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State/Territory Name: WI

State Plan Amendment (SPA) #: 24-0029

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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

March 14, 2025

William Hanna
Medicaid Director
Wisconsin Department of Health Services
1 W. Wilson Street
Madison, WI 53701

Re: Wisconsin State Plan Amendment (SPA) Transmittal Number WI-24-0029.

Dear Director Hanna:

This letter is being sent as a companion to the Centers for Medicare & Medicaid (CMS) approval of Wisconsin State Plan Amendment (SPA) Transmittal Number 24-0029, which made changes to the Wisconsin Medicaid Alternative Benefit Plan (ABP) to include non-routine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). This amendment was initially submitted on December 18, 2024, with an effective date of October 1, 2023.

Section 1902(a) of the Social Security Act (the Act) requires that states have a state plan for medical assistance that meets certain federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR 430.10 require that the state plan he a comprehensive written statement containing "all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the State program." Section 1937 of the Social Security Act increases the states flexibility to provide Medicaid coverage through benchmark or benchmark equivalent benefit packages through the formal submission of an. Alternative Benefit Plan (ABP).

Wisconsin submitted WI 24-0029 to add mandatory vaccine and vaccine administration coverage for adults according to section 1905(a)(13)(B) of the Social Security Act (SSA) to its ABP, which was approved April 18, 2014, with an effective date of October 1, 2023. Through the analysis of the SPA, CMS identified that this was the first amendment to its ABP since adding the benefit to the state's Medicaid program in 2014. On September 16, 2014, CMS issued an informational bulletin providing guidance to states on timeframes and requirements for amending ABPs when states are in full or partial alignment with the state's approved Medicaid State plan package. Specifically, the informational bulletin advised that ABP's must be kept in full or partial alignment with the state's approved underlying state plan on an ongoing basis, not just at the point of initial approval. States are required to update the ABP submissions on a quarterly basis (or more frequently at the state's choice) to keep the ABP in alignment with the state's approved underlying Medicaid state plan. Below we have provided guidance to assist the state in becoming compliant with ABP rules. In addition, we have included a variety of formal sub-regulatory guidance that

has been issued by CMS over the last several years, which will provide support to Wisconsin in updating its ABP to ensure that Wisconsin's eligible and enrolled Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care, and Children with Non-IV-E Adoption assistance are receiving the full benefits offered by the state.[1]

Wisconsin implemented the ABP benefit (January 1, 2014 (WI-13-0034). At that time, states were required to use a reference benchmark plan from plan year 2012 to define the essential health benefits provided through the ABP. On January 28, 2016, CMS issued an informational bulletin titled "Alternative Benefit Plan Conforming Changes" advising states of regulatory changes in Essential Health Benefit (EHB) standards affecting Medicaid Alternative Benefit Plans (ABPs). The guidance advised that states will be required to select a new base benchmark or update the base benchmark plan already in use to plan year 2014 from plan year 2012, for ABPs that are offered on or after January 1, 2017 (or managed care contract years beginning on or after that date) and update the ABP benefit package accordingly. The informational bulletin also advised that changes may be needed in the following areas: EHB coverage standards for habilitative services and devices; updating the benchmark plan year used to define EHBs; prescription drug benefits and preventive services and supplies. This change required states to submit an ABP amendment to record the change in base benchmark selection and make any other changes to benefit design that may result from using the new plan year.

On August 8, 2019, CMS issued another information bulletin titled "New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB)," explaining additional flexibilities states must define EHBs if they wanted to modify the benefit package.

Based on CMS's review of WI 24-0029, it appears the state has not changed or updated the 2012 Base Benchmark Plan (United Health Care Insurance Company - Choice Plus).

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To enable the state in updating its ABP we have compiled the following list of actions for the state to review and complete. Through this process, CMS is available to provide technical assistance to the state upon request.

1. If the state has made any changes to the population being served or the counties described in 'Alternative Benefit Plan Populations' template (ABP1), please revise the template.

2. If the state has made any changes to the 'Voluntary Enrollment Assurances for Eligibility Group other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act' (ABP2b), please revise the template.

