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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: WI-15-0009

This file contains the following documents in the order listed:

The complete final approved title XXI state plan for Wisconsin consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

Ms. Jennifer Mueller
Acting State CHIP Director
Division of Health Care Access and Accountability
1 Wilson Street, Room 365
P.O. Box 309
Madison, WI 53701-0309

Dear Ms. Mueller:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number WI-15-0009, submitted on June 26, 2015, with additional information and revised state plan pages submitted on June 22, 2016. It has an effective date of July 1, 2014.

Through this SPA, Wisconsin updates its CHIP family premium cost sharing amounts to reflect the conversion to the Modified Adjusted Gross Income equivalent standards. CHIP families are required to pay monthly premiums according to federal poverty levels (FPL) as detailed in the following table:

FPL		Monthly Premium Amount
> 201%	< 231%	$ 10.00 per family
≥ 231%	< 241%	$ 15.00 per family
≥ 241%	< 251%	$ 23.00 per family
≥ 251%	< 261%	$ 34.00 per family
≥ 261%	< 271%	$ 44.00 per family
≥ 271%	< 281%	$ 55.00 per family
≥ 281%	< 291%	$ 68.00 per family
≥ 291%	< 301%	$ 82.00 per family
= 301%		$ 97.53 per family

This SPA also permits Wisconsin to implement the following:

- Eliminate its benchmark-equivalent coverage and align CHIP benefit packages such that all children in CHIP will receive the same benefits as in Medicaid;
- Make reductions to certain copayments and increased the limit at which copayments no longer apply to mental health and substance abuse services provided through outpatient treatment facilities; and
- Eliminate Wisconsin's six-month waiting period for premium assistance.

Your title XXI project officer is Mr. Patrick Edwards. He is available to answer questions concerning these amendments and other CHIP-related issues. Mr. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-15
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6643
Facsimile: (410) 786-5882
E-mail: Patrick.Edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Edwards and to Ms. Ruth Hughes, Associate Regional Administrator (ARA) in our Chicago Regional Office. Ms. Hughes' address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

If you have additional questions or concerns, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs, at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Anne Marie Costello
Director

cc:
Ms. Ruth Hughes, ARA, CMS Region V, Chicago

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Wisconsin

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (41 CFR, 457.40(b))

_____

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c))

Name: Kitty Rhoades	Position/Title: Secretary, Department of Health and Family Services
Name: Kevin E. Moore	Position/Title: Wisconsin State Medicaid Director
Name: Shawn Tessmann	Position/Title: Wisconsin SCHIP Director

* Disclosure: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938 0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 750 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Section 1. General Description and Purpose of the Children's Health Plans and the Requirements

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) [(Section 2101(a)(1)]; (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program [Sections 2101(a)(1) and 2103]; OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2 ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); [Section 2101(a)(2)]; OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1 and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3 ☒ A combination of both of the above. [Section 2101(a)(2)]

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. [Section 2110(b)(5)]

1.2 ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. [42 CFR 457.40(d)]

1.3 ☒ Check to provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

(42 CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65) A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: **April 1, 1999**

Implementation Date:

Amendment #1 Effective date: July 1, 1999
Implementation date: July 1, 1999
Amendment #2 Effective date: October 18, 2001
Implementation date: November 1, 2001
Amendment #3 Effective date: July 14, 2004
Implementation date: August 1, 2004
Amendment #4 Effective date: November 1, 2005
Implementation date: January 1, 2006
Amendment #5 Effective date: January 14, 2008
Implementation date: February 1, 2008
Amendment #6 Effective date: February 1, 2008
Implementation date: February 1, 2008
Amendment #7 Effective date: July 1, 2008
Implementation date: July 1, 2008
Amendment #8 Effective date: December 18, 2009
Implementation date: January 1, 2010
Amendment #9 Purpose of SPA: End of Benchmark Plan coverage and general updates.
Proposed effective date: July 1, 2014
Proposed implementation date: July 1, 2014

1.4-TC **Tribal Consultation** [Section 2107(e)(1)(C)] Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Staff from the Department of Health Services travelled to Wausau, WI, to meet with the tribal health directors of the tribes located in Wisconsin. This meeting took place on May 6, 2015. Representatives of the 11 tribes located in Wisconsin were invited to the meeting and a majority were present. Representatives of the on urban Indian health center in Wisconsin were also invited. A summary of the planned changes to the CHIP plan were sent out in advance and were discussed at the meeting.

Staff promised to send the revised plan to the health directors when completed, and this will be done simultaneously with the submission of the plan to CMS. A subsequent meeting of the health directors is scheduled for July 1, 2015. Department staff will join the health directors in Wausau at that meeting and will provide information and solicit feedback on the changes to the plan.

TN No: Approval Date Effective Date

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1 can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of insured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). [(Section 2102 (a)(1); 42 CFR 457.80(a)]

The Wisconsin Department of Health Services conducts an annual Family Health Survey managed by the Department's Division of Public Health. The Wisconsin Family Health Survey was initiated in 1989 to provide reliable estimates of health status, health problems, health insurance coverage, and use of health care services among Wisconsin residents. A random sample of households is telephoned by trained interviewers, who speak with the household member most knowledgeable about the health of all household members. This respondent provides information for all people living in the household at the time of the interview.

The survey provides descriptive information about health insurance coverage among Wisconsin residents. To monitor health status and health care utilization issues, survey questions ask about the current health status, chronic conditions, and physical limitations of all household members, as well as the last visit to a doctor, visit to a dentist, and any use of an emergency room in the past year. Demographic characteristics, such as age, race, poverty status, and education, also are obtained for all persons in the household.
According to the Family Health Survey, in 2012 there were about 1,347,000 children under 19 years of age in Wisconsin. Approximately 1,118,000(83% of these children)

were white (majority) and 229,000 (17%) were minority or multiple race.

The 2012 Family Health Survey estimates that 15% of Wisconsin's population was living in a household below 100% of the Federal Poverty Level (FPL). That is, Wisconsin had an estimated 848,000 people in poverty in 2012.

According to the 2012 Wisconsin Family Health Survey, 6% of Wisconsin household residents had no health insurance during all of the previous 12 months, and 5% of household residents had no health insurance for part of the previous 12 months.

Information from the 2012 Family Health Survey provides estimates of the number of uninsured children by FPL. At any one time, an estimated 32,300 children under age 19 were uninsured in 2012.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently being funded (if applicable), also update the budget accordingly. [Section 2105(a)(1)(D)(ii); 42 CFR 457.10]

2.3-TC **Tribal Consultation Requirements-** [Sections 1902(a)(73) and 2107(e)(1)(C); ARRA #2, CHIPRA #3, issued May 28, 2009] Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such

advice.

Wisconsin's process for consulting with leaders of the 11 tribes located in the State of Wisconsin was enacted as amendment 09-020 to the Medicaid state plan. Amendment 09-020 became effective 09/01/2009 with its approval on 07/29/2010. The amendment added the following language to text page 9 of the state plan:

Wisconsin Department of Health Services staff will meet with tribal Health Directors and designees of Indian Health Service and Urban Indian Organizations during the last month in each quarter to discuss state plan amendments before they are submitted to CMS. A Consultation Implementation Plan is maintained which documents what the State and the tribes have agreed to do for the next period.

In practice, this has led to Department of Health Services staff travel to Wausau each quarter to attend meetings of the Wisconsin Tribal Health Directors Association (WTHDA). Adjustments have been made as needed for the convenience of the health directors. For instance, for the current calendar year, the health directors decided to go to an every other month schedule. As a result, for the current calendar quarter, Department staff met with the health directors the first week in May, and will do so the first week in July. In between those two meetings, updates will be sent to provide more current information about this quarter's submissions.

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions for section 1932 of the Act in the same manner as these provisions apply under Title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs [See 2105(c)(2)(A)]. Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding. If applicable, address how the new arrangements under Title XXI will work with existing

service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. [42 CFR 457.490(a)]

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations.
[Section 2102(a)(4); 42 CFR 457.490(a)]

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its manage care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval.
[Section 2103(f)(3)]

CHIP Enrollment Process. Enrollment for CHIP will use the same enrollment process that is currently used for Medicaid. We believe it is necessary to have coordinated *eligibility determinations* and subsequently *enrollment* into Medicaid managed care (or fee-for-service when required) for both Medicaid and CHIP because we expect many families to have both Title 19 and Title 21 eligible members in the same household. Applications for Medicaid, SCHIP and FoodShare can be submitted online at www.access.wisconsin.gov, in-person at the county office, over the phone or by mail.

Section 5.1 of this document describes the process to the greatest extent possible to allow families to apply for CHIP at locations convenient to them that fit their schedule, through an Internet website (https://access.wisconsin.gov/) or through telephone and mail-in application processes.

CHIP benefits are delivered through a managed care system. In areas of the State that do not have HMO services available, and in counties where there is only one HMO in operation (except in areas designated as rural exception counties), BadgerCare Plus is available on a fee-for-service basis.

<u>Current CHIP Managed Care Process.</u> All CHIP members throughout the state are eligible to participate in the Wisconsin BadgerCare Plus HMO program.

Once CHIP eligibility is established, members receive an enrollment packet including a list of available HMOs, how to choose an HMO and who to contact for assistance in determining if their current health care provider is participating in an HMO. Members have the option to enroll by phone or by mailing in the HMO enrollment choice form. If a member has not chosen an HMO within two weeks of receiving an enrollment packet, a reminder card is sent encouraging them to send in their HMO choice form or contact the enrollment contractor for assistance. At the same time, the enrollment contractor is supplied the list of CHIP eligible members who were sent reminder cards for the purpose of telephone and mail outreach.

If a member has not chosen an HMO after four weeks, the recipient is assigned to an HMO certified to provide services in the zip code where he or she resides. An enrollment letter is sent with the notice of auto-assignment, giving the member a final opportunity to change HMOs if they are not satisfied with the auto-assigned HMO. The member will also receive a notice confirming enrollment in their assigned HMO for the following month, then later receive a BadgerCare Plus HMO identification card. Members are covered under fee-for-service until they are enrolled into an HMO.

Members are auto-assigned to HMOs on a random and equal basis up to each HMO's enrollment limit. For example, if there are three available HMOs in a zip code, each will receive one-third of auto-assigned cases.

In addition, once members are in their first month of enrollment in an HMO, whether they have chosen or have been assigned, they still have the opportunity to change to a different HMO during that month.

<u>Enrollment Contractor</u>. Wisconsin contracts with a statewide enrollment contractor to provide assistance, education and outreach to CHIP and Medicaid recipients regarding the managed care program. The enrollment contractor's role is to perform enrollment, education, outreach and advocacy for Medicaid managed care enrollees. The enrollment contractor is an unbiased, knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. It is a resource where enrollees can receive help in making the appropriate choices and resolving problems. Members may call a toll free phone number to obtain assistance in selecting an appropriate HMO or may have a face-to-face meeting at numerous sites across the State.

The Enrollment Contractor also coordinates additional outreach and education to support enrollment in BadgerCare Plus and managed care enrollment.

<u>Disenrollments and Exemptions</u>. Wisconsin Medicaid and CHIP have short term and long term exemptions from HMO participation. In some situations a member may be

exempt from joining an HMO. Exempted members receive fee-for-service care for all Medicaid-covered services. Exemptions are granted to an individual who meets the specific criteria.

<u>Prenatal Care and Delivery Service</u>. Services provided to unborn children under the separate SCHIP program are not provided through HMOs, but on a fee-for-service basis.

3.2 Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. [Section 2102(a)(4); 42 CFR 457.490(b)].

Utilization controls in the Wisconsin plan (BadgerCare Plus) for targeted low-income children will vary depending on the health care delivery system from which targeted low-income children receive health care.

