OMB #: 0938-0707
Exp. Date:

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

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

State/Territory: Wisconsin
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

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

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

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

Name: Karen Timberlake Position/Title: Secretary, Department of Health and Family Services
Name: Jason A. Helgerson Position/Title: Wisconsin State Medicaid Director
Name: Richard Albertoni Position/Title: Wisconsin SCHIP Director

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2 ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3 ☒ A combination of both of the above.

1.2 Please 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))**

The State assures 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.

1.3 Please 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)**

The state assures that it 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.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Original State Plan effective date:	**April 1, 1999**
Amendment #1 Effective date:	**July 1, 1999**
Implementation date:	**July 1, 1999**
Amendment #2 Effective date:	**October 18, 2001**
Amendment #3 Effective date:	**July 14, 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**

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and 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). **(42 CFR 457.80(a))**

The Wisconsin Department of Health and Family 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 2005 there were about 1,376,000 children under 19 years of age in Wisconsin. Approximately 1,170,000 (85% of these children) were white (majority) and 206,000 (15%) were minority or multiple race.

The 2004 Family Health Survey estimates that 8% of Wisconsin's population was living in a household below 100% of the Federal Poverty Level (FPL). That is, Wisconsin had an estimated 445,000 people in poverty in 2005. The survey estimated that 12% of children (165,000) were below 100% FPL, and 19% of all children (261,000) were below 200% FPL.

According to the 2005 Wisconsin Family Health Survey, 5% 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. At any one time, 7% of Wisconsin household residents had no health insurance.

Information from the 2005 Family Health Survey provides estimates of the number of uninsured children by FPL. An estimated 72,000 children under age 19 were uninsured at any one time in 2005.

Wisconsin consistently has one of the lowest rates of uninsured residents in the nation. Moreover, even with broad eligibility coverage under Medicaid, the proportion of residents insured by Medicaid is also lower in Wisconsin than nationally (12.4% vs. 14.4%).

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42 CFR 457.80(b))**

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

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 1997-1999 biennium, Medicaid was the largest program supporting non-governmental entities funded by Wisconsin general purpose revenue (GPR). The Medicaid GPR budget for the biennium is approximately $1.85 billion. This amount represents roughly 40% of total program costs; federal funds support the remaining 60% of costs.

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:

- **Healthy Start Expansion. Wisconsin has increased the Medicaid income limit for low-income pregnant women and children under age six since 1988 when the program began, from 120% of FPL to the current level of 185% FPL. In 1989, the asset test was eliminated for Healthy Start.**

- **W-2 Health Plan. Provisions of 1995 Wisconsin Act 289 authorized the W-2 welfare reform program. As part of this reform, Wisconsin created the W-2 Health Plan, which was designed to provide health care to low-income families, dependent children, and working parents who could not afford health insurance. The program was designed as a bridge to self sufficiency, providing affordable health insurance to low-income, working families and assuring a transition to private health insurance. The program applied to persons in W-2 work programs and other low-income families. The federal waiver required for Wisconsin to implement this health care component was not granted.**

  BadgerCare. Provisions of 1997 Wisconsin Act 27, enacted on October 11, 1997, authorized statutory language and state matching funds from state GPR (tax revenues) to create the BadgerCare program. BadgerCare began July 1, 1998.

  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. Provisions in the 2007-2009 Biennial Budget, which was enacted on October 26, 2007, will authorize statutory language and state matching funds from state tax revenues to create the BadgerCare Plus program. This program, to begin February 1, 2008, will provide 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 full-time outreach coordinator is responsible for making sure that everyone in Wisconsin who has a child knows that Family Medicaid and BadgerCare are available to help them meet their health care needs. Using data on population, family health and the uninsured, the outreach coordinator has identified specific geographic locations in Wisconsin with low health care penetration rates and is working 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 in those areas.

In addition, BadgerCare Plus proposes to simplify 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.

Finally, we realize that some families find the application for assistance at their county human or social services office to be a barrier to their participation. In 1999, Wisconsin allowed each applicant and program participant to choose how they want to apply. Families can apply through the mail, over the phone or in-person. In addition, beginning in 2006 Wisconsin had deployed an innovative tool, www.access.wisconsin.gov, that allows for a five to ten minute assessment of eligibility, the ability to apply on-line in twenty to thirty minutes, the ability to see case information and manage your own case and to report changes to the eligibility worker from an Internet-connected personal computer or laptop. At this time, 14% of our applications are done using ACCESS. With BadgerCare Plus we plan to use our marketing and outreach efforts to aggressively push ACCESS as the preferred method for interaction between the program and the member. We also have begun working to identify community partners, including clinics, hospitals, schools, food pantries, churches, etc., who can use ACCESS to help those low-income families who come to their organization for help to apply for and manage their public assistance Under state and federal law, we allow for an electronic signature for applications made using ACCESS.

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

See 2.2.1

2.3 Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. *(Previously 4.4.5)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))**

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.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **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.

3.1 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))**

<u>BadgerCare Plus Enrollment Process</u>. Enrollment for BadgerCare Plus 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 BadgerCare Plus because we expect many families to have both Title 19 and Title 21 eligibles. Applications can be made using an Internet application, available at www.access.wisconsin.gov, that allows families to apply for Medicaid, SCHIP and Food Stamps on-line, in-person at county human services offices or through the mail.

Like Medicaid, for most recipients, health care benefits will be 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.

Recipients determined eligible for BadgerCare Plus are provided a packet of informational materials regarding the plans available to them in their area and will be required to select an HMO. The enrollment date is the earliest possible month after a family has chosen an HMO. Recipients will be covered on a fee-for-service basis until HMO enrollment is effective.

As described in sections 2.3 and 5.1 of this document, has streamlined the process to the greatest extent possible to allow families to apply for BadgerCare Plus at locations convenient to them that fit their schedule, through an Internet website (https://access.wisconsin.gov/) and through telephone and mail-in application processes.

<u>Current Medicaid Managed Care Process.</u> All AFDC Medicaid, AFDC-related Medicaid and Healthy Start eligible recipients throughout the state are eligible to participate in the Wisconsin BadgerCare Plus HMO program.