3. Per the 'Selection of Benchmark Benefit Package' template (ABP3), Wisconsin states the ABP, "...includes all benefits, including EPSDT, in the state's approved Medicaid state plan. Care4Kids will also cover additional services focused on specific needs of children in out-of-home care."
    a. CMS needs the state to update ABP3 with the newer ABP3.1 template to reflect the ABP guidance and to incorporate any changes to Wisconsin's Selection of

[1] The state has the authority to establish medical necessity criteria for covered services.

Benchmark Benefit Package or Benchmark-Equivalent Benefit Package. Please revise the template using the updated ABP3.1 template that has been provided.

4. If the state has made any changes to the ABP Cost-Sharing (ABP4), please revise the template.

5. Wisconsin is using the original 'Benefits Description' template (ABP5) from 2013, however a new ABP5 template was introduced for use in 2016 to comply with regulatory changes to the 'Essential Health Benefits' (EHBs). These changes included several new assurances (see below). Please use the updated ABP5 template (attached) to populate the benefits.

    a. ***Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment***
        i. *The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.*
    b. ***Essential Health Benefit 6: Prescription drugs***
        ii. *The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.*
    c. ***Essential Health Benefit 7: Rehabilitative and habilitative services and devices***
        iii. *The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.*
    d. Since 2014, have any other changes been made to state plan benefits in the state's traditional state plan, including but not limited to, Routine Cost for Clinical Trials and Medication Assisted Therapy that need to be included in the ABP to maintain alignment between the benefit packages? If so, these benefit changes need to be reflected in the ABP5 template.

6. If the state has made any changes to the Benefits Assurances (ABP7), please update the template.

7. If the state has made any changes to the service delivery model, or changes that would affect how that model is identified in the 'Service Delivery System' template (APB8), please update the template.

8. If the state has made any changes to the Employer Sponsored Insurance and Payment of Premiums (ABP9), please update the template.

9. If the state has made any changes to the Payment Methodology (ABP11), please update the template.

The State has 90 days from the date of this letter to respond to the issues described above. Within that period the State may submit a SPA to address the inconsistencies and/or submit a corrective action plan describing in detail how the state will resolve the issues identified above in a timely manner.

Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide technical assistance, as needed or required.

If you have any questions, please contact Mai Le-Yuen at 312-353-2853 or via email at mai.le-yuen@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

cc: Alexandra Merfeld, DHS

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

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

CMCS Informational Bulletin

DATE: January 28, 2016

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

SUBJECT: **Alternative Benefit Plan Conforming Changes**

Purpose

This informational bulletin provides information to states about recent regulatory changes in Essential Health Benefit (EHB) standards affecting Medicaid Alternative Benefit Plans (ABPs). The bulletin includes information about conforming changes that may be needed in the following areas: EHB coverage standards for habilitative services and devices; updating the benchmark plan year used to define EHBs; prescription drug benefits and preventive services and supplies. This bulletin also address the state-required actions as a result of these changes, including state plan amendment (SPA) submissions and ABP public notice requirements.

Background

The Affordable Care Act (ACA) amended section 1937 of the Social Security Act (the Act), to require that ABP coverage packages meet EHB standards. A regulation published in 2015 made several regulatory changes to EHB standards that impact Medicaid ABPs (The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016, Final Regulation (CMS-9944-F), published by the Center for Consumer Information and Insurance Oversight (CCIIO) on February 27, 2015, (hereby called the CCIIO 2016 Payment Notice)). In addition, the Department of Labor issued an interpretive information that also impacts preventive and contraceptive services under Medicaid ABPs.

EHB-Benchmark Coverage Standards for Habilitative Services & Devices

The CCIIO 2016 Payment Notice revised the EHB referred to as Rehabilitative and Habilitative Services and Devices by adding a definition for habilitative services. The following definition is now used to define habilitative services and devices at 45 CFR section 156.115(a)(5)(i): "health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." States will therefore need to determine if the habilitative coverage in their

approved ABP meets this definition. If not, states will need to amend the ABP to bring it into compliance with the new requirement. CMS will expect state plans to be in compliance for ABP coverage offered on or after April 1, 2016 (or under managed care contracts entered into on or after that date). States desiring to offer habilitative services and devices in parity with rehabilitative services and devices can continue to use the same services for rehabilitative and habilitative purposes, but coverage of habilitative services and devices must meet the definition above and meet the requirements for treatment limits as described below.

