Wisconsin CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Wisconsin

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

BadgerCare Plus

Who should we contact if we have any questions about your report?

4. Contact name:

Rachel Witthoft

5. Job title:

Eligibility Policy Analyst

6. Email:

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Include city, state, and zip code.

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PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Most BadgerCare Plus members are enrolled in an HMO. If the member lives in an area covered by two or more HMOs, enrollment in an HMO is mandatory. In areas with only one available HMO, enrollment in an HMO is voluntary. Members also may qualify for an exception from HMO enrollment if there are continuity of care concerns, chronic illness, or other situations. Members not enrolled in an HMO are covered by fee-for-service.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

◉ Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

- (●) Yes
- ( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at 201 → **FPL ends at** 231

Premium starts at $ 10 → **Premium ends at** $ 10

FPL starts at 231 → **FPL ends at** 241

Premium starts at $ 15 → **Premium ends at** $ 15

FPL starts at 241 → **FPL ends at** 251

Premium starts at $ 23 → **Premium ends at** $ 23

FPL starts at		FPL ends at
251	→	306

Premium starts at		Premium ends at
$ 34	→	$ 98

○ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

○ Yes

◉ No

3b. What's the maximum premium fee a family would be charged each year?

$

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No.

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Most BadgerCare Plus members are enrolled in an HMO. If the member lives in an area covered by two or more HMOs, enrollment in an HMO is mandatory. In areas with only one available HMO, enrollment in an HMO is voluntary. Members also may qualify for an exception from HMO enrollment if there are continuity of care concerns, chronic illness, or other situations. Members not enrolled in an HMO are covered by fee-for-service.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ◉ Yes
- ○ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ◉ Yes
- ○ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

6. The Department of Health Services and our community partners have engaged in various strategies to better connect with vulnerable populations in Wisconsin, particularly in light of the COVID-19 pandemic which affected the available methods of communicating with people. See Section 3A: Program Outreach for more details. 8. In agreement with CMS, we stopped charging copays for children as a means of meeting 5% cost share limit requirements and to simplify our ongoing administration of this policy. We will be submitting a SPA effective July 1, 2020, that will end copayments for all Expansion and Separate CHIP children. 16. Disaster SPA WI-20-0007 authorized us to extend reasonable opportunity periods to immigrants needing to verify their status during the public health emergency.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No
- ( ) N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the

past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ◉ Yes
- ○ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ◉ Yes
- ○ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ◉ Yes
- ○ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ◉ Yes
- ○ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to your Pregnant Women State Plan expansion?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

2, 8, 9, 19, 21. Through Disaster SPA WI-20-0005, received approval to not act timely on renewals or changes, to suspend premium lock-out periods and extend reasonable opportunity periods for immigrants to verify their status. 6. The Department of Health Services and our community partners have engaged in various strategies to better connect with vulnerable populations in Wisconsin, particularly in light of the COVID-19 pandemic which affected the available methods of communicating with people. See Section 3A: Program Outreach for more details. 8. As part of the response to COVID-19, the Department of Health Services waived premiums during the duration of the public health emergency. Premiums will resume after the public health emergency. In agreement with CMS, we stopped charging copays for children as a means of meeting 5% cost share limit requirements and to simplify our ongoing administration of this policy. We will be submitting a SPA effective July 1, 2020, that will end copayments for all Expansion and Separate CHIP children.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	99,006	86,637	-12.493%
Separate CHIP	89,788	86,087	-4.122%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Due to the economic impacts of COVID-19, families may have experienced a reduction in income. This may have resulted in children previously enrolled in CHIP becoming eligible for Medicaid. Wisconsin has seen an increase in children enrolled in Medicaid.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	29,000	3,000	2.2%	0.2%
2016	26,000	3,000	2%	0.2%
2017	28,000	3,000	2.1%	0.3%
2018	25,000	3,000	1.9%	0.2%
2019	26,000	3,000	2%	0.3%

Percent change between 2018 and 2019
NaN%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

(●) Yes

2a. What are some reasons why the American Community Survey estimates might not reflect the number of uninsured children in your state?

> The ACS health insurance question does not specifically ask about BadgerCare or other Wisconsin health insurance programs; it asks about "Medicaid, Medical Assistance and any kind of government-assistance plan". Respondents may not be aware that BadgerCare Plus is the name of Wisconsin's CHIP and Medicaid (not including elderly, blind, disabled) programs.

( ) No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

◉ Yes

3a. What is the alternate data source or methodology?

Wisconsin Family Health Survey Methodology: Annual statewide random sample telephone survey of Wisconsin household residents, conducted through most of the year. The adult in each sampled household who is most knowledgeable about the health of all household members answers all survey questions, providing information about everyone living in the household. Data results are weighted to account for disproportionate stratified sampling rates and response rates, and post-stratification provides population estimates corresponding to annual estimates of the statewide household population. Questions are asked about current insurance coverage, type of coverage, and coverage over the 12 months preceding the survey interview.

3b. Tell us the date range for your data

Start

mm/yyyy

03 / 2019

End

mm/yyyy

12 / 2019

3c. Define the population you're measuring, including ages and federal poverty levels.

