An Overview of Wisconsin's Medical Assistance, BadgerCare, and SeniorCare Programs

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Medical Assistance

Wisconsin's medical assistance (MA) program supports the costs of acute and long-term care services for certain groups of individuals—elderly, blind, disabled, children under the age of 19 and their parents or caretaker relatives, and pregnant women—who meet specified financial and nonfinancial criteria. MA recipients are entitled to receive covered, medically necessary services furnished by certified providers. The program is commonly referred to as "Medicaid" or "Title 19."

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 state's Department of Health and Family Services (DHFS). DHFS administers the program based on state statutes, 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, Centers for Medicare and Medicaid Services (CMS) assurances that the state is administering the program in conformity with federal law and policy.

Federal Cost-Sharing. All states' MA programs receive federal matching funds to support covered services and program administration. The federal matching rate for most program benefits, or federal financial participation (FFP) rate, is based on a formula that compares a state's per capita income to national per capita income. In federal fiscal year 2005-06 (the period from October 1, 2005 through September 30, 2006), Wisconsin's FFP rate is 57.65%. Most administrative costs are funded on a 50% state/50% federal basis, although certain types of administrative expenses qualify for greater federal cost-sharing. Federal law does not limit the amount of matching funds states can receive under MA. Consequently, the more funding a state provides to support the program, the more federal funding the state receives to partially support program costs.

Eligibility and Caseload. Federal law requires states to cover certain groups of individuals and permits states, at their option, to provide coverage to other groups of individuals. Table 1 lists the primary groups of individuals that are eligible for services and benefits under Wisconsin's MA program, including groups that federal law requires all state MA programs to cover and optional groups Wisconsin has elected to cover.

Some groups that are considered "optional" under federal law may, in practice, be mandatory due to the consequences of not covering these groups. For example, as a condition of a waiver agreement under which the state's BadgerCare program operates, Wisconsin has agreed to maintain eligibility for children covered under the state's MA program, including the optional groups

of children the state currently covers. In addition, many individuals in nursing homes that qualify for MA because they have income between 100% and 300% of the monthly federal SSI payment amount (in 2005, individuals with income between $579 and $1,737 per month) would qualify for MA-supported nursing home care by "spending down" to the state's medically needy standard if the state no longer used the 300% standard.

Table 1: Wisconsin's Primary MA Eligibility Groups

Mandatory Groups	Optional Groups
• Individuals in families that meet eligibility requirements for the aid to families with dependent children (AFDC) program that were in effect in Wisconsin on July 16, 1996 • Children under age six and pregnant women in families with income less than or equal to 133% of the federal poverty level (FPL)* • Children under age 19 in families with income less than 100% of the FPL • Infants up to age one born to women who were eligible for MA while they were pregnant, as long as the infant remains in the mother's household and the mother remains eligible , or would be eligible, if she were still pregnant • Children for whom adoption assistance and foster care payments are made under Title IV-E • Individuals who receive supplemental security income (SSI) payments • Certain elderly and disabled individuals that remain eligible for MA but may not be eligible for SSI as their income increases due to earnings from work and Social Security benefits increases • Certain low-income Medicare beneficiaries (who are eligible for certain services not covered under Medicare and premium payments only)	• Pregnant women in families with income between 133% and 185% of the FPL • Children up to age six in families with income between 133% and 185% of the FPL • Certain institutionalized individuals with low income and resources • Certain persons enrolled in home- and community-based services waivers • Individuals who receive state-only SSI payments or who qualify for, but do not receive, federal SSI payments • Individuals with tuberculosis • Certain women diagnosed with breast or cervical cancer • Certain working disabled persons • Certain "medically needy" persons — individuals that incur health care cost that result in their "spending down" to meet MA income eligibility standards • Women that receive family planning services under the family planning waiver program • Certain disabled children who would be eligible for MA if they were in an institution ("Katie Beckett" children) • Pregnant women eligible under presumptive eligibility criteria

**The 2005 FPL is $9,570 for an individual and $3,260 is added for each additional person in a family.*

Table 2 provides information on caseload for MA and MA-related programs for each of the last seven state fiscal years, by major groups of recipients. The MA groups in this table include recipients who: (a) are over the age of 65; (b) are blind; (c) are disabled; (e) meet AFDC-related financial eligibility requirements; and (f) are in a group that includes children and pregnant women in families with income that exceeds AFDC-related financial eligibility standards (in Wisconsin, this group is referred to as "Healthy Start"), individuals in home- and community-based waiver programs, children in foster care, and certain refugee groups, among others. These broad categories are used for state budgeting purposes. However, these categories are somewhat misleading, since some recipients share characteristics of more than one group. For example, since some elderly individuals are included in the "disabled" and "other" categories, the category of individuals age 65 understates the actual number of elderly MA recipients. The table also provides annual average caseload information for the BadgerCare and SeniorCare programs.