The state must not impose limits on habilitative services and devices that are more stringent than limits on rehabilitative services and devices (see 45 CFR 156.115(a)(5)(ii)). This provision is effective immediately and requires that states review the coverage in the ABP to ensure that limits are in compliance with this provision.

Separate coverage limits must also be established for rehabilitative and habilitative services and devices (see 45 CFR 156.115(a)(5)(iii)) for plan years beginning on or after January 1, 2017. A combined limit that cannot be exceeded based on medical necessity is not permissible. States will need to assess any existing limits on this coverage to determine if an amendment to the ABP SPA is required.

The provisions discussed in this section do not change a state's ability to define habilitative services and devices through the process called supplementation, where a state can add benefits that are not present in the plan used to define EHBs according to requirements at 45 CFR 156.110(f), if the base benchmark plan does not include habilitative services and devices.

Updating EHB Benchmark Plans

The CCIIO 2016 Payment Notice provided that states would select a new benchmark plan to define EHBs or default to the largest small group plan, and that revised benchmark plans would be based on 2014 plans (see 45 CFR 156.110). Issuers will start using the new benchmark plans as a reference plan for designing EHB-compliant benefit packages starting with the 2017 plan year. For Medicaid purposes, states will be required to select a new base benchmark or update the base benchmark plan already in use to plan year 2014 from plan year 2012, for ABPs that are offered on or after January 1, 2017 (or managed care contract years beginning on or after that date), and update the ABP benefit package accordingly. This will require states to submit an ABP amendment to record the change in base benchmark selection and make any other changes to benefit design that may result from using the new plan year.

Pediatric Age

The CCIIO 2016 Payment Notice specified that for EHBs, required pediatric services means services until at least the end of the month when the enrollee turns 19 years of age (see 45 CFR 156.115(a)(6). This change does not affect Medicaid ABPs, because they are required to provide all medically necessary services that would be covered under a traditional Medicaid program, including pediatric oral and vision services, under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which applies to children under 21 years old.

Prescription Drug Benefit

The CCIIO 2016 Payment Notice added new requirements for plans to use a pharmacy and therapeutics (P&T) committee starting in plan years beginning on or after January 1, 2017. The rule also included provisions regarding the P&T committee structure and operations, the formulary exceptions process, and the accessibility of formulary information.

States that establish preferred drug lists (PDLs) or formularies (for either traditional Medicaid, ABPs or managed care) consistent with the requirements of section 1927 of the Act will comply with the formulary exceptions process and new P&T committee requirements, as long as the Drug Utilization Review board or the P&T committee meeting occurs at least quarterly to ensure that the state's meeting standards comply with the meeting standards provided at 45 CFR 156.122(a)(3)(ii).

Publication of List of Covered Drugs

The CCIIO 2016 Payment Notice specified that for plan years beginning on or after January 1, 2016, in order to be considered to provide EHB prescription drug coverage, health plans must publish up-to-date, accurate, and complete lists of all covered drugs on their formulary drug lists, including any tiering structures that have been adopted, and any restrictions on the manner in which certain drugs can he ohtained (see 45 CFR 156.122(d)). A state that adopts an ABP formulary should publish on its website the list and tiering structure (if applicable) of ABP covered drugs. As long as the formulary or PDL is publicly available in a manner consistent with the public notice requirements for Medicaid premiums and cost sharing set forth at 42 CFR 447.57(b), such requirements fulfill the standards at section 45 CFR 156.122(d).

Network Access Standards

The CCIIO 2016 Payment Notice specified that for plan years beginning on or after January 1, 2017, health plans must allow enrollees access to prescription drug benefits at in-network retail pharmacies, unless the drug is subject to restricted distribution by the Food and Drug Administration (FDA), or the drug requires special handling (see 45 CFR 156.122(e)). To the extent that a Medicaid ABP is furnished through a fee-for-service delivery system, under section 1902(a)(23), beneficiaries have access to any willing pharmacy provider who will accept Medicaid payment. However, states must also continue to ensure that payments are sufficient to enlist enough providers so that prescription drug coverage is available under the state plan at least to the same extent as is available to the general population, per the statutory requirement at 1902(a)(30)(A). To the extent that a Medicaid ABP is furnished through a managed care network (including a pharmacy benefit manager), the ABP will satisfy the requirements of 45 CFR 156.122(e) by maintaining access to in-network retail pharmacies.