Once eligibility is established, recipients 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. Recipients may enroll by phone or by mailing in the HMO enrollment choice form. Recipients may make a choice at any time within the process by sending in the enrollment form or contacting the enrollment contractor and enrolling over the telephone.

If a recipient 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 recipients who were sent reminder cards for the purpose of telephone and mail outreach.

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

Recipients 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 recipients 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 BadgerCare Plus 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 a 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. Recipients 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 State intends to expand the services of the enrollment contractor and incorporate additional outreach and education functions to support enrollment for BadgerCare Plus. These additional functions will include after-hours availability. Currently the enrollment contractor is available by phone from 8:00 a.m. to 6:00 p.m. and in person at six regional sites from 8:00 a.m. to 4:30 p.m.

<u>Disenrollments and Exemptions</u>. Wisconsin Medicaid and BadgerCare Plus have short term and long term exemptions from HMO participation. In some situations a recipient may be exempt from joining an HMO. Exempted recipients receive fee-for-service care for all Medicaid-covered services. Exemptions are granted to an individual who meets the specific criteria. The exemptions currently allowed for BadgerCare and Medicaid will also be allowed for BadgerCare Plus. See Appendix B for a list of HMO exemptions.

<u>Prenatal Care and Delivery Service</u>. Services provided to unborn children under the separate SCHIP program will not be 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 childrenWe 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))**

☐ **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 5.

4.1 The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42 CFR 457.305(a) and 457.320(a))**

4.1.1 ☒ Geographic area served by the Plan:

Statewide.

4.1.2 ☒ Age:

Separate SCHIP:

Children from age 1 through age 5 with family income above 185% FPL up to and including 300%FPL and

Children ages 6 through age 18 with family income above 150% FPL up to and including 300% FPL

Unborn children from conception to birth up to and including 300% FPL.

Medicaid Expansion:

Children ages 6 through 18 with family income from above 100%FPL up to and including 150% FPL.

4.1.3 ☒ Income:

Wisconsin has a 300% of the Federal poverty level gross income test without any deductions.

4.1.4 ☐ Resources (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:

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):

An SSN is not required for non-qualifying immigrants, but is required for all others.

Wages and availability of employer-sponsored health insurance must be verified by the employer.

4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (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.

4.2.3 ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42 CFR 457.350)**

The methods of establishing eligibility and continuing enrollment are the same as under Title XIX.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any).

(Section 2106(b)(7)) (42 CFR 457.305(b))

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

4.4 Describe the procedures that assure that:

4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that 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 state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))**

Eligibility is determined in Wisconsin's automated eligibility system, CARES. CARES determines eligibility and benefits for Medicaid, BadgerCare Plus, SeniorCare, Food Stamp, and TANF (Wisconsin Works, Child Care and SSI Caretaker Supplement) programs. In determining eligibility for Medicaid and BadgerCare Plus, CARES will configure the group, check nonfinancial factors of eligibility, add together the appropriate financial resources of the group and determine eligibility, regardless of whether the individual would be Medicaid or BadgerCare Plus eligible. Once eligibility is determined, CARES checks nonfinancial factors, whether the individual is a child (under age 6 or age 6 to under age 19), parent, adult caretaker relative or pregnant woman and then determines which the federal poverty level for the individual based upon the family's income and size. CARES then assigns a medical status code, which indicates whether the individual's benefit and administrative costs are Title 19, or Title 21 or 100% state funded, for MMIS and MSIS.

4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42 CFR 457.350(a)(2))**
See 4.4.1

4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))**

Any applicant or enrollee who is found ineligible for Medicaid services (based on the eligibility of his or her mother) and appears eligible for the separate child health program is automatically reviewed for SCHIP eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42 CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1 ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Persons who are covered by employer health insurance plans that meet the Health Insurance Portability and Accountability Act (HIPAA) standards (and have not demonstrated good cause) will not be eligible for BadgerCare Plus. The eligibility worker will collect insurance information from the household to verify coverage and access. The HIPAA standard will be included in a question to the applicant family asking whether this is a major medical health insurance plan. EDS, Wisconsin Medicaid's fiscal agent, will then verify coverage through the eligibility exchange system currently in use, and through written and phone contacts with employers. When previously unreported insurance coverage is discovered, EDS will inform the worker who will close BadgerCare Plus coverage.

Persons who *have coverage* under employer health insurance that meets HIPAA are ineligible for BadgerCare Plus, unless they are able to demonstrate good cause. Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays 80% or more of the cost are also ineligible for BadgerCare Plus. 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.

4.4.4.2 ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

As part of the 2003-2005 Biennial Budget Act, Wisconsin implemented a mandatory employer verification of earnings and health insurance access/coverage at:

- **Application for BadgerCare;**
- **Annual Renewal of BadgerCare;**
- **Upon entry into a new job; and,**
- **When a family moved from Medicaid to BadgerCare.**

The process involved sending a pre-printed form to recipients asking them to verify with their employer their earnings and their health insurance status. We required the employer to sign the form. When the form was returned, the

information was entered into Wisconsin's automated eligibility system, CARES, where eligibility could be determined and confirmed. Within the first six months of implementation, BadgerCare enrollment dropped by 25%.

In response to this drastic change, the Department completed an evaluation and found that the most common reasons for the decrease was that employers were not completing the form that verified health insurance status and that some recipients simply did not attempt to complete the verification process. Interviews with employers revealed that they were too busy to comply and that completing the form was not a priority. Interviews with recipients revealed that they had not read the notice explaining what they needed to do or that, because of other factors in their lives, they were unable to comply. At this time, it was decided that with the 2007-2009 Biennial Budget, the Wisconsin Medicaid agency would seek a new solution.

