State: Wisconsin

MACPro Forms

Medicaid State Plan Administration

General Administration

Reporting

Package Header

Package ID	WI2024MS0007O	**SPA ID**	WI-24-0023
Submission Type	Official	**Initial Submission Date**	12/20/2024
Approval Date	01/02/2025	**Effective Date**	12/31/2024
Superseded SPA ID	NEW		
	User-Entered		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

☐ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

☐ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.

☐ 2. The agency reports annually, by December 31, on:

a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

This view was generated on 1/7/2025 12:33 PM EST

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2024MS0005O | WI-24-0010

Package Header

Package ID	WI2024MS0005O	**SPA ID**	WI-24-0010
Submission Type	Official	**Initial Submission Date**	6/28/2024
Approval Date	09/20/2024	**Effective Date**	3/1/2024
Superseded SPA ID	WI-18-0005		
	System-Derived		

A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

(•) 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

( ) 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

( ) 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID WI2025MS0001O
SPA ID WI-25-0005
Submission Type Official
Initial Submission Date 3/31/2025
Approval Date 06/09/2025
Effective Date 1/1/2025
Superseded SPA ID WI-24-0010
System-Derived

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☐	☐	◯	CONVERTED
Parents and Other Caretaker Relatives		☐	☐	◯	CONVERTED
Pregnant Women		☐	☐	◯	CONVERTED
Deemed Newborns		☐	☐	◯	APPROVED
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☐	☐	◯	NEW
Former Foster Care Children		☐	☐	◯	APPROVED
Transitional Medical Assistance		☐	☐	◯	NEW
Extended Medicaid due to Spousal Support Collections		☐	☐	◯	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☐	☐	◯	NEW
Closed Eligibility Groups		☐	☐	◯	NEW
Individuals Deemed To Be Receiving SSI		☐	☐	◯	NEW
Working Individuals under 1619(b)		☐	☐	◯	NEW
Qualified Medicare Beneficiaries		☐	☐	◯	APPROVED
Qualified Disabled and Working Individuals		☐	☐	◯	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Specified Low Income Medicare Beneficiaries		☐	☐	○	APPROVED
Qualifying Individuals		☐	☐	○	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
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Superseded SPA ID	WI-24-0010		
	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

◯ Yes ◉ No

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
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Superseded SPA ID	WI-24-0010		
	System-Derived		

The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.

2. Have income and resources at or below the standard for this group.

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

☐ Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

☐ A specified type of income is disregarded:

Name of income type:	Description:
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
Amounts Deemed to Children	Deeming to other eligible children an ineligible parent's income in excess of that which makes one child ineligible. Deemed parental income is equally split among siblings and no further computations are done.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise

Name of income type:	Description:
	excluded under federal law (e.g., P.L. 98-64).
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

[ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are disregarded as a resource.

Name of disregard:	Description:
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded as an asset for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
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	System-Derived		

C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
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	System-Derived		

The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.

2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

[ ] Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
Amounts Deemed to Children	Deeming to other eligible children an ineligible parent's income in excess of that which makes one child ineligible. Deemed parental income is equally split among siblings and no further computations are done.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise

Name of income type:	Description:
	excluded under federal law (e.g., P.L. 98-64).
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

[ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are disregarded as a resource.

Name of disregard:	Description:
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded as an asset for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

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Approval Date	06/09/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0010		
	System-Derived		

C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
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Approval Date	06/09/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0010		
	System-Derived		

The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.

2. Are not otherwise eligible for Medicaid under the state plan.

3. Have income below the income standard and resources at or below the resource standard for this group.

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System-Derived

B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

[ ] Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Guaranteed Income Programs	Means-tested, "guaranteed income" payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
Amounts Deemed to Children	Deeming to other eligible children an ineligible parent's income in excess of that which makes one child ineligible. Deemed parental income is equally split among siblings and no further computations are done.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not

Name of income type:	Description:
	received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise excluded under federal law (e.g., P.L. 98-64).

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

[ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are disregarded as a resource.

Name of disregard:	Description:
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded as an asset for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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	System-Derived		

C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID WI2019MS0003O
SPA ID WI-19-0011
Submission Type Official
Initial Submission Date 9/30/2019
Approval Date N/A
Effective Date 9/1/2019
Superseded SPA ID WI-00-004
User-Entered

A. Income Level Used

1. The state employs a single income level for the medically needy.

2. The income level varies based on differences between shelter costs in urban and rural areas.

- ○ Yes
- ◉ No

3. The level used is:

Household size	Standard
1	$591.67
2	$591.67
3	$689.33
4	$822.67
5	$944.00
6	$1021.33
7	$1105.33
8	$1172.00
9	$1226.67
10	$1257.33

The state uses an additional incremental amount for larger household sizes.

