Medical Assistance and BadgerCare #43

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Medical Assistance and BadgerCare

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Medical Assistance and BadgerCare

Introduction

Title XIX of the federal Social Security Act, enacted in 1965, establishes an entitlement program that pays for health services provided to certain groups of low-income persons. This program, commonly referred to as the "medical assistance (MA)" or "Medicaid" program, is jointly financed with state and federal funds and administered by states within federal guidelines pertaining to eligibility, types and range of services, payment levels for services and administrative operating procedures. Payments for services are made by the state to the individuals or entities that furnish the services.

The program supports the costs of providing acute and long-term care to persons who are aged, blind, disabled, children, members of families with dependent children and pregnant women who meet specified financial and nonfinancial criteria. Persons enrolled in the MA program are entitled to have payment made by the state for covered, medically necessary services furnished by certified providers.

States receive matching payments from the federal government for expenditures made for covered services and program administration. The federal matching rate for program benefits, or federal financial participation (FFP), is based on a statutory formula that compares a state's per capita income to national per capita income. The FFP rate is recalculated annually. The minimum federal share for any state is 50%. In federal fiscal year 2000-01, Wisconsin's FFP rate is 59.29%. Most administrative costs are funded on a 50% state / 50% federal basis. Federal law does not limit the amount of matching funds states can receive under MA.

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

On July 1, 1999, Wisconsin began enrolling individuals and families in the BadgerCare program, which provides health coverage to families and individuals in families with dependent children who have countable income that does not exceed 185% of the federal poverty level (FPL) but who are not eligible for MA and who: (a) do not have access to an employer-sponsored health plan in which the employer pays 80% or more of the costs of the plan; and (b) have not had insurance coverage during the three calendar months before the date they apply for BadgerCare. Once enrolled, families can remain enrolled as long as their countable household income does not exceed 200% of the FPL. BadgerCare services are identical to the services available to MA recipients, and fee-for-service providers receive the same reimbursement rates for providing services to BadgerCare enrollees as they do in serving MA enrollees. The program is funded with a combination of state, general

purpose revenue (GPR), federal funds (FED) available under MA and Title XXI of the Social Security Act (the state children's health insurance program, commonly referred to as "SCHIP") and premiums paid by participating families with countable income that exceeds 150% of the FPL. The premiums are identified as program revenue (PR) Unlike MA, HCFA provides states a sum certain, annual allocation of SCHIP funds. Wisconsin's FFP rate for SCHIP eligible services is approximately 71.2% in federal fiscal year 2000-01.

Approximately $5.6 billion (all funds) is budgeted for MA program benefits in the 1999-01 biennium, including $2.7 billion in 1999-00 and $2.9 billion in 2000-01. An additional $63.6 million (all funds) in 1999-00 and $134.2 million (all funds) in 2000-01 is budgeted to support BadgerCare. The GPR funds budgeted for MA and BadgerCare benefits for the 1999-01 biennium represent approximately 9% of the state's total general fund budget for the biennium. Table 1 summarizes MA and BadgerCare benefits funding budgeted for the 1999-01 biennium.

Table 1

MA and BadgerCare Program Benefits Funding 1999-01 Biennium

	1999-00	2000-01	1999-01
Medical Assistance			
GPR	$972,242,300	$995,912,200	$1,968,154,500
FED	1,764,341,100	1,863,412,700	3,627,753,800
Total	$2,736,583,400	$2,859,324, 900	$5,595,908,300
BadgerCare			
GPR	$22,356,500	$45,730,500	$68,087,000
FED	40,033,600	86,298,300	126,331,900
PR	1,199,300	2,209,200	3,408,500
Total	$63,589,400	$134,238,000	$197,827,400
Medical Assistance and BadgerCare			
GPR	$994,598,800	$1,041,642,700	$2,036,241,500
FED	1,804,374,700	1,949,711,000	3,754,085,700
PR	1,199,300	2,209,200	3,408,500
Total	$2,800,172,800	$2,993,562,900	$5,793,735,700

Note: FED and PR amounts represent estimates.

Eligibility

Federal law requires states to cover certain groups of individuals under their MA programs and permits states, at their option, to extend coverage to other groups of individuals. Aged, blind or disabled persons eligible for supplemental security income (SSI) benefits are automatically eligible for MA. Other individuals must meet certain financial and nonfinancial eligibility criteria to be eligible.

There are two categories of eligibility criteria, categorically needy and medically needy. Categorically needy MA recipients include those groups that federal law requires the states to cover under Medicaid programs and can include certain other groups. Additionally, federal law provides states the option of covering individuals who meet the demographic criteria of other MA-covered groups, but whose income and resources meet the medically needy income and asset criteria established by the state. Federal law limits the medically needy income criteria to 133 1/3% of the AFDC monthly payments for a family of the same size, except that states may apply the AFDC standard for two person families to single individuals.

The medically needy group also includes those individuals eligible for MA as a result of "spend down." These groups share the same demographic characteristics as other medically needy groups, but do not meet the medically needy income or asset criteria. Individuals in this group are only eligible for MA if, after deducting allowable medical expenses from their income, they meet the medically needy income criteria. The amount of medical expenses an individual would have to incur before being eligible for MA is referred to as the MA deductible.

In many states, categorically needy persons receive a broader range of benefits than do persons who qualify as medically needy. In Wisconsin, persons who are medically needy receive the same range of benefits available to persons who are categorically needy for MA, except that counties are responsible for burial expenses of categorically needy MA recipients, but not medically needy MA recipients. As a result, the distinction between medically and categorically needy eligible persons is less important in Wisconsin than in other states.

Although MA is a means-tested program, it does not provide coverage for all low-income individuals. MA coverage is available only to pregnant women, members of families with dependent children and to persons who are elderly, blind or disabled. Persons who do not meet these qualifications, such as childless, nonelderly, able-bodied adults, cannot qualify, no matter how little income they may have. Further, MA eligibility is not necessarily provided to all members of a particular family at a given time.

Eligibility for Families With Dependent Children and Pregnant Women

MA eligibility for families with dependent children and pregnant women was initially linked to a family's eligibility for the AFDC program. With the enactment of P.L. 104-193, which replaced the AFDC program with the temporary assistance for needy families (TANF) program, the link between these two programs was eliminated. Instead, MA eligibility continued to be based on a state's AFDC state plan as it was in effect on July 16, 1996, the effective date of P.L. 104-193. States may modify some policies in their AFDC plans, but to date, Wisconsin has not.

Additionally, federal law requires states to expand coverage to certain families with dependent children and pregnant women and provides states the option of expanding MA eligibility to others.

This section describes general eligibility criteria for Wisconsin's MA program for families with dependent children and pregnant women. The income eligibility criteria are based on a percentage of the FPL. Table 2 shows the FPL for 2000 based on the number of individuals in a family.

Table 2: **2000 Federal Poverty Level**

Family Size	Monthly Limit
1	$696
2	938
3	1,179
4	1,421
5	1,663
6	1,904
7	2,146
8	2,388

MA has numerous eligibility requirements. Certain types of expenses, such as child care, are deducted from household income before determining eligibility. Additionally, certain types of income, such as kinship care payments and a portion of child support payments, may not be included when determining a family's income. Certain types of assets are also not included in determining eligibility. The information provided here is intended to generally describe each eligibility category, not to describe all of the criteria used to determine eligibility.

AFDC and AFDC-Related Groups. As stated above, families with dependent children are eligible for MA if they meet the income and asset requirements of the state's AFDC program that were effective on July 16, 1996. Based on Wisconsin's AFDC state plan in effect at that time, the monthly income limit is based on the AFDC standard of need identified in state statute. This limit ranged from $311 per month for one individual to $1099 per month for eight individuals. This limit is equivalent to a range of approximately 45% to 59% of the 2000 FPL, depending on the family's size. An applicant's countable assets are limited to $1,000. Individuals qualifying under this criteria are considered categorically needy.

In addition, Wisconsin provides coverage to a variety of individuals and families that meet criteria related to the income and asset criteria under the state's AFDC plan. These individuals and families include the following:

- Certain families that do not meet the AFDC standard of need, but would have met the standard, except for certain circumstances;
- Children residing in a licensed foster home or group foster home;
- Children for whom an adoption assistance agreement is in effect and children adopted under a state-established agreement;
- Children residing with a relative and for whom a kinship care payment is being made;
- Certain pregnant women;
- Certain children residing in medical institutions, nursing facilities, psychiatric facilities or intermediate care facilities for the mentally retarded (ICFs-MR).

Healthy Start. Beginning in the 1980's, several federal law changes expanded MA coverage to more groups of low-income pregnant women and children. In Wisconsin, these expansions became known as "Healthy Start." Under Healthy Start, MA covers pregnant women and children less than six years of age in families with countable income of no more than 185% of the FPL. Children ages six through 18 years old are eligible if the family's income is no more than 100% of the FPL. The parents of these children are not eligible, except

that a pregnant mother is eligible for up to 60 days after the birth of her child if her family's income remains no more than 185% of the FPL. There is no asset limit under Healthy Start.

MA Spend-Down. Persons eligible for MA under the spend-down provision meet the demographic criteria of other MA-covered groups, but their income and resources exceed the financial limits. In Wisconsin, the following groups of low-income women and children are eligible for MA coverage under the spend-down provision:

- Any child under 18 years of age;
- An individual under the age of 21 who resides in an intermediate care facility, a skilled nursing facility or inpatient psychiatric hospital; and
- A pregnant woman (eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls).

Under the spend-down provision, a person can become eligible for MA if his or her medical expenses during a six-month period reduce income to the medically needy income limits established by the state. In this way, the spend-down provision offers protection against catastrophic medical costs, but only at the expense of the individual reducing income and resources to meet the eligibility criteria.

Presumptive Eligibility. A period of "presumptive eligibility" is available for pregnant women to ensure they have access to prenatal care. This period begins on the day on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman meets MA eligibility criteria. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to apply for MA, the last day of the month following the month in which the determination of presumptive eligibility is made, whichever is earlier.

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

In Wisconsin, the following types of providers can become certified to make presumptive eligibility determinations: (a) outpatient hospitals; (b) rural health clinics; (c) family planning clinics; (d) federally qualified health centers; (e) physicians; (f) nurse practitioners; (g) providers participating in the women, infants and children (WIC) supplemental food program; and (h) other clinics that provide prenatal care.

Transitional Eligibility. Federal law requires states to extend MA eligibility for certain individuals and families for specified periods. Families that would have lost eligibility for AFDC because of a change in income earned from employment can remain eligible for up to one year based on certain conditions. Families who would have lost AFDC eligibility because of an increase in child or family support payments can remain eligible for four months under certain conditions. Pregnant women remain MA eligible for up to 60 days postpartum and if the woman has a change in income during her pregnancy, she can retain her eligibility throughout her pregnancy and postpartum period. Additionally, newborn children can remain eligible for MA for up to one year if the mother received MA on the date the child was born.

Eligibility for Aged, Blind and Disabled Individuals

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

these states.

States may supplement federal SSI payments with state funds. The mandatory coverage of SSI eligibles applies only to those persons who qualify for the federal SSI payment and only to those persons who actually receive an SSI payment. In calendar 2000, the federal income limit for SSI was $512.00 per month for an individual and $769.00 per month for a couple. (These limits apply after income is adjusted to reflect certain deductions and exemptions.) Except for section 209(b) states, MA eligibility must be provided to aged and disabled individuals and couples with incomes below these limits who actually receive an SSI payment. States may provide MA coverage to individuals who receive a state-only supplemental payment and to individuals who are eligible for a SSI payment but do not receive a payment. Wisconsin chooses to cover both of these optional groups. In calendar year 2000, aged and disabled individuals with income below $595.78 per month and couples with income below $928.05 per month were eligible for MA.

States must continue MA coverage for several groups of individuals who previously were eligible for SSI. States may be required to provide MA coverage for disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all nondisability criteria for SSI except income. States must continue to provide MA coverage to such an individual if he or she needs MA coverage to continue employment and the individual's earnings are not sufficient to provide the equivalent of SSI, MA and attendant care benefits the individual would qualify for in the absence of earnings.

States must also continue MA coverage for persons 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. Similar MA continuations have been provided for certain other persons 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 persons who care for disabled individuals.

Low-Income Medicare Beneficiaries. States must provide limited MA coverage for several groups of Medicare beneficiaries: (1) qualified Medicare beneficiaries (QMBs); (2) two groups of specified low-income Medicare beneficiaries (SLMBs and SLMBs+); (3) additional low-income Medicare beneficiaries (ALMBs); and (4) qualified disabled and working individuals (QDWIs).

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

For QMBs, MA reimburses any required Medicare premium, coinsurance and deductibles for both Part A (hospital and nursing home insurance) and Part B (physician and other outpatient services) coverage. Cost-sharing amounts are paid up to the maximum amount MA would reimburse for the service rendered. QMBs pay copayments normally required of other MA beneficiaries. Finally, providers are required to accept the MA payment and the QMB's copayment (if any) as payment in full.

A more limited MA benefit is provided to SLMBs. States are required to pay the Medicare Part B premium for persons who otherwise meet the QMB requirements but have income between

100% and 120% of the FPL. No other premiums, deductibles or copayments are paid for individuals in this group. The federal balanced budget act of 1997 extended coverage of the Part B premium to two higher income groups. For persons who otherwise meet the QMB requirements but have income between 120% and 135% of the FPL (SLMBs +), MA pays the full Part B premium so that there is no difference between benefits provided to this group and the original SLMBs. However, MA pays a small part of the Part B premium for ALMBs, who are individuals with income between 135% and 175% of the FPL.

States are also required to pay the Part A premiums, but no other expenses, for QDWIs. These are persons who formerly received social security disability benefits and hence Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the Part A premium. Under this category, MA eligibility for payment of the Part A premium is limited to individuals under the age of 65 with income at or below 200% of the FPL with assets up to twice the SSI resource limits and who are not otherwise MA-eligible. States may require QDWIs with incomes between 150% and 200% of the FPL to pay a portion of the Part A premium. The portion paid by the person must vary inversely with the individual's income. Wisconsin pays the full Part A premium for all QDWIs.

Finally, states have the option of providing full MA benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a state-established income standard that is no higher than 100% of the FPL. Wisconsin does not utilize this option.

Medically Needy. Elderly and disabled persons are eligible for medically needy coverage under MA. Medically needy income and asset standards must be reasonable, based on family size, and uniform for all covered groups. For purposes of federal financial participation, the medically needy income standards may not exceed 133 1/3% of the maximum AFDC payment that would have been paid to the family as of July 16, 1996, for similar-sized families, except that states may apply the higher two-person standard to single individuals if the state did so in 1989. Wisconsin utilizes this option. A state can adjust this maximum limit for inflation if it amends AFDC standards under the AFDC state plan. Federal rules allow states to establish the medically needy asset limits at the highest asset standard used for the comparable categorically needy group, or the highest standard for all categorically needy groups if only one standard is used.

Wisconsin offers MA coverage to medically needy individuals, but the income standards for the aged and disabled are in most cases lower than the standards for categorically needy individuals. In Wisconsin, the AFDC payment standard is not increased annually to reflect inflation, while the SSI payment levels are. Therefore, the income criteria for the categorically needy increases annually, while the criteria for the medically needy has reached its limit and has not increased for couples since 1988 and for individuals since 2000. As a result, Wisconsin's medically needy program for the elderly and disabled persons is essentially an opportunity for individuals with high medical costs and with countable income that exceeds the categorically needy limit, to spend down to have a portion of those medical costs covered by MA.

Before medical costs would be covered under the medically needy program, the individual or family would first have to deplete assets to the respective level ($2,000 for an individual, $3,000 for a couple), and would have to spend any income over the medically needy income standard for medical expenses.

Because of the high cost of care in a nursing home, many elderly and disabled persons who require nursing home care use the medically needy option. Federal regulations allow states to exclude nursing home care from coverage under the medically needy program. However, Wisconsin includes nursing home care in its medically needy program.

Persons Receiving Institutional or Other Long-Term Care. Under federal law, states may provide MA coverage to nursing home residents and individuals participating in community-based waiver programs under a special institutional income rule. This rule permits individuals who are not categorically eligible for SSI and have income between 100% and 300% of the monthly federal SSI payment amount to be automatically eligible for MA coverage without "spending down" to the medically needy standards. Wisconsin provides coverage at the maximum of 300% of the monthly SSI payment level.

MA recipients who qualify for institutional care or care under a community-based waiver program under the special income limit or the medically needy standard must use any income in excess of allowable deductions for the costs of their care. Allowable deductions under the special institutional income rule include: (a) for institutionalized recipients, $40 per month in 2000 ($45 per month beginning July 1, 2001) or $90 per month for veterans and veterans' surviving spouse and $692 to $1,054 per month in 2000 for community-based waiver recipients as a personal allowance; (b) a transfer of income to a spouse and dependent children in the community; and (c) medical costs not covered by MA. Under the medically needy standard, the allowable deductions are similar except that for community-based waiver recipients the personal allowance would be less (in general $592 per month rather than $692 to $1,054).

Except for this difference in the personal needs allowance, the use of the special institutional income rule does not expand eligibility for institutional care and community-based waiver programs. The average cost of care for both nursing homes and community-based waiver programs exceed the institutional income limit. As a result, individuals with income at or below $1,536 per month can usually spend down to the medically needy income standard. The average cost of nursing home care was $3,929 per month in 1999 while the average cost of care for someone in the community-based waiver program was over $1,650 per month in that year. The only meaningful impact of qualifying under the institutional income limit is that the person can retain from $100 to $462 more per month as a personal allowance for food, rent and other non-medical expenses.

If a state provides nursing home coverage using the special institutional income rule and does not extend coverage to the medically needy, then federal law requires the state to allow individuals the option to establish a "Miller" or "qualifying income trust" to obtain eligibility for nursing home care. The practical effect of this requirement is that when a state uses the special institutional income rule, it is required to extend coverage to the medically needy either directly or through Miller trusts.

In order to form a Miller trust, federal law requires the following conditions: (1) the trust is funded only by social security, pension and other income (and interest income accumulated by the trust); and (2) upon the death of the person, the state has first priority on any remaining funds in the trust up to the amount that was provided in MA nursing home care.

In addition to community-based waiver programs, federal rules allow states to provide MA coverage to several other classes of persons who need the level of care provided by an institution and would be eligible if they were in an institution. First, persons receiving hospice benefits in lieu of institutional services and persons of any age who are ventilator-dependent can be covered under MA. Second, children with special health needs living at home ("Katie Beckett" children) can also be covered. Under federal law, a child may be eligible for SSI and, therefore, eligible for MA coverage while the child is institutionalized. However, the same child may not be eligible for MA or SSI if the child lives at home because of SSI rules relating to the treatment of parents' income. Before MA coverage was available for this optional group, some individuals remained in institutions even

though their medical needs could be taken care of at home so that they would remain eligible for SSI and MA. To be eligible under this provision, an individual must: (a) be under the age of 18; (b) be eligible for MA if in an institution: (c) require the level of care provided in a hospital or a nursing facility; (d) be appropriate for home-based care: and (e) have home-care costs that do not exceed the estimated cost of institutional care.

MA Purchase Plan. 1999 Wisconsin Act 9 authorized DHFS to implement a new option provided under federal MA law to extend MA coverage to certain working, disabled persons. This program, the MA purchase plan, was implemented beginning on March 1, 2000.

The program is intended to remove financial disincentives to work. A disabled person may be able to work, but may choose not to because the additional income would make him or her ineligible for MA or Medicare. The MA purchase plan provides the opportunity to earn more without the risk of losing health care coverage. This plan also allows an individual to accumulate savings from earned income in an independence account to increase the rewards from working.

An individual is eligible to participate in the MA purchase plan if:

- The individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL. Income disregards include the first $65 of earned income plus one-half of earned income over $65, $20 disregard of any type of income, health insurance premiums and other out-of-pocket medical expenses.

- The individual's countable assets do not exceed $15,000. Countable assets do not include assets that are excluded under MA financial eligibility rules (such as home, car with a value up to $4,500, household goods and personal effects, and property used in a business or trade) or assets accumulated in an independence account.

- The individual is determined to have a disability under SSI standards.

- The individual is engaged in gainful employment or is participating in a program that is certified by DHFS to provide health and employment services that are aimed at helping the individual achieve employment goals.

- The individual is at least 18 years old.

Individuals who obtain MA eligibility under the MA purchase plan pay a monthly premium if the individual's gross monthly income, before deductions or exclusions, exceeds 150% of the FPL. The premium consists of two parts, reflecting different rates for unearned and earned income. The part of the premium based on unearned income equals 100% of unearned income that is in excess of the sum of: (a) standard living allowance ($616 per month in calendar year 2000); (b) impairment-related work expenses; and (c) out-of-pocket medical and remedial expenses. The part of the premium based on earned income is equal to 3% of earned income, except that if the deductions for unearned income exceed unearned income, any remaining deductions can be applied to earned income before the 3% premium rate is applied.

Persons with Tuberculosis. Persons who are infected with tuberculosis and who meet the income and resource eligibility requirements for SSI are eligible for some MA-covered services. For these individuals, MA coverage is limited to: (a) prescription drugs; (b) physician services; (c) laboratory and x-ray services; (d) clinic services; (e) case management services; and (f) services designed to encourage individuals to take their medications.