If these children are enrolled in HMOs which participate in Medicaid/ BadgerCare Plus, their utilization will be reviewed and monitored based on the standard requirements for Utilization Control that are established by the BadgerCare HMO contract. These requirements are as follows:

- **The HMO must have documented policies and procedures for all Utilization Management (UM) activities that involve determining medical necessity, and the approval or denial of medical services. Qualified medical professionals must be involved in any decision-making that requires clinical judgment. Criteria used to determine medical necessity and appropriateness must be communicated to providers.**
- **If the HMO delegates any part of the UM program to a third party, there must be documented agreement, which includes a description of the delegated activities and reporting mechanisms for submitting data and information to the HMO.**
- **The HMO must provide active oversight and evaluation of all aspects of performance of the delegated UM organization's activities, particularly in the area of provider and member satisfaction.**

Other areas of HMO Quality Improvement contract requirements, which are quite detailed, would apply to BadgerCare Plus utilization controls.

If these children are enrolled in an employer's group health plan through a subsidy provided by the BadgerCare Plus program, BadgerCare Plus will provide "wraparound" services up to the Medicaid benefit level for these children. We will also apply the standard Medicaid fee-for-service utilization review policy and procedures to these "wraparound" services. The standard Medicaid fee-for-service utilization review

policies and procedures are encompassed in the currently certified and operational MMIS Surveillance/Utilization Review subsystem.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:
See SPA WI_13-0029, Section CS3

4.1. ☒ Separate Program Check all standards that will apply to the State plan.
[42 CFR 457.305(a) and 457.320(a)]

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
Wisconsin is using the SSA verification option for all applicants declaring U.S. Citizenship

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:

See SPA WI_13-0028, Section CS7

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
See SPA WI_13-0028, Section CS7

4.1.2.1-PC ☒ Age: _____ through birth (SHO #02-004, issued November 12, 2002)
See SPA WI_13-0028, Section CS9

4.1.3 ☒ Income of each separate eligibility group, (if applicable):

See SPA WI_13-0028, Section CS7

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

See SPA WI_13-0028, Section CS9

4.1.4 ☐ Resources of each separate eligibility group, (including any standards relating to spend downs and disposition of resources):

There is no resource test.

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

Be physically present in Wisconsin with the intent to reside in the state.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Not applicable.

4.1.7 ☒ Access to or coverage under other health coverage:

Unborn Children

May not be covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act during the month of application or in the previous three calendar months, unless a good cause exemption is granted.

May not have access to a State employee's health benefits plan or to an employer's group or individual health insurance plan in the month of application or in the three calendar months following the month of an application, annual review or the start of new employment, or in the previous 12 months, unless a good cause exemption is granted.

A good cause exemption is granted to those unborn children with past or present coverage or access to a health insurance or a group health plan, if the insurance only covers services provided in a service area that is beyond a reasonable driving distance from the individual's residence.

A good cause exemption is granted to those individuals who were covered by a group health plan or health insurance coverage in the three months prior to application, if insurance did not pay for pregnancy-related services or if:

- **The individual through whom the insurance was available**

involuntarily lost their job with the employer providing that insurance, or voluntarily ended their job because of the incapacitation of the individual or because of an immediate family member's health condition,

- **Employment of the individual through whom the insurance was available changed and the new employer does not offer health insurance coverage, or the employer discontinued health plan coverage for all employees**
- **COBRA continuation coverage was exhausted in accordance with federal regulations,**
- **Coverage was lost due to the death or change in marital status of the policy holder, or**
- **The insurance was provided by someone not residing with the unborn child;**

A good cause exemption is granted to individuals with current, future or past access to an employer's group health plan, if the available insurance is through a person who is not a member of the unborn child's household or the employer contributes less than 80 percent of the premium cost. The percentage of employer contribution is not applicable for the State employee's health plan.

A good cause exemption is granted to those unborn children who, in the past 12 months, had access to a group health plan or had access to access to a State employee's health benefits plan if:

- **Employment of the individual through whom the insurance was available ended, or the employer discontinued health plan coverage for all employees; or**
- **At the time the individual failed to enroll in the employer's health insurance coverage, one or more members of the individual's family were covered through:**
  - **A private health insurance policy or Medicaid, and**
  - **No one in the family was covered through SCHIP.**

<u>Children covered under Separate SCHIP</u>

May not be covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, during the month of application or in the previous three months, unless a good cause exemption is granted.

May not have access to a State employee's health benefits plan or to an employer's group health plan at the time of application or within the three

calendar months following the month of an application, annual review or the start of new employment, or in the previous 12 months, unless a good cause exemption is granted.

A good cause exemption is granted to those children who are covered by health insurance or a group health plan during the month of application or in the previous three months, if the individual is covered by health insurance:

- **That only covers services provided in a service area that is beyond a reasonable driving distance from the individual's residence,**
- **Provided by someone who is not a member of the child's household, or**
- **Which is not a group health plan, or for which an employer contributes less than 80 percent of the premium cost. This reason does not apply to State employee's health benefits plan.**

A good cause exemption is granted to those children who were covered by a group health plan in the three months prior to application, if:

- **The individual through whom the insurance was available involuntarily lost their job with the employer providing that insurance, or voluntarily ended their job because of the incapacitation of the individual or because of an immediate family member's health condition,**
- **Employment of the individual through whom the insurance was available changed and the new employer does not offer health insurance coverage, or the employer discontinued health plan coverage for all employees, or**
- **Coverage was lost due to the death or change in marital status of the policy holder.**

A good cause exemption is granted to individuals with current, future or past access to an employer's group health plan, if the available insurance is through a person who is not a member of the child's household or the employer contributes less than 80 percent of the premium cost. The percentage of employer contribution is not applicable for the State employee's health plan.

A good cause exemption is granted to those individuals who, in the past 12 months, had access to a group health plan or a State employee's health benefits plan, if:

- **Employment of the individual through whom the insurance was available ended, or the employer discontinued health plan coverage**

for all employees; or

- **The individual through whom the insurance was available failed to enroll in the employer's health insurance coverage because one or more members of the individual's family were covered through:**
  - **A private health insurance policy or Medicaid, and**
  - **No one in the family was covered through SCHIP.**

Other good cause exemptions, consistent with the above reasons, may be approved by the Department of Health Services on a case by case basis.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

Eligibility lasts until the birth of the baby for unborn children covered under SCHIP and for 12 months or until determined ineligible for all other children.

4.1.9 ☒ Other standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing an SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

An SSN is not required for unborn children, but is required for all other children requesting assistance.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant women option.** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same

reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1-LR ☒ **Lawfully residing option.** [Sections 2107(e)(1)(J) and 1903(v)(4)(A); CHIPRA #17, SHO # 10-006 issued July 1, 2010] Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 USC §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) [8 U.S.C. §1182(d)(5)] for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-

649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA [8 U.S.C. § 1101(a)(27)(J)];

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.

☒ Elected for children under age _19____.

4.1.1-LR ☒ The state provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the state cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** [Section 2103(c)(5)]- A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only

supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2 **Assurances** The state assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: [Section 2102(b)(1)(B) and 42 CFR 457.320(b)]

- **4.2.1.** ☒ These standards do not discriminate on the basis of diagnosis.
- **4.2.2.** ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
- **4.2.3.** ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2-DS ☐ Supplemental Dental - Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: [Section 2102(b)(1)(B) and 42 CFR 457.320(b)]

- **4.2.1-DS** ☐ These standards do not discriminate on the basis of diagnosis.
- **4.2.2-DS** ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- **4.2.3-DS** ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. [Section 2102(b)(2) and 42 CFR 457.350]

See SPA WI_13-0031, Section CS24

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplement coverage may not have a waiting list or limit eligibility in any way.

4.3.1 Limitation on Enrollment Describe the processes, if any, that a State will use for instituting

enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. [(Section 2102(b)(2) and 42 CFR 457.305(b)]

☒ Check here if this section does not apply to your state.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.1 ☐ Check if the State elects to provide presumptive eligibility for children that meet the requirements of section 1920A of the Act. [Section 2107(e)(1)(L) and 42 CFR 457.355]

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determination, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. [Section 2107(e)(1)(E)]

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty

level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening household, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. [Sections 2102(b)(3)(A) and 2110(b)(2)(B); 42 CFR 457.310(b)(2), 42 CFR 457.350(a)(1) and 457.80(c)(3)]

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a State health benefits plan) are furnished child health assistance under the plan. [Sections 2102(b)(3)(A), 2110(b)(2)(B), 42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 457.80(c)(3)] Confirm that the State does not apply a waiting period for pregnant women.

See SPA WI_13-0031, Section CS24

4.4.2. ☒ children found through the screening to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; [Section 2102(b)(3)(B), 42 CFR 457.350(a)(2)]

See SPA WI_13-0031, Section CS24

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP. **[**Sections 2102(a)(1) and (2) and 2102(c)(2); (42 CFR 431.636(b)(4)]

See SPA WI_13-0031, Section CS24

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. [Section 2102)(b)(3)(C), (42 CFR 457.805]
See SPA WI_13-0031, Section CS24

4.4.4.1. ☒ (formerly 4.4.4.4) If the state provides coverage under a premium assistance program, describe: 1) The minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

1) Six months
2) The minimum employer contribution is 40% of the cost of the premiums.
3) To determine the Premium Assistance cost effectiveness, we first determine the Premium Assistance cost. This is the sum of the premium amount of the employer plan, projected BadgerCare Plus Wrap-around cost and the administration cost associated with premium assistance. In the second step we determine the BadgerCare Plus Cost by adding the BadgerCare Plus HMO monthly Cap amount to a lower Wrap-around amount. If the Premium Assistance cost is less than the BadgerCare Plus Cost, we will proceed to buy in to the employer's insurance.

4.4.5. ☒ Child health insurance is provided to targeted low-income children in the State who are American Indian and Alaskan Native. [Section 2102)(b)(3)(D), (42 CFR 457.125(a)]

Wisconsin has a long-standing working relationship with tribal health directors in the State. From statewide HMO implementation, Medicaid staff met with tribal health directors over an 18-month period to coordinate HMO expansion with the needs of the tribes and with Indian Health Service responsibilities. A special disenrollment procedure was developed for tribal members that involves close coordination with Indian Health Clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non-HMO affiliated Indian Health Clinics could still be reimbursed by Medicaid for

fee-for-service funds for services provided to tribal members enrolled in HMOs, and so that Indian Health Service funds would not be jeopardized by the expansion of the HMO program.

We continue to hold regular meetings with tribal leaders to discuss health care related issues. We intend to use these meetings to solicit input and provide information to the tribes on BadgerCare Plus.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements.

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening household, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current state efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2: [Section 2102)(a)(2), (42 CFR 457.80(b)]

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1) The steps the state is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic round of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite this section but may instead update this section as appropriate.

Wisconsin Medicaid is the State's major public health program for children. Medicaid is a federal/state health care program for low-income families, elderly and disabled individuals. It serves many of the poorest and most vulnerable citizens of Wisconsin.

In the 2013 - 2014 fiscal year, the Medicaid GPR budget is approximately $2.3 billion.

Wisconsin Medicaid offers one of the most comprehensive benefit packages of any state Medicaid program and covers most individuals eligible under federal regulations. At the same time, Wisconsin Medicaid is a very cost-effective program.

The Wisconsin Department of Health Services is the largest single provider of direct as well as support services for uninsured and Medicaid-enrolled children and adolescents. Direct services for this population include: preventive child health services (well-child check-ups), prenatal services, Women Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning program services. Support services include case management services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC Program funds,

Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue.

The State of Wisconsin has increased the percentage of low-income families with health insurance through a variety of initiatives:

Prenatal Care for Unborn Children. Provisions of 2005 Wisconsin Act 25 enacted on July 25, 2005, authorized the Department of Health and Family Services to provide BadgerCare benefits to unborn children of women who are not otherwise eligible for Medicaid, such as non-qualifying aliens.

BadgerCare Plus. This program provides a consolidated, streamlined program for all children, pregnant women, parents and caretaker relatives. It also expands coverage for pregnant women to 300% FPL, caretaker relatives and parents to 200% FPL and covers all uninsured children. Under SCHIP we are requesting coverage of those children with incomes that exceed Medicaid income limits, but do not exceed 300% FPL.