- ◉ Yes
- ○ No

Incremental Amount:

$26.67

The dollar amounts increase automatically each year

- ○ Yes
- ◉ No

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID	WI2019MS0003O	**SPA ID**	WI-19-0011
Submission Type	Official	**Initial Submission Date**	9/30/2019
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Superseded SPA ID	WI-00-004		
	User-Entered		

B. Basis for Income Level

1. Minimum Income Level

The minimum income level for this eligibility group is the lower of the state's July 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

2. Maximum Income Level

The maximum income level for this eligibility group is 133 1/3 percent of the higher of the state's 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID WI2019MS0003O
SPA ID WI-19-0011
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C. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID	WI2019MS0003O	**SPA ID**	WI-19-0011
Submission Type	Official	**Initial Submission Date**	9/30/2019
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Superseded SPA ID	WI-91-0031, WI-14-021 User-Entered		

If countable income exceeds the income standard, the state must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party, in accordance with 42 CFR 435.831 and 42 CFR 435.121.

A. Budget Periods

Income in excess of the appropriate income standard is considered available for payment of medical or remedial care expenses in budget periods that do not exceed six months.

1. In determining income eligibility, countable income is reduced by the amount of incurred medical or remedial care expenses during the budget period specified below:

- (●) a. One budget period of:
  - (●) i. 6 months
  - ( ) ii. 5 months
  - ( ) iii. 4 months
  - ( ) iv. 3 months
  - ( ) v. 2 months
  - ( ) vi. 1 month
- ( ) b. More than one budget period, as described below:

2. The state includes part or all of the retroactive period in the budget period.

- (●) Yes
- ( ) No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID	WI2019MS0003O	**SPA ID**	WI-19-0011
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	User-Entered		

B. Types of Eligible Expenses

1. In determining incurred expenses to be deducted from income, the state includes:

a. Medicare, Medicaid, and other health insurance premiums and enrollment fees.

b. Cost sharing, including copayments, coinsurance, and deductibles, imposed by Medicare, Medicaid or other health insurance.

c. Expenses for necessary medical and remedial services recognized by state law but not included in the state plan.

d. Expenses for necessary medical and remedial services included in the state plan, including those that exceed limitations on the amount, duration, and scope of services.

2. The state also includes medical institutional expenses projected to the end of the budget period at the Medicaid reimbursement rate.

- (●) Yes
- ( ) No

3. Incurred expenses subject to payment by a third party are not deducted unless the third party is a public program (other than Medicaid) of a state and the program is financed by the state.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

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	User-Entered		

C. Timeframe of Deduction of Expenses

In determining incurred expenses to be deducted from income, the state deducts:

1. For retroactive budget periods and a budget period that includes both retroactive and prospective budget, the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses, which have not been deducted previously in establishing eligibility, and were incurred:

- (●) i. At any time prior to the budget period.
- ( ) ii. Prior to the third month before the month of application, but no earlier than:
- ( ) iii. No earlier than the third month before the month of application.

2. For prospective budget period(s), the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses that are carried over from the prior budget period and have not been deducted previously in establishing eligibility.

Handling of Excess Income (Spenddown)

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D. Order of Deduction of Expenses

Incurred medical or remedial care expenses are deducted in the following order:

◉ 1. By the type of service, in the following order:

a. Premiums, deductibles, coinsurance and co-payments.

b. Expenses for necessary medical or remedial care services that are recognized under state law but not included in the State Plan.

c. Expenses for necessary medical or remedial care services that are included in the state Plan that exceed agency limitations on amount, duration, or scope of services.

d. Expenses for necessary medical or remedial care services that are included in the state Plan that are within the agency limitations on amount, duration, or scope of services.

○ 2. In chronological order by the date of the service, or the date cost sharing payments are due.

○ 3. In chronological order by the date the bill is submitted to the state by the individual.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

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	User-Entered		

E. Reasonable Limitations

The state sets reasonable limits on the amount to be deducted for expenses.

- ○ Yes
- ◉ No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

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	User-Entered		

F. Spenddown Payments Made by Individuals

The state permits individuals to pay-in their spenddown liability.

