GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Wisconsin, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Wisconsin, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in Wisconsin are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Wisconsin, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Wisconsin's Medicaid LTC system has been subject to 3 major policy reforms: the expansion of home and community-based services (HCBS) through new programs in 2000 and 2008, and the expansion of Medicaid eligibility through the increase of the medically needy income limit (MNIL) to 100% of the federal poverty level in 2017.

Key Dates

First law: 1966

Major changes since 1992: 2000, 2008, 2017

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1999

Overview

Long-term care (LTC) benefits in Wisconsin are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Wisconsin is administered at the state level by the Wisconsin Department of Health and Social Services (DHSS), and enrollment is voluntary. In 1996, the DHSS was renamed the Department of Health and Family Services (DHFS), and renamed the Department of Health Services (DHS) in 2008. To maintain consistency, we use "Department of Health Services" throughout this policy period (chapter).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Wisconsin are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program —COP).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COP are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the COP program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and COP beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Policy changes during this period:

- (1995) Wisconsin expanded the Estate Recovery policy to include recovery for HCBS services received. Previously, estate recovery only applied to nursing facility care services (WSL § 49.496, 1992a).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (U.S. Congress —USC §§ 104-193, 1996).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. §§ 1396-1 to 1396w-5, Title XIX of the Social Security Act (Social Security Administration —SSA, 2025a)

Wisconsin Law for Medicaid

- Wisconsin Statutes, Chapter 46: Social Services (Wisconsin State Legislature —WSL, 2025a)
- Wisconsin Statutes, Chapter 49, Subchapter IV: Medical Assistance (WSL, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Wisconsin Medicaid spending on beneficiaries in fiscal year 1992 was 60.38%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Wisconsin Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Wisconsin.

Eligibility for Medicaid in Wisconsin for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2025b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Wisconsin resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a Wisconsin resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2025c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (DHSS § 103.04, 1985). In 1992, this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (Centers for Medicare and Medicaid Services —CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or enrolled in the COP program and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the COP program and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.

        - Asset transfer: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., COP).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to be equal to or less than the medically needy income limit (MNIL) (WAR § 103.08, 1993c; WSL § 49.47, 1992a). The MNIL is 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever is lower. For a household of 1 or 2, 133% of AFDC is lower. In 1992, this was $592 for an individual or couple. This standard has remained the same since 1987. Additional income disregards exist when a person is institutionalized or enrolled in the COP program and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. Additional asset disregards exist when a person is institutionalized or enrolled in the COP program and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program (COP)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and disabled (CMS, 2025a). Those applying for the COP program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program for All-Inclusive Care for the Elderly (PACE)
- Family Care Partnership Program —from 1995

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Home Health provides (Code of Federal Regulations —CFR, 1992a; Wisconsin Administrative Register —WAR § 107.11, 1993a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

Nursing Facility Care

Nursing Facility Care does not provide home care.

COP

COP provides (WAR § 10.41, 2000a):

- Home health services as described above
- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

Community care

Community care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

COP

COP provides adult day health care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAR § 10.41, 2000a).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, COP

These programs do not provide residential care.

Nursing Facility Care

Wisconsin Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (WAR § 107.09, 1988a). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Wisconsin's largest home and community-based services (HCBS) program.

Wisconsin Medicaid provides additional state plan benefits related to LTC (WAR § 107.09, 1988a):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COP

COP provides the following services in addition to those offered under the state plan, unless otherwise noted (WAR § 10.41, 2000a; DHFS, 2006a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care

- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Wisconsin Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services must be provided by a registered nurse or licensed practical nurse under the supervision of a licensed registered nurse (WAR § 107.11, 1993a). Home health aide services must be provided by a home health aide employed or contracted by a Medicaid certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992a).

COP

The provision of care for program services will vary by authorized service (WAR, 1993b).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

Home health services must be medically necessary, certified by the individual's attending physician, and included in a plan of care (WAR § 107.11, 1993a).

Nursing Facility Care

Applicants may only be admitted to a nursing facility upon the order of a physician and must meet a nursing facility level of care (NFLOC) (WAR § 49.45.6m.i, 1992a; WAR § 132.13, 1987a; WAR § 132.52, 1987a). An NFLOC is satisfied when an applicant requires at least limited nursing care. Wisconsin Medicaid policy defines this as "simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse."

COP

Applicants must meet an NFLOC as described above under nursing facility care, or have an Alzheimer's diagnosis and meet one of the following levels of care (WSL § 46.27.6r, 1992b):

- Noninstitutional personal care: requires personal assistance, supervision and protection, and periodic services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care.
- Care: requires social services or activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care at least every 62 days, or when the individual's medical condition changes, whichever occurs first (WAR § 105.16, 1993b).

Nursing Facility Care

Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's physical or mental condition (WSL § 49.498, 1992a).

COP, Family Care

Participants must be reassessed at least every 12 months (DHFS, 2006a; WAR § 10.32, 2000a).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 3 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

COP

The individual must be at least age 65, or 18-64 and disabled (DHFS, 2006a).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 3 largest programs.

Home Health Services

Home health services must be medically necessary in order to treat the individual's medical condition (WAR § 107.11, 1993a). Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

To qualify for care in a skilled nursing facility applicants must meet a nursing facility level of care (NFLOC) (WAR § 132.52, 1987a; WAR § 49.45.6m.i, 1992a). An NFLOC is satisfied if the individual is receiving 1 of the following:

- Limited nursing care: Simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.
- Intermediate nursing care: Basic nursing care procedures required by residents with long-term illnesses or disabilities which can be provided safely only by a person no less skilled than a registered nurse.
- Skilled nursing care: Care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary.

COP

Applicants must meet 1 of the following levels of care in order to be eligible for COP (WSL § 46.27.6r, 1992b):

- An NFLOC as described above under nursing facility care.
- Have an Alzheimer's diagnosis and meet 1 of the following levels of care:
  - Noninstitutional personal care: Requires personal assistance, supervision and protection, and periodic services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care.
  - Care: Requires social services or activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Home health services must be medically necessary based on the individual's medical condition (WAR § 107.11, 1993a). Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

Applicants are evaluated by a physician and must meet a nursing facility level of care (NFLOC) (WAR § 132.52, 1987a; WAR § 49.45.6m.i, 1992a). An NFLOC is satisfied if a physician, using their professional judgment, determines the individual needs limited, intermediate, or skilled nursing care.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

COP

Applicants must be evaluated by a physician and meet an NFLOC as described above under nursing facility care, or have an Alzheimer's diagnosis and require the level of care equivalent to either noninstitutional personal care or care (WSL § 46.27.6r, 1992b).

Evaluators

Evaluators vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (WAR § 107.11, 1993a).

Nursing Facility Care, COP

Level of care evaluations must be conducted by a physician based on their professional judgment (WSL § 49.498, 1992a; WSL § 46.27.6r, 1992b).

Benefit limitations

Can you mix LTC benefits?

All Wisconsin Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., COP). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 3 largest programs.

Medicaid

As required by federal law, Wisconsin enforces Estate Recovery. The acceptance of Medicaid in Wisconsin creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or, from 1995, for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (WSL § 49.496, 1992a; WAR § 3074.49.496.3.a, 1995a).