All residents of Wisconsin households with working landline and/or cellular telephones. Age Groups: 0 - 17; 18 - 44; 45 - 64; 65 + Income Levels: 0 - 100% FPL; 100 - 200% FPL; >200% FPL

3d. Give numbers and/or the percent of uninsured children for at least two points in time.

2019: Children uninsured for entire past 12 months Estimated percent (rate): 2.5% Unweighted sample size of 2019 survey: 5039 Estimated number (numerator): 31,000 Total estimated number of children in state (denominator): 1,238,000 2018 (data collection 03/2018 - 12/2018): Children uninsured for entire past 12 months Estimated percent (rate): 2.0% Unweighted sample size of 2018 survey: 5516 Estimated number (numerator): 25,000 Total estimated number of children in state (denominator): 1,248,000

3e. Why did your state choose to adopt this alternate data source?

The Wisconsin Family Health Survey (FHS) collects health-related information, so the survey respondent has been thinking about health care and health problems for several minutes when asked about the health insurance coverage of each household member. This health context enhances the accuracy of information provided. The FHS asks several detailed questions about health insurance, and provides results for two distinct measures of health insurance coverage: coverage (point-in-time), and coverage over the past year. Neither the ACS nor the CPS offers this comprehensive set of information.

3f. How reliable are these estimates? Provide standard errors, confidence intervals, and/or p-values if available.

Wisconsin Family Health Survey (FHS) estimates of the uninsured have been used by state planners, budget analysts and policymakers for several years. The survey is conducted by a reputable academic survey research organization (the University of Wisconsin Survey Center) and is managed by a trained survey researcher in the Department of Health Services. The survey is conducted in both English and Spanish. Results are considered to be representative of all Wisconsin household residents. When compared to other benchmarks for Wisconsin, the results are found to be similar and reasonable. 2019: Children uninsured for entire past 12 months Estimated percent (rate): 95% Confidence Interval: 1.2%% - 3.8% Estimated number (numerator): 95% Confidence Interval: 14,000 - 47,000 2018 (data collection 03/2018 - 12/2018): Children uninsured for entire past 12 months Estimated percent (rate): 95% Confidence Interval: 1.3%% - 2.8% Estimated number (numerator): 95% Confidence Interval: 16,000 - 35,000 For the 2019 survey, the confidence interval for the estimated percentage of children who were uninsured for the entire past year overlaps with the one from the prior year. This means the change from 2.0% (2018) to 2.5% (2019) is not a statistically significant increase.

3g. What are the limitations of this alternate data source or methodology?

The sample size of the Family Health Survey may limit the analysis possibilities for sub-state areas and for smaller population groups. For some analysis measures, confidence intervals around estimates are larger due to the limited sample size. The sample is selected randomly from all residential addresses in Wisconsin.

3h. How do you use this alternate data source in CHIP program planning?

Family Health Survey data have been extensively analyzed to examine characteristics and numbers of uninsured in Wisconsin. Policy staff in the Department of Health Services rely on FHS data analysis to inform their decisions. Analysis topics include the number of low-income uninsured children living with employed adults, changes in the number and proportions of low-income uninsured children and adults, geographic distribution of the uninsured, types of insurance coverage among low-income residents, and poverty status among the uninsured.

○ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

◉ Yes

1a. What are you doing differently?

The Wisconsin Department of Health Services has partnerships with several organizations and networks in Wisconsin. Covering Wisconsin (CWI) is a leader within statewide enrollment networks serving as a co-convener of the Milwaukee Enrollment Network (MKEN) and as a host of the statewide Regional Enrollment Network. They have focused on training professionals on health literacy, health insurance literacy, and communication techniques that will better support children and families who use Medicaid and CHIP. The Milwaukee Enrollment Network (MKEN) is a public/private coalition of nearly 100 organizations working together to support the enrollment of eligible individuals in public and private insurance, with a focus on low-income, vulnerable populations in Milwaukee County. MKEN focuses on building the capacity and capability of the enrollment assister workforce and infrastructure, supporting insurance enrollment and retention, facilitating consumer and mobilizer outreach and education, and measuring and monitoring coverage and enrollment processes and outcomes. The City of Milwaukee Health Department conducts outreach and provides enrollment and technical assistance to the community through the Community Healthcare Access Program (CHAP). CHAP staff provide in-person assistance to clients with applications for all ForwardHealth benefits (BadgerCare Plus, Food Share, Childcare, and Family Planning Only, Elderly, Blind and Disabled Medicaid, etc.), helps answer questions, and conducts outreach on ForwardHealth policy and program changes. The CHAP program continues to build on its successful approach to establishing community partnerships to engage clients where they are in the community. CHAP continues its efforts to coordinate with other organizations that conduct outreach and enrollment services in the Milwaukee area to ensure a maximum impact and geographic access/coverage. New Outreach Efforts in 2020 Covering Wisconsin CWI has taken an active role in the Department of Health Services/Office of the Commissioner of Insurance statewide health insurance workgroups. The purpose of the workgroups is for stakeholders to collaborate on and improve efforts in four areas: 1) Outreach and Education 2) Promotion and Marketing 3) Capacity and Workforce 4) Data and Analysis. CWI and MKEN focused on spreading the word about