With BadgerCare Plus, we employ a new process that does not rely on county/tribal eligibility workers or on applicant/recipients. The Department has built an employer health insurance database with all of the employers of BadgerCare Plus parents, caretakers and pregnant women. The database, which has been and will be populated using information from employers, contains information about whether the employer offers any insurance, rules for which employees have access to the benefit, the individual and family premium amount, and the amount the employer pays for the premium. At the time of application and review, when the family identifies their employer in the automated eligibility system, the system will automatically check the employer health insurance database. If the employer does not offer health insurance to anyone or offers health insurance at 80% or more of the premium to all, this information will be passed back to CARES and eligibility will be determined and confirmed. If the employer has rules about whom and when employees have access to their insurance and the employer pays 80% or more of the premium for that insurance, that information will be passed back to the worker who will use it to enter data into CARES at which time eligibility can be determined and confirmed. If the employer has not supplied complete information needed to make a determination, we (not the county or tribal eligibility worker) will contact the employer to request the information. By state law, if the employer does not supply the information within the time period allowed, usually 30 days, BadgerCare Plus eligibility will be granted and the employer will be fined an amount equivalent to the BadgerCare Plus per member per month cost until the information is supplied. (For those months, there will be no benefit cost to either the state or federal government). Employers are granted a fair hearing if they disagree with the fiscal penalty. There are maximum values for all employers that vary based upon the number of employees.

4.4.4.3 [3] Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

Wisconsin uses the same methologies indicated in Section 4.4.4.2 to monitor substitution and to prevent substitution.

4.4.4.4 [ ] If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska 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 Pus.

Section 5. Outreach (Section 2102(c))

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)**

The expansion of the BadgerCare Plus program will take advantage of the outreach efforts that are already under way (see 2.2.1). The Department of Health and Family Services has developed a comprehensive plan for outreach. The Department is undertaking a major outreach effort to inform eligible families of the availability of Medicaid and to assist them in enrolling in the program. These efforts transcend implementation of BadgerCare Plus. The Department's outreach plan will reach out to families potentially eligible for Medicaid under the old AFDC standards and establish the foundation for education and enrollment of families into BadgerCare Plus, highlighting the simplicity of the new program rules and new ways to apply for benefits. These efforts are highlighted by the following initiatives, described in detail in this section:

- **Implementation of the ACCESS internet tools (Am I Eligible, Apply for Benefits, Check My Benefits, and Report My Changes).**
- **Hiring of a full-time outreach coordinator.**
- **Development of an outreach plan to increase BadgerCare Plus enrollment and to implement strategies to promote public health.**

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 Medicaid.**
- **Extending health care coverage to working families with BadgerCare.**
- **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.**

<u>Outreach Plan</u>. The Outreach Plan has four major components:

- **Statewide public information campaign.**
- **Expanded training.**

- **Improved case-specific problem resolution.**
- **Systems changes.**

The outreach program for BadgerCare Plus will complement and build upon current Medicaid outreach initiatives that are underway to respond to federal welfare reform. This plan has been developed over the past six months with significant public input.

Our goals in developing the outreach plan are to:

- **Assure the participation of eligible families in Medicaid and BadgerCare Plus.**
- **Invest in proven activities that will support access to health care for families.**
- **Improve the health status of the Wisconsin population.**

Through our outreach plan, we hope to ensure that all uninsured families in Wisconsin are aware of the health care coverage that is available to them. As a result, we expect to enroll eligible families into Medicaid and BadgerCare Plus.

Public Information Campaign. A comprehensive and coordinated effort is underway to assure that accurate information is available to potential program members and agencies that work with them about the new streamlined and easy-to-use BadgerCare Plus program.

A new recipient brochure aimed specifically at potential members of the BadgerCare Plus program, accompanied by posters and potentially radio ads, will be distributed in late 2007.

Fact sheets describing various BadgerCare Plus program components are being developed as the basis for various informational materials and training. This approach will also be used to support BadgerCare Plus implementation. Promotional materials such as business cards, brochures (provider and recipient), posters and decals have already been created for ACCESS.

DHFS materials for beneficiaries are tested with focus groups. The Department translates these materials, as appropriate, into Spanish and Hmong, and distributes these materials based upon the demographics of particular communities, to reach out to individuals for whom English is not their primary language. Existing advocacy networks and mailing lists are continually updated to assure timely and accurate information about the impact of welfare reform.

The Department has created a BadgerCare Plus advisory group whose members include:

Bevan Baker	City of Milwaukee Health Department
John Chianelli	Milwaukee County Department of Health and Human Services
Melissa Duffy	Wisconsin Federation of Cooperatives
Donna Friedsam	University of Wisconsin Population Health Institute
Jason Helgerson	Dept. of Health & Family Services
Kathy Kaelin	Automated Health
Ed Kamin	Kenosha County Department of Human Services
Danyel McNeil	City of Milwaukee Health Department
Dr. John R. Meurer	Medical College of Wisconsin
Mark Miller	State Senator
Fr. 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 & Benefits Counseling for Health
Lori Pidgeon	Ho-Chunk Nation
Jon Richards	State Representative
David Riemer	The New Hope Project
Bill Smith	National Federation of Independent Business
Dr. Susan Turney	Wisconsin Medical Society
Nancy Wenzel	Wisconsin Association of Health Plans
Paul Zimmerman	Wisconsin Farm Bureau Federation

This group has met since 2006 on a bi-monthly basis to discuss the various components of the BadgerCare Plus program and to provide the Department with feedback on the program.

At more than 22 town hall meetings, the Governor, Department Secretary and/or the State Medicaid Director have described Wisconsin's BadgerCare Plus proposal and received input from citizens, doctors, nurses, public and private health clinic

administrators, HMO/insurance administrators, , health care advocates and Medicaid/BadgerCare eligibility agency administrators, and used that input to guide the BadgerCare Plus program creation.

Training. New training materials and presentations on BadgerCare Plus eligibility are being developed. Training for health care providers will be offered by the state's Medicaid fiscal agent, EDS. Training packages that can be used by other groups to reach their members will be available, for example, for staff of medical clinics and school nurses.

Training for advocacy groups and community-based agencies will be developed and offered by the Department. Training for workers in county agencies will be developed by the Department and should take place between December 1, 2007 and January 15, 2008.

Systems Changes. Changes are being made to the CARES eligibility determination system, the ACCESS system and to the MMIS system to accommodate BadgerCare Plus rules. In addition, improvements to recipient notices generated by CARES will be completed by February 1, 2008, as one component of the State's outreach strategy.

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 continue on to Section 7.

