA benefits with SEG revenues 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. In 2011-12 that amount was $414,507,300.

Revenues collected from the assessment are deposited into the hospital assessment fund. From that fund, a portion of the revenues (along with federal matching dollars) are used to increase MA payments to hospitals for providing inpatient and outpatient services to MA recipients. The additional reimbursement hospitals receive through the assessment, in the aggregate, is established by a statutory formula which has as its numerator the authorized assessment amount and which uses 0.6168 as its denominator. In 2011-12, that additional reimbursement was $414,507,300/.6168, or $672,028,700. Thus, the aggregate "net" gain to eligible hospitals in fiscal year 2011-12 from the hospital assessment was approximately $257,521,400 ($672,028,700 in additional reimbursement received less the $414,507,300 in assessments paid). Hospitals with proportionately larger MA caseloads benefit to a greater degree from the higher MA reimbursement rates financed by the assessment than hospitals with few or no MA patients.

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 HMOs, DHS makes monthly "access payments" to each HMO based on how many of their enrollees are MA recipients. The HMOs, in turn, are 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 MA enrollees during the preceding month.

Not all of the hospital assessment revenues collected by DHS are used to fund the state share of the additional MA reimbursement paid to hospitals under the statutory formula described above. The assessment revenues not needed for that purpose are transferred to the MATF where they are used to support MA benefits costs, thereby reducing the amount of GPR that would otherwise be required to fund those services. In 2011-12, $146.8 million in hospital assessment revenues were transferred to the MATF and used to support the overall MA program under this statutory mechanism.

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 Janu-

ary 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 58 CAHs in Wisconsin.

The state's MA program has typically reimbursed CAHs for 100% of the costs they incur to serve MA patients. As part of the cost-saving initiatives required under the 2009-11 state budget, DHS proposed reducing CAH reimbursement rates to 90% of costs. In part to avert that reduction, 2009 Wisconsin 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 rural physician residency assistance program administered by the University of Wisconsin.

The CAH assessment works similarly to the larger hospital assessment, except that the CAH assessment is based on gross inpatient revenues (rather than total gross patient revenues) and 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 2011-12, the CAH assessment generated revenues of approximately $9,870,000, a portion of which, when combined with federal matching funds, were used to make additional MA reimbursement payments to CAHs. The remaining assessment revenues were used for the UW items ($1,000,000) or transferred to the MATF to support MA benefit expenditures ($4,908,800).

Ambulatory Surgical Center Assessment. The 2009-11 budget created an assessment on ambulatory surgical centers. Federal regulations define an ambulatory surgical center (ASC) as any distinct entity that operates exclusively for the purposes of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. Those regulations also require that the entity have an agreement with CMS in order to participate in Medicare as an ASC.

State law authorizes the Wisconsin Department of Revenue (DOR) to collect an assessment on the gross patient revenues of ASCs located in Wisconsin consistent with federal regulations pertaining to provider assessments, which generally limit those assessments to 5.5% of the applicable patient revenue stream. In 2011-12, DOR collected and transferred to the MATF approximately $16.6 million in ASC assessment revenues. Those assessment revenues, along with federal matching dollars, were used to fund $20.0 million in additional reimbursement to ASCs that serve MA patients. The balance of the ASC assessment revenues not used for that purpose ($8.7 million) were used to support other MA benefit expenditures.

Other Assets Transferred to the MATF. The Legislature has, on occasion, authorized the transfer of assets from other state funds to the MATF to support MA benefits expenditures. These have included transfers from the state's general fund, the transportation fund, the permanent endowment fund (transfers which still occur in the amount of $50 million annually), and the injured patients and families compensation fund (IPFCF). The Wisconsin Supreme Court found the latter to be an unconstitutional taking of property without just compensation and ordered the state to return those funds, along with lost earnings, to the IPFCF.

Other Revenues Used To Support MA Expenditures

In addition to GPR, FED, and the revenues and other assets periodically deposited into the MATF, the hospital assessment fund, and the critical access hospital assessment fund, 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 the counties incur in providing home- and community-based waiver services that exceed their state allocations. In fiscal year 2011-12, counties and tribes contributed approximately $49.7 million under the MA waiver programs (including regular COP funding used for waivers), which generated approximately $75.7 million in additional federal matching funds.

School-Based Services. School districts and cooperative educational service agencies (CESAs) provide the non-federal match for the school-based health services described in Chapter 3. In 2011-12, the net federal matching dollars associated with those school-based services and claimed by the state totaled $97.7 million, of which approximately $70.5 million was distributed to the provider school districts and CESAs, and $27.2 million was reserved for future credits to the state's general fund.

Case Management Services, Community-Based Psychosocial Services, Community Support Programs. The non-federal share of the cost of these services, as explained in Chapter 3, is 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 2011-12, those federal matching dollars totaled approximately $83.0 million.

*Tribal Gaming Revenue***.** DHS is budgeted $825,000 annually from revenue the state receives from tribes from gaming proceeds to fund a portion of the state's share of MA payments to FQHCs that are not operated by tribes, but that serve tribal members.

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 certain BadgerCare Plus participants.

Under federal law, a drug manufacturer must enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services in order for states to receive federal MA matching funds for outpatient drugs dispensed to MA patients. In 2011-12, these federally mandated rebates, along with supplemental drug rebates negotiated by the state, totaled $328.9 million. Those rebates are used to offset, proportionately, the GPR and FED needed to fund MA benefits.

As described in Chapter 1, DHS collects premiums from certain BadgerCare Plus members, and those premiums are used to offset program costs. In 2011-12, those premiums totaled $19.7 million.

