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State/Territory Name: WI-19-0009

State Plan Amendment (SPA) #: Wisconsin

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850



Children and Adults Health Programs Group

March 22, 2021

Jim Jones
Medicaid Director
State of Wisconsin, Department of Health Services
1 West Wilson Street, Room 350
P.O. Box 309
Madison, WI 53701-0309

Dear Mr. Jones:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), WI-19-0009, submitted on June 28, 2019, with additional information submitted on January 14, 2021, has been approved. WI-19-0009 demonstrates compliance with the CHIP managed care regulations at 42 CFR 457, Subpart L, for utilization of a managed care delivery system. This SPA has an effective date of July 1, 2018 with the exception of the changes as identified in the companion letter issued with this approval.

Sections 2101(a), 2103(f)(3), 2107(b), and 2107(e) of the Social Security Act, as implemented through regulations at 42 CFR 457 Subpart L, describe the application of managed care requirements to CHIP. Wisconsin operates four managed care programs: a Health Maintenance Organization (HMO), Care4Kids prepaid inpatient health plans (PIHP), Children Come First (CCF) PIHP, and Wraparound Milwaukee (WAM) PIHP. The state has provided the necessary assurances indicating that the state complies with the managed care requirements in the delivery of CHIP services and benefits covered under the state's separate child health plan for their HMO and Care4Kids PIHP. As described in the enclosed companion letter, the state is working with CMS in order to comply with specific managed care requirements for their CCF and WAM PIHP behavioral health programs.

This SPA approval does not substitute for CMS review of any contracts between the state and managed care entities that serve the state's CHIP populations. All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review.

Your title XXI project officer is Ms. Dietrich Graham. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Graham's contact information is as follows:

Page 2 – Mr. Jim Jones

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601
Telephone: (312) 353-9355
E-mail: Dietrich.Graham@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs at (410) 786-1536.

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

Sincerely,
/Signed Amy Lutzky/

Amy Lutzky
Deputy Director

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

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

State/Territory: Wisconsin

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

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

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

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

Name: Andrea Palm	Position/Title: Secretary, Department of Health Services
Name: Jim Jones	Position/Title: Wisconsin State Medicaid Director
Name: Rebecca McAtee	Position/Title: Wisconsin SCHIP Director

* Disclosure: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938 0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX); (Section 2101(a)(2)); OR

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

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

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

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

1.3. Check to provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

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

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

Original Plan

Effective Date: **April 1, 1999**

Implementation Date:

Amendment #1 Effective date: July 1, 1999

Implementation date: July 1, 1999

- Amendment #2** Effective date: October 18, 2001
Implementation date: November 1, 2001
- Amendment #3** Effective date: July 14, 2004
Implementation date: August 1, 2004
- Amendment #4** Effective date: November 1, 2005
Implementation date: January 1, 2006
- Amendment #5** Effective date: January 14, 2008
Implementation date: February 1, 2008
- Amendment #6** Effective date: February 1, 2008
Implementation date: February 1, 2008
- Amendment #7** Effective date: July 1, 2008
Implementation date: July 1, 2008
- Amendment #8** Effective date: December 18, 2009
Implementation date: January 1, 2010
- Amendment #9** Purpose of SPA: End of Benchmark Plan coverage and general updates.
Effective date: July 1, 2014
Implementation date: July 1, 2014
- Amendment #10** Purpose of SPA: Initiate Health Service Initiative for a Poison Control Center.
Effective date: July 1, 2015
Implementation date: July 1, 2015
- Amendment #11** Purpose of SPA: Implement the Mental Health Parity and Addiction Equity Act (MHPAEA, Pub.L. 110-343)
Effective date: July 1, 2017
Implementation date: July 1, 2017
- Amendment #12** Purpose of SPA: Implement Lead Abatement HSI
Effective date: July 1, 2018
Implementation date: July 1, 2018
- Amendment #13** Purpose of SPA: Implement CMS Managed Care Final Rule of April 25, 2016
Effective date: July 1, 2018 for All Programs Excluding Children Come First and Wraparound Milwaukee PIHPs
Effective date: by June 30, 2021 for Children Come First and Wraparound Milwaukee PIHPs

Implementation date: July 1, 2018

Roster of SPAs superseding plan sections with MMDL forms

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NUMBER 13-028 Date Submitted: 09/27/2013 Approval Date: 08/12/2014 Effective/Implementation Date: 04/01/2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections 4.1.1, 4.1.2 and 4.1.3
		CS9	Eligibility – Coverage from Conception to Birth	Supersedes the current sections 4.1.2.1
		CS15	MAGI-Based Income Methodologies	Incorporated within a separate subsection under section 4.3
NUMBER 13-029 Date Submitted: 09/27/2013 Approval Date: 10/23/2013 Effective/Implementation Date: 04/01/2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NUMBER 13-030 Date Submitted: 09/27/2013 Approval Date: 10/23/2013 Effective/Implementation Date: 04/01/2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporated within a separate subsection under section 4.1
NUMBER 13-031 Date Submitted: 09/27/2013 Approval Date: 03/26/2014 Effective/Implementation Date: 04/01/2014	Eligibility Processing	CS24	MAGI-Based Eligibility Process	Supersedes the current items in sections 4.3 and 4.4 related to application processing, eligibility screening and enrollment, and renewals

State: Wisconsin

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NUMBER 13-032 Date Submitted: 09/27/2013 Approval Date: 11/22/2016 Effective/Implementation Date: 04/01/2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial Eligibility – Citizenship	Supersedes the current section 4.1.0
		CS19	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current Cost Sharing and Payment section 8.7

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

The Wisconsin Tribal Health Directors Association (WTHDA) held its bi-monthly meeting on Wednesday, May 8, 2019 at the Red Cliff Community Health Center in Bayfield, WI with a quorum in attendance. Several Wisconsin Department of Health Services (DHS) staff attended. A number of the health directors and additional DHS staff participated telephonically. Medicaid Director Jim Jones gave a presentation of the State Plan Amendment (SPA) process, inviting discussion of how the tribes could be more involved. Director Jones also presented an overview of SPA 19-0009-CHIP that Wisconsin intends to submit to bring the CHIP plan into compliance with the CMS MCO final rule of 2016. The health directors had no specific questions or concerns related to the SPA.

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

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

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

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

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

The Wisconsin Department of Health Services conducts an annual Family

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

The survey provides descriptive information about health insurance coverage among Wisconsin residents. To monitor health status and health care utilization issues, survey questions ask about the current health status, chronic conditions, and physical limitations of all household members, as well as the last visit to a doctor, visit to a dentist, and any use of an emergency room in the past year. Demographic characteristics, such as age, race, poverty status, and education, also are obtained for all persons in the household.

According to the Family Health Survey, in 2012 there were about 1,347,000 children under 19 years of age in Wisconsin. Approximately 1,118,000 (83% of these children) were white (majority) and 229,000 (17%) were minority or multiple race.

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

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

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

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

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

update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

2.2.1 WI Poison Control Center

Wisconsin will elect to use the health services initiative option as allowed at 42 CFR 457.10. Wisconsin is proposing to cover the efforts of the WI Poison Control Center under this initiative.

The Wisconsin Poison Control Center is located in Milwaukee, WI, and provides 24-hour, toll-free poison information for all individuals in the State of Wisconsin. Anyone who has had direct contact with a known or potential poison can receive immediate recommendations on what steps to take to prevent injury from that exposure.

The Wisconsin Poison Control Center provides immediate access to expert treatment advice and assistance over the telephone in case of exposure to poisonous or hazardous substances. A single toll-free telephone number allows for rapid and direct access to highly specialized care, including demographic populations that are typically underserved or lack access to high-quality health care, such as uninsured, low-income, and immigrant families. From anywhere within Wisconsin, the general public, industry, emergency medical services and health care professionals can contact the center at 1-800-222-1222. During 2013, approximately 64.5% of all those receiving services are age 19 or younger.

An electronic medical record is kept that identifies the demographics, interventions and outcomes of all poison exposure cases reported to the Poison Center. All information regarding patient and call identification is kept discreet, meeting all federal requirements pertaining to patient confidentiality. Across the United States, federal agencies recognize and endorse the importance of poison centers in providing medical consultation and public health surveillance. Consultation with Poison Center staff may assist and expedite medical care without concern of violation of patient privacy.

The WI Poison Center also collaborates with the WI Department of Health Services to provide poison surveillance data to public health administrators with specific state-wide monitoring for blue-green algae and weapons of mass destruction.

The Poison Center has been Wisconsin's only designated poison information service since 2001. It received national certification from the American Association of Poison Control Centers in 2005 and successfully re-accredited in 2009 and 2014.

Registered nurses and pharmacists trained and certified as specialists in

poison information directly handle telephone inquiries. Consultation with medical toxicologists is available 24 hours a day for health care providers.

The center's primary mission is to consistently deliver comprehensive and accurate information to callers faced with any poison or drug-related event. Recommendations are provided to individuals of all age groups who are concerned about an exposure to medications, illegal drugs, household chemicals, botanicals, animal and insect venom, food poisoning, occupational chemicals, environmental pollutants and other hazardous substances.

The center also provides poison prevention education through the public education program and public website. A variety of materials, including a comprehensive, standards-based poison prevention curriculum (K-12), are available at www.wisconsinpoison.org.

The overall cost of the program exceeds \$1.9M on an annual basis. It has reduced staff and marketing expenditures over the last few years due to lack of funding.

A portion of these costs are currently being funded via an agreement between Children's Hospital of WI and the State of WI. These funds are currently unmatched by federal funds and are at a maximum of \$425,000 annually from the State General Purpose Revenue (GPR.) An additional requirement is that Children's matches 50% of the GPR for the total agreement.

The Wisconsin Poison Control Center has been an outstanding example of how a public-private partnership can work in the state. CHIP funding will allow this organization to continue its strong track record of providing the residents of the State of Wisconsin access to valuable, cost-effective, and life-saving services.

For future administrative budget assistance, the WI Department of Health Services intends to use the same dollar amount of the current contract to receive the federal match under CHIP using the Health Services Initiatives (HSI) option.