6.1 The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42 CFR 457.410(a))**

6.1.1 ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420) ***

6.1.1.1 ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

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

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.)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3 ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4 ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

Wisconsin will provide the same benefits package to recipients of its BadgerCare Plus program as is currently provided to Wisconsin Medicaid recipients under Title XIX for those children with family incomes at or below 200% FPL. For those children with family incomes exceeding 200% FPL, but no greater than 300% FPL, Wisconsin will provide a Benchmark-Equivalent Plan benefit.

6.1.4.1 ☒ Coverage the same as Medicaid State plan

The coverage for children with family incomes no greater than 200% FPL is the same as our Medicaid benefit 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

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

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 (Please provide a sample of how the comparison will be done)

The Benchmark-Equivalent Plan which is provided to children with family incomes greater than 200% FPL is substantially equivalent to the most widely available and most widely purchased commercial plan in Wisconsin, the United Health Care Plan. We have reviewed the United Health Care Plan benefits and modified them slightly in regard to the copayments and service limits. This modified plan has been adopted as the Benchmark Plan for both children eligible for SCHIP with incomes greater than 200% FPL, but also for pregnant women, eligible under Medicaid, with incomes that exceed 200% FPL.

The benchmark-equivalent plan we're providing has slightly better benefits and cost sharing then the parent plan, United Health Care Group Health Plan, since we lowered the cost sharing and then added a more comprehensive mental health/substance benefit from the State Employee's Group Plan.

Wisconsin ensures that children covered through premium assistance receive benefits that are equivalent to the United Health Care Group Health Plan, with mental health and substance abuse treatment benefits from our state employee's plan. When a child is enrolled in an employer's group health plan, the benefits of the Standard or Benchmark Plan, whichever they are qualify for, are wrapped around that health plan to ensure a benefit that is at least equivalent to the benefit they would have received had they not been bought into the employer's plan.

6.1.4.7 ☐ Other (Describe)

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)

For the unborn child, the State covers pregnancy related services and services that if not treated could complicate the pregnancy. The list of services provided for our separate SCHIP unborn population is listed in the attached addendum.

The services checked below are for our separate SCHIP population of children from birth to 19 years up to and including 300% FPL. Children with family income at or below 200% FPL receive the Medicaid or Standard Plan benefit package, while children with family income greater than 200% FPL but no greater than 300% FPL receive a Benchmark-Equivalent Plan benefit package. Details about the amount, duration and scope of the covered services are provided in Attachment 3.

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 3

6.2.5 ☒ Clinic services (including health center services) and other ambulatory health care services **(Section 2110(a)(5))**
See Physician Services in Attachment 3

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 prepregnancy 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))**

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

6.2.15 ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
See Physician Services in Attachment 3

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))**

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 3.

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))**

6.2.24 ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (See instructions) **(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))**

6.2.27 ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**
See Transportation Services in Attachment 3.

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

6.3 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

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% 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))**

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))**

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)**

We propose to use the state employee standard benefit package which meets the requirements of a benchmark plan under Title XXI to compare the cost of covering two low-income children in an average three-person BadgerCare Plus family to the cost of covering the entire three-person family under a BadgerCare Plus /Medicaid HMO plan. The state employee standard benefit package meets the requirements of a benchmark plan under Title XXI. Our comparison of costs of children under the benchmark plan as opposed to the cost of families under BadgerCare Plus meets the cost effectiveness requirements of the law. It should be noted, however, that the State employee plan and other employer-based, commercial coverage are frequently limited to two options, single (employee only) or family (employee plus family members). Coverage for children only is generally not available unless family coverage is elected by the employee.

We propose to implement BadgerCare Plus by emphasizing the importance of providing health insurance coverage to low-income families in order to facilitate and expand access to health care coverage for children under Title XXI. Our BadgerCare Plus proposal creates a seamless program of family health insurance by using both Titles XIX and XXI in order to provide insurance for the whole family.

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 6.3.2.1, 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 relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)**
(Section 2105(c)(3)(A)) (42 CFR 457.1010(a))

We have identified a benchmark health insurance plan that is available to all state employees. For purposes of assuring the reasonableness of access to the plan, for the basis of comparison, we chose the State Employee Standard Plan. The Standard Plan is the only health insurance option that is available to all state employees in all seventy-two Wisconsin counties.

<u>Demographic assumptions</u>. We assumed the following about the average BadgerCare family size, based on Wisconsin-specific 2000 U.S. Census data:

Children	**1.91**
Adults	**<u>1.14</u>**
Total	**3.05**

Wisconsin will only provide premium assistance when it is proven to be cost effective to do so. This means that the cost of providing family coverage is no greater than the cost of SCHIP direct coverage for the children. For instance, with a per member per month cost of $105 per child under BadgerCare Plus, we would not purchase family insurance that would cover three children if our cost was more than $315 per month.

Therefore, the cost of covering the entire family under BadgerCare Plus is less than the cost of covering children under the Standard Plan, as required under Section 2105(c)(3)(A).

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.

Section 7. Quality and Appropriateness of Care

☐ **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.

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))**

Quality assurance mechanisms

BadgerCare Plus will include several quality assurance mechanisms to evaluate and improve the quality of medical care provided to BadgerCare Plus recipients. Every managed care organization under contract with the State will be required to have an active quality assurance system, including designated quality assurance staff devoted to evaluation of the care provided to BadgerCare Plus recipients.

The quality assurance activities carried out in BadgerCare Plus will focus on specific medical service delivery concerns. These medical and service delivery concerns will include the following:

- **Access to care**
- **Timeliness of care**
- **Appropriateness of care**
- **Appropriateness of setting**
- **Appropriateness of amount of care**
- **Consistency with current standards of medical practice**
- **Education and communication with recipients**
- **Ethnic and cultural responsiveness**

Improvements to Care and Service

In addition, each BadgerCare Plus managed care organization will be required to demonstrate how the organization has attempted to improve care and service for BadgerCare recipients enrolled in their program. The state will monitor compliance with the contract standards for BadgerCare Plus (as with Medicaid) in a number of ways:

- **An independent contractor will review a sample of recipient medical records annually to determine the adequacy of care and services being provided. The**

documentation in the medical record will be compared to specific criteria and standards developed by the Wisconsin Medicaid medical consultants with provider input.