Table 28 provides information on net benefit expenditures under the state's MA and MA-related programs, by funding source, for the five-year period 2007-08 through 2011-12. As explained in the Introduction section of this paper, the expenditure amounts shown in Table 28 are net of several items, including drug manufacturer rebates. When those rebates are received by DHS, they are used to proportionately reduce the GPR and FED needed to fund MA benefits. They are not reflected as PR in Table 28. A similar accounting treatment is given to amounts collected as a result of provider audits and amounts recovered from other payment sources such as participants' other insurance coverage.

SeniorCare expenditures are broken out separately in Table 28. Unlike their treatment in the larger MA program, the drug manufacturer rebates DHS receives for SeniorCare expenditures are classified as PR in the state's accounting system and are shown as such in Table 28.

The table shows how the relative contributions made by the funding sources that support MA benefit expenditures have changed in recent years. Two such funding shifts were particularly significant. The first was the large increase in SEG revenues that occurred in 2008-09. That increase coincided with the implementation of the hospital assessment described in Chapter 8. The second is the disproportionately large FED increases that occurred in 2008-09 through 2010-11. Those disproportionate increases were the product of the temporarily enhanced FMAPs provided to states under the American Recovery and Reinvestment Act of 2009. The state's FMAP returned to a more historically normal rate of approximately 60% on July 1, 2011, and that decline (relative to the previous three years) is evident in the lower FED expenditures for 2011-12.

Note that MA/BC Plus expenditures declined in 2011-12 compared to the prior year. This decline was primarily due to the fact that the state shifted approximately $430 million (all funds) of managed care capitation payments from 2011-12 to 2010-11 in order to capture the higher FMAP

Table 28: Net Benefit Expenditures for MA/BC Plus and SeniorCare, by Fund Source
Fiscal Years 2007-08 through 2011-12

	2007-08	2008-09	2009-10	2010-11	2011-12
MA/BC Plus					
GPR	$1,756,424,200	$1,102,495,600	$1,285,958,000	$1,446,356,000	$1,863,950,600
FED	2,905,844,900	3,878,779,400	4,675,132,000	4,960,883,300	3,979,299,400
PR	76,391,100	88,044,800	99,959,300	108,010,200	112,650,600
SEG	212,060,700	875,533,100	635,098,700	666,488,300	641,254,500
Total	$4,950,720,900	$5,944,852,900	$6,696,148,000	$7,181,737,800	$6,597,155,100
SeniorCare					
GPR	$38,797,300	$33,983,200	$18,273,100	$20,407,200	$21,200,200
FED	33,476,700	50,696,300	16,741,000	23,130,600	15,382,300
PR	54,780,900	40,033,800	79,682,300	64,348,800	51,614,800
Total	$127,054,900	$124,713,300	$114,696,400	$107,886,600	$88,197,300

rates that were available to the state prior to July 1, 2011.

As Table 28 indicates, MA benefit expenditures were significantly higher in 2011-12 (even with the payment shift noted above) than they were in 2007-08. A number of factors have contributed to that increase. One of those factors is the various assessments (Hospital, CAH and ASC) that the state has implemented starting in 2008-09. In the most recent fiscal year (2011-12), revenues generated by those assessments, together with the associated federal matching funds, increased total MA benefit expenditures by over $700 million, compared to 2007-08.

A second factor that has contributed to the MA expenditure increases of the past five years is the large enrollment increases experienced in certain parts of the program. Those enrollment trends are shown in Table 29, which summarizes the average monthly enrollment for various MA and MA-related programs and eligibility groups during the five-year period 2007-08 through 2011-12. In some cases, as with the BadgerCare Plus Core Plan, enrollment grew as a result of the state's decision to expand coverage. In others, the enrollment increases were amplified by the severe economic downturn that began in 2008. Enrollment in BadgerCare Plus is particularly sensitive to the lower incomes and reduced access to employer-sponsored health insurance that occurs in periods of economic recession, both of which are factors in determining eligibility for that program.

Note that beginning in 2007-08, the state began the phased-in statewide expansion of the Family Care program. Family Care enrollment is not shown separately in Table 29. Instead, Family Care enrollees are included within the larger "Elderly" and "Disabled" enrollment categories in Table 29.

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 managed care organizations. Table 30 shows total net MA benefit expenditures in 2011-12 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 physician/clinic services. In 2011-12, the state paid approximately $127.9 million (all funds) for such services that were delivered on a fee-for-service basis. HMO enrollees also received physician/clinic services. Reimbursement for those services is incorporated into the monthly capitation rates paid to those enrollees' HMOs and is not broken out separately in Table 30.

Average per Person MA Costs for the Primary MA Eligibility Groups

Table 31 shows the per member per month costs, enrollment, and expenditures for each of the major eligibility categories in the MA program. Note that the table does not include supplemental payments to providers, drug rebates, payment recoveries and collections, or payments to providers that occur outside of the standard fee-for-service or capitation payments. The purpose of Table 31 is to provide a general indication of the relative per member costs associated with different MA groups. Because of the adjustments noted above and the fact that only one

Table 29: Average Monthly Enrollment in MA and MA-Related Eligibility Groups, by State Fiscal Year

