3.1 c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Wisconsin

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality and a description of the standards established by the State to assure high quality care:

a. Provision is made for use of specialist and consultative medical service.

b. Provision is made for necessary transportation of categorically needy and medically needy recipients to and from the suppliers of medical and remedial care and services.

c. Priority will be given to the use of available semiprivate accommodations (2 bed, 3 bed and 4 bed rooms) for hospitalized recipients.

d. Standards for the long-term care of patients in medical institutions will include the following:

(1) There will be a medical-social plan for each patient, which includes the consideration of alternate types of care, and which is reassessed periodically accomplished through independent medical review or independent professional review.

(2) Each patient will be under care of a physician. All patients requiring a visit each 30 days will, in fact, be seen by a physician. Arbitrary and universal application of a 30 day visit requirement which would result in unnecessary physicians visits is not intended. When a physician specifically indicates that the patient's condition does not require monthly visits, they are not required.

(3) In other instances when 30 day physicians' visits are not made, there will be documentation to show that:

(a) The nursing home administrator has made a valid attempt to get the physician to visit his patients.

(b) The home has notified the single State agency of their difficulties regarding specific cases.

(c) The patient is notified of his right to placement in a facility where his need for skilled nursing home care can be met.

(4) Prescribed medications will be reviewed by the attending physician at least every 30 days and tests or observations of patients indicated by their medical regimen have been made at appropriate times and properly recorded.

State Wisconsin

(5) There will be a continuing clinical record for each patient.

e. Professional medical staff of the state agency, including the service areas of dentistry, nursing, restorative therapy, etc., will be in constant ongoing surveillance of medical care patterns of utilization and provision. Guidelines for specialized services, such as vocational rehabilitation and crippled childrens services, have been incorporated to assure maximum utilization in these specialized areas.

f. In the provision of drugs,

(1) The State uses professional pharmaceutical consultation;

(2) Standards and procedures provide for dispensing of drugs at the lowest cost consistent with quality; and

(3) There will be review and analysis of drug bills, including the compilation of statistics with respect to types, quantities, and cost of drugs dispensed.

g. There will be a specific plan for a continuous evaluation of the utilization and quality of medical and remedial care and services provided under the State plan.

h. Methods will exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.

i. Direct service workers will be kept currently informed of significant medical information concerning their clients.

DHS Note: See MMDL forms APB1-10 for current information.

State/Territory: Wisconsin

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

X Title of Alternative Benefit Plan B Foster Care Medical Home

1. Populations and geographic area covered

X a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution

under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age, or the individual has aged out of foster care, is under 26 years of age and qualifies on the basis of section 1902(a)(10)(A)(i)(IX).

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Voluntary Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance		
		Mandatory categorically needy poverty level infants eligible under		

State/Territory: Wisconsin

Required Enrollment	Voluntary Enrollment	1902(a)(10)(A)(i)(IV) **Full-Benefit Eligibility Group and Federal Citation**	**Targeting Criteria**	**Geographic Area**
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • •		
		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)		
		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: o Non title IV-E Foster Care	Excludes children in a secure facility or a Residential Care Center.	Southeast Wisconsin, including Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha Counties.

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

DHS Note: See MMDL forms APB1-10 for current information.

State/Territory: Wisconsin

Voluntary Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i)		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(VII)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
X	Children receiving foster care or adoption assistance under title IV-E of the Act	Excludes children in a secure facility or a Residential Care Center.	Southeast Wisconsin, including Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha Counties.
	An individual who received foster care assistance under title IV-E of the Act, and qualifies on the basis of 1902(a)(10)(A)(i)(IX)		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

State/Territory: Wisconsin

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

At the time of a child's entry into out-of-home care, the child's parent(s) or guardian will be offered a choice to enroll the child in the alternative benchmark program or fee-for-service Medicaid. The parent(s) or guardian will be informed using unbiased information, both verbally and in writing, indicating that their choice of Medicaid Program for their child is voluntary, and

that they may change their mind at anytime regarding their choice between Medicaid fee-for-service and the alternative benchmark plan.

Wisconsin will use different avenues to inform each child's parent(s) or guardian about their rights under this program. Below are some of the ways in which the State plans to inform individuals, Tribal governments, advocates, and the community about the program.

1. The State, through its Department of Health Services and the Department of Children and Families, plans to hold information sharing meetings with birth parents, foster parents, adoptive parents, the courts, local child welfare agencies (county and Tribal), established community and advocacy groups in the six-county area.

   These sessions will serve as a forum for the State to explain the new benefit, including the choice that the parent(s) or guardian will have regarding the Medicaid Alternative benchmark plan and Medicaid fee-for-service, respond to questions, and solicit feedback on its outreach strategies. In addition to explaining the framework for the enhanced services, the State will emphasize three points in its communications:

   a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package whether they choose the Alternative Benchmark Plan or Medicaid fee-for-service.
   b. There is no cost sharing for either plan.
   c. Participation will be voluntary upon entry into out-of-home care.
   d. That the parent(s) or guardian may change their choice between these two Medicaid options at any time.

