

## **Table of Contents**

**State/Territory Name: Wisconsin**

**State Plan Amendment (SPA) #: 16-0014**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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December 9, 2021

Jim Jones, Medicaid Director  
Division of Medicaid Services  
Wisconsin Department of Health Services  
1 W. Wilson Street  
Madison, WI 53701

Re: WI State Plan Amendment (SPA) 16-0014

Dear Mr. Jones:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (IN) 16-0014. This amendment proposes to update the third-party liability and the Health Insurance Premium Payment program (HIP) sections of the state plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 CFR Part 433 Subpart D. This letter is to inform you that Wisconsin Medicaid SPA 16-0014 was approved on December 9, 2021, with an effective date of October 1, 2021.

If you have any questions, please contact Mai Le-Yuen at 312.353.2853 or via email at [mai.le-yuen@cms.hhs.gov](mailto:mai.le-yuen@cms.hhs.gov).

Sincerely,

A black rectangular redaction box covers the signature area of the letter.

Digitally signed by James G.  
Scott -S  
Date: 2021.12.09 15:38:00  
-06'00'

James G. Scott, Director  
Division of Program Operations

Enclosures

cc: Autumn Knudtson

### TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER:  
16-0014

2. STATE  
Wisconsin

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
10/01/2021

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
  - AMENDMENT TO BE CONSIDERED AS NEW PLAN
  - AMENDMENT
- COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Se arate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
42 CFR Sections 433.137 to 433.139, 435.145 to 433.148,  
and 433.151 to 154, and 1902(a)(25)(H) and (I) of the  
Social Security Act.

7. FEDERAL BUDGET IMPACT:  
a. FFY 2017 ..... \$OK  
b. FFY 2018 ..... \$OK

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

- Page 69, 70
- None
- Attachment 4.22-A, pg 1
- Attachment 4.22-B, pg 1, 2, 3
- Attachment 4.22-C, pg 1, 2, 3
- None
- Supplement 1 to Attachment 4.22-C, pg 1

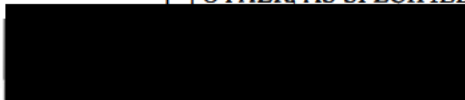
- Page 69, 69a, 70
- Attachment 4.22 Page 1
- Attachment 4.22-A Pages 1-5
- Attachment 4.22-B Pages 1-4
- Attachment 4.22-C Pages 1 to 5
- Attachment 4.22 Supplement 1 Page 1
- New

Third party liability.

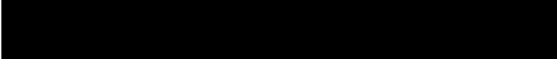
11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER AS SPECIFIED:



12. SIGNATURE OF STATE AGENCY OFFICIAL:



16. RETURN TO:  
Michael G. Heifetz  
State Medicaid Director  
Department of Health Services  
1 W. Wilson St.  
P.O. Box 309  
Madison, WI 53701-0309

13. TYPED NAME:

Michael G. Heifetz

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

December 23, 2016

#### FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

12/23/2016

18. DATE APPROVED: December 9, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2021

OFFICIAL:  
Digitally signed by James G. Scott - S  
Date: 2021.12.09 15:38:50 -06'00'

21. TYPED NAME:

James G. Scott

22. TITLE:

Director, Division of Program Operations

23. REMARKS: WI agreed to effective date change from  
10/1/2016 to 10/1/2021 upon discussion between CMS and the  
state on 12/8/21. MLY

## 4.22 Third Party Liability

Citation

42 CFR 433.137

- a. The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
  - (2) 42 CFR 433.145 through 433.148
  - (3) 42 CFR 433.151 through 433.154.
  - (4) Sections 1902 (a)(25) of the Social Security Act.

Sections 1902 (a)(25) of the Act

42 CFR 433.139 (b)(3)(ii)(A)

- c.  Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

42 CFR 447.20

- e. The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

42 CFR 433.151 (a)

- f. The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate)
- State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met
- Other appropriate State agency(s)
- Other appropriate agency(s) of another State
- Courts and law enforcement officials

1902 (a)(60) of the Act

- g. The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

- h. The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following:
- The Secretary's method as provided in the State Medicaid Manual, Section 3910.
- The State provides methods for determining cost effectiveness on Attachment 4.22-C.