- **Medical consultants who are specialists in the area under review will conduct a number of on-site administrative and clinical audits.**

- **Grievance audits and reviews of grievances received from recipients and providers will assure that the contracted managed care organizations are complying with the rules of BadgerCare Plus.**

- **The Wisconsin Medicaid contract will continue to require each HMO to employ at least one full-time internal advocate for recipients to help ensure that the HMO remains responsive to recipients' concerns.**

KEY ELEMENTS:

Performance-based contract

Defines roles, structure and process
Includes QAPI program, access and other requirements
Includes data system, encounter data and reporting requirements
Enforcement tools-intermediate sanctions up to termination

To view the HMO contract, go to:
http://www.dhfs.state.wi.us/medicaid7/providers/pdfs/mc10051.pdf

Automated performance measures:

Wisconsin monitors MCO performance using automated clinical performance measures called MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set). The measure set has been evaluated by AHRQ (the Agency for Healthcare Research and Quality) and approved for inclusion in the National Quality Measures Clearinghouse. Using the system, the state can monitor 59 indicators, including private accreditation status. Wisconsin publicly reports the clinical indicator data on its Medicaid managed care website. Reporting is done annually.

Non-clinical performance indicators:

Wisconsin reports non-clinical performance data based on enrollee satisfaction surveys which are done by the DHFS bi-annually on a state-wide basis. In addition, the DHFS monitors grievance and complaint data. Other non-clinical data sources include:

- **Disenrollment rates**
- **Encounter data validity audit (DVA)**
- **External Quality Review (EQR)**

Performance improvement projects:

Each HMO must report in detail on at least two performance improvement projects conducted by the organization in the previous year. Topics may be clinical or non-clinical and should relate to priority areas specified by the DHFS in the HMO contract.

Other performance improvement tools include:

- **MEDDIC-MS Goal-setting Process**
- **Care Analysis Projects**
- **Best practices symposium-diffusion of innovation**
- **HMO Report Card**
- **New Enrollee Health Needs Assessment (NEHNA) survey**
- ***Stay Safe & Healthy* enrollee safety education initiative**
- **External Quality Review reports**
- **Technical assistance, training**
- **Biannual QAPI recertification audit reports**
- **HMO performance improvement projects**
- **DHFS Strategic plan and biannual strategic plan assessment**
- **HMO Accreditation Incentive Program**
- **Other pay-for-performance incentives are in development.**

Structure and process tools-in contract (subject to certification and recertification review)

- **Written HMO access and availability standards**
- **HMO must provide written assurance of network adequacy**
- **Geo-access review of HMO provider network**
- **Coordination and continuity of care policies**
- **UM/UR, denial criteria and policies**
- **Clinical practice guidelines; development, update and dissemination policies**
- **Enrollee rights protections and policies**
- **Medical records content and confidentiality protections and policies**
- **Enrollment and disenrollment policies**
- **Grievance and complaint policies**
- **Internal advocate and grievance processes, formal and informal**
- **Delegation policies and agreements**
- **Demand management system (nurse line or phone triage) policies**
- **Provider/practitioner credentialing/recredentialing policies**

DHFS Oversight activities & tools

- **Certification and recertification audits**
- **Quality of care audits (internal & external)**
- **Data validity audits**
- **Complaint & grievance monitoring, audits and follow-up**
- **External quality review**

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

7.1.3 ☑ Information strategies

7.1.4 ☑ Quality improvement strategies

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

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))**

MEDDIC-MS includes a clinical performance measure for each of the following, which is monitored program-wide and on an HMO-specific basis annually:

- **EPSDT (well-child visits) for children two years of age and younger getting 5, 6 and 7 or more visits in the look-back period and visits for children age two to twenty years of age;**
- **Non-EPSDT well-child visits;**
- **Immunizations on a program-wide and HMO-specific basis in the look-back period;**
- **Primary care visits for children.**
- **Blood lead toxicity screening tests for children age one and two years;**

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))**

MEDDIC-MS includes a clinical performance measure for each of the following, which is monitored program-wide and on an HMO-specific basis annually:

- **General and specialty inpatient care, including maternity, surgical, medical, psychiatric, substance abuse and neonatal)**
- **General and specialty outpatient care (including emergency department care without admission, vision, primary care, audiology care, and general dental care)**
- **Dental preventive care;**
- **Women's health measures, including screening mammograms, Pap tests (and malignancy detection rates), maternity care, perinatal substance abuse care and HIV screening, prenatal care coordination)**

Data on Medicaid HMOs is collected and published annually, and audit findings indicate steady improvement in the provision of primary care by managed care organizations.

In linking BadgerCare Plus recipients to a "medical home" and in requiring strong quality assurance efforts, Wisconsin Medicaid plans to continue this progress and improvement in health care outcomes in the BadgerCare program.

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))**

MEDDIC-MS includes a clinical performance measure for each of the following, which is monitored program-wide and on an HMO-specific basis annually:

- **Ambulatory care for diabetes (including HbA1c and lipid profiles)**
- **Asthma care including monitoring of prevalence, inpatient and ED care for asthma**
- **Follow-up ambulatory care by specialists and PCPs for mental health and substance abuse diagnoses within 7 days and 30 days of discharge from inpatient care for those conditions;**
- **Mental health and substance abuse evaluations and day/outpatient care by specialists and PCPs**.

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))**

Wisconsin's performance-based contract provides as follows:

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 HFS 101.03 (96m) Wis. Adm. Code.

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 14 calendar days of the receipt of the request, or

   2) Within three 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.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **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)**

8.1.1 ☒ YES

8.1.2 ☐ NO**, skip to question 8.8.**

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 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) & (c), 457.515(a)&(c))**

8.2.1 Premiums:

Premiums will be imposed upon children with monthly family income greater than 200% 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 200 percent up to, but not including 230 percent of the FPL: $10;
Incomes at or above 230 percent up to, but not including 240 percent of the FPL: $15;
Incomes at or above 240 percent up to, but not including 250 percent of the FPL: $23;
Incomes at or above 250 percent up to, but not including 260 percent of the FPL: $34;
Incomes at or above 260 percent up to, but not including 270 percent of the FPL: $44;
Incomes at or above 270 percent up to, but not including 280 percent of the FPL: $55;
Incomes at or above 280 percent up to, but not including 290 percent of the FPL: $68;
Incomes at or above 290 percent up to, but not including 300 percent of the FPL: $82;
Incomes at 300 percent of the FPL: $97.53.

