State of Wisconsin
Medicaid 2014 Waiver

Understanding the Impact of New Federal Policies on the Affordability of Health Insurance, Medicaid Eligibility Simplification, Adoption of Rules on Income, and Medicaid Interaction with Real-time Web-Based Applications

1115 Demonstration Project Application

November 10, 2011

Wisconsin Department of Health Services

Table of Contents

Medicaid 2014 Demonstration Project

An initiative to test the policy impacts of the federal law on Medicaid to go into effect in 2014, including crowd-out policies, cost-sharing requirements, income determination methods, adverse selection provisions, the relevance of Transitional Medicaid and the impact of real-time eligibility on verification requirements and retroactive and presumptive determinations.

Part I: Statement of Purpose

Introduction

The Patient Protection and Affordable Care Act (PPACA) will fundamentally change policies that govern state Medicaid programs. Wisconsin is submitting this federal 1115 waiver to pilot several policies that will prepare our BadgerCare Plus programs to better align with the pending changes in federal law.

Wisconsin is uniquely positioned to undertake this pilot demonstration. Our existing BadgerCare Plus program includes parents and childless adults up to 200% of the federal poverty level (FPL) as well as children and pregnant women up to 300% FPL.

Thus, BadgerCare Plus currently includes families and individuals whose incomes cross the federal threshold for Medicaid and subsidized insurance authorized by PPACA beginning in 2014. In that year, adults with incomes greater than 133% FPL (or 138% without income disregards) will be required to purchase private health insurance, while adults with incomes below 133% will be eligible for Medicaid.

Wisconsin, therefore, through this Medicaid 2014 waiver, is positioned to demonstrate the impact of pending PPACA policies on potential Medicaid and subsidy participants and to model the way policy decisions will impact the interaction between these two coverage sources.

It is our belief that CMS approval of Wisconsin's Medicaid 2014 Waiver is critical not only to our own success in building a bridge to 2014 but to the national policy dialogue surrounding implementation of these untested federal policies.

The following summary of Medicaid 2014 Waiver provisions describes the key role each one plays in testing significant policy parameters of PPACA's impact on Medicaid and the resulting coverage outcomes of lower-income Americans.

Part II: Current Environment

Wisconsin has been successful achieving widespread health care access without a federal mandate. In 1999, the state implemented BadgerCare to provide a health care safety net for low-income families transitioning from welfare to work.

BadgerCare Plus expanded coverage to families at higher income levels. Beginning in 2008, the following groups were eligible for coverage:

1) All uninsured children (birth through age 18) regardless of income
2) Pregnant women with incomes up to 300% of the FPL
3) Parents and caretaker relatives with incomes up to 200% of the FPL
4) Caretaker relatives with incomes up to 200% of the FPL
5) Parents with children in foster care with incomes up to 200% of the FPL
6) Youth (ages 18 through 20) aging out of Wisconsin's foster care system
7) Farm families and other self-employed parents with dependent children with incomes up to 200% of the FPL, contingent upon depreciation calculations.

Wisconsin also implemented the Core Plan for childless adults with incomes less than 200% FPL through an 1115 waiver in 2009.

Wisconsin has also maintained for many years one of the leading eligibility information systems in the country. Our "Access" web portal (access.wi.gov) has been duplicated by many other states because it provides the public with an easy, online method for submitting a Medicaid application.

All of these factors make Wisconsin the ideal setting for implementation of a waiver aimed at understanding the impact of new federal policies on the affordability of health insurance, Medicaid eligibility simplification, adoption of rules on income, and Medicaid interaction with real-time web-based applications

III. Waiver Description

The following summary of Medicaid 2014 Waiver provisions describes the key role each one plays in testing significant policy parameters of PPACA's impact on Medicaid and the resulting coverage outcomes of lower-income Americans.

Crowd Out

The Patient Protection and Affordable Care Act (PPACA) disqualifies lower-income families above the poverty line from eligibility for government-subsidized health coverage if they have access to an employer-sponsored plan that does not require premiums in excess of 9.5% of household income.

The Medicaid 2014 Waiver will test this affordability threshold by applying a similar standard to BadgerCare Plus members in a similar income range. The waiver evaluation will look at how individuals not eligible for BadgerCare Plus based on this crowd-out provision subsequently interact with the private health care market. Do they follow-through with maintaining coverage at the expected levels of cost-sharing?

PPACA also disqualifies lower-income young adults above the poverty line from eligibility for government-subsidized health coverage if they have access to coverage under a parent's employer-sponsored insurance plan.

The Medicaid 2014 Waiver will align BadgerCare Plus crowd-out provisions with this policy to test whether or not young adults subsequently enroll in their parents plan and maintain access to health coverage.

Cost Sharing

PPACA requires families and individuals to purchase insurance that will require premium and copayment contributions. According to a recent study released by the Urban Institute, the estimated average annual premium cost for families with incomes between 138% and 200% FPL is $1,559 in 2014, with additional estimated out-of-pocket expenses of $457.

Wisconsin's Medicaid 2014 waiver will move toward aligning BadgerCare Plus cost-sharing provisions with those authorized by PPACA. This will demonstrate the impact of cost-sharing provisions on lower-income families above the poverty line. Will participants pay? Will the cost-sharing requirements slow the growth of health care spending? The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid, the Basic Health Plan and subsidized insurance.

Transitional Medical Assistance (TMA)

TMA itself is not authorized under PPACA, but has existed for many years to support the transition from welfare to work. TMA allows individuals to maintain their Medicaid coverage for 12 additional months once their income changes from an amount that would have qualified them for benefits under the former Aid to Families with Dependent Children (AFDC) cash assistance program to an amount above that income threshold.

In Wisconsin, the AFDC income threshold is 100% of the federal poverty level (FPL). TMA policy in Wisconsin has never been adjusted to reconcile to expanded eligibility criteria for Medicaid. Beginning in 2008, parents with incomes up to 200% FPL

became eligible for BadgerCare Plus. This meant that, even without TMA, a person below the poverty line could have at least twice as much earned income without losing Medicaid coverage.

The future of TMA in the context of PPACA implementation is uncertain since the program's authorization expires before 2014. Continuation of TMA will introduce inequities because it will result in families with the same income experiencing different eligibility outcomes.

Therefore, the Wisconsin 2014 Waiver proposes to demonstrate how ending TMA interacts with an environment where low-cost coverage remains available to individuals.

Under the waiver, those who would otherwise be exempt from cost-sharing under TMA will be expected to make modest premium and other cost-sharing contributions to maintain their Medicaid coverage. This simulates how a Medicaid to subsidized insurance transition would work for these same individuals if TMA is ended nationally.

This demonstration would have national significance for policy decisions related to the future of the Transitional Medical Assistance program.

Restrictive Re-Enrollment

Even with the tax penalties envisioned under PPACA for failure to comply with the insurance mandate, consumers may have financial incentives to selectively purchase coverage for specific months in which they anticipate high utilization

Therefore, policies to prevent such adverse selection will be critical in 2014 and beyond. The Wisconsin 2014 waiver will test the impact of applying restrictive re-enrollment as a measure of protection against adverse selection.

The waiver will evaluate the impact of the policy on premium payment compliance and the overall PMPM for BadgerCare Plus members in populations subject to this policy.

Again, the outcome of the demonstration will provide insights of national significance related to policies aimed at assuring the financial solvency of long-term health care.

Real-Time Eligibility

PPACA envisions that a real-time eligibility process for Medicaid and subsidized insurance is in place by January 1, 2014.

A key component of Wisconsin's Medicaid 2014 waiver will be to implement real-time eligibility during Demonstration Year 1. This implementation raises policy questions about a variety of Medicaid eligibility provisions designed to address application processing time and the definition of Medicaid eligibility begin and end dates.

The Medicaid 2014 waiver will test the impact on eligibility by replacing retroactive and presumptive eligibility policies with a real-time, online application system designed to facilitate immediate access to Wisconsin's health care safety net.

The real-time system will redefine and modernize the logic of outdated methods used to calculate a recipient's eligibility begin date and end date. Wisconsin's Medicaid 2014 Waiver will demonstrate the potential efficiency of operating a real-time eligibility system and the potential savings states can achieve by avoiding the unnecessary costs associated with arbitrary backdating and end-dating.

To assure program integrity and the effective use of public tax dollars, the accuracy of online eligibility determinations must be supported by a strong back end quality control process. In our Medicaid 2014 Waiver, Wisconsin proposes to demonstrate the interaction of real-time eligibility with a back end verification process by strengthening our state residency verification requirements.

Redefining Household Income

PPACA will fundamentally change the way income is measured for Medicaid eligibility purposes in 2014. The new method required for use is based on Internal Revenue Service (IRS) "Modified Adjusted Gross Income" rules.

In Wisconsin, it is unclear whether MAGI rules will accurately capture the total sum of household resources available to applicants and recipients of the publicly-funded Medicaid program.

Therefore, Wisconsin requests authority through our proposed Medicaid 2014 Waiver to pilot an alternative methodology that considers the resources of all adults living in the household of the person who is filing the application.

In doing this, Wisconsin will gather data significant to assessing whether MAGI comprehensively captures household resources. This demonstration will also help Wisconsin assess the expected total Medicaid enrollment in 2014 based on a clearer picture of how the income methodology affects household eligibility.

IV. Demonstration/Hypothesis

The Medicaid 2014 waiver will test the health policy impacts of the federal law that are scheduled to take effect in 2014, including crowd-out policies, cost-sharing requirements, income determination methods, adverse selection provisions, the relevance of Transitional Medicaid and the impact of real-time eligibility on verification requirements and retroactive and presumptive determinations.

The Medicaid 2014 Waiver will align BadgerCare Plus crowd-out provisions with this policy to test whether or not young adults subsequently enroll in their parents plan and maintain access to health coverage.

The waiver will demonstrate the impact of cost-sharing provisions on lower-income families above the poverty line. Will participants pay? Will the cost-sharing requirements slow the growth of health care spending? The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid, the Basic Health Plan and subsidized insurance.

The Wisconsin 2014 Waiver proposes to demonstrate how ending transitional Medical Assistance (TMA) interacts with an environment where low-cost coverage is otherwise available to individuals.

The waiver will evaluate the impact of restrictive re-enrollment policies on premium payment compliance and the overall PMPM for BadgerCare Plus members in populations subject to this policy.

The Medicaid 2014 waiver will test the impact of replacing retroactive and presumptive eligibility policies with a real-time, online application system designed to facilitate immediate access to Wisconsin's health care safety net.

The waiver will test the significance of household income resources not considered by MAGI rules. Is the income of other adults living in the household significant to the determination of eligibility for Medicaid?

The Medicaid 2014 Waiver provides the federal government with a budget neutral way to pilot policies related to Medicaid and the implementation of PPACA. Indeed, the provisions of this waiver are projected to not only further policy insights in order to achieve the best possible transition to 2014, but they generate savings for state and federal taxpayers as well.

To that end, this proposal requests waiving several provisions of federal law, including PPACA's own maintenance of effort (MOE) requirements. MOE flexibility is critical to the success of this demonstration because it facilitates testing ideas about the interaction between Medicaid and other health policies in PPACA.

The attached table reflects details of what provisions will be applied to whom for this demonstration.

Two existing Wisconsin 1115 waivers are affected by this proposal. The state is requesting to amend both our childless adults' demonstration waiver 11-W-00242/5 and our BadgerCare waiver 11-W-00125/5 to better align the policies contained therein with this Medicaid 2014 waiver. Wisconsin looks forward to partnering with CMS to enact this important demonstration project.

We are requesting authority to maintain the Wisconsin Medicaid 2014 waiver through December 31, 2013, the same sunset date currently scheduled for both the BadgerCare and Core waivers.

V. Waivers and Authority Requested

This demonstration program requires waivers from Titles XIX and XXI of the Social Security Act (the Act).

Wisconsin requests that the Secretary waive all relevant Medicaid and Children's Health Insurance Program (CHIP) laws and regulations which would allow Wisconsin to receive federal matching funds as described below. Wisconsin may also request waiving other Medicaid and CHIP laws and regulations not specified below to the extent we become aware that waiving additional citations would be necessary to implement the proposed demonstration program.

A. Demonstration Populations

Demonstration Population 1: pregnant women and non-disabled children < age 1 year.
Demonstration Population 2: non-disabled children ages 1 year through 5 years.
Demonstration Population 3: non-disabled children ages 6 through age 18 years.
Demonstration Population 4: parents and caretakers (age 19 years and older) who do not have a disability.

B. Expenditure Authority

a. Wisconsin requests that, under the authority of sections 1115(a)(1) and 2107(e)(2)(A) of the Act, expenditures for the items identified below be regarded as expenditures under Wisconsin's Medicaid and CHIP State Plans. These are the exceptions to Medicaid and CHIP requirements for the demonstration populations:

    1. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3) and 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for anyone who has access to

employer sponsored major medical insurance in which the monthly premium that the employee pays does not exceed 9.5% of the family's income as described in detail below. Wisconsin requests this change for children in Demonstration Population 1, 2 and 3, where family income exceeds 133% of the federal poverty level. Wisconsin also requests this change for Demonstration Populations 4 where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who have had access to employer-sponsored major medical health insurance (individual or family) in which the premium paid by the employee does not exceed 9.5 percent of the family's income in the previous 12 months from a household member's current employer, subject to the good cause exceptions in subparagraph (c), or

(b) Who will have access to the aforementioned insurance in subparagraph (a) from a household member's current employer in the 3 calendar months following:
   i. The month in which they apply for Medicaid, or
   ii. The month in which the State is conducting the annual redetermination of Medicaid eligibility, or
   iii. The month in which the household member begins employment.