Table 2 shows several caseload trends. First, most of the recent growth in MA caseload has occurred due to increases in the number of individuals who meet AFDC- and AFDC-related eligibility criteria (low-income families). Second, because women who participate in the MA family planning waiver are included in MA caseload totals, significant caseload growth occurred in the MA caseload totals after the MA family planning waiver was implemented in January, 2003. Third, during the past three years, there has been a significant increase in the number of individuals who qualify due to disabilities. Finally, enrollment in the state's SeniorCare program appears to have stabilized, and BadgerCare caseload decreased significantly between the 2003-04 and 2004-05 fiscal years.

Table 2: MA-Related Programs
Average Monthly Caseload, by Major Group
Fiscal Years 1998-99 through 2004-05

	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
Medical Assistance							
Age 65 and Older	45,841	44,832	43,657	43,177	42,394	41,192	40,303
Blind	1,152	1,111	1,091	1,058	1,051	1,045	1,022
Disabled	97,813	96,593	96,477	97,983	101,242	105,330	109,245
AFDC-Related	145,579	143,676	146,097	173,113	208,016	229,621	254,137
Other (includes Healthy Start, waiver clients, refugee groups, etc.)	106,040	116,784	134,233	148,304	155,025	165,284	175,096
Subtotal	396,425	402,995	421,555	463,636	507,727	542,471	579,802
MA Family Planning Waiver	0	0	0	0	7,050	36,379	49,388
Total MA Groups	396,425	402,995	421,555	463,636	514,777	578,850	629,191
BadgerCare							
Children	0	11,758	22,069	27,786	34,107	36,854	30,323
Adults	0	30,463	52,492	62,300	69,626	75,887	63,749
Total BadgerCare	0	42,221	74,561	90,086	103,733	112,741	94,072
SeniorCare	0	0	0	0	62,833	89,085	88,145
Grand Total	**396,425**	**445,216**	**496,116**	**553,722**	**681,343**	**780,676**	**811,408**

Services and Benefits. Federal law defines: (a) services that states must provide to all MA recipients; (b) services that states must provide to some, but not all, MA recipients; and (c) services that states may, at their option, provide to some or all MA recipients.

While some services are designated as "optional" under federal law, they may, in fact, be mandatory for certain groups of MA recipients. 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 (ESPDT) must be provided to the child who receives the EPSDT screen, regardless of whether the service is otherwise included in the state's 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 recipients -- children, pregnant women, and nursing home residents. Further, although "transportation services" is considered an optional service under federal regulations, states must assure necessary transportation of recipients to and from providers.

In Wisconsin, with limited exceptions, all MA recipients are eligible for the same services. However, certain MA recipient groups are eligible for limited benefits and services. For example, women ages 15 through 44 in families with income up to 185% of the FPL that do not qualify for full MA benefits may qualify for family planning services under the state's family planning waiver program. In addition, individuals who are enrolled in the state's home- and community-based waiver programs receive certain long-term care services that are not available to MA recipients that do not participate in these programs.

Many states, including Wisconsin, offer some optional services that serve as substitutes for, rather than additions to, services that would be otherwise used by MA recipients. For example, although coverage for rehabilitative services is optional, recipients that use these services could instead receive similar treatment from hospitals, either on an outpatient or inpatient basis, which may be more expensive than providing these services through agencies that specialize in providing these services.

Table 3 lists the federally required and optional services that are available to MA recipients in Wisconsin.