Many of the families with children who are currently eligible for Family Medicaid or BadgerCare and have chosen not to enroll, need to be provided with information that shows that the program is easier to understand and easier to access. The State's employs a Partner Outreach Coordinator who collaboratively with local and statewide groups, including the Robert Wood Johnson-funded Covering Kids and Families Initiative, to identify and enroll children who meet program requirements. The Partner Outreach Coordinator

In addition, BadgerCare Plus simplifies the program rules through Medicaid and SCHIP State Plan amendments and modify the current BadgerCare waiver by removing income disregards and deductions in ways that make the program easier for the average parent to understand and allows them to ascertain on their own that their income meets the limits being proposed.

Wisconsin offers applicants and participants multiple methods to apply for BadgerCare Plus: online, in-person, by phone or by mail. Applicants can complete an application at their convenience whenever they choose to and through any of these methods.

Online: To apply online, applicants go to www.access.wi.gov and complete an assessment if they want to see potential eligibility (Am I Eligible?) or applicants can complete and submit an online application (Apply for Benefits). At any time during the application process, the applicant can choose to save the information and complete the application at a later date. The information will be saved under his or her account for 30 days before it expires.

In-Person: The applicant can choose to go to an agency location and apply. Agency locations are listed at https://www.dhs.wisconsin.gov/forwardhealth/imagency/consortia.htm.

Telephone: An applicant can apply for benefits by telephone by calling his or her Income Maintenance consortia. These phone numbers are listed online at https://www.dhs.wisconsin.gov/forwardhealth/imagency/consortia.htm. They are also listed on several BadgerCare Plus factsheets and brochures. Income Maintenance staff can collect the applicant's signature over the phone.

Mail-In: Paper applications are available for order through the Department or printable online.

5.1.2. (formerly 2.2.2.) The steps the state is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership.

Guidance: The State should describe how its Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. [42 CFR 457.80(c)]

See . 5.1.1.

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. [Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2); 42 CFR 457.80(c)] This item requires a brief overview of how Title XXI efforts - particularly new enrollment outreach efforts - will be coordinated with and improve upon existing State efforts.

Applicants are eligible for BadgerCare Plus if they meet all of the following conditions:

- **They are not currently enrolled in any group or individual health insurance plan as defined in HIPAA.**
- **They have not been enrolled in a group or individual health plan meeting HIPAA criteria during the past six months.**
- **They have not had access to a State employee's health benefits plan in the previous 12 months.**
- **They have not had access to a group or individual health insurance plan in the previous 12 months in which their employer pays at least 80 percent of the premium.**

Good cause is granted to family members of those individuals who have been or are currently covered, if the individual, through whom the insurance was available, has involuntarily lost their job with the employer providing that insurance, or the employer providing the health insurance coverage does not pay 80% or more of the premium; Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays *at least 40 % but no more than 80% of the cost* will be eligible for the health insurance premium purchase under BadgerCare Plus to assure that BadgerCare Plus does not substitute for private coverage. These provisions apply to the SCHIP expanded population only.

In families, where the state purchases employer subsidized family group health plan for a household that includes both Medicaid funded and SCHIP funded members, we will prorate the cost of the plan based upon the number of members in the family who are funded through SCHIP and the members funded through Medicaid. For example, if a family with a mother and two children, ages seven and nine, applies for BadgerCare Plus and we determine that their family income is 130% of the FPL, we will check with their employer to determine if we should enroll them in HIPP. If their family premium is $99 per month and that proves to be cost effective, the Department will purchase their employer's group health plan for the family and say that $66 of the premium that is intended for the two children will come from SCHIP and $33 will come from Medicaid funds.

The Department will comply with the applicable SCHIP premium assistance rules when determining whether the Department will pay for the employee portion of an employer-subsidized health insurance plan that covers SCHIP children.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment

forms, case management and other targeting activities to inform families of low income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the state to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: [Section 2102(c)(1); 42 CFR 457.90]

<u>Community Partner Outreach</u>. The State currently employs a full-time Partner Outreach Coordinator who works directly with the community partners across Wisconsin to inform families about BadgerCare Plus, assist with getting health coverage and advocate on behalf of the member. The Partner Outreach Coordinator provides training on a regular basis to keep the community partners informed on Medicaid regulations and how members could be affected. In return, community partners provide feedback to the State on streamlining enrollment to best serve families and children.

The State also provides regular trainings for partners on how to use the online application tool, ACCESS (www.ACCESS.wi.gov), to assist members in applying for benefits, checking their case information and submitting information online. ACCESS has also been enhanced to allow qualified entities, approved by the State, to complete presumptive eligibility determinations.

In 2013, the State established Regional Enrollment Networks that assist all Wisconsin residents in applying for BadgerCare Plus and health insurance through the Federally-facilitated Marketplace. These networks are composed of community partners, health care providers, income maintenance agencies, managed care entities and other key stakeholders across 11 different regions of Wisconsin. These 11 regions align with the 11 Income Maintenance consortia so that both RENs and IM consortia can work together to address the needs of their region. Regional Enrollment Networks work at the local level directly with applicants to help identify and resolve issues and barriers according to the needs of that region and provide feedback to the State on methods to improve.

<u>Public Information Campaign</u>. With the implementation of the Affordable Care Act in 2014, the Department reviewed all of its BadgerCare Plus and Medicaid related content and materials to provide members with up-to-date information about getting health care coverage

whether it is provided through the State or through the Federal Marketplace. Wisconsin promotes a "No Wrong Door" approach, which emphasizes to the applicant that whether he or she applies through the State or through the Federal Marketplace, the applicant will always get the appropriate coverage for his or her family. Factsheets, brochures and web resources include information on where and how to apply in Wisconsin and in the Federal Marketplace.

Limited-English Proficiency. The Department has assessed the population of Wisconsin to determine areas with limited-English Proficiency (LEP) and develop methods to help meet the needs of the LEP population. ACCESS, is entirely translated into Spanish. The BadgerCare Plus paper application is translated into Spanish and Hmong.

Strategies to Promote Public Health. The Department is developing strategies to promote the health of the population through a variety of initiatives. These include the following:

- **Assuring that eligible families are enrolled in BadgerCare Plus.**
- **Establishing a medical home and access to quality preventive services through statewide expansion of managed care.**
- **Creating incentives for managed care organizations to support healthy living incentives and to pay for quality performance.**

In addition, the Department holds public health outreach contracts with seven public health agencies across Wisconsin:

- **Chippewa County Health Department**
- **Dunn County Health Department**
- **La Crosse County Health Department**
- **Partnership with Juneau County Health Department**
- **Polk County Health Department**
- **Sauk County Health Department**
- **Washburn County Health Department**

These agencies work with the Department to educate and inform the public about health care options for adults and children in Wisconsin and assist families and individuals maintain health care coverage. The public health agencies are required to submit proposals to the Department for the fiscal year and provide quarterly updates on how they are meeting their goals. The goals of these public health outreach contracts include:

- **Assisting residents with health care applications or renewals;**
- **Assisting individuals with applications for the Federal Marketplace;**
- **Providing education and targeted outreach to the public;**

- **Providing technical assistance to health care providers and community partners about health care in Wisconsin; and**
- **Increasing access to quality services.**

Training.

The State is continually providing training to Income Maintenance and tribal agencies and community partners about BadgerCare Plus and Medicaid programs. Ongoing training for health care providers is managed by the state's Medicaid fiscal agent, Hewlett-Packard (HP).

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) [Section 2103(c); 42 CFR 457.410(a)]

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. [Section 2103(c)]

6.1.1. ☐ Benchmark coverage; [Section 2103(c); 42 CFR 457.420]

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. [Section 2103(b)(1); 42 CFR 457.420(b)]

6.1.1.1. ☐ FEHBP-equivalent coverage; [Section 2103(c); 42 CFR 457.420(a)] (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. [Section 2103(b)(2)]

6.1.1.2. ☐ State employee coverage; [Section 2103(b)(2)] (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization [as defined in Section 2791(b)(3) of the Public Health Services Act] and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. [Section 2103(b)(3); 42 CFR 457.420(c)]

6.1.1.3. ☐ HMO with largest insured commercial enrollment [Section 2103(b)(3)] (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must first check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services
  - physicians' services
  - surgical and medical services
  - laboratory and x-ray services
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value of, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the

increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. [Section 2103(a)(2)]

6.1.2. ☐ Benchmark-equivalent coverage; [Section 2103(a)(2) and 42 CFR 457.430] Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**.**

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. [Section 2103(a)(3)]

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. [Section 2103(a)(4); 42 CFR 457.450]

6.1.4. ☐ Secretary-Approved Coverage. [Section 2103(a)(4); 42 CFR 457.450]

6.1.4.1. ☒ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount, and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. [Section 2110(a); 42 CFR 457.490]

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2 The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations)
[Section 2110(a); 42 CFR 457.490)]

Coverage for both children and unborn children under CHIP is the same as coverage under the Wisconsin Medicaid State Plan. Children and unborn children covered under CHIP receive all Wisconsin Medicaid covered services including EPSDT.

Details about the amount, duration and scope of the covered services are provided in Attachment 2.

6.2.1. ☒ Inpatient services [Section 2110(a)(1)]

6.2.2. ☒ Outpatient services [Section 2110(a)(2)]

6.2.3. ☒ Physician services [Section 2110(a)(3)]

6.2.4. ☒ Surgical services [Section 2110(a)(4)]
See Physician Services in Attachment 2.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services [Section 2110(a)(5)]
See Physician Services in Attachment 2.

6.2.6. ☒ Prescription drugs [Section 2110(a)(6)]

6.2.7. ☒ Over-the-counter medications [Section 2110(a)(7)]

6.2.8. ☒ Laboratory and radiological services [Section 2110(a)(8)]

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies [Section 2110(a)(9)]

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services [Section 2110(a)(10)]

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but

including services furnished in a state-operated mental hospital and including community-based services [Section 2110(a)(11)]

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) [Section 2110(a)(12)]

6.2.13. ☒ Disposable medical supplies [Section 2110(a)(13)]

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☒ Home and community-based health care services (See instructions) [Section 2110(a)(14)]

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school, or other setting.

6.2.15. ☒ Nursing care services [Section 2110(a)(15)]
See Physician Services in Attachment 2.

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest [Section 2110(a)(16)]

6.2.17. ☒ Dental services [Section 2110(a)(17)] States updating their dental benefits must complete 6.2-DC (CHIPRA #7, SHO #09-012 issued October 7, 2009)

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services [Section 2110(a)(18)]

6.2.19. ☒ Outpatient substance abuse treatment services [Section 2110(a)(19)]

6.2.20. ☒ Case management services [Section 2110(a)(20)]

6.2.21. ☒ Care coordination services [Section 2110(a)(21)]
See Case Management services in Attachment 2.

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders [Section 2110(a)(22)]

6.2.23. ☒ Hospice care [Section 2110(a)(23)]

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the discretion of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. [Section 2110(a)(24)]

6.2.25. ☒ Premiums for private health care insurance coverage [Section 2110(a)(25)]

6.2.26. ☒ Medical transportation [Section 2110(a)(26)]

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services) [Section 2110(a)(27)]
See Transportation Services in Attachment 2.

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this Section [Section 2110(a)(28)]

6.2-DC **Dental coverage** (CHIPRA #7, SHO #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children [Section 2103(a)(5)]:

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

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6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☐ State-developed Medicaid-specific
- ☐ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☒ Other (description attached)

Dental coverage under CHIP is the same as dental coverage under Wisconsin's Medicaid State Plan. Thus, the periodicity schedule under CHIP is the same as Wisconsin Medicaid.