Coverage of Certain Preventive Services

In May 2015, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury jointly released Frequently Asked Questions (FAQs)[1] related to coverage of preventive services, which are an EHB. The FAQs clarify that plans and issuers must cover at least one form

[1] See FAQs about Affordable Care Act Implementation, Part XXVI, available at http://www.dol.gov/ebsa/pdf/faq-aca26.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

of contraception within each method identified by the FDA. This information also applies to Medicaid ABPs, which are required to cover preventive services through the EHB standards. Additionally, CMS reminds states that there is a requirement to cover a broad range of preventive services, and cost sharing may not be applied to preventive services described under section 2713 of the Public Health Service Act and its implementing regulations.

State-Required Actions

As a result of the required changes identified in this CIB, states should assess the need to take the following actions:

1) After January 1, 2017 (or for ABP managed care contract years beginning on or after that date) ABPs must be compared to an EHB base benchmark plan from plan year 2014. Therefore, states must update and amend current ABPs by March 31, 2017 in order to secure the required effective date of January 1, 2017. States submitting a new ABP with a January 1, 2017 effective date and thereafter, will also be required to reference updated base benchmark plans when determining EHB-compliant ABP coverage. Additionally, states must determine if their selected 1937 benchmark plan coverage option should be updated to reflect this change.
2) If states have limits on habilitative services that are more stringent than rehabilitative services, then the state will need to remove or modify the limit and allow for equal limits. States must submit SPAs no later than June 30, 2016 to secure an effective date of April 1, 2016. If the new definition for habilitative services has an impact on ABPs in which the state defined habilitative services previously, then the state will need to submit a SPA to correct the coverage by June 30, 2016 to secure an effective date of April 1, 2016.
3) If the base benchmark or the resulting ABP benefit package applies combined treatment limitations that cannot be exceeded based on medical necessity to habilitative and rehabilitative services and devices, states must separate such limits in a manner such that limitations on habilitative services are no less favorable than rehabilitative services. These changes must be made for coverage provided on or after January 1, 2017, or under ABP managed care contract years beginning on or after that date. A SPA must be submitted by March 31, 2017 to effectuate this change by January 1, 2017.
4) After January 1, 2016, states that adopt an ABP formulary, or for managed care contract years beginning on or after that date for ABP coverage that includes a formulary, must ensure that the state or its contractor publish on its website the list and tiering structure (if applicable) of covered drugs.

Public Notice Requirement

CMS reminds states and stakeholders that prior to submitting a SPA to either establish an ABP or substantially modify an existing ABP, the state must have provided the public with advance notice of the amendment and reasonable opportunity to comment on such amendment as specified at 42 CFR 440.386. Tribal consultation is also required if applicable in the state. The notice published for public comment must include a description of the method for assuring compliance with 42 CFR 440.345 related to full access to EPSDT. If a state is unclear whether a change to its ABP SPA is substantive, we encourage the state to consult with CMS in advance of submission.

For additional information about this Informational Bulletin, please contact Kirsten Jensen, Director, Division of Benefits and Coverage at 410-786-8146.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: August 8, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: **New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB)**

Purpose

This Informational Bulletin provides updates to states about recent regulatory changes in Essential Health Benefit (EHB) standards affecting Medicaid Alternative Benefit Plans (ABPs). This Bulletin includes information about conforming changes related to updating the benchmark plan used to define EHBs. This Bulletin also addresses the state-required actions as a result of these changes, including state plan amendment (SPA) submissions and ABP public notice requirements.

Background

Under 42 CFR 440.347, ABPs authorized under section 1937 of the Social Security Act (the Act) are required to meet EHB standards. Currently, ABPs must include the EHB in one of the 10 base-benchmark plans provided at 45 CFR 156.100, subject to supplementation under 45 CFR 156.110(b) and substitution as permitted under 45 CFR 156.115(b). The base-benchmark plans provided at 45 CFR 156.100(a) are:

- The largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the state's small group market,
- Any of the largest three employee health benefit plan options by enrollment offered and generally available to state employees in the state,
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible Federal employees, or
- The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the state.

The Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2019 Final Regulation (referred to in this Bulletin as the CMS 2019 Payment Notice)[1] published on April 17, 2018 finalized changes that will provide new flexibility to states regarding EHB that

[1] 83 FR 16930.

impact Medicaid ABPs.

New State Flexibilities and EHB Requirements

EHB-Benchmark Plan Flexibilities

The CMS 2019 Payment Notice created new choices with respect to states' selection of EHB-benchmark plans applicable to their individual and small group markets for plan years beginning on or after January 1, 2020. These options will also be available to states when choosing the benchmark plan used to define EHB in an ABP. Please note that a state may continue to use its current benchmark plan selection, including when it amends an existing ABP. However, if a state decides to change its benchmark plan used to define EHB in its ABP, or a state decides to implement a new ABP in which an initial benchmark plan selection must be made, and is not the same as the state's benchmark plan chosen for the commercial market, the state would be required to choose one of the following options to define EHB for its ABP:

1. **Option 1 - Select an EHB-benchmark plan from another state** – Under this option a state may select one of the EHB-benchmark plans used for the 2017 plan year by any other state.

2. **Option 2 - Replace category or categories with categories from another state's EHB-benchmark plan** – Under this option a state may replace any of the 10 required EHB categories of benefits in its EHB-benchmark plan with the same category or categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year.

3. **Option 3 – Propose a set of benefits** – Under this option a state may select a set of benefits consistent with the 10 EHB categories that would become its EHB-benchmark plan.

Under any of the above options, the EHB-benchmark plan is required to meet coverage and scope of benefits standards specified at 45 CFR 156.111(b), including that it is no more generous than the most generous among a set of comparison plans, including the EHB-benchmark plan used by the state in 2017 and any of the base-benchmark plan options for the 2017 plan year as described in 45 CFR 156.100(a)(1), supplemented as necessary. Lastly, the scope of benefits must be equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category, the scope of benefits provided under a typical employer plan as defined at 45 CFR 156.111(b)(2). For this purposes, a state may choose to compare its EHB-benchmark plan to one of the 10 base-benchmark plan options established at 45 CFR 156.100 that the state could have selected for the 2017 plan year, or compare to the largest health insurance plan by enrollment in one of the five largest large group health insurance products by enrollment in the state in accordance with 42 CFR 156.111(b)(2)(B).

When comparing benefits under the ABP for purposes of the maximum generosity and typical employer plan standards, the state need only compare the benefits used to define EHB. Services

provided under 1937 that are not considered part of the EHB-benchmark plan for the ABP should not be included in the comparisons.

Additionally, states must document meeting these requirements through an actuarial certification and associated actuarial report from an actuary who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. For additional guidance please see Attachment A (Questions and Answers) and Attachment B (Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)).

ABP Process Reminders

Amendments to ABPs

States choosing to update the benchmark plan selection used to define EHB using one of the new options under 45 CFR 156.111 will be required to submit a SPA. CMS reminds states that have chosen to align their ABPs with their Medicaid state plan that ABPs must be kept in alignment with or exceed the scope of the state's approved underlying state plan on an ongoing basis. In order to maintain alignment, states are required to submit an ABP SPA when they amend benefits in the state plan. For example, revisions that add, delete or change coverage based on limitations of amount, duration or scope or authorization requirements in the state's state plan will need to also be included in an amendment to the state's ABP(s). States are required to submit amendments to an ABP in the same quarter as corresponding changes in the state's traditional state plan in order to keep effective dates aligned between the state's state plan and the ABP. Please see the "Process for Amending Alternative Plans" CMCS Information Bulletin dated September 16, 2014 for more information.

Public Notice Requirements

CMS reminds states and stakeholders that prior to submitting a SPA to either establish an ABP or substantially modify an existing ABP, the state must have provided the public with advance notice of the amendment and reasonable opportunity to comment on such amendment, as specified at 42 CFR 440.386. Tribal consultation is also required, if applicable in the state. The notice published for public comment must include a description of the method for assuring compliance with 42 CFR 440.345 related to full access to Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). If a state is not certain whether a change to its ABP is substantially modifying the existing ABP, please consult with CMS well in advance of submitting the ABP SPA, to confirm whether the change requires public notice and, if required, to allow sufficient time for public notice, including a reasonable opportunity to comment.