Table 3: Medical Assistance Services Covered in Wisconsin	
Mandatory Services	**Optional Items and Services**
Acute Care • Physicians' services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment services for individuals under 21 • Family planning services and supplies • Services provided by federally-qualified health centers • Rural health clinic services • Nurse midwife services • Certified nurse practitioner services **Long-Term Care** *Institutional Services* • Nursing facility services for individuals 21 years old and older *Home & Community-Based Services* • Home health care services	**Acute Care** • Medical care and remedial care furnished by license practitioners under state law • Prescribed drugs • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Primary care case management services • Dental services, dentures • Physical therapy and related services • Prosthetic devices, eyeglasses • TB-related services • Other specified medical and remedial care • Community-based psychosocial services **Long-Term Care** *Institutional Services* • Inpatient hospital and nursing facility services for individuals 65 or over in an institution for mental disease • Services provided by intermediate care facilities for the mentally retarded (ICFs-MR) • Inpatient psychiatric hospital services for individuals under age 21 *Home & Community-Based Services* • Home health care services for individuals not entitled to nursing facility care • Case management services • Respiratory care services for ventilator-dependent individuals • Personal care services • Private duty nursing services • Hospice care • Services furnished under a PACE • Home-and community-based services provided under an MA waiver

Distribution of MA Benefits Spending, by Service Category and Type of Recipient. Table 4 identifies MA benefits expenditures, by major service category, for fiscal years 1999-00 through 2003-04. This table indicates several trends over the five-year period. First, total payments for institutional, long-term care have increased slowly, at an average annual rate of 1.8%, while payments for community-based long-term care services have increased at a much greater rate, an annual rate of 6.4% during this period. Second, managed care payments have grown rapidly, at an average annual rate of 23.6% due to caseload increases (particularly with the creation of Family Care), as well as utilization increases, while payments for fee-for-service non-institutional services have increased by

Table 4: Major MA Expenditure Categories

Fiscal Years 1999-00 through 2003-04
(Excludes BadgerCare and SeniorCare)

Service Type	1999-00	2000-01	2001-02	2002-03	2003-04*
Long-Term Care Services					
Institutional Services					
Nursing Homes	$906,281,500	$916,181,100	$980,578,200	$990,587,000	$972,160,300
State Centers	135,932,400	115,304,000	126,885,800	123,875,900	143,039,700
Subtotal	$1,042,213,900	$1,031,485,100	$1,107,464,000	$1,114,462,900	$1,115,200,000
Community-Based Services					
MA Waivers	$360,117,400	$355,360,900	$356,107,400	$409,893,900	$443,314,100
Personal Care	74,380,800	100,427,700	104,476,400	113,096,200	123,040,100
Private Duty Nursing	15,005,900	14,874,200	15,203,700	17,622,900	17,688,300
Other Home Care	49,259,500	51,530,300	52,628,800	52,016,600	52,326,800
Subtotal	$498,763,600	$522,193,100	$528,416,300	$592,629,600	$636,369,300
Total Long-Term Care Services	$1,540,977,500	$1,553,678,200	$1,635,880,300	$1,707,092,500	$1,751,569,300
Acute Care Services					
Inpatient Hospital	$270,613,700	$297,828,400	$333,197,900	$332,029,100	$323,285,700
Outpatient Hospital	55,267,900	58,663,600	69,602,400	75,647,100	80,790,100
Subtotal	$325,881,600	$356,492,000	$402,800,300	$407,676,200	$404,075,800
Non-Institutional Fee-for-Service					
Physicians and Clinics	63,184,200	72,401,200	78,703,500	85,194,600	104,007,400
Outpatient Mental Health	35,205,200	40,625,400	47,813,300	57,185,400	35,228,300
Drugs	336,515,300	373,633,500	432,476,000	494,714,400	560,630,800
DME/DMS	32,187,500	33,970,100	37,766,700	37,233,600	35,505,300
SMV Transport and Ambulance	28,886,400	26,767,200	26,280,200	25,942,600	35,712,900
Dental	19,645,600	21,601,600	23,717,300	21,032,100	22,533,200
Other Care	135,912,100	157,102,900	183,639,900	193,066,300	225,468,300
Subtotal	$651,536,300	$726,101,900	$830,396,900	$914,369,000	$1,019,086,200
Total Acute Care Services	$977,417,900	$1,082,593,900	$1,233,197,200	$1,322,045,200	$1,423,162,000
Managed Care Payments	$394,389,300	$523,590,900	$681,842,400	$657,888,600	$887,135,000
Medicare Premiums and Payments	$131,260,600	$131,946,100	$149,951,400	$162,216,700	$162,414,200
Total Provider Payments**	$3,044,045,300	$3,291,809,100	$3,700,871,300	$3,849,243,000	$4,224,280,500

**DHFS accelerated payments to take advantage of the enhanced FFP rate available in 2003-04.*

***Does not include offsetting recoveries and collections, such as estate recoveries and drug rebates, and payments for common carrier transportation services, for CCIs/CCOs, the Bureau of Milwaukee Child Welfare and projects for children with severe emotional disturbances.*

an average of 9.9% annually during this period. Total payments to providers have increased at an average annual rate of 8.6% over this period.