## 4.22 Third Party Liability, continued

Citation

- |   |   |
|---|---|
| 42 CFR 433.138(f)   | <p>b. <b>ATTACHMENT 4.22-A</b> specifies the following:</p> <p>(1) The frequency with which the data exchanges required in 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in 433.138(e) are conducted;</p>   |
| 42 CFR 433.138 (g)(1)(ii) and (2)(ii)                       | <p>(2) The methods the agency uses for meeting the follow-up requirements contained in 433.138(g)(1)(i) and (g)(2)(i);</p>  |
| 42 CFR 433.138 (g)(3)(i) and (iii)                          | <p>(3) The methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under 433.138(d)(4)(ii), and specifies the time frames for incorporation, into the eligibility case file, into its third party database, and third party recovery unit, of all information obtained through the follow-up that identifies legally liable third party resources; and</p> |
| 42 CFR 433.138 (g)(4)(i) through (iii)                      | <p>(4) The methods the agency uses for following up on paid claims identified under 433.138(e), and specifies the time frames for incorporation, into the eligibility case file and into its third party recovery unit, of all information obtained through the follow-up that identifies legally liable third party resources.</p>   |
| <p>d. <b>ATTACHMENT 4.22-B</b> specifies the following:</p> |   |
| 42 CFR 433.139 (b)(3)(ii)(C)                                | <p>(1) The method used in determining a provider's compliance with the third party billing requirements at 433.139 (b)(3)(ii)(C).</p>   |
| 42 CFR 433.139 (f)(2)                                       | <p>(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would be cost effective.</p>   |
| 42 CFR 433.139 (f)(3)                                       | <p>(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.</p>  |
| 1902 (a)(25) of the Act                                     | <p>(4) The Medicaid agency assures that the State has in effect the laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility, and claims data, under section 1902(a)(25) of the Social Security Act, and specifies the compliance with 1902(a)(25)(E) and 1902(a)(25)(F).</p>   |

State: Wisconsin

## Requirements for Third Party Liability - Identifying Liable Resources

1. Frequency of data exchanges.

## 433.138 Determining Liability of Third Parties

(d)(1) – State Wage Information Collection Agencies (SWICA): The Department of Health Services (DHS) receives a SWICA file quarterly, but no longer uses this file to determine employer sponsored health insurance. Instead, DHS uses the Wisconsin Insurance Disclosure Program that requires health insurance carriers and pharmacy benefit managers to submit member eligibility data on a monthly basis.

(d)(2) – Commercial health insurance carriers: Monthly.

(d)(3) – IV-A: Part of the SWICA exchange, Quarterly.

(d)(4) – Workers compensation: Quarterly.

– Motor vehicle: DHS has a data exchange agreement with the Wisconsin DMV.

– Trauma codes: Daily.

2. Timeliness of follow-up.

433.138 (g)(1)(ii) SWICA The Income Maintenance system produces Employer Sponsored Health Insurance letters, and sends them to the recipient's employer for verification purposes. The Department of Health Services (DHS) processes the letters upon receipt.

433.138 (g)(2) Workers Compensation DHS contracts with a vendor who receives a quarterly file from the Department of Workforce Development (DWD) which contains social security numbers utilized for matching purposes.

433.138 (g)(2) The Insurance Disclosure Requirement is a program that requires health insurers to disclose eligibility information on all insured Wisconsin residents on a monthly basis. This information is used by Wisconsin to match against the Medicaid eligibility files to identify Medicaid members with insurance coverage.

3. Motor vehicle data match and tort/casualty processing:

433.138 (g)(2)(ii) The motor vehicle data exchange agreement allows for matching recipient claims data with the Department of Transportation's (DOT) accident files for potential matches.

433.138 (g)(3), 433.138 (g)(4): The DHS contracts with a vendor to identify and pursue paid claims that are indicative of trauma and injury for the purposes of determining the legal liability of third parties. These claims are processed under third party liability payment procedures on a daily basis. Information related to this type of liability is not carried on the MMIS. The collection case file maintained by the vendor contains all information relevant to management of the case.

State: Wisconsin

## Requirements for Third Party Liability – Payment of Claims

Guidelines Used to Determine When to Seek Reimbursement from a Liable Third Party

The following criteria are used in selecting claims which will be billed to third party insurers, or will be investigated for further collection action:

433.139 (d)(3); 433.139 (f): Health Insurance

Through analysis of schedules of benefits, payment statistics, and the denial notices sent to us by insurance carriers, certain items and services are excluded from cost avoidance and have been eliminated from post payment billing.

When it is discovered that commercial insurance benefits have been paid to the provider or the insured in duplication of the Medical Assistance payment to the provider, recovery of amounts that are greater than \$25 is sought from the provider within three years of the claim from date of service. Amounts of less than \$25 are pursued if staff time permits recovery.

433.139 (f)(2): Thresholds for seeking reimbursement

The Department of Health Services (DHS) uses no accumulation threshold for health insurance reimbursement.