   The State plans to hold separate meetings with Tribal representatives to discuss, in detail, all aspects of the Medicaid Program choices that parent(s) or guardian will have regarding their child's Medicaid program. This is to assure that American Indian and Alaskan Native children and their families understand the voluntary nature of enrollment.

2. The State will develop informing materials that:

   a. Identify the geographic area and the population eligible for the program.
   b. Explain the voluntary nature of the program and the option to discontinue at any time.
   c. Clearly inform the parent(s) or guardian that participation in the program will not reduce the child's access to all Medicaid benefits.
   d. Explain the benefits of the enhanced services in the alternate plan, including having a child-specific care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of the child's needs – from preventive services and health screenings, to specialty medical care, inpatient care, and crisis intervention.
   e. Provide a toll-free contact number for questions and information.

3. The duties of the Child Welfare Worker include-assisting the parent(s) or guardian in making their choice of Medicaid Program:

a. The Child Welfare Worker, as the primary contact with the child's parent of guardian upon removal of the child from their custody, offers the State-approved written documentation which outlines the Medicaid Program choices in an unbiased manner.
b. The Child Welfare Worker then documents the parent(s) or guardian's choice of Medicaid Program to the Enrollment Broker.
c. The business day after the Enrollment Broker notification, the enrollment package is mailed to the parent(s) or guardian.
d. The Enrollment Specialist will make up to three attempts to contact the parent(s) or guardian to offer additional counseling on Medicaid Program choices. This includes notification of the ability of the parent(s) or guardian to change their choice at any time.
e. The Children's Court will be engaged in determining the choice of Medicaid Program in instances when the parent(s) or guardian cannot be located or refuses to make a choice.

4. The State will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to the parent(s) or guardian.
   b. Informing the parent(s) or guardian about the voluntary nature of the program, including how to change their child's program participation at any time.
   c. Letting the parent(s) or guardian know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating the parent(s) or guardian about the benefits of participating in the alternative benchmark program, for example, improved communication and coordination between health care providers, child welfare and the parent(s) or guardian.
   e. Documenting all requests for enrollment or disenrollment.

5. The State will make direct mailings to the parent(s) or guardian informing them about the benefits of the alternative benchmark program and the option to enroll a child in the alternative benchmark program or to be covered through Fee-For-Service Medicaid.

6. The State will send written notification to the parent(s) or guardian and inform the health care coordinator and the Child Welfare Worker related to any change in Medicaid Program enrollment. The notification to the parent(s) or guardian will affirm their choice of Medicaid Program and will assure them that all Medicaid benefits and services remain available to their child. The State will include the number for the Enrollment Specialist, should the parent(s) or guardian have any follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) **X** Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to one or more of the three standard benchmark plans specified above or to the full State plan benefit.

The Alternative Benchmark Plan provides all benefits covered under the State Medicaid Standard Plan, as detailed below, as well as the additional services listed in "Section 2. c" of the SPA, "Additional Benefits". The additional benefits are focused on the specific needs of children in out of home care. A key component is health care coordination, including: (a) medical care plan development that addresses physical, dental and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intent is to link children with identified health needs to services and resources in a coordinated manner to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be child-centric, as well as trauma and evidence-informed. Service provision will include walk-in opportunities for specific, targeted care such as dental exams and sealants, as well as immunization clinics.

Covered Services — Both the Medicaid State Plan and the Alternative Benchmark Plan

- Case management services – Defined as Care Coordination in the Alternative Benchmark Plan
- Chiropractic services
- Dental services
- Directly observed therapy (DOT) for individuals with tuberculosis*
- Emergency services
- Family planning services and supplies

- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
  - Under 21 years of age
  - Under 22 years of age and was getting services when you turned 21 years of age
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Non-emergency transportation services*
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Pharmacy services*
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs*
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

* Under the Alternative Benchmark Plan, these services continue to be delivered on a fee-for-service basis.

The Medical Home provider will be required to establish a working relationship with the entities that are responsible for the services noted below, to ensure that services to the child are coordinated and to assure that duplication of service is avoided. The working relationship will be defined through memorandum of understanding, as well as the scope of services and responsibility for each entity.

- Community support program services

- Comprehensive community services
- Crisis intervention services
- School-Based Services
- Targeted Case Management Services

Further details about the Alternative Benchmark Plan include:

1. Benefits will be provided under a medical home framework that includes the following:

   a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to children in foster care;
   b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of children in out-of-home care. The team identifies the health needs of each child, creates a care plan, and ensures that each child is assigned a care coordinator;
   c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
   d. Services provided through open and flexible scheduling;
   e. Comprehensive transitional care as a child moves from one setting to another; and
   f. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of children in out-of-home care and on comprehensive care coordination, will assure a child-centric focus and continuity of care. Specifically, children may receive out-of-network care when it assures continuity with an existing service provider; it is needed to meet a child's unique needs; or the care is urgent. The care manager will collaborate with the family to identify providers who are experienced in meeting the needs of this population.