(c) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
   i. Loss of employment;
   ii. Discontinuation of health benefits to all employees by the client's employer; or
   iii. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:
      1) A private health insurance policy; or
      2) Medicaid, or CHIP, unless the eligible parent had a family income at or above 100 percent of the Federal poverty level, or the eligible child had a family income above 133 percent of the Federal poverty level.

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

2. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for anyone who has coverage under major medical insurance in which the monthly premium that the family pays does not exceed 9.5% of the family's income. Wisconsin requests this change for children in Demonstration Populations 1, 2 and 3 where family income exceeds 133% of the federal poverty level. Wisconsin also requests this change for Demonstration Populations 4 where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

   Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

   (a) Who currently have coverage under major medical health insurance, either through an employer or privately purchased, in which the monthly premium that the family pays does not exceed 9.5% of the family's income (individual or family), or
   (b) Who have had coverage to the aforementioned insurance in subparagraph (a), in the previous 3 months, subject to the good cause exceptions in subparagraph (c),
   (c) Exceptions to the aforementioned conditions defined in subparagraph (b) include:
      i. Health insurance was lost during the 3 month period for employment related reasons, including:
         I. Involuntary termination of employment;
         II. Voluntary termination due to the incapacitation or health condition of the individual or that of an immediate family member. An immediate family member is defined as a spouse, child or parent;
         III. The individual changed employers and the new employer does not offer health insurance coverage.
         IV. Employer discontinued health plan coverage for all employees.
      ii. Coverage was lost due to the death or change in marital status of the policy holder;
      iii. The Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage continuation period expired during the 12 month period.
      iv. The insurance is owned by someone not residing with the family and continuation of the coverage is beyond the family's control.
      v. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

3. Wisconsin requests a waiver of sections 1902(a)(74), 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid eligibility for adults under age 26 who have access to major medical coverage under their parents' employer sponsored health insurance. Wisconsin requests this change for pregnant women in Demonstration Population 1 where family income exceeds 100% of the federal poverty level. Wisconsin also requests this change for parents and caretakers in Demonstration Population 4, where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who currently have, or in the past 12 months, did have access to their parent's employer sponsored major medical health insurance, from their parent's current employer, subject to the good cause exceptions in subparagraph (b), or
(b) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
    i. Loss of employment;
    ii. Discontinuation of health benefits to all employees by the parent's employer;
    iii. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

4. Wisconsin requests a waiver of sections 1902(a)(74), 1902(a)(14) and 1916A(b)(3)(A)(i) of the Act to allow Wisconsin to charge premiums to children with incomes between 150 and 185% of the federal poverty level in a mandatory group. This applies to Demonstration Population 2.

5. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10), 1902(a)(14) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for twelve months for

anyone who has refused to pay a BadgerCare Plus premium or has been terminated for failure to pay a BadgerCare Plus premium. This applies to children in Demonstration Populations 1, 2, and 3 with incomes greater than 150% of the federal poverty level.

6. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(17)(D) of that Act to allow Wisconsin to include the income of all adults residing in the same household for at least 60 days, except grandparents not applying for or receiving Medicaid with the children (i.e., a three generation case), in determining the Medicaid and CHIP eligibility of individuals in Demonstration Populations 1, 2, and 3. Wisconsin also requests a waiver for Demonstration Population 4 with incomes up to 150% of the federal poverty level. This change does not extend to including the financial needs of the other adults as it pertains to household size for the determination of eligibility.

   NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

7. Wisconsin requests a waiver of sections 1902(a)(74) and 1902(a)(34) of that Act to allow Wisconsin to end backdating eligibility for individuals who meet all Medicaid requirements in the three months prior to the application month. This would be applied to Demonstration Populations 1, 2, and 3. Wisconsin also requests a waiver for Demonstration Population 4 with incomes up to 150% of the federal poverty level.

   NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

8. Wisconsin requests a waiver of sections 1902(a)(52), (63), (74) and 1902(e)(1) of that Act to allow Wisconsin to end:

   - 12 months of Transitional Medical Assistance (TMA) for families when earnings cause them to lose eligibility for Medicaid under section 1931,

   - 4 months of TMA for families when earnings cause them to lose eligibility for Medicaid under section 1902(e)(1), and

- 4 months of TMA for families when child support income cause them to lose eligibility for Medicaid under section 1931.

This would be applied to Demonstration Populations 1, 2, 3, and 4.

b. Wisconsin requests that, under the authority of section 1115(a)(1) and 2107(e)(2)(A) of the Act, expenditures for the items identified below be regarded as expenditures under Wisconsin's Medicaid and CHIP State Plans. The following items include those eligibility requirements that would be allowed under Wisconsin's Medicaid or CHIP State Plans, but for the imposition of section 1902(a)(74) and 2105(d)(3) of the Act as it applies to the Maintenance of Effort requirements of a state's programs and the claiming of federal financial participation (FFP). Wisconsin requests that we be allowed to change our policies or submit State Plan Amendments to implement the following items, and receive CMS approval without impact to the state's ability to receive FFP:

1. Provide the state with authority to establish and adjust premiums for individuals in Medicaid or CHIP with incomes above 150% of the FPL within the limits of the federal 5% of household income cost sharing cap. This applies to children in Demonstration Populations 1, 2, and 3, when family income exceeds 150% of the federal poverty level.

   NOTE: Wisconsin is requesting an 1115 waiver of 1902(a)(14) in section a. 4. above for the demonstration 2 population of children with family incomes from 150% to 185% of the federal poverty level.

2. End presumptive eligibility option for the children under Demonstration Populations 1, 2 and 3.

3. While this will not require a state plan amendment to either the Medicaid or CHIP State Plans, Wisconsin requests that the termination or reduction of existing eligibility be effective on the date ten days after adequate notice of an adverse action, rather than the current practice of ending or reducing eligibility at the end of the calendar month after a ten day notice has been provided. This would apply to Demonstration Populations 1, 2, and 3. This would also apply to Demonstration Population 4 with incomes up to 133% of the federal poverty level.

4. While this will not require a state plan amendment to either the Medicaid or CHIP State Plans, Wisconsin requests that we be allowed to require applicants and recipients to verify residence in the State of

Wisconsin. This applies to Demonstration Populations 1, 2, and 3. This would also apply to Demonstration Population 4 with incomes up to 133% of the federal poverty level. In the case of children under Demonstration Populations 1, 2 and 3, this requirement means that the child's parent or caretaker relatives would supply proof of intent to reside in Wisconsin.

Separately, the state is also filing proposed amendments to the Core childless adults waiver #11-W-00242/5 and the BadgerCare waiver #11-W-00125/5 seeking authority to better align the eligibility rules of those waivers to the Medicaid 2014 waiver.

Part VI: Public Input

The ideas for many of the efficiencies included in Wisconsin's Medicaid 2014 waiver reflect extensive public input gathered through Town Hall meetings held by DHS at locations throughout the state earlier this year.

DHS submits the Medicaid 2014 waiver after public hearing by the Legislature's Joint Committee on Finance, pursuant to direction of the Legislature in enactment of the 2011-13 budget.

On September 30, 2011 DHS posted specific information about this waiver on the Department website with an opportunity for public comment. In addition, DHS held public hearings on this and other Medicaid efficiencies provisions in Madison and Milwaukee on October 19 and 21, 2011.

Along with the website available to them, DHS separately solicited the input of Wisconsin tribes through letters sent on October 14, 2011 and during a meeting held on October 25 between DHS and tribal representatives.

Part VII. Evaluation

Wisconsin will conduct an external evaluation to test the impact of certain provisions of the Patient Protection and Affordable Care Act (PPACA) on Medicaid.

The evaluation will be developed in partnership with the University of Wisconsin Population Health Institute within the UW School of Medicine and Public Health. The Institute has been involved in the design of BadgerCare Plus and is currently evaluating the program expansion to all children, parents and pregnant women. Specific research questions being considered for the Medicaid 2014 waiver include:

<u>Program Impact Questions</u>

1. Is 9.5% of household income a reasonable threshold for affordability? Do members follow-through with maintaining coverage at the expected levels of cost sharing?

2. Do young adults enroll in their parent's major medical insurance policy as a result of the waiver's crowd-out restrictions for this population?

3. Do additional cost sharing requirements lower the growth rate of health care costs? Why or why not?

4. Does ending transitional medical assistance (TMA) create barriers to re-employment when coverage options exist at income levels that are at least twice the TMA income limit?

5. Do enhanced restrictive re-enrollment policies impact premium payment compliance and overall program per-member per-month costs?

6. Does a real-time eligibility system lessen the need for retroactive and presumptive eligibility policies?

7. How can back-end verification processes work effectively with online real-time eligibility to assure both efficiency and program integrity in Medicaid?

8. Does MAGI comprehensively capture household resources in light of the data collected under the authority of this waiver to consider the income of all adults living in the household?

9. Does the program lead to more continuous care and reduce churning as compared to the GAMP population experience?

VIII. Budget

The budget neutrality documents have been attached to this waiver proposal

BadgerCare + Maintenance of Effort Baseline & Savings

Agg. Exp. Difference	29,963,161	189,924,230
Agg Case Difference	12,601	64,646

Aggregate MOE Baseline (w/out Waiver)

	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	$ 1,480,110,259	$ 1,778,252,880	$ 1,805,071,462	$ 2,001,243,508	$ 2,170,544,602	$ 2,207,849,931	$ 2,278,333,048	$ 2,462,724,598	$ 2,662,066,790
Ave. Enrollment	605,217	687,148	731,234	766,000	783,876	763,852	752,632	767,480	782,624
Total PMPM	$ 204	$ 216	$ 206	$ 218	$ 231	$ 241	$ 252	$ 267	$ 283

Aggregate MOE w/ Waiver

	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	$ 1,480,110,259	$ 1,778,252,880	$ 1,805,071,462	$ 1,971,934,252	$ 1,989,287,409	$ 2,056,132,304	$ 2,135,899,243	$ 2,309,399,981	$ 2,498,801,608
Ave. Enrollment	605,217	687,148	731,234	753,635	720,847	718,272	709,034	724,058	739,406
Total PMPM	$ 204	$ 216	$ 206	$ 218	$ 230	$ 239	$ 251	$ 266	$ 282

	FY09	**FY10**	**FY11**	**FY12**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**
Aggregate Expenditure Difference*	**$ -**	**$ -**	**$ -**	**$ 29,309,256**	**$ 181,257,192**	**$ 151,717,627**	**$ 142,433,805**	**$ 153,324,617**	**$ 163,265,182**

* Declining annual savings beginning FY14 attributed to PPACA implementation
* Aggregate with and without waiver does not include Core.

MOE Waiver	**Exp. Difference**	-	-	-	**16,637,605**	**89,819,471**	**97,202,632**	**105,192,688**	**113,839,527**	**123,197,136**
	Caseload Difference	-	-	-	**6,353**	**29,258**	**29,843**	**30,440**	**31,049**	**31,670**

BC+ - Kids

Baseline	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	644,125,122	751,794,354	760,870,878	844,869,649	917,456,480	992,889,752	1,074,525,147	1,162,872,605	1,258,483,991
Ave. Enrollment	386,148	432,953	458,176	479,508	490,768	500,583	510,595	520,807	531,223
Total PMPM	139.0	144.7	138.4	146.8	155.8	165.3	175.4	186.1	197.4
PMPM Change		4.1%	-4.4%	6.1%	6.1%	0.061	6.1%	6.1%	6.1%

W. Waiver	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	644,125,122	751,794,354	760,870,878	828,232,043	827,637,009	895,687,120	969,332,460	1,049,033,078	1,135,286,855
Ave. Enrollment	386,148	432,953	458,176	473,155	461,510	470,740	480,155	489,758	499,553
Total PMPM	139.0	144.7	138.4	145.9	149.4	158.6	168.2	178.5	189.4
PMPM Change		4.1%	-4.4%	5.4%	2.4%	6.1%	6.1%	6.1%	6.1%

MOE Waiver	**Exp. Difference**	**-**	**-**	**-**	**-**	**4,049,127**	**4,339,085**	**4,649,807**	**4,982,780**	**5,339,596**
	Caseload Difference	**-**	**-**	**-**	**-**	**333**	**337**	**340**	**343**	**347**

BC+ Pregnant

Baseline	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	171,076,909	209,621,563	209,627,686	224,639,125	240,725,533	257,963,888	276,436,682	296,232,313	317,445,509
Ave. Enrollment	18,725	19,147	19,625	19,821	20,019	20,220	20,422	20,626	20,832
Total PMPM	761.4	912.3	890.1	944.4	1002.1	1063.2	1128.0	1196.8	1269.8
PMPM Change		19.8%	-2.4%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%

W. Waiver	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Expenditures	171,076,909	209,621,563	209,627,686	224,639,125	236,676,406	253,624,803	271,786,875	291,249,533	312,105,912
Ave. Enrollment	18,725	19,147	19,625	19,821	19,686	19,883	20,082	20,283	20,486
Total PMPM	761.4	912.3	890.1	944.4	1,001.9	1,063	1,128	1,197	1,270
PMPM Change		20%	-2%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%