BadgerCare Plus year round, letting the public know that unlike Healthcare.gov, there is no Open Enrollment Period for Medicaid and CHIP. This included an ongoing campaign highlighting various benefits provided by these programs. Emphasis was also put on refining Covering Wisconsin's BadgerCare Plus How-To sheets (available at https://www.coveringwi.org/badgercareplus). Due to the COVID-19 pandemic, outreach efforts included a strong focus on reaching families via the internet and phone. Online, social media presence was increased (facebook.com/coveringwi) letting families know about the availability of BadgerCare Plus as well as how to receive application assistance. Over the phone, Covering Wisconsin and the Wisconsin Department of Health Services began a pilot program in which specific individuals who have "churned" in and out of health insurance coverage are called with the goal of helping people who remain uninsured and are eligible for coverage get enrolled. Community Healthcare Access Program In 2020, the CHAP manager joined Office of the Commissioner of Insurance Marketing Workgroup to contribute to the marketing communication and promotion for Open Enrollment and year round awareness for healthcare. CHAP continues to partner with Anthem and GEE's Wellness Clinic. The GEE's Wellness Clinic is a barbershop initiative builds on the trust and strength of the barbershop among African American men. This critical, cultural asset has an opportunity to bridge client needs with the many assets that exist in Milwaukee related to health and social services. This initiative meets men where they are and support those who need support connecting to appropriate primary and behavioral health homes and/or social service providers and resources. CHAP originally provided onsite enrollment. All of CHAP's previous outreach efforts were based in person through various events and health fairs. However, due to the pandemic CHAP is receiving referrals and provided one-on-one appointments or virtual support via GoToMeeting to address health insurance needs. CHAP was also featured in a PSA alongside Anthem discussing the social determinants to health that effect the minority men in the city of Milwaukee. https://www.facebook.com/geesclippersbarberandbeautysalon/videos/362011144888131 CHAP faces various challenges due to COVID-19 as it primary duties require direct face to face contact with the public. Due to the inability to services the

community face to face when the pandemic first hit, CHAP focused on research and preparation for future webinars and presentation about health disparity and health insurance options for the purpose of providing this to our community at a later date. Since returning to limited in person services, CHAP has adapted to Virtual Enrollment Events to assist resident in navigating health insurance applications for the Federally Facilitated Marketplace and BadgerCare Plus. Although this platform is not as valuable for individual who are not technology savvy, CHAP provides one-on-one scheduled appointments to assist others in person at one of our three health centers. CHAP is working with City of Milwaukee Health Department on its' newly acquire software to supports CHAP's case management and verbal signature software needs to continue progressing and provide our community with Health Insurance application support. CHAP will continue providing Virtual Enrollment Events and develop Virtual Outreach for the community including a PSA about the health disparities in our community. CHAP has also assisted the City of Milwaukee Health Department with COVID-19 email inbox inquiries, COVID-19 screening at health centers, bereavement support, and mask distribution all in efforts to reduce health inequalities to the residents of Milwaukee. CHAP utilizes the City of Milwaukee's three social media platforms, Twitter, Facebook and Instagram, to promote upcoming events and valuable health insurance information. CHAP has also shifted its outreach efforts in partnership with the Milwaukee Fire Department (MFD), which was approved by the Common Council to join efforts to assist uninsured residents of Milwaukee. MFD provides demographic information from individuals they made contact with via ambulatory services who were uninsured at time of service. CHAP conducts outreach by conducting cold calls and sending outreach letters to residents of the city of Milwaukee in efforts of connecting them with health insurance and other resources that address the social determinants to health.

○ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

◉ Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

CWI is a founding member of the Wisconsin Collaboration on Immigrants and Public Benefits. This group aim to inform consumers and helping professionals around Wisconsin of the implications to new Public Charge rules so they can accurately advise members/clients from immigrant communities regarding enrollment of benefits such as health care coverage. The group has hosted numerous trainings and have developed several educational resources, found on the website: https://www.coveringwi.org/immigration. The information on this website has current public charge information for people getting their visas or green cards from inside the U.S. On July 29, 2020 the courts put a hold on the public charge rule for people processing from outside the U.S. There were Public Charge trainings for enrollment assisters (Navigators, Certified Application Counselors, public benefit specialists, financial counselors, agents and brokers) and other representatives from community-based organizations serving immigrants and refugees. Materials (in English, Spanish, and Hmong) help low literacy audiences understand many of the programs that help support health for children and families. Success is evaluated by assessing whether professionals indicate an increase in knowledge from training and materials. For consumers, it is considered successful when immigrant families enroll in the programs for which they are eligible. MKEN members include nearly 100 organizations working together to support the enrollment of eligible individuals in public and private insurance, with a focus on low-income, vulnerable populations, including minorities and immigrants. Member organizations include the Latino Health Coalition, Black Health Coalition, Free and Community Clinic Collaborative, Federally Qualified Health Centers, Disability Rights Wisconsin, and all of the major provider systems. MKEN provides capacity building, training, and outreach so that these organizations can better serve their members. MKEN communications including flyers/postcards, radio ads, and other printed materials are created in both English and Spanish, and some Hmong. The CHAP program targets minorities, immigrants, and children. Typically, CHAP does not encounter individuals from rural areas since Milwaukee is an

urban area, however CHAP occasionally may serve clients from rural areas that are in Milwaukee for other reasons. In order to evaluate success of their outreach and enrollment strategies, CHAP tracks high-level performance indicators. However, it does not track outcomes by specific population. CHAP tracks BadgerCare Plus and FoodShare applications, renewals, and technical assists by aldermanic district as well as zip code.