Table 3 describes, by eligibility group, the different income and asset qualifications an individual must meet to receive benefits under Wisconsin's MA program in the 2000 calendar year. The asset limits shown in the table are amounts in addition to excluded assets such as a home, automobile, certain burial funds and personal effects.

Table 3

Income and Asset Eligibility Criteria for MA by Group and Eligibility Category
Calendar Year 2000

FAMILIES, WOMEN AND CHILDREN

CATEGORICALLY NEEDY

AFDC AND AFDC-RELATED

- Persons who would have met AFDC eligibility criteria under the AFDC state plan in effect on July 16, 1996.
- Other AFDC-related groups

Family Size	Asset Limit	Maximum Monthly Income	Income as a % of 2000 FPL
1	$1,000	$311	45%
2	1,000	550	59
3	1,000	647	55
4	1,000	772	54
5	1,000	886	53
6	1,000	958	50
7	1,000	1,037	48
8	1,000	1,099	46

HEALTHY START

Pregnant Women and Children Under Age Six

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

Family Size	Asset Limit	Maximum Monthly Income	Income as a % of 2000 FPL
1	None	$926	133%
2		1,248	133
3		1,568	133
4		1,890	133
5		2,212	133
6		2,532	133
7		2,854	133
8		3,176	133

HEALTHY START

Children Ages Six Through Eighteen

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

Family Size	Asset Limit	Maximum Monthly Income	Income as a % of 2000 FPL
1	None	$696	100%
2		938	100
3		1,179	100
4		1,421	100
5		1,663	100
6		1,904	100
7		2,146	100
8		2,388	100

MEDICALLY NEEDY

AFDC AND AFDC-RELATED

- Persons in families that meet AFDC demographic criteria who meet the income and asset standards below.
- Persons in families that meet AFDC demographic criteria who incur medical expenses, resulting in a "spend down" to income and asset standards below.

Family Size	Asset Limit	Maximum Monthly Income	Income as a % of 2000 FPL
1	$2,000	$592	85%
2	3,000	592	63
3	3,300	689	58
4	3,600	823	58
5	3,900	944	57
6	4,200	1,021	54
7	4,500	1,105	52
8	4,800	1,172	49

HEALTHY START

Pregnant Women and Children Under Age Six

- Pregnant women, infants and children up to age 6 in families that have income above the categorically need income standard, but no more than 185 % of the FPL.
- Pregnant women, infants and children up to age 6 in families that have income above 185% of the FPL, but "spend down" to 185% of the FPL.

Family Size	Asset Limit	Maximum Monthly Income	Income as a % of 2000 FPL
1	None	$1,288	185%
2		1,735	185
3		2,181	185
4		2,629	185
5		3,077	185
6		3,522	185
7		3,970	185
8		4,418	185

NOTE: Income and asset levels are those in effect as of January 1, 2000, and federal poverty levels for the 2000 calendar year. Asset limits are in addition to excluded items such as the home, automobile, certain burial funds and personal effects. The federal poverty level is updated annually in mid-February.

Table 3 (continued)

Income and Asset Eligibility Criteria for MA by Group and Eligibility Category
Calendar Year 2000

AGED, BLIND AND DISABLED INDIVIDUALS AND COUPLES

CATEGORICALLY NEEDY

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

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2000 FPL
1	$2,000	$596[1,3]	86%
2	3,000	901[2]	99

[1] Assumes that person has actual shelter costs of at least $171.
[2] Assumes that family has actual shelter costs of at least $256.
[3] For long-term care in a nursing home or under a community-based waiver program, eligibility is based on a higher income standard, which is 300% of the federal SSI payment or $1,536 per month in 2000.

MEDICALLY NEEDY

- Persons who meet the demographic eligibility criteria for the aged, blind and disabled group who incur medical expenses, resulting in a "spend down" to medically needy asset and income criteria.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2000 FPL
1	$2,000	$592[1,]	85%
2	3,000	592[2]	63

COMMUNITY SPOUSE PROTECTED INCOME AND RESOURCES

- 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 toward the care costs for the institutionalized individual. If the total countable assets of the couple are less than $100,000, the community spouse asset share is $50,000. If the countable assets of a couple are between $100,000 and $168,240, the community spouse asset share is half of the total countable assets of the couple. If the countable assets of a couple are more than $168,240, the maximum community spouse asset share is $84,120. In each case, the institutionalized spouse may retain $2,000 in assets, in addition to the assets retained by the community spouse.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as % of 2000 FPL
2	See Text	$1,875	200%

MEDICARE BENEFICIARIES

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

Type	Asset Limit Indiv.	Asset Limit Couple	Maximum Monthly Income Indiv.	Maximum Monthly Income Couple	Benefits Paid
QMB	$4,000	$6,000	$696	$938	All Medicare premiums, coinsurance and deductibles.
SLMB[1]	4,000	6,000	835	1,125	Part B premium
SLMB+[2]	4,000	6,000	939	1,266	Part B premium
ALMB[3]	4,000	6,000	1,218	1,640	Part of Part B premium

[1] Income 100-120% of the FPL
[2] Income 120-135% of the FPL
[3] Income 135-175% of the FPL

QUALIFIED WORKING & DISABLED INDIVIDUALS

- Disabled persons who are working with income up to 100% of the FPL with resources at or below twice the SSI asset limit and not otherwise eligible for MA.
- MA pays Medicare Part A (hospital) premiums only.

Family Size	Asset Limit	Maximum Monthly Income	Monthly Income as a % of 2000 FPL
1	$4,000	$1,391	200%
2	6,000	1,875	200

MA PURCHASE PLAN

- Disabled adults who are working or enrolled in a certified job counseling program with income up to 250% of the FPL and assets below $15,000.

- All services under MA are covered, but a premium is charged for those with income in excess of 150% of the FPL.

Family Size	Maximum Asset Limit	Monthly Income	Monthly Income as a % of 2000 FPL
1	$15,000	$1,740	250%
2	15,000	2,344	250

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

Additional Requirements Affecting Eligibility

An individual's eligibility for MA can be affected by a number of other provisions, as described in the following section.

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

Asset Limit. When a married person enters a nursing home or a community-based care program, the county social services or human services department will, upon request, conduct an assessment of the couple's combined total assets. This "snapshot" includes all countable assets owned by either or both spouses. Countable assets do not include the couple's home, one vehicle, assets related to burial (including insurance, trusts, funds or plots), household furnishings and clothing or other personal items.

The amount of assets protected for the community spouse is calculated based on the amount of assets the couple has at the time of the assessment. Federal law allows states discretion in establishing the asset protection level but does impose some limits. In 2000, the maximum amount of assets that could be protected for the community spouse was $84,120, unless a higher amount was granted on a case by case basis under a fair hearing or court order. The minimum amount of assets that could be protected for the community spouse was the greater of: (a) $16,824; or (b) 50% of the couple's countable assets up to the federal maximum. Both federal limits are adjusted annually, based on changes in the consumer price index.

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

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

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 will it prevent the institutionalized spouse from being eligible for MA for long-term care costs.

In addition, spousal impoverishment provisions may allow part of the institutional spouse's income to be transferred to the community spouse to provide an adequate income for the community spouse. Again, federal law provides states some discretion in the amount that could be transferred, but does impose specific limits. Under federal law, the maximum amount that may be transferred to the community spouse is an amount that would raise the community

spouse's total income to $2,103 per month in 2000. This limit is increased annually by the increase in the consumer price index (CPI) the inflation rate. Additional income may also be transferred to provide for certain dependent family members living with the community spouse or if ordered by a court.

Under federal law, the minimum amount of income that states must allow to be transferred to the community spouse is an amount that would bring the community spouse's total income up to the sum of: (a) 150% of the FPL; and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the federal minimum amount (shelter costs in excess of $422 per month in 2000). Since the FPL is adjusted to reflect increases in the FPL each year, the federal minimum is increased each year. If the state establishes an income allowance that is below the federal maximum, an excess shelter allowance is required under federal law.

Wisconsin establishes its income allowance between the federally-established minimum and maximum amounts. Specifically, Wisconsin's income allowance is, subject to the federal maximum, the sum of: (a) 200% of the federal poverty level ($1,875 per month in 2000); and (b) an excess shelter allowance, if any, equal to the amount by which shelter costs exceed 30% of the state's standard (shelter costs in excess of $563 per month in 2000). In addition, Wisconsin allows an additional transfer of up to $469 per month in 2000 for each qualifying dependent family member living with the community spouse. Further, a fair hearing or court order could provide for a higher amount in an individual case if it causes undue financial hardship.

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 $40 per month ($90 for certain veterans) and will increase to $45 per month, beginning in July, 2001. If the person is a participant of a MA community-based waiver program, the allowance is higher (from $692 to $1,054 per month), to support food, shelter and other costs. Any income in excess of the amount transferred to the community spouse and the personal needs allowance must be used to pay for long-term care costs.

Divestment. Divestment regulations are intended to prevent persons with adequate resources from avoiding some liability for the cost of their medical care in a medical or nursing facility or other long-term care services which would unnecessarily result in greater state and federal MA costs. In other words, individuals may not dispose of assets or income for less than market value for purposes of becoming eligible for MA.

A person may be denied MA coverage of institutional and community-based waiver services (and other long-term care services provided on or after April 1, 1995), 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 passing the MA asset test. However, lack of eligibility for long-term care services does not preclude eligibility for physician visits and other short-term care services. If found ineligible for institutional and other long-term care services, the individual cannot be determined eligible again until he or she has satisfied certain conditions under federal and state laws. This rule applies to divestments made within 36 months (60 months for actions involving trusts) before the individual applies for MA or receives services, whichever is later. It also applies to divestment of property or goods that would be counted in the MA AFDC-related and SSI-related asset tests.

A person who has disposed of his or her resources through divestment generally cannot become eligible for MA until the amount of divestment (the fair market value of the divested resources minus the actual value received for the resources) equals the approximate amount spent by the person for institutional care. In order to determine the number of months of ineligibility,

the divested amount is divided by the statewide average monthly cost of nursing facility care for a private-pay patient.

There are two general situations for which the divestment is disregarded for purposes of MA eligibility. First, no penalty period is imposed if the person furnishes convincing evidence that the divestment was not made with the intent of receiving MA. This could be done, for example, by showing that, at the time of the divestment, provisions had already been made for future maintenance needs and medical costs. The other general exception is if denial of eligibility would cause an undue hardship on the person. Undue hardship is defined as a serious impairment to the person's immediate health status.

In addition to the two general exceptions, transfers or divestments to certain family members are permitted without any adverse effect on MA eligibility. Both homestead and non-homestead property can be transferred to: (1) a spouse; or (2) a child of any age who is either blind or permanently and totally disabled. In addition, homestead property can be transferred to: (1) a child under 21 years of age; (2) 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 (3) 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 which permitted the person to reside at home.

Citizenship. In order to be eligible for full MA benefits, a person must be a U.S. citizen or meet criteria for certain classes of aliens, such as aliens who are lawfully admitted for permanent residence in this country. Aliens who do not meet requirements for full MA benefits are eligible for emergency services, including labor and delivery.

In general, aliens lawfully admitted for permanent residence prior to August 22, 1996, are eligible for full MA benefits. Aliens admitted after August 22, 1996, are not eligible for full benefits, with certain exceptions, for five years after their admission. The groups that are exempted from this five-year ineligibility period include: (1) Cuban/Haitian entrants; (2) refugees and asylees; (3) veterans or active members of U.S. Armed Forces and their spouses and unmarried dependent children; (4) Amerasians (split American/Asian ancestry); (5) American Indians born in Canada who are at least 50% American Indian by blood or an American Indian born outside of the U.S. who is a member of a federally recognized Indian tribe. Illegal aliens, undocumented aliens and aliens admitted on a temporary basis are not eligible for full MA benefits. However, all aliens are eligible for emergency services as long as they meet other MA eligibility requirements.

Residence. States are required to cover eligible residents, including migrant workers. Federal law prohibits states from establishing a period of residency before an individual can become eligible for MA. In Wisconsin, an individual is considered a resident if he or she: (a) is physically present in the state; and (b) intends to reside in Wisconsin. A migrant worker is considered a Wisconsin resident if he or she: (a) is employed primarily in agriculture or in the cannery industry; (b) is authorized to work in the U.S.; (c) is not related by blood or marriage to the employer; and (d) routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

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

Number of Medical Assistance Eligibles by Category and Group

Table 4 identifies the annual distribution of MA caseload by the four primary groups covered under the program: (a) AFDC-related; (b) aged; (c) disabled and blind; and (d) Healthy Start / Other for fiscal years 1991-92 through 1999-00. Table 4 also separately lists BadgerCare enrollments beginning in 1999-00. For each category, the table provides information on the average number of persons enrolled during the fiscal year and the percent of total MA beneficiaries represented by the category.

Table 4 shows that the number of MA recipients decreased significantly from 1993-94 to 1998-99. This decrease was likely due to the elimination of AFDC and the automatic connection between cash assistance for families and MA eligibility and a strong economy with declining unemployment rates. In addition, AFDC-related financial criteria have not changed since 1988, so that the criteria does not reflect wage inflation since 1988. These factors may have contributed to the declining caseload under the AFDC-related category and the

Table 4:

Average Number of MA and BadgerCare Beneficiaries, by Type -- Fiscal Years 1991-92 through 1999-00

	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
Medical Assistance									
AFDC-Related									
Average Number	301,741	298,301	286,589	276,426	253,068	209,907	153,713	145,832	144,024
% Change from									
Previous Year	-1.9%	-1.1%	-3.9%	-3.5%	-8.5%	-17.1%	-26.8%	-5.3%	-1.2%
% of MA Total	65.9%	62.7%	58.7%	56.7%	53.6%	47.5%	38.1%	36.7%	35.6%
Aged									
Average Number	52,506	52,986	53,115	53,118	50,846	49,350	47,759	46,310	45,309
% Change from									
Previous Year	0.5%	0.9%	0.2%	-0.2%	-4.1%	-2.9%	-3.2%	-3.0%	-2.2%
% of MA Total	11.5%	11.1%	10.9%	10.9%	10.8%	11.2%	11.8%	11.6%	11.2%
Blind / Disabled									
Average Number	78,507	87,827	96,237	99,855	101,075	101,156	99,630	99,070	97,815
% Change from									
Previous Year	7.7%	11.9%	9.6%	3.8%	1.2%	0.1%	-1.5%	-0.6%	-1.3%
% of MA Total	17.1%	18.5%	19.7%	20.5%	21.4%	22.9%	24.7%	24.9%	24.2%
Healthy Start / Other*									
Average Number	25,324	36,844	52,303	58,333	66,785	81,182	102,665	106,322	117,183
% Change from									
Previous Year	63.0%	45.5%	42.0%	11.5%	14.5%	21.6%	26.5%	3.6%	10.2%
% of MA Total	5.5%	7.7%	10.7%	12.0%	14.2%	18.4%	25.4%	26.7%	29.0%
MA Total—All Groups									
Average Number	458,078	475,958	488,244	487,632	471,775	441,595	403,767	397,534	404,331
% Change from									
Previous Year	4.9%	3.9%	2.6%	-0.1%	-3.3%	-6.4%	-8.6%	-1.5%	1.7%
BadgerCare									
Average Number									42,605
Medical Assistance & BadgerCare									
Average Number	458,078	475,958	488,244	487,632	471,775	441,595	403,767	397,534	446,936
% Change from									
Previous Year	4.9%	3.9%	2.6%	-0.1%	-3.3%	-6.4%	-8.6%	-1.5%	12.4%

* Includes persons eligible for MA that are not defined under Title XIX of the Federal Social Security Act, such as persons formerly eligible for the relief for needy Indian persons (RNIP) program and certain refugees. Federal financial participation is not available for MA services provided to this group.

increasing caseload under the Healthy Start category, the eligibility for which is adjusted annually based on changes in the FPL.

The Healthy Start/Other category includes poverty-related pregnant women and children in families that would not have qualified for AFDC (the Healthy Start group), Native Americans eligible for relief for needy Indian persons (which was repealed, beginning January 1, 1996) and refugees. The increases in the Healthy Start/Other category in earlier years is also due to greater numbers of women and children accessing MA by meeting expanded Healthy Start eligibility criteria.

The average number of MA beneficiaries in the aged category decreased slightly over this time period, from 52,506 in 1991-92 to 45,309 in 1999-00. Over time, the percentage of the MA-eligibles attributable to aged recipients has remained relatively constant at 11% to 12% of total eligibles.

Disabled and blind MA-beneficiaries accounted for a growing share of the total MA caseload for eight years, from 17.1% in 1991-92 to 24.2% in 1999-00. Much of this increase is believed to be due to changes in federal law that strengthened outreach efforts and to the impact of the U.S. Supreme Court decision in Sullivan v. Zebley, which effectively expanded MA eligibility to more disabled children.

Covered Services and Provider Reimbursement

Federal regulations define the types of services states are required to provide to categorically and medically needy MA beneficiaries and selected optional services states may include in their MA programs.

Wisconsin's MA program provides all of the optional services identified under federal law with the exception of services provided by Christian Science nurses. There are a number of reasons that the state has elected to cover so many optional services.

While some services are designated as "optional" by federal rule, they may, in fact, be mandatory for certain groups of MA beneficiaries. For example, any service a state is permitted to cover under MA that is necessary to treat an illness or condition identified through an early and periodic screening, diagnostic and treatment (EPSDT) screen must be provided to the EPSDT client, regardless of whether the service is otherwise included in the state MA plan. In addition, certain "optional" services, such as drugs and medical equipment and supplies, must be provided to one or more of three groups of MA beneficiaries -- children, pregnant women and nursing home residents. Further, although payment for "transportation services" is considered an optional service under federal regulations, states are required to assure necessary transportation for recipients to and from providers. In addition, the use of some optional services by MA recipients results in lower costs for mandatory services than would otherwise be incurred. In this way, several optional services serve as substitutes, rather than additions, to mandatory services. For example, although coverage for rehabilitative services is optional, recipients currently using these services could instead receive similar treatment from hospitals on an outpatient or inpatient basis, which may be more expensive.

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

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

- 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, the recipient's symptoms, or other medically necessary services being provided to the recipient;

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

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

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

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

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

Table 5 lists the statutory benefits and services that are covered under Wisconsin's MA program. As previously noted, Wisconsin covers all of the federally-identified optional services except services provided by Christian Science nurses.

Service Limitations

Subject to federal limitations, states may use a variety of methods to control service utilization and costs under MA. The following is a summary of the major utilization controls used by the Wisconsin MA program.

Limitations on Quantity of Services. Certain services are subject to limits on the number of billable units of service that can be made on behalf of an MA beneficiary during a specified time period. For example, Wisconsin's MA program pays for one comprehensive, routine physical examination provided to an MA beneficiary in each calendar year.

Prior Authorization. Prior authorization is designed to safeguard against unnecessary utilization of care, promote the most effective and appropriate use of available services, and contain program costs. Providers are required to obtain prior authorization for certain specified services before delivery of those services. Payment for services that require prior authorization is made only if: (a) prior authorization is approved by qualified medical professionals and staff according to criteria established by DHFS; and (b) the service is performed between the dates indicated on the prior authorization request form. Generally, authorizations are valid for up to one year unless the authorization specifies a more limited time period.

Second Surgical Opinion. The second surgical opinion requirement is designed to help recipients make informed decisions about selected elective surgical procedures and effectively reduces the number of elective surgeries that might otherwise be performed. Examples of surgical procedures that require a second surgical opinion include cataract extractions, hysterectomies, tonsillectomies and varicose vein surgery. The second surgical opinion requirement applies only to non-emergency procedures.

Recipient Copayments. Federal regulations permit states to require MA beneficiaries to share in the cost of receiving certain services through the payment of a flat, nominal fee per service. These fees, commonly referred to as copayments, provide a minor funding source for services and also serve as a means of controlling utilization. Federal regulations establish maximum copayments for services and exempt some services and groups of MA beneficiaries from copayments altogether such as, any service provided to children under the age of 18 years and services relating to pregnancy. These copayments range from $0.50 to $3.00 per visit, service, item or procedure.

Table 5: **MA-Covered Services**

- Physicians' services
- Early and periodic screening, diagnosis and treatment (EPSDT) of persons under 21 years of age
- Rural health clinic services
- Medical services if prescribed by a physician:
    - Inpatient hospital services other than services in an institution for mental disease (IMD)
- Outpatient hospital services
- Skilled nursing home services other than in an IMD
- Home health services, or nursing services if a home health agency is unavailable
- Laboratory and x-ray services
- Family planning services and supplies
    - Intermediate care facility (ICF) services, other than IMD services
    - Physical and occupational therapy
    - Speech, hearing and language disorder services
    - Medical supplies and equipment
    - Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
      --who are under 21 years of age
      --are under 22 years of age and received services immediately prior to reaching age 21
      --who are 65 years of age or older
    - Medical day treatment, mental health and alcohol and other drug abuse services, including services provided by a psychiatrist
    - Nursing services, including services performed by a nurse practitioner
    - Legend drugs and over-the-counter drugs listed in the Wisconsin's MA drug index
    - Personal care services
    - Alcohol and other drug abuse day treatment services
    - Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
    - Respiratory care services for ventilator-dependent individuals
- Dental services
- Nurse midwifery services
- Optometrists' or opticians' services, including eyeglasses
- Transportation:
    - By emergency medical vehicle to obtain emergency medical care
    - By specialized medical vehicle to obtain medical care
    - By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Home and community-based services authorized under a waiver
- Case management services
- Community psychotherapy services
- Community-based psychosocial services
- Hospice care
- Podiatry services
- Care coordination for women with high-risk pregnancies
- Care coordination and follow-up of persons having lead poisoning or lead exposure, including lead inspections
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under MA that are required for enrollment in a group health plan
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act
- Prenatal, post partum and young child care coordination services for certain residents of Milwaukee County
- Mental health crisis intervention services
- School medical services

Federal Reimbursement Requirements

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

Federal law also contains requirements specific to certain types of services. One significant requirement limits the amount paid to inpatient hospitals and nursing homes. Specifically, aggregate payments for inpatient hospital services (or long-term care facility services in hospitals) and nursing facilities may not exceed the amount that the state estimates would have been paid under Medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "Medicare upper limit." Several upper limits apply, based on the type of facility and whether or not the facility is operated by the state. Further, if a state uses a separate rate-setting methodology within these categories of facilities, an upper payment limit is applied to each group of facilities under each of the separate reimbursement methodologies.

