Revision: HCFA-PM-91-1991 (MB)

ATTACHMENT 3.1-F
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State/Territory: WISCONSIN

COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES PROVIDED TO THE DEVELOPMENTALLY DISABLED

1. Personal assistance.

   Provided*: X Not Provided: ___

2. Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

   Provided*: ___ Not Provided: X

3. 24-hour emergency assistance (as defined by the Secretary).

   Provided*: X Not Provided: ___

4. Assistive technology.

   Provided*: ___ Not Provided: X

5. Adaptive equipment.

   Provided*: X Not Provided: ___

6. Support services necessary to aid an individual to participate in community activities.

   Provided*: ___ Not Provided: X

*In accordance with the requirements specified in approved form HCFA-322.

TN No. 92-0003
Supersedes
TN No. NEW

Approval Date JUN 29 1992
Effective Date 1-1-92

Substitute page submitted on 4-14-92

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State/Territory: WISCONSIN

7. Other services (listed below)*:

a) Daily living skills training

b) Communication Aids

c) Housing Modifications

d) Respite

e) Counseling and therapeutic resources

f) Specialized transportation

*In accordance with the requirements specified in approved form HCFA-322.

TN No. 92-0003
Supercedes
TN No. NEW

Approval Date JUN 29 1992
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Substitute page submitted on 4-14-92

State: Wisconsin

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Wisconsin enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ✓ MCO
   a. ✓ Capitation
   b. ✓ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

Citation	Condition or Requirement

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

_____

_____

42 CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

The State has established a process to involve the public in both the design and implementation of the SSI-Medicaid Managed Care Program. In 2015 the Department established a Community Advisory Committee (CAC) that consists of disability advocates, medical and mental health providers, and federally qualified health centers (FQHCs), minority coalitions, culturally competent organizations, and housing agencies. The CAC meetings are scheduled on a monthly basis and

State: Wisconsin

Citation	Condition or Requirement

C. Public Process, continued.

last 2 hours. The CAC has provided the Department direct input on the design and implementation of the managed care expansion project include the MCO contracts, State Plan Amendment, and member communications. The CAC will remain intact during and following the implementation to assist the Department in monitoring and making adjustments. Additionally, during the implementation phase the Department will hold public town hall meetings throughout the state.

Member letters will be mailed prior to the implementation of each area in the state and will inform members of the changes and invite them to attend the town hall meetings. While Native Americans and Tribal members are not impacted by this change the Department nevertheless consulted with the tribes.

If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee. (42 CFR 438.70 and 438.110)

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ✓ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ✓ The state assures that all the applicable requirements of section 1932 [including subpart (a)(1)(A)] of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4. ✓ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ✓ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

State: Wisconsin

Citation	Condition or Requirement
	D. State Assurances and Compliance with the Statute and Regulations, continued.
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ✓ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ✓ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
42 CFR 440.262	9. ✓ The State assures that all requirements of 42 CFR 440.262 to have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries are met.
45 CFR 75.326	10. ✓ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	11. Assurances regarding state monitoring requirements: ✓ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. ✓ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. ✓ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

State: Wisconsin

Citation	Condition or Requirement
1932(a)(1)(A) 1932(a)(2)	E. Populations and Geographic Area. 1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			STATEWIDE	
2. Pregnant Women	§435.116	X			STATEWIDE	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			STATEWIDE	
4. Former Foster Care Youth (up to age 26)	§435.150	X			STATEWIDE	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			STATEWIDE	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			STATEWIDE	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			STATEWIDE	

State: Wisconsin

Citation	Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	M			STATEWIDE	
9. Aged and Disabled Individuals in 209(b) States	§435.121					
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X				
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X				
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138			X		
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA		X			
14. Disabled Adult Children	1634(c) of SSA	X				

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. ~~Optional Parents and Other Caretaker Relatives~~	~~§435.220~~					
2. ~~Optional Targeted Low-Income Children~~	~~§435.229~~	X				
3. ~~Independent Foster Care Adolescents~~ Under Age 21	~~§435.226~~			E		
4. ~~Individuals Under Age 65 with Income~~ Over 133%	~~§435.218~~					
5. ~~Optional Reasonable Classifications of~~ Children Under Age 21	~~§435.222~~	X				
6. ~~Individuals Electing COBRA~~ Continuation Coverage	~~1902(a)(10)(F) of~~ SSA			E		

State: Wisconsin

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230	X				
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X				
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			E		
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616	§435.234					
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236			E		
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			E		
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA	X				
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA	X				
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA		X			
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA			E		
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219			E		