○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

CWI has created numerous outreach materials that explain health programs that support kids and families. The How-To sheets use everyday, plain language, representative images to communicate meaning, and clear action steps to help educate consumers. Some of the topics include: BadgerCare Basics, how to start using health care, signing up and renewing. CWI tested these materials in focus groups with target audiences of lower-income individuals who use them or may use them in the future. Many of the consumer participants have been parents. The consumer testing process allows CWI to improve the materials and make them more assessable to low literacy audiences. Additionally, CWI has found that testing has had the result of being exceptionally informative to the participants. Given the pandemic, consumer testing transitioned to a virtual or over-the-phone format. CWI has worked with organizations that serve vulnerable communities across the state to help schedule the aforementioned focus groups with consumers, and to offer trainings to professionals. CWI has found that many professionals at various organizations, ranging from community health centers, schools, to county health departments benefit from health/ health insurance literacy training, or skills in how to explain health programs to low literacy populations, including to parents and young adults. CWI conducts pre- and post- evaluations of their trainings, and attendees have significantly improved their knowledge of the concepts. MKEN partners with agencies serving low-income consumers and special populations, resulting in numerous educational opportunities and enrollment assistance. It's important to help consumers complete the entire application process, including submitting requested documents. MKEN regularly reports process and outcome measures according to its annual work plan and publishes a quarterly coverage report. The quarterly coverage report tracks trends for a number of indicators in a variety of domains, including: source of insurance; enrollment by eligibility group (e.g., BadgerCare Plus children, BadgerCare Plus parents, BadgerCare Plus childless adults, etc.) in Milwaukee County and across the state; Medicaid managed care enrollment; and uninsured population by poverty status and age range, and race. Success is evaluated based on the number of enrollments in CHIP, but also the improvement in knowledge and awareness among professionals trained to better assist and support families and their children in need of coverage. The

CHAP program is geographically located in the city of Milwaukee. Staff are regularly available from 8 a.m. to 4 p.m. daily at three health centers. Due to pandemic, CHAP efforts are majority via social media, word of mouth and through outreach letters. This is tracked via the data management system CHAPTrack. The CHAP program conducts outreach in the community at organizations and events where the target population is likely to be. CHAP provides concierge services to community partners by sending outreach workers and enrollment assisters to partners' events that are likely to draw a large number of Medicaid-eligible participants. This effort is part of a larger strategy to develop partnerships in order to strategically target specific populations. Staff also conduct outreach to raise awareness of the ability of individuals to enroll in Medicaid year-round and the support services that CHAP offers at other partner organizations throughout the community and staff large community events including at churches, daycares, neighborhood community events, Milwaukee Public School sponsored events, and other events. Most recently, CHAP's most successful outreach efforts have been outreach letters designed for the MFD project which included the City of Milwaukee Health Department Card and was sent to City of Milwaukee residents. CHAP continues to receive calls from recipients of this letter which result in health insurance enrollment.

4. Is there anything else you'd like to add about your outreach efforts?

2020 has proven to be a year in which CWI has needed to pivot and adjust their outreach and enrollment strategies given the pandemic. CWI reports that they have learned that it is important for CWI and MKEN staff to be familiar with a variety of programs. Even if the intention is to connect with families about CHIP, families may also have questions about FoodShare, Unemployment Insurance, and other support measures for financial security. That said, being attentive to and referring to other public programs for consumers is an approach that CWI has always prioritized. Social media promotions are showing greater positive results in the social distancing environment towards raising awareness of health insurance programs. With increased investment in social media advertising, CWI sees increased call volume and website hits. CHAP continues to partner with the University of Wisconsin- Milwaukee (UWM) Norris Health Center to provided enrollment services to the students of UWM that may have age out of parents' health insurance plans.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

(●) Yes

2a. Which database do you use?

The Employer Verification of Health Insurance (EVHI) database was developed in conjunction with the implementation of BadgerCare Plus in February 2008. The EVHI database contains data on insurance coverage available through over 40,000 employers in Wisconsin. Employers were sent a survey to answer questions about the insurance they offer. This information is entered into the EVHI database and will be updated annually. Local agency workers can look up an applicant's employer in the database to determine whether s/he has access to employer sponsored insurance. The database is linked to and can be accessed from the CARES system. If there are discrepancies or incomplete information in the database the agency worker communicates with the applicant to obtain the required information. As an alternative, an Employer Verification Form (EVF) is available which applicants can bring to their employer to be completed.