As with all state MA programs, Wisconsin's MA benefits expenditures that are attributable to the major groups covered under the program (low-income families, people with disabilities and individuals over the age of 65) are not proportional to the number of individuals in each of these categories. For example, DHFS reports that, in May, 2005: (a) low-income families comprised 67% of MA recipients, but accounted for only 24% of MA benefits costs, (b) people with disabilities comprised only 17% of total MA recipients, but accounted for 46% of benefits costs; and (c) people over the age of 65 comprised 16% of MA recipients, but accounted for 30% of the benefits costs.

MA-Related Programs

The state administers several programs under waivers of federal MA law, including BadgerCare, Family Care, SeniorCare, and multiple long-term care home- and community-based waiver programs, including the community options program (COP) waiver. These programs operate under broad guidelines specified in federal law and under the terms and conditions of the waiver agreements and the state MA plan approved by CMS. This federal/state relationship permits the state to receive significant federal funding to support these programs, but also limits the state's options regarding program eligibility, services, and recipient cost-sharing. BadgerCare and SeniorCare are budgeted separately from MA, but Family Care and COP are partially budgeted in the same MA benefits appropriations that support traditional MA.

BadgerCare. 1997 Wisconsin Act 27 established BadgerCare, a program that funds health services for individuals not eligible for MA in certain low-income families. Individuals and families began enrolling in the program in July 1999. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery, and administration. BadgerCare recipients are eligible to receive the same services that most MA recipients receive. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available from two federal programs -- the state children's health insurance program (SCHIP) and MA. Consequently, BadgerCare operates under federal requirements applicable to both programs. Further, Wisconsin received approval of a waiver of certain federal requirements under MA in order to implement BadgerCare. This waiver approval was granted based on a plan submitted by the state and approved by CMS. BadgerCare operates under the parameters established in that approved plan.

Eligibility for BadgerCare is based on both financial and nonfinancial criteria. Individuals in 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 family members are no longer eligible for the program. There is no asset test. Families with incomes above 150% of the FPL must pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 5% of the family's income.

A family that meets the financial and demographic eligibility criteria for BadgerCare cannot qualify for BadgerCare if the family has insurance or

access to a group health insurance plan for which an employer subsidizes at least 80 percent of the monthly premium cost. In addition, individuals who had health care coverage any time during the three months before they apply for BadgerCare are ineligible.

SeniorCare. SeniorCare was created as part of 2001 Wisconsin Act 16 to provide assistance to Wisconsin residents who are 65 years of age or older with the purchase of prescription drugs. Program benefits began September 1, 2002.

Any Wisconsin resident who is 65 years of age or older and pays a $30 annual enrollment fee is eligible for SeniorCare, except for: (a) individuals with prescription drug coverage under MA; (b) individuals who are not U.S. citizens and whose immigration status would make them ineligible for MA services; and (c) inmates of public institutions. Individuals who have other prescription drug coverage are eligible to participate in SeniorCare, although SeniorCare only pays for that portion of the eligible costs that are not payable from other sources.

All SeniorCare recipients partially contribute towards the costs of the program. In addition to paying the enrollment fee, which is required of all recipients as a condition of eligibility, recipients share in the cost of the program by paying copayments and meeting deductible and spenddown requirements, which are dependent on income.

Each SeniorCare recipient receives a SeniorCare card, which he or she must present to a pharmacy when they purchase prescription drugs. By using this card, DHFS electronically tracks each recipient's prescription drug purchases and lets the pharmacy know how much to charge the recipient at the time of purchase.

Copayments. Recipients pay a copayment for each drug they purchase under SeniorCare for which SeniorCare reimburses the pharmacy for the cost of the drug purchased. The copayment is $5 for each generic drug and $15 for each brand-name drug. The state's payment to the pharmacy is reduced by the amount of the copayment.