8.2.2 Deductibles:

A $200 deductible will apply for covered dental services, except preventive and diagnostic services, provided to children ages 1 to 18 with incomes from 200 - 300% FPL. Preventive and diagnostic dental services which include oral examinations, prophylaxis and topical fluoride applications, sealants and x-rays do not apply to the deductible. The deductible applies to fillings and other restorative services. The deductible is applied lies on a per member basis and is based on Benchmark Plan maximum allowable fees and is counted towards the enrollee's 5 percent cost-sharing cumulative maximum, described in section 8.5.

8.2.3 Coinsurance or copayments:

Description of Children Affected		
	Premium	**Co-payments**
Children ages 1 - 5 with incomes >185 FPL up to and including 200% FPL	None	See Attachment 1, included at the end of Section 8
Children ages 6 - 18 with incomes > 150% FPL up to and including 200% of FPL	None	
Children ages 1 - 18 with incomes from 200 - 300% FPL	200 < 230% FPL - $10 230 < 240% FPL - $15 240 < 250% FPL - $23 250 < 260% FPL - $34 260 < 270% FPL - $44 270 < 280% FPL - $55 280 < 290% FPL - $68 290 - 299.99% FPL - $82 300% FPL – $97.53	See Attachment 2, included at the end of Section 8

No cost sharing will be applied to unborn children.

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)(B)) (42 CFR 457.505(b))**

Outreach and application forms will include this information. Sections 2.2.1, 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))**

As an interim process, we are notifying families in the Enrollment & Benefits booklet that the Department will monitor their cost sharing expenditures on a quarterly basis to identify any family with out of pocket premium and co-payment costs that exceeded 5% of their income and will issue a refund in the amount that co-payments exceeded their family limit.

Once our system enhancements our implemented, the CARES Notices of Decision will include a new section to inform the recipients of the maximum dollar amount that their families have to contribute as a share of the cost of the SCHIP/Medicaid benefits they are receiving. This maximum will be 5% of their countable income as calculated by CARES.

The Medicaid Management Information System (MMIS) will be used to track the cost sharing expenses and let providers know when copayments are to no longer be charged to the families.

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.

This provision of the Separate SCHIP does not apply as Native Americans or Alaskan Natives as neither group could be considered as undocumented aliens.(explain)

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 200% 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

Applies only to groups with incomes above 200% FPL, listed in Benchmark Plan:

Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services. In addition, providers are permitted to reduce or waive cost sharing on a case-by-case basis.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ 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))**

☒ 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))**

☒ 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))**

☒ 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, copays, 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))**

Attachment 1
Co-payment Table
Wisconsin SCHIP children with family income that does not exceed 200% FPL

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

Service/Item	Co-payment	Limitations/Cumulative Maximum
Comprehensive Community Services (CCS)	No co-payment	n/a
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

Service/Item	Co-payment	Limitations/Cumulative 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 ▪ 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.	$1 per screen	Co-payment obligation is limited to members who are 18, 19, and 20 years old.
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

Service/Item	Co-payment	Limitations/Cumulative Maximum
Home Health Services	No co-payment	n/a
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 $500 of services, whichever comes first, per calendar year. ▪ No co-payment for services provided in a hospital setting.
Mental Health Day Treatment Services	$0.50 per day	Co-payment obligation limited to the first 15 hours or $500 of services, whichever comes first, per calendar year.

Service/Item	Co-payment	Limitations/Cumulative Maximum
Narcotic Treatment Services	No co-payment	n/a
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

Service/Item	Co-payment	Limitations/Cumulative Maximum
		• Co-payment obligation limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year.
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 anesthesia 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 $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
		• 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: **Fee** **Co-payment** $10 or less……$0.50 $10.01 to $25……...$1.00

Service/Item	Co-payment	Limitations/Cumulative Maximum
		$25.01 to $50…….……...$2.00 $50.01 or more…….…….$3.00

Attachment 2
Co-payment Table
Wisconsin SCHIP children with family income above 200% up to and including 300% FPL

Service/Item	Co-payment
Ambulance Services	$50 per trip
Ambulatory Surgery Services	$15 per visit
Chiropractic Services	$15 per visit
Dental Services	50% of allowable charges (A $200 deductible applies to all services except preventive and diagnostic.)
Disposable Medical Supplies	$0.50 per item
Drugs	$5 per item
Durable Medical Equipment	$5 per item, except rentals
Family Planning Services and Supplies	No co-payment
Health Screenings (EPSDT) for Children under age 21 years	No co-payment
Hearing Services	$15 per procedure

Service/Item	Co-payment
Home Health Services	$15 per visit
Hospice Services	No co-payment
Inpatient Hospital Services	• $50 per stay for mental health and/or substance abuse treatment • $100 per stay for medical stays
Mental Health and Substance Abuse Outpatient Treatment	$10 to $15 per visit for all outpatient services, except laboratory test, electroconvulsive therapy, and pharmacological management
Nursing Home Services	No co-payment
Occupational Therapy	$15 per visit
Outpatient Hospital Services	• $15 per visit (multiple visits to the same provider in the same day will be treated as a single visit) • $60 for emergency room visits (*waived if admitted to hospital*)
Physical Therapy	$15 per visit
Physician/Clinic Services (including Nurse Practitioner, Nurse Midwife, Laboratory and Radiology services)	$15 per visit , except for clozapine management, preventive medicine, and diagnostic services
Podiatry Services	$15 per visit

Service/Item	Co-payment
Speech Therapy (ST)	$15 per visit
Vision Care Services	$15 per visit

*The Benchmark Plan includes members with incomes over 200% of the federal poverty level, covered under Title XIX or Title XXI.

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

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))**

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

<u>BadgerCare Plus Goals</u>.

<u>Access to coverage</u>: 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 AFDC/HMO program currently provides financial incentives to participating HMOs that provide the targeted number of HealthCheck screens to enrolled eligible children. The AFDC/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.

<u>Delivery systems impacts</u>: 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, 14 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))

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

<u>Access to health care coverage</u>. 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.