2.2.2 Lead Abatement

As permitted under section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, the Wisconsin Department of Health Services (the Department) will conduct a health services initiative that will use CHIP funds, within the federal administrative expenditures cap allowed for states, to support expanded lead abatement activities in impacted areas of Wisconsin based on prioritization criteria as further described herein. Federal assistance is necessary to minimize and further prevent the long-term adverse health effects associated with lead exposure, in targeted high

risk areas and across the State. This health services initiative would complement other federal, state and local efforts to test, educate, and abate lead hazards from the homes and improve the health of Medicaid and CHIP-eligible individuals.

The Department is seeking federal funding pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act for the development and implementation of a lead abatement program through the use of a CHIP health services initiative. The Department will administer all aspects of the program. The Department will provide coordinated and targeted lead abatement services to eligible properties in the impacted area to mitigate lead hazards as outlined below.

2.2.2.1 Monitoring and Oversight

To help ensure a successful program, the Department will contract with regional or local housing agencies to administer and manage all daily aspects of the lead abatement projects. The contracted agencies' activities will include participant enrollment and income verification, generation of lead abatement specifications, and coordination of the bidding process for lead abatement activities. The contracted agencies have previous experience in operating and managing federal housing assistance programs.

2.2.2.2 Eligibility Criteria

Properties considered for enrollment must meet all the following conditions prior to the initiation of lead abatement activities. The property shall be:

- 1. Constructed prior to 1978;**
- 2. Occupied by tenants or owner-occupants at or below 300% of the FPL;**
- 3. Occupied by tenants or owner-occupants who have at least one Medicaid or CHIP-eligible child under 19 years of age or pregnant woman, or a child under 19 years of age or pregnant woman who visits regularly (e.g. home of a family member, relative or child care where a child spends 3 hours a day on two separate days a week and a total of 60 hours per year);**
- 4. Current on all property taxes or have a tax payment plan in place.**

2.2.2.3 Prioritization of Participants

The goal of the program is to assist Wisconsin families and property owners with addressing lead hazards in the home environment by providing the services needed to eliminate or control lead hazards. Property owners and families in all of Wisconsin's 72 counties are eligible for participation in the program if they meet the qualifications as outlined above.

The Department will initially prioritize services to properties where children with elevated blood lead levels reside that are subject to lead hazard reduction work orders issued by a local health department. There are

currently an estimated 400 properties across the state under lead hazard control work orders that may be eligible for lead abatement assistance through the CHIP health services initiative. These properties have undergone a thorough lead investigation which has identified lead hazards contributing to an eligible child's elevated blood lead level. The majority of these investigations were conducted as required by state law in response to a child with one venous blood lead level ≥ 20 $\mu\text{g}/\text{dL}$ or two venous blood lead levels ≥ 15 $\mu\text{g}/\text{dL}$ that were drawn at least 90 days apart.

Secondly, the Department will prioritize properties of children with blood lead levels meeting the Wis. Stat. 254.11(9) definition for lead poisoning (≥ 5 $\mu\text{g}/\text{dL}$) that are not subject to lead hazard reduction work orders. In 2016, there were more than 4,300 children with a blood lead level ≥ 5 $\mu\text{g}/\text{dL}$ many of whom may be eligible for assistance through the CHIP health services initiative.

For the third level of prioritization the Department will focus on a primary prevention approach. Project units will be identified from specific target areas with high rates of both childhood lead poisoning and pre-1950 housing. The Department or its designee will conduct community outreach efforts to identify properties to enroll in the project and engage affected families in these target communities. These outreach efforts may include direct mailings to families residing in the target area, flyers and postings in community areas, and other effective outreach activities as determined by the Department.

Target communities will be selected based on the following criteria:

- Percentage of children under age 6 with a blood lead level of ≥ 5 $\mu\text{g}/\text{dL}$;
- Percentage of population that is low-income;
- Percentage of pre-1950 housing stock. (90% of Wisconsin children first identified with lead poisoning from 1996 to 2006 lived in homes that were built before 1950.)

2.2.2.4 Income Verification and Enrollment

The purpose of the intake and enrollment process is to ensure the owners, tenants, or owner-occupants meet all qualifications for participation in the program through the collection of required documents and completion of enrollment forms. During intake and enrollment, the program process and expectations will be outlined to the participants.

During the enrollment process, the Department will determine if the occupants of the property include at least one Medicaid or CHIP-eligible child under 19 years of age or a pregnant woman. On a monthly basis, the Department will use the state blood lead database and Medicaid enrollment

database to generate a list of potential participants to share with the contracted agencies. The Department will inform the agencies to proceed with the program services for those we have agreed are potentially eligible.

If the potential participants are not enrolled in Medicaid or CHIP or covered by any other creditable health care insurance program, the contracted agencies and the Department will take steps to assist the participant's parent or guardian with completing enrollment materials and obtaining access to health care providers.

2.2.2.5 Lead Hazard Risk Assessment

Once a property is enrolled, the Department or contracted agency will arrange for a property assessment and lead hazard risk assessment of the child's residence or other eligible property to determine the presence of lead hazards. Only a certified lead risk assessor may conduct this assessment. Work specifications for lead abatement of identified hazards will be written by the certified lead risk assessor employed or contracted by the Department, a local health department, or the contracted agency.

2.2.2.6 Property Owner Contribution

Rental property owners may be required to pay up to 15% of the cost of the lead abatement work as a requirement for participation in the program. Owner-occupants will not be required to provide owner contribution.

2.2.2.7 Tenant Relocation Services

During the course of the lead abatement activities, it may be necessary for the occupants to relocate to ensure their health and safety. The average time frame for completion of lead abatement activities is projected to be 5 to 10 calendar days. Families will be allowed to return to the property upon completion of a successful clearance investigation.

Relocation will be carried out in accordance with the HUD guidelines. Occupants who must vacate the property while the work is ongoing will be treated fairly and equitably. Alternate housing will be identified for displaced families and efforts will be made to identify friends or family members who may be able to provide temporary housing that takes into consideration their specific needs, using HUD occupancy standards for the size and makeup of the household. Priority will be given to relocate the family in a nearby location, especially to maintain the same school district if applicable. At the time relocation occurs, and for the duration of the work, the Department will provide to the residents a per diem allowance to cover meals, lodging and transportation.

2.2.2.8 Lead Abatement Activities

After the scope of work has been determined, the lead abatement activity work will be bid and awarded by the contracted agency to certified lead

abatement contractors. The contracted agency will select the lowest, most reasonable bid taking into consideration the location of the project, the capability of the abatement contractor to meet project timelines and any other factor that may impact the flow or successful completion of the project.

Individuals performing abatement work must be properly certified by the Department. Only persons certified as lead abatement workers or supervisors may perform lead abatement activities in accordance with the state lead regulations in administrative code, chapter DHS 163, HUD's Lead Safe Housing Rule, the HUD Guidelines, and all other federal and state lead regulations and guidance. Project monitors will conduct random site visits to properties undergoing work to ensure that contractors follow proper lead abatement work practices in compliance with the regulations.

A certified lead abatement supervisor is required to be present at the job site while all abatement work is being done. This requirement includes all setup and clean-up work. All certified personnel must work for a certified lead company. The lead company and its employees must use abatement methods in accordance with state laws and regulations and use methods developed or provided by the U.S. Department of Housing and Urban Development (HUD) and/or the EPA.

Abatement activities are defined as measures to permanently eliminate lead-based paint hazards, and may include:

- **The removal, enclosure, or encapsulation of lead based paint and lead dust hazards from an eligible residence;**
- **The removal of lead-based painted surfaces, components or fixtures from an eligible residence;**
- **The removal or covering of lead-contaminated soil up to the eligible residence property line; and**
- **All worksite preparation, clean up, and disposal, and lead risk assessment and clearance activities, including lab sampling analysis, associated with such measures.**

For the purposes of this request, abatement does not include any of the following:

- **Work that does not prevent or reduce a lead hazard;**
- **Work outside the confines of the property lines that is not the responsibility of the property owner or landlord;**
- **Work on dwellings that do not have a Medicaid- or CHIP-eligible individual under the age of 19, or Medicaid/CHIP-eligible pregnant woman, residing or frequently visiting the structure;**
- **Work to replace lead service lines, including mail lines connecting home to city water.**

Once work has started on an eligible property, all surfaces, components and fixtures that have been identified as a lead hazard will be remediated. Eligible surfaces for abatement activities include all structural components identified during a risk assessment as hazards including but not limited to: all window components, doors and door frames, stairs, interior walls and ceilings, painted built-in cabinets, interior railings, painted floors, interior trim, exterior porches, exterior painted siding, exterior windows and trim, exterior trim boards on the residence, garages, and other structures, and soil. Services may be rendered to the physical structure and include the surrounding land up to the property line.

2.2.2.9 Limitations on the Use of CHIP Funds

Minimal rehabilitation work is permitted under this project if it is necessary to protect the integrity of the lead abatement work. In cases where the Department determines that the lead abatement work will fail without additional minor repairs, and certifies that the repairs are essential to maintain the integrity of the lead abatement work, these repairs will be covered. All services necessary for repair integrity will follow the minimum standards as established by HUD for lead-based paint hazard control and/or healthy homes grants (located at https://www.hud.gov/sites/documents/DOC_38179.PDF) and any subsequent amendments to the HUD guidelines.

The Department will not utilize funds from this health services initiative to replace lead service lines. The vast majority of lead poisoning cases in Wisconsin continue to be related to exposure to lead in paint. In the event that the source of lead exposure is related to water, the Department may utilize the health services initiative funds to install a water filter in the home and will refer the property owner to other resources to abate this problem.

Funds from this health services initiative will not be used to address soil contamination for any home where the federal Environmental Protection Agency (EPA) would handle that responsibility due to the location of a home within a designated superfund zone.

2.2.2.10 Use of CHIP Funds to Support Lead Abatement Activities

The Department and its contracted agencies will closely monitor the project and ensure compliance with HUD's Lead Safe Housing Rule, the HUD Guidelines, and all federal and state regulations and guidance. Project monitors will conduct regular onsite visits to properties undergoing work to ensure that contractors utilize proper lead abatement activity work practices, and that they do not utilize prohibited practices during the lead abatement activities.

For the purposes of this health services initiative, the Department requests

funding to increase the available abatement workforce by providing training for individuals in lead risk assessor and lead abatement worker and supervisor disciplines. Training for certification/licensure must be provided by an accredited lead training program. These funds will ensure that sufficient numbers of lead professionals are available to meet the increased demand for lead hazard investigation and abatement work using the CHIP funds.