- (●) Yes
- ( ) No

1. The state provides all individuals with the option to pay-in their spenddown or to use incurred expenses for spenddown.

2. The state disburses to the individual amounts for services not covered under the state plan.

3. The state refunds unused pay-in amounts, as follows:

- [x] a. The state refunds unused pay-in amounts on a case-by-case basis.
- [ ] b. The state applies unused pay-in amounts toward spenddown liability in a subsequent budget period on a case-by-case basis.

4. If the state uses a budget period of greater than one month:

- ( ) a. The state requires payment of the entire spenddown liability for the budget period.
- (●) b. The state permits the individual to make monthly installment payments toward the spenddown liability.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

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	User-Entered		

G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

Package ID	WI2019MS0003O	**SPA ID**	WI-19-0011
Submission Type	Official	**Initial Submission Date**	9/30/2019
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Superseded SPA ID	WI-91-0031		
	User-Entered		

A. Medically Needy Resource Level Structure

1. The state employs a single resource level for the medically needy.

2. The resource level is equal to or higher than the lowest resource standard used under the most closely related cash assistance program.

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

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User-Entered

B. Resource Level Used

The level used is:

Household size	Standard
1	$2000.00
2	$3000.00
3	$3300.00

The state uses an additional incremental amount for larger household sizes.

- (●) Yes
- ( ) No

Incremental Amount:

$300.00

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0003O | WI-19-0011

Package Header

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C. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WI2018MS0003O | WI-18-0005

Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and were in foster care when they turned age 18 or aged out of foster care.

Package Header

Package ID	WI2018MS0003O	**SPA ID**	WI-18-0005
Submission Type	Official	**Initial Submission Date**	4/5/2018
Approval Date	6/13/2018	**Effective Date**	1/1/2018
Superseded SPA ID	WI-13-0021		
	System-Derived		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group

B. Individuals Covered

1. The state covers individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) and were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act.

2. Additionally, the state covers individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☑ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☑ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | WI2018MS0003O | WI-18-0005

Package Header

Package ID	WI2018MS0003O	**SPA ID**	WI-18-0005
Submission Type	Official	**Initial Submission Date**	4/5/2018
Approval Date	6/13/2018	**Effective Date**	1/1/2018
Superseded SPA ID	WI-13-0021		
	System-Derived		

C. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID WI2025MS0001O
SPA ID WI-25-0005
Submission Type Official
Initial Submission Date 3/31/2025
Approval Date 06/09/2025
Effective Date 1/1/2025
Superseded SPA ID WI-25-0006A
User-Entered

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance		☐	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	CONVERTED
Optional Targeted Low Income Children		☐	☐	○	CONVERTED
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	CONVERTED
Individuals with Tuberculosis		☐	☐	○	CONVERTED
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	APPROVED

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	APPROVED
Optional State Supplement Beneficiaries		☐	☐	○	APPROVED
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	APPROVED
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	APPROVED
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	☐	○	APPROVED
Ticket to Work Basic		☐	☐	○	NEW
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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User-Entered

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☐	☐	○	APPROVED
Medically Needy Children under Age 18		☐	☐	○	APPROVED

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☐	☐	○	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals who are eligible for but not receiving federal cash assistance or an optional state supplement.

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Superseded SPA ID	WI-24-0010		
	System-Derived		

The state covers the optional Individuals Eligible for but Not Receiving Cash Assistance eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet the eligibility requirements of at least one of the following cash assistance programs:

- [ ] a. SSI
- [ ] b. Optional State Supplement
- [ ] c. AFDC

2. Do not receive cash assistance under these programs.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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Superseded SPA ID	WI-24-0010		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Individuals Eligible for but Not Receiving Cash Assistance

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System-Derived
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C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

[ ] Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
Amounts Deemed to Children	Deeming to other eligible children an ineligible parent's income in excess of that which makes one child ineligible. Deemed parental income is equally split among siblings and no further computations are done.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These

Name of income type:	Description:
	payments are not otherwise excluded under federal law (e.g., P.L. 98-64).
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.

4. Less restrictive methodologies are used in calculating countable resources.

- (●) Yes
- ( ) No

The less restrictive resource methodologies are:

- [ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately

Name of disregard:	Description:
	funded, non-profit organizations are disregarded as a resource.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded as an asset for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals Eligible for but Not Receiving Cash Assistance

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	System-Derived		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for but Not Receiving Cash Assistance

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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	System-Derived		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals who would be eligible for federal cash assistance or an optional state supplement, except for institutionalization.