6.2.2-DC ☐ Benchmark coverage; [Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420]

6.2.2.1-DC ☐ FEHBP-equivalent coverage; [Section 2103(c)(5)(C)(i)]; (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; [Section 2103(c)(5)(C)(ii)] (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment [Section 2103(c)(5)(C)(iii)] (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State

chooses to provide supplemental services, also attach a description of the services and applicable CDT codes

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children [Section 2110(b)(5)(C)(ii)]. Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

[2]Current Dental Terminology, ©2010 American Dental Association. All rights reserved.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6)

6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services [Section 2102(b)(1)(B)(ii)]; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2., formerly 6.4.2., of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) [Section 2103(f)]. Describe:

Guidance: States may request two additional purchase options in Title XXI; cost effective coverage through a community-based health-delivery system and for the purchase of family coverage [Section 2105(c)(2) and (3); 457.1005 and 457.1010]

6.4. **Additional Purchase Options-** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: [Section 2105(c)(2) and(3); 42 CFR 457.1005 and 457.1010]

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following [42 CFR 457.1005(a)]:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.
[Section 2105(c)(2)(B)(i); 42 CFR 457.1005(b)]

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis.
[Section 2105(c)(2)(B)(ii); 42 CFR 457.1005(b)]

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. [42 CFR 457.1005(a)]

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers

receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. [Section 2105(c)(2)(B)(iii); 42 CFR 457.1005(a)]

Guidance: Check 6.4.2. if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. [Section 2105(c)(3); 42 CFR 457.1010]

6.4.2. [x] **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: [Section 2105(c)(3); 42 CFR 457.1010]

Title XXI, Section 2105 provides CMS with the authority to waive requirements prohibiting the purchase of family coverage under Title XXI. This is possible provided the following two conditions are met: (1) such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved; and (2) the coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. In order to demonstrate compliance with Section 2105, we are providing the actuarial analysis found in section 6.4.2.1, which follows. The crowd-out provisions for BadgerCare Plus assure that only children who are not now covered would be eligible for health care.

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium

assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

To determine cost effectiveness, the State first determines the Premium Assistance cost. The Premium Assistance cost is the sum of the employer plan's premium, the projected BadgerCare Plus wrap-around cost, and the administrative expenditures associated with premium assistance. In the second step the State determines the BadgerCare Plus Cost by adding the BadgerCare Plus HMO statewide average monthly capitation rate by age and gender to the estimated wrap-around amount. If the Premium Assistance cost is less than the BadgerCare Plus cost, the State will purchase the employer's insurance.

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. [Section 2105(c)(3)(B); 42 CFR 457.1010(b)]

BadgerCare Plus coverage of families will provide coverage for children who do not currently have access to affordable health care coverage. It will not substitute for coverage which currently covers the children but does not cover the parents.

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. [42 CFR 457.1010(c)]

The State provides "wrap-around" benefits that cover any services not provided through the family coverage plan that are part of the regular SCHIP services provided under the plan.

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA #13, SHO #10-002 issued February 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. [Section 2105(c)(10)(A)] Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA Supplemental Coverage for Benefits and Cost Sharing Protections Provided Under the Child Health Plan

6.4.3.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Upon State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.1-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child. [Section 2105(c)(10)(G)]

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? [Section 2102(c)]

6.4.3.5-PA **Purchasing Pool-** A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool. [Section 2105(c)(10)(I] Does the State provide this option?

☐ Yes
☒ No

6.4.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.4.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.4.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance-** Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies. [Section 2105(c)(10)(K]

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality-** Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the

State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9.
[Section 2102(a)(7)(A); 42 CFR 457.495]

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. [2102(a)(7)(A); 42 CFR 457.495(a)] Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

•

Badger Care Plus has multiple quality assurance mechanisms to evaluate and improve HMO quality of care as a contracting condition prior to the start of the BadgerCare Plus contract and multiple monitoring mechanisms and performance incentives during the duration of the BadgerCare Plus HMO contract.

Certification Review as a Condition for BadgerCare Plus Contracting

Every HMO has to undergo an extensive certification review process conducted by the Department and its EQRO to assess HMO readiness to serve the BadgerCare Plus membership prior to the start of the contract period.

As part of the certification review process, the Department and the EQRO examine the processes and procedures the HMO has in place for:

- **Access to care**
- **Quality Improvement**
- **Provider Selection and Credentialing**
- **Member Outreach and Communication**
- **Protection of Member Rights**
- **Member Complaint and Grievance System**
- **Provider Appeals**
- **Data Administration and Reporting**
- **Language Access**

- **Care Management and Continuity of Care**

As part of the analysis on access to care, the Department evaluates the HMO network to determine if it has the capacity to adequately serve the BadgerCare Plus membership in their service area and meet the standards defined in Art. III, section H of the BadgerCare Plus Contract. First, the Department conducts a network analysis by HMO to ensure compliance with the distance requirements defined in the contract for access to primary care, behavioral health, hospital, dental, and urgent care. Second, the Department verifies that the HMO meets the minimum provider-to-member ratios for primary care, dental, and psychiatry provider specialties. Third, the Department reviews the HMO policies and procedures on waiting times especially for primary care, behavioral health, and dental as defined in the contract. Fourth, the Department analyzes the HMO processes to ensure that every BadgerCare Plus member has a primary care provider.

As part of the quality improvement evaluation, the Department and the EQRO review the following:

- **Quality Assurance and Performance Improvement Program (QAPI) – The most recent QAPI program description including its plan to meet pay-for-performance goals and develop Performance Improvement Projects annually, its QAPI committee structure, annual QAPI workplan, and related data.**
- **Clinical Practice Guidelines – Description of the guidelines used for utilization management and member education on health and disease management with a description of how the guidelines are made available to providers and members (upon request).**
- **Utilization Management (UM) and medical record review tools – A description of the UM tools used by the HMO and the HMO procedures to notify members of adverse actions (including urgent requests).**
- **Provider Selection and Credentialing – Policies and procedures to select providers that will be part of the HMO network ensuring that providers are BadgerCare Plus certified and that provider performance is taken into account for provider selection and retention.**

<u>Performance Monitoring Requirements in the BadgerCare Plus Contract</u>

Upon the start of the contract period, the HMO is responsible for meeting extensive BadgerCare Plus contract requirements on access to care, coordination of care, and quality of care. There are also multiple performance measurement and reporting mechanisms available to the Department to monitor quality of care and there is a pay-for-performance program that incentivizes HMOs to improve their performance on select quality measures.

- **Quality Assurance and Performance Improvement (QAPI) – Per Article IV of the BadgerCare Plus Contract, the HMOs are required to develop a QAPI program to evaluate and improve quality of care.**

- **Health Promotion and Disease Prevention – Per Art. IV, C of the BadgerCare Plus Contract, HMOs are required to identify at-risk population and provide health education and disease prevention to the BadgerCare Plus membership.**

- **Utilization Management – Per Art. IV, G of the BadgerCare Plus Contract, HMOs are required to have documented policies and procedures for all Utilization Management activities to determine medical necessity and the approval of services.**

- **Performance Monitoring – The Department utilizes the following performance monitoring tools for BadgerCare Plus HMOs:**

    - **Performance Improvement Projects (PIPs) – Submitted annually to the Department, the PIPs identify a focus area for improvement, a goal, the interventions implemented by the HMO to achieve the goal, and an evaluation of the effectiveness of the interventions with lessons learned. The HMOs usually select a PIP topic from the pay-for-performance focus areas. The Department and its EQRO review the PIPs annually and give feedback to the HMOs.**

    - **Pay-for-Performance – The Department introduced the pay-for-performance (P4P) program for BadgerCare Plus HMOs in 2009. Since then, the structure of the P4P program has changed significantly from an incentive to a withhold of monthly capitation payments. If HMOs do not meet the benchmarks for the different P4P measures in a given year, the HMO loses a certain portion of their monthly capitation payments. If the HMO meets all the goals in the P4P program for a given year, the HMO earns back the full withhold amount for that year and may qualify for a bonus (funded from forfeitures from other HMOs that do not meet all their P4P goals). The methodology used to set benchmarks for HMOs has also changed to align with Medicare's Value Based Purchasing initiative for hospitals. The number of measures included in the P4P program evolves year after year. The measures are primarily HEDIS measures that are part of the CHIPRA Core Set Measures for Children and the Medicaid Adult Core Set Measures with a few Wisconsin specific measures. The HEDIS measure Childhood Immunization Status has been consistently part of the P4P program since 2009.**

- **HealthCheck – HealthCheck is the Wisconsin name for the Early Periodic Screening Diagnostic Treatment (EPSDT) requirement. Per Art. III, K. HealthCheck, HMOs are required to provide HealthCheck screenings within 30 days. All HMOs are required to provide comprehensive HealthCheck screenings at 80% or higher which includes:**
    - **Health and developmental history**
    - **Physical examination**
    - **Vision and hearing screening**
    - **Dental screening and referral to a dentist from age one**
    - **Immunizations appropriate for age**
    - **Blood lead testing and other lab tests appropriate for age.**

  HealthCheck compliance is evaluated by the Department and reported to CMS annually. HMOs that fail to meet the 80% threshold are subject to a penalty.

- **Consumer Satisfaction Surveys – The Department also conducts consumer satisfaction surveys on the BadgerCare Plus population. The Department uses the CAHPS questionnaire and works with a CAHPS certified vendor to conduct the survey and analyze the results.**

- **Healthy Birth Outcomes – The Department launched the Obstetric Medical Home (OBMH) in 2011 to serve pregnant women in the counties with the highest rates of birth disparities in the state. Since 2011, the OBMH has expanded to additional counties. The goal of the OBMH is to provide comprehensive, coordinated prenatal and postpartum care to Medicaid members identified as high-risk, emphasizing member engagement in self-care. It has a specific focus on identifying and engaging African-American members to address long-standing disparities in birth outcomes and infant mortality. As an incentive, obstetric clinics serving as OBMH receive additional payment for timely enrollment of each high-risk member, and an additional payment if the delivery outcome is "good" as defined by the program. Quality of care is monitored by DHS' external quality review organization (EQRO) via quarterly chart reviews.**

  An OBMH Registry, a web-based tool to track Medicaid members enrolled in OBMH, is used by HMOs and the Department to determine clinic eligibility for reimbursement, and contains member demographics and limited clinical and birth outcome information. The Registry is managed by the EQRO.

- **HMO Report Card – After the P4P results are finalized, the Department creates an HMO Report Card comparing HMO performance across multiple quality metrics. The HMO Report Card is included in BadgerCare Plus member's enrollment packets to help members make an informed choice when selecting an HMO.**

- **EQRO Reports – The Department also monitors quality of care through reports from the EQRO to review HMO compliance with the federal Medicaid Managed Care requirements and additional requirements defined in the contract. The EQRO identifies strengths and areas of improvement opportunity for the HMO. If there are areas were the HMO failed to comply with any federal or state requirements, the HMO is put on a corrective action plan.**

- **Other Reports – The Department also monitors quarterly reports on member grievances to identify problems by HMO with access to covered services, denial of services, or quality of care. Additionally the Department tracks monthly encounter data submission reports, monthly enrollment trends, and quarterly reports on provider appeals to identify potential issues with access to care or quality of care.**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☑ Quality standards

7.1.2. ☑ Performance measurement

7.1.2(a) ☒ CHIPRA Quality Core Set

7.1.2(b) ☒ Other

7.1.3. ☑ Information strategies

7.1.4. ☑ Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. [Section 2102(a)(7)(B)]

7.2. Describe the methods used, including monitoring, to assure:
[2102(a)(7)(B); 42 CFR 457.495(a)]

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and

adolescent immunizations. [Section 2102(a)(7); 42 CFR 457.495(a)]

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The Department monitors *access to well-baby care* through the BadgerCare Plus HMO pay-for-performance (P4P) program which includes HEDIS measures for Prenatal and Postpartum Care and through the Obstetric Medical Home (OBMH) to improve healthy birth outcomes in areas with high birth disparities.

The Department has incorporated *childhood immunizations* into the BadgerCare Plus P4P program since 2009 and has seen sustained improvement in the HMO immunization rates over time.

***Well-child care, well-adolescent care* and *childhood and adolescent immunizations* are monitored as part of the HealthCheck requirement which is Wisconsin's name for the federal EPSDT requirement. HMOs are required to provide comprehensive HealthCheck screenings at a rate of 80% or above. HealthCheck performance is monitored by DHS annually and submitted to CMS every year. The Department is considering making changes to the BadgerCare Plus HMO P4P program in future years to include well-child care, well-adolescent care and adolescent immunizations HEDIS measures.**

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. [Section 2102(a)(7); 42 CFR 457.495(b)]

Per Art. III, E of the BadgerCare Plus Contract, HMOs are required to provide all Medicaid covered services as defined in Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and provide them in accordance with the principle of medical necessity defined in Wisconsin Administrative Code DHS 101.03(96m).