Lastly, the Department requests funding to supplement the administrative functions necessary to successfully implement this CHIP health services initiative. The funding received for this request will supplement but not supplant other federal funding sources for lead abatement or the training/credentialing process of lead risk assessors, lead workers or lead abatement contractors.

2.2.2.11 Post Lead Abatement Activities

The Department recognizes that abatement activities would only be eligible for federal assistance when performance of these activities can be demonstrated to be effective in remediating all identified lead-paint and soil hazards. State and federal laws dictate that a clearance test must be performed after lead abatement work is finished to verify the work area is safe for the resident(s) to return. At the completion of the lead abatement activities, a certified risk assessor will perform a clearance examination in accordance with Wisconsin regulations and the procedures outlined in this document. Only a certified risk assessor, who is independent of the abatement company, may perform clearance testing after abatement work is completed. The risk assessor who conducts the examination will be employed or contracted by the contracted agency. Re-examinations will be performed when an initial clearance examination fails. The family will return to the property when the property passes clearance.

After interior lead abatement work is completed, a certified lead risk assessor must perform clearance consisting of a visual inspection of the interior to ensure that all specified work was completed and all lead hazards were properly addressed. The certified lead risk assessor must also perform required dust wipe sampling to determine dust lead levels are below the clearance action levels on sampled surfaces. After exterior paint abatement work is completed, a risk assessor must perform a visual inspection of the exterior to ensure that all specified work was completed and lead hazards were properly addressed. Dust wipe clearance testing on porches will follow HUD policy guidance for abatement on the exterior of a house or rental property, using the clearance action level provided in the table below.

The final clearance report will be maintained by the Department. This report will include the results of the visual and any required sampling analysis results with units of measurement.

For purposes of this lead abatement program, the standards shown in the table below will be utilized when determining hazardous levels and the clearance standards for determining a unit is safe for re-occupancy.

Material and Location Tested	Considered hazardous if lead is present at or above these levels*
Bare soil (child play area)	At or above 400 ppm of lead
Bare soil (other areas)	At or above 1200 ppm of lead
Dust - floor	At or above 10 micrograms of lead per square foot of sampled area ($\mu\text{g}/\text{ft}^2$)
Dust – porch	At or above 40 $\mu\text{g}/\text{ft}^2$ of lead
Dust - window sill	At or above 100 $\mu\text{g}/\text{ft}^2$ of lead
Dust – window trough	At or above 100 $\mu\text{g}/\text{ft}^2$ of lead
Paint tested by an X-Ray Fluorescence (XRF) analyzer	Equal to or more than 1.0 milligrams per square centimeter (mg/cm^2) of lead on a deteriorated sampled surface
Paint tested by lab analysis	Equal to or more than 0.5% (one half of 1 percent) lead by dry weight, or equal to or more than 5,000 parts per million of lead in paint (ppm)

** All levels indicated in the table above will be utilized until and unless more stringent guidelines are promulgated at the state or federal level.*

2.2.2.12 Metrics/Reporting Requirements

The Department believes that this health services initiative will remediate identified lead hazards from the homes and improve the health of Medicaid and CHIP eligible children throughout Wisconsin. Providing for development and implementation of the lead hazard abatement program will reduce the potential for ongoing exposure or re-exposure to lead hazards for the eligible population and future populations. The Department will maintain a database of these ameliorated properties.

Key metrics the Department will track and report to CMS monthly or at another approved interval include:

- **Number of lead risk assessments completed;**

- **Number of houses identified with lead hazards in each of the targeted area(s);**
- **Number of houses in each of the targeted areas scheduled for lead hazard abatement;**
- **Number of houses in each of the targeted areas in which lead hazard abatement has occurred;**
 - **Number of houses abated for CHIP or Medicaid children under the age of 19;**
 - **Number of houses abated for pregnant women;**
- **Record of actual services provided in each house;**
- **Clearance testing results for each house receiving abatement services;**
- **Percentage of Medicaid-eligible children receiving blood lead testing under EPSDT (HealthCheck) statewide and in the areas targeted by this health services initiative;**
- **Percentage of children with elevated blood lead levels statewide and in this health services initiative.**

The Department assures that this health services initiative will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

2.3-TC

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

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

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

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

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

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFAS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

- 3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs,

PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

- No, the State does not use a managed care delivery system for any CHIP populations.
- Yes, the State uses a managed care delivery system for all CHIP populations.
- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Populations not enrolled in managed care for CHIP and instead receive services on a fee-for-service basis:

- **Pregnant mothers and their unborn children in the BadgerCare Plus Prenatal Program. This program provides services to pregnant women from 0% - 301% of the FPL who are ineligible for BadgerCare Plus solely due to their immigration status but meet all other financial and non-financial requirements for BadgerCare Plus.**

All other WI CHIP populations are enrolled into managed care.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))

The state uses its standard fee-for-service delivery system to provide benefits to this population.

- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

The state applies its standard fee-for-service policies to this population, including prior authorization requirements.

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State’s responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

- No
- Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

All services carved out of the managed care delivery system are provided under fee-for-service. The carved out services are listed below and detailed in the HMO Contract submitted to CMS at the corresponding citations:

- 1. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section A(6).**
- 2. Dental, unless the HMO elects to provide dental services. BadgerCare Plus HMOs serving Milwaukee, Waukesha, Racine, Kenosha, Ozaukee and Washington counties must provide dental services. SSI HMOs serving Milwaukee, Waukesha, Racine and Kenosha counties must provide dental services.**
- 3. Prenatal Care Coordination (PNCC), except the HMO must sign a Memorandum of Understanding (MOU) with the PNCC.**
- 4. Targeted Case Management (TCM), except the HMO must work with the TCM case manager as indicated in Addendum III.**
- 5. School-Based Services (SBS), except the HMO must use its best efforts to sign a Memorandum of Understanding (MOU). SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.**
- 6. Child Care Coordination.**
- 7. Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.**
- 8. Crisis Intervention Benefit.**
- 9. Community Support Program (CSP) services.**
- 10. Comprehensive Community Services (CCS).**
- 11. Community Recovery Services (CRS).**
- 12. Chiropractic services, unless the HMO elects to provide chiropractic services.**
- 13. Lead investigations, as defined in s. 254.11(8s), of persons having lead poisoning or lead exposure, as defined in s. 254.11(9).**
- 14. Medication therapy management.**

15. Prescription, over-the-counter drugs, and diabetic and other drug related supplies (as defined by the Department dispensed by a provider licensed to dispense by the Wisconsin Department of Safety and Professional Services (DSPS)).

16. Provider administered drugs, as discussed in Topic #5697 (Provider-Administered Drugs) of the Covered and Non-covered Services chapter of the ForwardHealth Online Handbook.

17. Behavioral Treatment Services (Autism Services) as defined in ForwardHealth Online Handbook

3.1.2 Use of a Managed Care Delivery System for All or Some of the State’s CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

Managed care organization (MCO) (42 CFR 457.10)

Capitation payment

Describe population served:

Children ages one to five from 191% - 306% of the FPL and children ages 6 – 18 from 156% to 306% of the FPL are covered by CHIP through the BadgerCare Plus HMO program.

Women in the BadgerCare Plus Prenatal Program from 0% - 306% of the FPL are covered by CHIP. These are pregnant women who are ineligible for BadgerCare Plus solely due to their incarceration or immigration status; but meet all other financial and non-financial requirements for BadgerCare Plus. This population is served through fee-for-service.

Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served:

Wisconsin currently operates three PIHPs that serve both the Medicaid and CHIP populations. Each of these PIHPs is operate through a contract with the local county agency. Whether the child is covered under Medicaid or CHIP

depends on the child’s income based on the income limits listed above.

Care4Kids (C4K) is a program offered in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties in southeast Wisconsin. Children and eligible youth up to age 21, who are placed in out-of-home care in one of the six counties, are eligible for C4K. Enrollment in C4K can continue for up to 12 months after the child is discharged from an out-of-home placement, as long as the child remains eligible for full Medicaid benefits and lives in one of the six identified counties.

Children Come First (CCF) serves children from birth through 18 years old whose parents, guardians, or primary caregivers reside in Dane County are eligible for BadgerCare Plus and have been determined to have a severe emotional disturbance. Children and youth eligible for CCF must be in an out-of-home placement or at imminent risk of admission to an institutional setting.

Wraparound Milwaukee (WAM) serves children and young adults, birth through 18 years of ages, and 19 and 20 years old for young adults aging out of foster care, whose parents, guardian, or primary caregiver resides in Milwaukee County, or the child is legally the responsibility of Milwaukee County. Eligible children will be determined to have a severe emotional disturbance, and reside in an out-of-home placement or are at imminent risk of admission to an institutional setting.

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
 Capitation payment
 Other (please explain)
Describe population served:

Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
 Case management fee
 Other (please explain)

- Primary care case management entity (PCCM Entity) (42 CFR 457.10)
 - Case management fee
 - Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
 - Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

- Provision of intensive telephonic case management
- Provision of face-to-face case management
- Operation of a nurse triage advice line
- Development of enrollee care plans
- Execution of contracts with fee-for-service (FFS) providers in the FFS program
- Oversight responsibilities for the activities of FFS providers in the FFS program
- Provision of payments to FFS providers on behalf of the State
- Provision of enrollee outreach and education activities
- Operation of a customer service call center
- Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
- Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- Coordination with behavioral health systems/providers
- Other (please describe)

- 3.1.2.2** The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the

State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

- The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):
- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
 - The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
 - The provision against provider discrimination in 42 CFR 457.1208.
 - The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
 - The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
 - The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
 - An enrollee's right to a State review under subpart K of 42 CFR 457.
 - Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
 - Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

- 3.2.1 The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))
- 3.2.2 The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as

required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

- 3.2.3** The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.
- 3.2.4** The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

- 3.3.1** The State assures that its payment rates are:
- Based on public or private payment rates for comparable services for comparable populations; and
 - Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

- 3.3.2** The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))
- 3.3.3** The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))
- 3.3.4** The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs,

PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

Wisconsin submits these reports for MCOs but not for PIHPs.