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X		
22. Individuals with Tuberculosis	§435.215			X		
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X		

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)	X				
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)	X				
3. Medically Needy Children Age 18 through 20	§435.308	X				
4. Medically Needy Parents and Other Caretaker Relatives	§435.310	X				
5. Medically Needy Aged	§435.320	X				
6. Medically Needy Blind	§435.322	X				
7. Medically Needy Disabled	§435.324	X				
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					

State: Wisconsin

Citation	Condition or Requirement

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

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

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

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

State: Wisconsin

Citation

Condition or Requirement

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

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance.	V		
Reside in **Nursing Facility or ICF/IID**--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		E	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program.		E	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.			
Participate in **HCBS** Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		E	
Retroactive Eligibility-Medicaid beneficiaries for the period of retroactive eligibility.		E	
Other (Please define): Stem cell or bone marrow transplant recipient or sickle cell disease gene therapy participant		E	The State may allow certain beneficiaries to be excluded from the program for a short-term basis as determined appropriate by the State.

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program [see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)], please complete the below

1. For **voluntary** enrollment: [see 42 CFR 438.54(c)]
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.lO(e) and 42 CFR 438.54(c)(3).

   New enrollees who may voluntarily enroll in managed care are provided with a notice and enrollment packet upon determination of eligibility which contain the information required in 42 CFR 438.10(c)(4), 42 CFR 438.lO(e) and 42 CFR 438.54(c)(3).

State: Wisconsin

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

State: Wisconsin

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

State: Wisconsin

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

State: Wisconsin

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

State: Wisconsin

Citation	Condition or Requirement
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. ✓ The state assures that each MCO has established an internal grievance and appeal system for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity.
	✓ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.
	✓ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.
	✓ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.
	✓ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.
	✓ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ✓ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ✓ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option.
	To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.
	1. The state will ☐/will not ✓ intentionally limit the number of entities it contracts under a 1932 state plan option.
	2. ☐ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
	3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)
	4. ✓ The selective contracting provision is not applicable to this state plan.

State: Wisconsin

Citation	Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Wisconsin enrolls Medicaid beneficiaries on a ~~mandatory~~ voluntary basis into managed care entities (managed care organization [MCOs] ~~primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority.~~ This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to ~~require~~ allow certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future.
Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒ MCO
   a. ☒ Capitation
   b. ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c ☐ Other (please explain below)

   If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:
   ☐ Provision of intensive telephonic case management
   ☐ Provision of face-to-face case management
   ☐ Operation of a nurse triage advice line
   ☐ Development of enrollee care plans.
   ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS

Citation	Condition or Requirement

program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

42 CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

This updated SPA continues the fully integrated Medicaid/Medicare Family Care Partnership Program. Originally authorized under 1115 waiver authority, Medicaid authority was changed to a 1932 (a) SPA coupled with the Family Care Program's 1915 (c) waiver made applicable to the Family Care Partnership Program effective 01/01/2008. This updated version of the 1932 (a) SPA follows the new preprint.

The Family Care Partnership Program integrates primary and acute care with long-term care for adults (ages 18 and over) with a physical or intellectual disability who meet an institutional level of care. A broad spectrum of stakeholders participated in the initial design of the program, including consumers, advocates, providers and their associations, legislators, county government and representatives of all State agencies involved in providing services to individuals needing long term care. The Wisconsin Council on Long Term Care then provided public input into design, implementation and monitoring of the Family Care Partnership Program and other publicly funded long-term care programs, advising the State Medicaid Agency (SMA) on these matters until 2012. The Council had broad stakeholder representation and a majority of its 20-25 members were consumers or their representatives or from advocacy agencies. It reserved time on each agenda to hear concerns from the public.

The Council was replaced in 2012 by the Wisconsin Long term Care Advisory

Citation	Condition or Requirement

Council. This body provides oversight of the public long-term care system and advice to the SMA on all public long-term care programs and related issues. It meets every two months. The Advisory Council is composed of representatives of organizations and disciplines related to long-term care with substantial consumer and advocacy agency representation. Current membership includes: the Wisconsin Assisted Living Association; the Board on Aging and Long Term Care; the Wisconsin Council on Physical Disabilities; the Aging and Disability Resource Center (ADRC) of Barron, Rusk and Washburn counties; Inclusa MCO; the Management Group; the Alzheimer's Association of Southeastern Wisconsin; Disability Rights Wisconsin; the Greater Wisconsin Agency on Aging Resources; the Wisconsin County Human Services Association; UW Waismen Center; Eau Claire School District; the Wisconsin Brain Injury Advisory Council; the Lac Courte Oreilles Tribal Government; the Wisconsin Coalition of Independent Living Centers; the Wisconsin Health Care Association; LeadingAge Wisconsin; and three independent beneficiary advocates.