Home Health Services, COP

There are no copayments or other charges for these programs (WAR § 107.11, 1993a).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules (WSL § 49.45.7, 1992a). In 1992, the PNA was $40 per month. See Table 3 for historical spousal impoverishment standards and Table 4 for historical PNAs.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2000-2007

Policy change in 2000

In 2000, Wisconsin implemented a new home and community-based services (HCBS) program called Family Care (DHS, 2025a). The new Family Care program provides HCBS through a managed care delivery system to adults at least age 65 (or 18-64 with a disability) who meet a nursing facility level of care (NFLOC). Applicants that meet an NFLOC are eligible for full benefits while those that meet a lower level of care, referred to as a non-nursing facility level of care (NNFLOC), are only eligible for limited services. Functional eligibility for the Family Care program is assessed through the Wisconsin Adult Long Term Care Functional Screen (LTC-FS). Those applying for Family Care are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. Family Care began as a pilot project in 5 counties to replace the Community Options Program (COP). It gradually expanded to additional counties over several years becoming a statewide program in 2018 when COP ended. Family Care is administered through a managed care delivery system that has a more limited provider network.

Other policy changes during this period:

- (2001) The personal needs allowance (PNA) for nursing facility residents increased to $45 per month (DHS § 39.4.3, 2024a). Previously, the PNA was set at $40 per month.
- (2005) The COP program began using LTC-FS for functional eligibility assessment (DHS § B, 2010a). This eliminated all other pathways to meet functional eligibility requirements.
- (2006) Wisconsin increased the look back period for asset transfers from 36 months (60 months for a trust) to 60 months for all assets (WSL § 49.453, 2025b).

Overview

Long-term care (LTC) benefits in Wisconsin are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Wisconsin is administered at the state level by the Wisconsin Department of Health and Family Services (DHFS), and enrollment is voluntary. In 2008, The DHFS was renamed the Department of Health Services (DHS). To maintain consistency, we use "Department of Health Services" throughout this policy period (chapter).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Wisconsin are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program —COP, Family Care).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COP and Family Care are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for COP and Family Care are not immediately guaranteed care, as the programs have strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and COP beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission. Family Care beneficiaries may meet either an NFLOC or a lower level of care, referred to as a non-nursing facility level of care (NNFLOC).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. §§ 1396-1 to 1396w-5, Title XIX of the Social Security Act (Social Security Administration —SSA, 2025a)

Wisconsin Law for Medicaid

- Wisconsin Statutes, Chapter 46: Social Services (Wisconsin State Legislature —WSL, 2025a)
- Wisconsin Statutes, Chapter 49, Subchapter IV: Medical Assistance (WSL, 2025b)

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Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Wisconsin Medicaid spending on beneficiaries in fiscal year 2000 was 58.78%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

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This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Wisconsin Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Wisconsin.

Eligibility for Medicaid in Wisconsin for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2000, the monthly federal benefit amount was $513 for an individual and $769 for a couple (SSA, 2025b). See Table 2 for historical monthly benefit amounts.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - ◇ Citizenship/immigration requirements: The applicant must be an Wisconsin resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2025c) for additional information.
  - ◇ Other requirements
    - ▪ The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC

- ◇ Income requirements: Income may not exceed 300% of the monthly federal SSI amount (DHSS § 103.04, 1985). In 2000, this was $1,539 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or enrolled in the COP or Family Care program and has a spouse residing in the community.[7] See Table 3 for historical monthly spousal disregards.
- ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the COP or Family Care program and has a spouse residing in the community.[8] See Table 3 for historical monthly spousal disregards.
  - ▪ Asset transfer: Same as eligibility track 1a.
- ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
- ◇ Other requirements
  - ▪ The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., COP, Family Care).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to be equal to or less than the medically needy income limit (MNIL) (WAR § 103.08, 2000b; WSL § 49.47, 1992a). The MNIL is 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever is lower. For a household of 1 or 2, 133% of AFDC is lower. In 2000, this was $592 for an individual or couple. This standard has remained the same since 1987. Additional income disregards exist when a person is institutionalized or enrolled in the COP or Family Care program and has a spouse residing in the community.[7] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. Additional asset disregards exist when a person is institutionalized or enrolled in the COP or Family Care program and has a spouse residing in the community.[8] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset transfer: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - ▪ The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (WSL § 1822, 2001a) —from 2002

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program (COP), Family Care

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18-64 and disabled (CMS, 2025a). Those applying for the COP and Family Care programs are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program for All-Inclusive Care for the Elderly (PACE)
- Family Care Partnership Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992a; WAR § 107.11, 1993a; DHS § 107.11, 2025c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

Nursing Facility Care

Nursing Facility Care does not provide home care.

COP, Family Care

COP and Family Care provide (WAR § 10.41, 2000a; DHFS, 2005a):

- Home health services as described above
- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

See Box 3 for an explanation of differences between COP and Family Care.

Community care

Community care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

COP, Family Care

COP and Family Care provide adult day health care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAR § 10.41, 2000a; DHFS, 2005a).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, COP, Family Care

These programs do not provide residential care.

Nursing Facility Care

Wisconsin Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (WAR § 107.09, 1988a; DHS §§ 132.60-132.70, 2025f). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Wisconsin's largest home and community-based services (HCBS) programs.

Wisconsin Medicaid provides additional state plan benefits related to LTC (WAR § 107.09, 1988a, DHS, 2025c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COP, Family Care

COP and Family Care provide the following services in addition to those offered under the state plan, unless otherwise noted (WAR § 10.41, 2000a; DHFS, 2005a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Wisconsin Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Family Care is administered through a managed care delivery system and has more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or licensed practical nurse under the supervision of a licensed registered nurse (WAR § 107.11, 1993a; DHS § 107.11, 2025c). Home health aide services must be provided by a home health aide employed or contracted by a Medicaid certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992a).

COP, Family Care

The provision of care for program services will vary by authorized service (WAR, 1993b; DHS, 2025h).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

Home health services must be medically necessary, certified by the individual's attending physician, and included in a plan of care (WAR § 107.11, 1993a).

Nursing Facility Care

Applicants may only be admitted to a nursing facility upon the order of a physician and must meet a nursing facility level of care (NFLOC) (WAR § 49.45.6m.i, 1992a; WAR § 132.13, 1987a; WAR § 132.52, 1987a). An NFLOC is satisfied when an applicant requires at least limited nursing care. Wisconsin Medicaid policy defines this as "simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse."

COP

Applicants must meet an NFLOC as described above under nursing facility care, or have an Alzheimer's diagnosis and meet one of the following levels of care (DHFS, 2006a; WAR § 10.33.2, 2004a):

- Noninstitutional personal care: requires personal assistance, supervision and protection, and periodic services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care.
- Care: requires social services or activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week.

From 2005 applicants must satisfy an NFLOC for home and community-based services (NFLOC for HCBS) and could no longer qualify by meeting a noninstitutional personal care or care level of care.[9] An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has a cognitive impairment
- The individual requires frequent medical or social intervention to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care

Applicants who meet a non-nursing facility level of care (NNFLOC) qualify for limited services (WAR § 10.33, 2000a).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is met when an individual needs assistance to safely or appropriately perform any of the following:

- One or more activities of daily living (ADLs)
- One or more of the following critical instrumental activities of daily living (IADLs):
  - Management of medications and treatments
  - Meal preparation and nutrition
  - Money management

For the full service package, applicants must meet an NFLOC for HCBS as described above under under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services
A physician must review the plan of care at least every 62 days, or when the individual's medical condition changes, whichever occurs first (WAR § 105.16, 1993b).

Nursing Facility Care
Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's physical or mental condition (WSL § 49.498, 1992a).

COP, Family Care
Participants must be reassessed at least every 12 months (DHFS, 2006a; WAR § 10.32, 2000a).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

COP, Family Care
The individual must be at least age 65, or 18-64 and disabled (WAR § 10.32, 2000a; DHFS, 2006a; DHS, 2025e; DHS, 2025i; DHFS, 2006a).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 4 largest programs.