3.3.5

Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

- No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
- Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
- Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

- The State assures that if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:
 - Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
 - Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6

The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4

Enrollment



The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));

- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

- Yes
- No

If the State uses a default enrollment process, please make the following assurances:

- The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))
- The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably

and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular

enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary’s initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

- Yes
- No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

- The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

- The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))
- The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:
 - During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
 - At least once every 12 months thereafter;
 - If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the

- beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and

readily accessible;

- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and

The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6

The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
 - That oral interpretation is available for any language and written translation is available in prevalent languages;
 - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
 - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7

The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the

alternatives available to the potential enrollee based on their specific circumstance;

- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
 - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
 - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

STATE RESPONSE: HMO managed care and the Care4Kids PIHP are in compliance with these citations. The state is currently working with CMS to bring the Children Come First and Wraparound Milwaukee PIHP contracts into compliance through updating the member handbooks in June 2020 to address the relevant notification requirements not otherwise met by PIHP program materials and the ForwardHealth eligibility & benefits handbook provided to all members/applicants.

3.5.8

The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9

The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing

to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10

The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition and emergency services;

- The fact that prior authorization is not required for emergency services; and
- The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
 - The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process; and
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

State: Wisconsin

3.5.13 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

STATE RESPONSE: Pharmacy is carved out of all HMO managed care and PIHP programs.

3.5.15 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in

accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

- 3.6.1** The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)
- 3.6.2** The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.3** The State assures that it:
- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
 - Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20).

- 3.6.4** The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.5** The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:
- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
 - Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
 - Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b))

State: Wisconsin

- 3.6.6** The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))
- 3.6.7** The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))
- 3.6.8** The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:
- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
 - Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
 - Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
 - Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
 - Establishing mechanisms to ensure compliance by network providers;
 - Monitoring network providers regularly to determine compliance;
 - Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))
- 3.6.9** The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)
- 3.6.10** The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each

MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

STATE RESPONSE: The HMO managed care contract and the Care4Kids PIHP contract are in compliance with these citations. The state is currently working with CMS to bring the Children Come First and Wraparound Milwaukee PIHP contracts into compliance by June 2021. Specifically, CCF and WM will be working over the next year to submit their behavioral health provider network in the same format and system as HMOs submit their comprehensive networks to the state.

3.6.11 ☒

Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

STATE RESPONSE: The HMO managed care contract and the Care4Kids PIHP contract are in compliance with these citations. The state is currently working with CMS to bring the Children Come First and Wraparound Milwaukee PIHP contracts into compliance by June 2021. Specifically, the CCF and WM contracts permit the programs to establish prior authorization requirement to determine medical necessity and utilization management of covered services. The state will be modifying the contracts to add clarity to covered services and appropriate codes, and over the next year the programs will be required to submit data to the state about approved prior authorizations, similar to the requirements for contracted HMOs.

3.6.12 ☒

Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;

- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

- 3.6.13** The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))
- 3.6.14** The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))
- 3.6.15** The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP
- 3.6.16** The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:
- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
 - Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
 - Provide the enrollee with information on how to contact their designated person or entity responsible for the enrollee's coordination of services;
 - Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;

- Make a best effort to conduct an initial screening of each enrollee's needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

- 3.6.17 The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.
- 3.6.18 The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))
- 3.6.19 The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:
- Is in accordance with applicable State quality assurance and utilization review standards;
 - Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

- 3.6.20** The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

- 3.7.1** The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

- 3.7.2** The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:
- Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
 - MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
 - MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
 - If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
 - MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

- 3.7.3** The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:
- The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
 - All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
 - All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and
 - The subcontractor agrees to the audit provisions in 438.230(c)(3).
- 3.7.4** The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))
- 3.7.5** The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))
- 3.7.6** The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims,

grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

- 3.7.7 The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

STATE RESPONSE: The HMO MC contract is in compliance with these citations. The state is currently working with CMS to bring the PIHP programs into compliance by June 2021 for information systems and encounter data requirements.

- 3.7.8 The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)
- 3.7.9 The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

- 3.8.1 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))
- 3.8.2 The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))
- 3.8.3 The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:
- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
 - Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR

438.106(b))

- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State’s review process for benefits.

3.9.1 The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?
 Yes
 No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

State: Wisconsin

- 3.9.7** The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))
- 3.9.8** The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))
- 3.9.9** The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.
- 3.9.10** The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
 - The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
 - The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
 - The procedures for exercising the rights specified above under this assurance.
 - The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))
- 3.9.11** The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))
- 3.9.12** The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13

The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

- Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
- Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal.
 - A grievance or appeal that involves clinical issues.
- All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14

The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15

The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

- 3.9.16** The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))
- 3.9.17** The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))
- 3.9.18** The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:
- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
 - Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
 - Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))
- 3.9.19** The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))
- 3.9.20** The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))
- 3.9.21** For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
 - For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.
 - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))
- 3.9.22 For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))
- 3.9.23 The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
 - The review is independent of both the State and MCO, PIHP, or PAHP; and
 - The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))
- STATE RESPONSE: The State does not offer an external medical review for MCO, PIHP, or PAHP.**
- 3.9.24 The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))
- 3.9.25 The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process;
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
 - The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished

while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

- 3.9.26 The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)
- 3.9.27 The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

- 3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:
 - Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
 - Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
 - Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

State: Wisconsin

- 3.10.2** The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)
- 3.10.3** The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))
- 3.10.4** The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:
- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
 - Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
 - Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
 - Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
 - Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
 - In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
 - Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and

- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

- 3.10.5** The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))
- 3.10.6** The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))
- 3.10.7** The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))
- 3.10.8** The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))
- 3.10.9** The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

State: Wisconsin

- 3.10.10** The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))
- 3.10.11** The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)
- 3.10.12** The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:
- Encounter data in the form and manner described in 42 CFR 438.818.

STATE RESPONSE: The HMO managed care contract and the Care4Kids PIHP contract are in compliance with these citations. The state is currently working with CMS to bring the PIHP programs into compliance by June 2021 for information systems and encounter data requirements.

- Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13

The State assures that:

- It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
- It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and
- It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14

The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15

The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16

The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

STATE RESPONSE: The HMO managed care contract and the

Care4Kids PIHP contract are in compliance with these citations. The state is currently working with CMS to bring the Children Come First and Wraparound Milwaukee PIHP contracts into compliance by June 2021.

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

- 3.11.1 The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)
- 3.11.2 The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))
- 3.11.3 The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

Yes

No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

State: Wisconsin

- 3.11.5** The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))
- 3.11.6** The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))
- 3.11.7** The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

- 3.12.1.1** The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:
- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
 - A description of:
 - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts,

- including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
- The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
 - Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
 - A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
 - The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
 - For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
 - A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
 - The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
 - Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
 - Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
 - The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to

the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

- 3.12.1.4** The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))
- 3.12.1.5** The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).
- 3.12.1.6** The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
 - A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))
- 3.12.1.7** Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
 - If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))
- 3.12.1.8** The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

- 3.12.2.1.1** The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:
- Standard performance measures specified by the State;
 - Any measures and programs required by CMS (42 CFR 438.330(a)(2));
 - Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
 - Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
 - Mechanisms to detect both underutilization and overutilization of services; and
 - Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

- 3.12.2.1.2** The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:
- Measurement of performance using objective quality indicators;
 - Implementation of interventions to achieve improvement in the access to and quality of care;
 - Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
 - Planning and initiation of activities for increasing or

sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

- 3.12.2.1.3** The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:
- Standard performance measures specified by the State;
 - Mechanisms to detect both underutilization and overutilization of services; and
 - Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

- 3.12.2.2.1** The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))
- 3.12.2.2.2** The State assures that it annually requires each MCO, PIHP, and PAHP to:
- 1) Measure and report to the State on its performance using the standard measures required by the State;
 - 2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
 - 3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

- 3.12.2.2.3** The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:
- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
 - The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

- 3.12.3.1** The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).
- 3.12.3.2** The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

- The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in

accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

- The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

- 3.12.5.1.1 The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

- 3.12.5.1.2 The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

- 3.12.5.2.1** The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))
- 3.12.5.2.2** The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State’s quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)
- 3.12.5.2.3** The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

- 3.12.5.2.4** The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:
- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
 - A review, conducted within the previous 3-year period, to determine the PCCM entity’s compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

- 3.12.5.3.1** The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))
- 3.12.5.3.2** The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).
- 3.12.5.3.3** The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:
- The EQRO has sufficient information to use in performing the review;
 - The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
 - For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
 - The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))
- 3.12.5.3.4** The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:
- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to

the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
 - Objectives;
 - Technical methods of data collection and analysis;
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
 - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42

CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

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

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

4.0. Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

See SPA WI_13-0029, Section CS3

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

State: Wisconsin

- 4.1.0. Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

Wisconsin is using the SSA verification option for all applicants declaring U.S. Citizenship

See SPA WI_13-032, Section CS18

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

See SPA WI_13-0028, Section CS7

- 4.1.2. Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

See SPA WI_13-0028, Section CS7

- 4.1.2.1-PC Age: _____ through birth (SHO #02-004, issued November 12, 2002)

See SPA WI_13-0028, Section CS9

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

See SPA WI_13-0028, Section CS7

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

See SPA WI_13-0028, Section CS9

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

There is no resource test.

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

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

See SPA WI_13-032, Section CS17

- 4.1.6. Disability Status (so long as any standard relating to disability status does

not restrict eligibility):

Not applicable.

4.1.7.

Access to or coverage under other health coverage:

Unborn Children

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

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

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

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

- **The individual through whom the insurance was available involuntarily lost their job with the employer providing that insurance, or voluntarily ended their job because of the incapacitation of the individual or because of an immediate family member’s health condition,**
- **Employment of the individual through whom the insurance was available changed and the new employer does not offer health insurance coverage, or the employer discontinued health plan coverage for all employees**
- **COBRA continuation coverage was exhausted in accordance with federal regulations,**
- **Coverage was lost due to the death or change in marital status of the policy holder, or**
- **The insurance was provided by someone not residing with the unborn child;**

A good cause exemption is granted to individuals with current, future

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

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

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

Children covered under Separate SCHIP

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

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

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

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

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

application, if:

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

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

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

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

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

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

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

4.1.9. Other standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not

addressed above. For instance:

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

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

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

See SPA WI_13-032, Section CS19

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

4.1.9.2. Continuous eligibility

4.1-PW **Pregnant women option.** (Section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

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

4.1-LR **Lawfully residing option.** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); CHIPRA

#17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 USC §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age 19.

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

4.1-DS **Supplemental Dental** (Section 2103(c)(5))- A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

- 4.2.1-DS** These standards do not discriminate on the basis of diagnosis.
- 4.2.2-DS** Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without

- covering children with a lower family income.
- 4.2.3-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

See SPA WI-13-0031, Sections CS15 & CS24

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

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below.
(Section 2102(b)(2) and 42 CFR 457.305(b))

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

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

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

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

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

2013.
(Section 2107(e)(1)(E))

- 4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.
- 4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.
- 4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.
- 4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening household, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances.