	State Fiscal Year				
	2007-08	2008-09	2009-10	2010-11	2011-12
Elderly	38,200	38,100	37,900	37,500	36,800
% Change from Prior Year		-0.3%	-0.5%	-1.1%	-1.9%
Disabled					
MA Only	76,500	78,600	85,300	88,600	89,900
Ma/Medicare Dual Eligibles	65,900	74,400	75,600	80,500	85,100
Total Disabled	142,400	153,000	160,900	169,100	175,000
% Change from Prior Year		7.4%	5.2%	5.1%	3.5%
BadgerCare Plus					
Children	351,500	392,600	442,300	466,900	477,500
Adults	175,400	204,600	241,000	258,600	264,200
Pregnant Women	15,200	20,600	21,000	21,400	20,800
Total BadgerCare Plus	542,100	617,800	704,300	746,900	762,500
% Change from Prior Year		14.0%	14.0%	6.0%	2.1%
BadgerCare Plus Core Plan	N.A.	12,000	56,000	45,100	28,900
% Change from Prior Year		N.A.	366.7%	-19.5%	-35.9%
BadgerCare Plus Basic Plan	N.A.	0	0	4,390	3,020
% Change from Prior Year				-31.2%	
Foster Children	15,800	16,100	16,800	17,200	17,400
% Change from Prior Year		1.9%	4.3%	2.4%	1.2%
Well Woman MA	470	570	660	780	880
% Change from Prior Year		21.3%	15.8%	18.2%	12.8%
Family Planning Only Services	51,700	48,200	50,100	58,900	67,300
% Change from Prior Year		-6.8%	3.9%	17.6%	14.3%
Limited Benefit Medicare Beneficiaries	10,500	14,000	15,800	18,100	19,800
% Change from Prior Year		33.3%	12.9%	14.6%	9.4%
Total MA Enrollment	801,170	899,770	1,042,460	1,097,970	1,111,600
% Change from Prior Year		12.3%	15.9%	5.3%	1.2%

* 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 2013-15 Agency Budget Request

month's expenditures are shown, the figures in Table 31 should be viewed as approximate per member costs for the various groups. As Table 31 indicates, individuals receiving EBD long term care have the highest per member per month costs of the various MA eligibility groups. Conversely, BadgerCare Plus children are by far the largest MA group by enrollment, but have relatively low per member costs compared to other full-benefit MA enrollees.

Table 30: Net MA Benefit Expenditures, Managed Care Capitation Payments and Twelve Largest Fee-For-Service Expenditure Categories, SFY 2011-12

	Expenditures	% of Net Total
Managed Care		
BadgerCare Plus HMO Payments (including Hospital Access Payments)	$1,231,635,200	18.7%
Family Care MCO Payments	1,018,632,600	15.5
SSI Managed Care HMO Payments (including Hospital Access Payments)	206,654,900	3.1
PACE/Partnership MCO Payments	159,281,500	2.4
Core Plan (Childless Adults) HMO Payments	56,539,500	0.9
Wraparound Milwaukee/Children Come First	18,681,100	0.3
Total Managed Care Payments	$2,691,424,800	40.8%
12 Largest Fee-For-Service Expenditure Categories		
Nursing Homes (including Veterans Homes, Private ICFs-ID, and NH Supplement)	$818,846,300	12.4%
Inpatient and Outpatient Hospitals (including Access Payments and Supplemental Payments)	636,696,300	9.7
Prescription Drugs	610,591,000	9.3
Long-Term Care Waiver Programs	381,994,600	5.8
MA Home Care (including Home Health, Personal Care, and Hospice)	280,005,900	4.2
Medicare Premiums and Cost-Sharing	266,950,300	4.1
Federal Funds Claimed on Certain County-Supported Services	205,911,200	3.1
Clawback Payments to CMS (100% GPR)	170,984,800	2.6
Federally Qualified Health Centers	138,145,200	2.1
Physicians/Clinics	127,854,200	1.9
State Centers for the Developmentally Disabled	127,446,400	1.9
Health Information Technology (HIT) Incentive Payments (100% FED)	91,025,000	1.4
Total of 12 Largest Fee-for-Service Expenditure Categories	$3,856,451,200	58.5%
Total Managed Care Payments and 12 Largest Fee-for-Service Expenditure Categories	$6,547,876,000	99.4%
All Other Expenditures	$479,221,100	7.3
Less: Collections, Rebates, Premiums, and Other Recoveries	-436,605,700	-6.6
Total Net Benefit Expenditures	$6,590,491,400	100.0%

* Source: DHS Budget Monitoring Reports, Projected Expenditures 2011-12 Total Net Benefit Expenditures differ slightly from 2011-12 MA/BC+ Expenditures in Table 28 due to treatment of recipient premiums and other factors.

Table 31: MA Per Member Per Month Costs, Enrollment, and Expenditures by Eligibility Category, March 2012*

	Per Member Per Month Costs	Enrollment	Expenditures
EBD Acute			
MA Only	$946.07	86,242	$81,591,020
Dual	232.93	55,072	12,827,917
EBD Long Term Care			
MA Only	3,740.03	22,626	$84,621,876
Dual	3,407.70	49,537	168,807,085
BC Plus Adults	271.45	265,123	71,967,237
BC Plus Children	125.05	478,244	59,802,335
BC Plus Pregnant Women	891.57	20,806	18,550,090
BC Plus Core	401.37	26,603	10,677,554
Foster Kids	387.15	17,483	6,768,464
Family Planning Waiver	40.01	68,211	2,728,860
Well Women	1,372.27	915	1,255,630
Medicare Savings Programs			
QMB	156.56	8,429	1,319,650
SLMB	105.08	11,457	1,203,885
TOTAL		1,110,748	$522,121,602

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

APPENDIX 1

Annual and Monthly Income at Various Percentages of the 2012 Federal Poverty Guidelines

