Table of Contents

State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 14-012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

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

Regional Operations Group

August 15, 2019

Jim Jones, Medicaid Director
Division of Medicaid Services
Wisconsin Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Laura Brauer, State Plan Amendment Coordinator

RE: Transmittal Number (TN) 14-012

Dear Mr. Jones:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

SPA TN 14-012: Removal of Reference to Co-Payments Assessed to Individuals Receiving Benefits Under the Benchmark Plan

- Effective Date: April 1, 2014
- Approval Date: August 14, 2019

If you have any questions, please have a member of your staff contact Mai Le-Yuen at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP
Regional Operations Group

Enclosures

cc: Karl Hauth, DHS
Laura Brauer, DHS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

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

Regional Operations Group

August 15, 2019

Jim Jones, Medicaid Director
Division of Medicaid Services
Wisconsin Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Laura Brauer, State Plan Amendment Coordinator

RE: Transmittal Number (TN) 14-012

Dear Mr. Jones:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) TN WI 14-012. Our review of this submission included a review of the state's proposal to align state cost sharing policies with the federal requirements and to memorialize the policies on the Medicaid Model Data Lab G1, G2a, G2b, G2c, and G3 state plan pages.

Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR §447.56(f), require the state to limit the amount of out of pocket expenditures that a beneficiary may incur. The state may not impose premiums and/or cost sharing that exceed an amount of five percent of family income (aggregate cap). During our review, the state informed CMS that it would comply with the aggregate cap and its associated tracking requirements by integrating functionality into its Medicaid Management Information System. This tracking functionality would allow the state to start and stop cost sharing once a beneficiary has reached his/her aggregate cap for the quarter. The state has procured a vendor and the state is working towards a timeline to implement this automated tracking system by January 1, 2020.

As the state works toward the implementation date, the state has agreed to a temporary process, which would stop cost sharing once a beneficiary has reached his/her aggregate cap for the quarter. Beneficiaries with documentation that shows the aggregate cap has been reached may contact the state to stop any cost sharing for the remainder of the quarter. The state will work with any providers, who collected copays in excess of the cap, to reimburse the beneficiary. To inform beneficiaries and providers, the state will provide a notice of this temporary process through a ForwardHealth Update. The state will also update its member handbooks to alert new members of this process. The state has agreed to implement this process for 12-months or until the tracking system is functional, whichever date is earlier.

To close out the expectations established in this companion letter, the state should provide CMS with documentation of its progress toward implementing both the temporary process and the automated tracking system. Please share with us a copy of the ForwardHealth Update, and the updated member handbooks. Also, please report back on the state's progress in implementing the automated tracking system by January of 2020.

If you have any questions about this letter or require any further assistance, please contact Mai Le-Yuen at (312) 353-2853, or mai.le-yuen@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP
Regional Operations Group

cc: Karl Hauth, DHS
Laura Brauer, DHS

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Wisconsin**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

WI-14-0012

Proposed Effective Date

04/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

s. 1916A and 1937 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Removal of reference to co-payments assessed to individuals receiving benefits under the benchmark plan.

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Laura Brauer**
Last Revision Date:	**Jul 8, 2019**
Submit Date:	**Mar 29, 2019**

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

Providers receive this information in the Wisconsin online provider handbook. The online handbook includes information regarding copayment amounts, exemptions, limitations, collecting/refunding copayments, and a statement that providers may not deny services to members who fail to make a copayment.

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

Medicaid Premiums and Cost Sharing

The state has established differential cost sharing for preferred and non-preferred drugs. No

☒ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Ambulatory Surgery Centers (ASC)	3.00	$	Procedure	Copay limited to procedure codes with a maximum reimbursement greater than $50.	Remove
Add	Chiropractic reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Chiropractic reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Chiropractic reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Chiropractic reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Dental reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Dental reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Dental reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Dental reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Disposable Medical Supplies reimbursed at $10 or less	0.50	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $10.01 to $25	1.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $25.01 to $50	2.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at more than $50	3.00	$	Item		Remove

Medicaid Premiums and Cost Sharing

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Diabetic Supplies	0.50	$	Prescription		Remove
Add	Drugs — Generic	1.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Brand	3.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Over-the-Counter	0.50	$	Prescription		Remove
Add	Durable Medical Equipment reimbursed at $10 or less	0.50	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $10.01 to $25	1.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $25.01 to $50	2.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at more than $50	3.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Hearing Services reimbursed at $10 or less	0.50	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at more than $50	3.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hospital — Inpatient	3.00	$	Day	$75 cap per inpatient stay.	Remove
Add	Hospital — Outpatient	3.00	$	Visit		Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove

	Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
	Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
	Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
	Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
	Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
	Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
	Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
	Add	Physician Services reimbursed at $10 or less	0.50	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove

	Add	Physician Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Physician Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Physician Services reimbursed at more than $50	3.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Physician Laboratory Services	1.00	$	Other	Unit is per lab test. Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Physician Radiology and Portable Xray Services	3.00	$	Procedure	Copayments are applicable on professional claims only. All radiation oncology services and add-on codes are exempt from the copayment requirement. Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Podiatry reimbursed at $10 or less	0.50	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Podiatry reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Podiatry reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Podiatry reimbursed at more than $50	3.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
	Add	Routine Foot Care	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Vision Care reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Vision Care reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Vision Care reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Vision Care reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Vision Care — Eyeglasses, New	3.00	$	Pair	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Frame, Lens, or Temple Replacement	2.00	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Repair	0.50	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Transportation — Non-emergency Ambulance Trips	2.00	$	Trip		Remove
Add	Transportation — Specialized Medical Vehicle (SMV)	1.00	$	Trip		Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add							Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional):

Eligibility Group(s) Included: Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes, stated below, whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C).