Home Health Services
Home health services must be medically necessary in order to treat the individual's medical condition (WAR § 107.11, 1993a). Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care
To qualify for care in a skilled nursing facility applicants must meet a nursing facility level of care (NFLOC) (WAR § 132.52, 1987a; WAR § 49.45.6m.i, 1992a). An NFLOC is satisfied if the individual is receiving 1 of the following:

- Limited nursing care: Simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.
- Intermediate nursing care: Basic nursing care procedures required by residents with long-term illnesses or disabilities which can be provided safely only by a person no less skilled than a registered nurse.
- Skilled nursing care: Care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary.

COP
Applicants must meet 1 of the following levels of care in order to be eligible for COP (WSL § 46.27.6r, 1992b):

- An NFLOC as described above under nursing facility care.
- Have an Alzheimer's diagnosis and meet 1 of the following levels of care:

- ◇ Noninstitutional personal care: Requires personal assistance, supervision and protection, and periodic services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care.
- ◇ Care: Requires social services or activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week.

From 2005 applicants must satisfy an NFLOC for home and community-based services (NFLOC for HCBS) and can no longer qualify with a noninstitutional personal care or care level of care (DHFS, 2006a; WAR § 10.33.2, 2004a). An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment
- The individual requires frequent medical or social intervention to to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care

Applicants who meets a non-nursing facility level of care (NNFLOC) qualify for limited services (WAR § 10.33, 2000a).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is is met when an individual needs assistance to safely or appropriately perform any of the following:

- 1 or more ADL
- 1 or more of the following critical IADLs
  - ◇ Management of medications and treatments
  - ◇ Meal preparation and nutrition
  - ◇ Money management

For the full service package, applicants must meet a NFLOC for HCBS services as described above under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

Home health services must be medically necessary based on the individual's medical condition (WAR § 107.11, 1993a). Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

Applicants are evaluated by a physician and must meet a nursing facility level of care (NFLOC) (WAR § 132.52, 1987a; WAR § 49.45.6m.i, 1992a). An NFLOC is satisfied if a physician, using their professional judgment, determines the individual needs limited, intermediate, or skilled nursing care.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

COP

Applicants must be evaluated by a physician and meet an NFLOC as described above under nursing facility care, or have an Alzheimer's diagnosis and require the level of care equivalent to either noninstitutional personal care or care (WSL § 46.27.6r, 1992b).

From 2005 applicants are evaluated by a registered nurse or social worker using the Adult Long Term Care Functional Screen (LTC-FS), which collects information including functional limitations and cognitive status (DHFS, 2006a). See Box 4 for the information collected on the LTC-FS form, and see DHFS (2004a) to view the full assessment form.

Family Care
Applicants are evaluated by a registered nurse or social worker using the LTC-FS as described above above under COP (WAR § 10.24, 2000a).

Evaluators
Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services
Medical necessity for home health services must be certified by the applicant's attending physician (WAR § 107.11, 1993a).

Nursing Facility Care
Level of care evaluations must be conducted by a physician based on their professional judgment (WSL § 49.498, 1992a).

COP
Level of care evaluations must be conducted by a physician based on their professional judgment (WSL § 46.27.6r, 1992b). From 2005, long term care functional screen (LTC-FS) evaluations may be performed by a registered nurse or social worker (DHFS, 2006a).

Family Care
LTC-FS evaluations may be performed by a registered nurse or social worker (WAR § 10.32, 2000a)

Benefit limitations

Can you mix LTC benefits?
All Wisconsin Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., COP, Family Care). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?
The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?
It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges
User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid
As required by federal law, Wisconsin enforces Estate Recovery. The acceptance of Medicaid in Wisconsin creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (WAR § 3074.49.496.3.a, 1995a).

Home Health Services, COP, Family Care
There are no copayments or other charges for these programs (WAR § 107.11, 1993a; HFS, 2004b; WAR § 10.34, 2000a).

Nursing Facility Care
Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules (WSL § 49.45.7, 1992a). In 2000, the PNA was $40 per month. In 2001, the PNA increased to $45 per month (WSL § 49.45.7.a, 1999a). See Table 3 for historical spousal impoverishment standards and Table 4 for historical PNAs.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2008-2016

Policy change in 2008
In 2008, Wisconsin implemented a new home and community-based services (HCBS) program called Include, Respect, I Self-Direct (IRIS) (DHS, 2024b). The new IRIS program provides HCBS to adults at least age 65 (or 18-64 with a disability) who meet a nursing facility level of care (NFLOC). Functional eligibility for the IRIS program is assessed through the Wisconsin Adult Long Term Care Functional Screen (LTC-FS).

Other policy changes during this period:
- (2008) Wisconsin implemented a home equity limit that made individuals with home equity above $750,000 ineligible for LTC (WSL § 1600, 2007a).
- (2015) Wisconsin closed the waiting list for the Family Care program (DHS, 2025b). Eligible program recipients could immediately enroll once they met level of care requirements.

Overview

Long-term care (LTC) benefits in Wisconsin are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Wisconsin is administered at the state level by the Wisconsin Department of Health Services (DHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Wisconsin are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program —COP, Family Care, Include, Respect, I Self-Direct —IRIS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COP, Family Care, and IRIS are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for COP, Family Care, and IRIS are not immediately guaranteed care, as the programs have strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. From 2015, there is no longer a waiting list for the Family Care program.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, COP, and IRIS beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission. Family Care beneficiaries may meet either an NFLOC or a lower level of care, referred to as a non-nursing facility level of care (NNFLOC).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. §§ 1396-1 to 1396w-5, Title XIX of the Social Security Act (Social Security Administration —SSA, 2025a)

Wisconsin Law for Medicaid
- Wisconsin Statutes, Chapter 46: Social Services (Wisconsin State Legislature —WSL, 2025a)
- Wisconsin Statutes, Chapter 49, Subchapter IV: Medical Assistance (WSL, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Wisconsin Medicaid spending on beneficiaries in fiscal year 2008 was 57.62%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Wisconsin Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Wisconsin.

Eligibility for Medicaid in Wisconsin for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2008, the monthly federal benefit amount was $637 for an individual and $956 for a couple (SSA, 2025b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: The equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services (WSL § 49.47.4.bc, 2025b).
  - Citizenship/immigration requirements: The applicant must be an Wisconsin resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2025c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (DHS, 2025b). In 2008, this was $1,911 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS program and has a spouse residing in the community.[11] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS program and has a spouse residing in the community.[12] See Table 3 for historical monthly spousal disregards.

        - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., COP, Family Care, IRIS).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to be equal to or less than the medically needy income limit (MNIL) (WSL § 49.47, 1992a; WAR § 103.08, 2008a). The MNIL is 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever is lower. For a household of 1 or 2, 133% of AFDC is lower. In 2008, this was $592 for an individual or couple. This standard has remained the same since 1987. Additional income disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS program and has a spouse residing in the community.[11] See Table 3 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. Additional asset disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS program and has a spouse residing in the community.[12] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (WSL § 1822, 2001a)

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program (COP), Family Care, Include, Respect, I Self-Direct (IRIS)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18 - 64 and disabled (CMS, 2025a). Those applying for the COP, Family Care, or IRIS programs are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. From 2015, there is no longer a waiting list for the Family Care program.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program for All-Inclusive Care for the Elderly (PACE)
- Family Care Partnership Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992a; WAR § 107.11, 1993a; DHS § 107.11, 2025c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

Nursing Facility Care

Nursing Facility Care does not provide home care.