Before 1998, inpatient hospitals and nursing homes were also subject to the "Boren Amendment" or "EEO requirement." This requirement directed states to establish reimbursement rates for inpatient hospitals and nursing homes that were "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers." During the years that the EEO requirement was in effect, providers in a number of states successfully challenged a state's payment methodology to such facilities by seeking judicial review of the reasonableness and adequacy of MA rates. However, the federal balanced budget act of 1997 eliminated the EEO requirement, beginning October 1, 1997, and instead, requires states to provide public notice when establishing reimbursement rates to inpatient hospitals and nursing homes. These providers must be notified and given an opportunity to comment on any changes in reimbursement rates. The federal legislation also requires the federal Department of Health and Human Services to conduct a study on the impact of this change on the adequacy of reimbursement rates and the availability of services. The study must be completed by October 1, 2001.

Nursing Facilities

In 1999-00, MA expenditures for nursing home care totaled $1,017.7 million (all funds), representing approximately 34.1% of gross MA expenditures in that year. As of December 1, 2000, there were 465 licensed nursing homes with 49,478 licensed beds. Only 20 of these nursing homes were not certified to serve MA-eligible patients. The 1999 nursing home survey indicated that, on average, 84.9% of licensed nursing home beds were occupied and that 68.3% of nursing home residents (approximately 29,000 residents) were supported by MA. Under the MA program, nursing homes are categorized into three groups: (1) nursing facilities, which consist of skilled nursing facilities (SNF) and intermediate care facilities (ICFs); (2) intermediate care facilities for the mentally retarded (ICFs-MR); and (3) institutions for mental diseases (IMDs).

In the mid-1980s, Wisconsin established a statewide nursing home bed cap to control MA nursing home expenditures. The bed cap established a statutory limit on the total number of nursing home beds that could be licensed. The bed cap limit can and is adjusted by DHFS under

limited conditions. Because the current average occupancy percentage is only 85%, the cap it not currently as important as it once was.

Federal law requires states to provide nursing facility services for categorically needy recipients, but not medically needy recipients. States have the option of covering ICF-MR and IMD services for the categorically needy as well as the medically needy. Federal law prohibits states from covering IMD services for individuals between the ages of 22 to 65. Of the 465 licensed nursing homes, 421 are nursing facilities, 40 are ICFs-MR and four are IMDs.

Nursing facilities are institutions that provide: (1) skilled nursing care and related services for residents who require medical or nursing care; (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons; or (3) 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) which can be made available to them only through institutional facilities. An institution primarily for the care and treatment of mental diseases would not qualify as a nursing facility. Nursing facilities are required to meet requirements relating to provision of services, residents' rights and administration.

Federal MA rules require that a physician personally approve a recommendation that an individual be admitted to a nursing facility. No later than four days following admission, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity must be conducted or coordinated by a registered nurse. Assessment must be done at least once every 12 months and after a significant change in the resident's condition. Federal law also requires that states establish preadmission screening and annual resident review (PASARR) programs to determine whether persons with mental illness and mental retardation require the level of services provided by nursing homes. PASARR requirements are intended to prevent the inappropriate placement of people with mental illness or mental retardation in nursing facilities where they do not receive the care and specialized services they need for their conditions.

Federal rules delineate a two-step screening process. The first step, referred to as a Level I screen, is used to identify whether or not the individual is suspected of having a serious mental illness or a developmental disability. If the Level I screen indicates one of these conditions, then except in certain short-term admissions cases, a Level II screen must be completed. This is a more extensive review that must be completed by appropriate medical professionals, such as psychiatrists and physicians. In fiscal year 1999-00, 26,980 Level I screens were completed at a total cost of $0.8 million ($30 per screen) while 4,869 Level II screens were completed at a cost of $1.1 million ($219 per screen).

Federal law requires that the NF must protect and promote residents' rights by providing residents: (a) free choice of a personal attending physician and the right to be fully informed in advance about care and treatment and any changes and (unless the resident is judged incompetent) to participate in planning treatment; (b) freedom from restraints, including being free from physical or mental abuse or punishment, involuntary seclusion, and any physical or chemical restraints, unless necessary to ensure the physical safety of the resident or other residents and only with a written physician's order specifying the length of restraint; (c) the right to privacy regarding accommodations, medical treatment, communications, visits and meetings of family or resident groups; and (d) confidentiality of personal and clinical records. The NF must inform each resident, orally and in writing, at admission of the resident's legal rights during the stay and periodically of the services available and the related charges.

Federal law also provides residents transfer and discharge rights. A facility cannot transfer or dis-

charge a resident unless: (a) it is necessary for the resident's welfare; (b) the resident's health has improved and the facility's services are no longer needed; (c) the health or safety of residents is endangered; (d) the resident has failed, after reasonable notice, to pay any allowable charges; or (e) the facility has closed. All discharges and the reasons for the discharges, except in the case of closure, must be documented in the clinical record by a physician (the attending physician in the first two instances). The resident (and a family member, if known) must be notified at least 30 days in advance of a transfer or discharge unless the resident's health or safety is endangered, health improvements have made continued stay unnecessary, urgent medical needs require a more immediate transfer or discharge or the resident has not been in the facility for 30 days. Each notice must include the resident's right to appeal under the state-established appeal process and the name, mailing address and telephone number of the state long-term care ombudsman. The NF must provide sufficient preparation to residents to ensure a safe and orderly transfer or discharge.

ICF-MR services may be covered under MA if: (1) the primary purpose of the institution is to provide health or rehabilitative services for such persons; (2) the institution meets requisite certification requirements; and (3) residents of the ICF-MR receive continuous, active treatment. The institution must provide ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitation services to help each individual function at his greatest ability. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous, active treatment program.

An institution for mental diseases (IMD) is defined by federal law as a hospital, nursing home or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care for persons with mental diseases, including medical care, nursing care and related services. Whether or not a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

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

Reimbursement of Nursing Homes Other than State Facilities. Under state law, DHFS is required to reimburse nursing homes for care provided to MA recipients according to a prospective payment system that is updated annually. The Department's formula must reflect a prudent buyer approach under which a reasonable price, recognizing select factors that influence costs, is paid for service of acceptable quality. DHFS must establish payment standards, using recent cost reports submitted by nursing homes. In conjunction with the federal repeal of the EEO requirement, 1997 Wisconsin Act 27 repealed the state requirement that MA payments to nursing homes be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Although the state's general EEO requirement was repealed, Act 27 retained statutory provisions that require payment of a facility's allowable costs by cost center up to the median cost level for all state nursing homes. In essence, state statutes imposed a specific interpretation of the EEO requirement but not a general EEO requirement. However, 1999 Wisconsin Act 9 repealed the state requirement that the standard be not less than the median, and instead, only requires DHFS to establish standards that take into account these costs.

When Wisconsin constructs the prospective daily payment rate, both patient levels of care and categories of expenditures are considered. Many states use this "cost center" approach to establish nursing home payment rates. State statutes require that DHFS consider six cost centers and permits DHFS to consider a seventh, over-the-counter-drugs, when developing facility-specific nursing home rates. These cost centers include: (1) direct care; (2) support services; (3) administrative and general; (4) fuel and other utilities; (5) property taxes, municipal services or assessments; (6) over-the-counter drugs; and (7) capital. The first six cost centers described constitute what is generally referred to as the operations portion of a facility's rate.

In general, nursing homes are reimbursed for their expenses in a given cost center as long as their expenses per patient day do not exceed "targets" (maximum rates) that are based on the costs for all nursing homes in the state.

Direct Care Expenses. Direct care expenses include staff and medical supplies used to provide direct patient care. DHFS is required, by statute, to establish "targets" for payment of allowable direct care costs which are based on direct care costs for all facilities, as adjusted to reflect regional labor cost variations. In 2000-01, DHFS established this target at 100.33% of the statewide median. DHFS must establish targets for ICFs-MR separately. Table 6 shows the different maximum per diem rates for the different levels of care for fiscal year 2000-01 before adjustment for regional cost valuation by the Medicare hospital wage index. State law permits DHFS to provide higher rates or supplements to these standard rates in certain cases.

The direct care component of a facility's rate is established by comparing actual allowable direct care cost information of the facility (adjusted for inflation) to the applicable direct care target. A higher, intense skilled nursing care (ISN) rate is paid to qualifying homes for the care of residents requiring supplemental skilled care due to complex medical conditions. Individuals with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC) and ventilator-dependent persons are paid under special per diem rates. For fiscal year 2000-01, the AIDS/ARC rate was $150 per patient day and the ventilator-dependent rate was $350 per patient day. Nursing facilities with 50 or fewer beds benefit from a 20% increase in the target rate.

Support Services. Support services are costs incurred by nursing homes related to the provision of meals, housekeeping, laundry, security and other services. As with direct care, DHFS establishes a target for support services equal to a

Table 6

Maximum Daily Per Patient Payment Rates Before Labor Cost and Inflation Adjustments by Level of Care (Fiscal Year 2000-01)

Level of Care		Rate
Nursing		
Intense Skilled Nursing (ISN)		$68.90
Skilled Nursing Care (SNF)		57.42
Intermediate Care (ICF 1)		40.19
Limited Care (ICF 2)		28.71
Personal Care (ICF 3)		14.36
Residential Care (ICF 4)		14.36
Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)		
DD-1a	(Fragile Health & Active Treatment)	$106.23
DD-1b	(Extensive Guidance & Active Treatment Needed)	106.23
DD2	(Moderately Retarded Adults Needing Active Treatment)	89.00
DD3	(Mildly Retarded Adults Needing Active Treatment)	63.16

Note: This rates will be adjusted for each nursing home based on the relative cost of labor in the area in which the home is located. In 2000-01, the adjustments for labor costs ranged from a decrease of 6% to an increase of 18%. Also, nursing facilities with 50 or fewer beds benefit from a 20% increase in the maximum rate.

specified percentage of the statewide median for these costs. In 2000-01, the target was set at 95.0% of the median. The support services component of a facility's rate is established by comparing the actual allowable support services costs of the facility (adjusted for inflation) to the applicable support services targets. DHFS may provide an efficiency incentive payment to a facility with support service costs below the target and to reimburse a portion of costs above the target.

For 2000-01, DHFS established two targets, $20.50 per patient day and $21.19 per patient day. If the facility's costs were below $20.50, the facility would be paid the sum of their costs, an inflation adjustment of $0.60 per patient day and an incentive payment of 4% of the difference between the facility's actual costs and target of $20.50. If a facility's actual costs were between $20.59 and $21.19, the payment per patient day would be $21.19. For facilities with costs in excess of $21.19 per patient day, the facility's payment would be equal to the sum $21.19 plus a cost share that is less than 5% of the amount that actual costs exceed this second target.

Administrative and General Expenses. Administrative and general expenses associated with a facility's operation are paid under this cost center. State law requires that such expenses be paid at no less than a target established by DHFS based on administrative and general costs for a sample of all facilities within the state. In 2000-01, two targets were established to provide different targets based on the size of the facility. For facilities with 40 or fewer beds, the target was equal to 100% of the median cost for all facilities while for facilities with over 40 beds the target was 91.9% of the median cost for all facilities. DHFS may provide an efficiency payment for facilities with costs below the standard.

For 2000-01, DHFS established two maximums, $10.81 per patient day for nursing homes with 40 or fewer beds and $12.07 for facilities with more than 40 beds. For 2000-01, DHFS did not provide any efficiency payment. If the facility's cost was less than the respective maximum, the facility was paid the sum of its cost and an inflation adjustment of $0.32 per patient day. If the facility's cost was greater than the maximum, the facility was paid the respective maximum ($10.81 or $12.07 per patient day) plus the inflation adjustment.

Fuel and Utility Expenses. Fuel and utility expenses, including the costs of electrical, water and sewer services, are paid as a separate cost center. The statutes direct DHFS to establish targets for these expenses based on fuel and other utility costs for a sample of all facilities within the state. In 2000-01, the maximum was set at 100% of the median. DHFS may adjust the target for regional heating cost variations based on heating degree day variation. In addition, DHFS may provide an efficiency incentive payment to a facility whose costs are below the target and to reimburse a portion of costs above the target.

For 2000-01, DHFS established targets for six different regions in the state that varied from a low of $2.09 (Southeastern Wisconsin) to $2.31 (Bayfield and Douglas Counties) per patient day. If a facility's cost was less than the target, it was paid its cost plus an inflation adjustment of 4%. A facility could not receive a payment greater than the maximum, adjusted for inflation (the target multiplied by 1.04). Although permitted by state statutes, DHFS chose neither to pay a share of costs above the target nor to provide an efficiency payment for costs below the target. However, DHFS did provide an incentive payment for energy-savings projects, which is described under "provider incentives."

Property Taxes, Municipal Services and Assessments. Property taxes, municipal services and assessments are also recognized as a cost center. For tax-paying facilities, the statutes direct that the payment be equal to the lesser of the actual tax amount due or a maximum established by the DHFS. For municipal service fees paid by tax-exempt facilities, the statutory provisions are the same, except that the payment period is determined by DHFS and does not have to be

based on the previous calendar year. Because of federal requirements, the assessment on occupied nursing home beds is not an allowable expense under this, or any other, cost center.

For 2000-01, the payment to a facility for property taxes or municipal service fees was subject to a maximum payment of the previous year tax or fees plus an inflation adjustment factor ($0.13 per patient day for taxable facilities and $0.01 per patient day for facilities subject to municipal service fees).

Capital Costs. Capital costs include payments necessary for the provision of service over time, including allowable facility expenses for suitable space, furnishings, property insurance and movable equipment for patient care. The statutes require that the capital payments be based on a replacement value for the facility, as determined by a commercial estimator hired by DHFS. However, the statutes permit DHFS to establish limits on the capital payments. By statute, a facility's final capital payment may not be reduced from its previous year's rate by more than $3.50 per patient day.

For 2000-01, DHFS limited the allowed value for a facility to no more than $50,100 per bed. Also, allowable property-related expenses cannot exceed 15% of the allowed value. If allowable property-related expenses are below 6.0% of allowed value (a minimum amount), the facility's payment rate is equal to the sum of its costs, an inflation adjustment and an efficiency payment equal to 20% of the difference between its costs and the minimum amount. Costs between 6.0% and 7.5% of allowed value are also fully reimbursed plus an inflation adjustment, but no efficiency payment is provided. For allowable expenses exceeding 7.5% of value, 20% of the excess is reimbursed by the state. The inflation adjustment per patient day was $1.06 for nursing facilities and $3.29 for ICFs-MR.

Provider Incentives. In 2000-01, nursing homes could receive three types of incentives payments. The first is for nursing homes with above average MA and Medicare populations. If a nursing home's total patient days consists of 70% or more of MA and Medicare residents, the facility receives an exceptional MA/Medicare utilization incentive payment that ranges from $0.55 per patient day to $0.78 per patient day (the rate increases as the percentage of patient days that are MA/Medicare increases).

A nursing facility with a high percentage of MA/Medicare residents (70% or more) can also receive a private room incentive, ranging from $0.15 per patient day to $2.00 per patient day, if 15% or more of its beds are in private rooms. The incentive payment increases in proportion to the percentage of licensed beds that are licensed for single occupancy.

Finally, an incentive payment is provided for facilities that complete a remodeling or renovation project specifically designed to reduce energy use. The incentive payment is made for two years and is equal to 25% of the lesser of the approved projected cost or the actual cost of the project. As a result, one-half of the project's cost can be funded from higher MA per diem rates. This incentive payment is in addition to the normal recovery of project expenses under the capital cost center.

Hold Harmless Rate. If the facility's projected expenses are greater than the rates determined for the operations portion of the facility's rate, then the facility is guaranteed that the payment rate for operational costs will not be less than the rate that was effective for June 30, 1994. Thus, a facility will not, in general, be subject to a operational payment rate less than the rate in 1993-94. The hold harmless determination does not include the capital payment, payment for ancillary services and materials, or the special payments to counties under the FFP program.

Final Payment Rate. The total payment rate for a facility is the sum of the rate, as calculated above, for the operations component of the formula, the

capital payment, payment for ancillary services and materials and supplemental payments (for residents dependent upon ventilators and residents with complex medical conditions). Ancillary services and materials are specifically-identified services and materials that could be billed separately to the MA program by an independent provider of the service, such as home health services.

Nurse Aide Wage Pass-Through. 1999 Wisconsin Act 9 provided $8.3 million in 1999-00 and $11.1 million in 2000-01 to fund a "wage pass-through" of 5% for nurse's assistants that was effective October 1, 1999. In order to receive this supplement, a nursing home was required to apply for the supplement and provide additional cost information to demonstrate that the supplement was used to increase total wages and fringe benefits of nurse's assistants over the previous year. DHFS is authorized to recoup payments if it determines that the facility did not meet this requirement. A nursing home can meet this requirement by increasing employee hours or fringe benefits, as well as by increasing wage rates.

County Supplemental Payments. County- and municipal-operated nursing facilities with operating costs that are not fully reimbursed by the MA per diem rate described above are eligible to apply for supplemental funding. In recognition of the higher costs of these nursing homes, $39.1 million in 1999-00 and $41.1 million in 2000-01 is budgeted to support supplemental payments to these facilities, and will be provided if projections of counties' unreimbursed expenses are accurate. If actual unreimbursed expenses are less than budget projections, county supplemental payments could decrease to $37.1 million in each year. These supplemental funds will be distributed to first fund any unreimbursed expenses in the direct care cost center, and then, if funding is available, to fund part or all of unreimbursed expenses in other cost centers. State rules prohibit a supplemental payment that would exceed the amount of the home's deficit. For 1999-00, counties had unreimbursed expenses of $73.5 million.

County- and municipal-operated nursing homes may receive total supplemental funding above the budgeted amounts of $39.1 million in 1999-00 and $41.1 million in 2000-01. Under the MA state plan, if the actual amount of federal matching funds received based on unreimbursed costs of these nursing homes exceed the budgeted amounts of $104.4 million in 1990-00 or $119.2 million in 2000-01, the additional federal funds must be used as additional supplemental payments as long as the additional payments do not cause the state to violate the Medicare upper limit. For 1999-00, federal matching funds based on certified losses of municipal- and county-owned homes slightly exceeded the budgeted amount, and resulted in additional supplemental payments of $0.6 million, resulting in total supplemental payments of $39.7 million.

Reimbursement for State Facilities. Payment for care at the three state Centers for the Developmentally Disabled and the Veterans Nursing Home at King is determined by DHFS separately from the methods established for all other nursing facilities. The state Centers and King are paid based on their actual and allowable costs, except that payment cannot exceed the Medicare upper limit or the amount appropriated by state law. Interim payment rates are established for the state Centers and King, but a cost reconciliation is done at the end of the state fiscal year to adjust payments to actual costs within the general limitations. For the 2000-01 fiscal year, expenditures for the three state Centers are estimated to be approximately $115 million while MA expenditures related to the Veterans Home at King is projected to be $15 million.

State Supplement for IMD Nursing Homes. Although federal law does not permit states to provide services in an IMD for individuals between the ages of 22 and 65 using federal MA funds, Wisconsin provides state funding for counties to pay a portion of the care of individuals between the ages of 22 and 65 in IMDs. This funding is not intended to cover all individuals in this group, but instead, funds services for

individuals previously eligible for MA coverage who resided in a nursing home that was found to be an IMD before July 1, 1989, or for persons who are eligible for MA who are admitted to replace those persons. Thus, the total number of individuals supported under this program cannot, in general, exceed the number covered in 1989-90. Funding supporting one of these individuals is continued if the individual relocates from the IMD to a community-based setting. These restrictions are intended to limit the state's liability for funding of IMDs and the institutional care of mentally ill persons. In the 1999-01 biennium, $12.3 million is budgeted annually for this program.

For each individual, the county receives 90% of the facility rate in effect on July 1, 1988, (on average, IMDs were receiving $65.00 per day per patient at that time) and $2.14 per day per patient to cover outpatient health services. The funds are provided to the Chapter 51 board of the county of residence of the individual or, if the county of residence cannot be determined, to the Chapter 51 board of the county in which the facility is located. The boards contract with IMDs for care for these individuals. Contracts are submitted to the county board for review and approval. Most counties supplement the IMD payment with their own funds.