(Sections 2102(b)(3)(A) and 2110(b)(2)(B); 42 CFR 457.310(b)(2), 42 CFR 457.350(a)(1) and 457.80(c)(3))

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

- 4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to

a State health benefits plan) are furnished child health assistance under the plan.

(Sections 2102(b)(3)(A), 2110(b)(2)(B), 42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 457.80(c)(3))

Confirm that the State does not apply a waiting period for pregnant women.

See SPA WI-13-0031, Section CS24

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

See SPA WI-13-0031, Section CS24

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

See SPA WI-13-0031, Section CS24

- 4.4.4. the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C), (42 CFR 457.805)

See SPA WI_13-032, Section CS20

- 4.4.4.1. (formerly 4.4.4.4) If the state provides coverage under a premium assistance program, describe: 1) The minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42 CFR 457.810(a)-(c))

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

BadgerCare Plus Cost, we will proceed to buy in to the employer’s insurance.

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

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

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

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

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

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

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

Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

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

Section 5. Outreach and Coordination

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

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

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

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

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

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

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

The Wisconsin Department of Health Services is the largest single provider of direct as well as support services for uninsured and Medicaid-enrolled children and adolescents. Direct services for this population include: preventive child health services (well-child check-

ups), prenatal services, Women Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning program services. Support services include case management services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue.

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

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

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

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

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

Wisconsin offers applicants and participants multiple methods to

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

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

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

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

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

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

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

See . 5.1.1.

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

particularly new enrollment outreach efforts - will be coordinated with and improve upon existing State efforts.

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

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

Good cause is granted to family members of those individuals who have been or are currently covered, if the individual, through whom the insurance was available, has involuntarily lost their job with the employer providing that insurance, or the employer providing the health insurance coverage does not pay 80% or more of the premium.

Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays *at least 40 % but no more than 80% of the cost* will be eligible for the health insurance premium purchase under BadgerCare Plus to assure that BadgerCare Plus does not substitute for private coverage. These provisions apply to the SCHIP expanded population only.

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

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

children.

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

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low income children of the availability of the health insurance program under the plan or other private or public health coverage.

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

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

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

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

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

level directly with applicants to help identify and resolve issues and barriers according to the needs of that region and provide feedback to the State on methods to improve.

Public Information Campaign. With the implementation of the Affordable Care Act in 2014, the Department reviewed all of its BadgerCare Plus and Medicaid related content and materials to provide members with up-to-date information about getting health care coverage whether it is provided through the State or through the Federal Marketplace. Wisconsin promotes a “No Wrong Door” approach, which emphasizes to the applicant that whether he or she applies through the State or through the Federal Marketplace, the applicant will always get the appropriate coverage for his or her family. Factsheets, brochures and web resources include information on where and how to apply in Wisconsin and in the Federal Marketplace.

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

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

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

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

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

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

- **Assisting residents with health care applications or renewals;**
- **Assisting individuals with applications for the Federal Marketplace;**
- **Providing education and targeted outreach to the public;**
- **Providing technical assistance to health care providers and community partners about health care in Wisconsin; and**
- **Increasing access to quality services.**

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

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

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

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

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

6.1.1. Benchmark coverage; (Section 2103(a)(1); 42 CFR 457.420)

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

6.1.1.1. **FEHBP-equivalent coverage;** (Section 2103(b)(1); 42 CFR 457.420(a)) (If checked, attach copy of the plan.)

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

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

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

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

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

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

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

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

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

coverage.

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

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

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all the services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment.

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

6.1.4.3. Coverage that the State has extended to the entire Medicaid population

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

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage.

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

(under 457.440)

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

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

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

6.1.4.7. Other (Describe)

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

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

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

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

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

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))

See Physician Services in Attachment 2.

- 6.2.5. Clinic services (including health center services) and other ambulatory health care services (Section 2110(a)(5))

See Physician Services in Attachment 2.

- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care

services, respite care services, training for family members, and minor modifications to the home.

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

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

- 6.2.15. Nursing care services (Section 2110(a)(15))

See Physician Services in Attachment 2.

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

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

- 6.2.18. Vision screening and services (Section 2110(a)(24))

- 6.2.19. Hearing screening and services (Section 2110(a)(24))

- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))

- 6.2.22. Case management services (Section 2110(a)(20))

- 6.2.23. Care coordination services (Section 2110(a)(21))

See Case Management services in Attachment 2.

- 6.2.24. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

- 6.2.25. Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

- 6.2.26. EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act.

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

- 6.2.27. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

- 6.2.28. Premiums for private health care insurance coverage (Section 2110(a)(25))

- 6.2.29. Medical transportation (Section 2110(a)(26))

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

- 6.2.30. Enabling services (such as transportation, translation, and outreach services)
(Section 2110(a)(27))

See Transportation Services in Attachment 2.

- 6.2.31. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

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

- 6.2.1-DC **State Specific Dental Benefit Package.** The State assures dental services represented by the following categories of common dental terminology

(CDT¹) codes are included in the dental benefits:

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

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

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

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

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

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)); (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

6.2-MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1-MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1-MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for

different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: _____)
- Other (Describe: _____)

6.2.1.2-MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1-MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

- Yes
- No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3-MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.

6.2.2.2-MHPAEA EPSDT benefits are provided to the following:

- All children covered under the State child health plan.
 A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3-MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3-MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions.
(Section 1905(r))
- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan.
(Section 1905(r))
- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))
- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness.
(Section 1905(r)(5))
- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an

individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

- EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))
- The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))
- All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary’s income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3-MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1-MHPAEA Please describe below the standard(s) used to place covered

benefits into one of the four classifications.

6.2.3.1.1-MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2-MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No

6.2.3.1.2.1-MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

- Mental health/substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan. (42 CFR 457.496(d)(2)(ii)).

Annual and Aggregate Lifetime Dollar Limits

6.2.4-MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1-MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

- Aggregate lifetime dollar limit is applied
- Aggregate annual dollar limit is applied
- No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5-MHPAEA.

6.2.4.2-MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

- Yes (Type(s) of limit: _____)
- No

Guidance: If no aggregate lifetime dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3-MHPAEA States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR

457.496(c)(3))

- The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state’s methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1-MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2-MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on any mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on any mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1-MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all

medical/surgical benefits, the State assures the following:
(42 CFR 457.496(c)(4)(i)(B); (42 CFR 457.496(c)(4)(ii))

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state’s methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state’s methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2-MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following:
(42 CFR 457.496(c)(2)(i); 42 CFR 457.496(c)(2)(ii))

- The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or
- The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5-MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

- Yes (Specify: _____)
- No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6-MHPAEA. If the state does apply QTLs to any mental health or substance use disorder

benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1-MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6-MHPAEA related to non-quantitative treatment limitations.

6.2.5.2-MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits.
(42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification?
(42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels

combined to meet the one-half threshold.
(42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6-MHPAEA The State may utilize non-quantitative treatment limitations (NQTLS) for mental health or substance use disorder benefits, but the State must ensure that those NQTLS comply with all the mental health parity requirements. (42 CFR 457.496(d)(4); 42 CFR 457.496(d)(5))

6.2.6.1-MHPAEA If the State imposes any NQTLS, complete this subsection. If the State does not impose NQTLS, please go to Section 6.2.7-MHPAEA.

- The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLS to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLS include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLS are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2-MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1-MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2-MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

- The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out-of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7-MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1-MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both
- Other

Guidance: If other is selected, please specify the entity.

6.2.7.2-MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities

Both

Other

Guidance: If other is selected, please specify the entity.

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

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

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

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

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

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

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

6.4.1.2. The cost of such coverage must not be greater, on an average per child

basis, than the cost of coverage that would otherwise be provided for the coverage described above. Describe the cost of such coverage on an average per child basis.

(Section 2105(c)(2)(B)(ii); 42 CFR 457.1005(b))

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

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

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system.
(Section 2105(c)(2)(B)(iii); 42 CFR 457.1005(a))

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

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

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

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

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

- 6.4.2.2.** The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section

2105(c)(3)(B); 42 CFR 457.1010(b))

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

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

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

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

- Yes
- No

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

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

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

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

6.4.3.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income

child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

- 6.4.3.2.2-PA** Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.
- 6.4.3.2.3-PA** If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).
- 6.4.3.3-PA** Application of Waiting Period Imposed Upon State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).
- 6.4.3.3.1-PA** Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).
- 6.4.3.1-PA** Opt-Out and Outreach, Education, and Enrollment Assistance
- 6.4.3.4.1-PA** Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child. (Section 2105(c)(10)(G))
- 6.4.3.4.2-PA** Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))
- 6.4.3.5-PA** **Purchasing Pool-** A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool. (Section 2105(c)(10)(I) Does the State provide this option?

- Yes
- No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

Quality standards are often used to assure the presence of structural and process

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

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

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

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

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

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

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

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

- 7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A);

42 CFR 457.495(a) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

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

Certification Review as a Condition for BadgerCare Plus Contracting

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

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

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

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

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

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

Performance Monitoring Requirements in the BadgerCare Plus Contract

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

- **Quality Assurance and Performance Improvement (QAPI) –** Per Article IV of the BadgerCare Plus Contract, the HMOs are required to develop a QAPI program to evaluate and improve quality of care.
- **Health Promotion and Disease Prevention –** Per Art. IV, C of the BadgerCare Plus Contract, HMOs are required to identify at-risk population and provide health education and disease prevention to the BadgerCare Plus membership.
- **Utilization Management –** Per Art. IV, G of the BadgerCare Plus Contract, HMOs are required to have documented policies and procedures for all Utilization Management activities to determine

medical necessity and the approval of services.