For additional information about this Informational Bulletin, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Attachment A
Questions and Answers

1) **Does a state with an existing Medicaid alternative benefit plan (ABP) have to change its base benchmark plan for purposes of defining EHB for the ABP when the new CCIIO flexibilities take effect?**
No. There is no requirement for the state to make a change. Unless there are future regulatory changes, the state may continue to use its existing base benchmark plan.

2) **My state would like to offer a new Medicaid ABP. For the commercial market, the state uses a small group market plan for its Essential Health Benefits (EHB) benchmark plan. May we use the same EHB benchmark plan as the basis to define EHBs for our ABP?**
Yes. The state would identify the benchmark plan in its SPA submission. An actuarial certification is not necessary in this circumstance.

3) **My state would like to offer an ABP. For the commercial market, our state uses a small group market plan for its EHB benchmark plan. However, for the ABP, we want to use the largest insured commercial non-Medicaid HMO another state used for the 2017 plan year. May we identify that plan as our benchmark plan used to define our ABP EHBs?**
Yes. If the largest insured commercial non-Medicaid HMO was the other state's EHB benchmark plan for plan year 2017, then this decision would fall under Option 1 described in the Informational Bulletin. If it was not available, then this decision would fall under Option 3. Under either option, the state would identify the plan and the state the plan is from in its SPA submission.

4) **Our state would like to define EHB for our ABP using our state EHB benchmark plan, except for mental health services defined in the plan. We would like to use the mental health services defined in the EHB benchmark another state used in 2017. May we do that?**
Yes. This decision would fall under Option 2 described in the Informational Bulletin. The state would identify the benchmark plan and the benchmark plan from which it selected the substituted category in its SPA submission.

5) **Prior to January 1, 2020, a state that wanted to create an ABP that aligned with the state's Medicaid state plan had to complete a two-step process to define the traditional services under EHB rules. Does the new flexibility require the same process?**
Under the new flexibility, a state can use Option 1, 2 or 3 described in the Informational Bulletin. Using Option 1 and 2 would require the state to complete the same two-step process used prior to January 1, 2020. For example, under Option 3, a state may propose a set of benefits from its traditional Medicaid state plan to define EHB. However, the state must ensure that the set of benefits provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB

category, the scope of benefits provided under a typical employer plan, and are no more generous than the most generous of the comparison plans in the state. The state would do this by having an actuary perform this comparison and certify that the EHB services meet this criteria. The requirements for this certification are found at 45 CFR 156.111(e)(2). An example of an acceptable methodology for comparing benefits of a state's EHB-benchmark Plan Selection is found in Appendix B "Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)"[2].

[2] Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii), April 9, 2018. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

Attachment B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: April 9, 2018

Title: Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)

Background

New flexibility will be available allowing Under 45 CFR 156.111 in the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) displayed on April 9, 2018,[1] we finalized that States may select a new essential health benefits (EHB) benchmark plan for plan years beginning on or after January 1, 2020. If a State opts to select a new EHB-benchmark plan utilizing any of the selection options at §156.111(a), the State is required under §156.111(e)(2)(i) and (ii) to submit an actuarial certification and associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

This actuarial certification and associated actuarial report must affirm that the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan ("Typical Employer Plan"), as defined at §156.111(h)(2)(i), and that it does not exceed the generosity of the most generous among the plans ("Comparison Plan") listed at §156.111(b)(2)(ii)(A) and (B). This set of comparison plans for purposes of the generosity standard includes the State's EHB-benchmark plan used for the 2017 plan year, and any of the State's base-benchmark plan options used for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.[2]

This methodology below outlines an example of one approach for actuaries to follow when comparing benefits in order to complete the required actuarial certification and associated actuarial report under §156.111(e)(2)(i) for typicality. This approach could also be taken for comparing benefits for generosity in order to complete the required actuarial certification and associated actuarial report under §156.111(e)(2)(ii).