Number in Family	100%	133%	150%	185%	200%	240%	300%
Annual							
One	$11,170	$14,856	$16,755	$20,665	$22,340	$26,808	$33,510
Two	15,130	20,123	22,695	27,991	30,260	36,312	45,390
Three	19,090	25,390	28,635	35,317	38,180	45,816	57,270
Four	23,050	30,657	34,575	42,643	46,100	55,320	69,150
Five	27,010	35,923	40,515	49,969	54,020	64,824	81,030
Six	30,970	41,190	46,455	57,295	61,940	74,328	92,910
Seven	34,930	46,457	52,395	64,621	69,860	83,832	104,790
Eight	38,890	51,724	58,335	71,947	77,780	93,336	116,670
Monthly							
One	$931	$1,238	$1,396	$1,722	$1,862	$2,234	$2,793
Two	1,261	1,677	1,891	2,333	2,522	3,026	3,783
Three	1,591	2,116	2,386	2,943	3,182	3,818	4,773
Four	1,921	2,555	2,881	3,554	3,842	4,610	5,763
Five	2,251	2,994	3,376	4,164	4,502	5,402	6,753
Six	2,581	3,433	3,871	4,775	5,162	6,194	7,743
Seven	2,911	3,871	4,366	5,385	5,822	6,986	8,733
Eight	3,241	4,310	4,861	5,996	6,482	7,778	9,723

Note: The 2013 Federal Poverty Guidelines are expected to be published in the Federal Register in January or February, 2013.

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 non-covered 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. Pregnant women are exempt from deductible and cost-sharing requirements for dental 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
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. Coverage for opioid drugs is limited to five prescriptions per month. Copayments are as follows: • $0.50 for OTC drugs. • $1.00 for generic drugs. • $3.00 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. Coverage for opioid drugs is limited to five prescriptions per month. 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. Coverage for opioid drugs is limited to five prescriptions per month. 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. Of the 10 total prescriptions allowed per month, up to 5 prescriptions per month are covered for opioid drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. There is up to a $5.00 copayment per generic drug prescription with no upper limit. There is a $10.00 copayment for brand name drugs. There is a $10.00 copayment for the flu shot.
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. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.	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.
End-Stage	Full coverage.	Full coverage.	Full coverage.	Full coverage.

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
Renal Disease (ESRD)	No copayment.	No copayment.	No copayment.	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. • $50.00 copayment per stay for mental health and/or substance abuse treatment.	Full coverage (not including inpatient psychiatric stays in either an Institute for Mental Disease (IMD) or the psychiatric ward of an acute 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	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 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

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
			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.	will be capped at the length of 14 days. Outlier costs and 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). • $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.	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.
Nursing Home Services	Full coverage. No copayment.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.	No coverage.	No coverage.

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
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. $3.00 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 Speech and Language Pathology (SLP)	Full coverage. $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 calendar year (copayment limits calculated separately for each discipline).	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation 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.	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. (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).	Full coverage, limited to 10 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count towards the 10-visit limit for PT.) $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
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. Most radiology services have a $5.00 or $20.00 copayment.
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. • 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 Only Services program.	Family planning services provided by family planning clinics will be covered separately under the Family Planning Only Services program.

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
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.	General ophthalmological services are covered if billed with CPT codes 92002-92014 and certain qualifying diagnosis codes.	General ophthalmological services are covered if billed with CPT codes 92002-92014 and certain qualifying diagnosis codes.
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

Average Monthly SSI Managed Care Enrollment by County for FY 2011-12

County	MA Only	Dual Members	Total Enrollment	Total Capitation Payments
Adams	2	1	3	$16,833
Ashland	48	7	55	345,131
Barron	7	1	9	173,407
Bayfield	21	6	27	168,973
Brown	1,199	369	1,568	8,821,897
Buffalo	16	13	29	118,121
Burnett	36	6	43	278,327
Calumet	59	16	76	424,637
Chippewa	200	20	220	1,353,154
Clark	55	23	78	397,811
Columbia	38	5	43	266,271
Crawford	36	10	46	222,585
Dane	17	1	18	118,782
Dodge	8	2	10	109,833
Door	60	5	65	436,951
Douglas	407	62	469	2,797,460
Dunn	0	0	0	72,417
Eau Claire	321	23	344	1,990,541
Florence	0	0	0	1,519
Fond du Lac	270	85	354	2,033,019
Forest	4	0	4	110,702
Grant	106	15	121	640,841
Green	49	14	63	317,842
Green Lake	57	16	73	410,521
Iowa	36	3	39	215,484
Jackson	47	19	66	335,003
Jefferson	72	16	88	490,846
Juneau	90	21	111	625,232
Kenosha	914	412	1,325	6,145,777
Kewaunee	49	6	55	338,020
La Crosse	296	96	393	1,929,165
Lafayette	22	5	27	177,683
Langlade	95	28	123	671,450
Lincoln	78	22	101	591,203
Manitowoc	262	72	334	1,865,971
Marathon	365	102	467	2,590,278
Marinette	203	13	215	1,341,262
Marquette	38	10	48	254,145
Menominee	0	0	0	27,061
Milwaukee	12,973	5,904	18,877	126,909,145
Monroe	0	0	0	53,773
Oconto	137	47	185	1,041,333
Oneida	128	29	157	822,550
Outagamie	491	177	667	3,699,085
Ozaukee	66	35	101	441,896

APPENDIX 3 (continued)

Average Monthly SSI Managed Care Enrollment by County for FY 2011-12

County	MA Only	Dual Members	Total Enrollment	Total Capitation Payments
Pepin	7	3	10	56,263
Pierce	0	0	0	4,809
Polk	66	11	77	445,599
Portage	161	37	198	1,081,686
Price	5	0	5	57,616
Racine	1,136	421	1,557	7,415,995
Richland	48	8	57	356,955
Rock	398	119	517	2,654,652
Rusk	7	0	7	68,528
Sauk	2	0	2	32,821
Sawyer	22	2	24	177,391
Shawano	127	29	157	822,821
Sheboygan	412	117	529	3,116,039
St. Croix	87	18	105	617,541
Taylor	43	10	53	283,816
Trempealeau	46	13	59	295,934
Vernon	65	17	82	398,246
Vilas	63	14	77	439,060
Walworth	163	42	204	1,084,059
Washburn	93	19	112	684,863
Washington	167	54	221	1,057,231
Waukesha	555	237	792	3,462,381
Waupaca	167	45	212	1,256,982
Waushara	96	24	120	612,199
Winnebago	540	192	732	4,179,702
Wood	149	34	183	1,070,744
Total	24,005	9,184	33,189	$203,929,946