COP, Family Care, IRIS

COP, Family Care, and IRIS provide (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e):

- Home health services as described above
- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

See Box 3 for an explanation of differences between COP, Family Care, and IRIS.

Community care

Community care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

COP, Family Care, IRIS

COP, Family Care, and IRIS provide adult day health care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services, COP, Family Care, IRIS,

These programs do not provide residential care.

Nursing Facility Care

Wisconsin Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (WAR § 107.09, 1988a; DHS §§ 132.60-132.70, 2025f). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Wisconsin's largest home and community-based services (HCBS) programs.

Wisconsin Medicaid provides additional state plan benefits related to LTC (WAR § 107.09, 1988a; DHS, 2025c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COP, Family Care, IRIS

COP, Family Care, and IRIS provide the following services in addition to those offered under the state plan, unless otherwise noted (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Wisconsin Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Family Care is administered through a managed care delivery system and has more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or licensed practical nurse under the supervision of a licensed registered nurse (WAR § 107.11, 1993a; DHS § 107.11, 2025c). Home health aide services must be provided by a home health aide employed or contracted by a Medicaid certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992a).

COP, Family Care, IRIS

The provision of care for program services will vary by authorized service (WAR, 1993b; DHS, 2025h).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 5 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

Home health services must be medically necessary, certified by the individual's attending physician, and included in a plan of care (DHS § 107.11, 2025c).

Nursing Facility Care

Applicants may only be admitted to a nursing facility upon the order of a physician and must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied when an applicant requires at least limited nursing care. Wisconsin Medicaid policy defines this as "simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse."

COP, IRIS

Applicants must satisfy an NFLOC for HCBS (WSL § 46.27, 2018a; DHS § 10.33.2, 2025g; DHS, 2025e).[9] An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has a cognitive impairment
- The individual requires frequent medical or social intervention to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care

Applicants who meet a non-nursing facility level of care (NNFLOC) qualify for limited services (DHS § 10.33.2, 2025g).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is met when an individual needs assistance to safely or appropriately perform any of the following:

- One or more ADL
- One or more of the following critical IADLs:
  - Management of medications and treatments
  - Meal preparation and nutrition
  - Money management

For the full service package, applicants must meet the NFLOC for HCBS as described above under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 5 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care at least every 62 days, or when the individual's medical condition changes, whichever occurs first (WAR § 105.16, 1993b).

Nursing Facility Care

Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's physical or mental condition (WSL § 49.498, 1992a).

COP, Family Care, IRIS

Participants must be reassessed at least every 12 months (DHFS, 2006a; WAR § 10.32, 2000a; DHS, 2009b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 5 largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

COP, Family Care, IRIS
The individual must be at least age 65, or 18-64 and disabled (WAR § 10.32, 2000a; DHFS, 2006a; DHS, 2009c; DHS, 2017a; DHS, 2025e; DHS, 2025i).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 5 largest programs.

Home Health Services
Home health services must be medically necessary in order to treat the individual's medical condition (DHS § 107.11, 2025c). Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care
To qualify for care in a skilled nursing facility applicants must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied if the individual is receiving 1 of the following:

- Limited nursing care: Simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.
- Intermediate nursing care: Basic nursing care procedures required by residents with long-term illnesses or disabilities which can be provided safely only by a person no less skilled than a registered nurse.
- Skilled nursing care: Care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary.

COP, IRIS
Applicants must satisfy an NFLOC for home and community-based services (NFLOC for HCBS) (WSL § 46.27, 2018a; DHS § 10.33.2, 2025g; DHS, 2025e).[9] An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment
- The individual requires frequent medical or social intervention to to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care
Applicants who meet a non-nursing facility level of care (NNFLOC) qualify for limited services (DHS § 10.33.2, 2025g).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is met when an individual needs assistance to safely or appropriately perform any of the following:

- One or more ADL
- One or more of the following critical IADLs:
  - Management of medications and treatments
  - Meal preparation and nutrition

- ◇ Money management

For the full service package, applicants must meet the NFLOC for HCBS services as described above under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Home health services must be medically necessary based on the individual's medical condition (DHS § 107.11, 2025c). Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

Applicants are evaluated by a physician and must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied if a physician, using their professional judgment, determines the individual needs limited, intermediate, or skilled nursing care.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

COP, Family Care, IRIS

Applicants are evaluated by a registered nurse or social worker using the Adult Long Term Care Functional Screen (LTC-FS), which collects information including functional limitations and cognitive status (DHS, 2025j). See Box 4 for the information collected on the LTC-FS form, and see DHFS (2025k) to view the full assessment form.

Evaluators

Evaluators vary by health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (DHS § 107.11, 2025c).

Nursing Facility Care

Level of care evaluations must be conducted by a physician based on their professional judgment (WSL § 49.498, 2025b).

COP, Family Care, IRIS

Long term care functional screen (LTC-FS) evaluations may be performed by a registered nurse or social worker (DHS, 2009c; WAR § 10.32, 2000a; DHS, 2025j).

Benefit limitations

Can you mix LTC benefits?

All Wisconsin Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., COP, Family Care, IRIS). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 5 largest programs.

Medicaid

As required by federal law, Wisconsin enforces Estate Recovery. The acceptance of Medicaid in Wisconsin creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (WSL § 49.496, 2025b).

Home Health Services, COP, Family Care, IRIS

There are no copayments or other charges for these programs (DHS § 107.11, 2025c; DHFS, 2004b; DHS § 39.4.3, 2024a).

Nursing Facility Care

Beneficiaries in an institution are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules (WSL § 49.45.7.a, 2025b). In 2008, the PNA was $45 per month. See Table 3 for historical spousal impoverishment standards and Table 4 for historical PNAs.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 4: Policy enacted 2017-2025

Policy change in 2017
In 2017, Wisconsin passed legislation that increased the medically need income limit (MNIL) for eligibility track 3a. (Aged, blind, or disabled) to 100% of the federal poverty level (WSL § 933, 2017a; DHS, 2019). While enacted in 2017, the new standard did not take effect until September 1, 2019. Previously, the MNIL was set to 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever was lower.

Other policy changes during this period:

- (2018) The Community Options Program (COP) ended (CMS, 2025a).
- (2021) Wisconsin closed all remaining waiting lists for HCBS programs (Gunn, 2021). Eligible program recipients could immediately enroll once they met level of care requirements.
- (2024) The personal needs allowance (PNA) for nursing facility residents increased to $55 per month (WSL § 49.45.7.a, 2025b). Previously, the PNA was set at $45 per month.

Overview

Long-term care (LTC) benefits in Wisconsin are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Wisconsin is administered at the state level by the Wisconsin Department of Health Services (DHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Wisconsin are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program —COP, Family Care, Include, Respect, I Self-Direct —IRIS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COP, Family Care, and IRIS are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for COP and IRIS are not immediately guaranteed care, as the programs have strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available (until 2021).

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, COP, and IRIS beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission. Family Care beneficiaries may meet either an NFLOC or a lower level of care, referred to as a non-nursing facility level of care (NNFLOC).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. §§ 1396-1 to 1396w-5, Title XIX of the Social Security Act (Social Security Administration —SSA, 2025a)

Wisconsin Law for Medicaid

- Wisconsin Statutes, Chapter 46: Social Services (Wisconsin State Legislature —WSL, 2025a)
- Wisconsin Statutes, Chapter 49, Subchapter IV: Medical Assistance (WSL, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Wisconsin Medicaid spending on beneficiaries in fiscal year 2014 was 59.06%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Wisconsin Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Wisconsin.