( ) No

( ) N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

Information for Question 3 (What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?): Wisconsin does not currently have the capability to report on this metric because BadgerCare Plus is a combined Medicaid-CHIP program, and so we screen for Medicaid and CHIP eligibility at the same time. We do not have a distinct count of individuals screened just for CHIP eligibility to use in calculating this percentage.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?
This question should only be answered in respect to Separate CHIP.

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ○ Yes
- ◉ No

3. Do you send renewal reminder notices to families?

(●) Yes

3a. How many notices do you send to families before disenrolling a child from the program?

2

3b. How many days before the end of the eligibility period did you send reminder notices to families?

6 weeks and 2 weeks

( ) No

4. What else have you done to simplify the eligibility renewal process for families?

Wisconsin does administrative renewals for a portion of our CHIP cases. In addition, members may submit their renewals online through our portal at ACCESS.gov. Finally, most of the managed care organizations in Wisconsin send out their own reminders to members to complete their renewals.

5. Which retention strategies have you found to be most effective?

We feel that administrative renewals are most effective at providing members with a simplified renewal process that results in the fewest number of terminations for not meeting the administrative requirements of the program. We have not evaluated the effectiveness of the strategies.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

We have not evaluated the effectiveness of the strategies.

7. Is there anything else you'd like to add that wasn't already covered?

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

5. Did you have any limitations in collecting this data?

Wisconsin is unable to provide data for Part 2: CHIP Eligibility Denials (Not Redetermination).

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	
Denied for procedural reasons	
Denied for eligibility reasons	
Denials for other reasons	

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2020?

66584

2. Of the eligible children, how many were then screened for redetermination?

53988

3. How many children were retained in CHIP after redetermination?

43719

4. How many children were disenrolled in CHIP after the redetermination process? This number should be equal to the total of 4a, 4b, and 4c below.

10269

4a. How many children were disenrolled for procedural reasons? This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4639

4b. How many children were disenrolled for eligibility reasons? This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

5630

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting this data?

No

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	80.98%
Children disenrolled after redetermination	19.02%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	45.17%
Children disenrolled for eligibility reasons	54.83%
Children disenrolled for other reasons	0%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year

changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2020?

377170

2. Of the eligible children, how many were then screened for redetermination?

353706

3. How many children were retained in Medicaid after redetermination?

316365

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

37341

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

16332

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

21009

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting this data?

No.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	89.44%
Children disenrolled after redetermination	10.56%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	43.74%
Children disenrolled for eligibility reasons	56.26%
Children disenrolled for other reasons	0%

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or

younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	1161	3005	1089

July - September 2020 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	643	1947	716

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	98	123	41

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	42	76	28

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	420	935	332

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	365	866	310

9. Is there anything else you'd like to add about your data?

No.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7946	9129	7480	2861

July - September 2020 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7708	8495	6975	2664

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
75	194	137	45

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	69	60	17

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
163	440	368	152

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
17	240	205	74

9. Is there anything else you'd like to add about your data?

No.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in Medicaid 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")
- ○ Health plans
- ◉ States
- ○ Third party administrator
- ○ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Healthcare providers can view if a household member has met the cost sharing limit when they check eligibility through MMIS. Also, when a health provider submits a claim, the MMIS system will determine what copay to charge for the service or claim. If the household member has met their monthly limit, there will be no copay charge to the member.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

No estimate for 2020 is available.

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

We are not monitoring the impact. Due to the public health emergency, eligibility impacts are skewed and would not provide reliable data

8. Is there anything else you'd like to add that wasn't already covered?

In 2020, the Department of Health Services implemented enhancements to the cost sharing functionalities in our systems. This did not change the cost sharing requirements, but it improved the tracking of the 5% cost share cap and the communications on cost sharing that are sent to members.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [√] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [ ] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- (●) Yes
- ( ) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- ( ) Yes
- ( ) No
- ( ) N/A

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- ( ) Yes
- ( ) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- ○ Yes
- ○ No
- ○ N/A

7. How many children were enrolled in the premium assistance program on average each month in FFY 2020?

15

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 350.36

9. What's the average monthly contribution the employer pays towards coverage of a child?

$ 200

10. What's the average monthly contribution the employee pays towards coverage of a child?

$ 367

Table: Coverage breakdown

Child

State	Employer	Employee
350.36	200.00	367.00

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at **$** 112.23 → **Ends at** **$** 660

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at **$** 70.50 → **Ends at** **$** 1,061.22

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at → **Ends at**

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

Wisconsin has not evaluated the effectiveness of strategies for reducing administrative barriers.

15. What challenges did you experience with your premium assistance program in FFY 2020?

Fewer employers are offering plans and the premiums/cost shares are increasing on the available plans so fewer plans are cost effective.

16. What accomplishments did you experience with your premium assistance program in FFY 2020?

No changes since last reporting period.