Delivery system impacts. 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))

A table entitled "Timeframes and Specific Objectives/Goals for Phase 1 of BadgerCare" is included as Appendix B of this document. A summary of how performance under the plan will be measured follows.

Data Sources/Analysis Plan

The analysis plan uses a variety of approaches and multiple data sources. Some aspects of the analysis are much more difficult to quantify than others. While there is considerable existing data available, some analyses will require primary data collection through direct contact via a survey or other means. Some parts of the evaluation will require the development of a control or comparison group to determine program impact.

Baseline Data

The state will measure these types of outcomes and behavior from standard enrollment data available from the CARES system and utilization data reported by BadgerCare HMOs. BadgerCare HMOs will provide the state summary utilization survey data on key indicators (PAP tests, mammograms, immunizations, HealthChecks, mental health and substance abuse evaluations, emergency room visits, etc.) as well as complete utilization history for all BadgerCare recipients. In addition, beginning in the year 2000, BadgerCare HMOs will be required to submit complete encounter data for all their recipients. Access and utilization data for the general population is available in reports and databases produced and maintained by the Department's Office of Health

Care Information, the Department's Center for Health Statistics, and the Wisconsin Office of the Commissioner of Insurance.

With this comprehensive utilization data available, the State will be able to analyze BadgerCare access and utilization data and compare it to traditional Medicaid populations and general populations. Wisconsin has been in the forefront of states in its ability to report health care utilization and status across Medicaid, commercial, and other public program populations, and to measure utilization rates and health status indicators against defined public goals such as the Wisconsin Public Health Agenda 2000.

The reporting and evaluation of BadgerCare will continue that tradition.

Subsequent data collection

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

- **Surveys - An enrollee satisfaction survey will 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 premium amounts, the accessibility of care and the quality of care. The survey will also be a basis for self-reported health status and health risk behavior data as well as utilization data. A stratified random sample of enrollees will be selected to ensure geographic and demographic representation. Consideration will be given to whether it will be necessary to conduct this survey at least twice, once as a baseline and at least once as follow-up.**
- **Interviews - To obtain information on employers' response to BadgerCare it will be necessary to contact employers through either a survey or an interview method or both. The favored approach will be to survey a sample of employers and, based on the survey results, select a small number for in-depth interviews.**
- **HMO Histories - Enrollee and service specific data will be generated for all BadgerCare enrollees. These data will form the basis for special studies and auditing individual recipients. Quality of care and access issues will be addressed using these data as a sampling frame. The data received through the ongoing Medicaid Managed Care Quality Improvement Program will serve as the source for such data.**
- **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.**

- **Some special reports may be developed to monitor service utilization and outcomes for BadgerCare enrollees who have been bought into health insurance plans offered through their employers. In these cases, detailed utilization data may not be available in a feasible and cost-effective manner, so proxy measures may have to be developed.**
- **Medical Records Audits - The current auditing of the Medicaid managed care program, performed by Department staff and contractors, will be expanded to encompass the BadgerCare program.**

Control Group

A number of hypotheses suggest an evaluation design that requires a control group or a pre-post design. A suitable control group for many of the hypotheses will be Medicaid recipients either selected randomly or matched by characteristics to better mirror the BadgerCare enrollees. On other occasions a pre-post analysis will dictate that baseline information be collected and then replicated at a later date.

Other control groups may be some subset of the general insured population that may have health insurance with a less generous benefit package than BadgerCare.

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.

Please see attached "Addendum IV - Contract-Specified Reporting Requirements," from the January 1998 - December 1999 Contract for Medicaid services Between HMO and Wisconsin Department of Family Services."

The Wisconsin Medicaid Health Maintenance Organization (HMO) Reporting Documentation User Manual, January 1998, provides a correlation between the reports listed in Addendum IV and the strategic objectives and performance goals which we indicate that they address. A copy of the User Manual was included with our responses to HCFA's questions about Wisconsin's Phase 1 application.

Data from the utilization survey requirement described in Addendum IV will provide indications of health care utilization in key preventive health areas within the HMOs. Important indicators we will use include the following: rates of HealthCheck (EPSDT) services, rates of PAP testing, rates of ambulatory follow-up for recipients discharged from a hospital with mental health or AODA diagnoses, rates of hospitalization for recipients with asthma, rates of primary care provider visits, and rates of preventive dental care.

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 child care
- 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)**

9.5 ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the states 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)**

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)

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 insuring 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. Appendix G to the waiver application detailed minutes of four meetings the Department attended with Wisconsin tribes on managed care and BadgerCare Plus during 1997.

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 Public Notices</u>

Providers and recipients will be informed of the BadgerCare Plus initiative in December 2007 and January 2008 through member updates and provider updates.

The state law language changes were included in Wisconsin's 2007-2009 Biennial Budget, 2007 Wisconsin Act 20, to authorize the BadgerCare Plus program. Public notice for all laws, as part of enactment, is announced in the state's largest newspaper, Milwaukee Journal-Sentinel. 2007 Wisconsin Act 20 was published on public notice provided on October 26, 2007.

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. **(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.

9.10 Provide a one year projected budget. A suggested financial form for the budget is attached. 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

A budget entitled "SCHIP Budget Plan FFY 09" 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 Year 08 were appropriated in the State's 2007-2009 Biennial Budget Legislation (2007 Wisconsin Act 20) and the 2009-2011 Biennial Budget Legislation (2009 Wisconsin Act 28). 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.

SCHIP Budget for New Populations

Note: Estimated costs are shown for July 2008 - September 2009 since costs before Oct. 2008 will be claimed as a prior period adjustment in FFY 09.