- **Performance Monitoring – The Department utilizes the following performance monitoring tools for BadgerCare Plus HMOs:**
 - **Performance Improvement Projects (PIPs) – Submitted annually to the Department, the PIPs identify a focus area for improvement, a goal, the interventions implemented by the HMO to achieve the goal, and an evaluation of the effectiveness of the interventions with lessons learned. The HMOs usually select a PIP topic from the pay-for-performance focus areas. The Department and its EQRO review the PIPs annually and give feedback to the HMOs.**
 - **Pay-for-Performance – The Department introduced the pay-for-performance (P4P) program for BadgerCare Plus HMOs in 2009. Since then, the structure of the P4P program has changed significantly from an incentive to a withhold of monthly capitation payments. If HMOs do not meet the benchmarks for the different P4P measures in a given year, the HMO loses a certain portion of their monthly capitation payments. If the HMO meets all the goals in the P4P program for a given year, the HMO earns back the full withhold amount for that year and may qualify for a bonus (funded from forfeitures from other HMOs that do not meet all their P4P goals). The methodology used to set benchmarks for HMOs has also changed to align with Medicare’s Value Based Purchasing initiative for hospitals. The number of measures included in the P4P program evolves year after year. The measures are primarily HEDIS measures that are part of the CHIPRA Core Set Measures for Children and the Medicaid Adult Core Set Measures with a few Wisconsin specific measures. The HEDIS measure Childhood Immunization Status has been consistently part of the P4P program since 2009.**
 - **HealthCheck – HealthCheck is the Wisconsin name for the Early Periodic Screening Diagnostic Treatment (EPSDT) requirement. Per Art. III, K. HealthCheck, HMOs are required to provide HealthCheck screenings within 30 days. All HMOs are required to provide comprehensive HealthCheck screenings at 80% or higher which includes:**
 - **Health and developmental history**
 - **Physical examination**
 - **Vision and hearing screening**
 - **Dental screening and referral to a dentist from age one**

- **Immunizations appropriate for age**
- **Blood lead testing and other lab tests appropriate for age.**

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

- **Consumer Satisfaction Surveys – The Department also conducts consumer satisfaction surveys on the BadgerCare Plus population. The Department uses the CAHPS questionnaire and works with a CAHPS certified vendor to conduct the survey and analyze the results.**
- **Healthy Birth Outcomes – The Department launched the Obstetric Medical Home (OBMH) in 2011 to serve pregnant women in the counties with the highest rates of birth disparities in the state. Since 2011, the OBMH has expanded to additional counties. The goal of the OBMH is to provide comprehensive, coordinated prenatal and postpartum care to Medicaid members identified as high-risk, emphasizing member engagement in self-care. It has a specific focus on identifying and engaging African-American members to address long-standing disparities in birth outcomes and infant mortality. As an incentive, obstetric clinics serving as OBMH receive additional payment for timely enrollment of each high-risk member, and an additional payment if the delivery outcome is “good” as defined by the program. Quality of care is monitored by DHS’ external quality review organization (EQRO) via quarterly chart reviews.**

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

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

- **EQRO Reports – The Department also monitors quality of care through reports from the EQRO to review HMO compliance with the federal Medicaid Managed Care requirements and additional requirements defined in the contract. The EQRO identifies strengths and areas of improvement opportunity for the HMO. If there are areas where the HMO failed to comply with any federal or state requirements, the HMO is put on a corrective action plan.**
- **Other Reports – The Department also monitors quarterly reports on member grievances to identify problems by HMO with access to covered services, denial of services, or quality of care. Additionally the Department tracks monthly encounter data submission reports, monthly enrollment trends, and quarterly reports on provider appeals to identify potential issues with access to care or quality of care.**

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

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
 - 7.1.2(a) CHIPRA Quality Core Set
 - 7.1.2(b) Other
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

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

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

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7); 42 CFR 457.495(a))

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

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

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

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

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

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

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

To monitor compliance with those requirements, the Department analyzes the HMO network to determine their adequacy to serve BadgerCare Plus members prior to the start of the BadgerCare Plus contract. As part of the network adequacy analysis, the Department

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

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

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

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

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

As part of pay-for-performance, the Department monitors HMO performance on management of certain chronic conditions such as diabetes, behavioral health, high blood pressure, and dental care.

- 7.2.4.** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for

services. (Section 2102(a)(7); 42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

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

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

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

HMO's policies must specify time frames for responding to requests for initial and continued service determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the HMO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

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

- 1) **The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.**
 - 2) **The enrollee’s right to file a grievance or request a state fair hearing.**
- b) **Authorization decisions must be made within the following time frames and in all cases as expeditiously as the enrollee’s condition requires:**

- 1) **Within 10 business days of the receipt of the request, or**
- 2) **Within two business days if the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the enrollee’s health or ability to regain maximum function.**

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

The Department monitors member grievances and complaints via quarterly reports.

Section 8. Cost Sharing and Payment

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

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

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

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.40 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the

family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO #09-006, issued May 11, 2009; Section 2103(e)(1)(A); 42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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

8.2.1. Premiums:

Premiums will be imposed upon children with monthly family income greater than 201% FPL. The rate is based upon family income and will not exceed 5% of monthly family income. Recipients will receive a notice telling them how much their premiums will be. Children ages 1 – 18, with:

Incomes at or above 201 percent up to, but not including 231 percent of the FPL: \$10; Incomes at or above 231 percent up to, but not including 241 percent of the FPL: \$15;

Incomes at or above 241 percent up to, but not including 251 percent of the FPL: \$23; Incomes at or above 251 percent up to, but not including 261 percent of the FPL: \$34;

Incomes at or above 261 percent up to, but not including 271 percent of the FPL: \$44; Incomes at or above 271 percent up to, but not including 281 percent of the FPL: \$55;

Incomes at or above 281 percent up to, but not including 291 percent of the FPL: \$68; Incomes at or above 291 percent up to, but not including 301 percent of the FPL: \$82;

Incomes at 301 percent up to and including 306 percent of the FPL: \$97.53.

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

Description of Children Affected	Premium	Co-payments
Children ages 1 - 5 with incomes > 186% FPL up to and including 201% FPL	None	See Attachment 1, included at the end of Section 8
Children ages 6 - 18 with incomes > 151% FPL up to and including 201% of FPL	None	

Children ages 1 - 18 with incomes from 201 - 306% FPL	201 < 231% FPL - \$10	
	231 < 241% FPL - \$15	
	241 < 251% FPL - \$23	
	251 < 261% FPL - \$34	
	261 < 271% FPL - \$44	
	271 < 281% FPL - \$55	
	281 < 291% FPL - \$68	
	291 - 301% FPL - \$82	
	301 - 306% FPL - \$97.53	

No cost sharing will be applied to unborn children.

8.2.3. Other:

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

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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

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

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

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

- 8.4.1.** Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B); 42 CFR 457.530)
- 8.4.2.** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2); 42 CFR 457.520)
- 8.4.3.** No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A); 42 CFR 457.515(f))

8.4.1-MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2-MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3-MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary’s income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4-MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: Inpatient, Outpatient, Pharmacy)

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section

8.2.

8.4.5-MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6-MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

Within each classification, the financial requirement that applies to MH/SUD benefits is no more restrictive than the same financial requirement that applies to M/S benefits in that classification.

8.4.7-MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8-MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

- The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))
- The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold.
(42 CFR 457.496(d)(3)(i)(B)(2))

Within each classification, the financial requirement that applies to MH/SUD benefits is no more restrictive than the same financial requirement that applies to M/S benefits in that classification.

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

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

- 8.6.** Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children

will be excluded from cost-sharing. (Section 2103(b)(3)(D); 42 CFR 457.535)

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

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

- 8.7.** 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))

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

See SPA WI_13-032, Section CS21

Premiums

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

- 1. The end of the six month after which benefits were lost, so long as they pay the premium arrears or 12 months after benefits were lost without paying the premium arrears amount;**
- 2. The beginning of the month following an adult caretaker's absence from the home for 30 consecutive days;**
- 3. The beginning of the month in which the family's income dips below the premium requirement limit of 201% of the Federal Poverty Level;**
or

4. Immediately, if the reason the premium payment was not made was beyond the control of the family.

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

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

Copayments

None. Providers may not deny services for lack of payment.

Providers are permitted to reduce or waive cost sharing on a case-by-case basis, if the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

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

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

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

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

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

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

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

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

- 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward state matching requirements.
(Section 2105(c)(5); 42 CFR 457.224) (Previously 8.4.5)
- 8.8.3.** No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A); 42 CFR 457.626(a)(1))
- 8.8.4.** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.
(Section 2105(d)(1); 42 CFR 457.622(b)(5))
- 8.8.5.** No funds provided under this title or coverage funded under this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
(Section 2105(c)(7)(B); 42 CFR 457.475)
- 8.8.6.** No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).
(Section 2105(c)(7)(A); 42 CFR 457.475)

**Attachment 1
Co-payment Table**

Service/Item	Co-payment	Limitations/Cumulative Maximum										
Ambulance Services	\$2 for non-emergency trip only	n/a										
Ambulatory Surgery Services	\$3 per surgery	n/a										
Case Management Services	No co-payment	n/a										
Chiropractic Services	\$0 to \$3 per procedure	Co-payment obligation depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service: <table border="0"> <thead> <tr> <th data-bbox="1312 959 1367 987"><u>Fee</u></th> <th data-bbox="1545 959 1705 987"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="1260 992 1419 1019">\$10 or less.....</td> <td data-bbox="1629 992 1696 1019">\$.50</td> </tr> <tr> <td data-bbox="1260 1024 1419 1052">\$10.01 to \$25.....</td> <td data-bbox="1629 1024 1696 1052">\$1.00</td> </tr> <tr> <td data-bbox="1260 1057 1419 1084">\$25.01 to \$50.....</td> <td data-bbox="1629 1057 1696 1084">\$2.00</td> </tr> <tr> <td data-bbox="1260 1089 1419 1117">\$50.01 or more.....</td> <td data-bbox="1629 1089 1696 1117">\$3.00</td> </tr> </tbody> </table>	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											
Clozapine Management	No co-payment	n/a										
Community Support Program	No co-payment	n/a										

State: Wisconsin

Service/Item	Co-payment	Limitations/Cumulative Maximum										
Comprehensive Community Services (CCS)	No co-payment	n/a										
Crisis Intervention	No co-payment	n/a										
Dental Services	\$0.50 to \$3 per service	<p>Co-payment obligation depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service:</p> <table border="0"> <thead> <tr> <th data-bbox="1312 732 1367 760"><u>Fee</u></th> <th data-bbox="1545 732 1705 760"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="1260 764 1409 792">\$10 or less.....</td> <td data-bbox="1629 764 1694 792">\$0.50</td> </tr> <tr> <td data-bbox="1260 797 1409 824">\$10.01 to \$25.....</td> <td data-bbox="1629 797 1694 824">\$1.00</td> </tr> <tr> <td data-bbox="1260 829 1409 857">\$25.01 to \$50.....</td> <td data-bbox="1629 829 1694 857">\$2.00</td> </tr> <tr> <td data-bbox="1260 862 1409 889">\$50.01 or more.....</td> <td data-bbox="1629 862 1694 889">\$3.00</td> </tr> </tbody> </table>	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											
Disposable Medical Supplies	\$0.50 per item	n/a										
Drugs	<p>Over-the-counter (OTC): \$0.50 Generic: \$1.00 Brand name: \$3.00</p>	<ul style="list-style-type: none"> ▪ Co-payment obligation limited to \$12 per month, per member, per provider ▪ OTCs are excluded from this \$12 per month maximum 										