17. Is there anything else you'd like to add that wasn't already covered?

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

• The Fraud Prevention and Investigation Program (FPIP) is designed to provide program integrity for the FoodShare (FS), Wisconsin Medicaid and SCHIP programs (i.e., BadgerCare Plus). These programs are administered through contractual agreements between the Department of Health Services (DHS) and local agencies. • Each agency administering public assistance programs is responsible for providing program integrity for the programs administered by that agency. The DHS State/County Contracts contains the requirement to provide integrity for the programs administered by these agencies. • Each agency has a FPIP Plan that addresses three specific areas of requirements for Medicaid, CHIP and FS programs.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  HMOs must submit a compliance plan that includes written procedures, a description & designation of a compliance officer and compliance committee. It must also describe: the training requirements for compliance officer & employees; the enforcement standards & disciplinary guidelines; the plan's internal monitoring & auditing procedures; and how the plan will provide a prompt response to detected problems. The plan must also provide the name & contact information of the Compliance Officer.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2020?

7. How many cases have been found in favor of the beneficiary in FFY 2020?

8. How many cases related to provider credentialing were investigated in FFY 2020?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

0

10. How many cases related to provider billing were investigated in FFY 2020?

1326

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

11

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

7837

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

<11

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

(●) Yes

15a. How do you provide oversight of the contractors?

• For prevention of beneficiary eligibility fraud, local county and tribal agencies are allowed to contract out for fraud prevention services. Local agencies are responsible for monitoring their contractors. The state Medicaid agency monitors performance. As part of the local agencies' Fraud Prevention Plan that they submit to the state, they must include information about their contractor, including their org chart, process flow, agreements with providers and proof that they are certified investigators.
• For prevention of provider fraud, the state Medicaid agency performs post pay reviews of providers. In addition, the state Medicaid agency has contracts with vendors including a Recovery Audit Contractor, External Quality Review Organization as well as an Advanced Fraud Analytic Vendor and has a Joint Operating Agreement with the Unified Program Integrity Contractor. The state Medicaid agency has regular meetings with contractors that perform program integrity work and additionally reviews the work products of these contractors before collecting any identified overpayments.

( ) No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

( ) Yes

(●) No

17. Is there anything else you'd like to add that wasn't already covered?

In regards to Questions 6 (How many eligibility denials have been appealed in a fair hearing in FFY 2020?) and 7 (How many cases have been found in favor of the beneficiary in FFY 2020?), eligibility appeals are handled by the Wisconsin Department of Administration, Division of Hearings and Appeals. Due to the way eligibility appeals are managed and categorized, we do not have data on just the CHIP population.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

(●) Yes

( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	4145	7575	16637	21595	11380

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	481	2532	8391	9902	4232

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	432	2365	7856	8950	3456

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	20	647	2977	3549	2024

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

2124

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - (●) Yes
    - ( ) No
- ( ) No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ○ Separate CHIP
- ○ Both Separate CHIP and Medicaid Expansion CHIP
- ◉ Other

2a. Which population did you survey?

Survey includes Medicaid and CHIP population combined

2b. How many children were included in the survey?

23972

3. Which version of the CAHPS survey did you use?

- ○ CAHPS 5.0
- ◉ CAHPS 5.0H
- ○ Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- ☑ None
- ☐ Children with Chronic Conditions
- ☐ Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- ☑ NCQA HEDIS CAHPS 5.0H
- ☐ HRQ CAHPS
- ☐ Other

6. Is there anything else you'd like to add about your CAHPS survey results?

For question 2b How many children were included in the survey?: 23,972 children were sampled. This includes both CHIP and Medicaid children. We do not have the break out of which of these children were enrolled in CHIP and which were enrolled in Medicaid. Of these 23,972 children, 4,086 responded to the survey. 671 of the 4,086 were in the CHIP program.

Part 3: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Wisconsin Poison Center

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

The population of the State of Wisconsin.

4. How many children do you estimate are being served by the HSI program?

0

5. How many children in the HSI program are below your state's FPL threshold?

0 see attachment

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Percent of all calls that are children under 19 years old that have used the service, calculated monthly.

7. What outcomes have you found when measuring the impact?

8. Is there anything else you'd like to add about this HSI program?

The Wisconsin Poison Center's (WPC's) mission is to consistently deliver comprehensive and accurate information to callers presented with complications or real or potential toxicity from any poison or drug. The Wisconsin Poison Center provides emergency information for people exposed to toxic amounts of substances including but not limited to household products, drugs or medications, chemicals, plants, and animal or insect bites. In addition, poison centers provide important standardized public health messaging during times of disaster or pandemics. The WPC is also a resource for healthcare providers for hospitalized patients. On March 2, 2001 the State of Wisconsin (WI) Department of Health Services (DHS) approved the consolidation of poison center services into a single state center. Subsequently, since February 21, 2005, the WPC is the only poison center accredited by the American Association of Poison Control Centers (AAPCC) to provide poison information and guidance services to the entire State of Wisconsin. The WPC falls under administrative direction of Children's Hospital of Wisconsin (CHW) and is a wholly owned and operated program of CHW. The WPC is located in the Corporate Center on the Milwaukee Regional Medical Center complex. The WPC and CHW are affiliated with adult and pediatric Regional Level 1 Trauma Centers as well as adult and pediatric tertiary care hospitals. Toxicologic expertise is accessed through affiliated colleges and universities. Challenges include the potential for loss of funding through any of the current revenue streams, including loss of CHIP administrative funding after the current federal authorization bill expires. Additional challenges are inherent in the ongoing reduction in case volume for cases that involve pediatric patients, compromising the state's access to pediatric poison center services. A recent societal trend in utilization of communication technologies has expanded layperson and provider access to potentially unreliable poisoning information. Wisconsin's birth rate continues to decline since 1960 and has remained below the national average throughout that time. Anticipated further reduction in the pediatric population in Wisconsin with concomitant increase in the predicted population at risk for poisoning poses a unique challenge for the WPC in the near future. Additionally, COVID has impacted the ability of the WPC to participate in community education opportunities limiting the education opportunities during interactions. CARTS will not allow me to upload attachments on this page, so I've attached a document with the detailed responses to Questions 4 (How many children do you estimate are being served by the HSI program?) and 5 (How many children in the HSI