   A more streamlined prior authorization process will apply with respect to OT, PT, speech and mental health services. Specifically, the authorization for these services will be the responsibility of the Integrated Health System. The process is expected to be more efficient because of the care coordinator's role, as well as ease of access to all information needed to establish the medical necessity of the service. Additionally, timely delivery of identified services will be a quality measure for the Integrated Health System.

   The plan will attract providers by allowing enhanced, flexible services. Providers are expected to have an interest in working in a system which promotes best practices and individual child outcomes. The Integrated Health System may provide flexibility on location of services consistent with evidence-informed practices. For example, mental health services could be delivered in the home or another community-based setting, rather than in a clinic or hospital setting.

3. Providers will be required to ensure services under EPSDT based on best practices and each child's needs, including:

   a. Timely and trauma-informed screening, assessment and referral, including comprehensive mental health screening;
   b. Evidence informed and comprehensive interventions in children's mental and behavioral health;
   c. Mobile response and stabilization services for mental/behavioral health;
   d. Oversight of psychotropic medication, including pharmacist consultant services; and
   e. Enhanced schedule for physical, behavioral and dental care as necessary.

4. To ensure the continuity of care for these children, this plan will authorize participation for up to 12 months after a child exits out-of-home care. Continuation in the plan would be contingent on Medicaid eligibility and a judgment of necessity by the multidisciplinary care coordination team.

The State will ensure that the Foster Care Medical Home care coordination activities to be claimed under Medicaid will only include Medicaid allowable services and will not include activities that are part of the direct delivery of foster care services per the guidance in the State Medicaid Director's Letter #01-013.

b) ☐ Benchmark-Equivalent Benefits.
Please specify below which benchmark plan or plans this benefit package is equivalent to:

☐ (i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

☐ Inpatient and outpatient hospital services;

☐ Physicians' surgical and medical services;

☐ Laboratory and x-ray services;

☐ Coverage of prescription drugs;

☐ Mental health services;

☐ Well-baby and well-child care services as defined by the State/Territory, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

☐ Emergency services;

☐ Family planning services and supplies.

☐ (ii) Additional services
Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

☐ (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;

- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

  Please insert a copy of the report.

☐ (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75% of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) **X** Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Children in out-of-home care often have difficulty accessing appropriate medical and behavioral health care in the Medicaid fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many children in out-of-home care have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. This plan provides care coordination and enhanced services for children in out-of-home care in southeast Wisconsin, where over half of the children in out- of-home care are living. The plan includes all benefits, including EPSDT, under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these children:

- A medical home framework specific to children in out-of-home care:
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each child;
- Comprehensive dental services;
- As deemed necessary by the care coordination team, up to 12 months of continued eligibility for coverage under the plan when a child moves to permanent placement. Contingent on continued Medicaid eligibility.

The Department will certify one or more health systems to provide a medical home for children in the target population. A health system in this context means a group of physicians and other licensed medical practitioners that has a hospital affiliation. This could also include a physician practice affiliated with a hospital. The providers interested in being a health system for this Foster Care Medical Home Initiative will need to meet all certification criteria including robust provider network requirements.

3. Service Delivery System

Check all that apply.

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438. PIHPs will be paid on a non-risk basis.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures that prior to submitting this State plan amendment the State/Territory provided the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment and included in the notice a description of the method for complying with the provisions of §440.345 and sections 5006(e) of the American Recovery and Reinvestment Act of 2009, as required by §440.305(d). Please provide copies of public notices, publication dates and a list of any public meetings.

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

☐ Per §440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Certified health systems will be required to provide EPSDT services along with the other services paid for through the all-inclusive rate. The health care coordinator for each individual will be responsible to ensure that individuals have access to the full EPSDT benefit.

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

X Transportation is assured as under the Medicaid and BadgerCare Plus Standard Plans.

X The State/Territory assures that there is no significant difference in cost sharing or treatment limits between mental health/substance abuse disorder benefits and medical/surgical benefits.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

X The State/Territory assures that if the benchmark/benchmark-equivalent plan includes cost-sharing the State/Territory will comply with the cost-sharing rules under section 1916 and 1916(A) of the Act and 42 CFR §447.50-82, and has described such cost sharing in section 4.18 of the State plan.

X The State assures that services included under the alternative benchmark plan will not duplicate services that are required under other authorities, such as Title IV-E of the Social Security Act.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

DHS Note: See MMDL forms APB1-10 for current information.

State/Territory: Wisconsin

8. Implementation Date

The State/Territory will implement this State/Territory Plan amendment on __July 1, 2012_____ *(date).*