Eligibility for Medicaid in Wisconsin for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2017, the monthly federal benefit amount was $735 for an individual and $1,103 for a couple (SSA, 2025b). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: The equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services (WSL § 49.47.4.bc, 2025b). This standard has remained the same since 2008.
  - Citizenship/immigration requirements: The applicant must be an Wisconsin resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2025c) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly federal SSI amount (DHS, 2025b). In 2017, this was $2,205 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS program and has a spouse residing in the community.[13] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS and has a spouse residing in the community.[14] See Table 3 for historical monthly spousal disregards.

        - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., COP, Family Care, IRIS).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to be equal to or less than the medically needy income limit (MNIL) (WSL § 49.47, 1992a; DHS § 103.08, 2025l). The MNIL is 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever is lower. For a household of 1 or 2, 133% of AFDC is lower. In 2017, this was $592 for an individual or couple. This standard has remained the same since 1987. From 2019, the MNIL was set at 100% of the federal poverty level (DHS, 2019). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS and has a spouse residing in the community.[13] See Table 3 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. Additional asset disregards exist when a person is institutionalized or enrolled in the COP, Family Care, or IRIS and has a spouse residing in the community.[14] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (WSL § 1822, 2001a)

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program (COP) —until 2017, Family Care, Include, Respect, I Self-Direct (IRIS)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 18 - 64 and disabled (CMS, 2025). Those applying for the COP and IRIS programs are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. From 2021, there is no longer a waiting list for these programs (Gunn, 2021).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Program for All-Inclusive Care for the Elderly (PACE)
- Family Care Partnership Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Home Health provides (CFR, 1992a; WAR § 107.11, 1993a; DHS § 107.11, 2025c):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Skilled therapy services: Physical therapy, occupational therapy, and speech-language pathology

Nursing Facility Care

Nursing Facility Care does not provide home care.

COP, Family Care, IRIS

COP, Family Care, and IRIS provide (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e):

- Home health services as described above
- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker services: Home management assistance such as grocery shopping, light housekeeping, laundry, and changing beds (IADLs only)
- Chore services: Short-term, intermittent tasks necessary to maintain a clean, safe, sanitary and habitable home environment, including washing walls and cleaning closets

See Box 3 for an explanation of differences between COP, Family Care, and IRIS.

Community care

Community care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

COP, Family Care, IRIS

COP, Family Care, and IRIS provide adult day health care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services, COP, Family Care, IRIS,

These programs do not provide residential care.

Nursing Facility Care

Wisconsin Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (WAR § 107.09, 1988a; DHS §§ 132.60-132.70, 2025f). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Wisconsin's largest home and community-based services (HCBS) programs.

Wisconsin Medicaid provides additional state plan benefits related to LTC (WAR § 107.09, 1988a; DHS, 2025c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COP, Family Care, IRIS

COP, Family Care, and IRIS provide the following services in addition to those offered under the state plan, unless otherwise noted (WAR § 10.41, 2000a; DHFS, 2005a; DHS, 2009a; DHS, 2014a; DHS, 2025d; DHS, 2025e):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention
- Home modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Wisconsin Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Family Care is administered through a managed care delivery system and has more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse or licensed practical nurse under the supervision of a licensed registered nurse (WAR § 107.11, 1993a; DHS § 107.11, 2025c). Home health aide services must be provided by a home health aide employed or contracted by a Medicaid certified home health agency. Skilled therapy services may be provided by licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants under the direction of a physical therapist, or certified occupational therapy assistants under the direction of a licensed occupational therapist who are contracted or employed by a Medicaid certified home health agency.

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (CFR, 1992a).

COP, Family Care, IRIS

The provision of care for program services will vary by authorized service (WAR, 1993b; DHS, 2025h).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 5 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

Home health services must be medically necessary, certified by the individual's attending physician, and included in a plan of care (DHS § 107.11, 2025c).

Nursing Facility Care

Applicants may only be admitted to a nursing facility upon the order of a physician and must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied when an applicant requires at least limited nursing care. Wisconsin Medicaid policy defines this as "simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse."

COP, IRIS

Applicants must satisfy an NFLOC for HCBS (WSL § 46.27, 2018a; DHS § 10.33.2, 2025g; DHS, 2025e).[9] An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has a cognitive impairment
- The individual requires frequent medical or social intervention to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care

Applicants who meet a non-nursing facility level of care (NNFLOC) qualify for limited services (DHS § 10.33.2, 2025g).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is met when an individual needs assistance to safely or appropriately perform any of the following:

- One or more ADL
- One or more of the following critical IADLs:
  - Management of medications and treatments
  - Meal preparation and nutrition
  - Money management

For the full service package, applicants must meet the NFLOC for HCBS as described above under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 5 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

A physician must review the plan of care at least every 62 days, or when the individual's medical condition changes, whichever occurs first (WAR § 105.16, 1993b).

Nursing Facility Care

Nursing facility residents must be reassessed at least every 12 months, or after a significant change in the patient's physical or mental condition (WSL § 49.498, 1992a).

COP, Family Care, IRIS

Participants must be reassessed at least every 12 months (DHFS, 2006a; WAR § 10.32, 2000a; DHS, 2009b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 5 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

COP, Family Care, IRIS

The individual must be at least age 65, or 18-64 and disabled (WAR § 10.32, 2000a; DHFS, 2006a; DHS, 2009c; DHS, 2017a; DHS, 2025e; DHS, 2025i).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 5 largest programs.

Home Health Services

Home health services must be medically necessary in order to treat the individual's medical condition (DHS § 107.11, 2025c). Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

To qualify for care in a skilled nursing facility applicants must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied if the individual is receiving 1 of the following:

- Limited nursing care: Simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.
- Intermediate nursing care: Basic nursing care procedures required by residents with long-term illnesses or disabilities which can be provided safely only by a person no less skilled than a registered nurse.
- Skilled nursing care: Care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary.

COP, IRIS

Applicants must satisfy an NFLOC for home and community-based services (NFLOC for HCBS) (WSL § 46.27, 2018a; DHS § 10.33.2, 2025g; DHS, 2025e).[9] An NFLOC for HCBS is satisfied when an applicant meets any of the following criteria:

- The individual cannot safely or appropriately perform 3 or more activities of daily living (ADLs)
- The individual cannot safely or appropriately perform 2 or more ADLs and 1 or more instrumental ADL (IADLs)
- The individual cannot safely or appropriately perform 5 or more IADLs
- The individual cannot safely or appropriately perform 1 or more ADL and 3 or more IADLs
- The individual cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment
- The individual requires frequent medical or social intervention to to safely maintain acceptable health or developmental status
- The individual requires frequent changes in service due to intermittent or unpredictable changes in his or her condition
- The individual requires a range of medical or social interventions due to a multiplicity of conditions

See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Family Care

Applicants who meet a non-nursing facility level of care (NNFLOC) qualify for limited services (DHS § 10.33.2, 2025g).[10] This includes services such as case management, skilled nursing, skilled therapy, medical supplies, and medical transportation. An NNFLOC is met when an individual needs assistance to safely or appropriately perform any of the following:

- One or more ADL
- One or more of the following critical IADLs:
  - Management of medications and treatments
  - Meal preparation and nutrition
  - Money management

For the full service package, applicants must meet the NFLOC for HCBS services as described above under COP. See Box 4 for items assessed in the LTC-FS, including ADLs and IADLs and Box 5 for definitions of each ADL.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Home health services must be medically necessary based on the individual's medical condition (DHS § 107.11, 2025c). Services must be ordered by the beneficiary's physician, performed in accordance with a written plan of care, and provided to beneficiaries in their residence.