State: Wisconsin

Service/Item	Co-payment	Limitations/Cumulative Maximum										
Durable Medical Equipment	\$0.50 to \$3 per service	<ul style="list-style-type: none"> ▪ Co-payment amount is based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the item: <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> <ul style="list-style-type: none"> ▪ DME rental items are not subject to co-payment. 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											
Family Planning Services and Supplies	No co-payment	n/a										
HealthCheck Screenings (EPSDT) for Children under age 21 years.	No co-payment	n/a										
Hearing Services	\$0.50 to \$3 per procedure	<ul style="list-style-type: none"> ▪ Co-payment amount depends on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> <ul style="list-style-type: none"> ▪ No co-payment obligation for hearing aid batteries 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											

Service/Item	Co-payment	Limitations/Cumulative Maximum										
Home Health Services	No co-payment	n/a										
Hospice Services	No co-payment	n/a										
Hospital Services - Inpatient	\$3 per day	Co-payment obligation limited to \$75 per stay.										
Hospital Services - Outpatient	\$3 per visit	Multiple visits to the same provider on the same day are treated as a single visit.										
Mental Health and Substance Abuse Outpatient Treatment	\$0.50 to \$3 per visit	<ul style="list-style-type: none"> ▪ Visit co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 20px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> ▪ Co-payment obligation limited to the first 15 hours or \$ 825 of services, whichever comes first, per calendar year. 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											
Mental Health Day Treatment Services	\$0.50 per day	Co-payment obligation limited to the first 15 hours or \$ 825 of services, whichever comes first, per calendar year.										

State: Wisconsin

Service/Item	Co-payment	Limitations/Cumulative Maximum										
Narcotic Treatment Services	No co-payment	n/a										
Nursing Home Services	No co-payment	n/a										
Personal Care Services	No co-payment	n/a										
Occupational Therapy	\$0.50 to \$3 per procedure	<ul style="list-style-type: none"> ▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Co-payment obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year. 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											
Physical Therapy	\$.50 to \$3 per procedure	<ul style="list-style-type: none"> ▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table>	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
<u>Fee</u>	<u>Co-payment</u>											
\$10 or less.....	\$0.50											
\$10.01 to \$25.....	\$1.00											
\$25.01 to \$50.....	\$2.00											
\$50.01 or more.....	\$3.00											

State: Wisconsin

Service/Item	Co-payment	Limitations/Cumulative Maximum										
		<ul style="list-style-type: none"> • Co-payment obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year. 										
<p>Physician Services (including Nurse Midwife, Nurse Practitioner, Laboratory and Radiology services)</p>	<p>\$0.50 to \$3 per service, except allergy testing co-payment is applied per date of service</p>	<ul style="list-style-type: none"> ▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table border="0" style="margin-left: 20px;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> ▪ The co-payment obligation for physician services is limited to \$30 per member, per provider, per calendar year. ▪ There is no co-payment for: <ul style="list-style-type: none"> ▪ Anaesthesia services. ▪ US Preventive Services Task Force (USPSTF) recommendations with an A or B rating. ▪ Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). ▪ Emergency services. 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
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Service/Item	Co-payment	Limitations/Cumulative Maximum										
Podiatry Services	\$.50 to \$3 per visit	<ul style="list-style-type: none"> ▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 20px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> • Limited to \$30 per member, per provider, per calendar year 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
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\$50.01 or more.....	\$3.00											
Private Duty Nursing	No co-payment	n/a										
Respiratory Care Services	No co-payment	n/a										
Specialized Medical Vehicle (SMV) Services	\$1 per trip	n/a										
Speech and Language Pathology	\$0.50 to \$3 per procedure	<ul style="list-style-type: none"> ▪ Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table style="margin-left: 20px; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Fee</u></th> <th style="text-align: left;"><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
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State: Wisconsin

Service/Item	Co-payment	Limitations/Cumulative Maximum										
		<ul style="list-style-type: none"> Co-payment obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year. 										
Vision Care Services	\$0.50 to \$3 per service	<ul style="list-style-type: none"> Co-payment based on the Wisconsin Medicaid and BadgerCare Plus maximum allowable fee for the service provided: <table data-bbox="1255 639 1705 802"> <thead> <tr> <th><u>Fee</u></th> <th><u>Co-payment</u></th> </tr> </thead> <tbody> <tr> <td>\$10 or less.....</td> <td>\$0.50</td> </tr> <tr> <td>\$10.01 to \$25.....</td> <td>\$1.00</td> </tr> <tr> <td>\$25.01 to \$50.....</td> <td>\$2.00</td> </tr> <tr> <td>\$50.01 or more.....</td> <td>\$3.00</td> </tr> </tbody> </table> 	<u>Fee</u>	<u>Co-payment</u>	\$10 or less.....	\$0.50	\$10.01 to \$25.....	\$1.00	\$25.01 to \$50.....	\$2.00	\$50.01 or more.....	\$3.00
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State: Wisconsin

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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

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

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

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

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

BadgerCare Plus Goals.

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

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

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

Just as welfare reform is now experimenting with creative links between cash

assistance and employment, BadgerCare Plus is an innovative and progressive model to effectively integrate Medicaid with employment-based health insurance. BadgerCare Plus builds upon the intent of Title XXI to accomplish this integration.

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

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

- **The Wisconsin Medicaid fiscal agent will establish a communication protocol with each employer regarding notification of the applicant's employment, coverage levels and premium amounts.**
- **The Wisconsin Medicaid fiscal agent will monitor employers' health insurance plans for open enrollment periods and will conduct an employer telephone inquiry to obtain the necessary cost-effectiveness information to facilitate insurance buy-in when available.**
- **The Wisconsin Medicaid fiscal agent will gather information regarding the applicant's access to and/or participation in the employer's health insurance plan beyond the previous six-month period for informational purposes only. EDS and Department staff will monitor this information for crowd-out impact.**
- **The Wisconsin Medicaid fiscal agent will verify health insurance coverage through the existing insurance exchange process with insurance carriers and telephone inquiries. EDS currently electronically exchanges insurance information with 95% of the insurance carriers, by market share in the state.**

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

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

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

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

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

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

- **Establishing limited entry/enrollment periods for BadgerCare Plus. This will encourage employees to purchase ongoing medical care through employer-subsidized insurance, rather than depending on BadgerCare Plus exclusively for episodes of ill health.**
- **Enactment of insurance reforms to encourage coverage of all employees. The Department intends to continue working with employers and the state Office of the Commissioner of Insurance to encourage broad-based health coverage of all employees.**

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

Health outcomes and quality of care: The major goal of BadgerCare Plus is to improve the health of Wisconsin’s low-income families with children by providing access to affordable health care for low-income families with children. We expect to improve health outcomes and reduce unnecessary and uncompensated health care costs by establishing a medical “home” for all low-income families and children, thereby strengthening health care

prevention in the community.

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

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

In addition, the Department is in the planning stages of establishing a series of performance-based contract measures designed to enhance quality of care and administrative efficiencies. The system will initially be limited to four or five measures that are attainable and consistent with established guidelines and standards. A bonus payment system is being planned for the 1999 contract year for the AFDC/Healthy Start HMO program and possibly for BadgerCare Plus HMO programs. This bonus system will provide financial incentives to HMOs that meet performance targets. HMOs that fall below minimum performance standards will not be eligible for the incentive payments.

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

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

Currently, 18 licensed HMOs in Wisconsin participate in the Wisconsin Medicaid HMO program. Medicaid-certified HMOs will participate in all of the State's 72 counties (fee-for-service remains in the two small, rural

counties). With clear and measurable performance standards, and ongoing, continuous quality improvement activities, the Wisconsin Medicaid HMO program has demonstrated improved health outcomes. The Wisconsin Medicaid HMO contract for low-income families with children is frequently identified as one of the best in the nation.

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

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

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

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

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

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

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

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

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

We do not believe adverse selection will be an issue in the implementation of BadgerCare Plus. Disabled children will continue to be eligible for Medicaid through the State's categorical and medically needy provisions for SSI-related recipients. We believe enrollees in BadgerCare Plus will report that they are satisfied with the price they have to pay for coverage and the choice of coverage available to them.

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

Health outcomes and quality of care. Wisconsin predicts that BadgerCare Plus will produce positive results relating to health outcomes and quality of care. BadgerCare Plus enrollees will self-report improved health status. BadgerCare Plus enrollees will utilize more preventive and primary care services than a comparison population. BadgerCare Plus enrollees will have greater continuity of care than a comparison population. BadgerCare Plus enrollees will have fewer preventable hospitalizations than a comparison

population. Enrollees in BadgerCare Plus will report they are satisfied with the quality of care they receive.

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

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

Evaluation Plan

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

Data Sources

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

Baseline Data

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

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

such as:

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

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

Data collection

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

- **Surveys - An enrollee satisfaction survey could be administered to obtain data to test a number of hypotheses. The survey will provide information on enrollees' satisfaction with their choice of plan, the care they receive, the accessibility of care and the quality of care.**
- **Enrollment and Utilization Trends - Enrollee and service specific data will be generated for BadgerCare enrollees as baseline data for inpatient and Emergency Department utilization. For enrollment trends, data on BadgerCare Plus eligibility will be used and data on HMO enrollment and churn obtained from the CARES system and Interchange. For utilization trends, data on inpatient stays, Emergency Department, and other key areas of focus will be used from the encounter data system and the FFS claims system.**
- **Performance Measurement – Data from the BadgerCare Plus pay-for-performance (P4P) program will be used to monitor improvement in health care outcomes and quality of care as well as data from consumer satisfaction surveys, HealthCheck, and birth data. Some of the P4P data will be reported by HMOs but audited by their HEDIS vendor. Other data will be extracted from the HMO encounter data system and the FFS claims system. Consumer satisfaction surveys will**

be conducted by a CAHPS certified vendor.