Funds are also provided to counties to pay a portion of community-based care for persons relocated from IMDs. These payments are intended to provide counties an incentive to relocate mentally ill persons between the ages of 21 and 65 to the community. While in the community, these individuals' medical care and some nonmedical services are funded by MA and, therefore, eligible for federal MA funds at the regular matching rate.

For individuals who were relocated from an IMD before January 1, 1993, a county receives up to 60% of the July 1, 1988, per diem. This calculation results in payments to counties of $35 to $40 per day of care. In order to encourage community placements, for relocations on or after January 1, 1993, a county can receive up to 90% of the per diem if the IMD closes a bed. If the facility does not close a bed, a payment of up to 60% of the per diem can still be made if DHFS waives the bed-closing requirement (certain requirements must be met) or if the IMD agrees to receive a permanent limitation on the facility's payment under this program for each person relocated. State IMD coverage allows payment to an IMD for persons who are relocated from an IMD, but who reenter the facility within a six-month period.

Previously, facilities at risk of being declared IMDs had been required, if appropriate, to license a distinct part of their institution as an IMD nursing home. Distinct part licensure was intended to allow the state to continue to collect federal matching MA funds for all other appropriately placed nursing home residents in the facility. However, in 1992, the federal government determined that it would no longer pay for care for individuals in distinct part IMDs. Since this federal action, one IMD, the Badger Prairie Health Care Center in Dane County, has been resurveyed and reclassified as a nursing facility.

Hospitals

Inpatient Services. In fiscal year 1999-00, MA payments for inpatient hospital services totaled $248.8 million, representing 8.6% of gross MA expenditures in that year.

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

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

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

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

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

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

The DRG payment system covers most general and specialty hospitals in the state, hospital institutions for mental disease and most major border states' hospitals. MA payment for inpatient hospital services provided at the two state-operated institutes for mental disease (Mendota Mental Health Institute and Winnebago Mental Health Institute) are initially paid on a per diem basis. At the end of each state hospital's fiscal year, its costs for services provided in that year are determined and a final reimbursement settlement is made to reflect the hospital's actual costs of providing services, except that total reimbursement cannot exceed the hospital's charges.

A privately-operated, rehabilitation hospital, Sacred Heart Rehabilitation Hospital in Milwaukee, does not receive MA payments based on the DRG system. Instead, this hospital is paid on a per diem basis to reflect the special nature of the patient mix at this facility.

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

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

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

Disproportionate Share Hospitals. An adjustment may be made to a hospital's DRG base rate if the hospital provides a disproportionate share of services to MA and low-income patients. A hospital may qualify for a disproportionate share adjustment if: (1) the hospital's MA utilization rate, as measured by the percent of inpatient days attributable to MA patients is at least one standard deviation above the mean MA utilization rate for hospitals receiving MA payment (18.07% for 2000-01) and not less than 1%; or (2) the hospital has a "low-income utilization rate" of more than 25% and not less than a 1% MA utilization rate.

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

In fiscal year 1999-00, 26 hospitals (including eight out-of-state) qualified for disproportionate share adjustments, ranging from 3.0% to 5.5% of each hospital's DRG base rate. Total disproportion-

ate share payments were approximately $12.0 million in 1999-00.

Federal law caps the amount of federal funds that are available for disproportionate share payments to hospitals. In 1999-00, federal funds for Wisconsin's disproportionate share were limited to $7.0 million or approximately $12.0 million (all funds).

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

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

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

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

- The hospital did not exceed the median for urban hospitals in Wisconsin for each of the following operating statistics:

(a) total discharges, excluding newborns;

(b) the Medicare case mix index; and

(c) the Wisconsin MA case mix index.

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

In fiscal year 1999-00, 58 hospitals qualified for the rural hospital adjustment, ranging from 8.0% to 35% of each hospital's DRG base rate. In 1999-00, $2.2 million was available for rural hospital adjustment payments.

Indirect Medical Education Adjustment. An indirect medical education adjustment is used to adjust the hospital-specific DRG base rate in order to take into consideration the costs hospitals incur by supporting interns and residents. In 1999-00, 29 hospitals qualified for indirect medical education adjustments, totaling $17.0 million.

Direct Medical Education Payments. Direct medical education payments are added to a hospital's specific base DRG rate. Hospitals located in Wisconsin are eligible for this payment. In 1999-00, 33 hospitals qualified for direct medical education payments, totaling approximately $7.6 million.

Capital Reimbursement. Allowable capital costs are added to a hospital's specific base DRG weight. Wisconsin and major border-states' hospitals are eligible for this reimbursement. Allowable costs are determined based on the inpatient costs attributable to MA recipients compared with total inpatient revenues.

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

Outpatient Services. Technology has allowed more procedures, formerly available only as an inpatient service, to be available on an outpatient basis.

Under MA, hospitals are initially paid an interim rate for outpatient services provided

throughout the year. At the end of a hospital's fiscal year, a retrospective final settlement is made based on the hospital's audited cost report. The final settlement identifies a hospital's allowable outpatient costs and is limited to the lesser of the following:

- Customary outpatient charges in the final settlement year; or

- The sum of the outpatient visit rate effective for the final settlement year multiplied by the number of MA outpatient visits for the period, plus the rural hospital adjustment rate, if allowable, multiplied by the number of MA outpatient visits for the period;

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

The outpatient rate per visit is based on a hospital's base year, which is its first fiscal year after January 1, 1987, modified to reflect several factors. These factors are: (a) the cost of mental health services (b) capital costs reductions; and (c) inflationary costs from the base year forward.

A hospital qualifies for the rural hospital adjustment if it has a combined Medicare and MA utilization rate equal to or greater than 50% based on charges. Additionally, a hospital must meet all of the following to be considered a rural hospital;

- The hospital cannot be located in an MSA under Medicare;

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

- The hospital has not been permanently assigned MSA status as of July 1, 1993;

- Medicare does not classify the hospital as a rural referral center

Outpatient hospital services provided at major and minor border status hospitals, and all other out-of-state hospitals, are reimbursed at 50% of allowable charges. In 1999-00, 47 hospitals qualified for the outpatient rural adjustment, totaling approximately $1.0 million.

Supplemental Hospital Payments. In addition to reimbursement for services billed, some hospitals may receive supplemental payments. These supplemental payments are available to recognize the unique circumstances associated with a hospital that adds to its financial burden. Federal law limits the amount the state can pay for hospital supplements in two ways. First, no hospital can receive funding (both reimbursements and supplements) for more than its total charges. Second, the total funding spent on hospital services (both reimbursements and supplements) cannot exceed the total amount of funding that would have been paid by Medicare for comparable services. This is referred to as the Medicare upper limit and it applies to each group of health care facilities (hospitals, nursing facilities and intermediate care facilities for the mentally retarded). Specific information on each of these payments, including the eligibility criteria, and a description of how the payments are calculated, is available in the MA hospital state plan, which is updated annually by DHFS. Each of these supplements is paid monthly, except where otherwise noted.

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

General Relief/Inter-Governmental Transfer Payments. Supplemental MA payments are made to hospitals that provide a significant quantity of services to low-income persons covered by a county administered general assistance program and to MA recipients. These supplemental payments were created to enable some medical costs that would otherwise be funded from GPR exclusively under the state's general relief block grant program to, instead, be supported through supplemental MA hospital payments. Froedtert Lutheran Memorial and Sinai Samaritan Hospitals in Milwaukee received these payments totaling $15.4 million ($6.3 million GPR and $9.1 million FED) in 1999-00. The payment is limited to no more than $16.6 million annually and is only available for hospitals in Milwaukee County.

1999 Wisconsin Act 9 created an additional payment for Milwaukee County's general assistance medical program (GAMP). Act 9 authorized DHFS to receive $2.5 million annually from Milwaukee County, as an intergovernmental transfer (IGT). This revenue is deposited in a PR appropriation in DHFS. This funding is then matched with federal MA funding (approximately $3.6 million) and distributed to Froedtert Lutheran Memorial Hospital and Sinai Samaritan Hospital for GAMP.

Both the general relief and IGT supplement are paid once annually.

Pediatric Inpatient Supplement. Supplemental payments are provided to acute care hospitals located in Wisconsin that provide a significant amount of services to persons under the age of 18. In order to qualify for the supplement, a hospital must: (a) be an acute care hospital located in Wisconsin; and (b) have inpatient days for stays in the hospital's acute care pediatric units of the facility that exceed 12,000 days in the second calendar year preceding the hospital's fiscal year. For 2000-01, the calculation is based on a hospital's inpatient days in calendar year 1998. Days for neonatal intensive care units are not included in this determination. The pediatric supplement is $2.0 million annually. In 2000-01, Children's Hospital of Wisconsin is expected to receive $1.7 million and University of Wisconsin Hospital is expected to receive $300,000 as a pediatric inpatient supplemental payment.

MA Utilization Supplement. 1999 Wisconsin Act 9 authorized a one-time MA utilization supplement of $2,448,700 to be paid in 2000-01 only. To be eligible for this supplemental payment, a hospital must be an acute care hospital located in Wisconsin providing services to MA recipients and for the most recent fiscal year, the MA inpatient and outpatient revenues must equal at least 8% of the hospital's total inpatient and outpatient revenues. The amount paid to each hospital is based on each hospital's proportion of the total MA revenue for hospitals in the most recent fiscal year. It is estimated that 15 hospitals will be eligible for this supplement in 2000-01.

Hospital Operating Deficit Reduction Program. Similar to the nursing home federal county FFP program, this program allows state, county, municipal or village-owned hospitals with operating deficits to use state or local funds as match for federal funds. Annually, $3,300,000 FED is budgeted for these matching payments.

Federal MA payments to institutional providers are limited by the Medicare upper limit. Although publicly owned hospitals may use the FFP program to enhance their reimbursement, that payment may not exceed the amount that would have been paid using Medicare hospital reimbursement methods.

Managed Care Supplement. Hospitals participating in the state's MA managed care initiative are eligible to receive supplemental payments of up to $250,000 annually. To be eligible, a hospital must qualify for a DRG disproportionate share adjustment, have more than 9.0% of its patient days for newborns, be located in a county other than Milwaukee County that is participating in MA man-

aged care for that year and be a major provider of managed care services to MA recipients in that county. In 2000-01, St. Luke's Memorial Hospital in Racine County is expected to receive the full amount of the supplement.

Border/Metropolitan Statistical Area Supplement. Hospitals located in MSAs outside of Wisconsin that serve primarily urban areas may be eligible for a supplement totaling up to $250,000. The total amount paid is based on each qualifying hospitals' outpatient services provided to Wisconsin MA recipients. Five hospitals are expected to receive this supplement in 2000-01.

Other Services

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

Many types of physicians' services are subject to prior authorization requirements. In addition, some medical services that are considered by DHFS to be obsolete, unnecessary or ineffective are not covered at all. Among these services are acupuncture, artificial insemination, cosmetic services, personal comfort items and vitamin C injections. Further, MA does not cover services that are considered to be experimental in nature. A service is considered experimental if DHFS has determined that the procedure or service is not generally recognized by the professional medical community as effective or proven treatment for the condition for which it is being used.

Physician services are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by DHFS. The maximum fee schedule reflects higher rates paid for certain types of services provided to MA beneficiaries in health professional shortage areas (HPSAs). MA payment rates for primary care services other than obstetric and gynecological procedures, in HPSAs are equal to 120% of the rates paid for the same services in other areas of the state. Obstetric and gynecological services provided to adult MA beneficiaries in HPSAs are paid at a rate equal to 150% of the rates paid for such services in other areas of the state. Primary care providers are eligible for HPSA-enhanced reimbursement. HealthCheck services, described below, are not eligible for the enhanced HPSA reimbursement.

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

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

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

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. Other ambulatory services, such as dental, podiatry and optician services may be provided at an RHC if persons meeting all applicable MA provider eligibility criteria furnish these services. For clinics located in rural areas with less than 50 beds, MA pays 100% of the clinics cost for services. For other clinics, the MA payment for services is the Medicare per visit rate for rural health clinic services, currently $61.85 per visit. As of January, 2001, there were 63 certified rural health clinics in the state.

Federally Qualified Health Centers. Federally qualified health centers (FQHCs) are federally-funded migrant and community health centers, health care for the homeless projects, tribal health clinics and similar entities that provide comprehensive primary and preventive health services to medically underserved populations. FQHCs are currently paid 100% of their reasonable costs, recognizing that FQHCs serve a disproportionate share of the state's MA, Medicare and uninsured population and are unable to shift costs of providing services for these populations to other payment sources. There are currently 27 FQHCs operating in Wisconsin, including 15 centers operating under federal grants from the U.S. Public Health Service, 11 Indian tribal clinics and one health center that meets the operating requirements of federally-funded community health centers but does not receive federal operating grants (a "look-alike" FQHC).

In December, 2000, the federal Benefits Improvement and Protection Act modified the provisions regarding payment of RHCs and FQHCs under MA. Beginning in January, 2001, states are required to pay RHCs and FQHCs under a prospective payment system, similar to the DRG system used to pay hospitals. If the state proposes to pay RHCs and FQHCs under an alternative methodology, that methodology must be agreed to by the state and each individual FQHC and RHC to which the payments would apply and result in payments at least equal to what the FQHCs and RHCs would be paid under the prospective payment system.

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

Home Health Services. Home health agencies provide a variety of services in an individual's home, including: (a) home health services provided by nurses and aides; (b) therapy services provided by physical therapists, occupational therapists and speech and language pathologists; (c) private-duty nursing services; (d) respiratory care services; and (e) personal care services. All home health services eligible for payment under the MA program must be certified as necessary by a physician and specified in a written plan of care.

Home Health Nursing Services. These services are medically necessary skilled-nursing services provided in the client's home. These services are available to individuals who require less than eight

hours of direct, skilled-nursing services per calendar day. In determining whether or not a service requires the skills of a registered nurse or licensed practical nurse, the complexity of the service, the condition of the client and the accepted standards of medical and nursing practice are considered.

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

Skilled-Therapy Services. Services provided by physical therapists, occupational therapists and speech and language pathologists are covered as a home health service if certain guidelines are met. For example, such services must be reasonable and necessary within the context of the recipient's medical condition, and be considered, under accepted standards of medical practice, to be specific and effective treatment for the individual's condition or for the restoration or maintenance of an individual's function.

Private-Duty Nursing Services. These services are medically necessary skilled-nursing services for an individual who requires eight or more hours of direct, skilled-nursing services per calendar day. All private-duty nursing services must receive prior authorization before the services are provided.

Respiratory Care Services. These services are provided for ventilator-dependent persons residing at home. Registered nurses, licensed practical nurses or respiratory therapists must perform these services.

Personal Care Services. These services are medically-oriented activities related to assisting an individual with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. These services may only be provided under the written orders of a physician. Covered personal care services include activities of daily living (such as assistance with eating, dressing and bathing), meal preparation, and accompanying an individual to obtain medical diagnosis and treatment. Prior authorization is required for personal care services in excess of 50 hours per calendar year.

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.

MA payment for home health services is based on the lesser of a home health agency's usual and customary charges or a maximum allowable fee schedule determined by DHFS. Home health aides, home health nurses and therapists are reimbursed on a per visit basis. Private duty nurses, personal care workers and providers of respiratory care services are reimbursed on an hourly basis.

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

Family Planning Services and Supplies. Family planning services are services prescribed by a physician. They include physical examinations and health histories, office visits, laboratory services, the provision of contraceptive devices and supplies and prescribing medication for specific

treatments. Unlike most services covered under Wisconsin's MA program, the costs of most family planning services are supported on a 90% FED / 10% GPR basis. MA payment for these services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS.

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

Dental Services. Wisconsin's MA program covers basic dental services within the following categories of service: (a) diagnostic; (b) preventive; (c) restorative; (d) endodontics; (e) periodontics; (f) fixed and removable prosthodontics; (g) oral and maxillofacial surgery; (h) orthodontics; and (i) adjunctive general services. Limitations apply to the frequency and type of covered dental services. For example, examinations and teeth cleanings are limited to twice per year for children through the age of 12. For clients 13 years of age and older, cleanings are limited to twice per year and exams are limited to once per year. A tooth extraction is only covered in cases of a medical emergency or when it is necessary for orthodontia. Orthodontic services are provided only to children up to age 20 with cases of severe malocclusion after prior authorization is given. MA payment for dental services is the lesser of the provider's usual and customary charges or amounts prescribed under a fee schedule established by DHFS.

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

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

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

SMVs may be use to transport indefinitely disabled or blind individuals who are unable to take public common carrier or private motor vehicle transportation if the purpose of the trip is to receive covered MA services. An "indefinite disability" is defined by DHFS as a physical or mental impairment that includes an inability to move without personal assistance or mechanical aids, such as a wheelchair, walker or crutches or a mental impairment that prohibits the individuals from using common carrier transportation reliably or safely. A physician must prescribe all transportation services provided by SMVs.

Ambulance and SMV providers are paid a base

rate and other applicable rates, such as mileage rates (both for miles traveled with a client and without a client) and waiting time. Providers may not be reimbursed more for transportation provided to an MA recipient than the provider's usual and customary charges.

Counties, through contracts with common carriers and private motor vehicles, provide transportation services for ambulatory clients. Such services may be provided by buses, trains, taxis, and in some instances, airplanes. In providing these services, counties must use the least expensive means the individual is capable of using and that is reasonably available at the time the service is required. These services are covered only after a county department of human services approves the service.

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

Physical and Occupational Therapy. Therapies prescribed by a physician that are provided by certified physical and occupational therapists, or by a certified physical or occupational therapy assistant under the direct, immediate on-premise supervision of a certified physical or occupational therapist, are covered under Wisconsin's MA program. Prior authorization is required for therapy services provided in excess of 35 treatment days per spell of illness, except if the therapy is provided to a hospital inpatient or an individual who receives the service through a home health agency. Therapy providers are reimbursed for evaluations, modalities and procedures at the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

Speech, Hearing and Language Disorder Services. Coverage is provided for medically necessary diagnostic, screening, preventive or corrective speech and language pathology services prescribed by a physician and provided by a certified speech and language pathologist or under the direct, immediate, on-premises supervision of a certified speech or language pathologist. Covered services are specified by rule and include evaluation procedures and speech treatments. Prior authorization is required for all services provided in excess of 35 treatment days per spell of illness, except if the therapy is provided to a hospital inpatient or an individual who receives the service through a home health agency. Providers are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

Medical Supplies and Equipment. Coverage is provided for certain disposable medical supplies and durable medical equipment (DME) when a physician prescribes them and when specified providers supply them.

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

Durable medical equipment are medically necessary devices that can withstand repeated use. Examples include wheelchairs, crutches, respiratory equipment and prostheses. A physician, podiatrist, nurse practitioner or chiropractor must prescribe all DME services, including purchases, rental and repairs. The item must be necessary and reasonable for treating an illness or injury, or for improving the function of a malformed body part.

Most DME services, including the purchase of wheelchairs, wheelchair accessories and hospital beds, require prior authorization. In cases where DHFS determines that a piece of equipment will only be needed on a short-term basis, equipment is rented, rather than purchased, for the client. Payment for medical supplies and DME is based on the lesser of the provider's usual and customary charges or the amounts in a fee schedule established by DHFS.

Mental Health and AODA Services. Wisconsin's MA program provides outpatient and day treatment mental health and alcohol and other drug abuse (AODA) services if prescribed by a physician and other conditions are met.

Prior authorization is required for both mental health and AODA outpatient services if MA payments for services exceed $500 or after 15 hours of services are provided to a recipient in a calendar year.

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

1999 Wisconsin Act 9 provided that MA recipients could receive up to 45 days of residential AODA treatment services if a county, city, town or village elects to become a certified provider of such services or contracts with a certified provider. Local governments that elect this option are required to pay the state share of the total MA costs of providing these services. This provision does not apply after July 1, 2003.

Independent Nurse Practitioner Services. Nursing services delegated in a written protocol to licensed nurse practitioners and clinical nurse specialists by a licensed physician are covered. Such services include medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative service provided in a medical setting, the recipient's home or elsewhere. Nurse practitioners and clinical nurse specialists are paid the lesser of their usual and customary charges or amounts prescribed under a fee schedule developed by DHFS.

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

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

Federal law also requires drug use review programs to assure that prescriptions are appropriate, medically necessary and unlikely to produce adverse effects. The drug use review must be both prospective and retrospective. The prospective part of this review, conducted by the pharmacist at the point of sale or distribution, must include a screening for drug interactions and incorrect dosage and a processing system to identify patterns of fraud, abuse or inappropriate care.

DHFS reimburses pharmacists and physicians licensed to practice medicine and surgery for all covered prescription drugs at the lesser of: (a) the usual and customary charge; or (b) the estimated acquisition cost (EAC) plus a dispensing fee. The

EAC for brand name and not readily-available generic drugs is generally equivalent to the average wholesale price (AWP), as reported by pharmaceutical manufacturers to First Data Bank, minus 10%. The EAC for readily-available generic drugs is determined based on the maximum allowable cost (MAC) list, developed by DHFS.

Reimbursement for over-the-counter drugs is limited to the amount paid for nonprescription generic drugs, except for insulin that may be a brand name drug. MA recipients must have a prescription for payment of any nonprescription drug. Coverage of over-the-counter drugs is limited to antacids, analgesics, insulins, contraceptives, cough preparations, ophthalmic lubricants, and iron supplements for pregnant women.