MOE Waiver	**Exp. Difference**	-	-	-	2,837,001	32,948,703	18,481,774	32,591,310	34,502,311	34,728,449
	Caseload Difference	-	-	-	2,731	16,581	6,409	12,818	12,030	11,201
MOE Waiver Adults (w/ PPACA)										
	Baseline	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	608,403,406	745,615,967	759,046,344	847,434,110	918,268,592	904,483,748	927,371,219	1,003,619,681	1,086,137,291
	Ave. Enrollment	182,827	213,525	229,866	241,879	247,008	229,330	221,615	226,047	230,568
	Total PMPM	277.3	291.0	275.2	292.0	309.8	328.7	348.7	370.0	392.6
	PMPM Change		4.9%	-5.4%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
	W. Waiver	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	608,403,406	745,615,967	759,046,344	844,597,109	885,319,888	886,001,975	894,779,909	969,117,370	1,051,408,841
	Ave. Enrollment	182,827	213,525	229,866	239,148	230,427	222,921	208,797	214,017	219,367
	Total PMPM	277.3	291.0	275.2	294.3	320.2	331.2	357.1	377	399
	PMPM Change		4.9%	-5.4%	7.0%	8.8%	3.4%	7.8%	5.7%	5.8%

MOE Waiver	**Exp. Difference**	-	-	-	9,834,650	54,439,891	31,694,137	-	-	-
	Caseload Difference	-	-	-	3,281	16,857	8,991	-	-	-
BC+ Waiver: Adults 150% - 200% (w/ PPACA)										
	Baseline	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	56,504,822	71,220,997	75,526,554	84,300,625	94,093,997	52,512,543	0	0	0
	Ave. Enrollment	17,516	21,524	23,567	24,792	26,081	13,719	0	0	0
	Total PMPM	268.8	275.7	267.1	283.4	300.6	319			
	PMPM Change		2.6%	-3.1%	6.1%	6.1%	6.1%			
		FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	56,504,822	71,220,997	75,526,554	74,465,975	39,654,106	20,818,406	0	0	0
	Ave. Enrollment	17,516	21,524	23,567	21,511	9,224	4,727	0	0	0
	Total PMPM	268.8	275.7	267.1	288.5	358.2	367.0			
	PMPM Change		2.6%	(0)	8.0%	24.2%	2.4%			

MOE Waiver										
				Exp. Difference	**653,905**	**8,667,038**				
BC+ CORE - Childless Adults				**Caseload Difference**	**236**	**1,617**				
	Baseline	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	22,547,210	153,040,505	132,605,863	167,642,410	174,542,026	174,542,026	174,542,026	174,542,026	174,542,026
	Ave. Enrollment	8,265	50,627	45,349	34,047	34,047	30,813	27,578	27,578	27,578
	Total PMPM	227	252	244	258.54	274.31	291.04	308.80	327.63	347.62
	PMPM Change				6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
	W. Waiver	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
	Expenditures	22,547,210	153,040,505	132,605,863	167,642,410	174,542,026	174,542,026	174,542,026	174,542,026	174,542,026
	Ave. Enrollment	8,265	50,627	45,349	33,811	32,430	29,349	26,268	26,268	26,268
	Total PMPM	227.33	251.91	243.67	258.73	265.72	281.92	299.12	317.37	336.73
	PMPM Change				5.4%	-1.7%	6.1%	6.1%	6.1%	6.1%
	Exp.Savings									

Budget neutrality for the Core plan is based on the States Disproportionate Share Hospital Allocation.
Due to PPACA starting January 1, 2014, Core plan enrollees under 138% FPL will be covered under the state plan instead of the 1115 waiver.

RE: Wisconsin BadgerCare Plus Health Insurance 1115 Demonstration Waiver, **Waiver 11-W-00125/5**

Per the terms of Wisconsin's approved 1115 demonstration waiver (11-W-00125/5) that includes the population of categorically needy parents and caretaker relatives who would be eligible for Medicaid under Wisconsin's Medicaid state plan under section 1902(a)(10)(A)(ii)(I) of the Act, who are not pregnant and whose countable income is at or above 150% of the FPL, up to and including 200% FPL, the State of Wisconsin is writing to request the following modifications to the Special Terms and Conditions (STCs) that were last amended and approved effective January 1, 2011.

Modification to Section V, Item 15

This amendment modifies the insurance crowd out provisions applied to the demonstration population as follows:

Under this demonstration, the State may exclude from eligibility under the State plan the following individuals who:

1. Have access to employer sponsored major medical insurance in which the monthly premium that the employee pays does not exceed 9.5% of the family's income as described in detail below.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who have or have had access to employer-sponsored major medical health insurance (individual or family) in which the premium paid by the employee does not exceed 9.5 percent of the family's income in the previous 12 months from a household member's current employer, subject to the good cause exceptions in subparagraph (c), or

(b) Who will have access to the aforementioned insurance in subparagraph (a) from a household member's current employer in the 3 calendar months following:
i. The month in which they apply for Medicaid, or
ii. The month in which the State is conducting the annual redetermination of Medicaid eligibility, or
iii. The month in which the household member begins employment.

(c) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
i. Loss of employment;
ii. Discontinuation of health benefits to all employees by the client's employer; or

iii. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:

1) A private health insurance policy; or

2) Medicaid, or CHIP, unless the eligible parent had a family income at or above 100 percent of the Federal poverty level of the eligible child had a family income at or above 133 percent of the Federal poverty level.

2. Have coverage under major medical insurance in which the monthly premium that the family pays does not exceed 9.5% of the family's income.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who currently have coverage under major medical health insurance, either through an employer or privately purchased, in which the monthly premium that the family pays does not exceed 9.5% of the family's income (individual or family), or

(b) Who have had coverage to the aforementioned insurance in subparagraph (a), in the previous 3 months, subject to the good cause exceptions in subparagraph (c),

(c) Exceptions to the aforementioned conditions defined in subparagraph (b) include:

i. Health insurance was lost during the 3 month period for employment related reasons, including:

I. Involuntary termination of employment;

II. Voluntary termination due to the incapacitation or health condition of the individual or that of an immediate family member. An immediate family member is defined as a spouse, child or parent;

III. The individual changed employers and the new employer does not offer health insurance coverage.

IV. Employer discontinued health plan coverage for all employees.

ii. Coverage was lost due to the death or change in marital status of the policy holder;

iii. The Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage continuation period expired during the 12 month period.

iv. The insurance is owned by someone not residing with the family and continuation of the coverage is beyond the family's control.

v. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

3. Are under age 26 and have access to major medical coverage under their parents' employer sponsored health insurance.

   Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

   (a) Who currently have or have had access to their parent's employer sponsored major medical health insurance in the previous 12 months, from their parent's current employer, subject to the good cause exceptions in subparagraph (b), or
   (b) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
      i. Loss of employment;
      ii. Discontinuation of health benefits to all employees by the parent's employer;
      iii. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

Additionally, the State requests authority to broaden the BadgerCare waiver to include the following provisions:

Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10), 1902(a)(14) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for twelve months for anyone included in this demonstration who has refused to pay a BadgerCare Plus premium or has been terminated for failure to pay a BadgerCare Plus premium.

Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(17)(D) of that Act to allow Wisconsin to include the income of all adults residing to in the same household for at least 60 days, except grandparents not applying for or receiving Medicaid with the children (i.e., a three generation case), in determining the eligibility of anyone in this demonstration. This change does not extend to including the financial needs of the other adults as it pertains to household size for the determination of eligibility.

These provisions may be added as amendments to Section V, Item #15 of the Special Terms and Conditions.

Revised Budget Neutrality Assessment

See attached chart for projected, all funds and federal funds, impact of the benefit modifications.

RE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults Section 1115 Demonstration Waiver, **Waiver 11-W-00242/5**

Per the terms of Wisconsin's approved 1115 demonstration waiver (11-W-00242/5) extending Medicaid coverage to uninsured childless adults, the State of Wisconsin is writing to request the following modifications to the Special Terms and Conditions (STCs) that were last amended and approved effective July 1, 2010.

Modification to Section IV, Item 17(f)

This amendment modifies the definition of household income by adding the following language to Section IV, item 17(f):

Income is defined as the total income of all adults residing in the household for at least 60 days. For purposes of determining income eligibility by household size, the household composition includes the applicant and, if applicable, his or her spouse.

Modification to Section IV, Item 17(m)

This amendment adds monthly premium requirements for eligible individuals with incomes between 150% and 200% FPL by adding the following language to Section IV, item 17(m):

Individuals with incomes between 150% and 200% FPL are required to pay a monthly premium that shall not exceed 5% of the individual's household income. Failure to meet this premium requirement will result in twelve months of restrictive re-enrollment. Premiums will be in addition to copayment and application fee requirements established in STC item 28.

Modification to Section IV, Item 17

This amendment waives maintenance of effort requirements for certain eligibility procedures and methods by adding the following paragraph (not lettered) to the end of item 17:

Additionally, maintenance of effort provisions required under Section 1902(a)(74) of the Social Security Act shall be waived for the following eligibility procedures and methods:

1) *Verification of Residency – Eligibility procedures shall be modified to require each applicant, both at the time of initial application and at each required eligibility renewal, to provide verification of their state residency.*
2) *Eligibility End Date – Eligibility procedures shall be modified to end eligibility ten days after adequate notice of adverse action. This replaces the current*

practice of ending eligibility on the last day of the calendar month after a ten day notice has been provided.

3) *Income Methodology – As identified in the proposed amendment to Section IV, Item 17(f), eligibility methods shall be modified related to determination of income. Income will be defined as the total income of all adults living in the household. For purposes of determining income eligibility by household size, the household composition includes the applicant and, if applicable, his or her spouse.*

Modification to Section V, Item 28

This amendment adds premiums to the cost sharing requirements for eligible individuals with incomes between 150% and 200% FPL by adding the following language to Section V, item 28:

Individuals with incomes between 150% and 200% FPL are requested to pay a monthly premium that shall not exceed 5% of the individual's household income.

Revised Budget Neutrality Assessment

See attached chart for projected, all funds and federal funds, impact of the benefit modifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

d. Enforcement

Applies only to: i. Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 200 to 300% of the Federal income poverty line, whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C); ii. Infants with incomes from 200 through 300% of the official Federal income poverty line, under 1902(a)(10)(A)(ii)(IX).

1. _X/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

2. _X/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

a. __/ No premiums are imposed.

b. X_/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

Group of Individuals	Premium*	Method for Determining Family Income (including monthly or quarterly period)
Parents and caretaker relatives 1902(a)(10)(A)(ii) With incomes above 150% and at or below 200% of the official Federal poverty line income (FPL) Infants 1902(a)(10)(A)(ii)(IX) With incomes from 150% through 300% of the FPL Children 1902(a)(10)(A)(i)(VI) With incomes above 150% through 185% of the FPL	Countable income — Premium Amount Above 150% - 159.99% FPL: .... 5% of 150% FPL 160% - 169.99% FPL: ..... 5% of 160% FPL 170% - 179.99% FPL: ..... 5% of 170% FPL 180% - 189.99% FPL: ..... 5% of 180% FPL 190% - 199.99% FPL: ..... 5% of 190% FPL 200% - 209.99% FPL: ..... 5% of 200% FPL 210% - 219.99% FPL: ..... 5% of 210% FPL 220% - 229.99% FPL: ..... 5% of 220% FPL 230% - 239.99% FPL: ..... 5% of 230% FPL 240% - 249.99% FPL: ..... 5% of 240% FPL 250% - 259.99% FPL: ..... 5% of 250% FPL 260% - 269.99% FPL: ..... 5% of 260% FPL 270% - 279.99% FPL: ..... 5% of 270% FPL 280% - 289.99% FPL: ..... 5% of 280% FPL 290% - 300.00% FPL: ..... 5% of 290% FPL	The methodology used to determine family income is the same as the methodology used to determine eligibility, except that depreciation expenses are added back in.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

* Premium calculations shown in the previous table are reduced as described below when the household is paying premiums for major medical health insurance for other members of the Medicaid/CHIP household.

Household income	Medicaid Premium Reduction Amount
Above 150% FPL up to 200% FPL	50%, not to exceed other premium amount paid
Above 200% FPL up to 250% FPL	33%, not to exceed other premium amount paid
Above 250% FPL up to 300% FPL	20%, not to exceed other premium amount paid

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

STATE: Wisconsin

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Group Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1920A of the Act ___ 24. Presumptive Eligibility for Children

Children under age 19 who are determined by a qualified entity (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid Is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the state agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Supersedes Approval Date:_____ Effective Date:_____
TN No.__07-007_____

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 the amount they pay for premiums is no more than 9.5% of their household income.**

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 employee pays more than 9.5% of their household income for employer health insurance coverage;
Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays *at least 40 % 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 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 household gross income test without any deductions. "Household gross income" includes the income of all adults residing in the home for at least 60 days, except for grandparents if they are not applying for or receiving Medicaid with the children (i.e., a three generation case). Financial needs of adults whose income is being counted are not considered unless they are legally responsible for the child.

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:

<u>Unborn Children</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 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 household's share of the premium exceeds 9.5% of household income.