The Department has the following requirements on access to care and BadgerCare Plus covered services defined in Art. III, H, Provider Network and Access Requirements of the BadgerCare Plus Contract:

- **Use of BadgerCare Plus certified providers only in the HMO network.**
- **Waiting Times – Have written standards for access to care including defined maximum waiting times for primary care, behavioral health, and dental appointments.**
- **Distance Requirements – HMOs are required to meet the minimum distance requirements for primary care, behavioral health, dental, hospital, and urgent care.**
- **Ensure adequate access to Women's Health specialists**

- **Ensure adequate access to Tribal Health providers upon request**
- **Provider-to Member Ratio Requirements – For primary care, dentists, and psychiatry provider specialties.**

To monitor compliance with those requirements, the Department analyzes the HMO network to determine their adequacy to serve BadgerCare Plus members prior to the start of the BadgerCare Plus contract. As part of the network adequacy analysis, the Department creates provider count tables per HMO by county for multiple provider specialties to determine if the HMO complies with the minimum provider-to-member ratios and then develops maps by HMO and provider specialty to assess compliance with the minimum distance requirements defined in the contract for primary care, behavioral health, dental, hospital, and urgent care. If there are gaps, the Department recommends the HMO to strengthen their network in a particular county and does not grant approval to serve that county until the gap is addressed.

Afterwards, the Department evaluates the HMO policies and procedures on maximum waiting times for primary care, behavioral health, and dental care as well as their to processes to (a) ensure every BadgerCare Plus member has a primary care provider, (b) provide access to women's health specialists and (c) Tribal Health providers upon request.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. [Section 2102(a)(7); 42 CFR 457.495(c)]

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As part of Article IV. Quality Assessment and Performance Improvement of the BadgerCare Plus Contract, HMOs are required to identify at-risk population and conduct disease management and health education for members with chronic conditions. HMOs have to submit to the Department their policies and procedures to identify members with chronic conditions and coordinate care for them as part of the HMO readiness evaluation prior to the start of the BadgerCare Plus contract.

The Department also analyzes the HMO's network of specialists, calculates provider-to-member ratios and per Art. III, H. Provider Network and Access Requirements of the BadgerCare Plus Contract, requires the HMO to provide access to out-of-network providers when a medical service is not available through the HMO.

As part of pay-for-performance, the Department monitors HMO performance on

management of certain chronic conditions such as diabetes, behavioral health, high blood pressure, and dental care.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or**,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. [Section 2102(a)(7); 42 CFR 457.495(d)] Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Per Art. III, E of the BadgerCare Plus Contract, HMOs are required to provide all Medicaid covered services as defined in Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and provide them in accordance with the principle of medical necessity defined in Wisconsin Administrative Code DHS 101.03(96m). For BadgerCare Plus members that are not enrolled in HMOs, the Department works with medical consultants and benefit specialists staff to develop prior authorization guidelines that are available to providers and the public online via the ForwardHealth Portal (https://www.forwardhealth.wi.gov/WIPortal/Default.aspx). BadgerCare Plus HMOs have online access to the Department's prior authorization guidelines for fee-for-service members. HMOs use the online prior authorization guidelines to determine medical necessity and coverage of services.

Qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected enrollee's condition(s). Criteria used to determine medical necessity and appropriateness must be communicated to providers. The criteria for determining medical necessity may not be more stringent than DHS 101.03(96m) Wis. Adm. Code.

BadgerCare Plus HMOs are required to include member grievance information in all notifications to members about denial of services. Per Art. IX. Complaint, Grievance, and Appeal Procedures of the BadgerCare Plus Contract, HMOs are required to have written policies and procedures on resolving member grievances and appeals including an expedited process for urgent requests.

HMO's policies must specify time frames for responding to requests for initial and continued service determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed

services. In addition, the HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

a. Within the time frames specified, the HMO must give the enrollee and the requesting provider written notice of:

1) The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.

2) The enrollee's right to file a grievance or request a state fair hearing.

b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the enrollee's condition requires:

1) Within 10 business days of the receipt of the request, or

2) Within two business days if the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the enrollee's health or ability to regain maximum function.

One extension of up to 14 calendar days may be allowed if the enrollee requests it or if the HMO justifies the need for more information.

The Department monitors member grievances and complaints via quarterly reports.

Section 8. Cost Sharing and Payment

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO #09-006, issued May 11, 2009)

8.1.1. ☒ YES
8.1.2. ☐ NO**,** skip to question 8.8.

8.1.1-PW ☐ YES
8.1.2-PW ☒ NO**,** skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.40 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services.
[CHIPRA #2, SHO #09-006, issued May 11, 2009; Section 2103(e)(1)(A); 42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c)]

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. [Section 2103(e)(1)(A); 42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c)]

8.2.1. ☒ Premiums:

Premiums will be imposed upon children with monthly family income greater than 201% FPL. The rate is based upon family income and will not exceed 5% of monthly family income. Recipients will receive a notice telling them how much their premiums will be. Children ages 1 – 18, with
Incomes at or above 201 percent up to, but not including 231 percent of the FPL: $10;
Incomes at or above 231 percent up to, but not including 241 percent of the FPL: $15;
Incomes at or above 241 percent up to, but not including 251 percent of the FPL: $23;
Incomes at or above 251 percent up to, but not including 261 percent of the FPL: $34;

Incomes at or above 261 percent up to, but not including 271 percent of the FPL: $44;
Incomes at or above 271 percent up to, but not including 281 percent of the FPL: $55;
Incomes at or above 281 percent up to, but not including 291 percent of the FPL: $68;
Incomes at or above 291 percent up to, but not including 301 percent of the FPL: $82;
Incomes at 301 percent up to and including 306 percent of the FPL: $97.53.

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:

Description of Children Affected		
	Premium	**Co-payments**
Children ages 1 - 5 with incomes > 186% FPL up to and including 201% FPL	None	See Attachment 1, included at the end of Section 8
Children ages 6 - 18 with incomes > 151% FPL up to and including 201% of FPL	None	
Children ages 1 - 18 with incomes from 201 - 306% FPL	201 < 231% FPL - $10 231 < 241% FPL - $15 241 < 251% FPL - $23 251 < 261% FPL - $34 261 < 271% FPL - $44 271 < 281% FPL - $55 281 < 291% FPL - $68 291 - 301% FPL - $82 301 - 306% FPL – $97.53	

No cost sharing will be applied to unborn children.

8.2.3. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA #7, SHO #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. [Section 2103(e)(1)(A); 42 CFR 457.505(a), 457.510(b) and (c, 457.515(a) and (c), and 457.560(a)] Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. [Section 2103(e)(1)(A); 42 CFR 457.505(b)]

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

Outreach and application forms will include this information. Sections 5.1, and 9.9 provide detailed descriptions of our outreach efforts. In addition, the State informs providers and members (beneficiaries) of allowable cost sharing amounts via Provider Updates and member Enrollment and Benefits booklet.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: [Section 2103(e)]

8.4.1. ☑ Cost-sharing does not favor children from higher income families over lower income families. [Section 2103(e)(1)(B); 42 CFR 457.530]

8.4.2. ☑ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. [Section 2103(e)(2); 42 CFR 457.520]

8.4.3. ☑ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. [Section 2103(e)(1)(A); 42 CFR 457.515(f)]

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: [Section 2103(e)(3)(B); 42 CFR 457.560(b) and 457.505(e)]

The Department is currently in discussions with CMS about systematic solutions to track the 5% cap for the Medicaid population. The solution developed for Medicaid will also apply to CHIP.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. [Section 2103(b)(3)(D); 42 CFR 457.535]

The state ensures that American Indian and Alaska Native children, eligible for the separate SCHIP benefit, are excluded from cost-sharing by assigning them an eligibility code that identifies them as such. This identifying information is retained in the Medicaid Management Information System (e.g., claims processing and eligibility file) which automatically exempts all cost-sharing.

Providers are notified of this requirement via written Updates and through the various eligibility verification methods available in the state. Families identify their children as Alaskan Natives or American Indian Tribal members through the application process.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. [42 CFR 457.570 and 457.505(c)]

Premiums

Each family is sent an invoice in the tenth day of the month prior to the month in which the premium is due. When a family does not pay their premium by the date required (the 10th of the month for which it is due), the family is sent a termination notice that indicates that they must pay the premium by the end of the calendar month or lose eligibility for those members for whom the premium is owed. If they pay by the end of the month, eligibility is not interrupted. If the family pays the premium by the end of the following month, their eligibility is restored without any gaps. However, if the family does not pay by the end of the month after the calendar month in which the premium was due, the individuals for whom the premium was owed cannot be restored to benefits until:

1. **The end of the six month after which benefits were lost, so long as they pay the premium arrears or 12 months after benefits were lost without paying the premium arrears amount;**
2. **The beginning of the month following an adult caretaker's absence from the home for 30 consecutive days;**
3. **The beginning of the month in which the family's income dips below the premium requirement limit of 201% of the Federal Poverty Level; or**
4. **Immediately, if the reason the premium payment was not made was beyond the control of the family.**

Good cause reasons for not paying the BadgerCare Plus premium are:

- **Problems with the financial institution.**
- **System problem.**
- **Local agency problem.**
- **Wage withholding problem.**
- **Fair hearing decision.**

Copayments

None. Providers may not deny services for lack of payment.
Providers are permitted to reduce or waive cost sharing on a case-by-case basis, if the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their right and responsibilities with respect to payment of premiums. [Section 2103(e)(3)(C)]

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. [42 CFR 457.570(a)]

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. [42 CFR 457.570(b)]

8.7.1.3. ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. [42 CFR 457.570(b)]

8.7.1.4. ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. [42 CFR 457.570(c)]

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: [Section 2103(e)]

8.8.1. ☒ No Federal funds will be used toward state matching requirements. [Section 2105(c)(4); 42 CFR 457.220]

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward state matching requirements. [Section 2105(c)(5); 42 CFR 457.224] (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. [Section 2105(c)(6)(A); 42 CFR 457.626(a)(1)]

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. [Section 2105(d)(1); 42 CFR 457.622(b)(5)]

8.8.5. ☒ No funds provided under this title or coverage funded under this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. [Section 2105(c)(7)(B); 42 CFR 457.475]

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). [Section 2105(c)(7)(A); 42 CFR 457.475]

Attachment 1
Co-payment Table

Service/Item	Co-payment	Limitations/Cumulative Maximum
Ambulance Services	$2 for non-emergency trip only	n/a
Ambulatory Surgery Services	$3 per surgery	n/a
Case Management Services	No co-payment	n/a
Chiropractic Services	$0 to $3 per procedure	Co-payment obligation depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service: **Fee** — **Co-payment** $10 or less……$0.50 $10.01 to $25……....$1.00 $25.01 to $50……....$2.00 $50.01 or more…….….$3.00
Clozapine Management	No co-payment	n/a
Community Support Program	No co-payment	n/a
Comprehensive Community Services (CCS)	No co-payment	n/a

Service/Item	Co-payment	Limitations/Cumulative Maximum
Crisis Intervention	No co-payment	n/a
Dental Services	$0.50 to $3 per service	Co-payment obligation depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service: **Fee** **Co-payment** $10 or less…….$0.50 $10.01 to $25……....$1.00 $25.01 to $50……....$2.00 $50.01 or more…….….$3.00
Disposable Medical Supplies	$0.50 per item	n/a
Drugs	Over-the-counter (OTC): $0.50 Generic: $1.00 Brand name: $3.00	▪ Co-payment obligation limited to $12 per month, per member, per provider ▪ OTCs are excluded from this $12 per month maximum
Durable Medical Equipment	$0.50 to $3 per service	▪ Co-payment amount is based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the item: **Fee** **Co-payment** $10 or less…….…….$0.50 $10.01 to $25……..$1.00 $25.01 to $50…….....$2.00 $50.01 or more……..….$3.00

Service/Item	Co-payment	Limitations/Cumulative Maximum
		▪ DME rental items are not subject to co-payment.
Family Planning Services and Supplies	No co-payment	n/a
HealthCheck Screenings (EPSDT) for Children under age 21 years.	No co-payment	n/a
Hearing Services	$0.50 to $3 per procedure	▪ Co-payment amount depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00 $25.01 to $50……...$2.00 $50.01 or more…….$3.00 ▪ No co-payment obligation for hearing aid batteries
Home Health Services	No co-payment	n/a

Service/Item	Co-payment	Limitations/Cumulative Maximum
Hospice Services	No co-payment	n/a
Hospital Services - Inpatient	$3 per day	Co-payment obligation limited to $75 per stay.
Hospital Services - Outpatient	$3 per visit	Multiple visits to the same provider on the same day are treated as a single visit.
Mental Health and Substance Abuse Outpatient Treatment	$0.50 to $3 per visit	▪ Visit co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……....$1.00 $25.01 to $50……...$2.00 $50.01 or more……$3.00 ▪ Co-payment obligation limited to the first 15 hours or $ 825 of services, whichever comes first, per calendar year. ▪
Mental Health Day Treatment Services	$0.50 per day	Co-payment obligation limited to the first 15 hours or $ 825 of services, whichever comes first, per calendar year.
Narcotic Treatment Services	No co-payment	n/a

Service/Item	Co-payment	Limitations/Cumulative Maximum
Nursing Home Services	No co-payment	n/a
Personal Care Services	No co-payment	n/a
Occupational Therapy	$0.50 to $3 per procedure	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00 $25.01 to $50……...$2.00 $50.01 or more……$3.00 • Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year.
Physical Therapy	$.50 to $3 per procedure	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00 $25.01 to $50……...$2.00 $50.01 or more……$3.00 • Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year.