COST PROJECTIONS FFY09	FFY 2009 Costs
Enhanced FMAP Rate	71.57%

Population #1 (children between 250% to 300% FPL)	
Gross Insurance Payments	$8,139,620.97
Gross per member/per month rate @ 70,927 member months (July 08 - September 09)	$114.76
Gross Benefit Costs Subtotal for Population #1	$8,139,620.97
Net Benefit Costs (net of cost share) Subtotal for Population #1	**$7,075,715.97**

Population #2 (Unborn Children of Pregnant Immigrants 250% to 300% FPL)	
Insurance Payments	$25,614.05
per member/per month rate@ 97 member months (July 08 - September 09)	$264.06
Benefit Costs Subtotal for Population #2 (no cost share applies)	***$25,614.05***

Total Benefit Costs	**$8,165,235.02**
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	**$7,101,330.02**

Administration Costs	
Personnel**	$11,726.29
General administration - Eligibility Administration**	$770,963.12
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs**	$1,707.84
Other - Prenatal Care Coordination**	$4,639.41
Total Administration Costs	**$789,036.67**
10% Administrative Cap (net benefit costs ÷ 9)	**$789,036.67**

Federal Share (multiplied by enh-FMAP rate)	**$5,647,135**
State Share	**$2,243,231**

TOTAL PROGRAM COSTS	**$7,890,366.69**

Total SCHIP Budget for FFY 09

Notes: 1) Estimated costs for new populations are shown for July 2008 - September 2009 since costs before Oct. 2008 will be claimed as a prior period adjustment in FFY 09.

2) Population #2 includes a reversal of a prior period adjustment for services provided in previous federal fiscal years, artificially increasing the PMPM for this population.

COST PROJECTIONS FFY09	FFY 2009 Costs
Enhanced FMAP Rate	71.57%

Population #1 (Separate SCHIP Children)	
Gross Insurance Payments	$50,084,500
gross per member/per month rate @ 426,228 member months	$117.51
Gross Benefit Costs Subtotal for Population #1	$50,084,500
Net Benefit Costs (net of cost share) Subtotal for Population #1	***$43,691,048***

Population #2 (Unborn Children of Pregnant Immigrants)	
Insurance Payments	$25,156,665
per member/per month rate@ 28,091 member months	$895.54
Benefit Costs Subtotal for Population #2 (no cost share applies)	***$25,156,665***

Population #3 (MCHIP Children)	
Insurance Payments	$59,214,100
per member/per month rate@ 525,406 member months	$112.70
Benefit Costs Subtotal for Population #3 (no cost share applies)	***$59,214,100***

Total Benefit Costs	**$134,455,265**
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	**$128,061,813**

Administration Costs	
Personnel	$211,466
General administration - Eligibility Administration	$13,903,171
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	$30,798
Other - Prenatal Care Coordination	$83,665
Total Administration Costs	**$14,229,100**
10% Administrative Cap (net benefit costs ÷ 9)	**$14,229,100**

Federal Share (multiplied by enh-FMAP rate)	**$101,837,606**
State Share	**$40,453,307**

TOTAL PROGRAM COSTS	**$142,290,913**

Section 10. Annual Reports and Evaluations (Section 2108)

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.

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 states 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 items 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 (Sections 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**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

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

Health Services Matters

12.2 Please 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.

Premium Assistance Programs

12.3 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 3
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 of the Standard and Benchmark Plans. Members with income at or below 200% of the FPL receive the Standard Plan benefits, and members with income above 200% FPL receive the Benchmark Plan benefits.

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan
Case Management Services	
Limited to case management provided by public entities or AIDS service organizations.	No coverage.
Chiropractic Services	
Full coverage	Full coverage
Dental Services	
Full coverage	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions for pregnant women and children Coverage limited to $750 per enrollment year.
Disposable Medical Supplies (DMS)	
Full coverage	Coverage of syringes, diabetic pens and DMS that is required with the use of a durable medical equipment (DME) item.
Drugs	
Comprehensive drug benefit with coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs	Generic drug-only formulary with a few generic OTC drugs Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.
Durable Medical Equipment (DME)	
Full coverage	Full coverage up to $2,500 per enrollment year
Health Screenings for Children	
Full coverage of HealthCheck screenings and other services for individuals under age 21 years	Full coverage of HealthCheck screenings HealthCheck “Other” services and Interperiodic services for individuals under age 21 years are not covered.

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	
Hearing Services		
Full coverage	Limited coverage of services provided by an audiologist. Hearing aids, hearing aid batteries, cochlear implants and bone-anchored hearing devices are not covered.	
Home Care Services (Home Health, Private Duty Nursing and Personal Care)		
Full coverage of private duty nursing, home health services, and personal care	Full coverage of home health services Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care are not covered.	
Hospice Services		
Full coverage	Full coverage, up to 360 days per lifetime	
Inpatient Hospital Services		
Full coverage	Full coverage, with the following dollar amount limits per enrollment year: - $6,300 for stays in a general acute care hospital for substance abuse - $7,000 for stays in an IMD (Institutes for Mental Disease) for substance abuse treatment Hospital stays for mental health and substance abuse services have a 30-day limit	
Mental Health and Substance Abuse Treatment*		
Full coverage (not including room and board)	Coverage of this service is based on the Wisconsin State Employee Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, and child/adolescent mental health day treatment and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program (CSP), Comprehensive Community Services	

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	
	(CCS), outpatient services in the home and community for adults, and substance abuse residential treatment. Mental health services have no dollar maximums. Substance abuse services are limited to $7,000. Costs of mental health services, including inpatient stays, apply to this overall limit. Also, there are separate dollar limits for specific substance abuse services: - $4,500 for outpatient substance abuse services including $2,700 for outpatient services (including narcotic treatment) for substance abuse day treatment. - $6,300 for inpatient hospital stays in a general acute care hospital.	
Nursing Home Services		
Full coverage	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year.	
Outpatient Hospital – Emergency Room		
Full coverage	Full coverage	
Outpatient Hospital Services		
Full coverage	Full coverage	
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)		
Full coverage	Full coverage, limited to 20 visits per therapy discipline per enrollment year Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20 PT visits.)	
Physician Services		
Full coverage, including laboratory and radiology	Full coverage, including laboratory and radiology	
Podiatry Services		
Full Coverage	Full coverage	

BadgerCare Plus Standard Plan	BadgerCare Plus Benchmark Plan	
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	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	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization	
Routine Vision		
Full coverage including coverage of eyeglasses	One eye exam every year, with refraction	
Smoking Cessation Services		
Coverage includes prescription and OTC tobacco cessation products.	Coverage includes prescription generic and OTC tobacco cessation products.	
Transportation – Ambulance, Specialized Medical Vehicle (SMV), Common Carrier		
Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.	Coverage limited to emergency transportation by ambulance.	