program are below your state's FPL threshold?) to Section 6. CARTS will not let me leave these fields blank, so I put in "0" or "0 see attachment." I have also attached the Wisconsin Poison Center 2020 Annual Report to Section 6.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Lead-Safe Homes Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Low income children (under age 19) and pregnant women who are eligible for CHIP and live in, or visit regularly, a home built before 1978.

4. How many children do you estimate are being served by the HSI program?

300

5. How many children in the HSI program are below your state's FPL threshold?

281

Computed: 93.67%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

7. What outcomes have you found when measuring the impact?

8. Is there anything else you'd like to add about this HSI program?

More details on Question 4 (How many children do you estimate are being served by the HSI program?) and 5 (How many children in the HSI program are below your state's FPL threshold?): In 2020, about 300 children were being served by the HSI, but this is our first year. We anticipate that as the number of homes we can enroll increases, this number will increase to 1,000 children annually. 281 of the 300 children served in the HSI program are from households below the state's FPL threshold of 301% FPL. The remaining 19 children in the HSI program are visitors to the homes that are enrolled in the program who are not currently enrolled in a CHIP benefit plan. We do not verify or track visiting children's household income as long as at least one child associated with the home that is CHIP eligible.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Maintain the percent of children without health insurance for an entire year at 2%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Estimated number of children who were uninsured for the entire year.

4. Numerator (total number)

31000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Total estimated number of children in the state of Wisconsin.

6. Denominator (total number)

1238000

Computed: 2.5%

7. What is the date range of your data?

Start

mm/yyyy

03 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The estimated rate is 2.5%. 95% Confidence Interval is 1.2%% - 3.8%. The confidence interval for the estimated percentage of children who were uninsured for the entire past year overlaps with the one from the prior year. This means the change from 2.0% (2018) to 2.5% (2019) is not a statistically significant increase.

10. What are you doing to continually make progress towards your goal?

Wisconsin plans to continue engaging in outreach efforts and collaboration opportunities with partners to maintain or reduce the percent of children without health insurance.

11. Anything else you'd like to tell us about this goal?

Unweighted sample size of 2019 survey: 5039

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access to coverage

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Monitor/increase the number of previously uninsured children between 100 - 300% FPL who get enrolled in BadgerCare Plus.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Number of children enrolled in October 2020 - number of children enrolled in October 2019.

4. Numerator (total number)

3393

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Number of children enrolled in October 2019.

6. Denominator (total number)

137519

Computed: 2.47%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

10 / 2020

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, Wisconsin continued to monitor the BadgerCare Plus enrollment of children in this category. Enrollment increased from October 2019 to October 2020 by 2.5%.

10. What are you doing to continually make progress towards your goal?

Wisconsin will continue to monitor enrollment data while analyzing the impacts of internal (e.g. policies and operational processes) and external (e.g. economic and political) influences.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Monitor/increase the number of previously uninsured children below 100% FPL who get enrolled in BadgerCare Plus.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Number of children enrolled in October 2020 - number of children enrolled in October 2019

4. Numerator (total number)

28242

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Number of children enrolled in October 2019

6. Denominator (total number)

246972

Computed: 11.44%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

10 / 2020

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, Wisconsin continued to monitor the BadgerCare Plus enrollment of children in this category. Enrollment increased from October 2019 to October 2020 by 11.4%.

10. What are you doing to continually make progress towards your goal?

Wisconsin will continue to monitor enrollment data while analyzing the impacts of internal (e.g. policies and operational processes) and external (e.g. economic and political) influences. The economic impact of COVID-19 may have influenced this large increase in enrollment.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Improved health outcomes and quality of care

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Improving the immunizations rate for children under 2 years of age.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Includes CHIP and Medicaid. Combination 3 - Number of children who turned 2 years of age in the calendar year that had at least: • 4 DTaP vaccinations • 3 IPV vaccinations • 1 MMR vaccination • 3 HiB vaccinations • 3 Hep B vaccinations • 1 VZV vaccination • 4 PCV

4. Numerator (total number)

3927

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Includes CHIP and Medicaid. Number of children who turned 2 years of age in the calendar year.

6. Denominator (total number)

5505

Computed: 71.34%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

For CY2019, Wisconsin used Combination 3. Compared to CY2018 combination 3 rate of 71.5%, the 2019 rate is 71.3%.

10. What are you doing to continually make progress towards your goal?

For CY2020, HMOs will continue to be required to perform at the 75th percentile for Combination 3.