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 had Medicaid, unless the eligible parent had a family income above 100% of the FPL, or the eligible child had an income above 133% of the FPL, and**
  - **No one in the family was covered through CHIP.**

<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 the employee's contribution exceeds 9.5% percent of the household's income. 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 for which the employee's contribution exceeds 9.5% percent of the household's income. The percentage of employee 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 had Medicaid, unless the eligible parent had a family income above 100% of the FPL, or the eligible child had an income above 133% of the FPL, and**
  - **No one in the family was covered through CHIP.**

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 premiums the employee pays is 9.5% or less of the household's income 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 % of the premium and the employee would pay in excess of 9.5% of household income for his/her share of the premium* 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 300% 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 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 cost of the premium that employee pays is 9.5% or less of household income 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 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 150% FPL. The base 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. Base rates for children ages 1 – 18, with
Incomes at or above 150% FPL up to, but not including 160% FPL: 5% of 150% FPL;
Incomes at or above 160% FPL up to, but not including 170% FPL: 5% of 160% FPL;
Incomes at or above 170% FPL up to, but not including 180% FPL: 5% of 170% FPL;
Incomes at or above 180% FPL up to, but not including 190% FPL: 5% of 180% FPL;
Incomes at or above 190% FPL up to, but not including 200% FPL: 5% of 190% FPL;
Incomes at or above 200% FPL up to, but not including 210% FPL: 5% of 200% FPL;
Incomes at or above 210% FPL up to, but not including 220% FPL: 5% of 210% FPL;
Incomes at or above 220% FPL up to, but not including 230% FPL: 5% of 220% FPL;
Incomes at or above 230% FPL up to, but not including 240% FPL: 5% of 230% FPL;
Incomes at or above 240% FPL up to, but not including 250% FPL: 5% of 240% FPL;
Incomes at or above 250% FPL up to, but not including 260% FPL: 5% of 250% FPL;
Incomes at or above 260% FPL up to, but not including 270% FPL: 5% of 260% FPL;
Incomes at or above 270% FPL up to, but not including 280% FPL: 5% of 270% FPL;
Incomes at or above 280% FPL up to, but not including 290% FPL: 5% of 280% FPL;
Incomes at or above 290% FPL up to, 300% FPL : 5% of 290% FPL;

In cases where the household is paying premiums for major medical health insurance for other members of the Medicaid/CHIP household we will reduce the amount of the base rates as indicated below.

Household income	**Medicaid Premium Reduction Amount**
Above 150% FPL up to 200% FPL	**Up to 50%, not to exceed the amount paid for the other premium**
Above 200% FPL up to 250% FPL	**Up to 33%, not to exceed the amount paid for the other premium**
Above 250% FPL up to 300% FPL	**Up to 20%, not to exceed the amount paid for the other premium**

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 150 - 300% FPL	See 8.2.1	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))**

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

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 twelfth month after which benefits were lost;**
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 150% 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 150% 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))**

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.**

The State will solicit proposals from managed care organizations either to provide the HMO benefit package that has the largest insured commercial, non-Medicaid enrollment in the State, or to provide a benefit package that meets the requirements for benchmark-equivalent coverage under SSA § 1937(b)(2). In the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage, the State will make all required assurances and showings relating to actuarial equivalence.

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)**

6.1.4.1 ☐ Coverage the same as Medicaid State plan

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

6.1.4.3 ☒ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

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)

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 services checked below are for our separate SCHIP population of children from birth to 19 years up to and including 300% FPL. 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

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:

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 2, 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))**

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

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 are 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 Department will develop a systems solution within the Medicaid Management Information System (MMIS) to track the cost sharing expenses and alert providers when copayments are to no longer be charged to 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.

Attachment 2
Co-payment Table
Wisconsin SCHIP children with 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	$15 per visit
Disposable Medical Supplies	$0.50 per priced unit
Drugs	$4 for generic $8 for brand name
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
Home Health Services	$15 per visit

Service/Item	Co-payment
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	No co-payment
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) • $100 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 services, and diagnostic services, emergency services and anesthesia.
Podiatry Services	$15 per visit
Speech Therapy (ST)	$15 per visit
Vision Care Services	$15 per visit

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 Benchmark Plans.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.
Chiropractic	Full coverage. $15.00 copayment per visit.
Dental	Full coverage for members 20 years of age and younger. For members 21 years of age and older, dental coverage is limited to: • Diagnostic • Preventive • Simple Restorative • Surgical Procedures • Dentures Cost Sharing: • $15 copayment per visit for all members
Dental (continued)	

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Disposable Medical Supplies (DMS)	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). $0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.
Drugs	Coverage of generic drugs, certain preferred brand name drugs on Wisconsin Medicaid's Preferred Drug List and some OTC drugs. Members are limited to 5 prescriptions per month for opioid drugs. Prior authorization will be available for select drug classes and brand medically necessary drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. Copayments are as follows: • $4.00 for generic drugs. • $8.00 for brand name drugs.
Durable Medical Equipment (DME) DME (continued)	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to

Service	Coverage Under the BadgerCare Plus Benchmark Plan
	copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21.
Hearing Services	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.
Hospice	Full coverage, up to 360 days per lifetime. No copayment.
Inpatient Hospital	Full coverage. Copayments are as follows: • $100.00 per stay for medical stays. • $50.00 copayment per stay for mental health and/or substance abuse treatment.
Mental Health and Substance Abuse Treatment	Full Coverage (not including room and board.) up to 200% FPL. No copayment.
Nursing Home Services	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.
Outpatient Hospital — Emergency Room	Full coverage. $100.00 copayment per visit

Service	Coverage Under the BadgerCare Plus Benchmark Plan
	(waived if the member is admitted to a hospital).
Outpatient Hospital	Full coverage. $15.00 copayment per visit.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP)	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-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits over 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.
Physician	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia,

Service	Coverage Under the BadgerCare Plus Benchmark Plan
	preventive services or clozapine management.
Podiatry	Full coverage. $15.00 copayment per visit.
Prenatal/Maternity Care	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	One eye exam with refraction and a single pair of eye glasses per enrollment year. $15.00 copayment per visit.
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by

Service	Coverage Under the BadgerCare Plus Benchmark Plan
	ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.

Coverage Offered through a Commercial HMO
Benchmark Plan
Attachment A

Service	Commercial Insurance
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. Deductible & coinsurance.
Chiropractic Chiropractic (Continued)	PCP Copay if copay applies. Deductible and Coinsurance if no copay applies.
Dental	Accidental dental only; subject to deductible and coinsurance and limited. Limited to $3000 maximim per year, and $900 maximum per tooth.

Service	Commercial Insurance
Dental (Continued)	
Disposable Medical Supplies (DMS)	Ostomy supplies are limited to $2500 per year. Other DMS are deductible and coinsurance limitations apply, coverage is available if filled at the pharmacy under the prescription drug benefit.

Service	Commercial Insurance
DMS (Continued)	
Drugs Drugs (Continued)	Comprehensive prescription drug benefit; copays apply. Most common card is $10 Genric $35 Brand $60 Non-Preferrred Brand $100 Specialty injectible drugs OTC drugs are not covered. Tiering changes 2 times per year. Drugs are place on tiers based on chemical effectiveness versus cost.

Service	Commercial Insurance
Drugs (Continued)	
Durable Medical Equipment (DME) Durable Medical Equipment (DME) cont'd	Deductible and coinsurance; limited to $2500 per year; single purchase of a type of DME (including repair & replacement) every 3 years. Cochlear implants are included under DME as required by WI state law.
End-Stage Renal Disease (ESRD)	Deductible and coinsurance, preservice notification required.
Health Screenings for Children	Preventative physicals covered at 100%; no copay or deducitble applies. Sports physicals are not covered.

Service	Commercial Insurance
Hearing Services	Hearing screenings covered under preventative physical benefit. No coverage for hearing aids. Cochlear implants are covered under durable medical equipment.
Hearing Services (Continued)	

Service	Commercial Insurance
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Deductible and coinsurance limited to 60 visits per year.
Hospice Hospice (Continued)	Deductible and coinsurance apply.
Inpatient Hospital	Deductible and Coinsurance apply.

Service	Commercial Insurance
Inpatient Hospital (Continued)	
Mental Health and Substance Abuse Treatment	Deductible and Coinsurance; copay applies for outpatient office calls and transitional treatment
Mental Health and Substance Abuse Treatment (Continued)	

Service	Commercial Insurance
Mental Health and Substance Abuse Treatment (Continued)	

Service	Commercial Insurance
Mental Health and Substance Abuse Treatment (Continued)	
Nursing Home Services	Skilled nursing facility/inpatient rehab facility services: 30 days per inpatient stay for skilled nursing services; 60 days per year for inpatient rehab services
Outpatient Hospital — Emergency Room	$250 copay applies on copay plans followed by 100% coverage; deductible & coinsurance applies on non-copay plans

Service	Commercial Insurance
Outpatient Hospital	Deductible & coinsurance
Outpatient Hospital (Continued)	

Service	Commercial Insurance
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP)	Copay applies on copay plans, deducitble and coinsurance applies on non-copay plans. Benefits are limited to 20 visits for PT, 20 visits for OT, 20 visits for speech, 20 visits for pulmonary rehabilitation, 36 visits for post-cochlear implant aural surgery, visits do not apply to manipulative treatment or autism.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP) (Continued)	
Physician	Copay applies on copay plans followed by 100% including any laboratory services when completed at an in network facility. Deductible and coinsurance apply on non-copay plans.

Service	Commercial Insurance
Physician (Continued) Physician (Continued)	
Podiatry	Subject to a copay on copay plans or deductible and coinsurance on non-copay plans.

Service	Commercial Insurance
Podiatry (Continued)	
Prenatal/Maternity Care	Deductible and coinsurance.
Reproductive Health Service	Deductible and coinsurance. No coverage for fertility services.
Routine Vision	Subject to an office call copay on copay plans and deducitble and coinsurance on non-copay plans. Vision screenings are covered at 100% under the preventive benefit.

Service	Commercial Insurance
Routine Vision (Continued)	
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier Transportation — Ambulance, SMV, Common Carrier (Continued)	Deductible and coinsurance for air and ground.

State/Territory: Wisconsin

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

X Title of Alternative Benefit Plan A: Family Medicaid Benchmark Plan
☐ Title of Alternative Benefit Plan B
☐ Add Titles of additional Alternative Benefit Plans as needed

1. **Populations and geographic area covered**

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in a benchmark benefit plan to obtain medical assistance.

State/Territory: Wisconsin

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

State/Territory: Wisconsin

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan.
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan.
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Caretakers and Children above 100% FPL	Statewide
X		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)	100-150% FPL	Statewide
X		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)	100-185% FPL	Statewide
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group:		
X		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	200-300% FPL	**Statewide**
X		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)	150-300% FPL	Statewide
X		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	Caretakers 100-200% FPL	Statewide
X		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)	Children age 6-18, 100-150% FPL	Statewide

State/Territory: Wisconsin

Chart, continued

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: **Newborns who are deemed eligible under 1902(e)(4) and whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C).**	150-200% FPL	Statewide

☐ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

None of these groups will be given the option to voluntarily enroll in an alternative benefit plan.

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan.
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		

State/Territory: Wisconsin

Chart, continued

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Neither of these groups will be given the option to voluntarily enroll in an alternative benefit plan.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☐ (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment.
  - The individual was given ample time to arrive at an informed choice.
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

State/Territory: Wisconsin

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

  Wisconsin is not offering voluntary enrollment to these individuals.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual of all of the following:

- Enrollment is voluntary.
- Each individual may choose at any time not to participate in an alternative benefit package.
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

Populations and individuals in the early option group will not be given the option to voluntarily enroll in an alternative benefit plan.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment.
  - The individual was given ample time to arrive at an informed choice.
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

State/Territory: Wisconsin

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/ benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

  Wisconsin is not offering voluntary enrollment to these individuals.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual of all of the following:
  - Enrollment is voluntary.
  - Each individual may choose at any time not to participate in an alternative benefit package.
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

Not applicable.

State/Territory: Wisconsin

X **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

X The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438.

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

See Attachment A for a copy of the HMO's benefit package.

☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

State/Territory: Wisconsin

b) X Benchmark-Equivalent Benefits.

The State will solicit proposals from managed care organizations either to provide the HMO benefit package that has the largest insured commercial, non-Medicaid enrollment in the State, or to provide a benefit package that meets the requirements for benchmark-equivalent coverage under SSA § 1937(b)(2). In the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage, the State will make all required assurances and showings relating to actuarial equivalence.

Please specify below which benchmark plan or plans this benefit package is equivalent to:
Coverage Offered Through a Commercial Health Maintenance Organization (HMO)

X (i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

X Inpatient and outpatient hospital services.

X Physicians' surgical and medical services.

X Laboratory and x-ray services.

X Coverage of prescription drugs.
Prescription drugs are carved out of HMO coverage and are covered on a fee-for-service basis.

X Mental health services.

X Well-baby and well-child care services as defined by the State/Territory, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices.

X Emergency services.

X Family planning services and supplies.

X (ii) Additional services
Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.
The Family Medicaid Benchmark Plan covers additional benefits in the following service areas:

- Dental
- Hearing Services - hearing aids
- SLP services following a cochlear implant
- Vision - coverage of one pair of eyeglasses

State/Territory: Wisconsin

X (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that has all of the following characteristics:

- Has been prepared by an individual who is a member of the American Academy of Actuaries.
- Uses generally accepted actuarial principles and methodologies.
- Uses a standardized set of utilization and price factors.
- Uses a standardized population that is representative of the population being served.
- Applies the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Please insert a copy of the report.

Actuarial report will be provided in the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage.

X (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

Response will be provided in the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage.