Health insurance recovery action on claim types likely to be covered by insurance occurs when payments made by the DHS are greater than \$5.00.

Personal injury investigative action occurs when hospital bills with trauma diagnoses having billed amounts equal to or greater than \$250 are investigated. Investigative resources which would be required to pursue smaller bills can be used more productively to carry out tasks that yield much higher rates of return.

Cases having recoverable amounts of less than the investigative threshold are sometimes identified by means of provider referrals, attorney, or insurance carrier contacts. Although costs of collection may be relatively great as compared to any potential recovery, when a provider reports sending a small bill to an attorney, it cannot be determined immediately whether the bill reported by the provider was the only one involved or if it was one of several or many. As a precaution, the attorney or adjuster is sent a notice of lien immediately. Whatever the recoverable amount may later prove to be, recovery is sought because most of the work has already been completed and the costs of obtaining it have been incurred by that time. If billing is requested by an attorney or an adjuster in a small claim, as a matter of public policy, it should not be ignored even though it is not cost effective to comply with the request.

TN #16-0014

Supersedes

TN #93-041, #95-032

Approval date: 12/09/2021

Effective date: 10/01/2021

State: Wisconsin

## Requirements for Third Party Liability – Payment of Claims, continued

Third party billing conditions:

1. Monitoring provider compliance:  
433.139 (b)(1); 433.139 (b)(3): Cost Avoidance

Claims are processed in a totally automated environment, according to configurable table rules. These rules describe avoidance criteria in terms of claim content and provider supplied insurance explanation codes on claims. When the claim conditions match the configured table rules, the cost avoidance edits prevent payment, and tell providers that other insurance is available to bill prior to ForwardHealth.

433.139 (c): When a provider has received no response within 45 days of having billed an insurer, a follow-up inquiry must be directed to the insurer. If no response is received after a further 30 days, the provider may bill Medical Assistance using an appropriate insurance explanation code. Wisconsin ForwardHealth will rebill these claims to the insurer with the insurance based billing process.

433.139 (b)(3): If the insurance provided by a non-custodial parent has restrictions for services received outside a service area, the dependents are treated as uninsured. This kind of insurance information is either not added to the dependent's eligibility record on MMIS or it is removed when the situation is identified. This assures that access to medical care is not precluded or diminished by provider concerns about payment when a non-custodial parent is uncooperative in claiming insurance benefits.

Wisconsin complies with the following requirements.

- SSA Section 1902 (a)(25)(E): The requirement for states to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.
- SSA Section 1902 (a)(25)(E): The requirement for states to make payments without regard to potential third party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.
- SSA Section 1902 (a)(25)(F): State flexibility to make payments without regard to potential third party liability for up to 100 days for claims related to child support enforcement beneficiaries.

433.139 (b)(1); 433.139 (d): Providers are monitored for compliance with insurance billing requirements through post payment recovery responses. If a report of prior payment to either the provider or the insured person is received, the amount paid by the insurer is recouped from the provider.

TN #16-0014

Supersedes

TN #93-041, #95-032

Approval date: 12/09/2021

Effective date: 10/01/2021



State: Wisconsin

## Requirements for Third Party Liability – Payment of Claims, continued

2. 433.139 (d), 433.139 (f): Provider Based Billing / also called “Disallowment” nationally

Provider Based Billing occurs when Medicare (Parts A, B and D), Medicare Advantage insurance coverage, Medicare supplemental insurance coverage, and other commercial health insurance coverage is discovered after Medicaid has paid provider claims. Under provider-based billing, Medicaid produces claims that are sent to the providers of service with instructions to bill Medicare or the other health insurance carrier. If payment is received from Medicare or the other health insurance carrier, providers need to adjust their original Medicaid claim. If an adjustment is not received, or if the provider does not forward a copy of the Medicare or other health insurance carrier denial, Medicaid will recoup its payment 120 days from the date of the provider-based billing.

3. 433.139 (d), 433.139 (f): Insurance Based billing / also called “Direct Billing” nationally

Insurance Based Billing occurs when Medicare Advantage insurance coverage, Medicare supplemental insurance coverage, or other commercial health insurance coverage is found after Medicaid has paid provider claims, after a provider’s timely filing allowance has expired with these carriers, and/or when providers have not received a response in a timely manner from the other health insurance carrier. Under insurance-based billing, Medicaid produces and sends claims to the other health insurance carrier directly for payment recovery purposes.

Note: An electronic insurance based billing system implemented in autumn 2018. Carriers who accept electronic insurance-based billing from Wisconsin will also receive claims for which the provider added a disclaimer that they did not believe the service was covered or for which they believe the service was exhausted, in addition to claims for services that plans may cover for some employer groups but not the majority. Wisconsin uses the claim payment/denials to validate the cost avoidance rule criteria.

