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State/Territory: Wisconsin

State Plan Amendment (SPA)#: 20-0018

This file contains the following documents in the order listed:

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

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

Medicaid and CHIP Operations Group

December 23, 2020

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

ATTN: Laura Brauer, SPA Coordinator

RE: Transmittal Number (TN) 20-0018

Dear Mr. Jones:

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

SPA TN 20-0018: - Cost Share Modification

- Effective Date: July 1, 2020
- Approval date: December 23, 2020

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

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Laura Brauer, DHS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
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December 23, 2020

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

Dear Mr. Jones:

This letter is being sent as a companion to the approval of Wisconsin State Plan Amendment (SPA) #20-0018, which proposed to eliminate cost sharing for individuals under 19 years old and to implement a tracking system to comply with the statutory and regulatory cost sharing tracking requirements in section 1916A of the Social Security Act ("Act"). The effective date of the approved SPA is July 1, 2020. This letter serves to memorialize agreement that the state will reimburse providers, who in turn, will reimburse beneficiaries who were assessed a copay between July 1, 2020 and November 1, 2020.

Prior to July 1, 2020, the state complied with the cost sharing tracking requirements in sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Act, as implemented at 42 C.F.R. § 447.56(f), by suspending all cost sharing while the state integrated tracking functionality into its Medicaid Management Information system (MMIS) claims system. The state completed updates to MMIS and resumed cost sharing on July 1, 2020.

In response to the COVID-19 public health emergency (PHE), Congress passed and the President signed into law the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). The FFCRA authorizes a temporary 6.2 percentage point increase to each qualifying state Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Act. States may claim this enhanced FMAP for expenditures beginning January 1, 2020 and extending through the last day of the calendar quarter in which the PHE, including any extensions, terminates. However, in order to qualify for the enhanced FMAP, states need to meet certain requirements in section 6008 of the FFCRA. Section 6008(b)(3) of the FFCRA provides that a state may not receive a temporary FMAP increase "if the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date of enactment of this section or enrolls for benefits under such plan (or waiver) during the period beginning on such date of enactment and ending the last day of the month in which the emergency period described in subsection (a) ends shall be treated as eligible for such benefits through the end of the month in which such emergency period ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State".

[1]https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
[1] https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency

Under the Centers for Medicaid & Medicare Services' (CMS) initial interpretation of section 6008(b)(3) of the FFCRA, which is in the COVID-19 Frequently Asked Questions for State Medicaid and Children's Health Insurance Programs Agencies, "a state is not eligible for the enhanced FMAP if it increases cost sharing for individuals enrolled as of or after March 18, 2020" because such an increase reduces the amount of medical assistance for which the beneficiary is eligible.[1] However, on November 2, 2020, CMS revised its interpretation of section 6008(b)(3) of the FFCRA through publication of an interim final rule. Under 42 CFR § 433.440(c)(3), states may make programmatic changes to coverage, cost sharing, and beneficiary liability without violating the requirements for receiving the temporary FMAP increase, provided that such changes do not violate the individual beneficiary protections at § 433.400(c)(2) or the requirements under section 6008(b)(4) of the FFCRA to cover COVID–19 testing and treatment services without cost-sharing.[2]
Because the state suspended all cost sharing prior to the start of the PHE, the earliest date that the state may resume cost sharing and continue to claim the temporary FMAP increase is November 2, 2020. In order to continue claiming the enhanced FMAP, the state has agreed to reimburse providers, who then must reimburse beneficiaries, for any cost sharing that was charged between July 1, 2020 and November 1, 2020. The state has agreed to reimburse providers by June 30, 2021.

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

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Laura Brauer, DHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **WI-20-0018**

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: **Title XIX Of The Social Security Act (Medicaid)**

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

4. PROPOSED EFFECTIVE DATE
7/1/2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Sections 1916 and 1916A of the Act
42 CFR 447.50 through 447.57 (excluding 447.55)

7. FEDERAL BUDGET IMPACT
a. FFY 2020 **$996K**
b. FFY 2021 **$3,773K**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
MMDL Forms G2c and G3……..……

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

10. SUBJECT OF AMENDMENT
Cost-Share Modification

11. GOVERNOR'S REVIEW *(Check One)*
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

7DD4E580-7A7425...

Jim Jones

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
9/28/2020

16. RETURN TO
Laura Brauer
State Plan Amendment Coordinator
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 28, 2020

18. DATE APPROVED: December 23, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2020

20. SIG

21. TYPED NAME: James G. Scott

22. TIT Director
Division of Program Operations

23. REMARKS:

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 20 - 0018

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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

V.20181119

Transmittal Number: WI 20-0018

Supersedes: 14-0012

Approval Date: December 23, 2020

Effective Date: July 1, 2020

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 20 - 0018

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

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

Exemptions

Groups of Individuals - Mandatory Exemptions

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

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

Groups of Individuals - Optional Exemptions

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

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

Indicate below the age of the exemption:

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

Description:

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

Individuals under age 19.

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

Services - Mandatory Exemptions

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

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

Enforceability of Exemptions

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

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

☐ The state runs periodic claims reviews

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

☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

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

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

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

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

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

☐ Other procedure

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

Payments to Providers

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

Payments to Managed Care Organizations

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

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

Aggregate Limits

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

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

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

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

- ( ) Quarterly
- (●) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

[■] Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

[ ] As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

[☒] Managed care organization(s) track each family's incurred cost sharing, as follows:

All managed care organizations have elected to not impose cost sharing on their recipient members.

[☒] Other process:

A monthly family cap is determined each month by the eligibility system. The family cap is split between all individuals subject to copayments with each individual having their own monthly cap. As claims are submitted for dates of services within the individual's current monthly cap period, the state applies the incurred cost sharing for that service to the individual's limit. Once the individual reaches the limit, based on incurred cost sharing and any applicable premiums, the state notifies the individual and providers that the individual has reached his or her limit for the current month, and is no longer subject to cost sharing.

[■] Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The eligibility system (CARES) determines the monthly family income and derives from that the monthly 5% cap amount. CARES also determines if a member of the family has to pay any premiums. Any such premium amount is subtracted from the 5% cap and the remaining amount is sent to the MMIS system as the monthly cap amount for copayments. CARES then issues a notice to the member informing them of the cap amount. The MMIS provides the cap amounts to providers and tracks all copayments required for services received in the month. When those

copayments reach the cap, MMIS informs providers that the member is no longer subject to copayments for the rest of the month. In addition, a file is sent to CARES, which then issues a letter to the member informing them that they have reached the limit for the month.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The state will use the same appeals process available for eligibility determinations

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

Claims will be adjusted when it's discovered that a member has paid over their aggregate limit. Providers are expected to reimburse members for their excess payments.

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

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

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

Description of additional aggregate limits:

Wisconsin has aggregate limits on the following benefits:

• Drugs
• Inpatient services
• Outpatient services
• Physician services
• Podiatry services
• Therapy services

Refer to G2a and G2c for details.

PRA Disclosure Statement