

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wisconsin

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER  
THE AGE OF 21, 20, 19 AND 18

- Individuals for whom public agencies are assuming full or partial financial responsibility under title IV-E and who are in foster homes under the age of 19.
- Individuals in SNFs who are under the age of 21.
- Certain disabled children under the age of 19 who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of children at home.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Wisconsin

Name and address of State Administering Agency, if different from the State Medicaid Agency.

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I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. \_\_\_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. \_\_\_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

**Regular Post Eligibility**

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Wisconsin

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. \_\_\_ The following standard included under the State plan (check one):

(a) \_\_\_ SSI

(b) \_\_\_ Medically Needy

(c) \_\_\_ The special income level for the institutionalized

(d) \_\_\_ Percent of the Federal Poverty Level: \_\_\_%

(e) \_\_\_ Other (specify): \_\_\_\_\_

2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. X The following formula is used to determine the needs allowance:

The basic needs allowance, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first 65 dollars of earned income and 1/2 of remaining earned income; plus special exempt income which includes court ordered support amounts (child or spousal support) and court ordered attorney and /or guardian fees; plus a special housing amount that includes housing costs over \$350 per month. The total of these 4 allowances cannot exceed 300% of the SSI federal benefit.

Note: If the amount protected for PACE enrollees in item (A.) is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items (B.) and (C.).

(B.) Spouse only (check one):

1. X SSI Standard

2. \_\_\_ Optional State Supplement Standard

3. \_\_\_ Medically Needy Income Standard

4. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

5. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of \_\_\_\_\_ standard.

6. \_\_\_ The amount is determined using the following formula:

7. \_\_\_ Not applicable (N/A)

(C.) Family (check one):

1. X AFDC need standard

2. \_\_\_ Medically needy income standard

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Wisconsin

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- 3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
- 4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of \_\_\_\_\_ standard.
- 5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
- 6.  Other
- 7.  Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State of Wisconsin

**Regular Post Eligibility**

2. \_\_\_\_\_ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. \_\_\_ The following standard included under the State plan (check one):

(a) \_\_\_ SSI

(b) \_\_\_ Medically Needy

(c) \_\_\_ The special income level for the institutionalized

(d) \_\_\_ Percent of the Federal Poverty Level: \_\_\_%

(e) \_\_\_ Other (specify): \_\_\_\_\_

2. \_\_\_ The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

3. \_\_\_ The following formula is used to determine the needs allowance:

\_\_\_\_\_  
\_\_\_\_\_

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State of Wisconsin

(B.) Spouse only (check one):

1.  The following standard under 42 CFR 435.121:  
\_\_\_\_\_
2.  The medically needy income standard  
\_\_\_\_\_
3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
6.  Not applicable (N/A)

(C.) Family (check one):

1.  AFDC need standard
2.  Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.  The following dollar amount: \$ \_\_\_\_\_  
Note: If this amount changes, this item will be revised.
4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
5.  The amount is determined using the following formula:  
\_\_\_\_\_  
\_\_\_\_\_
6.  Other
7.  Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State of Wisconsin

**Spousal Post Eligibility**

3.  X  State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).   The following standard included under the State plan (check one):

- 1.  X  SSI
- 2.   Medically Needy
- 3.   The special income level for the institutionalized
- 4.   Percent of the Federal Poverty Level:   %
- 5.   Other (specify):

(B).   The following dollar amount: \$

Note: If this amount changes, this item will be revised.

(C).   The following formula is used to determine the needs allowance:

\_\_\_\_\_

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State of Wisconsin

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. \_\_\_ Rates are set at a percent of fee-for-service costs
2. \_\_\_ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. \_\_\_ Adjusted Community Rate (please describe)
4. X Other (please describe)

**Summary of Methodology to Calculate Fee-for-Service Equivalents for the Community Care for the Elderly PACE Program in Milwaukee, Wisconsin.**

**Community Care for the Elderly (CCE)** is a community based organization in Milwaukee County that serves PACE enrollees if they meet the nursing home admission criteria and are defined as frail elderly (over 54 years of age). The PACE rates are based on the fee for service equivalent costs and waiver costs for a nursing home eligible population with a physical disability primary diagnosis or a definition of frail elderly over 54 years of age.

The three most recent years (CY1999, CY2000 and CY2001) of historical fee for service Medicaid claims data and home and community based waiver (HCBW) costs for a nursing home eligible population are used as the basis for calculating the CY2003 effective Medicaid per eligible per month (PEPM) PACE capitation rates. The Medicaid Management Information System (MMIS) paid claims data net of copay and deductibles include three years of statewide costs, level of care information, Medicare eligibility and age data for the physically disabled and the elderly NH eligible populations. The NH residents are identified by claim type, age, level of care and medical status codes that indicate NH residence. A Claims Completion Factor Derivation is calculated by category of service. Categories of Services capture costs by provider type and reflect different providers billing processes. This completion factor is used to adjust the claims data to reflect 100% claim processed. The Human Services Reporting System (HSRS) waiver data include costs and eligible months for the NH eligible home and community based waiver population who are identified by their age and CIPII/COPW waiver enrollment status indicating NH eligibility and frailness.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Wisconsin