Incomes Greater than 151% FPL TO Incomes Less than or Equal to 301% FPL

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Ambulatory Surgery Centers (ASC)	3.00	$	Procedure	Copay limited to procedure codes with a maximum reimbursement greater than $50.	Remove
Add	Chiropractic reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Chiropractic reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Chiropractic reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Chiropractic reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Dental reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Dental reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Dental reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Dental reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Disposable Medical Supplies reimbursed at $10 or less	0.50	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $10.01 to $25	1.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $25.01 to $50	2.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at more than $50	3.00	$	Item		Remove
Add	Diabetic Supplies	0.50	$	Prescription		Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Drugs — Generic	1.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Brand	3.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Over-the-Counter	0.50	$	Prescription		Remove
Add	Durable Medical Equipment reimbursed at $10 or less	0.50	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $10.01 to $25	1.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $25.01 to $50	2.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at more than $50	3.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Hearing Services reimbursed at $10 or less	0.50	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at more than $50	3.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hospital — Inpatient	3.00	$	Day	$75 cap per inpatient stay.	Remove
Add	Hospital — Outpatient	3.00	$	Visit		Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physician Services reimbursed at $10 or less	0.50	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at more than $50	3.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Laboratory Services	1.00	$	Other	Unit is per lab test. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Radiology and Portable Xray Services	3.00	$	Procedure	Copayments are applicable on professional claims only. All radiation oncology services and add-on codes are exempt from the copayment requirement. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $10 or less	0.50	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Podiatry reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at more than $50	3.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Routine Foot Care	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Vision Care reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Vision Care reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Vision Care reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Vision Care reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Vision Care — Eyeglasses, New	3.00	$	Pair	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Frame, Lens, or Temple Replacement	2.00	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Repair	0.50	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Transportation — Non-emergency Ambulance Trips	2.00	$	Trip		Remove
Add	Transportation — Specialized Medical Vehicle (SMV)	1.00	$	Trip		Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **No**

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. **No**

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

Medicaid Premiums and Cost Sharing

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Population Name (optional):

Eligibility Group(s) Included: Infants with incomes stated below, whose eligibility was determined under 1902(a)(10)(A)(ii)(IX)

Incomes Greater than 151% FPL TO Incomes Less than or Equal to 301% FPL

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Ambulatory Surgery Centers (ASC)	3.00	$	Procedure	Copay limited to procedure codes with a maximum reimbursement greater than $50.	Remove
Add	Chiropractic reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Chiropractic reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Chiropractic reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Chiropractic reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Dental Services reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Dental Services reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Dental Services reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Dental Services reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Disposable Medical Supplies reimbursed at $10 or less	0.50	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $10.01 to $25	1.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $25.01 to $50	2.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at more than $50	3.00	$	Item		Remove
Add	Diabetic Supplies	0.50	$	Prescription		Remove
Add	Drugs — Generic	1.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Drugs — Brand	3.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Over-the-Counter	0.50	$	Prescription		Remove
Add	Durable Medical Equipment reimbursed at $10 or less	0.50	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $10.01 to $25	1.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $25.01 to $50	2.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at more than $50	3.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Hearing Services reimbursed at $10 or less	0.50	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at more than $50	3.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hospital — Inpatient	3.00	$	Day	$75 cap per inpatient stay.	Remove
Add	Hospital — Outpatient	3.00	$	Visit		Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physician Services reimbursed at $10 or less	0.50	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at more than $50	3.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Laboratory Services	1.00	$	Other	Unit is per lab test. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Radiology and Portable Xray Services	3.00	$	Procedure	Copayments are applicable on professional claims only. All radiation oncology services and add-on codes are exempt from the copayment requirement. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $10 or less	0.50	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Podiatry reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at more than $50	3.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Routine Foot Care	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Vision Care reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Vision Care reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Vision Care reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Vision Care reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Vision Care — Eyeglasses, New	3.00	$	Pair	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Frame, Lens, or Temple Replacement	2.00	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Repair	0.50	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Transportation — Non-emergency Ambulance Trips	2.00	$	Trip		Remove
Add	Transportation — Specialized Medical Vehicle (SMV)	1.00	$	Trip		Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **No**

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. **No**

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

Medicaid Premiums and Cost Sharing

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Population Name (optional):

Eligibility Group(s) Included: Children 6 to 18 years old with incomes stated below, whose eligibility was determined under 1902(a)(10)(A)(ii)(XIV)