State/Territory: Wisconsin

c) **X** Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

The Family Medicaid Benchmark Plan covers additional benefits in the following service areas:

- Dental
- Hearing Services - hearing aids
- SLP services following a cochlear implant
- Vision - coverage of one pair of eyeglasses

3. Service Delivery System

Check all that apply.

X The benchmark benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The benchmark benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The benchmark benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The benchmark benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The benchmark benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The benchmark benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

X The benchmark benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

State/Territory: Wisconsin

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only.

X As an Additional benefit under section 1937 of the Act.

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Wisconsin has instituted a transportation management system under the authority of section 1902(a)(7) of the Social Security Act.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures benchmark benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on *(date).*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

A. For groups of individuals with family income above 100 percent but at or below 150 percent of the FPL:

1. Cost sharing

a. __/ No cost sharing is imposed.

b. X/ Cost sharing is imposed under section 1916A of the Act as follows [specify the amounts by group and services (see below)]:

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)
Benchmark Parents and caretaker relatives , with incomes above 100% and at or below 150% of the official Federal income poverty line 1902(a)(10)(A)(ii) Mandatory categorically needy poverty level infants of 100-150% of the federal poverty line, 1902(a)(10)(A)(i)(IV) Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 100-150% of the federal poverty line, 1902(a)(10)(A)(i) Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance of 100-150% of the federal poverty line Mandatory categorically needy poverty level children age 1-5 of 100-150% of the federal poverty line, eligible under 1902(a)(10)(A)(i)(VI) Children 6-18 with incomes above 100 through 150% of the federal poverty line eligible under 1902(a)(10)(A)(ii)(XIV)	Refer to Attachments 4.18-F	None	Refer to Attachments 4.18-F	Refer to Attachments 4.18-F	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

The methodology used to determine family income is the same as the methodology used to determine eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for any of the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income.
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.
- Services furnished to a terminally ill individual who is receiving hospice care, [as defined in section 1905(o) of the Act].
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act.
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act.
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. _X_/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
2. _X_/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

B. For groups of individuals with family income above 150 percent of the FPL:

1. Cost sharing amounts

a. __/ No cost sharing is imposed.

b. X/ Cost sharing is imposed under section 1916A of the Act as follows [specify amounts by groups and services (see below)]:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)
Benchmark Plan Parents and caretaker relatives , with incomes above 150% and at or below 200% of the official Federal income poverty line 1902(a)(10)(A)(ii) Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 150 – 300% of the federal poverty line, whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C) Infants with incomes from 150% through 300% of the federal poverty line, 1902(a)(10)(A)(ii)(IX) Mandatory categorically needy poverty level children age 1-5 with incomes of 150-185% of the federal poverty line, 1902(a)(10)(A)(i)(VI) Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance above 150% of the federal poverty line	Refer to Attachments 4.18-F	None	Refer to Attachments 4.18-F	Refer to Attachments 4.18-F	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

The methodology used to determine family income is the same as the methodology used to determine eligibility.

Attach a copy of the schedule of the cost sharing amounts for specific items and the various eligibility groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for any of the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act).
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act.
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act.
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

c. No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Pregnant women.
- Any terminally ill individual receiving hospice care, as defined in section 1905(o).
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. X / Prepayment required for the following groups of individuals who are applying for Medicaid: Infants with incomes from 200 - 300% FPL

2. X / Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid: Infants with incomes from 200 - 300% FPL

3. __/ Payment will be waived on a case-by-case basis for undue hardship.

C. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

_X_/ Quarterly

___/ Monthly

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

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 are 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 Department will develop a systems solution within the Medicaid Management Information System (MMIS) to track the cost sharing expenses and alert providers when co-payments are to no longer be charged to families.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

The State informs providers and members (beneficiaries) of allowable cost sharing amounts via Provider Updates and member Enrollment and Benefits booklet.

	BadgerCare Plus - Benchmark Plan		
Service/Item	**Copayment**	**Cost-Sharing**	**Deductible**
Ambulance Services	$50 co-payment per trip.		n/a
Chiropractic Services	$15 co-payment per visit.		n/a
Dental Services	$15 co-payment per visit.		n/a
		50% cost-sharing for dentures for members 21 years of age or older.	
Disposable Medical Supplies	$0.50 co-payment per priced unit.		n/a
Drugs	$4 co-payment for generic drugs $8 copayment for brand name drugs		n/a
Durable Medical Equipment	$5 co-payment per item. Co-payment is capped at $2,500 of paid amount in an enrollment year.		n/a
	Rental items are not subject to co-payment but count toward the $2,500 cap.		
Enhanced Pregnancy-Related Services (care coordination, health education, preventive mental health and substance abuse screening)	No co-payment.		n/a
Family Planning Services and Supplies	No co-payment.		n/a
Health Screenings (EPSDT) for Children under age 21 years.	No copayment.		n/a
Home Health Services	$15 co-payment per visit.		n/a
Hospice Services	No copayment.		n/a

	BadgerCare Plus - Benchmark Plan	
Service/Item	**Copayment**	**Deductible**
Inpatient Hospital Services	$100 per stay for medical stays	n/a
	$50 co-payment per stay for mental health and/or substance abuse treatment	
Mental Health and Substance Abuse Treatment	No co-payment.	n/a
Nursing Home Services	No co-payment.	n/a
Outpatient Hospital Services	$15 co-payment per visit (multiple visits to the same provider in the same day will be treated as a single visit)	n/a
	$100 co-payment for emergency room visits (waived if admitted to hospital)	
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	$15 co-payment per visit per date of service.	n/a
Physician Services (including laboratory and radiology services)	$15 co-payment per visit.	n/a
	No co-payment for preventive services and pregnancy-related services.	
	No co-payment for emergency services.	
	No copayment for clozapine management.	n/a
	No copayment for anesthesia.	
Podiatry Services	$15 co-payment per visit.	n/a

	BadgerCare Plus - Benchmark Plan	
Service/Item	**Copayment**	**Deductible**
Vision Care Services	$15 co-payment per visit.	n/a
Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.		
Providers are permitted to reduce or waive cost sharing on a case-by-case basis.		

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

☒ Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
☒ Title of Alternative Benefit Plan I: Birth to 3 Benchmark Plan
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

☒ **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

(i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low- income children eligible under		

		1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • •		

☒ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
X	Individuals qualifying for Medicaid on the basis of disability	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		

X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
X	Disabled children eligible under the TEFRA option - section 1902(e)(3)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Child is also receiving services identified in an IFSP under IDEA, Part C, Wisconsin's Birth to 3 Program	Statewide
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

- Infants and toddlers who meet all the financial and non-financial eligibility criteria for Medicaid and also meet the eligibility criteria for the IDEA, Part C, Wisconsin's Birth to 3 Program, including is:
  - between birth and 36 months of age
  - meets level of care eligibility as determined by the county early intervention team
  - meets Wisconsin residency requirements and lives in a non-residential/institutional living situation
  - experiencing developmental delay(s) as evidenced by a minimum of a 25% delay in any one area, or
  - diagnosed with a condition known to result in a development delay

Opt-In Enrollment	**Included Eligibility Group and Federal Citation**	**Targeting Criteria**	**Geographic Area**
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☒ (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

The time period during which parents and guardians are determining a suspected diagnosis and/or determination of disability or developmental delay of their child is a stressful time. To minimize additional stress on the family system and ensure that the aligning of early intervention services, assessment and care needs are addressed, this program will enroll children into the Birth to 3 alternative benchmark program on a voluntary basis, as determined by the parent or guardian.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform county birth to 3 agencies, families, advocates, and the community about the program:

1. The state, through its Department of Health Services will hold information sharing meetings with the Governor appointed Interagency Children's Council (ICC), county birth to 3 agencies, parents, local school districts, service providers and partners, as well as community and advocacy groups across the state.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies. In addition to explaining the framework for the enhanced services, the state will emphasize two points in its communications:

   a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package.
   b. There is no cost sharing for this service.

   The state will hold separate meetings with Tribal representatives to obtain their recommendations. Children who are identified as American Indian or Alaskan Native will be exempted if it is the recommendation from the Tribes.

2. The state will develop informing materials that:

   a. Identify the Birth to 3 participants who may be voluntarily enrolled in the program.
   c. Clearly inform families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the benchmark services, including the potential for increased access to services, as providers will receive an enhanced rate under the benchmark plan.
   e. Provide a toll-free contact number for questions and information.

3. Each infant or toddler receives a screening and multi-disciplinary evaluation (MDE) prior to determining Birth to 3 eligibility and enrollment in the benchmark plan, which determines the need for early intervention services. Based on the results of the MDE an individual family service plan (IFSP) is developed and early intervention services that meet the child's needs are identified. Additionally, family assessments are completed to determine the resources, priorities and concerns of the family and to identify necessary services and supports. Medicaid/early intervention and/or State/County funds may be utilized for the provision of early intervention and other services in excess of the state's institutional cost limit. County birth to 3 agencies inform families of infants and toddlers of these alternate funding sources at the time the change in the child's condition is identified.

   Any infant or toddler affected by the State's institutional cost limit will be offered the opportunity to request a Fair Hearing regarding their Birth to 3 benchmark plan service decisions.

   County Birth to 3 agencies are responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to families.
   b. Informing families about the voluntary nature of the program, including how to discontinue their participation.

c. Informing families that there is no cost or reduction of benefits; emphasizing this benefit is offered to complement the services already covered under Medicaid.
d. Educating families about the benefits of participating in this program, for example, improved coordination between health care providers.
e. Documenting all requests for disenrollment.

4. The state will issue direct mailings to families informing them about their enrollment in the program, the period of enrollment, and the benefits of the program.
5. Families of infants and toddlers eligible for the Birth to 3 benchmark plan are informed of feasible alternatives available by service coordinators, along with other feasible funding and program alternatives in the home and community. Service coordinators offer the family the choice of receiving benchmark plan funded IFSP services.

6. Before the family is offered the choice of services, the service coordinator is responsible to assure that the family is informed: 1) of other feasible funding alternatives for the child, such as Early Periodic Screening, Diagnosis and Treatment (EPSDT), and county-funded early intervention; 2) that services authorized in the child's IFSP will not be affected by the family's choice to receive or not receive benchmark plan funded services; 3) that benchmark plan funded IFSP services can be authorized in conjunction with other services the child needs as part of the IFSP; 4) of other funding streams, such as federal, state and county early intervention revenues and the Medicaid/Early Intervention Fee Schedule; 5) that benchmark plan funded IFSP services must occur in natural environments with the participation of the family or caregiver; and 6) that the family can change their choice to receive or not receive benchmark plan funded IFSP services at any time.

7. The family's choice to receive Birth to 3 benchmark plan services will be documented on the IFSP. The notice regarding fair hearing rights for the Birth to 3 benchmark plan will also be provided to families.

8. The state will send written notification to the family and inform the health care coordinator of all disenrollments. The notification to the family will explain that the child's regular benefit package will remain unchanged. The State of Wisconsin ensures equitable access and participation in programs and services for eligible infants and toddlers through the availability of all public awareness brochures, posters and information materials in English and Spanish languages. Early Intervention Services regulations, DHS 90 require that tests and other evaluation materials and procedures, including translation and interpretation, are administered in the parent's native language unless it is clearly not feasible to do so. In addition, assessment and evaluation procedures are administered so as not be racially or culturally discriminatory. County Birth to 3 agencies are required to take steps to ensure that notices are translated orally or by other means when the native language of the parent is not a written language. The DHS offers interpreters for public meetings or hearings as needed.

☒ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☒ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

Birth to 3 participants that voluntarily choose to enroll in the Birth to 3 benchmark plan will be covered on a Statewide basis.

☒ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

☒ The State/Territory will provide the following alternative benefit package (check the one that applies).

a) ☒ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐ The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

☒ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes the early intervention services described below, focused on the specific needs of children with suspected or diagnosed developmental disabilities or delay that are enrolled in the Birth to 3 Program. The intention is to link children with identified health needs to services and resources in a coordinated effort to ensure the effective delivery of services.

1. The benchmark plan benefits will includes the following:

   a. Screening
   b. Developmental Treatment Services
   c. Teaming/Consultation Services (under Primary Coaching)
   d. Developmental Therapies (including speech, occupational and physical therapy)
   e. Support and Service Coordination - Care Management

☐ Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:

☒ a. The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

☐ b. The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

☒ c. The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

For a description of the scope of benefits under this Birth to 3 benchmark plan see Attachment 1

b) ☒ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

☒ Inpatient and outpatient hospital services;

☒ Physicians' surgical and medical services;

☒ Laboratory and x-ray services;

☒ Coverage of prescription drugs;

☒ Mental health services;

☒ Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

☒ Emergency services;

☒ Family planning services and supplies.

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or
- categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) ☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

3. Service Delivery System

Check all that apply.

☒ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

☒ The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

☒ As an Additional benefit under section 1937 of the Act

☒ The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

☒ The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

☒ The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Standard Plan via a transportation broker.

☒ The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

☒ The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

☒ The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

☒ The State/Territory will implement this State/Territory Plan amendment on October 1, 2011 *(date).*

ATTACHMENT 1

Benefits Comparison for Alternative Benefit Plan B: Birth to 3 1937 SPA

Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services

- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:

    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older

- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

Services Outside the Medical Home Contract

The all-inclusive rate for the Foster Care Medical Home would include all services covered under Medicaid/Standard Plan, except:

- Non-emergency transportation services
- Targeted case management services*
- School-based services*
- Directly observed therapy (DOT) for individuals with tuberculosis
- Crisis intervention services*
- Community support program services*
- Comprehensive community services*
- Pharmacy services

*The Medical Home provider will be required to establish a working relationship (for example, through a memorandum of understanding) with these entities to ensure that services to the member is coordinated.