Deductible. Some SeniorCare recipients pay a $500 or $850 annual deductible, depending on their income, before SeniorCare pays for drugs they purchase. Recipients receive a discount for drugs they purchase during the deductible period, since they pay the MA rate for these drugs, rather than the usual retail rate. This discount equals the difference between the retail price of the drug and the rate at which SeniorCare reimburses pharmacies.

Spenddown. Individuals and married couples with income above 240% of the FPL are required to meet a spenddown requirement. The amount of the spenddown requirement is equal to the amount that the individual's or couple's household income exceeds 240% of the FPL.

Pharmacies may not charge SeniorCare recipients more than the retail price of the drug during the spenddown period. If a pharmacy accepts a discount available from a separate program for the purchase of a drug that counts towards recipient's spenddown requirement, only the amount the recipient actually pays for the drug counts towards the spenddown requirement.

Once a recipient meets a spenddown requirement, he or she must meet an $850 deductible before SeniorCare pays for drugs. For married couples with both

spouses participating in the program, the spenddown requirement is a joint requirement -- purchases of prescription drugs for both spouses count towards the spenddown requirement. Once the joint spenddown requirement is met, each spouse must meet the annual deductible and copayment requirements.

DHFS has established four "participation levels" for SeniorCare recipients, which are based on the amount of cost-sharing required of the enrollee.

Level 1 — Copayment. Individuals with income at or below 160% of the FPL are enrolled in SeniorCare at Level 1. There is no deductible or spenddown requirement for these individuals. These individuals pay copayments for each drug they purchase under the program.

Level 2a — $500 Deductible. Individuals with income above 160% of the FPL but no more than 200% of the FPL are enrolled in SeniorCare at Level 2a. These individuals pay a $500 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 2b — $850 Deductible. Individuals with income above 200% of the FPL but no more than 240% of the FPL are enrolled in SeniorCare at Level 2b. These individuals pay the $850 annual deductible before SeniorCare pays for drugs on their behalf. Once individuals participating at this level have met their deductible requirement, they only pay copayments for each drug they purchase.

Level 3 — Spenddown. Individuals with income above 240% of the FPL are enrolled in SeniorCare at Level 3. These individuals are first responsible for the spenddown requirement and then the $850 annual deductible requirement. Once both of these requirements have been met, they pay copayments for each drug they purchase.

Drugs covered under SeniorCare include prescription drugs that are covered under MA that are produced by manufacturers that have entered into rebate agreement with DHFS. The only over-the-counter medication covered under SeniorCare is insulin.

The list of drugs covered for a SeniorCare recipient depends on whether the recipient is in a family with income less than 200% of the FPL and therefore is part of the state's demonstration waiver, which is discussed later in this section. For those recipients, the drugs covered are identical to the drugs covered under MA. For those that do not participate in the waiver, the list of covered drugs only includes drugs produced by manufacturers that have signed a separate rebate agreement with the state. Most manufacturers that participate in the MA rebate program have signed rebate agreements for the non-waiver SeniorCare population. Consequently the lists of covered drugs for waiver and non-waiver SeniorCare recipients are nearly identical.

The SeniorCare program operates under the terms and conditions of a federal waiver that is scheduled to terminate on July 1, 2007. This waiver has enabled the state to receive federal MA matching funds to support a portion of the costs of providing benefits to SeniorCare enrollees with income up to 200 percent of the FPL. At this time, it is not known whether CMS will permit the state to continue to receive federal MA matching funds to support program costs after that date.

Recent Cost Containment Initiatives

The state has taken several measures to reduce the rate of growth in the costs of providing benefits under Wisconsin's MA and MA-related programs. Some of these initiatives are listed below.

2003-05 Biennium. In the 2003-05 state budget (2003 Wisconsin Act 33), the following cost containment measures were approved.