At the plan level, each MCO offering the Family Care Partnership Program has a governing board which is required to have at least 25% consumer representation and beginning in 2018 each will also have a separate member advisory committee. In addition the SMA contracts with aging and disability resource centers independent of the MCOs. ADRCs are responsible for providing options and enrollment counseling and processing enrollments in MCOs, making ADRCs well situated to report issues to the SMA. The SMA also contracts with independent entities to provide ombudsman assistance to enrollees. Information from these entities is another source of public input and monitoring.

To carry out its tribal consultation responsibilities the SMA meets with Tribal Health Directors and designees of Indian Health Service and Urban Indian Organizations during each quarter to discuss state plan amendments before they are submitted to CMS. Accordingly, The SMA consulted with tribes regarding this SPA at the November 8, 2018 Tribal Health Directors meeting.

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ☒ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)

42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR Part 438 1903(m)	6. ☒ The state assures that all applicable requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: ☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met
1932(a)(1)(A) 1932(a)(2)	E. <u>Populations and Geographic Area.</u> 1. **<u>Included Populations.</u>** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

Citation | Condition or Requirement

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110		V		* See after Sec. E	**See after Sec. E
2. Pregnant Women	§435.116		V		* See after Sec. E	**See after Sec. E
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118		V		* See after Sec. E	**See after Sec. E
4. Former Foster Care Youth (up to age 26)	§435.150		V		* See after Sec. E	**See after Sec. E
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119					N/A
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2)		V		* See after Sec. E	**See after Sec. E
7. Extended Medicaid Due to Spousal Support Collections	§435.115		V		* See after Sec. E	**See after Sec. E

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120		V		* See after Sec. E	**See after Sec. E
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135		V		* See after Sec. E	**See after Sec. E
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137		V		* See after Sec. E	**See after Sec. E
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138		V		* See after Sec. E	**See after Sec. E
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q)		V		* See after Sec. E	**See after Sec. E
14. Disabled Adult Children	1634(c)		V		* See after Sec. E	**See after Sec. E

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229		V		* See after Sec. E	**See after Sec. E
3. Independent Foster Care Adolescents Under Age 21	§435.226		V		* See after Sec. E	**See after Sec. E
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
5. Optional Reasonable Classifications of Children Under Age 21	§435.222		V		* See after Sec. E	**See after Sec. E
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F)					N/A

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230		V		* See after Sec. E	**See after Sec. E
8. Individuals eligible for Cash except for Institutionalized Status	§435.211		V		* See after Sec. E	**See after Sec. E
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217		V		* See after Sec. E	**See after Sec. E
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232		V		* See after Sec. E	**See after Sec. E
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236		V		* See after Sec. E	**See after Sec. E
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			E		
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA		V		* See after Sec. E	**See after Sec. E
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1)					N/A
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII)		V		* See after Sec. E	**See after Sec. E
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV)					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI)					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX)					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			E		
22. Individuals with Tuberculosis	§435.215			E		
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			E		

C. Medically Needy

Eligibility Group	Citation	M	V	E	Geographic Area	Notes

Citation | Condition or Requirement

	(Regulation [42 CFR] or SSA)				(include specifics if M/V/E varies by area)	
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)		V		* See after Sec. E	**See after Sec. E
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			E		
3. Medically Needy Children Age 18 through 20	§435.308		V		* See after Sec. E	**See after Sec. E
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320		V		* See after Sec. E	**See after Sec. E
6. Medically Needy Blind	§435.322		V		* See after Sec. E	**See after Sec. E
7. Medically Needy Disabled	§435.324		V		* See after Sec. E	**See after Sec. E
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

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

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

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s)		E		
"Dual Eligibles" – not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare		V		* See after Sec. E	**See after Sec. E Dual eligibles must also enroll in the managed care entity's Partnership Medicare D-SNP.
American Indian/Alaskan Native – Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	V		* See after Sec. E	**See after Sec. E
Children Receiving SSI who are Under Age 19 – Children under 19 years of age who are eligible for SSI under title XVI	§435.120	V		* See after Sec. E	**See after Sec. E
Qualified Disabled Children Under Age 19 – Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3)	V		* See after Sec. E	**See after Sec. E
Title IV-E Children – Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	V		* See after Sec. E	**See after Sec. E
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	V		* See after Sec. E	**See after Sec. E

Citation | Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Children with Special Health Care Needs – Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.			E		

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

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

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

***Geographic Area – Family Care Partnership Program is Currently Available In These 14 Counties:** Calumet, Columbia, Dane, Dodge, Jefferson, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Sauk, Washington, Waukesha, Waupaca. The SMA may procure for expansion of the Family Care Partnership Program to any other county in the State.