Nursing Facility Care

Applicants are evaluated by a physician and must meet a nursing facility level of care (NFLOC) (WSL § 49.47.6m.i, 2025b; DHS § 132.13, 2025f; DHS § 132.52, 2025f). An NFLOC is satisfied if a physician, using their professional judgment, determines the individual needs limited, intermediate, or skilled nursing care.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

COP, Family Care, IRIS

Applicants are evaluated by a registered nurse or social worker using the Adult Long Term Care Functional Screen (LTC-FS), which collects information including functional limitations and cognitive status (DHS, 2025j). See Box 4 for the information collected on the LTC-FS form, and see DHFS (2025k) to view the full assessment form.

Evaluators

Evaluators vary by health benefit program. The details of the 5 largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (DHS § 107.11, 2025c).

Nursing Facility Care

Level of care evaluations must be conducted by a physician based on their professional judgment (WSL § 49.498, 2025b).

COP, Family Care, IRIS

Long term care functional screen (LTC-FS) evaluations may be performed by a registered nurse or social worker (DHS, 2009c; WAR § 10.32, 2000a; DHS, 2025j).

Benefit limitations

Can you mix LTC benefits?

All Wisconsin Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program (e.g., COP, Family Care, IRIS). Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 5 largest programs.

Medicaid

As required by federal law, Wisconsin enforces Estate Recovery. The acceptance of Medicaid in Wisconsin creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (WSL § 49.496, 2025b).

Home Health Services, COP, Family Care, IRIS

There are no copayments or other charges for these programs (DHS § 107.11, 2025c; DHFS, 2004b; DHS § 39.4.3, 2024a).

Nursing Facility Care

Beneficiaries in an institution are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules (WSL § 49.45.7.a, 2025b). In 2008, the PNA was $45 per month. See Table 3 for historical spousal impoverishment standards and Table 4 for historical PNAs.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Wisconsin Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2025)

Fiscal Year	FMAP
1992	60.38%
1993	60.42
1994	60.47
1995	59.81
1996	59.67
1997	59.00
1998	58.84
1999	58.85
2000	58.78
2001	59.29
2002	58.57
2003	59.98
2004	60.64
2005	58.32
2006	57.65
2007	57.47
2008	57.62
2009	67.46
2010	70.63
2011	66.14
2012	60.53
2013	59.74
2014	59.06
2015	58.27
2016	58.23
2017	58.51
2018	58.77
2019	59.37
2020	64.01
2021	65.57
2022	66.08
2023[1]	65.08
2024	61.04
2025	60.43

Source: U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2% increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period.[1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Wisconsin Medicaid Income Limits (1992-2025)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	MNIL (Individual)	MNIL (Couple)
1992	$422	$633	$1,266	$1,899	$592	$592
1993	434	652	1,302	1,956	592	592
1994	446	669	1,338	2,007	592	592
1995	458	687	1,374	2,061	592	592
1996	470	705	1,410	2,115	592	592
1997	484	726	1,452	2,178	592	592
1998	494	741	1,482	2,223	592	592
1999	500	751	1,500	2,223	592	592
2000	513	769	1,539	2,307	592	592
2001	531	796	1,593	2,388	592	592
2002	545	817	1,635	2,451	592	592
2003	552	829	1,656	2,487	592	592
2004	564	846	1,692	2,538	592	592
2005	579	869	1,737	2,607	592	592
2006	603	904	1,809	2,712	592	592
2007	623	934	1,869	2,802	592	592
2008	637	956	1,911	2,868	592	592
2009	674	1,011	2,022	3,033	592	592
2010	674	1,011	2,022	3,033	592	592
2011	674	1,011	2,022	3,033	592	592
2012	698	1,048	2,094	3,144	592	592
2013	710	1,066	2,130	3,198	592	592
2014	721	1,082	2,163	3,246	592	592
2015	733	1,100	2,199	3,300	592	592
2016	733	1,100	2,199	3,300	592	592
2017	735	1,103	2,205	3,309	592	592
2018	750	1,125	2,250	3,375	592	592
2019	771	1,157	2,313	3,471	1,041	1,409
2020	783	1,175	2,349	3,525	1,063	1,437
2021	794	1,191	2,382	3,573	1,073	1,452
2022	841	1,261	2,523	3,783	1,134	1,523
2023	914	1,371	2,742	4,113	1,215	1,526
2024	943	1,415	2,829	4,245	1,255	1,703
2025	967	1,450	2,901	4,350	1,304	1,763

Source: SSA (2025b), CMS (2025b), WSL § 49.47 (1991a), WSL § 933 (2017a), DHS (2019)

Notes: Income limits for individuals and couples are monthly. From 1992-2016 the medically needy income limit (MNIL) was 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the State Supplemental Payment (SSP), whichever was lower. For a household of 1 or 2, 133% of AFDC was lower. From 2017, the MNIL was set at 100% of the FPL.

Table 3: Wisconsin Spousal Impoverishment Standards (1992-2025)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA	Maximum CSRA
1992	$1,739.58	$1,718.00	$13,740	$68,700
1993	1,799.08	1,769.00	14,148	70,740
1994	1,1,847.29	1,817.00	14,532	72,660
1995	1,230.00	1,871.00	50,000	74,820
1996	1,671.67	1,919.00	50,000	76,740
1997	1,726.67	1,976.00	50,000	79,020
1998	1,768.33	2,019.00	50,000	80,760
1999	1,808.33	2,049.00	50,000	81,960
2000	1,843.33	2,103.00	50,000	84,120
2001	1,875.00	2,175.00	50,000	87,000
2002	1,935.00	2,232.00	50,000	89,280
2003	1,990.00	2,266.50	50,000	90,660
2004	2,020.00	2,319.00	50,000	92,760
2005	2,081.67	2,377.50	50,000	95,100
2006	2,138.33	2,488.50	50,000	99,540
2007	2,200.00	2,541.00	50,000	101,640
2008	2,281.67	2,610.00	50,000	104,400
2009	2,333.33	2,739.00	50,000	109,560
2010	2,428.33	2,739.00	50,000	109,560
2011	2428.33	2,739.00	50,000	109,560
2012	2,451.67	2,841.00	50,000	113,640
2013	2,521.67	2,898.00	50,000	115,920
2014	2,585.00	2,931.00	50,000	117,240
2015	2,621.67	2,980.50	50,000	119,220
2016	2,655.00	2,980.50	50,000	119,220
2017	2,670.00	3,022.50	50,000	120,900
2018	2,706.67	3,090.00	50,000	123,600
2019	2,743.33	3,160.50	50,000	126,420
2020	2,818.33	3,216.00	50,000	128,640
2021	2,903.33	3,259.50	50,000	130,380
2022	2,903.33	3,435.00	50,000	137,400
2023	3,051.67	3,715.50	50,000	148,620
2024	3,3286.67	3,853.50	50,000	154,140
2025	3,406.67	3,948.00	50,000	157,920

Source: WSL (1993a), WSL § 3003 (1995a)

Notes: Starting in 1989 the minimum monthly maintenance needs allowance (MMNA) was $1,500 and increased with inflation until 1995. From 1995, the MMNA became 200

Box 1: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138 (2025b)

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2023b)

Table 4: Wisconsin Personal Needs Allowances (PNA), 1992-2025

Year	PNA (monthly)
1992-2000	$40
2001-2023	45
2024-2025	55

Source: WSL § 49.45.7 (1992a), WSL (1999a), WSL § 49.45.7.a (2025b)
Notes: Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA).