11. Anything else you'd like to tell us about this goal?

The data source is Administrative (claims data).

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

Wisconsin has a pay-for-performance (P4P) program with HMOs in which a certain percentage of their monthly capitation payments is withheld and given back to HMOs only if they meet benchmarks on several performance measures. The program started in 2009 and has evolved throughout the years. We have learned that once a measure is included in the P4P program, statewide averages for those measures improve.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

Wisconsin plans to continue using the P4P program and other public reporting initiatives like the development of the HMO Report Card to monitor quality of care. Wisconsin is currently working on updating its quality measures and expects to complete this work in [insert date].

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

No.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 106,605,170.61	**$** 108,321,287.02	**$** 110,229,962.94

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 171,223,883.98	**$** 173,980,224.19	**$** 177,045,843.81

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 291,439.84	**$** 296,131.40	**$** 301,349.39

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ -48,757,406	**$** -49,542,296	**$** -50,415,257

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	106605170.61	108321287.02	110229962.94
Fee for Service	171223883.98	173980224.19	177045843.81
Other benefit costs	291439.84	296131.40	301349.39
Cost sharing payments from beneficiaries	-48757406	-49542296	-50415257
Total benefit costs	229363088.42999995	233055346.60999995	237161899.14

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$	**$**	**$**

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 15,571,190.72	**$** 21,279,598	**$** 22,224,765

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 1,964,285	**$** 16,178,925	**$** 16,178,925

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2020	FFY 2021	FFY 2022
Personnel			
General administration	15571190.72	21279598.00	22224765.00
Contractors and brokers			
Claims processing			
Outreach and marketing			
Health Services Initiatives (HSI)	1964285.00	16178925	16178925
Other administrative costs			
Total administrative costs	17535475.72	37458523	38403690
10% administrative cap	30902277.16	31399738.07	31953017.35

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	**FFY 2021**	**FFY 2022**
Total program costs	295655970.15	320056165.61	325980846.14
eFMAP	83.05	71.56	82.28
Federal share	245542283.21	229032192.11	268217040.2
State share	50113686.94	91023973.5	57763805.94

8. What were your state funding sources in FFY 2020?
Select all that apply.

- [x] State appropriations
- [x] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
113614	114750	115898

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$	**$**	**$**

	FFY 2020	FFY 2021	FFY 2022
PMPM cost			

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
11903	12022	12143

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020	2021	2022
$	**$**	**$**

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost			

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

The decreased amount of net benefit cost of 2020 is resulted from a substantial amount out of CHIP T21 funds refunded to CMS by WI Department of Health Services (DHS) to satisfy a PERM audit finding identified as FFS Error Category #4: Non-covered Service/Recipient (DP2). The DHS eligibility system was incorrectly claiming CHIP T21 FFP instead of T19 FFP for children with dual enrollment in the Katie Beckett program. In addition, Wisconsin did not receive Lead Abatement funds for which $16 million was included in the previous year's projection so the actual expenditure on Lead abatement program is $0 in SFY2020. Administrative Costs: HSI Breakdown FFY 2020 Poison Control $1,964,285.00 Lead Abatement $0 FFY 2021 Poison Control $1,964,285.00 Lead Abatement $14,214,640.00 FFY 2022 Poison Control $1,964,285.00 Lead Abatement $14,214,640.00 See attachment for information on the per member per month (PMPM) cost.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

The state environment continues to be supportive of ensuring the healthcare needs for low-income, uninsured children in particular. Especially in light of the COVID-19 public health emergency, Gov. Tony Evers' administration has made it a priority to enroll more Wisconsin residents in affordable health coverage plans, including Medicaid and CHIP. The Wisconsin Department of Health Services, in partnership with other state and local agencies and organizations, continues to work on educating consumers about available health care programs.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

While the state has many initiatives and outreach efforts to inform Wisconsin residents about health care programs, including BadgerCare Plus, it is a continuing challenge to make sure that information is shared with all who may be eligible. Due to the economic impacts of COVID-19, many families have experienced a decrease in income. Some of these families may now financially qualify for CHIP, so we want to make information about BadgerCare Plus easily accessible to this population. Health care in general is a complex topic that can be confusing even to the best informed, so it can be a challenge to make sure that the information available is clear and comprehensive. With COVID-19 driving an increased interest in health, we want to make sure that we are sharing timely and accurate information about Wisconsin's health care programs.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

The BadgerCare Plus program continued to enroll families without any major cuts in eligibility and services. The Wisconsin Department of Health Services, the county economic support agencies, and numerous stakeholders throughout the state have collaborated on fast-paced efforts to address the challenges posed by COVID-19 in order to best serve our members.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

In 2020, the Wisconsin Department of Health Services implemented a complex project to track the 5% cost sharing cap. For 2021, the Department is working on a significant update to the online application and member-facing benefit management system. This project will make it easier for members to navigate through the application and manage their benefits. These changes are planned as part of the Department's ongoing system enhancements efforts.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

The Wisconsin Department of Health Services will continue to address the challenges from the COVID-19 pandemic while moving forward with our ongoing plans to improve member experience with BadgerCare Plus.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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