APPENDIX 4

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

County	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Barron	$225,257	$260,279	$348,911	$598,184	$485,346	$515,000	$676,305
Brown	962,382	804,579	494,862	647,647	582,588	620,700	633,783
Calumet	456,671	447,481	216,588	158,825	52,546		
Clark	1,120,334	1,125,853	1,272,522	1,823,697	1,561,458	1,596,000	1,854,241
Columbia	566,934	603,726	741,026	1,023,601	833,273	823,100	1,001,173
Dane	700,298	697,231	855,541	1,253,381	1,017,664	1,038,900	1,180,690
Dodge	1,563,848	1,488,884	1,709,935	2,292,131	1,718,519	1,770,100	2,065,154
Dunn	895,958	882,931	918,271	982,599	704,314	710,900	836,826
Eau Claire		17,049	1,015	3,582			
Fond du Lac	1,139,941	1,018,463	898,647	1,238,415	923,610	907,200	1,021,526
Grant	827,053	790,945	917,578	1,139,872	1,087,818	1,132,800	1,381,033
Green	699,604	717,589	795,798	1,156,187	979,785	1,010,100	1,199,780
Iowa	290,820	340,945	411,509	570,524	435,304	469,700	588,630
Jackson	543,457	455,537					
Jefferson	723,478	741,174	796,109	1,158,965	867,407		
Kenosha	651,378	725,604	811,833	1,123,651	827,184	931,600	1,189,495
Kewaunee	261,032	295,982	333,245	380,127	296,933	441,800	499,303
La Crosse	2,117,188	1,751,103	1,828,967	2,417,384	1,965,088	2,094,100	2,575,044
Lafayette	416,067	395,067	473,761	606,255	504,372	544,400	645,255
Lincoln	1,032,199	1,083,243	1,283,228	1,465,296	1,492,934	1,534,500	1,743,489
Manitowoc	890,083	871,045	624,838				
Marathon	1,824,701	1,950,520	2,212,014	3,019,262	2,258,168	2,082,500	2,344,553
Milwaukee	1,144,149	1,140,820	1,136,977	1,541,768	1,232,672	1,256,100	1,330,974
Monroe	538,753	547,835	648,926	882,558	728,585	801,800	1,004,705
Outagamie	1,259,592	1,193,131	1,320,029	1,853,282	1,435,187	1,419,600	1,721,423
Ozaukee	998,739	1,111,116	1,305,978	1,874,013	1,472,522	1,516,400	1,566,245
Pierce	154,381	106,938	164,577		25,643		64,171
Polk	549,689	560,325	696,721	728,594	649,033	894,700	1,044,514
Portage	492,949	346,628	400,742	542,501	403,143	405,000	473,833
Racine	1,210,116	1,238,156	1,331,906	1,844,600	1,335,015	1,265,100	1,359,365
Richland	488,345	334,617	386,994	477,630	425,270	505,200	640,585
Rock	1,145,300	1,170,524	1,093,437	1,475,410	1,175,353	1,268,100	1,474,493
Rusk	537,860	451,291	400,635	497,011	439,249	466,200	544,441
Sauk	677,396	618,526	619,700	746,160	683,674	602,600	726,779
Shawano	618,474	617,319	560,244	797,170	439,278		
Sheboygan	2,461,374	2,478,267	973,903	1,312,031	1,147,909	1,265,000	1,396,895
St. Croix	552,553	511,910	562,763	554,238	501,170	594,200	685,517
Trempealeau	865,164	918,976	962,257	967,021	611,485	787,900	1,029,233
Vernon	600,448	725,904	728,982	832,976	746,216	881,400	1,013,465
Walworth	1,102,493	839,634	901,400	1,243,172	946,052	927,200	1,152,523
Washington	1,077,785	1,098,709	1,180,160	1,463,916	1,259,687	1,169,800	1,158,579
Waupaca	446,113	428,018	344,421	422,459	336,820	317,600	443,399
Winnebago	1,411,333	1,435,220	1,456,339	1,816,266	1,433,872	1,470,800	1,752,623
Wood	858,311	921,773	984,634	1,265,049	972,953	957,000	979,226
Subtotal	$37,100,000	$36,260,867	$36,107,923	$46,197,409	$36,995,100	$36,995,100	$42,999,269
Family Care Awards	$0	$839,133	$992,077	$1,200,000	$1,104,900	$1,104,900	$1,604,900
Total Payments	$37,100,000	$37,100,000	$37,100,000	$47,397,409	$38,100,000	$38,100,000	$44,604,169

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).	No	No	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
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

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
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 refers to the provision of meals to individuals at risk of institutional care due to inadequate nutrition. Individuals who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician. Home delivered meals cannot meet the full daily nutritional needs of an individual.	Yes	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.	Yes	Yes	No	Yes
Residential care complex is a residence for five or more adults that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, and individual bathroom, sleeping and living areas, and that provides not more than 28 hours per week of supportive, personal and nursing services.	No	No	No	Yes
Respite care services provide temporary relief to the primary caregiver.	Yes	Yes	Yes	Yes
Supported employment services include individualized assessments, job development and placement, on-the-job training, performance monitoring, and related support and training to enhance employment.	Yes	Yes	Yes	No
Supportive home care refers to 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