Box 3: Explanation of differences in Wisconsin HCBS programs

In 2000, Wisconsin introduced Family Care as a pilot project in 5 counties to replace the Community Options Program (COP). home and community-based services (HCBS) in Family Care counties were only available through Family Care and enrollees of COP were transitioned to Family Care. Family Care expanded to additional counties over several years becoming statewide in 2018 when COP ended.

In order to provide beneficiaries with more control over how they receive HCBS, Wisconsin introduced the Include, Respect, I Self-direct (IRIS) program in 2008. Once enrolled in IRIS, each participant receives an individual budget based on the LTC needs as collected on the Long-term care functional screen (LTC-FS). Participants are then allowed to choose which benefits they receive from the list of those available but must stay within their budget. If they choose to work with a medical provider, they must negotiate the rates for services. If they choose to hire their own workers, they are responsible for recruiting, hiring, training, scheduling, and supervising those workers.

From 2008, HCBS eligible applicants who live in a Family Care county may choose to enroll in IRIS or Family Care. Family Care is administered through a managed care delivery system that has a more limited provider network. If applicants choose to enroll in Family Care, they become a member of a managed care organization (MCO), which coordinates services based on the individual's need, situation, and preference.

Source: DHSF (2006a), CMS (2025a); DHS (2024b)

Box 4: Wisconsin Adult Long Term Care Functional Screen (LTC-FS), 2000-2025

The Long Term Care Functional Screen (LTC-FS) is used by registered nurses or social workers to collect medical information and determine functional eligibility for applicants of home and community based services (HCBS) programs in Wisconsin (e.g., COP —from 2005-2017, Family Care, IRIS). See Box 5 for definitions of activities of daily living (ADLs). The LTC-FS collects the following information:

- Current and preferred living situation
- Diagnoses
- ADLs, including, mobility in the home, transferring, bathing toileting, dressing, and eating and drinking
- Instrumental activities of daily living (IADLs), including medication management and administration, meal preparation, money management, ability to use telephone, access to a telephone, laundry and chores, and ability to drive
- Overnight care or supervision requirement
- Expected diagnosis duration and disability determination
- Health related services including:
  - Behaviors requiring interventions
  - Exercises/Range of motion
  - IV Medications, fluids, or IV line flushes
  - Medication administration (not IV) or assistance with pre-selected or set-up medications
  - Medication management: Set-up and/or monitoring medications (for effects, side effects, adjustments, pain management) and/or blood levels
  - Ostomy-related skilled services
  - Positioning in bed or chair every 2-3 hours
  - Oxygen and/or respiratory treatments: Tracheal suctioning, C-PAP, Bi-PAP, nebulizers, IPPB treatments (does not include inhalers)
  - Dialysis
  - Total parenteral nutrition
  - Transfusions
  - Tracheostomy care
  - Tube feedings
  - Ulcer - Stage 2, 3, or 4
  - Other wound cares
  - Ventilator-related interventions
  - Requires nursing assessment and interventions
  - Skilled therapy
- Communication and cognition including:
  - Communication
  - Memory loss
  - Cognition for daily decision making
  - Physically resistive to care
- Behavioral health including:
  - Wandering
  - Self-injurious behaviors
  - Offensive or violent behaviors to others
  - Mental health needs
  - Substance use disorder
- Risk factors including:
  - Current Adult Protective Services client
  - Current Elder Adult/Adult at Risk agency
  - Risk evident during screening process such as risk of abuse, neglect, exploitation, falling, failing to obtain nutrition, self-care, safety, imminent risk of institutionalization

Source: DHS (2025q),DHFS (2004a)
Notes: The Wisconsin adult LTC-FS is used to assess functional eligibility for LTC services provided through home and community-based services (HCBS) programs (e.g., COP —from 2005-2017, Family Care, IRIS). See (DHS, 2025q) to view the full assessment form.

Box 5: Wisconsin LTC-FS Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) Definitions (2000-2025)

The Long Term Care Functional Screen (LTC-FS) is used by registered nurses or social workers to collect medical information and determine functional eligibility for applicants of home and community based services (HCBS) programs in Wisconsin (e.g., COP —from 2005-2017, Family Care, IRIS). See Box 4 for a list of the information collected by the LTC-FS. The ADLs are defined as follows:

- Mobility in home: The ability to move between locations in the individual's living environment —defined as kitchen, living room, bathroom, and sleeping area. This excludes basements, attics, yards, and any equipment used outside the home.
- Transferring: The physical ability to move between surfaces, such as from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. Excludes toileting transfers.
- Bathing: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash and dry fully.
- Toileting: The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes.
- Dressing: The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, antiembolism hose (e.g., "TED" stockings) with or without assistive devices, and includes fine motor coordination for buttons and zippers. Includes choice of clothing appropriate for the weather.
- Eating and drinking: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Source: DHS (2025q), DHFS (2004a)

Notes: ADLs and IADLs as defined by the adult LTC-FS, which is used to assess functional eligibility for LTC services provided through home and community-based services (HCBS) programs (e.g., COP —from 2005-2018, Family Care, IRIS). See (DHS, 2025q) to view the full assessment form.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: “Alt” + “←”; In Adobe Acrobat on a MAC: “command” + “←”; In Preview on a MAC: “command” + “[”.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Aid to Families with Dependent Children (AFDC): A federally funded public assistance program which provides financial assistance to needy children and their parents or relatives. Until 2017, the medically needy income limit (MNIL) was either based on 133% the AFDC amounts from 1987 or the combined amount of SSI and state supplemental payments (SSP), whichever is lower.

Care: A level of care used by the Community Options Program (COP) that requires social services or activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week. From 1992-2004 applicants could qualify for the COP with this level of care combined with an Alzheimer's diagnosis.

Chore Services: Chore services are household tasks necessary to maintain a safe and habitable home environment provided intermittently as needed by a trained homemaker. Chore services include: light cleaning (e.g., washing walls, windows, rugs), pest and rodent control (e.g., spraying the home with over-the-counter supplies, setting traps), simple household repair (e.g., repairing water faucets, unclogging drains), and disposal of garbage.

Community Options Program (COP): Wisconsin home and community-based services program for disabled or older adults that meet a nursing facility level of care. COP started in 1991, and enrollees have a variety of services available to them, such as case management. From 2002, those in a county with Family Care were not able to enroll in COP. COP ended in 2018 when Family Care became available statewide.

Community Spouse Resource Allowance (CSRA): Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care.

Community Transition Service: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting. This includes services such as case management and support for moving expenses.

Comprehensive Functional Capacity Level of Care (CFCLOC): The nursing facility level of care (NFLOC) for HCBS starting in 2000. The Community Options Program (COP) began using this criteria in 2005. In 2024, the CFCLOC was renamed the Nursing Home Level of Care (NHLOC), although the criteria for this level of care remained the same. To maintain consistency, we use "NFLOC for HCBS" throughout this document.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300% of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 3a. Medically Needy Aged, blind, or disabled: Optional coverage group under Medicaid for individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. States are

required to seek recovery of payments from the individual's estate for nursing facility services, and for individuals age 55 or older, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Wisconsin enforced estate recovery for the cost of care in a nursing home until 1994. From 1995, Wisconsin enforced estate recovery for all LTC services.

Family Care: Wisconsin home and community-based services program for disabled or older adults that meet a nursing facility level of care. Family Care enrollees have a variety of services available to them, such as case management. In 2000, Family Care began as a pilot project in 5 counties to replace the community options program (COP). Family Care expanded to additional counties over several years becoming statewide in 2018 when COP ended. Applicants may be eligible for a limited service package with a lower level of care Wisconsin called an intermediate functional capacity level of care until 2023. In 2024 the IFCLOC was renamed the non-nursing home level of care (NNHLOC), but the requirements stayed the same. To maintain consistency, we use "non-nursing facility level of care (NNFLOC)" throughout this document.