Under the incentive-based pharmacy payment system, pharmacies are eligible for an enhanced dispensing fee. Pharmacies may receive the enhanced fee when their services achieve a positive patient outcome and they increase patient compliance or prevent potential adverse drug reactions.

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

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

1997 Wisconsin Act 27 created a community-based psychosocial benefit targeted to MA recipients whose mental health needs are more than outpatient counseling, but less than the services provided by the community support program. Counties that elect to provide this service are responsible for providing the state matching funds for this service.

Clozapine Management. Clozapine management is a specialized management service provided to ensure the safety of recipients who are using the psychoactive medication Clozapine. The dispensing of Clozapine requires the patient to submit to weekly blood tests. Payment for this service is based on a fee per seven-day period for all allowable Clozapine management services delivered over the course of one week. Physicians, pharmacies and CSPs may provide Clozapine management services.

Case Management Services. Case management services assist individuals in accessing, coordinating and monitoring an array of services, including services covered by MA and services provided under other programs. Case management providers are required to perform a written comprehensive assessment of a person's abilities, deficits and needs. Following the assessment, providers develop a case plan to address the needs of the client.

Case management is a covered benefit for an individual who: (a) has a developmental disability; (b) has a chronic mental illness; (c) has Alzheimer's disease; (d) is alcoholic or drug dependent; (e) is physically disabled; (f) is a child with severe emotional disturbance; (g) is age 65 or over; (h) is a member of a family that has a child at risk of physical, mental or emotional dysfunction; (i) is infected with HIV; (j) is infected with tuberculosis; (k) is a child eligible for the birth-to-three program;

(l) is a child with asthma; or (m) is a women between the ages of 45 and 64 and who is not residing in a nursing home.

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

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

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

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

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

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

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

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

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

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

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

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

Managed Care

Wisconsin uses managed care to provide health services to certain MA populations to better meet the needs of these populations and improve the quality of services they receive.

Health maintenance organizations (HMOs) are health care plans that provide comprehensive health services to enrolled members for a fixed, periodic payment ("capitation rate"). If enrollees use more, or more costly, services than anticipated, the HMO may incur a financial loss. If enrollees use the estimated number of services, or fewer or less costly services, the HMO may realize a profit. In this way, the delivery of services through HMOs provides an alternative to the fee-for-services method, since the HMO, rather than the state, assumes the financial risks associated with utilization of most MA services by the covered population. The delivery of MA benefits through HMOs is also considered a method for increasing the use of preventive services and improving continuity of care for MA recipients.

Low-Income Families

Currently, the managed care program for low-income families enrolled in MA and BadgerCare operates in 68 of 72 counties. As of December, 2000, 15 HMOs were providing health care services to 237,609 MA and BadgerCare recipients. Table 7 lists the participating HMOs and their enrollment as of December, 2000. As a condition of serving low-income families enrolled in MA, HMOs must agree to also serve families enrolled in BadgerCare.

Table 7:
HMOs with MA and BadgerCare Enrollees as of December, 2000

HMO	Enrollment
Atrium Health Plan	16,381
Dean Health Plan	7,640
Greater LaCrosse Health Plans	3,916
Group Health Cooperative of Eau Claire	8,498
Group Health Cooperative of South Central WI	1,907
Humana Wisconsin Health Organization	41,815
Managed Health Services	42,682
MercyCare Health Plan	4,282
Network Health Plan	17,488
Physicians Plus	1,924
Security Health Plan	21,116
Touchpoint Health Plan	12,457
United Healthcare of WI	53,284
Unity Health Plan	3,368
Valley Health Plan	851
Total	237,609

Low-income families and children enrolled in MA and BadgerCare are required to enroll in an HMO if they live in some counties (or zip codes within counties) and may enroll in HMOs if they

live in other counties or zip codes within counties. The criteria for determining whether or not a county will have mandated HMO enrollment is based on the number of HMOs that have contracted to participate in the program in that county. HMO enrollment is mandatory in counties with two or more participating HMOs. In areas where there is only one participating HMO, enrollment is voluntary. MA recipients living in counties that do not have a participating HMO receive MA benefits on a fee-for-service basis. In order to participate in the program, an HMO must be licensed by the Wisconsin Office of the Commissioner of Insurance and must meet MA standards for quality assurance, cultural competency, enrollment capacity and coordination of care. Table 8 provides a summary of each county's status for HMO enrollment, as of July, 2000.

Table 8:

Mandatory and Voluntary HMO Enrollment -- July, 2000

Mandatory			
Barron	Brown	Calumet	Chippewa
Dane	Eau Claire	Fond du Lac	Green Lake
Jackson	Kenosha	LaCrosse	Manitowoc
Marathon	Milwaukee	Monroe	Outagamie
Ozaukee	Pierce	Polk	Racine
Rock	Rusk	St. Croix	Sheboygan
Vernon	Washington	Waukesha	Waupaca
Waushara	Winnebago	Wood	

Voluntary & Mandatory*	Voluntary & Fee for Service**	Voluntary Only	Fee-for-Service Only
Buffalo	Adams	Forest	Door
Burnett	Ashland	Langlade	Florence
Clark	Bayfield	Lincoln	Kewaunee
Crawford	Columbia	Marquette	Marinette
Dunn	Dodge	Menominee	
Grant	Douglas	Oconto	
Juneau	Green	Oneida	
Pepin	Iowa	Price	
Portage	Iron	Shawano	
Sawyer	Jefferson	Vilas	
Taylor	Lafayette		
Trempealeau	Richland		
Walworth	Sauk		
Washburn			

*Mandatory participation for selected zip codes and voluntary participation for other zip codes.

** Voluntary participation for selected zip codes and fee for service in other zip codes.

MA and BadgerCare low-income families who are enrolled in HMOs are generally entitled to receive, as needed, all MA benefits available to persons who do not participate in an HMO plan. There are a number of exceptions to this rule. HMOs have the option of covering dental and chiropractic services. If an HMO decides not to provide these services, they must accept a lower capitation rate. If the HMO does not offer these services, enrollees may obtain them from MA-certified providers on a fee-for-services basis. While HMOs are responsible for providing family planning services, enrollees may obtain these services from a primary physician of choice, whether or not that provider is in the HMO's plan or not. If the enrollee chooses a primary care physician outside of the HMO, those services will be reimbursed on a fee-for-service basis. Finally, HMOs may provide services that are not MA-covered services. HMOs must provide all services at no cost to the recipient. Table 9 provides a summary of the 2000 capitation rates.

There are a number of services that are reimbursed outside of the capitation payment system. DHFS reimburses HMOs for a portion of neonatal intensive care unit (NICU) costs if the HMO's average number of NICU days per thousand member years exceeds 75 days per thousand member years. DHFS also fully reimburses HMOs for costs incurred for qualifying persons with HIV or AIDS and ventilator-assisted patients.

Table 9: **2000 HMO Rates for AFDC/Healthy Start MA Enrollees**

County or Region	Eligibility Group	Base Capitation Rate	Dental	Chiropractic	Comprehensive Rate
Dane	AFDC	$ 108.64	$3.76	$0.50	$112.90
	Pregnant Women	559.34	2.23	0.38	561.95
Eau Claire	AFDC	105.54	5.18	1.80	112.52
	Pregnant Women	623.77	2.70	1.65	628.12
Kenosha	AFDC	114.89	5.88	0.20	120.97
	Pregnant Women	565.93	4.14	0.14	570.21
Milwaukee	AFDC	125.43	4.79	0.13	130.35
	Pregnant Women	615.17	1.68	0.18	617.03
Waukesha	AFDC	121.06	5.30	0.56	126.92
	Pregnant Women	522.42	3.47	0.23	526.12
Region 1	AFDC	106.17	4.96	0.78	111.91
(Duluth / Superior)	Pregnant Women	505.26	5.18	0.87	511.31
Region 2	AFDC	103.95	4.45	0.72	109.12
(Wausau / Rhinelander)	Pregnant Women	507.25	2.92	1.14	511.31
Region 3	AFDC	103.64	4.84	0.65	109.12
(Green Bay)	Pregnant Women	507.74	3.03	0.54	511.31
Region 4	AFDC	101.58	6.17	1.37	109.12
(Twin Cities)	Pregnant Women	504.26	5.62	1.43	511.31
Region 5	AFDC	103.42	5.02	0.68	109.12
(Marshfield / Stevens Point)	Pregnant Women	518.32	3.27	1.05	522.64
Region 6	AFDC	104.33	4.96	0.74	110.03
(Appleton / Oshkosh)	Pregnant Women	506.71	4.03	0.57	511.31
Region 7	AFDC	102.99	5.18	0.95	109.12
(La Crosse)	Pregnant Women	505.91	3.86	0.95	511.31
Region 8	AFDC	103.71	5.01	0.40	109.12
(Madison / South Central)	Pregnant Women	522.59	4.17	0.55	527.31
Region 9	AFDC	104.21	4.55	0.36	109.12
(Southeast)	Pregnant Women	507.92	2.89	0.50	511.31

The contract between DHFS and participating HMOs contains a number of requirements relating to certain activities. HMOs must report to DHFS the number of HealthCheck screens that they conduct for MA children enrolled in the HMO. If an HMO fails to screen at least 80% of the number of expected screens, as calculated according to the contract, DHFS would penalize the HMO by recouping MA payments from the HMO. HMOs are also required to develop and implement targeted performance improvement measures that address the following seven areas.

- *Immunization Performance Improvement.* In 2000, HMOs will increase to 90%, the proportion of children, two years of age, who are fully

immunized.

- *Dental Preventive Care Performance Improvement.* In 2000, enrollees will receive preventive dental services at a rate of 110% of the rate at which individuals receive preventive dental services on a fee-for-service basis.

- *Lead Toxicity Screening Performance Improvement.* In 2000, HMOs must ensure that at least 65% of all MA enrollees with a first or second birthday during the reporting period had one lead toxicity screen. In 2001, at least 85% of all MA enrollees with a first or second birthday during the reporting period will receive a lead toxicity screen.

- *Mental Health Follow-Up Care Performance Improvement.* In 2000 and 2001, HMOs will reduce the number of individuals that do not receive ambulatory follow-up treatment within seven and 30 days of hospital discharge for treatment of selected mental heath disorders, by 10% in each year.

- *Substance Abuse Follow-Up Care Performance Improvement.* In 2000 and 2001, HMOs will reduce the number of individuals that do not receive ambulatory follow-up treatment within seven and 30 days of hospital discharge for treatment of selected substance abuse disorders, by 10% in each year.

- *Outpatient Management of Diabetes Performance Improvement.* In 2001, HMOs will improve the rates of hemoglobin A1c testing and lipid profile testing for individuals with Type 1 and Type 2 diabetes by achieving a 10% reduction in the number of individuals with adverse outcomes. Calendar year 2000 will be used to develop baseline data for measuring 2001 performance.

- *Mental Health/Substance Abuse Services Referral Performance Improvement.* 2000 and 2001 will be used to develop baseline data to measure enrollees' satisfaction with referrals for mental health and substance abuse services. The standardized consumer assessment of health plan survey will be used to gather the data.

Other MA Managed Care Programs

Community Care Case Management for High-Cost Recipients. DHFS administers a targeted case management program that assigns high-cost, SSI-related MA clients to case managers contracted by DHFS to coordinate medical care and monitor services to ensure that these clients receive the most efficient and cost-effective treatment alternatives. DHFS currently pays case managers $87.25 per month under this program to provide this service. In December, 2000, 20 persons were enrolled in this program.

Independent Care Program. The independent care (I-Care) program, which began as a three-year research and demonstration program, provides coordinated medical and social services for SSI-related MA recipients ages 15 and older in Milwaukee County. The program operates under a joint venture agreement between the Milwaukee Center for Independence (a Milwaukee social service agency) and Wisconsin Health Organization (a health maintenance organization).

Under the program, care coordinators assess the medical needs of enrollees and develop case plans with enrollees and their providers. In 2000, the state paid a capitation rate of $602.72 per month for most individuals enrolled in the program (a rate of $456.34 per month is paid for disabled persons who do not receive SSI cash payments). As of December, 2000, there were 4,131 individuals in Milwaukee County enrolled in the program.

PACE/Wisconsin Partnership Program. The program for all-inclusive care for the elderly (PACE) and the Wisconsin partnership program (WPP) are managed care programs that provide both acute health and long-term care services to elderly and disabled persons who are eligible for nursing home care. The programs provide a comprehensive system of health care and other

supportive services to maintain people in the community. These programs are voluntary, and are available to people that are eligible for both MA and Medicare.

There are two primary differences between PACE and WPP. First, PACE uses a day health center setting to deliver many services and requires enrollees to attend the day center on a regular basis. In contrast, WPP does not require members to attend a day center. Second, PACE requires that the client's primary physician be a physician who is a member of the PACE organization, while WPP attempts to retain the client current's primary physician by recruiting that physician to the WPP organization. PACE programs serve only elderly individuals, while the WPP also serves individuals with physical disabilities.

There are two PACE sites in Wisconsin, Community Care for the Elderly (CCE) in Milwaukee County and Eldercare in Dane County. CCE began operating in 1989 while Eldercare started in 1995. Eldercare plans to close its PACE site on April 1, 2001, and expects that most participants will choose to receive services from WPP. In addition, the Community Living Alliance (CLA) of Dane County began operating a WPP site in 1996 that exclusively enrolls disabled persons under 65 years of age. Finally, in 1997, the Community Health Partnership (CHP) began operating a multi-county WPP program serving both younger disabled persons and elderly persons residing in Eau Claire, Chippewa, Clark and Dunn Counties.

The PACE and WPP sites are paid a monthly capitation rate to fund services for each enrollee. During the first three years of operation of a WPP site, the state shares in any costs that exceed the capitation rate. The MA capitation rate paid for elderly clients varies by site. In 2000, CCE was paid $2,438.49 per month per client for both its PACE site and WPP site. Eldercare was paid $2,465.41 per month for its PACE site and WPP site, while CHP was paid $2,373.97 per month. Capitation rates for disabled clients varied from $3,358.69 per month for CHP to $3,522.22 per month for CLA. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services. The MA capitation rate reflects an estimated 5% savings from the average fee-for-service equivalent for nursing home care. As of December, 2000, there were 1,425 persons enrolled in these programs.

Children Come First and Wraparound Milwaukee. The children come first (CCF) program, which has been operated by CCF Managed Care in Dane County since 1989, provides community-based mental health and AODA services to eligible children with severe emotional disturbances (SED). These services serve as an alternative to inpatient psychiatric care and provide a more comprehensive level of services that includes a care coordinator and individualized services. The program is funded through MA and county matching funds on a capitated basis. Under the program, Dane County contracts with CCF Managed Care, Inc., a limited service health organization, to arrange services for program clients. In calendar year 2000, the total capitation rate was approximately $3,500 per child per month, of which $1,890.50 was paid by MA and the remainder was paid by Dane County. The amount paid by MA reflects an estimate of the amount MA would have paid for services to enrollees if, instead, they received services under the MA fee-for-service system.

The Wraparound Milwaukee program developed in Dane County. The program is operated by the Children and Adolescent Treatment Center in Milwaukee, which also provides inpatient services to children. Similar to the CCF program, the county pays a portion of the costs. In 2000, the monthly capitation rate was approximately $4,800 per child, of which $1,542 was paid by MA, the remainder paid by Milwaukee County or the DHFS Bureau of Milwaukee Child Welfare. In December, 2000, the CCF and Wraparound programs had a combined enrollment of 541 children.

The federal government awarded Wisconsin a five-year grant to establish a similar program that

would serve SED children in Marathon, Lincoln and Langlade Counties. Funding for services is currently available under the federal grant, however, it is expected that payments made on a capitated basis will not begin until July, 2001.

Home- and Community-Based Waiver Services

HCFA may waive certain requirements of federal MA law to permit states to develop innovative methods of delivering or paying for MA services. For example, HCFA may permit states to limit enrollees' freedom to choose providers to enable states to enroll recipients in managed care programs. In Wisconsin, HCFA has approved waivers to enable the state to deliver services to certain MA populations through health maintenance organizations and to provide home- and community-based services as an alternative to institutional care.

Under the community-based waiver provisions of federal MA law, states may offer medical and support services to certain groups of MA-eligible recipients. Community-based waiver services provide a cost-effective alternative to institutional care through the provision of services that may not otherwise be available to MA recipients. Medical support and social services generally excluded from MA coverage that can be offered to waiver participants include supportive home care services that are significantly broader than MA personal care services, home modifications, adaptive aids, transportation services to nonmedical destinations, adult day care and supportive services in community-based residential facilities, as well as any other services requested by the state and approved by HCFA. The appendix to this paper provides a list of waiver services.

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

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

Before 1994, the number of waiver participants was limited to the number of persons who would have been served in an institution in the absence of the waiver. However, this limit is no longer applicable. Also, although a state's waiver application is required to specify a limit on the number of individuals who will participate in the waiver, HCFA usually increases the limit at the state's request. Waivers are granted for an initial period of three years. Waiver renewals are usually authorized for five-year periods.

Under four federal MA waivers, Wisconsin operates six programs which are intended to reduce the number of persons who would receive long-term care services in nursing homes or institutions. Persons who are elderly and physically disabled are served under one federal waiver that encompasses two state programs – the community options waiver program (COP-W) and the community integration (CIP II) program. Persons with developmental disabilities may receive services under four state programs

authorized under three federal waivers. The community integration programs CIP IA and CIP IB are under one federal waiver while the brain injury waiver (BIW) and the community supported living arrangements waiver (CSLA) programs are under separate federal waivers.

Community Integration Program -- CIP IA. This program is designed to relocate residents of the three state Centers for the Developmentally Disabled (Northern Center located in Chippewa Falls, Central Center in Madison and Southern Center located in Union Grove) into community-based settings. State law requires that following a CIP IA placement, a Center bed must be held vacant for 360 days and then closed.

For the 2000-01 fiscal year, DHFS provides counties a maximum average per day allowance of $125 for each person relocated from the Centers before to July 1, 1995, $153 for relocations between July 1, 1995 and June 30, 1997, $184 for relocations that occurred between July 1, 1997 and June 30, 2000 and $190 for persons placed on or after July 1, 2000. For CIP IA participants whose service costs exceed the fully-funded rate, counties can be reimbursed for approximately 59% of the difference between the state rate and the actual costs of providing the service as long as the average cost of CIP IA placements statewide does not exceed the average cost of care at the centers. As of December 31, 2000, 1,115 individuals were participating in CIP IA. In calendar year 1999, MA expenditures under CIP IA totaled $63.4 million (all funds), including $21.5 million GPR.

The average cost of serving residents at the three state Centers was $334 per day in 1999, compared to $208 per day for persons enrolled in CIP IA when MA card services expenditures are included.

Community Integration Program -- CIP IB. This program is primarily designed to relocate or divert developmentally disabled persons from ICFs-MR other than the state Centers for the Developmentally Disabled. In 2000-01, the maximum average per day allowance for state reimbursement under CIP IB is $48.33, although a higher rate is available for placements from facilities that close or have on file a Department-approved plan for significant downsizing over five years. The enhanced rate is determined by a formula that is related to the facility's MA reimbursement rate. For county costs in excess of state reimbursement, federal matching funds can be claimed for costs up to a maximum of the average cost of care in an ICF-MR (approximately $135 per day). As of December 31, 2000, there were 2,379 state-funded individuals participating in CIP IB.

In addition to these state-matched slots, Wisconsin claims federal funding for persons for whom counties elect to provide the state match with county funds. As of December 31, 2000, Wisconsin was claiming federal funds for an estimated 5,470 locally matched slots. Thus, it is estimated that 7,849 persons received services under CIP IB as of December 31, 2000. In calendar year 1999, MA expenditures for waiver services for CIP IB participants totaled $198.5 million, including $17.2 million GPR.

As of December 31, 1999, 1,951 developmentally disabled persons resided in ICFs-MR other than the three state Centers, and 142 developmentally disabled persons resided in other nursing homes. Combined with the 839 persons in the three state Centers, 2,932 Wisconsin residents with developmental disabilities were residing in ICFs-MR or nursing homes as of that date. In contrast, 8,492 persons with developmental disabilities were participating in CIP IA and CIP IB on that date.

The average cost of serving persons with developmental disabilities in ICFs-MR (excluding the three state Centers) was $134 per day in 1999. In comparison, the average actual cost to serve a person under CIP IB was $94 per day when MA card services expenditures were included.

Community Integration Program -- CIP II. CIP II participants are individuals who are either over

the age of 65 years or physically disabled who are either relocated or diverted from nursing homes. Under state statutes, a CIP II placement requires the closing of a nursing facility bed. Once a nursing home bed has been delicensed and a community "slot" has been established, the number of MA recipients who receive CIP II services at any time may not exceed the number of MA beds that are closed.

For 2000-01, the daily reimbursement rate available to counties serving CIP II clients is $40.78. In order to maximize state funding, counties are more likely to place higher cost, disabled persons in the CIP II program for which the county has a fixed number of slots, than under the COP-waiver program, for which the county is allocated a fixed amount of funding. As of December 31, 2000, there were 2,516 slots available to counties. In calendar year 1999, MA expenditures for waiver services for CIP II participants totaled $31.3 million, including $12.9 million GPR.