Incomes Greater than 133% FPL TO Incomes Less than or Equal to 151% FPL

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Ambulatory Surgery Centers	3.00	$	Procedure	Copay limited to procedure codes with a maximum reimbursement greater than $50.	Remove
Add	Chiropractic Services reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Chiropractic reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Chiropractic reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Chiropractic reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Dental Services reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Dental Services reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Dental Services reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Dental Services reimbursed at $25.01 to $50	3.00	$	Procedure		Remove
Add	Disposable Medical Supplies reimbursed at $10 or less	0.50	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $10.01 to $25	1.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $25.01 to $50	2.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at more than $50	3.00	$	Item		Remove
Add	Diabetic Supplies	0.50	$	Prescription		Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Drugs — Generic	1.00	$	Prescription	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Brand	3.00	$	Prescription	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Over-the-Counter	0.50	$	Prescription		Remove
Add	Durable Medical Equipment reimbursed at $10 or less	0.50	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $10.01 to $25	1.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $25.01 to $50	2.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at more than $50	3.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Hearing Services reimbursed at $10 or less	0.50	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at more than $50	3.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hospital — Inpatient	3.00	$	Day	$75 cap per inpatient stay.	Remove
Add	Hospital — Outpatient	3.00	$	Visit		Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
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Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
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Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at more than $50	3.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Laboratory Services	1.00	$	Other	Unit is per lab test. Copayment limited to $30.00 per provider, per calendar year.	Remove
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Add	Podiatry reimbursed at $10 or less	0.50	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Podiatry reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at more than $50	3.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Routine Foot Care	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Vision Care Services reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Vision Care Services reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Vision Care Services reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Vision Care Services reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Vision Care — Eyeglasses, New	3.00	$	Pair	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Frame, Lens, or Temple Replacement	2.00	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Repair	0.50	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Transportation — Non-emergency Ambulance Trips	2.00	$	Trip		Remove
Add	Transportation — Specialized Medical Vehicle (SMV)	1.00	$	Trip		Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **No**

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. **No**

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ☐ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ☐ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ☐ 133% FPL; and
  - ☐ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ☐ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ☐ SSI Beneficiaries (42 CFR 435.120).
  - ☐ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ☐ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ☐ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ☐ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ☐ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ☐ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ☐ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ☐ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ☐ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ○ Under age 21
- ◉ Other reasonable category

Description:

Individuals under age 21 who are in: Nursing Facilities, Intermediate Care Facilities, Skilled Nursing Facilities and Institutions for Mental Diseases.

Individuals under age 19 in foster homes for whom a public agency is assuming a full or partial financial responsibility.

Certain disabled individuals under the age of 19, who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section1902(e)(3)(B) of the Act.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☑ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☑ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

Medicaid Premiums and Cost Sharing

■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:

☐ The state accepts self-attestation

☐ The state runs periodic claims reviews

☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document

☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

☒ The Wisconsin Medicaid and BadgerCare Plus application for health care coverage includes questions to determine if the applicant is a member, child, or grandchild of a member of an American Indian or Alaskan Native tribe; if s/he is eligible to receive services from a Tribal clinic, Indian Health Services (IHS) or urban Indian health program; or, if s/he has ever received services from one of the above. Based on the responses to the questions, an indicator is triggered to "Yes" on the member's eligibility file in MMIS. The "Yes" indicator exempts the member from the copay requirement. Providers using the Eligibility Verification System (EVS) to check eligibility receive a response indicating that the member is exempt from the co-payment requirement.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. ☒ Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Medicaid Premiums and Cost Sharing

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

The state has recently executed a new contract with our Fiscal Agent that specifies, among other things, that the MMIS system shall track and limit a family's cost share liability (including both premiums and copayments) to no more than 5 percent of the family's income, per quarter. The solution includes notifying providers and members when a family's cost share liability is reached. The state plans to implement this enhancement by January 1, 2020.

The annual limits identified in templates G2a and G2c will be enforced in addition to, but not in lieu of, this quarterly family cost share liability limit.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **No**

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

These cases are handled on a case-by-case basis and the Department works directly with the providers and beneficiaries to ensure they are reimbursed appropriately.

■ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Reassessment of the family aggregate limit would be done systematically in conjunction with any change in circumstance and/or other eligibility reviews that would happen for a family.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). Yes

Description of additional aggregate limits:

Wisconsin has aggregate limits on the following benefits:

- Drugs
- Inpatient services
- Outpatient services
- Physician services
- Podiatry services
- Therapy services

Refer to G2a and G2c for details.

PRA Disclosure Statement

V.20160722

This attachment has been superseded by MMDL Forms G1, G2a, G2c, and G3.

This attachment previously included the following pages:

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13	93-040
14	10-016

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Page	**Superseded TN No.**
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1a	08-006
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3a	08-025
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10	08-006

Section 4.18 has been superseded by MMDL Forms G1, G2a, G2c, and G3.

Section 4.18 (continued) has been superseded by MMDL Forms G1, G2a, G2c, and G3.

Section 4.18 (continued) has been superseded by MMDL Forms G1, G2a, G2c, and G3.

Section 4.18 page 56 previously included pages 56, 56a, 56b, 56c, 56d, 56e, and 56f.