Family Care Partnership: Wisconsin home and community-based services program for disabled or older adults that meet a nursing facility level of care, or a non-nursing facility level of care. Family Care Partnership covers all of the services covered by Family Care, but also covers primary health services. As of 2025, Family Care Partnership is only available in 12 counties.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50%. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50% with exceptions for some administrative activities such as training and compensation of skilled professionals (75%) and preadmission screening and resident review (75%).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100% of the FPL), meaning households with annual/monthly income at or below 100% of the FPL would qualify based on financial eligibility.

Homemaker Services: General household activities provided by a trained homemaker when the beneficiary is unable to manage home care for themselves, or when others who are regularly responsible for these activities are temporarily absent. Homemaker services can include assistance with meal planning, meal preparation, grocery purchase planning, assisting consumers with shopping and other errands, laundry, house cleaning, kitchen care, bathroom care, emptying and cleaning bedside commodes, changing bed linens, washing inside windows within reach from the floor, and removing trash.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home Modifications: Physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Nursing Care (INC): In Wisconsin, there are 3 types of nursing services that qualify an individual for nursing facility care. Intermediate nursing care is basic nursing care procedures by residents with long-term illnesses or disabilities which can be provided safely only by a person no less skilled than a registered nurse.

Include, Respect, I Self-Direct (IRIS): Wisconsin home and community-based services program for disabled or older adults that meet a nursing facility level of care. IRIS started in 2008, and enrollees are able to self-direct the services they choose to receive within their budget. See Box 5 for more information.

Limited Nursing Care (LNC): In Wisconsin, there are 3 types of nursing services that qualify an individual for nursing facility care. Intermediate nursing care is simple nursing care procedures by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Managed Care Organization (MCO): Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (Medically Needy Aged, blind, or disabled). Until 2017 the MNIL in Wisconsin was determined by either the 1987 aid to families with dependent children (AFDC) amount or supplemental security income (SSI) plus the state supplemental payment (SSP), whichever was lower. This amount was very low. From 2017, the MNIL was set at 100% of the federal poverty level (FPL).

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Noninstitutional Personal Care: A nursing facility level of care (NFLOC) that requires personal assistance, supervision and protection, and periodic services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care. From 1992-2004 an applicant could qualify for the community options program (COP) with an Alzheimer's diagnosis combined with a NPCLOC.

Non-Nursing Facility Level of Care (NNFLOC): Level of care lower than what an individual would receive in a nursing facility. This is the minimum level of dependence required for the Family Care program. Applicants who qualify for the Family Care program at this level of care may only receive limited benefits. Applicants may also qualify for Family Care with an NFLOC for HCBS. Those who do are eligible for full benefits. From 2000-2024 the NNFLOC for the Family Care program was referred to as an intermediate functional capacity level of care (IFCLOC). In 2024, this was officially renamed to the non-nursing home level of care, although the criteria for this level of care remained the same. To maintain consistency, we use "NNFLOC" throughout this document.

Nursing Facility Care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Nursing Facility Level of Care for home and community-based services (NFLOC for HCBS): The level of care required for most Wisconsin HCBS programs starting in 2000 with the Family Care program. The Community Options Program (COP) began using this criteria in 2005.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Emergency Response System (PERS): Devices that are used to contact emergency medical services in the event of a fall or other emergency requiring medical assistance. They are light-weight and can be worn around the neck or on the wrist or belt.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Program for All-inclusive Care for the Elderly (PACE): A program of managed healthcare for Wisconsinites age 55 or older who live in an area with a PACE site. Services include primary and specialty care, adult day care, personal care, inpatient hospital care, prescription drugs, physical and occupational therapies, and nursing home care. Medicaid will pay for PACE services for those who qualify for eligibility track 2b. Institutional rules.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Skilled Nursing Care: In Wisconsin, there are 3 types of nursing services that qualify an individual for nursing facility care. Skilled nursing care is care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the resident's condition or the type or number of procedures that are necessary, including any of the following: Direct patient observation or monitoring or performance of complex nursing procedures by registered nurses or licensed practical nurses on a continuing basis; repeated application of complex nursing procedures or services every 24 hours; frequent monitoring and documentation of the resident's condition and response to therapeutic measures.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be ordered by a physician and performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Skilled Therapy Services: Physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.

State Supplemental Payment (SSP): Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses. In Wisconsin, the medically needy income limit (MNIL) was 133% of the maximum monthly Aid to Families with Dependent Children (AFDC) or the combined monthly benefit amount of SSI and the (SSP), whichever was lower. For a household of 1 or 2, 133% of AFDC was lower. From 2017, the MNIL because 200% of the federal poverty level (FPL).

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Wisconsin Department of Health Services (DHS): The DHS is Wisconsin's single state agency that administers the state Medicaid program. The Department was named the Department of Health and Social Services until 1996 when it became the Department of Health and Family Services. The Department was renamed again in 2008 when it became the Department of Health Services.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients in some states may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2011) for more information.

2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. In 2006 the look back period was extended to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999; WSL 2025h).

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2025d) for more information on these requirements.

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in the COP program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Wisconsin was $1,739.58 per month, and the maximum was $1,718. This standard increases annually with inflation. See Table 3 for historical MMNAs.

6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA). which ranged between $13,740 to $68,700 in 1992. In 1995, the minimum CSRA increased to $50,000 and has remained at that level since. In Wisconsin, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

7. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or is enrolled in the COP or Family Care program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2000, the minimum MMNA in Wisconsin was $1,843 per month, and the maximum was $2,103. This standard increases annually with inflation. See Table 3 for historical MMNAs.

8. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA). which ranged between $50,000 to $84,120 in 2000. The minimum CSRA has remained $50,000 since 1995. In Wisconsin, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

9. From 2000-2023 the nursing facility level of care for home and community-based services (NFLOC for HCBS) for the Family Care program was referred to as a comprehensive functional capacity level (CFCL). The Community Options Program (COP) began using this criteria in 2005. In 2024, the CFCL was renamed the Nursing Home Level Functional Capacity (NHLFC), although the criteria for this level of care remained the same. To maintain consistency, we use "NFLOC for HCBS" services throughout this document.

10. From 2000-2023 the non-nursing facility level of care (NNFLOC) for the Family Care program was referred to as an intermediate functional capacity level (IFCL). In 2024, the IFCL was renamed the non-nursing home level (NNHL), although the criteria for this level of care remained the same. To maintain consistency, we use "NNFLOC" throughout this document.

11. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or is enrolled in the COP, Family Care, or IRIS program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2000, the minimum MMNA in Wisconsin was $2,281 per month, and the maximum was $2,610. This standard increases annually with inflation. See Table 3 for historical MMNAs.

12. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA). which ranged between $50,000 to $104,400 in 2000. The minimum CSRA has remained $50,000 since 1995. In Wisconsin, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

13. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or is enrolled in the COP, Family Care, or IRIS program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Wisconsin was $2,585 per month, and the maximum was $2,931. This standard increases annually with inflation. See Table 3 for historical MMNAs.

14. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA). which ranged between $50,000 to $117,240 in 2000. The minimum CSRA has remained $50,000 since 1995. In Wisconsin, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

Version information

Current Version: 1.0 (April 2025)

Version History

- 1.0 (April 2025): First Version.