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Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
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	System-Derived		

The state covers the optional Individuals Eligible for Cash Except for Institutionalization eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are in a medical institution.

2. Would meet the eligibility requirements for at least one of the following cash assistance programs, but for the lower income standards used to determine eligibility for institutionalized individuals:

- [ ] a. SSI
- [ ] b. Optional State Supplement
- [ ] c. AFDC

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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Submission Type	Official	**Initial Submission Date**	3/31/2025
Approval Date	06/09/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0010		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (●) Yes
- ( ) No

Individuals Eligible for Cash Except for Institutionalization

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Package ID WI2025MS0001O
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C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

[ ] Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise excluded under federal law (e.g., P.L. 98-64).
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.

4. Less restrictive methodologies are used in calculating countable resources.

- (•) Yes
- ( ) No

The less restrictive resource methodologies are:

- [ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Medicare Advantage Special Supplemental Benefits	Medicare Advantage Special Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

- [ ] The state uses a less restrictive methodology with respect to resources set aside for burial.
  - [ ] Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable,

Name of methodology:	Description:
	$1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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	System-Derived		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0004O | WI-20-0013

Individuals who would be eligible for Medicaid if they were in an institution and who receive home and community-based services.

Package Header

Package ID WI2020MS0004O

Submission Type Official

Approval Date 11/6/2020

Superseded SPA ID WI-15-004; Att 2.2-A B.4
User-Entered

SPA ID WI-20-0013

Initial Submission Date 6/30/2020

Effective Date 7/1/2020

The state operates the Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would be eligible for Medicaid if in a medical institution.

2. But for the provision of home and community-based services under a waiver granted under section 1915(c), (d) or (e) of the Act:

   a. For waivers granted under 1915(c), the individuals would otherwise require the level of care furnished in a hospital, a nursing facility or an intermediate care facility for individuals with intellectual disabilities.

   b. For waivers granted under 1915(d) or (e), the individuals would otherwise require the level of care furnished in a hospital or nursing facitlity.

3. Will receive the waivered services.

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0004O | WI-20-0013

Package Header

Package ID WI2020MS0004O
SPA ID WI-20-0013
Submission Type Official
Initial Submission Date 6/30/2020
Approval Date 11/6/2020
Effective Date 7/1/2020
Superseded SPA ID WI-15-004; Att 2.2-A B.4
User-Entered

B. Income and Resource Methodologies

1. The income and resource methodologies used for this group are those used to determine eligibility for a state plan group under which the individual would be eligible if in an institution.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

[ ] Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

[ ] A specified type of income is disregarded:

Name of income type:	Description:
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.

3. Less restrictive methodologies are used in calculating countable resources.

( ) Yes
(•) No

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0004O | WI-20-0013

Package Header

Package ID WI2020MS0004O

Submission Type Official

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SPA ID WI-20-0013

Initial Submission Date 6/30/2020

Effective Date 7/1/2020

C. Income and Resource Standards

The income and resource standards used for this group are those used to determine eligibility for a state plan group under which the individual would be eligible if in an institution.

Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0004O | WI-20-0013

Package Header

Package ID WI2020MS0004O

Submission Type Official

Approval Date 11/6/2020

Superseded SPA ID WI-15-004; Att 2.2-A B.4

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SPA ID WI-20-0013

Initial Submission Date 6/30/2020

Effective Date 7/1/2020

D. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals who are in medical institutions for at least 30 consecutive days who are eligible under a special income level.

Package Header

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	System-Derived		

The state covers Individuals in Institutions Eligible under a Special Income Level in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have been in a medical institution for at least 30 consecutive days.

2. Have income at or below a standard described in section D.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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Superseded SPA ID	WI-24-0010		
	System-Derived		

B.Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (●) Yes
- ( ) No

Individuals in Institutions Eligible under a Special Income Level

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C. Financial Methodologies

1. In calculating household income, the methodologies of the most closely related cash assistance program are used, except that disregards are not applied.

2. In calculating household resources, the methodologies of the most closely related cash assistance program are used Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☐ General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Medicare Advantage Special Supplemental Benefits	Medicare Advantage Special Supplemental Benefits are disregarded as a resource.