State: Wisconsin

## Cost Effectiveness Determination for Employer-Based Group Health

The Health Insurance Premium Payment (HIPP) program is a voluntary program for qualified members with full ForwardHealth coverage. ForwardHealth will supplement an Employer-Based Group (EBG) Health benefit where necessary to ensure the member receives the equivalent of full ForwardHealth coverage. HIPP approved ForwardHealth eligible members shall receive services that are unavailable from third party coverage and offered by ForwardHealth. For services covered by both ForwardHealth and the EBG health benefit, ForwardHealth will pay for the member's third party cost share up to the ForwardHealth allowable amounts on claims submitted without error.

The methodology for determining the cost effectiveness of paying HIPP is pursuant to Section 1906A of the Social Security Act. An EBG health benefit is assessed for cost effectiveness only after it has been determined that the employer contribution toward the health benefit premium is at least 40 percent.

**COST EFFECTIVENESS METHODOLOGY:**

Using an automated comparison tool, supplied by the fiscal agent, DHS determines cost effectiveness by subtracting the total HIPP cost from the average ForwardHealth cost to determine if the EBG health benefit will be cost effective. Rates and comparisons are made within gender/age/location groupings. The calculations are explained more fully below.

**Average ForwardHealth Cost**

This is the average cost ForwardHealth would expect to incur providing full ForwardHealth coverage to the individual(s) through ForwardHealth's normal delivery systems in the member's locale. This cost will include the following components:

- ForwardHealth HMO Capitation. This value may contain average ForwardHealth HMO dental costs and average chiropractic costs, depending on location grouping.
- Average FFS Costs for non-ForwardHealth HMO contracted services.

**HIPP Cost**

Premiums plus average FFS costs expended for services not covered by the EBG health benefit yet provided to ForwardHealth members.

- Member's portion of the EBG plan premium
- An Administrative Fee including: 1) the estimated cost of operating the the program, based on the salary of HIPP staff divided by the number of HIPP participants (currently \$10) and 2) one full month of the member's portion of the EBG plan premium divided over the 12 month determination period.
- Average cost for ForwardHealth covered services either not covered or not paid by the EBG, including the member's cost share in excess of the ForwardHealth cost share limits.
- Cost paid by ForwardHealth when the person cannot access a provider in their EBG network.

If the difference is a positive number, DHS will approve the member for HIPP participation, as there is a projected cost savings. If the difference is a negative number, there is no projected cost savings, and the application for HIPP participation is denied. DHS shall complete a redetermination review at least yearly for all HIPP enrollees.

TN #16-0014

Supersedes

TN #92-0023

Approval date: 12/09/2021

Effective date: 10/01/2021

## Cost Effectiveness Determination for Employer-Based Group Health, continued

Benefits Wrap Costs Calculations:**HIPP Calculation Example #1**

Calculate Average ForwardHealth Cost (Region 6).

In this case, the HMO Capitation includes major medical and dental coverage.

Case Members	ForwardHealth HMO Capitation	Average FFS Costs for non-HMO contracted services
Alexander (employee) Age 45	\$126.11	\$314.45
Dawn (spouse) Age 42	\$126.11	\$81.82
Catalina (child) Age 15	\$126.11	\$35.40
<b>Total</b>	<b>\$378.33</b>	<b>\$431.67</b>

$$\begin{aligned} \text{Average ForwardHealth Cost} &= \text{ForwardHealth HMO Capitation} + \text{Average FFS Costs for} \\ \text{non-HMO contracted services} &= \$378.33 + \$431.67 \\ &= \$810.00 \end{aligned}$$

*Calculate HIPP Cost*

*Assumptions: Member's Employer-Based Group Health benefit includes major medical and pharmacy coverage. The Average FFS Costs for non-Employer-Based Group covered services will include dental, Medicaid only services, and member cost share on major medical and pharmacy services.*

Case Members	Premium Amount	Admin Cost	Average costs of ForwardHealth services not covered and/or paid by the the EBG, including member cost share
Alexander (employee) Age 45	\$251.49	\$10.00 + \$20.96 = \$30.96	\$118.86
Dawn (spouse) Age 42			\$104.31
Catalina (child) Age 15			\$53.37
<b>Total</b>	<b>\$251.49</b>	<b>\$30.96</b>	<b>\$276.54</b>

$$\begin{aligned} \text{HIPP Cost} &= \text{Premium} + \text{Admin} + \text{Average costs of ForwardHealth services not covered and/or} \\ \text{paid by the the EBG, including member cost share} &= \$251.49 + \$30.96 + \$276.54 \\ &= \$558.99 \end{aligned}$$

*Calculate Cost Savings*

$$\begin{aligned} \text{Cost Savings} &= \text{MA Cap Cost} - \text{HIPP Cost} = \$810.00 - \$558.99 \\ &= \$251.01 \end{aligned}$$

State: Wisconsin

## Cost Effectiveness Determination for Employer-Based Group Health, continued

*Decision Recommendation*

For this example, ForwardHealth would approve the member for HIPP participation in their Employer-Based Group Health insurance as there is a projected savings to ForwardHealth of \$251.01 each month.