- **Cost Trends – BadgerCare Plus members utilizations and costs will be looked at on an ongoing baseline to analyze the cost-effectiveness of the program. The data will be obtained from the encounter data and FFS claims systems.**
- **Special reports - Special ad hoc reports will be designed based on claims or aggregate HMO reporting. These reports can be used to monitor BadgerCare performance on various utilization and health status measures. Sentinel indicators will be identified and included in these reports.**

Check the applicable suggested performance measurements listed below that the State plans to use:

(Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.

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

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

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

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

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

9.3.8. Performance measures for special targeted populations.

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

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

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2); 42 CFR 457.750)

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

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

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

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

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

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

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

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

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

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

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

Public Process

1. Public Meetings and Hearings

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

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

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

Wisconsin has also held eight focus group discussions to identify problems with current programs, suggest improvements, and provide feedback on concepts and strategies proposed for BadgerCare Plus. One group was

composed of BadgerCare Plus and Medicaid providers from throughout Wisconsin. The remaining seven groups, with representatives from thirteen communities across the state, were composed of low-income families, both individuals currently enrolled in Family Medicaid, BadgerCare and Healthy Start, and parents without current health insurance coverage. Each focus group included 15-20 individuals and lasted an average of one and one-half hours. Each participant received a stipend of \$20 to offset transportation and/or child care expenses.

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

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

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

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

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

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

January 18th, 2006	Marshfield	Secretary Nelson
January 19th, 2006	Rhineland	Secretary Nelson
January 20th, 2006	Baraboo	Secretary Nelson
January 30th, 2006	Beloit	Secretary Nelson
May 2nd, 2006	Green Bay	Secretary Nelson and Jason Helgerson
June 14th, 2006	Wausau	Governor Doyle and Secretary Nelson
June 21st, 2006	Racine	Governor Doyle and Jason Helgerson
July 20th, 2006	Eau Claire	Governor Doyle and Secretary Nelson
July 20th, 2006	Superior	Governor Doyle and Jason Helgerson
July 24th, 2006	Beloit	Governor Doyle and Jason Helgerson
July 25th, 2006	Prairie Du Chien	Governor Doyle and Secretary Nelson
July 31st, 2006	Shawano	Lt. Governor Lawton
August 1st, 2006	Jefferson	Secretary Nelson

August 4th, 2006	Portage	Secretary Nelson
August 8th, 2006	Oshkosh	Secretary Nelson
August 14th, 2006	Milwaukee, Northside	Governor Doyle and Secretary Nelson
August 15th, 2006	Madison	Lt. Governor Lawton and Secretary Nelson
August 23rd, 2006	Ashland	Secretary Nelson
August 24th, 2006	Antigo	Lt. Governor Lawton and Secretary Nelson
September 5th, 2006	Milwaukee, Southside	Lt. Governor Lawton and Secretary Nelson

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

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

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

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

2. Communication and Feedback Process for Public Meetings, Hearings,

and Other Interested Parties, Including Written Comments/Response

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

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

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

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

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

3. Coordination of BadgerCare Plus with Native Americans

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

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

The Department Secretary meets with tribal leaders at least every six months

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

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

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

4. BadgerCare Plus Public Notices

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

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

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

- 9.9.2.** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

The cost sharing changes in this plan amendment were part of the

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

- 9.9.3.** Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.
- 9.10.** Provide a one year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d); 42 CFR 457.140)
- Planned use of funds, including --
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
 - Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
 - Include a separate budget line to indicate the cost of providing coverage to pregnant women.
 - States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
 - Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
 - Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
 - Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

9.10.1 CHIP Budget for FFY 15

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

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

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

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

Total SCHIP Budget for FFY 15

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

	Actual FFY 2014 Costs	Projected FFY 2015 Costs
COST PROJECTIONS FFY15		
Enhanced FMAP Rate	71.34%	70.79%

Population #1 (Separate SCHIP Children)		
Gross Insurance Payments	\$95,916,746	\$81,969,457
gross per member/per month rate	\$176.27	\$161.93
Gross Benefit Costs Subtotal for Population #1	\$92,092,906	\$78,169,651
Net Benefit Costs (net of cost share) Subtotal for Population #1	\$92,092,906	\$78,169,651

Population #2 (Unborn Children of Pregnant Immigrants)		
Insurance Payments	\$23,552,628	\$26,130,753
per member/per month rate	\$1,192.06	\$1,402.09
Benefit Costs Subtotal for Population #2 (no cost share applies)	\$23,552,628	\$26,130,753

Population #3 (MCHIP Children)		
Insurance Payments	\$111,186,135	\$105,887,717
per member/per month rate	\$194.99	\$141.46
Benefit Costs Subtotal for Population #3 (no cost share applies)	\$111,186,135	\$105,887,717
Total Benefit Costs		
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)	\$230,655,509	\$213,987,927
Administration Costs		
General administration - Eligibility Administration	\$11,240,795	\$11,385,204
Health Service Initiative - Lead Poisoning		\$425,000
Total Administration		\$11,810,204
Federal Share (multiplied by enh-FMAP rate)	\$169,840,896	\$156,851,757
State Share	\$60,814,613	\$57,136,170
TOTAL PROGRAM COSTS	\$238,072,464	\$221,998,325

9.10.2 Lead Abatement HSI FFY 2019 Budget

Health Service Initiative Costs FFY 19	
FMAP	94.5%
Administrative Costs (Salary, Fringe, Supplies)	342,400
Information Technology	300,000
Abatement Training	300,000
Lead Poisoning Prevention and Activities	13,529,700
Federal CHIP Funding	13,717,600
State Funding	754,500
Total HSI Costs	14,472,100

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made

between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1 to be compliant with requirements.

- 10.1. Annual Reports.** The state assures that it will assess the operation of the State plan under this Title in each fiscal year, including:
(Section 2108(a)(1), (2); 42 CFR 457.750)
- 10.1.1.** The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
- 10.2.** The state assures it will comply with future reporting requirements as they are developed.
(42 CFR 457.710(e))
- 10.3.** The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.
- 10.3-DC** The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.
- 11.1.** The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a); 42 CFR 457.940(b))
- 11.2.** The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX:
(Section 2107(e); 42 CFR 457.935(b))
(The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9)
- 11.2.1.** 42 CFR Part 455 Subpart B (relating to disclosure of information by

State: Wisconsin

- providers and fiscal agents)
- 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. Section 1128A (relating to civil monetary penalties)
- 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

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

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

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

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

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

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

N/A

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

From Section 6.2, the following chart shows the amount, duration and scope of covered benefits provided to members.

BadgerCare Plus Standard Plan	
Case Management Services	Limited to case management provided by public entities, Independent Living Centers, or AIDS service organizations.
Chiropractic Services	Full coverage
Dental Services	Full coverage
Disposable Medical Supplies (DMS)	Full coverage
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs
Durable Medical Equipment (DME)	Full coverage
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under age 21 years
Hearing Services	Full coverage
Home Care Services (Home Health, Private Duty Nursing and Personal Care)	Full coverage of private duty nursing, home health services, and personal care
Hospice Services	Full coverage
Inpatient Hospital Services	Full coverage
Mental Health and Substance Abuse Treatment*	Full coverage (not including room and board)
Nursing Home Services	Full coverage
Outpatient Hospital – Emergency Room	Full coverage
Outpatient Hospital Services	Full coverage
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	Full coverage
BadgerCare Plus Standard Plan, continued	
Physician Services	Full coverage, including laboratory and radiology

Podiatry Services
Full Coverage
Prenatal /Maternity Care
Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems
Reproductive Health Services
Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization
Routine Vision
Full coverage including coverage of eyeglasses
Smoking Cessation Services
Coverage includes prescription and OTC tobacco cessation products.
Transportation – Ambulance, Specialized Medical Vehicle (SMV), Common Carrier
Full coverage of emergency and non-emergency transportation to and from an enrolled provider for a BadgerCare Plus covered service.



Children and Adults Health Programs Group

March 22, 2021

Jim Jones
Medicaid Director
State of Wisconsin, Department of Health Services
1 West Wilson Street, Room 350
P.O. Box 309
Madison, WI 53701-0309

Dear Mr. Jones:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA), WI-19-0009, submitted on June 26, 2019. This SPA approval will be effective as of July 1, 2018. This SPA has an effective date of July 1, 2018 with the exception of the changes highlighted below.

All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review. During the review of Wisconsin's Children Come First (CCF) and Wraparound Milwaukee (WAM) Prepaid Inpatient Health Plans (PIHP) contracts, CMS identified some areas where the state was not in operational compliance. CMS approved the contracts on March 16, 2020, dependent on the state's commitment to continue the corrective action process with the CCF and WAM programs to rectify the non-compliance. CMS meets with the state biweekly for updates on the corrective action process, and to provide technical assistance as necessary.

For the areas that CMS identified as non-compliant during the contract review process, SPA WI-19-0009 indicates when the state anticipates coming into compliance, as reflected in the table below. Failure to meet these timelines will result in initiation of a formal compliance action. CMS is available to provide technical assistance to the state to achieve timely compliance, either through the existing biweekly meetings on contract compliance, or separately.

Compliance with Managed Care Program Requirements for CCF and WAM PIHPs	
Necessary changes:	Date by which changes will be completed:
1. 3.6.10 - Benefits and Services The state will submit their behavioral health provider network in the same format and system as the HMOs submit their comprehensive networks to the state.	June 2021
2. 3.6.11 - Benefits and Services The state will establish prior authorization requirement to determine medical necessity and utilization management of covered services.	June 2021

3. 3.7.7 – Operations The state will review and validate the encounter data collected, maintained, and submitted by the PIHPs to ensure its complete and accurate representation of the services provided to the enrollees under the contract between the state and the PIHP.	June 2021
4. 3.10.12 – Program Integrity The state will assure that the PIHPs meet the data, documentation and information requirements for this section.	June 2021
5. 3.10.16 – Program Integrity The state will assure that the state’s website provides documentation on certification, information on ownership and control of PIHPs and subcontractors, if applicable, and results of any audits that were conducted.	June 2021

If you have any questions about this letter, please contact Dietrich Graham at (312) 353-9355 or Dietrich.Graham@cms.hhs.gov .

Sincerely,

Meg Barry
Director
Division of State Coverage Programs