Community Options Waiver Program. The community options waiver program (COP-W) provides services to elderly and physically disabled persons who would otherwise receive care in a nursing facility. Used primarily to divert persons from nursing homes, COP-W was initiated when federal funding became available to support the types of community-based care services that were already being provided under the state-funded COP program. COP-W serves MA-eligible individuals who, with medical and support services, can be cared for in the community. The original waiver for this program became effective January 1, 1987.

In calendar year 1999, 11,447 persons received services supported by COP-W funds. MA expenditures for COP-W waiver services totaled $81.4 million, including $32.1 million GPR. Unlike other community-waiver programs, under COP-W, counties are allocated a given amount of dollars, rather than a given number of slots or placements. Thus, a county can serve more or fewer clients depending on the average expenditure per client. However, counties are subject to the federally imposed waiver-requirement that the average cost of care statewide under COP-W does not exceed the average cost of care in nursing homes. Because of this federal limit, DHFS limits the average expenditure per COP-W client to $40.78 per day, which is the same limit as under CIP II.

Although it is not an MA waiver program and is not eligible for federal MA matching dollars, Wisconsin's state-funded COP program provides additional resources to promote community-based services for the elderly, physically disabled, developmentally disabled, chronically mentally ill and persons with Alzheimer's disease.

In calendar year 1999, $69.7 million GPR was expended under the COP program, providing services to 7,538 persons. COP provides a means to serve some groups that would not be eligible under one of the waiver programs. In addition, COP funds are used for MA-waiver clients for some services that are not eligible under the MA waiver programs and for MA-eligible services when costs exceed the state reimbursement rate for that waiver program.

DHFS prepares an annual report that compares the average cost of care for participants in the COP-W and CIP II programs to the cost for MA recipients in nursing homes. This comparison includes not only direct costs, but other costs such as MA card costs for hospital care and other services and SSI costs. The calendar year 1999 report indicated that the average total cost of care for COP-W and CIP II participants was $59.09 per day ($24.53 GPR per day) while the average cost for MA nursing home recipients was $87.29 per day ($35.89 GPR per day).

Brain Injury Waiver (BIW). Individuals who are substantially handicapped by a brain injury and receive or are eligible for post acute rehabilitation institutional care may receive community services under this special waiver program, which

began on January 1, 1995. On December 31, 2000, the program was serving 208 persons. Expenditures under the BIW totaled $10.4 million in calendar year 1999. Currently, the maximum reimbursement rate is $184.19 per day. Before DHFS implemented this program, brain-injured individuals would typically have to be institutionalized because the other MA waiver programs for which these individuals are eligible do not provide sufficient funding to meet the needs of this group and 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.

Community Supported Living Arrangements Waiver (CSLA). Individuals who meet a developmental disability level of care are eligible for care under CLSA if: (1) the person/guardian, through a person-centered planning process, identifies and chooses the supports and services which best meet the recipient's needs; and (2) the recipient lives in his or her own home where the setting is controlled by the person/guardian and not a service provider. The CSLA waiver was first available to counties beginning in 1996, and from 1992 through September 30, 1995, Wisconsin was one of eight states that participated in a CSLA demonstration grant. The CSLA waiver is open to children and adults and is a federal/local match program similar to locally-matched slots in CIP IB. Possible sources of funding for the county match include community aids, COP funds, funds available under the family support program, and the local property tax levy. In calendar year 1999, expenditures under the program totaled $1,019,200 ($599,800 FED and $419,400 county). On December 31, 2000, there were 207 active participants in the program.

Family Care

Family Care (FC) is a pilot program that was created to change the manner in which state residents receive long-term care services. The FC program replaces other long-term care programs available in participating counties as the means of consolidating eligibility and services.

The pilot program was created to address several problems in the current system. One concern is that the current system consists of too many programs, each with its own eligibility standards and services. A second criticism of the current system is that it encourages individuals to receive institutional care because nursing home care under MA is an entitlement, while the amount of funding budgeted for the MA waiver programs and COP-R is limited to the amounts provided for these programs as part of the state budget, resulting in waiting lists. FC also expands long-term care options by reducing barriers to the use of CBRFs and other types of facilities. Another goal of FC is to provide the type of long-term care services that consumers desire.

It is hoped that FC will improve the long-term care system by: (a) delivering services under a managed care system with a strong monitoring system and performance expectations; (b) increasing flexibility in the provision of services and providing case management services to coordinate long-term care with acute care services; and (c) increasing the amount of information consumers have to enable them to make informed decisions.

FC provides services to elderly persons, physically disabled adults, and, to a limited degree, adults with developmental disabilities. Adults with developmental disabilities may enroll in the FC pilots established in the 1999-01 biennium, but may not enroll in counties that establish FC pilots in future biennia. Children and persons with chronic mental illness may not participate in the FC pilot program.

FC includes three major components. First, resource centers provide information, assessments, eligibility determinations and other preliminary

services. Resource centers provide potential long-term care users with information so that they are aware of the alternatives to nursing homes that may be more satisfying or cost effective. In areas where a resource center is established, nursing homes and other long-term care facilities must inform and refer prospective residents to the resource center before admitting that person.

Second, care management organizations (CMOs) provide long-term care services for every person enrolled in FC under a capitated, risk-based payment system. Initially, only counties and tribes may serve as CMOs, but after four years, other entities may serve as CMOs. CMOs are required to monitor and report a number of measures, such as the rate of hospitalization, so that their performance can be assessed. CMOs must meet performance standards that are part of the CMO contract.

The final component of the FC program is the FC benefit, which provides a comprehensive and flexible range of long-term-care services, including the types of services currently available under COP, the MA community-based waiver programs, and the MA fee-for-service program. Examples of services CMOs must provide include supportive living services, supported employment services, adult day care, respite care, supportive home care, residential services, nursing home services, personal care services, home health services, and therapy services. In addition, CMOs may provide any other service that enrollees may need.

The FC benefit does not provide acute care services, such as hospital care or physician care, which enrollees continue to receive on a fee-for-service basis. Although acute care is not provided by CMOs, the CMO's case managers must coordinate acute care to ensure the enrollees' total health care needs are met.

In addition to providing benefits to persons who meet a nursing home level of care standard, FC serves persons with fewer long-term care needs, but who are at risk of losing their independence or functional capacity unless they receive some assistance. There are two capitation rates CMOs may receive: (a) a comprehensive rate to support services for enrollees who meet a nursing home level of care standard; and (b) an intermediate level rate to support services for enrollees whose independence is threatened.

As of January 1, 2001, nine counties were operating resource centers and five counties were operating CMOs. The capitation rates differ by county to reflect the experience of long-term care recipients in each county. The calendar year 2001 rates at the comprehensive level range from $1,768 per month in Milwaukee County to $2,482 per month in Portage County. The intermediate rate is the same for all five CMOs -- $629 per month. The Milwaukee County CMO only serves persons over the age of 60 who are frail, physically disabled or developmentally disabled, while the other four CMOs serve all three FC target groups -- elderly persons, persons with physical disabilities and persons with developmental disabilities age 18 and over.

Nonfinancial Eligibility. All FC enrollees must be at least 18 years of age or older and their primary disability must be something other that mental illness, substance abuse or developmental disability, although persons with developmental disabilities may participate in counties or tribes where a CMO has operated before July 1, 2001.

FC requires that a person meet one of the following three functional eligibility criteria.

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

b. The person's functional capacity is at the intermediate level, which is defined as a condition

that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others; or

c. The person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the date that the FC benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by DHFS, funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county.

The comprehensive level of functional capacity is approximately equivalent to a nursing home level of care under MA. The distinction between comprehensive and intermediate levels is important, since it may affect whether a person is entitled to FC services

Financial Eligibility. A person is financially eligible for the FC benefit if, as determined by DHFS or its designee, the person: (a) is eligible for MA and accepts MA unless he or she is exempt from the acceptance under DHFS rules (Family Care MA); or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rule (Family Care Non-MA). Because the deductions and allowances for Non-MA Family Care are more generous, individuals not eligible for MA may still be eligible for FC.

FC enrollees, including both MA-eligible and MA-ineligible enrollees, are required to share in program costs. If a FC participant is MA-eligible, the cost-share is identical to that required under MA community waiver cost-share rules. Non MA-eligible participants have a cost-share based on the alternative financial eligibility test, which requires the person to contribute to the cost of care any countable income and assets in excess of non-MA FC exclusions.

Entitlement. A primary goal of FC is to eliminate waiting lists for community-based long-term care. To achieve this goal, certain individuals are entitled to the FC benefit. A person is entitled to the FC benefit through enrollment in a CMO if he or she meets eligibility requirements, fulfills any applicable cost-sharing requirements and: (a) is functionally eligible at the comprehensive level; (b) is functionally eligible at the intermediate level and is eligible for MA; (c) is functionally eligible at the intermediate level and is determined to be in need or protective services or protective placement; (d) has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and on the date that the FC benefit became available in the person's county of residence, the person was a resident in a nursing home or had been receiving for at least 60 days, under a written plan of care, long-term care services funded under COP, MA community-based waivers, the Alzheimer's family caregiver support program, community aids or other county funding documented by the county; or (e) has a primary disabling condition that is a developmental disability and is a resident of a county or tribe that has operated a CMO before July 1, 2001.

Within each county and for each client group, entitlement first applies on the effective date of a contract under which a CMO accepts a capitated payment. However, during the first 24 months after this date, the CMO is provided a phase-in period to build the capacity to serve all entitled persons in that county. Entitlement for persons not eligible for MA first began on July 1, 2000. A person who is eligible for FC but who is not entitled to receive the FC benefit can be put on a waiting list for services even after the phase-in period for building capacity. However, while waiting for enrollment, a person who is eligible but not entitled to FC services may purchase services from a CMO.

Alternative Funding Sources

During the late 1980s and early 1990s, states' MA expenditures grew significantly due to rising health care costs, expanding access to care and increasing reimbursement to providers. In response to rising program costs, many states enacted various mechanisms, permitted under federal law, to capture additional federal matching funds for MA costs. In general, funds from these other sources are used in place of the state match for MA funds.

Under federal law, states may use:

- Provider taxes, which may be levied on classes of health care providers, including nursing facility services, hospital services, physician services and other health care services for which the state has enacted a licensing or certification fee.

- Donations or voluntary contributions made by health care providers to a state or local government.

- Assessments, including licensing and certification fees imposed on health care providers or institutions.

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

While many of these mechanisms have existed since the inception of the MA program, states have increasingly used these options since the 1980s. However, federal changes have placed restrictions on a number of these provisions, including:

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

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

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

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

- A limit of 12% of total MA expenditures for payments to hospitals serving a disproportionate share of the indigent population; and

- Intergovernmental transfers from local governments funded by taxes or donations prohibited under MA law cannot be used as a state match for federal dollars.

Wisconsin has used both the provider assessment and intergovernmental transfers as a way to increase federal matching dollars.

Provider Assessments. Beginning in 1991-92, the state established a provider assessment on nursing homes. Initially, the assessment was only applied to MA nursing home revenues and the assessment was an allowable cost for MA reimbursement. Subsequent changes in federal law required the state to change its provider assessment so that now the provider assessment is a broad-based assessment, rather than an assessment limited to MA residents. Currently, the nursing home assessment is an amount per occupied nursing home bed and applies to all nursing home beds, except those in the state Centers for the Developmentally Disabled, the Veterans Home and beds occupied by Medicare beneficiaries. The current monthly rate per bed is $32 for nursing facilities and $100 for ICFs-MR. Because the federal government funds approximately 59% of MA nursing home expenditures, the estimated $16.0 million in assessments in 2000-01 will generate approximately $23.2 million in federal dollars.

Payment of the nursing home assessment on occupied beds is the responsibility of each nursing

home. Although federal rules prohibit any hold harmless provisions that directly tie MA reimbursement levels to the amount of the tax paid by the provider, nursing homes indirectly benefit since the assessment and the federal matching funds are used to fund higher MA provider payments, which permits nursing facilities to recover more of their costs related to their MA residents. Non-MA residents may benefit to some degree if higher MA provider rates result in less cost-shifting to private-pay patients or if the resident ultimately becomes eligible for MA. Nursing homes with few or no MA patients and their residents do not receive any significant benefit from higher MA provider rates. However, most nursing homes have a large number of MA residents. As of December 1, 2000, only 20 of the 465 licensed nursing homes in the state were not certified to serve MA patients. In 1999, approximately 67% of Wisconsin nursing home residents used MA as their primary source of payment for services. For private pay residents, a nursing home may elect to include the assessment in their bill, either in the overall rate or as a separate, billable amount.

Table 10

Intergovernmental Transfer Program ($ in Millions)

Fiscal Year	County Certified Losses	IGT Used as County Supplemental Payments	IGT Used for General Rate Payments to Nursing Homes	Total IGT
1992-93	$47.2	$18.6	$0.0	$18.6
1993-94	43.1	37.1	5.4	42.5
1994-95	48.1	37.1	30.4	67.5
1995-96	56.4*	37.1	26.1	63.2
1996-97	61.1	46.1	72.4**	118.5**
1997-98	65.8	40.2	53.9	94.1
1998-99	66.7	37.1	58.3	95.4
1999-00	73.6	39.7	65.3	105.0
2000-01 (est)	78.5	41.1	72.8	113.9

*The state only certified losses of $52.2 million in 1995-96 because of concerns of exceeding the Medicare upper limit.

**This higher amount resulted from accelerating the claiming of IGT funds, which cannot be repeated in future years.

Intergovernmental Transfer Program. Under an intergovernmental transfer program (IGT), the state certifies counties' MA allowable expenditures and claims federal matching funds for those expenditures at the regular federal matching rate of 59%. The largest source of intergovernmental transfers has been county expenditures for nursing homes.

Before the 1993-95 biennium, the Department's use of IGT payments was limited to the county federal financial participation (FFP) program, under which DHFS distributed all federal funds generated by county nursing homes' unreimbursed expenses to county nursing homes. In 1992-93, $18.6 million of federal funding was generated under the FFP program.

Beginning in 1993-94, the amounts of IGT claims increased significantly. Table 10 illustrates the expansion of IGT claims and the distribution of the additional federal MA funds generated under the program. In conjunction with the expansion, the state began using part of the IGT funds to fund general nursing home rate increases. As shown in Table 10, the amount of IGT will increase to an estimated $113.9 million in 2000-01, of which $41.1 million will be used for special payments to county-owned nursing homes and $72.8 million will be used to fund the general MA rate payments to nursing homes.

A provision included in the 1995-97 biennial budget act requires DHFS to supplement the annual base supplemental payment of $37.1 million to county-operated facilities if the amount of IGT funds exceeds budget projections and if the supplement would not violate the Medicare upper limit. In the 1995-96 fiscal year, although unreimbursed expenses for county-operated facilities were greater than projected, the Department did not claim additional IGT funds because of concerns about violating the Medicare upper limit for nursing home payments. However, in 1996-97, 1997-98, and 1999-00 additional supplemental payments of $9.0 million, $3.1 million and $2.6 million, respectively, were made.

The Medicare upper limit requires that total MA payments, which includes both the county-certified losses and the matching federal funds, be equal to or less than the amount the state estimates would have been paid under Medicare payment principles. Until 1998-99, Medicare used a "retrospective cost" payment system that paid the lowest of the following three amounts: (a) allowable costs; (b) routine service limit; or (c) the private pay rate. For Wisconsin during this period, the limit based on allowable costs was the lowest of the three.

Beginning on July 1, 1998, the Medicare payment system began moving to a prospective payment system that uses a nationally determined payment schedule for 44 care levels that is adjusted for regional cost variations. The change will be phased-in over a three-year period, beginning with cost reporting periods starting on or after July 1, 1998. This change has increased Wisconsin's aggregate Medicare upper limit, and has provided more room for the claiming of IGT funds.

The Medicare upper limit must be calculated by the state MA agency (DHFS) before it implements any changes in the MA payment levels for nursing homes. The test is applied separately to nursing facilities and ICFs-MR.

Recent actions at the federal level may affect Wisconsin's ability to claim additional federal funds based on unreimbursed expenses of county-owned nursing homes. First, on January 12, 2001, HCFA published a final rule to modify the Medicare upper payment limit for nursing homes. This change establishes an additional Medicare upper limit test that would be applied separately to non-state, public nursing facilities. This change restricts payments or claims related to non-state public nursing facilities, since it will no longer be possible to use any gaps between what Medicare allows as payments to private nursing homes and actual payments to private nursing homes to increase payments or claims related to non-state, public nursing homes. Although the rule substantially restricts IGT claiming, there are transitional provisions included in the rule.

HCFA has recently challenged Wisconsin's method of claiming federal MA matching funds for nursing home care under its IGT program. On June 28 and July 31, 2000, HCFA deferred approval of a part of the state's claims for federal matching funds in three previous quarters. In its deferral letter, HCFA limited federal matching funds to 59% (the federal matching rate) of the counties' unreimbursed costs. The total amount of federal funds that have been deferred for 1999-00 is $31.4 million. If these deferrals are not reversed and are continued in 2000-01, federal MA matching funds would be reduced by an additional $67 million in 2000-01.

Although the use of county nursing home expenditures is commonly referred to as the state's IGT program, there are several other services provided under the state's MA program where county expenditures are used to generate federal matching funds. For example, the state does not support case management services with GPR, but permits counties to capture federal matching dollars ($8.3 million in 1999-00) for county-provided services. Under CIP IB, the state allows counties to claim federal matching dollars for county-supported placements and county costs in excess of the state reimbursement level, but below the federal limit. In calendar year 1999, county CIP IB expenditures of $101.6 million generated approximately $145.3 million in federal matching funds. Counties can also claim federal matching dollars for their spending on allowable costs that exceed the state maximum reimbursement rates for other community-based waiver programs (CIP IA and COP-W). Finally, there are several other MA services, similar to case management services, for which the counties are required to provide the state match. In 1999-00, DHFS claimed the following amounts for these services: community support program, $14.3 million, county deficit reduction program, $13.1 million, crisis intervention services, $1.5 million, community supported living arrangements, $0.7 million and child caring institutions, $0.5 million.

Coordination With Other Payment Sources

Coordination of Benefits

Federal law requires states to take all reasonable measures to ascertain the legal liability of other resources to pay for care and services furnished to MA recipients, and set forth provisions for payment of claims where other resources are available. DHFS refers to this activity as coordination of benefits (COB). COB seeks payment from any individual, entity or program that is, or may be, able to pay all or part of the expenditures for MA services furnished by the state. Wisconsin law requires the use of other health insurance benefits, such as Medicare, commercial health insurance and settlements resulting from subrogation (injury, medical malpractice, product liability) to defray the costs incurred by MA. Any COB savings generated by states are shared with the federal government in the same proportion as each state's MA benefits expenditures. The use of MA as the payer of last resort is important because federal and state MA costs are reduced without affecting the quality of MA services, or access to health care.

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

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

DHFS uses three methods to ensure that other liable payment sources are used to pay for services to MA recipients. First, there is "cost avoidance," where the state avoids paying claims when Medicare or other health insurance is available, by requiring the service provider to obtain reimbursement from other liable sources. A second method is "postpayment recovery," where the state initially pays provider claims, then attempts to recover payments from liable sources. Finally, there is "provider-based billing." The state initially uses MA funds to pay provider claims. It then identifies retroactive health insurance coverage that requires documentation (for example, a physician's plan of care, prescriptions or discharge notes), and a bill is produced for the provider to use to bill the health insurer. The provider has 120 days to collect payment from the insurer and refund the MA payment. If the provider does not refund the MA payment within 120 days, the MA payment is automatically recouped from the provider through a claims adjustment.

Table 11 summarizes all coordination of benefits savings achieved in 1999-00 and funds received through estate recovery.

Estate Recovery Program

DHFS uses estate recovery to offset MA program costs. Under the estate recovery program, MA recipients share in the cost of their health care, after death, through payments from their estates. The estate recovery program allows the state to recover MA payments for nursing home care (and for hospital care if the person was required to contribute to the cost of care). In addition, the state may recover MA payments for personal care, home- and community-based waiver services and

Table 11

Coordination of Benefits and Estate Recovery Payments Fiscal Year 1999-00

Category	Cost Avoidance	Postpayment Recoveries	Claims Adjustments
Medicare	$579,132,300	$41,100	
Other Health Insurance	194,223,000*	6,239,700	
Subrogation		1,427,400	
Provider-Based Bills		110,000	$6,638,600
Medical Support Liability		14,349,900	
Estate Recovery		15,269,200	
Miscellaneous		10,378,900	
Total	$773,355,300	$47,816,200	$6,638,600
Grand Total			$827,810,100

*Includes: (a) claims returned with no payment because insurance company partial payment equaled or exceeded the MA rate; (b) partial payment by insurance companies; (c) claims denied due to suspected insurance coverage. Does not include services never billed to MA due to payment in full by insurance companies.

related hospital and prescription drug services provided to recipients 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 has two ways to recover MA costs. First, DHFS may place liens on the home of an MA recipient who is in a nursing home or hospital facility if the individual is not expected to be discharged from the nursing home or hospital 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 or disabled, or the recipient's sibling who is an owner of the home and who has lived in the home continuously beginning at least 12 months before the recipient was admitted to the nursing home.