Service	CIP IA CIP IB	BIW	CLTS	COP-W CIP II
Specialized transportation refers to 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 intellectually disabled (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 2012

County	COP	COP-W	CIP II	CIP 1A	CIP 1B	BIW
Adams	$275,891	$179,394	$420,612	$151,514	$65,136	$26,300
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	3,663,099	1,565,756	6,381,784	105,198
Buffalo	71,440	0	0	0	0	0
Burnett	54,476	0	0	0	0	0
Calumet	126,161	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	4,064,206	2,251,720	3,099,125	447,088
Dodge	95,539	0	0	0	0	0
Door	226,179	131,006	461,382	110,896	353,353	52,598
Douglas	110,247	0	0	0	0	0
Dunn	88,642	0	0	0	0	0
Eau Claire	548,426	0	0	0	0	0
Florence	85,094	48,704	41,686	18,264	85,667	0
Fond du Lac	558,868	0	0	0	0	0
Forest	185,286	99,272	201,565	0	0	0
Forest-Vilas-Oneida	0	0	0	514,736	1,380,449	78,898
Grant-Iowa	91,361	0	0	0	0	0
Grant	123,556	0	0	0	0	0
Green	87,217	0	0	0	0	0
Green Lake	22,443	0	0	0	0	0
Iron	14,730	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	481,718	207,618	134,018	91,266
Kenosha	0	0	0	0	0	0
La Crosse	473,532	0	0	0	0	0
Lafayette	12,376	0	0	0	0	0
Langlade	0	0	0	0	0	0
Lincoln-Langlade-Marathon	404,045	0	0	0	0	0
Lincoln	0	0	0	0	0	0
Manitowoc	331,198	0	0	0	0	0
Marinette	479,442	353,420	730,051	201,774	376,173	78,898
Marquette	24,676	0	0	0	0	0
Menominee	154,765	99,104	103,990	0	147,582	0
Milwaukee	1,525,673	0	0	0	0	0
Monroe	174,167	0	0	0	0	0
Oconto	334,117	178,226	549,921	262,846	284,976	105,198

APPENDIX 6 (continued)

GPR MA Home- and Community-Based Waiver Allocations by County
Calendar Year 2012

County	COP	COP-W	CIP II	CIP 1A	CIP 1B	BIW
Oneida	$393,136	$153,094	$613,676	$0	$0	$0
Outagamie	293,760	0	0	0	0	0
Ozaukee	79,566	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	208,843	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	1,157,598	2,763,021	0	0	0
Rock's 51.437 Board	838,367	0	0	697,954	1,978,573	162,178
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	493,582	1,092,102	411,364	597,799	0
Sheboygan	251,093	0	0	0	0	0
Taylor	214,550	177,526	473,881	318,222	264,105	52,598
Trempealeau	94,162	0	0	0	0	0
Vernon	34,668	0	0	0	0	0
Vilas	260,686	266,294	615,529	0	0	0
Walworth	156,879	0	0	0	0	0
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	162,446	0	0	0	0	0
Waushara	77,571	0	0	0	0	0
Winnebago	1,063,468	0	0	0	0	0
Wood	175,481	0	0	0	0	0
Total All Counties	$24,133,589	$8,430,460	$16,276,439	$6,712,664	$15,148,740	$1,200,220
Oneida Tribe	$110,302	$79,104	$12,722			
Menominee Tribe	0	0	12,030			
Total Tribes	$110,302	$79,104	$24,752			
Total Counties and Tribes	**$24,243,891**	**$8,509,564**	**$16,301,191**	**$6,712,664**	**$15,148,740**	**$1,200,220**