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[1] A copy of the final rule is available on the Center for Consumer Information and Insurance Oversight website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

[2] The States' EHB-benchmark plans used for the 2017 plan year are based on plans from the 2014 plan year, but we occasionally refer to them as 2017 plans because these plans are applicable as the States' EHB-benchmark plans for plan years beginning in 2017. The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf. States' EHB-benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

Methodology for Comparing Benefits

The actuarial certification and associated actuarial report required by §156.111(e)(2) are required to comply with generally accepted actuarial principles and methodologies. This includes complying with all applicable Actuarial Standards of Practice (ASOPs). For example, ASOP 41 on Actuarial Communications[3] includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. ASOP 8 on Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits[4] and ASOP 50 on Determining Minimum Value and Actuarial Value under the Affordable Care Act [5] also provides additional guidance. The actuarial certification for this requirement is in a template incorporated in the Paperwork Reduction Act (PRA) notice on the EHB-benchmark plans (OMB Control Number: 0938-1174).[6] This PRA notice includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary must be a Member of the American Academy of Actuaries.

One example of an acceptable methodology for comparing the benefits of a "Typical Employer Plan" or the "Comparison Plan" to the State's proposed EHB-benchmark plan is to compare expected values as follows. Note that there are other requirements that a State's EHB-benchmark plan must comply with at §156.111(b). If the actuary is using different plans as the "Typical Employer Plan" and "Comparison Plan," the actuary will need to repeat the below steps.

1. **Select a "Typical Employer Plan" Pursuant to §156.111(b)(2)(i) or a "Comparison Plan" Pursuant to §156.111(b)(2)(ii).** The 2019 Payment Notice defines a "Typical Employer Plan" as either:

    1. One of the selecting State's ten base-benchmark plan options established at §156.100 and available for the selecting State's selection for the 2017 plan year; or
    2. The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103, provided that:
        A. The product has at least ten percent of the total enrollment of the five largest large group health insurance products in the State;
        B. The plan provides minimum value, as defined under §156.145;
        C. The benefits are not excepted benefits, as established under §146.145(b), and §148.220; and
        D. The benefits in the plan are from a plan year beginning after December 31, 2013.

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3 http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041_120.pdf.

4 http://www.actuarialstandardsboard.org/wp-content/uploads/2014/08/asop008_176.pdf.

5 http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050_182.pdf.

6 The PRA documents include the required template for this actuarial certification. Documents associated with the PRA are posted on the Centers for Medicare & Medicaid Services' PRA website at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html. Comments on these documents should be submitted to www.regulations.gov.

To select a "Typical Employer Plan," the State may need to determine which of the plans in the State meet the above definition and depending on the selection under this definition, the actuary may need to affirm that the plan provides minimum value in accordance with §156.145.

A "Comparison Plan" is defined as the State's EHB-benchmark plan used for the 2017 plan year, or any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110. Specifically, if a State selects as a "Comparison Plan" under the above definition a base-benchmark plan that does not provide any coverage in one or more of the categories of EHB, as defined at §156.110(a),[7] the actuary would need to supplement the selected plan with the category or categories of such benefits from another plan that meets the definition of "Comparison Plan," using the supplementation process described at §156.110(b).

To reduce burden, the actuary may want to consider using the same plan, for both the typicality and the generosity tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii). For example, the actuary may only need to do one plan comparison for the purposes of both of these certification requirements. Specifically, the actuary could use the same plan, such as the State's EHB-benchmark plan used for the 2017 plan year. That plan would, by definition, be a "Comparison Plan." Because the State's EHB-benchmark plan used for the 2017 plan year would simply be one of the State's base-benchmark plans, supplemented as necessary under §156.110, that plan also could be used for purposes of determining typicality, as a proposed State EHB-benchmark plan that was equal in scope of benefits to the State's EHB-benchmark plan used for the 2017 plan year within each EHB category at §156.110(a) would be equal to or greater in scope of benefits within each EHB category at §156.110(a) than the base-benchmark plan underlying the EHB-benchmark plan used for the 2017 plan year, to the extent of the required supplementation.