Before placing a lien, DHFS must notify the recipient in writing that the recipient is not expected to be discharged, that DHFS intends to obtain a lien and that the recipient has a right to a hearing on whether the conditions for placing a lien have been satisfied. DHFS may enforce a lien before the recipient's death if the recipient sells the home, but not if the recipient has: (a) a living spouse; (b) a child who is under 21 or disabled; (c) a sibling who resides in the home, if the sibling resided in the home for at least 12 months before the recipient was admitted to the nursing home; or (d) a child of any age who resides in the home, if that child resided in the home for at least 24 months before the recipient was admitted to the nursing home and provided care to the recipient that delayed the recipient's admission to the nursing home.

In addition to placing liens, DHFS can place claims against a recipient's estate. When the program was created, the state could also recover from the estates of surviving spouses of MA recipients. However, in 1995, the Wisconsin Court of Appeals ruled that MA estate recovery could not be applied to the estates of surviving spouses. Beginning April 1, 1995, except in cases of undue hardship, claims must be filed. The claim may be up to the amount MA paid for the MA services subject to estate recovery.

A court may reduce claims against the recipient's estate by up to $5,000, if it determines that it is necessary to allow the recipient's heirs to retain certain personal property, including: (a) the decedent's wearing apparel and jewelry; (b) household furniture, furnishings and appliances; and (c) tangible personal property that is not used in trade, agriculture or other business and does not exceed $3,000 in value.

County and tribal governing body participation in the estate recovery program is limited to the collection and transmittal of information to DHFS relating to homestead property, legal descriptions of property and notices of death. Each county or tribe receives 5% of collections made under the estate recovery program. They may use these monies to fund activities related to estate recovery

and income maintenance administration. The federal government also receives a portion of the proceeds equal to its share of the recipient's health care expenditures.

Administration

The state's MA program is operated in accordance with an MA state plan that describes the state's basic eligibility, coverage, reimbursement and administrative policies. The plan must be approved by HCFA and is periodically updated to reflect changes in state policy or to conform to new federal requirements. The MA program is administered by a single state agency under general oversight by HCFA. States are required to designate a single administrative agency for program operations. In Wisconsin, MA is administered by DHFS. Agency responsibilities include: (a) eligibility determinations; (b) provider certification; (c) claims processing; (d) review and inspections of facilities providing care; and (e) maintenance of the program's integrity and administration. Federal MA regulations also require the establishment of an MA advisory committee, including provider and beneficiary representatives, to review and make recommendations on Medicaid policy.

Functions for which counties are currently responsible include: (a) determination of MA eligibility and informing recipients of their rights and duties; (b) recovery of incorrect payments; (c) authorization of payments for certain mental health benefits for certain MA recipients; (d) establishing a program of medical support liability; and (e) health insurance reporting (for which counties receive an incentive payment).

DHFS contracts with outside providers for most of the remaining administrative functions, such as claims processing, review of prior authorization requests, actuarial services, and other consulting services and administrative activities. Most of these services are provided under a contract with the current MA fiscal agent, Electronic Data Systems, Inc. (EDS).

MA and BadgerCare administrative expenses totaled approximately $198.4 million ($87.0 million GPR and $111.4 million FED) in 1999-00. Of this amount, $40.5 million ($13.7 million GPR and $26.8 million FED) was paid for services provided by the state's fiscal agent. The share of county income maintenance administration costs and other costs claimed by the Department of Workforce Development (DWD) totaled approximately $95.5 million ($47.74 million GPR and $47.74 million FED) in 1999-00. Costs for DHFS operations and other contract costs totaled approximately $62.5 million (all funds) in 1999-00. Generally, administrative contracts are eligible for 50% federal funding. However, some administrative costs, including the fiscal agent contract, are matched at a higher rate. Table 12 summarizes MA and BadgerCare administrative costs in 1999-00.

Table 12
MA and BadgerCare Administrative Costs -- Fiscal Year 1999-00

	GPR	FED	Total
Fiscal Agent Contract	$13,658,200	$26,805,000	$40,463,200
Eligibility Determinations and Related Costs*	47,741,000	47,741,100	95,482,100
Other DHFS Contracts and Operations	25,649,600	36,841,200	62,490,800
Total	$87,048,800	$111,387,300	$198,436,100

*Costs claimed by DWD.

Eligibility Determination. SSI recipients qualify automatically for MA based on their eligibility for SSI. The local Social Security Administration office processes applications for SSI. That office forwards a list of persons determined to be eligible for SSI to DHFS so that they can be enrolled in MA.

Since MA eligibility for families with

dependent children is tied to the AFDC program, as it existed on July 16, 1996, eligibility for cash assistance under the W-2 program (Wisconsin's TANF program) does not automatically confer eligibility for MA. However, applicants for the W-2 program will typically be evaluated for MA eligibility as part of the application process at the W-2 agency.

In Wisconsin, except for SSI-recipients, MA eligibility is determined by county income maintenance (IM) workers under contract with DWD. SSI-related individuals (someone who meets the non-financial criteria of SSI but not the financial requirements), as well as the medically needy, pregnant women and children and families with dependent children, are included in the groups whose eligibility is reviewed by county IM workers.

Federal regulations require states to conduct periodic redeterminations of eligibility and to take action between redeterminations if it learns of changes in a beneficiary's circumstances. In general, federal regulations require that redetermination must occur at least every 12 months, although longer intervals are permissible for blind or disabled beneficiaries.

In Wisconsin, the redetermination interval for families with dependent children, pregnant mothers and children is 12 months, but if the family or individual were receiving food stamps, the case would be reviewed every three months under requirements for food stamps. Families or individuals with earned income must submit monthly financial statements. Although review of impairments may be infrequent for disabled recipients, income and resource evaluations are done at least yearly for disabled and elderly recipients. Applicants who are denied eligibility must be given notice and an opportunity for a fair hearing.

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

Fiscal Agent Services. The MA fiscal agent provides a variety of administrative services. In 1999-00, DHFS paid EDS approximately $40.5 million for fiscal agent and related services. Of this amount, approximately $17.3 million was paid for processing claims submitted by providers. Other services provided by EDS include distribution of MA cards to recipients, coordination of benefits activities, review and approval of prior authorization requests, operation of the pharmacy point-of-sale system and collection of premiums from BadgerCare recipients.

Provider Certification. States must determine which service providers are eligible to participate in the MA program. Federal law specifies the standards and certification procedures for institutional providers, such as hospitals and nursing homes. For certain other kinds of providers, such as physicians and pharmacies, states generally follow their own laws on licensure and monitoring.

Both Medicare and MA use state certification agencies to determine compliance by institutional providers with program standards. For hospital certification, both Medicare and MA rely on the findings of one of two organizations (the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, whichever is appropriate) for determining whether an institution meets most program requirements. In Wisconsin, the Joint Commission on the Accreditation of Health Care

Organizations surveys most hospitals and DHFS survey activity is limited to a sample to validate the reviews by the Joint Commission and to surveys of a few hospitals that are not surveyed by the Joint Commission. For Wisconsin nursing homes, surveys performed by DHFS serve as the basis for Medicare and MA certification and state licensure.

A state may terminate the certification of a facility that no longer meets the requirements for participation. If the deficiencies do not immediately jeopardize the health and safety of patients, the provider may be granted a reasonable period of time to achieve compliance and may be subject to other sanctions. In the case of nursing homes where the deficiencies threaten patient health and safety, a nursing home monitor can be established to ensure that adequate care is being provided. If the nursing home is unable to provide adequate care, DHFS can petition the court to place the nursing home into receivership, which allows DHFS to assume operation of the facility until residents can be relocated to another facility or other type of care setting.

Program Controls. Federal regulations require a variety of activities to ensure that the MA program is properly administered. One of these activities is state monitoring of its administrative performance. The chief focus for Medicaid eligibility quality control (MEQC) is the identification of eligibility errors that may result in improper federal payments. States with high error rates may be subject to financial penalties. Since the 1996-97 fiscal year, Wisconsin has had a waiver from the MA quality control requirements. Under the waiver, the state is able to conduct special studies in place of routine case recorded reviews.

Most states are required to operate a computerized Medicaid management information system (MMIS), which maintains information on beneficiaries and providers, processes claims, and produces program reports. In Wisconsin, as in most states, the state's fiscal agent maintains the MMIS.

MA law and regulations include detailed provisions relating to the quality and appropriateness of care rendered to MA beneficiaries. Required state activities include development of a utilization review plan and provision for external reviews of certain facilities. Activities conducted by the facilities themselves include initial and periodic recertification of each patient's need for care, development of plans for the care of each patient and operation of an approved utilization review (UR) program.

One of the methods used by Wisconsin to assure quality and appropriateness of care is the administrative contract with MetaStar, Inc. In order for a state to receive federal MA matching funds, a peer review organization must review services provided to MA recipients. In 1999-00, DHFS paid MetaStar approximately $1.1 million to conduct such reviews.

Each state is required to establish methods for identifying and investigating cases of potential fraud and abuse. One service performed as part of this program is surveillance and utilization review (SUR). Under SUR, potential cases of abuse by providers (providing unnecessary services or overcharging) and recipients (overutilization of services) are identified using information on paid claims.

In addition, special federal funding is available for state MA fraud control units (MFCUs), which investigate allegations of state law fraud violations. Wisconsin has established a MFCU in the attorney general's office that receives special federal funding for investigating MA fraud in the state. In 1999-00, expenditures were $722,700 ($157,100 GPR and $565,600 FED), which supported 11.0 full-time positions. Investigations are initiated based on referrals or on leads developed by investigators in the Department of Justice. Most referrals are from employees of providers, recipients, self-generated investigations from DHFS and anonymous tips.

Introduction

1997 Wisconsin Act 27 established BadgerCare, a health insurance program for certain low-income families. The program began enrolling families in July, 1999. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery and administration. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available under the federal state children's health insurance program (SCHIP) and Medicaid. Therefore, BadgerCare operates under federal requirements for both of these programs. Further, Wisconsin received approval of a waiver of certain federal requirements under Medicaid in order to implement BadgerCare. This waiver approval was granted based on a plan submitted and approved by HCFA. BadgerCare also operates under the parameters established in that approved plan.

Eligibility

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

Uninsured families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before the family is no longer eligible for the program. There is no asset limit for eligibility for BadgerCare. Table 13 identifies the initial income eligibility levels for BadgerCare and the ongoing income eligibility limits based on the 2000 FPL.

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

Table 13
BadgerCare Eligibility -- Maximum Countable Monthly Income (Based on 2000 FPL)

Family Size	Initial Eligibility 185% of FPL	Ongoing Eligibility 200% of FPL
1	$1,287	$1,392
2	1,734	1,875
3	2,181	2,358
4	2,629	2,842
5	3,076	3,325
6	3,523	3,808
7	3,970	4,292
8	4,417	4,775

Families with incomes above 150% of the FPL are required to pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 3% of the family's income. Table 14 provides the premium schedule for families required to pay a premium based on the family's countable income, using the 2000 FPL.

Table 14: **BadgerCare Premium Schedule***

Family Size	Families with income of at least 150% of the FPL but less than 185% of the FPL: Monthly Minimum Income	Families with income of at least 150% of the FPL but less than 185% of the FPL: Monthly Premium	Families with income of at least 185% of the FPL but less than 200% of the FPL: Monthly Minimum Income	Families with income of at least 185% of the FPL but less than 200% of the FPL: Monthly Premium	Families with income of no more than 200% of the FPL: Monthly Minimum Income	Families with income of no more than 200% of the FPL: Monthly Premium
1	$1,044	$30	$1,287	$30	$1,392	$30
2	1,406	30	1,734	45	1,875	45
3	1,769	45	2,181	60	2,358	60
4	2,131	60	2,629	75	2,842	75
5	2,494	60	3,076	90	3,325	90
6	2,856	75	3,523	90	3,808	105
7	3,219	90	3,970	105	4,292	120
8	3,581	90	4,417	120	4,775	135

* Based on 2000 federal poverty level.

The financial eligibility criteria for BadgerCare are similar to the financial eligibility criteria for MA Healthy Start. Healthy Start covers pregnant women and children under age six in families with income not exceeding 185% of the FPL and there is no asset limit. However, Healthy Start does not cover non-pregnant parents with income that exceeds the AFDC-related criteria, nor does it cover children six and older in families with income above 100% of the FPL. However, these individuals are often eligible for BadgerCare.

The nonfinancial eligibility criteria for BadgerCare are significantly different than MA eligibility criteria. Families that have insurance or have access to a group health insurance plan for which their employer subsidizes at least 80% of the monthly premium cost are not eligible for BadgerCare. In addition, individuals who have health care coverage or had health care coverage any time during the three months before they apply for BadgerCare are ineligible. DHFS may waive this provision for good cause on a case-by-case basis.

Under MA, a family that meets the financial and demographic criteria is eligible regardless of whether the family has access to health insurance. Because MA is a payer of last resort, if a person has access to other health insurance, MA would only pay for those services that are not covered from another source.

When a family applies for BadgerCare, all family members are first reviewed to determine whether they may be eligible for MA. If one or more of the family members were found to be eligible for MA, those individuals would be enrolled in MA. The remaining family members are reviewed for eligibility for BadgerCare and enrolled in BadgerCare if they meet that eligibility criteria.

Another significant difference between BadgerCare and MA is that current law specifies that an individual enrolled in BadgerCare is not entitled to BadgerCare benefits, regardless of their eligibility for the program. Under federal law, states cannot deny benefits to individuals who are eligible for MA. These individuals are entitled to MA benefits.

Services

Individuals enrolled in BadgerCare are eligible to receive all of the benefits available to MA recipients. BadgerCare recipients may receive services from any MA certified provider.

Approximately 70% of BadgerCare recipients are enrolled in HMOs. HMOs that enroll MA recipients are required to enroll BadgerCare clients as well. Capitation rates for BadgerCare clients are generally higher than the rates paid for AFDC-related and Healthy Start MA recipients. These higher rates reflect that a greater proportion of adults are enrolled in BadgerCare than MA under AFDC-related and Healthy Start criteria. On average, adults have greater health care costs than children.

1999 Wisconsin Act 9 provided funding to support a 3% increase in the BadgerCare capitation rates beginning in 2000, and an additional 3% increase in 2001. However, HMOs were unwilling to renew their contracts for calendar year 2000 based on the rates budgeted in Act 9 because the HMOs believed that the average cost of providing services to BadgerCare recipients was greater than the budgeted capitation rates. To maintain HMOs' participation in the program, DHFS offered HMOs two options for rates beginning in calendar year 2000. One option increased rates in 2000 by 12% over the 1999 rates. The other option increased rates in 2000 by 8% over the 1999 rates, but the state and the HMO would share financial responsibility for any losses incurred by the HMO from serving BadgerCare clients. Of the 16 HMOs that were participating in MA and BadgerCare at the time, 11 HMOs choose the option providing the 12% rate increase, four accepted the 8% rate increase with the risk-sharing, and one HMO declined to renew its contract for 2000. Table 15 identifies the capitation rates for BadgerCare recipients under both options.

Funding

BadgerCare costs are supported with GPR, federal funding available under Medicaid and SCHIP and premiums paid by some recipients. Table 16 identifies the amounts budgeted for BadgerCare in the 1999-01 biennium.

MA funding is available to support approximately 59% of the costs of services for adults with income at or below 100% of the FPL. SCHIP funding is available to support approximately 71% of the costs of services for children enrolled in BadgerCare. In January, 2001, DHFS received approval of its request to waive provisions of federal law that prohibit the use of SCHIP funds for services provided to adults. Under the terms of the waiver, DHFS is able to claim reimbursement under SCHIP for the costs of adults with household income above 100% of the FPL.

Table 15: **State BadgerCare Capitation Rates -- Calendar Year 2000**

	12% Increase Option				8% Increase with Risk-Sharing Option			
Region	Base Rate	Dental	Chiro.	Comprehensive Rate	Base Rate	Dental	Chiro.	Comprehensive Rate
Dane County	$118.13	$4.09	$0.54	$112.76	$113.91	$3.95	$0.52	$118.38
Eau Claire County	114.76	5.62	1.97	112.35	110.66	5.43	1.89	117.98
Kenosha County	124.94	6.39	0.21	131.54	120.47	6.17	0.21	126.85
Milwaukee County	136.39	5.21	0.14	141.74	131.52	5.02	0.13	136.67
Waukesha County	131.64	5.77	0.60	138.01	126.94	5.56	0.58	133.08
Region 1 (Duluth/Superior)	115.45	5.39	0.85	121.69	111.33	5.19	0.82	117.34
Region 2 (Wausau/Rhinelander)	113.03	4.84	0.78	118.65	109.00	4.67	0.75	114.42
Region 3 (Green Bay)	112.71	5.25	0.69	118.65	108.68	5.07	0.67	114.42
Region 4 (Twin Cities)	110.45	6.71	1.49	118.65	106.51	6.47	1.44	114.42
Region 5 (Marshfield/Stevens Point)	112.46	5.46	0.73	118.65	108.44	5.27	0.71	114.42
Region 6 (Appleton/Oshkosh)	113.44	5.40	0.81	119.65	109.39	5.21	0.78	115.38
Region 7 (LaCrosse)	111.99	5.63	1.03	118.65	107.99	5.44	0.99	114.42
Region 8 (South Central)	112.77	5.44	0.44	118.65	108.75	5.26	0.41	114.42
Region 9 (Southeast)	113.31	4.95	0.39	118.65	109.27	4.77	0.38	114.42

Table 16

BadgerCare Funding -- 1999-01 Biennium

	1999-00	2000-01	Total
GPR	$22,356,500	$45,730,500	$68,087,000
FED	40,033,600	86,298,300	126,331,900
PR	1,199,300	2,209,200	3,408,500
Total	$63,589,400	$134,238,000	$197,827,400

Note: Includes funding provided in 1999 Wisconsin Act 9 and 2001 Wisconsin Act 1. The FED and PR amounts represent estimates.

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

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

In the spring of 2000, the funding budgeted for the program in Act 9 was projected to be insufficient to meet program costs in the 1999-01 biennium. However, DHFS did not request the Joint Committee on Finance to permit DHFS to implement the enrollment trigger. Instead, DHFS informed legislators of the projected deficit and was advised that the Legislature would address the deficit early in the 2000-01 legislative session. On February 1, 2000, Governor Thompson signed 2001 Wisconsin Act 1, which provided approximately $11.5 million GPR in 2000-01 to fund projected program costs through the 2000-01 fiscal year.

Enrollment

As of the end of December, 2000, approximately 74,700 persons were enrolled in BadgerCare, including 52,000 adults and 22,700 children. Approximately 85% of enrollees were in families that had countable income less than 150% of the FPL and therefore did not pay monthly premiums. Table 17 identifies enrollment in BadgerCare as of the end of December, 2000, by income.

Table 17

BadgerCare Enrollment -- End of December, 2000

Income Range Based On the % of FPL	Adults	Children	Total	% of Total
Less than 100%	24,835	n/a *	24,835	33%
Greater than 100% but Less than 150%	21,151	17,819	38,970	52
Greater than 150% but Less than 185%	5,224	4,040	9,264	12
Greater than 185% but Less than 200%	784	808	1,592	2
	51,994	22,667	74,661	100%

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

Table 18 provides historical information on MA and BadgerCare benefits expenditures, by source, for 1988-89 through 1999-00, and the percent change in expenditures from the previous year. The table shows that MA benefits expenditures increased significantly in the late 1980's and early 1990's but decreased to the 3% to 4% range in the mid- and late-1990's. The greater increase in 1999-00 is largely due to costs of BadgerCare and increased costs for certain MA services, such as prescription drugs.

A number of factors may have contributed to the reduced rate of growth in program expenditures during the mid- and late-1990's, including: (a) increased use of managed care, which may have slowed the growth in hospital, physicians and clinic services; (b) enactment of new federal and state divestment provisions that have tightened eligibility requirements for MA-supported nursing home services; (c) increased availability and access to lower-cost or community-based services, which may result in decreased utilization of inpatient hospital and nursing home services; (d) reductions in AFDC-related caseload; and (e) the use of IGT revenues to offset MA expenditures.

Expenditures by Type of Eligible Person

Table 19 provides information on the average number of eligibles in each eligibility group and program expenditures for the 1990-91 through 1999-00 fiscal years. The figures include BadgerCare expenditures and enrollees. The AFDC, Healthy Start, BadgerCare and Other groups are combined in the low-income families group. For each year, information is provided on the total number of eligibles in each recipient group and that group's percentage of total MA and BadgerCare eligibles. Corresponding information on expenditures for each group is also provided, along with the annual average cost per eligible.