Service/Item	Co-payment	Limitations/Cumulative Maximum
Physician Services (including Nurse Midwife, Nurse Practitioner, Laboratory and Radiology services)	$0.50 to $3 per service, except allergy testing co-payment is applied per date of service	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00 $25.01 to $50……...$2.00 $50.01 or more……$3.00 ▪ The co-payment obligation for physician services is limited to $30 per member, per provider, per calendar year. ▪ There is no co-payment for : ▪ Anaesthesia services. ▪ US Preventive Services Task Force (USPSTF) recommendations with an A or B rating. ▪ Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). ▪ Emergency services.
Podiatry Services	$.50 to $3 per visit	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less……$0.50

Service/Item	Co-payment	Limitations/Cumulative Maximum
		$10.01 to $25……..……...$1.00 $25.01 to $50……..……...$2.00 $50.01 or more……..…….$3.00 • Limited to $30 per member, per provider, per calendar year
Private Duty Nursing	No co-payment	n/a
Respiratory Care Services	No co-payment	n/a
Specialized Medical Vehicle (SMV) Services	$1 per trip	n/a
Speech and Language Pathology	$0.50 to $3 per procedure	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: **Fee** **Co-payment** $10 or less…….……$0.50 $10.01 to $25……..……...$1.00 $25.01 to $50……..……...$2.00 $50.01 or more……..…….$3.00 • Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year.
Vision Care Services	$0.50 to $3 per service	▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided:

Service/Item	Co-payment	Limitations/Cumulative Maximum
		Fee **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00 $25.01 to $50……...$2.00 $50.01 or more…….…….$3.00

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: [Section 2107(a)(2); 42 CFR 457.710(b)]

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

Wisconsin's BadgerCare Plus program will attempt to address four fundamental goals:

1) **Increased access to coverage**
2) **Increased access to services**
3) **Improved health outcomes and quality of care**
4) **Improved delivery systems impacts**

BadgerCare Plus Goals.

Access to coverage: Some families who join the workforce have access to affordable, employer-sponsored health care. For many others, however, access and affordability is an issue. Through a comprehensive, integrated program, BadgerCare Plus builds a bridge between Medicaid and employer-sponsored health care coverage, just as welfare reform has transformed the ties between welfare and work.

To preserve access to health care for low-income families and children, BadgerCare Plus recognizes that a majority of low-income families work, that current BadgerCare Plus and AFDC income standards required for Medicaid are significantly less than the minimum wage, and that health care is not always accessible or affordable through employment. Through strengthening the ability of both parents to be employed and to care for their children, BadgerCare Plus supports the transition to independence.

In addition, given the different and more generous standards for W-2 and the complexity and intricacies of former AFDC rules, many low-income families are no longer eligible for Medicaid based on prior AFDC standards or no longer understand that they may be eligible under obsolete, confusing AFDC standards.

Just as welfare reform is now experimenting with creative links between cash assistance and employment, BadgerCare Plus is an innovative and progressive model to effectively integrate Medicaid with employment-based health insurance. BadgerCare Plus builds upon the intent of Title XXI to accomplish this integration.

BadgerCare Plus will provide access to health care, without supplanting private insurance by incorporating the following mechanisms:

- **Applicants who are covered under a health insurance plan as defined in HIPAA will not be eligible for BadgerCare Plus.**
- **Applicants who have access to coverage under family health insurance subsidized by an employer at 80% or more of the premium cost will not be eligible for BadgerCare Plus.**
- **Applicants who were covered during the six months prior to application under employer family health insurance plans meeting HIPPA standards for family coverage will be ineligible for BadgerCare Plus. However, exceptions will be made where prior coverage ended due to reasons unrelated to the availability of BadgerCare Plus. These reasons include, but are not limited to:**
  - **Loss of employment due to factors other than voluntary termination;**
  - **Change to a new employer that does not offer family coverage;**
  - **Change of address so that the individual is now outside the employer-sponsored insurance plan's service territory;**
  - **Discontinuation of health benefits to all employees by the applicant's employer; and**
  - **Expiration of COBRA coverage period.**
- **The Department intends to purchase family coverage made available by the employer of members of an eligible family when the employer's contribution is greater than 40% but less than 80%. This will only occur when the Department determines that purchasing the employer coverage would be more cost-effective than providing the coverage directly under BadgerCare Plus. The cost effectiveness will compare the cost to the State to buy in to the employer's plan versus the cost to directly provide coverage to the recipient.**
- **The Wisconsin Medicaid fiscal agent will notify the applicant, employer, insurance company, if necessary and the involved certifying agency of the cost-effectiveness decision and terms of the agreement.**
- **The Wisconsin Medicaid fiscal agent will establish a communication protocol with each employer regarding notification of the applicant's employment, coverage levels and premium amounts.**
- **The Wisconsin Medicaid fiscal agent will monitor employers' health insurance plans for open enrollment periods and will conduct an employer telephone inquiry**

to obtain the necessary cost-effectiveness information to facilitate insurance buy-in when available.

- **The Wisconsin Medicaid fiscal agent will gather information regarding the applicant's access to and/or participation in the employer's health insurance plan beyond the previous six-month period for informational purposes only. EDS and Department staff will monitor this information for crowd-out impact.**

- **The Wisconsin Medicaid fiscal agent will verify health insurance coverage through the existing insurance exchange process with insurance carriers and telephone inquiries. EDS currently electronically exchanges insurance information with 95% of the insurance carriers, by market share in the state.**

If the verification shows that BadgerCare Plus family members are currently covered or were covered within the past six months by an insurance plan meeting HIPAA standards, or currently have access to such a plan, subsidized at 80% or more of the premium cost, eligibility for BadgerCare Plus ends.

If the verification shows that BadgerCare Plus family members have access to (but not coverage) employer family health insurance coverage subsidized at less than 80% of the premium cost, they continue to receive BadgerCare Plus benefits on a fee-for-service basis, pending qualification for the HIPP Program

Participating families with incomes at or above 150% FPL will be assessed a premium cost share of 5% of their monthly family income.

- **The Department will limit eligibility to those families whose income does not exceed 185% FPL. Employer-subsidized health insurance is not common among families with incomes this low.**

- **A provision of 1995 Wisconsin Act 289 required Wisconsin employers offering employee health insurance to include all employees. This was designed to prevent employers from offering a health insurance plan to only higher-compensated employees.**

- **Wisconsin has legislation pending to create a small employer insurance pool.**

While we believe the measures listed above will be sufficient to prevent crowd-out, implementation of BadgerCare Plus will be carefully monitored to assess any adverse impact BadgerCare Plus may create for both employee use of employer-subsidized coverage, and employer reductions in coverage for workers. Monitoring can be done using reports produced by the Department's Center for Health Statistics. If it appears additional measures are needed, the state will

investigate the following mechanisms as additional tools to use in preventing insurance crowd-out:

- **Establishing limited entry/enrollment periods for BadgerCare Plus. This will encourage employees to purchase ongoing medical care through employer-subsidized insurance, rather than depending on BadgerCare Plus exclusively for episodes of ill health.**

- **Enactment of insurance reforms to encourage coverage of all employees. The Department intends to continue working with employers and the state Office of the Commissioner of Insurance to encourage broad-based health coverage of all employees.**

<u>Access to services</u>: Through BadgerCare Plus, the Department will integrate employer health care and Medicaid without supplanting private insurance. This will help to assure access to health care for all low-income families who do not have employer insurance. Access is balanced with personal responsibility through cost-sharing.

<u>Health outcomes and quality of care</u>: The major goal of BadgerCare Plus is to improve the health of Wisconsin's low-income families with children by providing access to affordable health care for low-income families with children. We expect to improve health outcomes and reduce unnecessary and uncompensated health care costs by establishing a medical "home" for all low-income families and children, thereby strengthening health care prevention in the community.

To measure these health outcomes, we will use the same HEDIS measures as we do for the current AFDC-related/Healthy Start HMO program.

Wisconsin's HMO program currently provides financial incentives to participating HMOs that provide the targeted number of HealthCheck screens to enrolled eligible children. The HMO contract and capitation rate provides additional funds to HMOs to meet targeted levels of screening equal to 80 percent of those eligible. Funds are recouped at the close of the contract year if the HMO does not meet the required target. The HMOs have the financial incentive to meet the screening targets and retain the HealthCheck funds. A HealthCheck screening requirement and financial incentive will be a requirement of HMOs serving the BadgerCare Plus population.

In addition, the Department is in the planning stages of establishing a series of performance-based contract measures designed to enhance quality of care and administrative efficiencies. The system will initially be limited to four or five measures that are attainable and consistent with established guidelines and

standards. A bonus payment system is being planned for the 1999 contract year for the AFDC/Healthy Start HMO program and possibly for BadgerCare Plus HMO programs. This bonus system will provide financial incentives to HMOs that meet performance targets. HMOs that fall below minimum performance standards will not be eligible for the incentive payments.

We are currently considering linking HMO bonus payments to meeting new performance targets that address the health needs of women and children by assuring that HMOs provide PAP and STD screening and childhood immunizations at appropriate rates and intervals. If there is sufficient time to develop initiatives for BadgerCare in 1999, we will consider implementing performance standards in the year 2000.

Delivery systems impacts: As part of the BadgerCare Plus program, Wisconsin will make an effort to further streamline eligibility procedures. The BadgerCare program will build upon the success of the State's program of HMO enrollment for health care. BadgerCare Plus will provide Wisconsin Medicaid's comprehensive benefits and services through a health care delivery system with strong quality assurance safeguards.

Currently, 18 licensed HMOs in Wisconsin participate in the Wisconsin Medicaid HMO program. Medicaid-certified HMOs will participate in all of the State's 72 counties (fee-for-service remains in the two small, rural counties). With clear and measurable performance standards, and ongoing, continuous quality improvement activities, the Wisconsin Medicaid HMO program has demonstrated improved health outcomes. The Wisconsin Medicaid HMO contract for low-income families with children is frequently identified as one of the best in the nation.

BadgerCare Plus will prevent crowd-out of private insurance by buying employees into employer-based group health coverage when it is available and it is cost-effective to do so. In these situations, BadgerCare Plus will provide wraparound services to BadgerCare Plus recipients in employer health insurance plans up to the Medicaid benefit level, including any deductibles, coinsurance, and copayments that may be imposed on the employee by the employer's health insurance plan.

9.2. Specify one or more performance goals for each strategic objective identified: [Section 2107(a)(3); 42 CFR 457.710(c)]

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g. ages <1, 1-9, 10-19), are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

As described in response to question 9.1, BadgerCare Plus will promote the achievement of the following four goals:

1) **Increasing access to coverage**
2) **Increasing access to services**
3) **Improved health outcomes and quality of care**
4) **Improved delivery systems impacts**

Access to health care coverage. BadgerCare Plus will increase the number of insured Wisconsin residents, primarily children. BadgerCare Plus will increase the number of children insured by enrolling entire families. BadgerCare Plus will improve the outreach to and increase the enrollment of Medicaid-eligible children and adults.