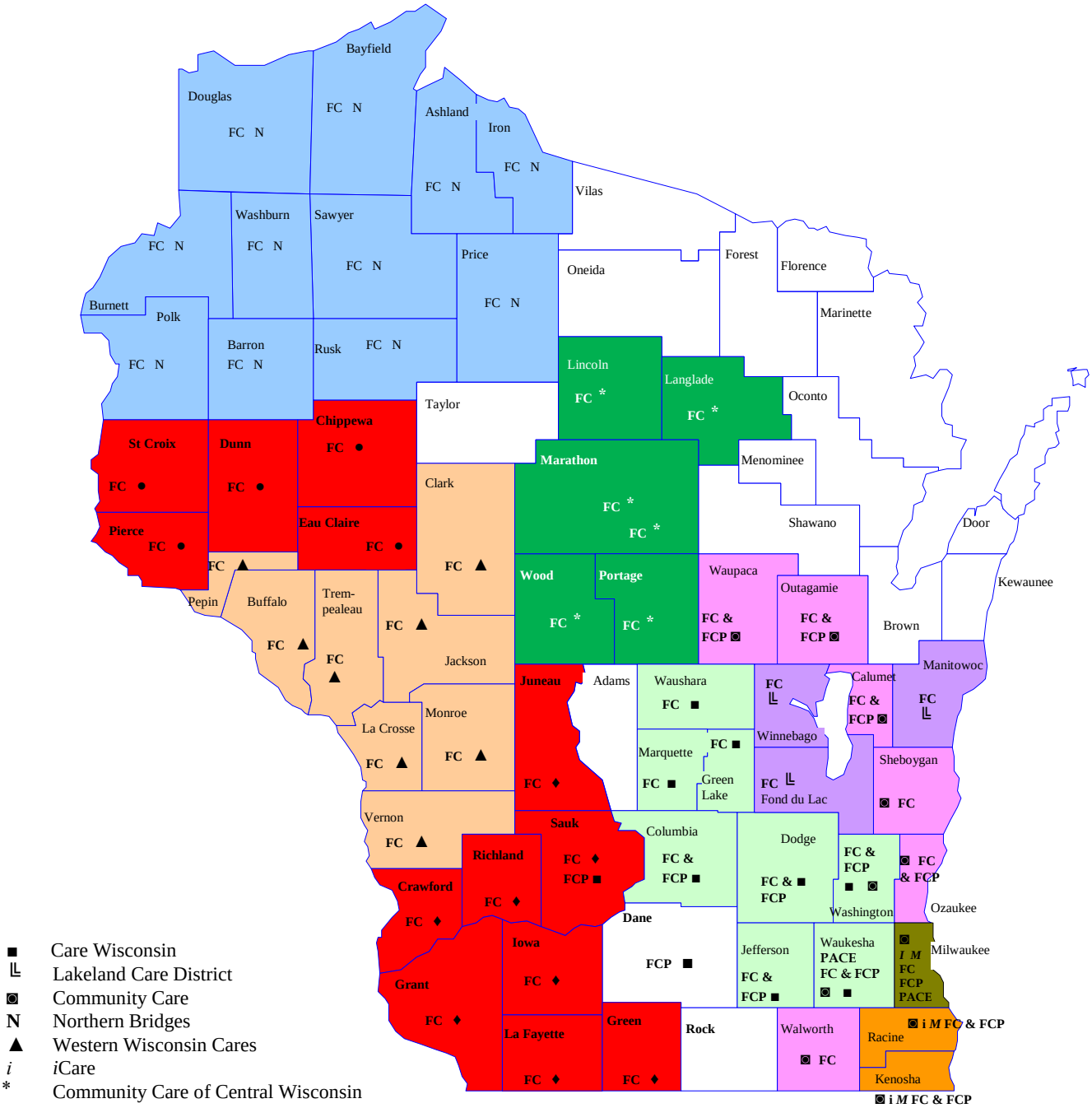
APPENDIX 7

Covered Items and Services under the Family Care Benefit

- Adaptive Aids
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services
- 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)
- Home Health
- Home Modifications
- Housing Counseling
- Meals (home-delivered)
- Medical Supplies
- Mental Health Day Treatment Services
- Mental Health Services (except those provided by a physician or on an inpatient basis)
- Nursing Facility (including care in ICFs-ID and IMDs)
- Nursing Services (including respiratory care, intermittent, and private duty nursing)
- 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 (including care provided by residential care apartment complexes, community-based residential facilities, and adult family homes)
- 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 (except ambulance and transportation by common carrier) and non-Medicaid covered transportation services

APPENDIX 8

Family Care County Participation and MCO Regions
January, 2013



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

APPENDIX 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

Aging and Disability Resource Centers (ADRCs)
As of January, 2013

Single County or Tribe ADRCs
Bad River Tribe
Brown
Chippewa
Columbia
Dodge
Douglas
Dunn
Eau Claire
Fond du Lac
Ho Chunk Nation
Jefferson
Kenosha
Lac Courte Oreilles
Marinette
Milwaukee (Aging Resource Center and Disability Resource Center)
Ozaukee
Pierce
Portage
Racine
Red Cliff
Sheboygan
St. Croix
Trempealeau
Walworth
Washington
Waukesha
Winnebago

Multi-County or Tribe ADRCs
Adams - Green Lake - Marquette - Waushara
Ashland - Bayfield - Iron - Price - Sawyer
Barron - Rusk - Washburn
Buffalo - Clark - Pepin
Burnett - Polk - St. Croix Chippewa Indians of WI
Calumet - Outagamie - Waupaca
Crawford - Juneau - Richland - Sauk
Forest - Forest County Potawatomi - Lac du Flambeau - Oneida
- Sokaogon Chippewa - Taylor - Vilas
Grant - Green - Iowa - Lafayette
Jackson - La Crosse - Monroe - Vernon
Kewaunee - Manitowoc
Langlade - Lincoln - Marathon - Wood
Menominee - Oconto - Shawano - Stockbridge Munsee