This information for fiscal year 1999-00 is

Table 18: **MA and BadgerCare Expenditures**

	GPR		FED		All Funds	
Fiscal Year	Amount	% Change from Previous Year	Amount	% Change from Previous Year	Amount	% Change from Previous Year
1988-89	$532,100,900	13.2%	$734,275,400	8.7%	$1,266,376,300	10.6%
1989-90	588,625,000	10.6	834,079,500	13.6	1,422,704,600	12.3
1990-91	659,903,700	12.1	995,906,600	19.4	1,655,810,300	16.4
1991-92	759,254,100	15.1	1,166,618,800	17.1	1,925,872,800	16.3
1992-93	801,366,500	5.5	1,262,895,100	8.3	2,064,261,500	7.2
1993-94	834,672,500	4.2	1,368,388,000	8.4	2,203,060,500	6.7
1994-95	843,300,500	1.0	1,449,711,600	5.9	2,293,012,000	4.1
1995-96	877,119,800	4.0	1,496,161,100	3.2	2,373,281,000	3.5
1996-97	865,590,400	-1.3	1,589,367,100	6.2	2,454,957,400	3.4
1997-98	904,817,400	4.5	1,614,030,300	1.6	2,518,847,700	2.6
1998-99	927,869,500	2.5	1,677,182,600	3.9	2,605,052,100	3.4
1999-00	992,970,800	7.0	1,871,054,000	11.6	2,864,024,800	9.9

*1999-00 includes approximately $21.9 million GPR and $35.7 million FED for BadgerCare.

shown graphically in Figures 1 and 2. Although low-income families and others represented 66.8% of all MA and BadgerCare eligibles in 1999-00, they accounted for only 23.4% of all MA and BadgerCare expenditures. In contrast, the aged, who represented 9.8% of all eligibles, accounted for 33.9% of all expenditures. Disabled MA recipients accounted for 42.7% of all expenditures in 1999-00, although they represented only 26.5% of all eligibles. The average annual cost per eligible for each group in 1999-00 was as follows: (a) aged, $19,063; (b) disabled, $10,042; and (c) low-income families and others; $1,928.

Expenditures by Type of Service

Figure 3 provides information on MA and BadgerCare funding, by major service category, for the 1999-00 year. The table shows that spending for nursing home services, including the state Centers for the Developmentally Disabled, accounted for 34.1% of total spending in 1999-00, while programs for community-based long term care accounted for 17.2% of total spending. Long-term care services costs represented 51.3% of all spending. Acute care spending represented 44.1% of gross expenditures.

Figure 4 shows MA and BadgerCare fee-for-service spending in 1999-00 by major acute care services categories. Inpatient hospital and net drug expenditures represent 27.8% and 30.7%, respectively, of fee-for-service acute care expenditures. Physician and clinic services, which account for 7.0% of fee-for-service acute care, is the next largest category.

Additional information on MA spending in 1999-00 is illustrated in Table 20. Table 21 shows how the composition of spending has changed between 1995-96 to 1999-00. The service categories identified in Table 20 have been collapsed in Table 21 to highlight historical trends in major service areas.

Table 21 indicates several trends over the recent five-year period. First, expenditures for institutional long-term care have grown at a very slow rate (average annual rate of 0.7%) while expenditures for community-based, long-term care have increased at a high rate (average annual rate of 18.5%). Second, managed care has grown rapidly (12% average annual rate) while fee-for-services expenditures have increased slowly (3% annually on average), except for drug expenditures, which grew at a 16.1% average annual rate. Although estate recoveries grew at a 12% average annual rate, the total amount collected represents less than one percent of total expenditures.

Table 19: MA and BadgerCare Eligibles and Expenditures by Eligibility Group -- Fiscal Years 1990-91 through 1999-00

	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
AGED										
Total Expen.	$576,451,469	$644,615,217	$689,135,190	$723,421,580	$767,127,017	$788,708,171	$794,905,954	$808,754,408	$823,386,163	850,746,256
% of Total	37.4%	36.0%	35.9%	36.3%	36.3%	37.3%	36.6%	36.9%	36.3%	33.9%
Total Eligibles	52,233	53,325	53,760	53,784	53,024	50,625	48,935	47,335	45,674	44,629
% of Total	12.0%	11.5%	11.1%	10.8%	10.7%	10.6%	10.9%	11.5%	11.3%	9.8%
Avg. Cost/Eligible	$11,036	$12,088	$12,819	$13,450	$14,468	$15,579	$16,244	$17,086	$18,027	$19,063
DISABLED/BLIND										
Total Expend.	$558,310,094	$670,279,277	$728,921,148	$756,974,572	$809,407,494	$808,042,960	$854,798,407	$909,117,616	$50,205,191	$1,073,025,691
Percent of Total	36.2%	37.5%	38.0%	37.9%	38.3%	38.2%	39.4%	41.5%	41.9%	42.7%
Total Eligibles	72,922	79,774	89,335	97,601	103,709	106,687	107,807	107,867	107,126	106,853
Percent of Total	16.7%	17.3%	18.4%	19.7%	20.9%	20.9%	22.3%	24.0%	26.3%	26.5%
Avg. Cost/Eligible	$7,656	$8,402	$8,159	$7,756	$7,805	$7,574	$7,929	$8,428	$8,870	$10,042
LOW-INCOME FAMILIES & OTHERS										
Total	$406,593,239	$474,342,008	$501,208,219	$514,735,881	$538,410,342	$518,488,845	$521,101,975	$473,783,517	$492,713,296	$586,790,646
Percent of Total	26.4%	26.5%	26.1%	25.8%	25.5%	24.5%	24.0%	21.6%	21.7%	23.4%
Total Eligibles	311,703	329,355	341,108	345,175	338,478	321,744	291,666	255,053	251,098	304,354
Percent of Total	71.4%	71.2%	70.4%	69.5%	68.4%	67.2%	65.0%	62.2%	62.2%	66.8%
Avg. Cost/Eligible	$1,304	$1,440	$1,469	$1,491	$1,591	$1,611	$1,787	$1,858	$1,962	$1,928
TOTAL										
Expenditures	$1,541,354,803	$1,789,236,501	$1,919,264,558	$1,995,132,033	$2,114,944,853	$2,115,239,976	$2,170,806,337	$2,191,655,541	$2,266,304,650	$2,510,562,593
Eligibles	436,858	462,455	484,203	496,560	495,211	479,056	448,408	410,255	403,898	455,836

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

FIGURE 1

Average Monthly MA and BadgerCare Recipients by Group
Fiscal Year 1999-00

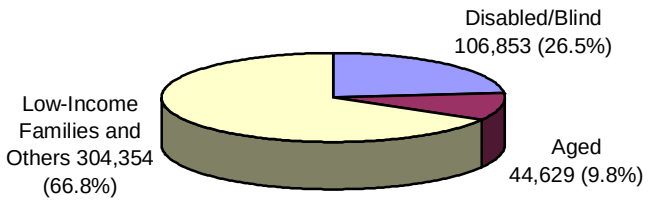

FIGURE 2

Total MA and BadgerCare Expenditures by Group
Fiscal Year 1999-00
($ In Millions)

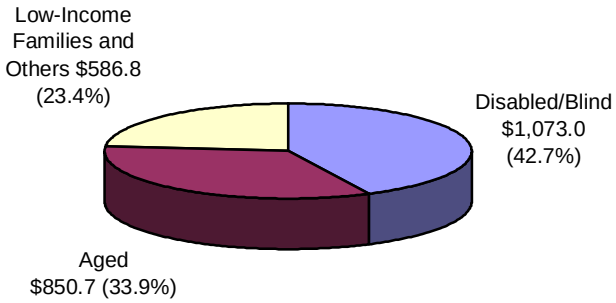

FIGURE 3

Selected Services as a Percent of Total Gross MA and BadgerCare Expenditures
Fiscal Year 1999-00

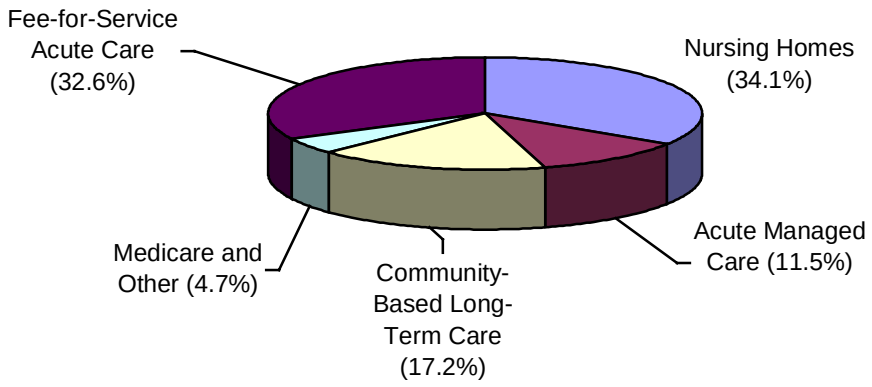

FIGURE 4

Composition of Fee-for-Service Acute Care Spending
Fiscal Year 1999-00

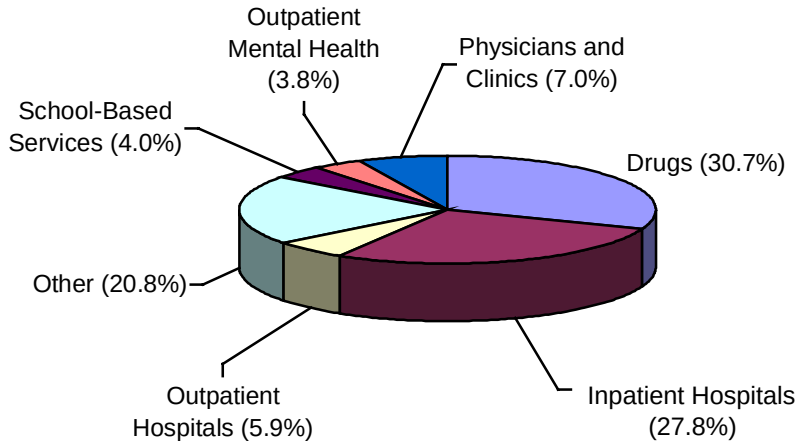

Table 20

MA and BadgerCare Benefits Expenditures, by Service Category -- Fiscal Year 1999-00

	Expenditures		% of Total Gross Expenditures
	GPR	All Funds	All Funds
Long-Term Care			
Institutional			
Nursing home	$288,330,715	$903,545,311	30.2%
State Centers	47,075,326	114,135,586	3.8
Subtotal	$335,406,041	$1,017,680,897	34.1%
Community-Based			
CIP IA	$22,846,966	$62,900,500	2.1%
CIP IB	21,198,920	142,980,519	4.8
CIP II	15,250,125	58,018,643	1.9
COP-Waiver*	0	49,715,720	1.7
CSLAs	0	650,835	0.0
Brain injury	4,764,879	11,663,645	0.4
PACE / Partnership	17,635,607	42,802,273	1.4
Family Care CMOs	2,874,503	6,973,563	0.2
Home health	9,939,289	23,975,563	0.8
Personal care	30,618,810	73,576,464	2.5
Private duty nursing	6,177,426	14,849,765	0.5
Respiratory care services	8,707,853	20,882,259	0.7
Hospice	1,632,970	3,960,125	0.1
Subtotal	$141,647,346	$512,949,874	17.2%
Total Long-Term Care	$477,053,387	$1,530,630,771	51.2%
Acute Care			
Managed Care			
Low-Income Families (AFDC, HS & BC)	$122,052,493	$300,568,893	10.1%
HMO supplements	3,193,370	7,751,319	0.3
Elderly / Disabled (I-Care)	11,031,557	26,774,000	0.9
Children's mental health	4,036,624	9,801,853	0.3
Subtotal	$140,314,045	$344,896,065	11.5%
Fee-For-Service Institutional			
Inpatient hospital	$104,756,978	$257,100,806	8.6%
Outpatient hospital	19,842,862	47,833,072	1.6
OP hospital-psych	2,813,834	6,804,585	0.2
Subtotal	$127,413,674	$311,738,463	10.4%

Table 20 (continued)

MA and BadgerCare Benefits Expenditures by Service Category -- Fiscal Year 1999-00

	Expenditures		% of Total Gross Expenditures
	GPR	All Funds	All Funds
Fee-For-Service			
Non-Institutional			
Physicians & clinics	$25,897,882	$62,444,768	2.1%
Lab & X-ray	7,399,604	17,857,110	0.6
HealthCheck	2,381,865	5,797,718	0.2
Family planning	1,859,700	7,872,690	0.3
Prenatal care coordination	966,192	2,344,955	0.1
FQHCs	4,119,611	9,983,223	0.3
Rural health clinic	1,038,882	2,523,932	0.1
Therapies	6,755,564	16,250,771	0.5
Outpatient mental health	14,471,383	34,933,956	1.2
Drugs	138,427,884	332,474,821	11.1
DME / DMS	13,245,254	31,802,003	1.1
Ambulance transportation	1,727,569	4,164,201	0.1
SMV transportation	10,151,971	24,369,141	0.8
Dental	7,967,354	19,491,744	0.7
Vision	1,626,014	3,946,198	0.1
Chiropractic	651,464	1,588,059	0.1
County-matched services	200,672	37,017,232	1.2
School-based services	196,142	36,154,187	1.2
Other care	5,285,245	10,811,289	0.4
Subtotal	$244,370,252	$661,827,998	22.1%
Fee-For-Service Total	$371,783,926	$973,566,461	32.6%
Acute Care Total	$512,097,971	$1,318,462,526	44.1%
Medicare/Other			
Medicare crossovers Part A	$13,072,443	$31,345,230	1.0%
Medicare crossovers Part B	17,828,586	42,855,372	1.4
Medicaid premiums	23,149,547	56,194,540	1.9
Milwaukee child welfare	0	1,479,208	0.0
CCIs	0	534,749	0.0
County transportation	4,256,098	8,512,196	0.3
Dane / Milw. SED Project	721,300	721,300	0.0
Appn. and split corrections	-22,398	-2,294,274	-0.1
Subtotal	$4,955,000	$8,953,179	4.7%
TOTAL GROSS EXPENDITURES	$1,048,156,934	$2,988,441,618	100.0%
Recoveries/collections			
Audit / recoveries	-5,498,406	-$14,226,565	-0.5%
COB collections	-3,664,188	-9,034,721	-0.3
Drug rebates	-23,849,784	-58,198,359	-1.9
Estate recoveries	-6,128,126	-15,269,189	-0.5
Medical support collections	-7,032,030	-14,349,893	-0.5
BadgerCare premiums	-715,960	-1,189,051	-0.0
Subtotal	-$46,888,494	-$112,267,778	-3.8%
TOTAL NET EXPENDITURES	$1,001,268,440	$2,876,173,840	96.2%

*GPR-funded COP-W funding is not budgeted in the GPR MA benefits appropriation.

Table 21: **Major MA Expenditure Categories -- Fiscal Years 1995-96 through 1999-00**

Service	Expenditures 1995-96	1996-97	1997-98	1998-99	1999-00	Percent Change Over Previous Year 1996-97	1997-98	1998-99	1999-00	Ave. Annual Percentage Change
Long-Term Care										
Institutional										
Nursing Home	$875,138,957	$870,764,500	$870,893,960	$887,000,286	$903,545,311	-0.5%	0.0%	1.8%	1.9%	0.8%
State Centers	116,060,945	116,699,898	111,929,875	115,656,332	114,135,586	0.6	-4.1	3.3	-1.3	-0.4
Total Institutional	$991,199,902	$987,464,398	$982,823,835	$1,002,656,618	$1,017,680,897	-0.4%	-0.5%	2.0%	1.5%	0.7%
Community-Based										
Waiver Programs	$159,958,158	$191,465,340	$243,427,989	$262,790,277	$325,929,862	19.7%	27.1%	8.0%	24.0%	19.5%
Special Managed Care	8,751,276	11,876,600	18,335,800	26,611,000	42,802,300	35.7	54.4	45.1	60.8	48.7
Family Care CMOs	0	0	0	0	6,973,563	0.0	0.0	0.0	0.0	0.0
Home Hlth/ Personal Care	91,165,211	101,415,656	117,605,544	127,161,980	137,244,176	11.2	16.0	8.1	7.9	10.8
Total Community-Based	$259,874,645	$304,757,596	$379,369,333	$416,563,257	$512,949,901	17.3%	24.5%	9.8%	23.1%	18.5%
Total Long-Term Care	$1,251,074,547	$1,292,221,994	$1,362,193,168	$1,419,219,875	$1,530,630,798	3.3%	5.4%	4.2%	7.9%	5.2%
Acute Care										
Acute Managed Care	$218,726,970	$273,377,312	$305,214,577	$312,406,822	$344,896,038	25.0%	11.6%	2.4%	10.4%	12.1%
Fee-For-Service										
Institutional										
Inpatient Hospital	$299,382,360	$290,931,529	$253,100,377	$245,395,128	$257,100,806	-2.8%	-13.0%	-3.0%	4.8%	-3.7%
Outpatient Hospital	65,558,940	60,325,280	49,375,336	48,399,572	54,637,657	-8.0	-18.2	-2.0	12.9	-4.5
Total Hospital	$364,941,300	$351,256,809	$302,475,713	$293,794,700	$311,738,463	-3.7%	-13.9%	-2.9%	6.1%	-3.9%
Non-Institutional										
Net Drug (Payments-Rebates)	$151,050,250	$165,139,772	$183,761,501	$210,079,213	$274,276,452	9.3%	11.3%	14.3%	30.6%	16.1%
Physicians	84,255,694	74,555,174	57,429,785	53,318,644	62,444,768	-11.5	-23.0	-7.2	17.1	-7.2
Dental	16,078,533	15,517,444	14,719,247	14,877,518	19,491,744	-3.5	-5.1	1.1	31.0	4.9
Other Non-Institutional	192,627,229	196,330,689	193,800,538	205,980,733	247,416,675	1.9	-1.3	6.3	20.1	6.5
Total Non-Insit. Fee-For-Service	$444,011,706	$451,543,079	$449,711,071	$484,256,108	$603,629,639	1.7%	-0.4%	7.7%	24.7%	8.0%
Total Fee-For-Service Acute Care	$808,953,006	$802,799,888	$752,186,784	$778,050,808	$915,368,102	-0.8%	-6.3%	3.4%	17.6%	3.1%
Total Acute Care	$1,027,679,976	$1,076,177,200	$1,057,401,361	$1,090,457,630	$1,260,264,140	4.7%	-1.7%	3.1%	15.6%	5.2%
Other Items										
Medicare Premium, Copays, Deduc	$130,181,545	$132,048,715	$131,426,207	$127,814,009	$130,395,142	1.4%	-0.5%	-2.7%	2.0%	0.0%
Other Payments	11,445,612	5,090,898	8,573,132	10,945,167	8,953,179	-55.5	68.4	27.7	-18.2	-6.0
Estate Recoveries	-9,711,562	-12,407,317	-13,224,471	-13,375,781	-15,269,189	27.8	6.6	1.1	14.2	12.0
Other Recoveries	-37,349,157	-38,174,065	-27,521,702	-30,008,821	-38,800,230	2.2	-27.9	9.0	29.3	1.0
Total Other Items	$94,566,438	$86,558,231	$99,253,166	$95,374,574	$85,278,902	-8.5%	14.7%	-3.9%	-10.6%	-2.6%
TOTAL NET EXPENDITURES	$2,373,320,961	$2,454,957,425	$2,518,847,695	$2,605,052,079	$2,876,173,840	3.4%	2.6%	3.4%	10.4%	4.9%

APPENDIX

Medical Assistance Waiver Services*

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

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

Service	CIP IA CIP IB	BIW	CSLA	COP-W CIP II
Home Delivered Meals is the provision of meals to persons at risk of institutional care due to inadequate nutrition. Individuals who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician. Home delivered meals cannot meet the full daily nutritional needs of an individual.	No	No	No	Yes
Housing Counseling provides assistance in acquiring housing in the community, where ownership or rental of housing is separate from service provision.	Yes	No	Yes	No
Nursing services are medically necessary skilled nursing services that cannot be provided safely and effectively without the skills of an advance practice nurse, a registered nurse or a licensed practical nurse under the supervision of a registered nurse. Nursing services may include, but are not limited to, periodic assessments of a participant's medical condition and monitoring when the evaluation requires a skilled nurse and the monitoring of a participant with a history of non-compliance with medical needs. Nursing services that are covered as an MA card service are not eligible under the waiver program.	No	No	No	Yes
Personal Emergency Response Systems (PERS) are community-based electronic communications devices activated by the consumer in the event of a physical, emotional or environmental emergency	Yes	Yes	Yes	Yes
Prevocational services include teaching and activities related to concepts to prepare an individual for paid or unpaid employment such as work directions and routines, mobility training, interpersonal skills development and transportation to and from work	Yes	Yes	No	No
Protective Payment/Guardianship Services involve managing the client's money or supervising the client's use of funds. Services are provided to persons who have an agency as guardian and / or who have demonstrated a lack of ability to use their funds properly	No	No	No	Yes
Residential care complex is a residence for 5 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

Service	CIP IA CIP IB	BIW	CSLA	COP-W CIP II
Supported employment services include individualized assessments, job development and placement, on-the-job training, performance monitoring, and related support and training to enhance employment	Yes	Yes	Yes	No
Supportive home care are services to maintain persons in independent or supervised living situations.	Yes	Yes	Yes	Yes
Specialized transportation are services to improve access to needed community services and the ability to perform tasks independently	Yes	Yes	Yes	Yes

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

Note: CIP IA and CIP IB funds services for individuals who are relocated from the state Centers for the Developmentally Disabled (CIP IA) and persons who are relocated or diverted from other intermediate care facilities for the mentally retarded (CIP IB). The brain injury waiver (BIW) program funds services to persons with brain injuries who require post acute rehabilitation institutional care. The community supported living arrangements (CSLA) funds services fro certain persons with developmental disabilities who live at home. The community options waiver program (COP-W) and the community integration program (CIP II) provide community based services for elderly and physically disabled persons. Three programs are described on pages 44 through 47 of this paper.