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses

- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ **Title of Alternative Benefit Plan H: Community Recovery Services (CRS) Benchmark Plan**

1. Populations and geographic area covered

X a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)

The State/Territory will provide the benefit package to the following populations:

☐ (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age, or the individual has aged out of foster care, is under 26 years of age and qualifies on the basis of section 1902(a)(10)(A)(i)(IX).

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Voluntary Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-		

		income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).

TN No._____

Supersedes_____ Approval Date_____ Effective Date_____

- Specify the geographic area in which each population will be covered.

Voluntary Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	**Mandatory categorically needy low-income families and children eligible under 1931 of the Act**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Individuals qualifying for Medicaid on the basis of blindness**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Individuals qualifying for Medicaid on the basis of disability**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Individuals receiving SSI. 1902(a)(10)(A)(i)(I)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.**	**WI Counties May Opt-In to be Certified to Provide this Benefit.**

***See footnote which follows this table.**

		Falls within limit on number of persons to be served established by county of residence.*	
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(VII)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	**Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** ***See footnote which follows this table.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**Disabled children eligible under the TEFRA option - section 1902(e)(3)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
	Medically frail and individuals with special medical needs		
X	**Children receiving foster care or adoption assistance under title IV-E of the Act**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to be served established by county of residence.***	**WI Counties May Opt-In to be Certified to Provide this Benefit.**
X	**An individual who received foster care assistance under title IV-E of the Act, and qualifies on the basis of 1902(a)(10)(A)(i)(IX)**	**At or Below 150% of FPL.** **Functional Eligibility See Attachment A.** **Age 14 and Over.** **Falls within limit on number of persons to**	**WI Counties May Opt-In to be Certified to Provide this Benefit.**

		be served established by county of residence.*	
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	At or Below 150% of FPL. Functional Eligibility *See footnote which follows this table. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Receiving home and community-based waiver services who would only be eligible for Medicaid under the State plan if they were in a medical institution. 1902(a)(10)(A)(ii)(VI)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Individuals under age 21 who are under State adoption agreements. 1902(a)(10)(A)(ii)(VIII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. *See footnote which follows this table. number of persons to	WI Counties May Opt-In to be Certified to Provide this Benefit.

		be served established by county of residence.*	
X	Receiving only an optional State supplement which is more restrictive than the criteria for an optional State supplement under title XVI. 1902(a)(10)(A)(ii)(XI)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Working disabled individuals who buy in to Medicaid (BBA working disabled group). 1902(a)(10)(A)(ii)(XIII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to be served established by county of residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Individuals under age 21 who were in foster care on 18th birthday. 1902(a)(10)(A)(ii)(XVII)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to *See footnote which follows this table. residence.*	WI Counties May Opt-In to be Certified to Provide this Benefit.
X	Individuals eligible as medically needy under section 1902(a)(10)(C)	At or Below 150% of FPL. Functional Eligibility See Attachment A. Age 14 and Over. Falls within limit on number of persons to	WI Counties May Opt-In to be Certified to Provide this Benefit.

		be served established by county of residence.*	
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

***[From section 1.a)(ii)] In accordance with federal Benchmark legislation and rules, Wisconsin offers the CRS Benchmark Plan notwithstanding and without regard to comparability within the meaning of Social Security Act § 1902(a)(10)(B) [42 USC § 1396(a)(10)(B)] Among other things, the principle of comparability of amount, duration and scope of services prohibits states from imposing enrollment caps or otherwise limiting the number of persons eligible for services. Consistent with other provisions of federal law that permit states to offer medical assistance benefits without regard to comparability of amount, duration and scope of services, the federal Benchmark legislation and rules authorize states that offer Benchmark plans to limit the number of persons served by those plans.**

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. &1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

Participation in the CRS Benchmark Plan is entirely voluntary, and all potential participants will be informed of this prior to enrollment in the benefit. The individual's care manager will inform the potential benefit recipient, and/or his/her legal representative, both verbally and in writing that they may choose at any time not to participate in the benefit. Copies of such notifications shall be kept in the individual's case file. Determination of eligibility for enrollment in the CRS Benchmark Plan is based upon:

- **An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;**
- **Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;**
- **A determination that service-specific additional needs-based criteria are met.**

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) ☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

□ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

□ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

□ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to one or more of the three standard benchmark plans specified above or to the full State plan benefit.

b) □ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

□ (i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

□ Inpatient and outpatient hospital services;

□Physicians' surgical and medical services;

□Laboratory and x-ray services;

□Coverage of prescription drugs

□Mental health services

□Well-baby and well-child care services as defined by the State/Territory, including age appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

□Emergency services

□Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

TN No._____

Supersedes_____ Approval Date_____ Effective Date_____

Please insert below a full description of the benefits in the plan including any additional services and limitations.

☐ (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Please insert a copy of the report.

☐ (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) **X** Additional Benefits

If checked please insert a full description of the additional benefits including any limitations.

Psychosocial Rehabilitative Services:

Community Living Supportive Services (CLSS)

This service covers activities necessary to restore individuals with severe and persistent mental illness to their best possible functional level, allowing them to live with maximum independence in community integrated settings. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. CLSS services focus on meal planning/preparation, household cleaning, personal hygiene, self-administration of medications and monitoring symptoms and side effects, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. The tasks on which CLSS focuses, such as meal planning, cleaning, etc. are not done for the individual, but rather the participant is assisted in becoming more independent in accomplishing these tasks through training, cueing, and supervision.

Wisconsin would make these services available in a variety of community locations that encompass residential, social/recreational, and business settings. Residential settings are limited to an individual's own apartment or house, children's foster homes, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive) and including those comprised of independent apartments. The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The 1937 CRS Benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving the 1937 CRS Benefit:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State.

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1937 services in a CBRF. The care manager together with the person receiving 1937 services will determine that the residence is a community setting and offers opportunities for independence, choice, and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

Supported Employment

This service covers activities necessary to restore individuals with severe and persistent mental illness to their best possible functional level in connection with obtaining and maintaining competitive employment. This service may be provided by an agency or individual employment rehabilitation specialist. The service will follow the Individual Placement and Support (IPS) model recognized by SAMHSA to be an evidence-based practice. This model has been shown to be effective in helping individuals overcome the symptoms and manage the behaviors associated with severe and persistent mental illness such that they may obtain and maintain competitive employment. This in turn promotes recovery through a community integrated socially valued role and increased financial independence.

The core principles of this approach are:

- **Participation is based on consumer choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.**
- **Supported Employment services are closely integrated with mental health treatment. Employment rehabilitation specialists are part of the mental health treatment team and meet with the team frequently to coordinate treatment plans.**
- **Restoring function to obtain and maintain competitive employment is the goal. The focus of the rehabilitative service is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.**
- **Treating and managing the symptoms and behaviors associated with the participant's mental illness to facilitate job search starts soon after a consumer expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).**
- **Follow-along services are continuous (provided there remains an assessed need). Individualized services to address symptoms and behaviors that may interfere with maintaining employment continue as long as the consumer wants assistance (provided there remains an assessed need).**
- **Consumer preferences are important. Choices and decisions about work and needed services are individualized based on the person's preferences, strengths, and experiences.**

The service covers employment-related rehabilitative service intake, assessment (not general intake and assessment), services to assist in individual job development, job placement, work related symptom management, employment-related mental health crisis support, and follow-along services by an employment rehabilitation specialist. It also covers employment rehabilitation specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor (to coordinate service plans). The Wisconsin 1937 Supported Employment services will

not duplicate other services covered under Wisconsin's Medicaid State Plan. The Supported Employment service does not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under s. 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Peer Supports

Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in community settings. All consumers receiving 1937 peer support services will reside in home and community settings. Under direct supervision by a mental health professional, Certified Peer Specialists perform a wide range of tasks to assist consumers and/or families in regaining control over their lives and over their own recovery process. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: (a) offering effective recovery-based services; (b) assisting consumers in finding self-help groups; (c) assisting consumers in obtaining services that suit that individual's recovery needs; (d) teaching problem solving techniques; (e) teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears; (f) assisting consumers in building social skills in the community that will enhance integration opportunities; (g) lending their unique insight into mental illness and what makes recovery possible; (h) attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; (i) informing consumers about community and natural supports and how to utilize these in the recovery process; and (j)assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities. Peer Specialists includes Parents or other adult family caregivers of children with mental illness or co-occurring substance use disorders who provide peer services to other families with a youth with mental illness or co-occurring substance use disorders.

3. Service Delivery System

Check all that apply.

X The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures that prior to submitting this State plan amendment the State/Territory provided the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment and included in the notice a description of the method for complying with the provisions of §440.345 and sections 5006(e) of the American Recovery and Reinvestment Act of 2009, as required by §440.305(d). Please provide copies of public notices, publication dates and a list of any public meetings.

Wisconsin assures that proper notice requirements will be observed immediately following the decision to officially pursue a 1937 SPA.

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

☐ As an Additional benefit under section 1937 of the Act

X Per §440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of theses processes in order to ensure individuals have access to the full EPSDT benefit.

The State assures that additional benefits will be provided for individuals under 21 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Additional benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary.

Notification will be via the same prior authorization process Wisconsin has in place to provide Medicaid coverage of EPSDT "other services" that are not otherwise covered under the State Plan. Providers are made aware through the EPSDT provider handbook and the covered services sections of other online provider handbooks.

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

X The State/Territory assures that there is no significant difference in cost sharing, lifetime or annual dollar limits, or treatment limits between mental health/substance abuse disorder benefits and medical/surgical benefits.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

X The State/Territory assures that if the benchmark/benchmark-equivalent plan includes cost-sharing the State/Territory will comply with the cost-sharing rules under section 1916 and 1916(A) of the Act and 42 CFR §447.50-82, and has described such cost sharing in section 4.18 of the State plan.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on **January 1, 2012.**

1937 CRS Benchmark Benefit Plan Attachment A

Financial Eligibility

TN No._____

Supersedes_____ Approval Date_____ Effective Date_____

1. **Income Limits.** Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1937 provided they meet all other requirements of the 1937 State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

Functional Eligibility

1. Eligibility for the 1937 CRS Benchmark benefit is determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the benefit are performed directly by the Medicaid agency.

The1937 program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
− Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
− Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
− Completing the online course, or
− Attending an in-person training by Department staff (or watching video of same), **and**
− Reading and following screen instructions.

1937 CRS Benchmark Benefit Plan Attachment A

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

2. Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS. The criteria take into account the individual's support needs, and may include other risk factors:

Wisconsin's 1937 needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder) The following is the minimum possible combinations of factors that demonstrate 1937 eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric or cognitive impairment.

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

3. Reevaluation Schedule. Needs-based eligibility reevaluations are conducted at least every twelve months.

TN No._____

Supersedes_____ Approval Date_____ Effective Date_____

4. Residence in home or community. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. Each individual receiving services through the 1937 CRS Benchmark benefit:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State.

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan B: Foster Care Medical Home
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

(i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;

- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	x	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • Non title IV-E Foster Care	Excludes children in a secure facility or a Residential Care Center. Coverage could be continued	Southeast Wisconsin, including Kenosha, Milwaukee, Ozaukee, Racine, Washington, and

			for a period after a child leaves out-of-home care	Waukesha Counties. Based on the lessons learned in this area, a future plan for statewide expansion will be submitted.

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
x	Children receiving foster care or adoption assistance under title IV-E of the Act	Excludes children in a secure facility or	Southeast Wisconsin, including

		a Residential Care Center. Coverage could be continued for a period after a child leaves out-of-home care – see Section 2 "Description of the Benefits – Secretary-Approved Coverage."	Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha Counties. Based on the lessons learned in this area, a future plan for statewide expansion will be submitted.
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,

- The individual was given ample time to arrive at an informed choice,
- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

The time of a child's entry into out-of-home care represents a traumatic period for children and parents alike. To minimize additional stress on the family system and ensure that the immediate medical assessment and care needs are addressed, this program will initially enroll all children into the alternative benchmark program, as the program includes the full benefit package under the Medicaid/Standard Package and adds a component that is critical for this vulnerable population -- health care coordination. Therefore, the program will operate on an all in/opt out model. An authorized medical decision maker for a child will have the option of disenrolling the child after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state, through its Department of Health Services and the Department of Children and Families, plans to hold information sharing meetings with birth parents, foster parents, adoptive parents, the courts, local child welfare agencies (county and Tribal), established community and advocacy groups in the six-county area.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies. In addition to explaining the framework for the enhanced services, the state will emphasize three points in its communications:

   a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package.
   b. There is no cost sharing for this service.

c. Participation will be automatic upon entry into out-of-home care, with voluntary opt-out after the first six months.

The state will hold separate meetings with Tribal representatives to discuss the program as it would affect American Indian and Alaskan Native children and will obtain and follow their recommendations.

2. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process
   c. Clearly inform families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a child-specific care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of the child's needs − from preventive services and health screenings, to specialty medical care, inpatient care, and crisis intervention.
   e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to families.
   b. Informing families about the voluntary nature of the program, including how to discontinue their participation.
   c. Letting families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating families about the benefits of participating in this program, for example, improved communication and coordination between health care providers, child welfare and the family.
   e. Documenting all requests for disenrollment.