2. **Calculate the expected value of covering all of the benefits at 100 percent actuarial value in each EHB category in the proposed EHB-benchmark plan and in the "Typical Employer Plan" or "Comparison Plan," including any necessary supplementation.** The State must use reasonable actuarial assumptions and methods in accordance with generally accepted actuarial principles and methodologies. For example, the actuary may use data acquired from issuers in the State for a recent plan year, and weight the services and benefits provided in each EHB category. Other potential data sources include any all-payer claims databases maintained by the State or other databases that reflect the State's population.

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[7] The EHB categories at §156.110(a) are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

3. **Compare the expected value of covering all of the benefits (at 100 percent actuarial value) in each EHB category of the "Typical Employer Plan" or the "Comparison Plan" to that of the corresponding EHB category of the proposed State's EHB-benchmark plan.** Under this example methodology, we would consider the State's proposed EHB-benchmark to satisfy the "Typical Employer Plan" requirement, if the State's actuary certifies that the expected value of each applicable EHB category of benefits in the State's proposed EHB-benchmark plan has an expected value equal to, or greater than, 100 percent of the expected value for those same categories of benefits of the "Typical Employer Plan." In the case of the generosity standard, we would not consider the State's proposed EHB-benchmark to satisfy the requirement if the expected value for each applicable EHB category of benefits in the proposed State's EHB-benchmark plan exceeds 100 percent of expected value for those same EHB categories of benefits in the most generous "Comparison Plan."

Alternative Benefit Plan

State Name: _____ Attachment 3.1-L- ____ OMB Control Number: 0938-1148

Transmittal Number: ___ - __ - ____

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3.1

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ○ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: _____

Selection of EHB-Benchmark Plan

The state/territory must select an EHB-benchmark plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

EHB-benchmark plan name: _____

The EHB-benchmark plan is the same as the Section 1937 Coverage option: ____

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ○ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

Other Information Related to Selection of the Section 1937 Coverage Option and the EHB-Benchmark Plan (optional):

V.20190813

Alternative Benefit Plan

State Name: | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: ___ - __ - ____

Benefits Description	ABP5
The state/territory proposes a "Benchmark-Equivalent" benefit package.	

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. 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 0938-1188. The time required to complete this information collection is estimated to average 5 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.20190808

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

March 14, 2025

William Hanna
Medicaid Director
Wisconsin Department of Health Services
1 W. Wilson Street
Madison, WI 53701

Re: Wisconsin State Plan Amendment (SPA) – 24-0029

Dear Director Hanna:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0029. This amendment proposes to add non-routine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) to the alternative benefit plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act, section 1905(a)(13)(B). This letter informs you that Wisconsin Medicaid SPA TN 24-0029 was approved on March 14, 2025, effective October 1, 2023.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Wisconsin State Plan.

If you have any questions, please contact Mai Le-Yuen at 312.353.2853 or via email at mai.le-yuen@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Alexandra Merfeld, DHS

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Wisconsin**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

WI-24-0029

Proposed Effective Date

10/01/2023 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Sections 1937 and 1945 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2023	$ 0.00
Second Year	2024	$ 0.00

Subject of Amendment

Resubmission of Foster Care Health Home Benchmark Plan, amendment 24-0029, on 12/18/2024, to include vaccine coverage expansion from the Inflation Reduction Act according to section 1905(a)(13)(B) of the Social Security Act (SSA).

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Alexandra Merfeld**
Last Revision Date:	**Mar 4, 2025**
Submit Date:	**Dec 18, 2024**

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. [No]

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

UnitedHealthcare Insurance Company - Choice Plus

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved. Wisconsin will have no limitation on services since all individuals in this ABP are children and they are eligible for EPSDT services.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Tobacco Cessation for Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No prior authorization required. Services as allowed under 1905(a)(4)(D) of the SSA.

Other 1937 Benefit Provided:
Intermediate Care Facilities for Intellectual/Dev

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
30 days

Scope Limit:
None

Other:
No prior authorization required. Children will not be enrolled in the Care4Kids if stays beyond 30 days is necessary.

Other 1937 Benefit Provided:
Non-routine ACIP recommended vaccines

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

1. Effective October 1, 2023.
2. Wisconsin covers the non-routine ACIP recommended vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act.
3. Wisconsin has a method to ensure that, as changes are made to ACIP recommendations, Wisconsin will update their coverage and billing codes to comply with those revisions.

Add