****Notes** – To be eligible for the Family Care Partnership Program persons must be in an included eligibility group, be age 18 or older, and be determined to need the level of care required under the State Medicaid plan for coverage of nursing home or ICF/IID services.

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.
~~Based on whether m~~andatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR

Citation	Condition or Requirement

438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      The SMA has developed standardized definitions of managed care terminology, a model member handbook and standardized notices which managed care entities are contractually obligated to use and make available (438.10(c)(4)).

      The SMA contracts with Aging and Disability Resource Centers (ADRCs) in each service area to provide information to potential enrollees. ADRCs use standardized materials that meet the informational requirements for explaining the basic features of the SMA's LTSS managed care programs (438.10(e)). ADRCs also use standardized informational materials to explain to those newly eligible their enrollment options and how to exercise them as well as the implications of not making an active decision, especially for those in the §435.217 eligibility group whose Medicaid eligibility is contingent on enrollment (438.54(c)(3)).

      States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☒ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

      i. Please indicate the length of the enrollment choice period:
      The enrollment choice period is open-ended as long as the person continues to meet all conditions of eligibility for enrollment. During the enrollment choice period Medicaid eligible persons may continue to receive covered State plan services through the FFS delivery system. Once all conditions for eligibility and enrollment are established, the enrollment broker will customarily contact the potential enrollee within five (5) business days to determine his or her enrollment choice.

   c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

      i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
      ii. Please indicate how long the enrollee will have to disenroll from the

Citation	Condition or Requirement

plan and return to the fee-for-service delivery system:

_____

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).
   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
      i. Please indicate the length of the enrollment choice period:

      _____

   c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

   d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

   Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

   a. ☐ The state assures that, per the choice requirements in 42 CFR 438.52:

      i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
      ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
      iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

      ☒ This provision is not applicable to this 1932 State Plan Amendment

42 CFR 438.52

   b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

      ☒ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

42 CFR 438.56(g)

c. ☐ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
☒ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

G. Disenrollment.

1932(a)(4)
42 CFR 438.56

1. The state will ☐/ will not☒ limit disenrollment for managed care.

2. The disenrollment limitation will apply for _____ (up to 12 months).

3. ☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*
Members can request disenrollment from Family Care Partnership at any time without cause, not only during the first 90 days after enrollment. The SMA sends all members an annual notice informing them of their right to disenroll, explaining how to do so and how to learn about other program options for long-term care and medical care.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1. List all benefits for which the MCO is responsible.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

Family Care-Partnership MCOs provide all medically necessary services identified in Attachment 3.1A Supplement 1, with the following exceptions as these services are provided FFS:

- **Behavioral treatment services**
- **Comprehensive community services**
- **Community recovery services**
- **Prenatal care coordination**
- **School-based services**
- **Medication therapy management**
- **Tuberculosis-related services**
- **Covered outpatient drugs that are not reimbursable as part of the rate paid for a physician office visit or a stay in a hospital or nursing home**
- **Prescription drugs administered by a physician as part of a physician office visit or incident to a physician's service**

The Family Care-Partnership MCO is also responsible for providing medically

Citation	Condition or Requirement

necessary services identified in the § 1915(c) home and community based waiver identified in Appendix C1 of the Family Care waiver (WI-0367).

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity.

☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

1932(c)(1)(A)
42 CFR 438.330
42 CFR 438.340

L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.

1932(c)(2)(A)
42 CFR 438.350
42 CFR 438.354
42 CFR 438.364
1932(a)(1)(A)(ii)

M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.

Citation	Condition or Requirement

N. Selective Contracting Under a 1932 State Plan Option.

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ☒/will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*
The number of entities the SMA will contract with in a service area is based upon an actuarial analysis of the projected number of enrollees needed to allow an MCO to manage risk and remain financially viable in comparison to the total number of potential enrollees in that service area.

4. ☐ The selective contracting provision is not applicable to this state plan.

Citation	Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at §438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in §438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)

Citation | Condition or Requirement

Compliance Dates	Sections
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

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 0938-0933. The time required to complete this information collection is estimated to average 10 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

CMS-10120 (exp. TBD – currently 4/30/17)