4. The state will make direct mailings to families informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

5. The state will send written notification to the family and inform the health care coordinator and the child welfare worker of all disenrollments. The notification to the family will explain that the child's regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the family have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

State/Territory Employee Coverage – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of children in out of home care. A key component is health care coordination, including: (a) medical care plan development that addresses physical, dental and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link children with identified health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be child-centric, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to children in foster care;
b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of children in out-of-home care. The team identifies the health needs of each child, creates a care plan, and ensures that each child is assigned a care coordinator;
c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
d. Services provided through open and flexible scheduling;
e. Comprehensive transitional care as a child moves from one setting to another; and
f. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of children in out-of-home care and on comprehensive care coordination, will assure a child-centric focus and continuity of care. The care manager will collaborate with the family to identify providers who are experienced in meeting the needs of this population. A more streamlined prior authorization process will apply with respect to OT, PT, speech and mental health services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure services under EPSDT based on best practices and each child's needs, including:

   a. timely and trauma-informed screening, assessment and referral, including comprehensive mental health screening;
   b. evidence informed and comprehensive interventions in children's mental and behavioral health;
   c. mobile response and stabilization services;
   d. oversight of psychotropic medication, including pharmacist consultant services;
   e. enhanced schedule for physical, behavioral and dental care as necessary.

4. To ensure the continuity of care for these children, this plan will authorize participation for up to 12 months after a child exits out-of-home care. Continuation in the plan would be contingent on Medicaid eligibility and a judgment of necessity by the multidisciplinary care coordination team.

Note: For a summary of benefits under this Foster Care Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent

coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Children in out-of-home care often have difficulty accessing appropriate medical and behavioral health care in the Medicaid fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many children in out-of-home care have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. This plan provides care coordination and enhanced services for children in out-of-home care in southeast Wisconsin, where over half of the children in out- of-home care are living. The plan includes all benefits, including EPSDT, under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these children:

- A medical home framework specific to children in out-of-home care:
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each child;
- Comprehensive dental services;
- As deemed necessary by the care coordination team, up to 12 months of continued eligibility for coverage under the plan when a child moves to permanent placement. Contingent on continued Medicaid eligibility.

The Department will certify one or more health systems to provide a medical home for children in the target population. A health system in this context means a group of physicians and other licensed medical practitioners that also includes a hospital affiliation.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-

service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services

- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan F: Medical Home Pilot to Promote Healthy Birth Outcomes for Pregnant Women
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;

- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI recipients • 1902(a)(10)(A)(i)(I)	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	Pregnant women not enrolled in an HMO	Southeastern Wisconsin
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: •		

X (ii) The following populations will be given the option to voluntarily enroll in an alternative

benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
X	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	Women who are not enrolled in an HMO	Southeastern Wisconsin
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Pregnant women who are not enrolled in an HMO	Southeastern Wisconsin
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Pregnant women who are not enrolled in an HMO	Southeastern Wisconsin
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In	Included Eligibility Group and Federal	Targeting	Geographic

Enrollment	Citation	Criteria	Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

Wisconsin has one of the worst infant mortality rates among African Americans in the country (rank 36 of 40). Key indicators of perinatal health include entry into prenatal care and rates for prematurity, low birth weight, and infant mortality. Prematurity and low birth weight are important risk factors for infant mortality and are themselves costly outcomes in terms of both the health of those infants and expensive medical care. Hospitalization costs alone in the first

year for a low birth weight baby can range from 10-50 times the cost for a normal birth weight baby. Approximately eighty-five percent of African American births in Wisconsin are to Medicaid mothers in the southeastern part of the state. The southeastern part of the state has the highest number of babies that die within the first year of life. Two counties (Milwaukee and Racine) in this part of the state have the highest and second highest rate (the number of infant deaths per 1000 live births) of infant mortality in the state.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, health care providers, Tribal governments, advocates, and the community about the program:

1. The state will hold a meeting with Tribal representatives to obtain their recommendations. Pregnant women who are identified as American Indian or Alaskan Native will be exempted if it is the recommendation from the Tribes.

2. The state will develop informing materials that:

    a. Identify the geographic area and the population to be enrolled in the program.
    b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process
    c. Clearly inform women that participation in the program will not reduce their regular benefit package under Medicaid.
    d. Explain the benefits of the enhanced services, including having an individualized care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of a woman's needs.
    e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

    a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to individuals.
    b. Informing individuals about the voluntary nature of the program, including how to discontinue their participation.
    c. Informing individuals that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
    d. Educating pregnant women about the benefits of participating in this program, for example, improved communication and coordination between the medical prenatal care provider, specialty care providers and the pregnant woman.
    e. Documenting all requests for disenrollment

4. The state will make direct mailings to women informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first two months.

5. The state will send written notification to the pregnant woman and inform her obstetric care provider and care coordinator of all disenrollments. The notification to the woman will explain that her regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the woman have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.
- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.
- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

 FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

 State/Territory Employee Coverage – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

 Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of pregnant women who are at a higher risk for a poor birth outcome. A key component is health care coordination, including: (a) the development of a comprehensive care plan that addresses physical, behavioral health and psychosocial needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link the member to necessary services and resources in a coordinated effort to reduce her stress, ensure that all services are received and eliminate duplication of effort and services. The medical care will be patient-centered and evidence-based. Service delivery will include open and flexible scheduling and the use of non-traditional approaches to care.

1. Benefits will be provided under a medical home framework that includes the following:

   a. Assignment of an obstetric care provider who is experienced in providing care to high-risk pregnant women;
   b. Coordination of health care through a multidisciplinary team, including the obstetric care provider. The team identifies the health and psychosocial needs of each pregnant woman;

c. The identification of a team lead, which may be the obstetric care provider or a care coordinator;
d. Prompt development of a patient-centered, multidisciplinary care plan
e. Timely follow up on referrals
f. Establishment of regular communication between the obstetric care provider and other health care providers, including acute care (including emergency room visits), institutional care, chronic care and other specialty care;
g. Services provided through open and flexible scheduling;
h. Establishment of an electronic care plan and regular communication between, at a minimum, the obstetric care provider and the care coordinator.

2. This medical home framework, with its coordinated, comprehensive and patient-centered approach to services delivery will ensure that the unique needs of this population are addressed appropriately. The care coordinator will make home visits if appropriate, ensuring that the provision of medical prenatal care is linked to community resources and care. The care coordinator will ensure continuity of care between detention facilities and community health care should the woman be incarcerated during her pregnancy.

3. Providers will be required to offer the following services:

a. systematic assessment, counseling and referral for tobacco, alcohol and other substance abuse;
b. routine screening for domestic violence and depression;
c. evidence informed care and treatment, including screening for periodontal disease
d. an enhanced schedule for prenatal visits
e. mobile response and stabilization services;
f. oversight of psychotropic medication, including pharmacist consultant services;
g. increased schedule of laboratory tests related to the identification and treatment of infections that are known to prompt preterm labor in this population, including testing for urinary tract infections, STDs, asymptomatic bacteriuria, and Chlamydia

4. Up to 12 months of continued enrollment in the medical home to improve the health outcomes for low birth weight and pre-term infants. These infants are at an increased risk of dying in the first year of life. Continuation in the plan would be contingent on Medicaid eligibility and a judgment of necessity by the multidisciplinary care coordination team.

Note: For a summary of benefits under the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:
(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

This plan provides care coordination and enhanced access to pregnancy-related services for women in the southeastern counties. These women are at an increased risk of having a low birth weight or premature infant. These indicators are strong predictors of an infant dying in the first year of life. The plan includes all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of this population:

- A medical home framework specific to pregnant women. The following elements are critical components of this approach:
  - Early identification of the pregnancy
  - The assignment of a care coordinator
  - A comprehensive assessment of medical and psychosocial risk factors
  - The establishment of an electronic treatment plan that is accessible to all members of the woman's core team. The care plan must be patient-centered and address all aspects of the woman's medical and nonmedical care
  - A comprehensive, coordinated and integrated approach to care
  - The establishment of a multi-disciplinary team, with the obstetric care provider as an integral member of the care team. The care coordinator must be a core member of the team
  - Flexible and open scheduling
  - 24/7 support for the pregnant woman and her family
  - The use of evidence-based obstetric care guidelines in the delivery of services
  - The establishment of an automatic referral system between the medical home provider and hospitals, both inpatient and outpatient, to ensure that risk factors associated with the hospitalization or emergency room use are addressed within 24 hours of the event.
  - The establishment of procedures to systematically track patient test results and identify and follow up on abnormal test results
  - The establishment of a system to track referrals and ensure timely follow up on those referrals
  - The use of non-traditional approaches to addressing the unique needs of the population, this could include licensed midwives, in-home one-on-one peer support, and group prenatal visits
- Enhanced schedule of prenatal visits for women determined to be at higher risk for a preterm birth
- Increased lab testing as indicated, including urine dipstick at every visit
- Peer support and group prenatal visits offered

- Health literacy, including the appropriate use of the health care delivery system
- Enhanced patient education to include the following elements:
  - Patient self-management, including the signs of preterm labor and fetal movement
  - Stress reduction and medication management
  - Nutritional counseling
  - Abnormal weight gain
  - Child birth education, including counseling each trimester for women considering "trial of labor after cesarean" (TOLAC)
  - Breast feeding preparation and support
  - Early infant care, including safe sleep practices
- Home visits and/or links to community support programs, including WIC, food pantries, and faith-based organizations providing services and support to the community

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

□ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

□ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X □ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

□ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

□ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan C: Mental Health/Substance Abuse Medical Home Pilot
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	FFS indivi-duals with a diagnosis of a serious	Pilot areas to be determined

			mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
	X	Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation	FFS indivi-duals with a diagnosis of a	Pilot areas to be determined

		from the Social Security Act for each eligibility group: • SSI Recipients • 1902(a)(10)(A)(i)(I)	serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	FFS indivi-duals with a diagnosis of a serious mental illness	Pilot areas to be determined

			or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	X	Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI-related • • •	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more	Pilot areas to be determined

			hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations	Pilot areas to be determined

		or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
X	Individuals qualifying for Medicaid on the basis of blindness	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals qualifying for Medicaid on the basis of disability	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the	Pilot areas to be determined

		following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Disabled children eligible under the TEFRA option - section 1902(e)(3)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined

X	Medically frail and individuals with special medical needs	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	Children receiving foster care or adoption assistance under title IV-E of the Act		
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency	Pilot areas to be determined

		room visits in the past 12 months; or other key risk factors developed by the DHS.	
X	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,

- The individual was given ample time to arrive at an informed choice,
- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

When comparing all diseases, mental illnesses rank first in terms of causing disability in the United States. Mental health disorders are an enormous social and economic burden to society by themselves, but are also associated with increases in the risk of physical illness. More specifically, mental health disorders are associated with increased rates of chronic health problems and risk factors such as smoking, physical inactivity, obesity, and substance abuse and dependence. Among Wisconsin adults, the burden of chronic physical disease falls heavily on those with mental health problems, as evidenced by comparatively higher rates of cardiovascular disease and diabetes. Individuals with serious mental illnesses and substance use disorders often find it difficult to manage the primary health care system due to the symptoms of their illness and receive care only at the point of a health care crisis which results in poor health care outcomes and increased cost to the health care system.

The Mental Health and Substance Abuse Medical Home will initially pilot a medical home to enroll fee-for-service individuals who have a serious mental illness or substance use disorder that experience risk factors such as two or more hospitalization or emergency room visits in the past year or other risk factors to be developed, into the Mental Health and Substance Abuse Medical Home Alternative Benchmark Plan C. This plan includes the full benefit package under the Medicaid/Standard Package but adds additional components that are critical for this vulnerable population with emphasis on the health care and behavioral health coordination thru a Medical Home and other additional services. The program will operate on an all in/opt out model. The participants will have the option of disenrolling after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will hold information sharing meetings with consumer groups, counties, tribes, mental health and substance abuse providers, and established community and advocacy groups.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies.

2. The state will meet with Tribal representatives to discuss the program as it affects persons who are identified as American Indian and Alaskan Native and will obtain their recommendations.

3. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process.
   c. Clearly inform individuals and families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a person-centered and recovery based multi-disciplinary treatment plan that addresses access and coordination across the full spectrum of the individual's needs − from preventive services and health screenings, to specialty medical care, inpatient care, and community treatment services.
   e. Provides a toll-free contact number for questions and information.

4. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to individuals and families.
   b. Informing individuals and families about the voluntary nature of the program, including how to discontinue their participation.
   c. Letting individuals and families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating individuals and families about the benefits of participating in this program, for example, improved communication and coordination between health care providers and the individuals and their family.
   e. Documenting all requests for disenrollment.