**HIPP Calculation Example #2**

Calculate Average ForwardHealth Cost (Region 2).

In this case, the HMO Capitation includes major medical coverage.

Case Members	ForwardHealth HMO Capitation	Average FFS Costs for non-HMO contracted services
Susan (employee) Age 29	\$106.67	\$81.82
John (child) Age 6	\$106.67	\$58.73
<b>Total</b>	<b>\$213.34</b>	<b>\$140.55</b>

$$\begin{aligned} \text{Average ForwardHealth Cost} &= \text{ForwardHealth HMO Capitation} + \text{Average FFS Costs for non-HMO contracted services} \\ &= \$213.34 + \$140.55 \\ &= \$353.89 \end{aligned}$$

*Calculate HIPP Cost*

Assumptions: Member's Employer-Based Group Health benefit includes major medical, dental and pharmacy coverage. The Average FFS Costs for non-Employer-Based Group covered services will include Medicaid only services, and member cost share on major medical, dental, and pharmacy services.

Case Members	Premium Amount	Admin Cost	Average costs of ForwardHealth services not covered and/or paid by the the EBG, including member cost share
Susan (employee) Age 29	\$251.49	\$10.00 + 20.96 = 30.96	\$98.21
John (child) Age 6			\$83.30
<b>Total</b>	<b>\$251.49</b>	<b>\$30.96</b>	<b>\$181.51</b>

$$\begin{aligned} \text{HIPP Cost} &= \text{Premium} + \text{Admin} + \text{Average costs paid by ForwardHealth not covered and/or paid by the the EBG, including Member Cost Share} \\ &= \$251.49 + \$30.96 + \$181.51 \\ &= \$463.96 \end{aligned}$$

*Calculate Cost Savings*

$$\begin{aligned} \text{Cost Savings} &= \text{MA Cap Cost} - \text{HIPP Cost} = \$353.89 - \$463.96 \\ &= \text{\textbf{\$-110.07}} \end{aligned}$$

*Decision Recommendation*

For this example, ForwardHealth would deny the member for HIPP participation in their Employer-Based Group Health insurance as there is no projected savings to ForwardHealth.

TN #16-0014

Supersedes

TN #92-0023

Approval date: 12/09/2021

Effective date: 10/01/2021

## Effectuating the Cost Sharing Wrap

In addition to the member's EBG plan benefits and cost share, ForwardHealth will pay for any Medicaid cost share amounts exceeding the member's Medicaid permissible cost share limit. ForwardHealth has provider enrollment strategies to ensure members have access to as many EBG providers as possible.

For services covered by both the EBG and ForwardHealth, the member is generally expected to use an EBG participating provider enrolled with ForwardHealth. Exceptions to this policy for all ForwardHealth members include, but are not limited to the following:

- The member denied coverage by the EBG and/or would not cooperate with the provider.
- The ForwardHealth provider knows the service in question is not covered by the EBG.
- The member's EBG failed to respond to initial and follow-up claims.
- Benefits are not assignable or cannot get assignment.
- The member's EBG benefits are exhausted.

To ensure network adequacy, HIPP members reporting a lack of adequate providers for medical services will be permitted to see any Medicaid provider for that particular service on a case-by-case basis. HIPP participation is voluntary and members are allowed to disenroll from the program at any time, for any reason, including if they feel their access to providers enrolled with both ForwardHealth programs and their EBG health plan is limited.

There are three options at ForwardHealth to effectuate HIPP premium payment:

- Send payment directly to the carrier
- Send payment directly to the employer
- Send payment directly to the member; The Department will pay the HIPP member prospectively for the member's premiums when the HIPP member submits a bill, invoice or other documentation demonstrating the member's liability to the Department no less than thirty (30) calendar days before payment is due. The Department may, at its discretion, pay the member's premiums if the member submits a bill or invoice less than thirty (30) calendar days before payment is due.

Members are given ForwardHealth Medicaid benefit cards to present in addition to their EBG health plan materials.