APPENDIX 11

Income Maintenance Expenditures, by County and Tribe

County Name	CY 2010 Total	CY 2010 County Share	CY 2010 % of Total	CY 2011 Total	CY 2011 County Share	CY 2011 % of Total
Adams	$265,729	$11	0.0%	$301,441	$31,168	10.3%
Ashland	397,524	32,751	8.2	427,394	58,718	13.7
Barron	945,986	166,042	17.6	963,363	211,219	21.9
Bayfield	372,193	94,744	25.5	381,057	104,855	27.5
Brown	3,099,172	724,795	23.4	3,322,527	953,970	28.7
Buffalo	297,467	65,013	21.9	265,626	54,597	20.6
Burnett	482,418	133,005	27.6	437,085	121,675	27.8
Calumet	584,997	184,859	31.6	472,387	141,185	29.9
Chippewa	1,106,116	254,877	23.0	1,150,906	302,143	26.3
Clark	491,514	86,156	17.5	478,203	92,228	19.3
Columbia	1,034,491	321,884	31.1	872,355	259,872	29.8
Crawford	588,931	190,737	32.4	639,173	224,199	35.1
Dane	6,280,691	1,808,572	28.8	6,587,603	2,136,997	32.4
Dodge	1,554,438	477,442	30.7	1,487,339	473,770	31.9
Door	682,453	229,018	33.6	604,120	198,658	32.9
Douglas	1,211,552	309,726	25.6	1,187,430	325,967	27.5
Dunn	1,144,754	378,412	33.1	1,104,716	380,783	34.5
Eau Claire	2,110,434	597,850	28.3	1,947,143	568,049	29.2
Florence	139,514	0	0.0	173,049	6,359	3.7
Fond du Lac	2,998,682	1,083,223	36.1	2,535,433	885,831	34.9
Forest	176,646	6,743	3.8	173,033	9,529	5.5
Grant	538,975	51,094	9.5	536,137	67,751	12.6
Green	514,690	108,448	21.1	554,165	143,826	26.0
Green Lake	353,347	87,663	24.8	375,579	106,988	28.5
Iowa	423,237	119,930	28.3	388,370	111,385	28.7
Iron	301,793	71,263	23.6	261,372	55,651	21.3
Jackson	593,532	178,997	30.2	582,302	182,691	31.4
Jefferson	1,413,083	431,393	30.5	1,317,327	412,584	31.3
Juneau	465,797	96,856	20.8	443,606	97,701	22.0
Kenosha	11,624,446	4,997,109	43.0	12,173,275	5,380,854	44.2
Kewaunee	199,564	15,958	8.0	190,590	18,652	9.8
La Crosse	1,427,189	177,274	12.4	1,448,061	241,203	16.7
Lafayette	270,886	52,493	19.4	257,430	52,414	20.4
Langlade	543,790	121,485	22.3	651,842	189,948	29.1
Lincoln	508,959	107,167	21.1	586,317	155,545	26.5
Manitowoc	1,484,926	423,428	28.5	1,543,641	477,221	30.9
Marathon	2,362,601	677,394	28.7	2,525,086	814,588	32.3
Marinette	1,462,412	492,866	33.7	1,499,678	536,893	35.8
Marquette	586,972	208,667	35.5	544,419	194,638	35.8
Milwaukee	0	0	0.0	0		0.0
Monroe	1,027,633	303,965	29.6	918,949	266,431	29.0
Oconto	593,079	144,263	24.3	628,332	178,134	28.4
Oneida	688,065	135,954	19.8	674,211	149,997	22.2
Outagamie	2,922,056	1,056,953	36.2	2,727,698	1,017,328	37.3
Ozaukee	832,181	271,887	32.7	935,620	336,884	36.0
Pepin	205,001	16,489	8.0	232,937	34,468	14.8

APPENDIX 11 (continued)

Income Maintenance Expenditures, by County and Tribe

County Name	CY 2010 Total	CY 2010 County Share	CY 2010 % of Total	CY 2011 Total	CY 2011 County Share	CY 2011 % of Total
Pierce	$734,145	$256,580	34.9%	$698,374	$250,372	35.9 %
Polk	899,551	248,525	27.6	897,057	265,235	29.6
Portage	1,210,529	314,237	26.0	1,163,348	313,669	27.0
Price	394,160	65,087	16.5	382,733	68,614	17.9
Racine	4,108,513	1,124,565	27.4	3,846,321	1,124,433	29.2
Richland	245,958	6,484	2.6	354,447	72,137	20.4
Rock	3,619,903	957,849	26.5	3,749,485	1,145,253	30.5
Rusk	391,468	72,306	18.5	417,137	96,437	23.1
St Croix	1,304,474	462,471	35.5	1,010,930	338,125	33.4
Sauk	654,782	86,498	13.2	758,993	158,372	20.9
Sawyer	523,497	119,496	22.8	552,998	145,621	26.3
Shawano	696,440	159,175	22.9	712,199	187,820	26.4
Sheboygan	1,504,247	349,151	23.2	1,554,678	428,206	27.5
Taylor	396,475	69,984	17.7	392,647	80,872	20.6
Trempealeau	550,639	110,901	20.1	496,594	100,164	20.2
Vernon	641,073	177,630	27.7	558,877	149,336	26.7
Vilas	453,972	132,882	29.3	462,710	147,406	31.9
Walworth	1,880,356	613,701	32.6	1,851,046	641,054	34.6
Washburn	422,428	92,806	22.0	456,776	123,072	26.9
Washington	1,756,812	581,517	33.1	1,818,435	648,525	35.7
Waukesha	4,139,804	1,424,644	34.4	3,945,026	1,384,759	35.1
Waupaca	1,273,115	352,427	27.7	1,250,366	356,221	28.5
Waushara	672,782	212,901	31.6	684,469	230,324	33.7
Winnebago	2,705,533	787,796	29.1	2,770,806	883,125	31.9
Wood	1,688,948	460,615	27.3	1,484,222	399,616	26.9
Menominee	199,254	12,033	6.0	233,287	36,042	15.4
County Totals	$90,378,774	$26,747,117	29.6%	$90,012,288	$28,540,357	31.7%

Tribes	Federal Fiscal Year 2009-10 Total	Federal Fiscal Year 2009-10 Tribal Share	Federal Fiscal Year 2009-10 % of Total	Federal Fiscal Year 2010-11 Total	Federal Fiscal Year 2010-11 Tribal Share	Federal Fiscal Year 2010-11 % of Total
Bad River	$163,311	$0	0.0%	$162,234	$522	0.3%
Lac du Flambeau	154,399	0	0.0	146,756	0	0.0
Oneida Tribe	110,134	0	0.0	109,763	0	0.0
Potawatomi Tribe	98,030	0	0.0	98,276	0	0.0
Red Cliff	160,861	0	0.0	157,308	0	0.0
Sokaogon	97,596	0	0.0	98,546	0	0.0
Stockbridge Munsee	99,115	0	0.0	98,359	0	0.0
Tribal Totals	$883,446	$0	0.0%	$871,242	$522	0.1%
Grand Total	**$91,262,220**	**$26,747,117**	**29.3%**	**$90,883,530**	**$28,540,879**	**31.4%**

*Includes expenses funded from the income maintenance administrative allocations, estate recovery incentives, and Family Care-related income maintenance expenses, where applicable, in addition to local sources.