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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 21-0021

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

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

Medicaid and CHIP Operations Group

February 17, 2022

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

Re: WI State Plan Amendment (SPA) 21-0021

Dear Ms. Olson:

The Centers for Medicare & Medicaid Services (CMS) completed review of Wisconsin's State Plan Amendment (SPA) Transmittal Number 21-0021 submitted on December 2, 2021. The purpose of this SPA is to allow for passive enrollment of BadgerCare Plus and SSI-Related Medicaid beneficiaries, who are required to join a Health Maintenance Organization, effective December 11, 2021.

We conducted our review of this amendment according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This letter is to inform you that Wisconsin Medicaid SPA Transmittal Number 21-0021 is approved effective December 11, 2021.

If you have any questions regarding this amendment, please contact Melanie Benning at (404) 562-7414 or via email at Melanie.Benning@cms.hhs.gov.

Sincerely,

Bill Brooks
Director
Division of Managed Care Operations

cc: Autumn Knudtson, DHS
Mara Siler-Price, CMS
Renee Frandson, CMS

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TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
21-0021

2. STATE
WI

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
12/11/2021

5. FEDERAL STATUTE/REGULATION CITATION
1902(a)(10)(E) and 1905(p) and (s) of the Act
42 CFR 438.10(c)(4) and (e) and 438.54(c)(1)(i), (c)(2)(i) (c)(3), and (d)(3)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 **$0**
b. FFY 2023 **$0**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F pages 9-12.b…………………………………………

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Medically Needy Passive Enrollment into Health Maintenance Organizations

10. 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

DocuSigned by: Nathan Bollhorst 12/1/2021

11. SIGNATURE OF STATE AGENCY OFFICIAL
DocuSigned by: [redacted] 12/1/2021

12. TYPED NAME
Jim Jones

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
~~**12/17/2021**~~

15. RETURN TO
Autumn Knudtson
Director, Bureau of Benefits Policy
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR CMS USE ONLY

16. DATE RECEIVED
December 2, 2021

17. DATE APPROVED
February 17, 2022

PLAN APPROVED – ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
December 11, 2021

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Bill Brooks

21. TITLE OF APPROVING OFFICIAL
Director, Division of Managed Care Operations

22. REMARKS

State: Wisconsin

Citation	Condition or Requirement

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity [per 42 CFR 438.50(d)]. Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

   Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation [Regulation (42 CFR) or SSA]	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		E		
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare		V			
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	V			
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120		E		
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA		E		
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145		E		
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227		E		
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.			E		

* Note. Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

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Citation	Condition or Requirement
	3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance			
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		E	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		E	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		E	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		E	
Other (Please define):			

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.54	F. Enrollment Process. Based on whether mandatory and/or voluntary enrollment are applicable to your program [see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)], please complete the below:
	1. For **voluntary** enrollment: [see 42 CFR 438.54(c)] a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3). **New enrollees who may voluntarily enroll in managed care are provided with a notice and enrollment packet upon determination of eligibility which contain the information required in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).**

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Citation	Condition or Requirement
	States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program: b. ✓ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system. Please indicate the length of the enrollment choice period: **A voluntary enrollee in fee-for-service may choose to enroll in the managed care at any time. The enrollment in the managed care entity would be effectuated no later than the first of the second month after the member makes the election.**
	c.☐If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment. i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8). ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:
	2. For mandatory enrollment: [see 42 CFR 438.54(d)]
	a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3). **New enrollees with mandatory enrollment are provided a notice, enrollment packet, and/or information via the online Enrollment Tool upon determination of eligibility which contain the information specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).**
	b. If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process. Please indicate the length of the enrollment choice period: ____

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Citation	Condition or Requirement
	c. If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment. i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8). ____________________________
	d. ✓ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment. i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8). **Enrollees who were in an MCO within the past 12 months will be passively enrolled in the prior MCO. Mandatory enrollees who were not in an MCO within the past 12 months and who do not select an MCO will be passively enrolled using a round-robin algorithm.**
1932(a)(4) 42 CFR 438.54	3. State assurances on the enrollment process. Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
42 CFR 438.52	A. ✓ The state assures that, per the choice requirements in 42 CFR 438.52:
	i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
	ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
	iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.
42 CFR 438.52	b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: ✓ This provision is not applicable to this 1932 State Plan Amendment.
42 CFR 438.56(g)	c. ✓ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ☐ This provision is not applicable to this 1932 State Plan Amendment.

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Citation	Condition or Requirement
42 CFR 438.71	d. ✓ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.
1932(a)(4) 42 CFR 438.56	G. Disenrollment. 1. The state will ✓/ will not☐limit disenrollment for managed care.
	2. The disenrollment limitation will apply for **9 months** (up to 12 months).
	3. ✓ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.
	4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. (Examples: state generated correspondence, enrollment packets, etc.) **State generated correspondence upon enrollment and enrollment packet notify Medicaid beneficiaries of their right to disenroll without cause from the MCO within 90 days of enrollment.**
	5. Describe any additional circumstances of "cause" for disenrollment (if any). **Poor quality of care, lack of access to special services, maintaining continuity of care, or other reasons satisfactory to the state.**
	H. Information Requirements for Beneficiaries.
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	✓ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

State: Wisconsin

Citation	Condition or Requirement
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	1. List all benefits for which the MCO is responsible. **Medicaid HMOs cover all medically necessary services identified in Attachment 3.1-A Supplement 1 with the following exceptions:** **— Prenatal Care Coordination (obtained on a FFS basis)** **— Tuberculosis-related services (obtained on a FFS basis)** **— Targeted Case Management (obtained on a FFS basis)** **— Chiropractic services (optional for MCOs - can be obtained on a FFS basis)** **— Community support program services for the chronically mentally ill (obtained on a FFS basis)** **— Prescription drugs and medical supplies listed in the Department's Prescription Drug Index or Disposable Medical Supplies Index (and obtained on a FFS basis), that are not reimbursable as part of the rate paid for a physician office visit or a stay in a hospital or nursing home.** **— Prescription drugs administered by a physician as part of a physician office visit or incident to a physician's service.** **— Non-emergency medical transportation.** **— Dental, unless the HMO elects to provide dental services.** **— School-based services.** **— Child care coordination.** **— Crisis intervention.** **— Comprehensive community services (CCS).** **— Community recovery services (CRS).** **— Lead investigations for persons having lead poisoning or lead exposure.** **— Medication therapy management.** **— Behavioral treatment services (autism services).** **— Residential Substance Use Disorder (RSUD) Treatment** **FFS = fee for service**