- Reducing or freezing provider reimbursement rates, including:
  (a) reducing reimbursement for brand name drugs from the average wholesale price (AWP) -11.25% to AWP-13%
  (b) eliminating MA payments that support hospitals' indirect graduate medical costs
  (c) changing the method MA pays hospitals for outpatient services provided to Medicare beneficiaries with income at or below 100% of the FPL
  (d) reducing rates for oxygen, end-stage renal dialysis services and durable medical equipment.
- Increasing prior authorization requirements for physical, occupational, and speech therapy services
- Expanding managed care for low-income families and SSI recipients
- Increasing recipient cost-sharing, including:
  (a) increasing, from $1 to $3, the copayment MA recipients (regardless of their income) and BadgerCare enrollees pay for each brand name drug, and increasing the maximum monthly total amount of copayments for prescription drugs purchased by MA recipients
  (b) increasing the SeniorCare deductible amount for individuals with income above 200% of the FP: from $500 to $850
  (c) increasing premiums paid by families enrolled in BadgerCare with income greater than 150% of the FPL
- Reducing prescription drugs costs by establishing a preferred drug list, increasing prior authorization requirements, and negotiating supplemental rebates with drug companies

2005-07 Biennium. In the 2005-07 state budget (2005 Wisconsin Act 25), the following cost containment measures were approved.

- Reducing or freezing provider reimbursement rates, including:
  (a) reducing reimbursement for brand name drugs from AWP-13% to AWP-16%
  (b) reducing the dispensing fee paid to pharmacies from $4.38 to $3.88 per prescription
  (c) reducing payments for certain medications administered by physicians
  (d) reducing outpatient hospital rates for therapy services
  (e) reducing rates to certain hospitals that provide end state renal dialysis
  (f) providing no rate increase for nursing homes

- Reducing estimated MA payments to nursing homes by providing additional home- and community-based care
- Modifying policies to reduce costs of providing personal care services
- Using disease management services to reduce emergency room usage
- Transferring the costs of providing prenatal care costs for certain unborn children from MA to BadgerCare to increase federal support for these costs
- Funding projects to expand MA second-party review activities, improve the accuracy of eligibility and benefit determinations, and improving verification activities
- Contracting to increase fraud prevention and recovery of overpayment activities
- Contracting to conduct additional third-party liability identification and recovery activities

In addition, the state has implemented several initiatives that increased the amount of federal MA matching funds the state receives without increasing general purpose revenue (GPR) support for the program. These initiatives have included:

- Claiming certain MA-eligible costs counties incur as the state match for federal MA funds
- Increasing the nursing home bed assessment, from $32 to $100 per bed per month, and applying the assessment on all licensed beds so that the assessment is paid for beds occupied by private-pay recipients, Medicare recipients, MA recipients and unoccupied licensed beds, and using the assessment revenue as the state match for claiming additional federal funds

Program Funding — 2005-07 Biennium

Table 5 identifies the amounts budgeted for the MA, SeniorCare and BadgerCare programs in the 2005-07 biennium, by source of funds, under 2005 Wisconsin Act 25. These sources include: (a) general purpose revenue (GPR), which are state general revenue funds; (b) segregated tax funds (SEG) from the MA trust fund, which includes a portion of the revenue the state collects from the nursing home provider tax, and funds the state receives under the certified public expenditure program; (c) federal funds (FED), including both federal MA (Title 19) and SCHIP funds (Title 21); and (d) PR funds the state receives from manufacturers under SeniorCare and premiums paid by certain families enrolled in BadgerCare.

Table 5: Benefits Funding by Program and Source — 2005-07 Biennium ($ in Millions)				
	2005-06	2006-07	2005-07 Biennium	2005-07 Biennium % of Total Program Funding
Medical Assistance				
GPR	$1,360.8	$1,716.1	$3,076.9	35.1%
SEG	384.4	110.3	494.7	5.6
FED	2,556.0	2,648.9	5,204.9	59.3
Total	$4,301.2	$4,475.3	$8,776.5	100.0%
BadgerCare				
GPR	$62.4	$78.1	$140.5	34.5%
PR	6.9	7.3	14.2	3.5
FED	121.3	130.9	252.2	62.0
Total	$190.6	$216.3	$406.9	100.0%
SeniorCare				
GPR	$52.1	$57.6	$109.7	36.8%
PR	40.1	44.1	84.2	28.3
FED	50.5	53.6	104.1	34.9
Total	$142.7	$155.3	$298.0	100.0%
Grand Total — All Programs				
GPR	$1,475.3	$1,851.8	$3,327.1	35.1%
SEG	384.4	110.3	494.7	5.2
PR	47.0	51.4	98.4	1.0
FED	2,727.8	2,833.4	5,561.2	58.7
Total	$4,634.5	$4,846.9	$9,481.4	100.0%