We exclude from the base data the costs and eligible months for populations that are not eligible for the program. We exclude costs and eligible months for individuals who do not have an ICF1, ICF2, SNF or ISN level of care. We exclude costs and eligible months for individuals who are less than 55 years of age, who are in an ICF/MR or IMD, and who have a DD status. We exclude costs and eligible months for individuals whose claims are paid outside of capitation methodology (aids/vent), and who are in managed care or other programs that erode the fee-for-service costs. State Categories of services are used to group the claims data. Non-contracted and non-allowable service costs are separated from contracted service costs and are excluded from the allowable rate data. The excluded costs include community support program costs, targeted case management costs, and ICF/IMD costs. Capitation payments for enrollees in HMOs, WPP, PACE, Family Care and other special managed care programs are excluded from the rate data. Costs related to the treatment of aids and ventilator dependency are excluded as they are paid outside of the capitation methodology. Otherwise all FFS costs and waiver service costs are included. The base data thus reflect the non-capitated costs of the eligible population and is the proxy for the development of the PACE rate. The trends from the base data year to the rate years are calculated by the actuary, Milliman, USA. The cost trending (inflation) is based upon the State's historical fee-for-services inflation rates and incorporates changes to payments or costs that may not be included in the paid claims data.

A per eligible per month (PEPM) amount is calculated based on costs and eligibility for the same population. The numerator is total costs and the denominator is total number of eligible months. Since individuals may only be eligible for a partial year, EM factors eligibility across year. The resulting per capita base data is not a "case rate", i.e., dependent upon a beneficiary actually receiving services. The per capita amount reflects average costs of all eligible beneficiaries in the specific county of the program. Eligible months were calculated as follows: Days/(365.25/12). Pharmacy costs are factored out separately to calculate the drug rebate adjustment.

The PACE PEPMs costs are based on Milwaukee county specific nursing home, non-nursing home fee-for-service Medicaid paid claims data and CIPII/COPW home and community based waiver (HCBW) costs. FFSE PEPM costs are allocated to the various eligibility categories using statewide age group (55-64, 65-74, 75-84, 85-94, 94+), statewide Medicare status (Medicaid only and Dual (Medicare and Medicaid)) and statewide level of care (ICF1, ICF2, SNF, ISN) cost relativity indices. The FFSE PEPM are adjusted by three years of Milwaukee county eligible month data normalized with the statewide indices. The FFSE PEPMs are also adjusted by the site's projected mix of enrollees by eligibility categories. End of year adjustments are done to adjust the FFSE PEPM to reflect actual age, Medicare eligibility and level of care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Wisconsin

Non-NH costs are allocated by age group, LOC and Medicare eligibility to derive the FFSE PEPMs. NH costs are not allocated by age group, as NH costs do not vary by age group. NH costs are allocated by LOC and Medicare eligibility to derive the FFSE PEPMs. The combination of the population's nursing home cost per eligible month, the non-nursing home cost per eligible month, the drug rebate, the 5.1% administrative add on and the 5% DHFS discount produce the final FFSE PEPMs for both the community based population and for the nursing home resident population.

The same methodology is used to derive the FFSE PEPMs for the NH residents and the FFSE PEPM for the HCBW population. Separate skilled nursing facility (SNF)/intermediate care facility (ICF) Fee-for-Service Equivalent Costs (FFSEC) PEPM are established for CY 2003 for the NH resident population and for the NH eligible community population. These FFSEC PEPMs are developed for the elderly and physically disabled NH eligible populations for Milwaukee County based on services at the skilled nursing facility (SNF) and the intermediate care facility (ICF) level of care. We assume that the community population is comprised of individuals whose services reflect only the skilled nursing facility (SNF) or the intermediate care facility (ICF). A Separate intensive skilled nursing (ISN) Fee-for-Service Equivalent Costs (FFSEC) PEPM is established for CY 2003 for the NH eligible population for individuals whose services are at the intensive nursing home (ISN) level of care. This is derived from the MMIS NH resident data. We develop a final blended rate based on a weighted average of the NH FFS equivalent costs and the CY2001 Milwaukee county Medicaid eligible months with the HCBW FFS equivalent costs and the CY2001 Milwaukee county waiver eligible months. The blended calculation is derived after the drug rebate reduction, the 5.1% administration add on and the 5% DHFS discount. The 5% discount ensures that the monthly capitation payment amounts are less than the amount that would have been paid if the services were provided on a fee-for-service basis to a similar population.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State of Wisconsin

The actuaries reviewed the 2003 FFSE calculations and concluded, "the methodology and calculation of the estimated CY 2003 FFSE costs appear to be actuarially sound and should produce a reasonable estimate of FFS costs for this population given the available data."

**Actuary:**

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- B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
- C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

Method for Determining Cost Effectiveness of Caring for  
Certain Disabled Children At Home  
(Katie Beckett Program)

Cost effectiveness is determined in accordance with federal statute 42 U.S.C. 1396a(e)(3)(B)(iii), which states "the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution . . ."

To become eligible for the Katie Beckett Program, the child must meet a level of care typically provided in a hospital, skilled nursing facility or intermediate care facility. Level of care is determined by reviewing the child's needs against screening criteria which correspond to admission criteria of certain institutions. The nurses who review the child's application assign the appropriate level of care based on the most recent medical records, information from the family and other sources.

From the medical records provided and the "Home Service Identification Plan" written for each child, an estimate of the total annual cost of in-home services to Medical Assistance is developed. This cost is then compared with the annual cost that would be charged to the Medical Assistance Program if the child were in an institution meeting the child's level of care needs. Annual institutional rates are extrapolated from the daily rates allowed through Wisconsin's Medical Assistance Program. For each program applicant, the cost of in-home services to the Medical Assistance Program must be no greater than the cost that would be incurred if the child were placed in an institution which meets the child's level of care needs.

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