5. The state will make direct mailings to individuals and families informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

6. The state will send written notification to the individual or family regarding all disenrollments. The notification to the individual or family will explain that the individual's regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the individual or family have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

State/Territory Employee Coverage – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of individuals with serious mental illnesses and substance use disorders. A key component is health care coordination, including: (a) medical care plan development that addresses physical, dental and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation including outcome measures. The intention is to link participants to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and increased effectiveness of health and related healthcare services. The medical care will be person-centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to individuals with serious mental health and substance use disorders.;
b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of individuals with serious mental health and substance use disorders. The team identifies the health needs of each individual, creates a care plan, and ensures that each individual is assigned a care coordinator;
c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
d. Services provided through open and flexible scheduling;
e. Comprehensive transitional care as the individual moves from one setting to another;
f. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of individuals with serious mental illnesses and substance use disorders and on comprehensive care coordination, will assure a person-centered, recovery focus and continuity of care. The care coordinators will collaborate with the individual and/or family to identify providers who are experienced in meeting the needs of this population. The medical home must work with counties and tribes in their service area to assure seemless coordination and referral services. A more streamlined prior authorization process will apply with respect to mental health and substance abuse services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure services under EPSDT based on best practices and each child's needs, including:

a. Timely and trauma-informed screening, assessment and referral, including comprehensive mental health screening;
b. Evidence informed and comprehensive interventions in children's mental and behavioral health;
c. Mobile response and stabilization services;
d. Oversight of psychotropic medication, including pharmacist consultant services;
e. Enhanced schedule for physical, behavioral and dental care as necessary.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent

coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Individuals with serious mental illnesses and substance use disorders often have difficulty accessing appropriate medical and behavioral health care in the Medicaid fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many individuals with serious mental illnesses and substance use disorders have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. This plan provides care coordination and enhanced services for individuals in fee-for-service Medicaid with serious mental illnesses and substance use disorders with significant risk factors living in pilot areas of the state. The services and supports will follow the best evidence-based approaches and protocols for people with serious mental illnesses and substance use disorders as appropriate. The plan includes all benefits, including EPSDT, under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these individuals:

- A medical home framework specific to individuals with serious mental illnesses and substance use disorders;
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each individual;
- Individualized wellness plan and support to promote healthy behaviors, including but not limited to: smoking or tobacco use cessation, appropriate nutrition and exercise, support for behavioral interventions for depression, risky drinking or drug use.
- Comprehensive care coordination services bringing together the health and behavioral health needs of the individual;
- Peer and recovery support services;
- Substance Abuse Residential Treatment services;
- Short Term Residential Support services;
- Access to Urgent Care psychiatric and mental health treatment services in the community (access 24 hours a day/7 days a week);
- Medication utilization management
- Medication assisted treatment for substance use disorders

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older

- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

DRAFT CJ Preprint v. 1.3
UPDATED 10/20/11 _____

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan E: Medical Home Pilot for Persons with Severe Mental Illness Leaving Criminal Justice and Mental Health Institutes
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;

- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI Recipients • 1902(a)(10)(A)(i)(I)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health	Pilot areas to be determined.

			Institutes	
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI-related •	MA eligible persons with mental illness and chronic health conditions placed in	Pilot areas to be determined.

		• •	communities under supervision after leaving prisons and Mental Health Institutes	

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
X	Individuals qualifying for Medicaid on the basis of disability	MA eligible persons with	Pilot areas to be determined.

		mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	
X	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
X	Medically frail and individuals with special medical needs	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after	Pilot areas to be determined.

		leaving prisons and Mental Health Institutes	
	Children receiving foster care or adoption assistance under title IV-E of the Act		
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

This medical home targets individuals eligible for Medicaid who are exiting the criminal justice system and mental health institutes.

Many of these individuals may have chronic conditions like asthma, diabetes or heart conditions that which need care coordination services to improve health outcomes. Individuals with serious mental illnesses and substance use disorders often find it difficult to manage the primary health care system due to the symptoms of their illness and receive care only at the point of a health care crisis which results in poor health care outcomes and increased cost to the health care system.

This medical home alternative benchmark plan targets three sets of individuals:

1) those eligible for Wisconsin Medicaid who have major mental illness and are placed in the community under supervision after leaving prisons and Mental Health Institutes
2) those eligible for Wisconsin Medicaid who have multiple chronic health conditions who are exiting the prison system

3) Medicaid Eligible individuals who are participants in either of the two following programs and placed within communities in the SE Region of the State:
    a. The Department of Health Services' Conditional Release Program. The Conditional Release Program funds mental health services for indigent persons who are committed as Not Guilty By Reason of Mental Disease or Defect (NGI) and are subsequently conditionally released by the court to the community. Examples of the types of services that the Department is authorized by statute to fund include: mental health medications, counseling, community support program services, residential placement costs - including community based residential facilities and alcohol and other drug abuse (AODA) outpatient treatment.
    b. The Department of Corrections' Opening Avenues to Re-entry Success (OARS) Program. This program, which works through a partnership with the Department of Health Services, targets inmates with severe and persistent mental illness who are at a medium to high risk of having their parole revoked. These are inmates who have reached their Mandatory Release date from prison and must be released to the community on parole.

Persons participating in the Conditional Release and OARS Programs may be eligible for Wisconsin Medicaid as a result of membership in a variety of eligibility groups. What the individuals have in common is involvement in the criminal justice system and severe mental illness. To maximize the coordination of critical medical and behavioral health needs with the other essential supports available to this population under the Conditional Release and OARS Programs, all eligible participants will initially be enrolled in the alternative benchmark program.

This program includes the full benefit package under the Medicaid/Standard Package but adds benefits critical for this vulnerable population – care coordination, medical assessments, and medication therapy management. The program will operate on an all in/opt out model. The member will have the option of disenrolling from the medial home after six months of continuous enrollment.

This plan includes the full benefit package under the Medicaid/Standard Package and adds health care coordination and other additional services. The program will operate on an all in/opt out model. Participants will have the option of disenrolling after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will meet with Tribal representatives to discuss the program as it affects persons who are identified as American Indian and Alaskan Native and will obtain and follow their recommendations.

2. The state will develop informing materials that:

    a. Identify the geographic area and the population to be enrolled in the program.
    b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process.
    c. Clearly inform individuals and families that participation in the program will not reduce their regular benefit package under Medicaid.
    d. Explain the benefits of the enhanced services, including having a person-centered and recovery based multi-disciplinary treatment plan that addresses access and coordination across the full spectrum of the individual's needs − from preventive services and health screenings, to specialty medical care, inpatient care, and community treatment services.

e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the staff of Criminal Institutions and Mental Health Institutes from which individuals are released to include outreach and information sharing to this population. These staff will be responsible for the following:

   a. Informing eligible individuals, in writing about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.
   b. Informing eligible individuals about how to discontinue their participation.
   c. Letting individuals and families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating eligible individuals and families about the benefits of participating in this program, including improved communication and coordination between all health care providers.
   e. Documenting all requests for disenrollment.

4. In the case of a request for disenrollment, the state will send written notification to the participant and inform the health care coordinator and case manager. The notification will explain that disenrollment from the alternative benchmark plan will not end the individual's eligible for Wisconsin Medicaid. The state will include the number for the staffs described above who are responsible for communicating information on enrollment and disenrollment, should there be follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,

- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐ The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of individuals with severe and persistent mental illness and those with chronic health conditions. A key component is health care coordination, including: (a) medical care plan development that addresses physical and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation including outcome measures. The intention is to link participants with identified health physical and mental health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be person-centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

    a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to individuals with severe and persistent mental illness;
    b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of individuals with serious mental illness. The team identifies the health needs of each individual, creates a care plan, and ensures that each individual is assigned a care coordinator;
    c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), chronic care and other specialty care, including relevant services provided through the Conditional Release and OARS Programs;
    d. Services provided through open and flexible scheduling;
    e. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of individuals with severe and persistent mental illness and on comprehensive care coordination, will assure a person-centered, recovery focus and continuity of care. The Care Coordinator will collaborate with the case manager in the Conditional Release or OARS program to identify providers who are experienced in meeting the needs of this population. A more streamlined prior authorization process will apply with respect to mental health and substance abuse services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure medical and behavioral health services based on best practices, including:

    a. timely and comprehensive behavioral screening (SBIRT, depression screening, tobacco screening, and trauma screening) and assessment;
    b. evidence informed and comprehensive interventions in mental and behavioral health;

c. mobile response and stabilization services;
d. oversight of psychotropic medication, including pharmacist consultant services;
e. enhanced schedule for physical and behavioral health care as necessary.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) □ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;

- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x Additional Benefits

If checked please insert a full description of the additional benefits including any limitations.

This plan provides care coordination and enhanced services for individuals with serious mental illnesses living in the pilot area. The services and supports will follow the best evidence-based approaches and protocols for people with serious mental illnesses and chronic health conditions as appropriate. The plan covers all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these individuals:

- A medical home framework specific to individuals with serious mental illnesses and criminal justice history;
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each individual;

- Individualized wellness plan and support to promote healthy behaviors, including but not limited to: smoking cessation, appropriate nutrition and exercise, support for behavioral interventions for depression, risky drinking and drug use.
- Enhanced patient education to include:
  - Self-management
  - Health education services
  - Nutritional counseling from dieticians
- Comprehensive care coordination services bringing together the health and behavioral health needs of the individual;
- Peer and recovery support services;
- Substance Abuse Residential Treatment services;
- Short Term Residential Support services;
- Access to Urgent Care psychiatric and mental health treatment services in the community (access 24 hours a day/7 days a week);
- Medication utilization management
- Medication assisted treatment for substance use disorders
- Any additional care coordination services needed to address the complex needs associated with this population.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan D: Medical Home Pilot for Persons with Chronic Conditions
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;

- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	x	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	x	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI recipients • 1902(a)(10)(A)(i)(I) • •	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more	Pilot area to be determined

			ER visits or 1 hospitalization in past 2 years	
	x	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	x	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed	Adult FFS BadgerCare	Pilot area to be

		below and include the citation from the Social Security Act for each eligibility group: • SSI-related • • •	Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	determined

(ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
x	Mandatory categorically needy low-income parents eligible under 1931 of the Act	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	Adult FFS BadgerCare Plus and SSI population with	Pilot area to be determined

		two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	
x	Individuals qualifying for Medicaid on the basis of blindness	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals qualifying for Medicaid on the basis of disability	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined

x	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
	Institutionalized individuals assessed a patient contribution towards the cost of care		
x	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
x	Medically frail and individuals with special medical needs	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart	Pilot area to be determined

		conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	
	Children receiving foster care or adoption assistance under title IV-E of the Act		
x	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)	Adult FFS BadgerCare Plus and SSI	Pilot area to be determined

		population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

A medical home targeting adult Fee-For-Service BadgerCare Plus and SSI members with multiple chronic conditions like asthma, diabetes or heart conditions (excluding mental health comorbidities) will enable this vulnerable population to receive the care coordination services they greatly need to improve health outcomes. To maximize the benefits of the medical home and ensure the immediate medical assessment and care needs of members are addressed, this program will initially enroll all eligible members into the alternative benchmark program. This program includes the full benefit package under the Medicaid/Standard Package but adds benefits critical for this vulnerable population – care coordination, medical assessments, and medication therapy management. The program will operate on an all in/opt out model. The member will have the option of disenrolling from the medial home after six months of continuous enrollment.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will hold meetings with Tribal representatives to obtain their recommendations.

2. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the **voluntary** enrollment, including the period of enrollment, exemption criteria, and the opt-out process
   c. Clearly inform members that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of the patient's needs − from preventive services and health screenings, to specialty medical care, inpatient care, and crisis intervention.
   e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights.
   b. Informing members about the voluntary nature of the program, including how to discontinue their participation.

c. Letting members know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
d. Educating members about the benefits of participating in this program, for example, improved communication and coordination between health care providers and the member.
e. Documenting all requests for disenrollment

4. The state will make direct mailings to members informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

5. The state will send written notification to the member and inform the health care coordinator of all disenrollments. The notification will explain that the regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the member have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

 FEHBP-equivalent Health Insurance Coverage – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

 State/Territory Employee Coverage – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

 Coverage Offered Through a Commercial Health Maintenance Organization (HMO) – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the

Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of adult members with multiple chronic conditions. A key component is health care coordination, including: (a) medical care plan development that addresses physical needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link members with identified health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be member centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

    a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to patients with multiple chronic conditions;
    b. Coordination of health care through a multidisciplinary team, including the primary care physician that works to identify and meet the medical needs of patients with multiple chronic conditions. The team identifies the health needs of each member, creates a care plan, and ensures that each member is assigned a care coordinator;
    c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
    d. Services provided through open and flexible scheduling;
    e. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of members with multiple chronic conditions and on comprehensive care coordination, will assure a member-centric focus and continuity of care. Members will not be limited in their choice of service providers; however, the care manager will collaborate with the member to identify providers who are experienced in meeting the needs of this population.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that

category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Persons receive SSI Medicaid coverage if they meet the federal eligibility criteria of being either elderly, blind or disabled and meet income qualifications. Many SSI-eligible Medicaid members receive care in a managed care environment through the Department's SSI Medicaid HMO contracts; however, there continues to be a population of members who receive care on a fee-for-service basis. This population, along with a small subset of BadgerCare Plus members, is receiving medical care on a fee-for-service basis that is often fragmented, with very little overall care coordination. The combination of multiple chronic conditions and poor care coordination has lead to suboptimal health outcomes for individual members and increased costs to the Medicaid program. This plan provides an outline of the care coordination process and enhanced services for members with multiple chronic conditions (excluding mental health comorbidities) in the designated pilot area. The plan includes all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and ongoing needs of this high risk population:

- A medical home framework specific to adult members with multiple chronic conditions;
- Comprehensive medical assessment and treatment based on best practices and the needs of each member;
- Referral for a comprehensive medication therapy management review by a qualified pharmacist to increase adherence for medication use;
- Enhanced patient education to include:
  - Self-management
  - Health education services
  - Nutritional counseling from dieticians
- Any additional care coordination services needed to address the complex needs associated with this population.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent

with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program

- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services