BadgerCare will not cause crowd out. That is, persons who enroll in BadgerCare Plus will not drop other insurance coverage in order to participate in BadgerCare Plus. Employers will not change the coverage they offer in response to the availability of BadgerCare Plus.

We do not believe adverse selection will be an issue in the implementation of

BadgerCare Plus. Disabled children will continue to be eligible for Medicaid through the State's categorical and medically needy provisions for SSI-related recipients. We believe enrollees in BadgerCare Plus will report that they are satisfied with the price they have to pay for coverage and the choice of coverage available to them.

<u>Access to services</u>. Wisconsin predicts that BadgerCare Plus will produce positive results relating to access to services. A greater share of BadgerCare Plus enrollees will have a primary care physician than the general public. Utilization of services patterns for BadgerCare Plus enrollees will be enhanced by linking recipients to a "medical home." BadgerCare Plus and Medicaid enrollees will report satisfaction with the simplified eligibility process. BadgerCare Plus enrollees will report that they are satisfied with their access to services as measured by criteria such as waiting times for appointments. Enrollees in BadgerCare Plus will be satisfied with their ability to get referrals to specialists. Pregnant women enrolled in BadgerCare Plus will have greater access to prenatal care services than a comparison population.

<u>Health outcomes and quality of care</u>. Wisconsin predicts that BadgerCare Plus will produce positive results relating to health outcomes and quality of care. BadgerCare Plus enrollees will self-report improved health status. BadgerCare Plus enrollees will utilize more preventive and primary care services than a comparison population. BadgerCare Plus enrollees will have greater continuity of care than a comparison population. BadgerCare Plus enrollees will have fewer preventable hospitalizations than a comparison population. Enrollees in BadgerCare Plus will report they are satisfied with the quality of care they receive.

<u>Delivery system impacts</u>. Wisconsin predicts that BadgerCare Plus will produce positive results relating to delivery system impacts. BadgerCare Plus will not result in employers reducing their health insurance benefit packages. Persons enrolling in BadgerCare Plus will not drop existing coverage to enroll in BadgerCare Plus. Enrollment in BadgerCare Plus will increase the likelihood of obtaining employment. Enrollment in BadgerCare Plus will reduce the likelihood that an enrollee will utilize welfare services. BadgerCare Plus will result in greater HMO capacity in Wisconsin. BadgerCare Plus will result in long-term savings for the Medicaid program.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
[Section 2107(a)(4)(A),(B); 42 CFR 457.710(d)]

Evaluation Plan

A workgroup would be created to develop the evaluation plan including defining the specific research questions, hypothesis, the data analysis sources, and the statistical methodologies to respond to the research questions.

Data Sources

The analysis plan would use a variety of approaches and multiple data sources. The primary data sources will be the encounter data system, the FFS claims system, Interchange, and the CARES system. Some analyses may require primary data collection via a survey .

Baseline Data

The state will create baselines on enrollment, utilization, and costs. Data from the CARES system will be used to analyze BadgerCare Plus eligibility, Managed Care enrollment trends will be evaluated from Wisconsin's Interchange system and data from the encounter data system and the fee-for-service claims system will be used to analyze costs and utilization patterns on areas like inpatient stays and Emergency Department usage.

For health care outcomes information, the Department will use pay-for-performance data for BadgerCare HMOs on keyperformance measures such as:

- **HEDIS childhood immunizations**
- **HEDIS diabetes care**
- **HEDIS mental health and substance abuse**
- **HEDIS prenatal and postpartum care**
- **HEDIS dental care for children**
- **HEDIS emergency room visits measure**
- **Wisconsin's EPSDT requirement "HealthCheck"**
- **Wisconsin data on birth outcomes (from the Birth Outcomes Registry Network)**
- **Wisconsin data on asthma management**

With the data available, the State will be able to analyze BadgerCare access and utilization data and compare it to national and regional benchmarks as well as state averages.

Data collection

The primary sources of data envisioned for this evaluation are as follows:

- **Surveys - An enrollee satisfaction survey could be administered to obtain data to test a number of hypotheses. The survey will provide information on enrollees' satisfaction with their choice of plan, the care they receive, the accessibility of care and the quality of care.**
-
- **Enrollment and Utilization Trends - Enrollee and service specific data will be generated for BadgerCare enrollees as baseline data for inpatient and Emergency Department utilization. For enrollment trends, data on BadgerCare Plus eligibility will be used and data on HMO enrollment and churn obtained from the CARES system and Interchange. For utilization trends, data on inpatient stays, Emergency Department, and other key areas of focus will be used from the encounter data system and the FFS claims system. Performance Measurement – Data from the BadgerCare Plus pay-for-performance (P4P) program will be used to monitor improvement in health care outcomes and quality of care as well as data from consumer satisfaction surveys, HealthCheck, and birth data. Some of the P4P data will be reported by HMOs but audited by their HEDIS vendor. Other data will be extracted from the HMO encounter data system and the FFS claims system. Consumer satisfaction surveys will be conducted by a CAHPS certified vendor.**
- **Cost Trends – BadgerCare Plus members utilizations and costs will be looked at on an ongoing baseline to analyze the cost-effectiveness of the program. The data will be obtained from the encounter data and FFS claims systems.**
- **Special reports - Special ad hoc reports will be designed based on claims or aggregate HMO reporting. These reports can be used to monitor BadgerCare performance on various utilization and health status measures. Sentinel indicators will be identified and included in these reports.**

Check the applicable suggested performance measurements listed below that the State plans to use: [Section 2107(a)(4)]

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☐ The reduction in the percentage of uninsured children.

9.3.3. ☐ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

For health care outcomes information, the Department will use pay-for-performance data for BadgerCare HMOs on key performance measures such as:

- **HEDIS childhood immunizations**
- **HEDIS diabetes care**
- **HEDIS mental health and substance abuse**
- **HEDIS prenatal and postpartum care**
- **HEDIS dental care for children**
- **HEDIS emergency room visits measure**
- **Wisconsin's EPSDT requirement "HealthCheck"**
- **Wisconsin data on birth outcomes (from the Birth Outcomes Registry Network)**
- **Wisconsin data on asthma management.**

To monitor member satisfaction, data from the CAHPS survey on children will be used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- **9.3.7.1.** ☑ Immunizations
- **9.3.7.2.** ☑ Well childcare
- **9.3.7.3.** ☑ Adolescent well visits
- **9.3.7.4.** ☑ Satisfaction with care
- **9.3.7.5.** ☑ Mental health
- **9.3.7.6.** ☑ Dental care
- **9.3.7.7.** ☑ Other, please list: **Please see response to # 9.3.6.**

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. [Section 2107(b)(1); 42 CFR 457.720]

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and

reports. [Section 2107(b)(2); 42 CFR 457.750]

The data sources and analysis plan described in the response to Question 9.3 will provide the information necessary to prepare these reports.

In addition, to obtain information about children without creditable coverage, we will rely on the *Wisconsin Family Health Survey*, which was discussed extensively in Section 2.1. As indicated in section 2.1, the survey was started in 1989 to collect information on the health status, health problems, health insurance coverage, and use of health care services among Wisconsin residents. The survey will create the baseline data on children without creditable coverage sufficient to provide the information requested in the table to Section 10.1.

United States Census data will also be used to create the baseline information needed to evaluate the success of BadgerCare.

Further, the Department is creating a data warehouse. This warehouse will compile data from the CARES system and from Medicaid. This warehouse should be up and running by the year 2000.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42 CFR 457.720)**

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. [42 CFR 457.710(e)]

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: [Section 2107(e); 42 CFR 457.135]

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and

taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. [Section 2107(c); 42 CFR 457.120(a) and (b)]

Public Process

1. Public Meetings and Hearings

Since the announcement of the BadgerCare Plus initiative in January, the State has worked diligently to inform Wisconsin citizens about the proposal as well as to seek input into its design. We have formed a BadgerCare Plus Advisors Group, conducted focus groups with current and potential members and with providers, and held town hall meetings across the state. This effort is described below in the following sections.

The BadgerCare Plus Advisors Group is responsible for providing guidance and advice to the State on all policy and program design issues. The group has met eight times during the development of BadgerCare Plus to review and discuss recommendations from the internal Steering Committee and offer suggestions for improvements. Each of these two-hour sessions was a public meeting. The Advisors Group includes representatives from business, health plans, providers, public health, farmers, Native American tribes, the State Legislature, faith-based organizations, county government, children's advocacy groups, and the University of Wisconsin. The Advisors Group includes:

Bevan Baker, City of Milwaukee Health Department
Melissa Duffy, Wisconsin Federation of Cooperatives
Donna Friedsam, University of Wisconsin Population Health Institute
Sabrina Gentile, Wisconsin Farm Bureau Federation
Representative Curt Gielow and Representative Jon Richards, Wisconsin State Assembly

Michael Jacob, Covering Kids and Families—Wisconsin
Nyree Kedrowski and Lori Pidgeon, Ho-Chunk Nation
Ed Kamin, Kenosha County Department of Human Services
Dr. John Meurer and Dr. Glenn Flores, Medical College of Wisconsin
Senator Mark Miller and Senator Dan Kapanke, Wisconsin State Senate
Father Thomas Mueller, St. Cyril and Methodist Orthodox Church, Milwaukee
Paul Nannis, Aurora Health Care
Jon Peacock, Wisconsin Council on Children and Families
Bobby Peterson, Advocacy and Benefits Counseling (ABC) for Health, Inc.
David Riemer, Wisconsin Health Project
Bill Smith, National Federation of Independent Business
Dr. Susan Turney, Wisconsin Medical Society
Nancy Wenzel, Wisconsin Association of Health Plans

Wisconsin has also held eight focus group discussions to identify problems with current programs, suggest improvements, and provide feedback on concepts and strategies proposed for BadgerCare Plus. One group was composed of BadgerCare Plus and Medicaid providers from throughout Wisconsin. The remaining seven groups, with representatives from thirteen communities across the state, were composed of low-income families, both individuals currently enrolled in Family Medicaid, BadgerCare and Healthy Start, and parents without current health insurance coverage. Each focus group included 15-20 individuals and lasted an average of one and one-half hours. Each participant received a stipend of $20 to offset transportation and/or child care expenses.

The provider group included representatives from HMOs and physicians. Responses revealed that providers remain concerned about 'no-shows,' that reimbursement rates are too low, and that Medicaid patients are often difficult to treat due to their chaotic lives. A key theme among the group was the need for patients to have a primary care physician. A second theme was the need to help patients understand the importance of getting and staying healthy, and using incentives as one strategy for achieving this goal. The lack of access to dental care and mental health services was a third theme of the discussion.

Findings from the participant groups indicated a preference for submitting applications by mail or over the telephone; some individuals expressed appreciation for face-to-face appointments because it allows them an opportunity to ask questions and get immediate answers. As expected, key reasons for the lack of health insurance were high premiums and/or employers not offering insurance. When asked about their willingness to participate in smoking cessation or weight management programs, the majority of participants expressed an interest and suggested that State health programs partner with local gyms, the YWCA, or fitness centers to encourage individuals to use these

benefits.

As noted earlier, each group acknowledged the importance of dental coverage and the continuing difficulty of finding a dentist who would accept their Medicaid card. One participant noted that in her community, individuals were placed on waiting lists for up to two years for routine dental care. Many participants said that access to dental care would not be an issue if they had private insurance.

Finally, several participants in each group felt that they were treated differently in health care settings than individuals with private insurance. Other findings include: satisfaction with Wisconsin's existing programs, concern that single adults would not be included in BadgerCare Plus, and concern that increased co-payments would have a negative impact on their family. See Appendix E for specific focus group questions.

Wisconsin Executive Order #39, issued in February 2004, affirms the government-to-government relationship between the State of Wisconsin and the eleven American Indian tribal governments located within the State of Wisconsin. The "Department of Health and Family Services Policy on Consultation with Wisconsin's Indian Tribes," developed by consensus with the Wisconsin tribes, formalizes the tribal-state relationship. Wisconsin has sent an invitation to all Wisconsin tribes to participate on the BadgerCare Plus Advisors Group and two tribal representatives are participating.

Governor Doyle, Lieutenant Governor Barbara Lawton, and Secretary Helene Nelson hosted twenty town hall meetings across the state throughout the planning process to discuss the new program, gather comments about existing programs, and obtain input from interested parties. Each town hall meeting included current Medicaid/BadgerCare participants, health care providers, county staff, advocates, reporters, and others. BadgerCare Plus cards with the program's e-mail address were distributed at each meeting and participants were encouraged to send written comments. Two or three e-mails are received daily via this site. The town hall meetings were developed in partnership with the Wisconsin Council on Children and Families and ABC for Health, Inc. The list of sites and presenters follows.

January 18th, 2006	**Marshfield**	**Secretary Nelson**
January 19th, 2006	**Rhinelander**	**Secretary Nelson**
January 20th, 2006	**Baraboo**	**Secretary Nelson**
January 30th, 2006	**Beloit**	**Secretary Nelson**
May 2nd, 2006	**Green Bay**	**Secretary Nelson and Jason Helgerson**

June 14th, 2006	**Wausau**	**Governor Doyle and Secretary Nelson**
June 21st, 2006	**Racine**	**Governor Doyle and Jason Helgerson**
July 20th, 2006	**Eau Claire**	**Governor Doyle and Secretary Nelson**
July 20th, 2006	**Superior**	**Governor Doyle and Jason Helgerson**
July 24th, 2006	**Beloit**	**Governor Doyle and Jason Helgerson**
July 25th, 2006	**Prairie Du Chien**	**Governor Doyle and Secretary Nelson**
July 31st, 2006	**Shawano**	**Lt. Governor Lawton**
August 1st, 2006	**Jefferson**	**Secretary Nelson**
August 4th, 2006	**Portage**	**Secretary Nelson**
August 8th, 2006	**Oshkosh**	**Secretary Nelson**
August 14th, 2006	**Milwaukee, Northside**	**Governor Doyle and Secretary Nelson**
August 15th, 2006	**Madison**	**Lt. Governor Lawton and Secretary Nelson**
August 23rd, 2006	**Ashland**	**Secretary Nelson**
August 24th, 2006	**Antigo**	**Lt. Governor Lawton and Secretary Nelson**
September 5th, 2006	**Milwaukee, Southside**	**Lt. Governor Lawton and Secretary Nelson**

Since September 5th, 2006, Governor Doyle, Lieutenant Governor Lawton, Secretaries Nelson and Hayden and Jason Helgerson have conducted eight additional town hall meetings.

January 31st, 2007	**Oshkosh**
March 8th, 2007	**Green Bay**
March 22nd, 2007	**Eau Claire**
April 5th, 2007	**Verona**
April 13th, 2007	**Kenosha**
April 16th, 2007	**Wausau**
April 23rd, 2007	**Racine**
April 23rd, 2007	**Polk County**
May 3rd, 2007	**La Crosse**
May 4th, 2007	**Green Bay**
May 14th, 2007	**Stevens Point**
June 20th, 2007	**Waukesha**

In addition to legislative participation on the BadgerCare Plus Advisors Group, several legislators participated in the town hall meetings. As development of the proposal continues, the Department will provide briefings for members of the Wisconsin State Legislature.

The Department has also arranged individual briefings for interested legislators and/or their staff and the Legislative leadership. Special outreach has been conducted for legislators on key committees, including the Joint Committee on Finance; Senate Committee on Health, Children, Families, Aging and Long Term Care; the Assembly Committee on Health; the Assembly Committee on Children and Families; and the Assembly Committee on Medicaid Reform.

2. **<u>Communication and Feedback Process for Public Meetings, Hearings, and Other Interested Parties, Including Written Comments/Response</u>**

   The Department has had and will have a comprehensive set of procedures to communicate with various parties on our proposal for BadgerCare and to receive and discuss feedback on BadgerCare received from these parties.

   - **Feedback Process for Public Meetings, Hearings, and Other Interested Parties, Including Written Comments/Responses**

     In our meetings with various interested parties, and in our distribution of various written BadgerCare documents, we have solicited written questions, ideas, and concerns about BadgerCare from any interested parties.

     In addition to input received at Town Hall meetings and at the BadgerCare Plus Advisors Group meetings described above, the Department has received many written questions and concerns about BadgerCare from various individuals and organizations. We have found these questions and concerns fruitful, in that they have helped Department staff focus on addressing various implications, permutations, and impacts of BadgerCare Plus that were not immediately apparent.

     Throughout the course of BadgerCare development and implementation, we envision continued verbal and written feedback from interested parties, and will use question and answer documents and/or individual policy statements to respond.

3. **<u>Coordination of BadgerCare Plus with Native Americans</u>**

The Department has extensive experience working closely with Native Americans in developing and implementing State health programs.

For statewide Medicaid HMO implementation, Department staff met with tribal health directors over an 18-month period to coordinate HMO expansion with the needs of the tribes and with Indian Health Service responsibilities. A special disenrollment procedure was developed for tribal members that involves close coordination with Indian Health Clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non-HMO affiliated Indian Health Clinics could still be reimbursed by Medicaid FFS funds for services provided to tribal members enrolled in HMOs, so that Indian Health Service funds would not be jeopardized by the expansion of the HMO program.

The Department Secretary meets with tribal leaders at least every six months to discuss health care related issues. We use these meetings to solicit input and provide information to the tribes on BadgerCare Plus. In particular, tribes may be interested in buying into BadgerCare Plus on behalf of their tribal members who are subject to cost sharing. Department staff is also included in a monthly work group with tribal health directors to focus on health care issues identified by the tribal leaders and the Department Secretary in their semi-annual meetings.

Department staff attends regular meetings with the Great Lakes Inter-Tribal Council, Inc. (GLITC Inc.) and individual tribal health clinics to discuss various aspects of BadgerCare and its impact on the Indian Health Service. In addition, staff attends regular meetings of the Council on American Indian Health and the soon to be established Wisconsin American Indian Forum. The forum, as its predecessor the Council, will meet monthly to explore a wider range of issues including social service issues.

The Department plans to extend the current special procedures for Native Americans that we have in the Medicaid managed care program to the BadgerCare program. Additional special procedures might also be required for Native Americans in BadgerCare. Our goal is to assure that BadgerCare is coordinated with Indian Health Service benefits and funding sources so that IHS benefits and funds are used most effectively for those Native Americans that do not have alternative sources of health care.

4. <u>BadgerCare Plus Public Notices</u>

Providers and recipients are informed of BadgerCare Plus changes in the form of member updates and letters.

9.9.1. Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions.
[Section 2107(c); 42 CFR 457.120(c)]

Please see paragraph 3. in the previous response, to Question # 9.9.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

The cost sharing changes in this plan amendment were part of the BadgerCare Plus program which was created by 2007 Wisconsin Act 20. Public notice procedures were part of the legislative process. Legislative committee meetings, including those in which bill hearings are conducted, must comply with the Wisconsin open meetings law. This law generally requires that notice be given at least 24 hours prior to the meeting of a governmental body. In addition, once a bill is enacted, the secretary of state publishes a notice of enactment in the official state newspaper. The law was enacted on October 26, 2007, and was published that same date.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a one year projected budget. A suggested financial form for the budget is below. The budget must describe: [Section 2107(d); (42 CFR 457.140]

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, etc.

- All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

A budget entitled " Total CHIP Budget for FFY 15" is attached.

Wisconsin's state match for the population identified in the SCHIP State plan is provided through State General Purpose Revenue (state tax dollars). Funds for Federal Fiscal Years 14 and 15 were appropriated in the State's 2013-2015 Biennial Budget Legislation (2013 Wisconsin Act 20) . These funds are authorized through s. 20.435 (4)(b), Wis. Stats., which allows payment for the recipients who are eligible under s. 49.471(4), Wis. Stats.

In addition, premium revenue is collected from members and offsets state and federal costs for the SCHIP program. Co-pay revenues are not directly collected from members to offset state and federal costs for the SCHIP program. However, rates paid to providers are reduced for co-pay amounts, therefore indirectly reducing costs for SCHIP.

All PMPMs reported are the average statewide capitation rates for these recipient groups and are net of premiums.

Total SCHIP Budget for FFY 15

Notes: **Estimated costs for FFY15 reflect the annualized experience from October 2014 - March 2015.**

COST PROJECTIONS FFY15	Actual FFY 2014 Costs	Pr FFY 2
Enhanced FMAP Rate	71.34%	
Population #1 (Separate SCHIP Children)		
Gross Insurance Payments	$95,916,746	$8
gross per member/per month rate	$176.27	
Gross Benefit Costs Subtotal for Population #1	$92,092,906	$7
Net Benefit Costs (net of cost share) Subtotal for Population #1	$92,092,906	$7
Population #2 (Unborn Children of Pregnant Immigrants)		
Insurance Payments	$23,552,628	$2
per member/per month rate	$1,192.06	
Benefit Costs Subtotal for Population #2 (no cost share applies)	$23,552,628	$2
Population #3 (MCHIP Children)		
Insurance Payments	$111,186,135	$10
per member/per month rate	$194.99	
Benefit Costs Subtotal for Population #3 (no cost share applies)	$111,186,135	$10
Total Benefit Costs	$230,655,509	$21
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	$226,831,669	$21
Administration Costs		
General administration - Eligibility Administration	$11,240,795	$1
Federal Share (multiplied by enh-FMAP rate)	$169,840,896	$15
State Share	$60,814,613	$5
TOTAL PROGRAM COSTS	**$238,072,464**	**$22**

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1 to be compliant with requirements.

10.1. **Annual Reports.** The state assures that it will assess the operation of the State plan under this Title in each fiscal year, including:
[Section 2108(a)(1),(2); 42 CFR 457.750]

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. [42 CFR 457.710(e)]

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. **Program Integrity [Section 2101(a)]**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. [Section 2101(a); 42 CFR 457.940(b)]

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: [Section 2107(e); 42 CFR 457.935(b)] (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections [Section 2101(a)]

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

The review process for eligibility and enrollment matters is the same as the Medicaid Fair Hearing process.

Guidance: "Health service matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

The review process for health service matters is the same as the Medicaid Fair Hearing process.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each re-determination of eligibility.

N/A

Attachment 2
Wisconsin Description of the Amount, Duration and Scope of Services Covered
Section 6.2

The following chart shows the amount, duration and scope of covered benefits provided to members.

BadgerCare Plus Standard Plan		
Case Management Services		
Limited to case management provided by public entities, Independent Living Centers, or AIDS service organizations.		
Chiropractic Services		
Full coverage		
Dental Services		
Full coverage	.	
Disposable Medical Supplies (DMS)		
Full coverage		
Drugs		
Comprehensive drug benefit with coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs		
Durable Medical Equipment (DME)		
Full coverage		
Health Screenings for Children		
Full coverage of HealthCheck screenings and other services for individuals under age 21 years		
Hearing Services		
Full coverage		
Home Care Services (Home Health, Private Duty Nursing and Personal Care)		
Full coverage of private duty nursing, home health services, and personal care		
Hospice Services		
Full coverage		
Inpatient Hospital Services		

BadgerCare Plus Standard Plan		
Full coverage		
Mental Health and Substance Abuse Treatment*		
Full coverage (not including room and board)	-	
Nursing Home Services		
Full coverage		
Outpatient Hospital – Emergency Room		
Full coverage		
Outpatient Hospital Services		
Full coverage		
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)		
Full coverage		
Physician Services		
Full coverage, including laboratory and radiology		
Podiatry Services		
Full Coverage		
Prenatal /Maternity Care		
Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems		
Reproductive Health Services		
Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization		
Routine Vision		
Full coverage including coverage of eyeglasses		
Smoking Cessation Services		
Coverage includes prescription and OTC tobacco cessation products.		
Transportation – Ambulance, Specialized Medical Vehicle (SMV), Common Carrier		

BadgerCare Plus Standard Plan		
Full coverage of emergency and non-emergency transportation to and from an enrolled provider for a BadgerCare Plus covered service.		