Name of disregard:	Description:
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals in Institutions Eligible under a Special Income Level

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D. Income Standard Used

The income standard for this group is:

- (•) 1. 300% of the SSI Federal Benefit Rate (FBR) for an individual
- ( ) 2. Other lower income level

Individuals in Institutions Eligible under a Special Income Level

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E.Resource Standard Used

The resource standard for this group is the one used for the most closely-related cash assistance program.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

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F.Additional Information (optional)

Eligibility Groups - Options for Coverage

Work Incentives

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals with a disability with income below 250% of the FPL, who would qualify for SSI except for earned income.

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	System-Derived		

The state covers the optional Work Incentives eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have earned income.

2. Meet the SSI definition of disability, but for earned income.

3. Meet income and resource standards following a two-step process, which includes:

    a. Step One - A comparison of family net income to 250% FPL; and

    b. Step Two - A comparison of individual net income and resources to the SSI standards, excluding earned income.

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B. Step One Financial Methodologies and Income Test

1. Financial methodologies

a. SSI methodologies are used in calculating family income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

- (•) Yes
- ( ) No

The less restrictive income methodologies are:

☐ Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

☐ A specified type of income is disregarded:

Name of income type:	Description:
Guaranteed Income Programs	Means-tested, "guaranteed income" payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member's deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from

Name of income type:	Description:
	tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise excluded under federal law (e.g., P.L. 98-64).
Excessive Medical and Remedial Expenses	Monthly out-of-pocket medical and remedial expenses incurred by a work incentives applicant or member (or his or her spouse, if living together), if greater than $500, are completely disregarded.

☐ Specific income changes are disregarded between redeterminations.

☐ Income increases due to the cost of living adjustment received from Social Security are disregarded.

Description: The annual COLA is disregarded until the month following the month in which the new federal poverty levels are published.

2. Income Test

Family net income must be less than 250% FPL. Please refer as necessary to Non-MAGI Methodologies for the definition of family size.

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C. Step Two Financial Methodologies and Income/Resource Test

1. Financial methodologies

a. SSI methodologies are used in calculating income and resources, except that earned income is not counted. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

- (•) Yes
- ( ) No

The less restrictive income methodologies are:

- [ ] Income from household members is disregarded.
  - [ ] Income of the spouse is disregarded.
    Description: All income of the spouse is disregarded when determining whether or not the individual meets the financial eligibility requirements for the SSI program.
- [ ] The total amount of unearned income is disregarded.
  Description of disregard: All of an individual's unearned income shall be disregarded when determining whether or not the individual meets the financial eligibility requirements for the SSI program.

c. Less restrictive methodologies are used in calculating countable resources.

- (•) Yes
- ( ) No

The less restrictive resource methodologies are:

- [ ] A dollar amount of resources in excess of the resource standard is disregarded.
  The disregard equals: $13000.00
- [ ] Resources from household members are disregarded.
  - [ ] Resources of the spouse are disregarded.
    Description: All resources of the individual's spouse are disregarded.
- [ ] General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.

Name of disregard:	Description:
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	A resource disregard shall be given to a working disabled individual eligible for the Work Incentives group, who holds monies in an Independence Account. To be eligible for this resource disregard, the Independence Account is subject to the following provisions: 1. Deposits made to an approved Independence Account only while an individual is eligible for Medicaid under the Work Incentives group will be disregarded as a resource. 2. Deposits into the account must not exceed 50% of gross earned income earned by the individual during the 12-month certification period under the Work Incentives group (with deposits exceeding this threshold being disregarded as resources but included in the formula for calculating premiums). 3. These accounts will be held separate from non-exempt resources, in an account for which prior approval has been obtained from the Department, and for which the owner authorizes regular monitoring and/or reporting including deposits, withdrawals, and other information deemed necessary by the Department for the proper administration of this provision. 4. The separateness requirement may be waived in the case of an employer's pension and/or a retirement account. 5. All gains, dividends or interest accruing to: a. An Independence Account, b. An employer’s retirement fund, or c. An individual's IRA account that has been registered and approved as an Independence Account, which occur after that person's first enrollment in Medicaid under the Work Incentives group, will also be disregarded resources. Funds described above in a qualified Independence Account are disregarded as a resource for applicants or recipients of this Medicaid eligibility category, or their spouses.

Name of disregard:	Description:
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are disregarded as a resource.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded as a resource for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

2. Income Test

For individuals who pass Step One, in Step Two, the individual's unearned income (plus deemed income, if appropriate) must be less than one of the following income standards:

◉ a. The SSI income standard.

○ b. The income standard of the state supplement program.

3. Resource Test

The individual's resources must be less than the SSI resource standard.

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D. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

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E. Additional Information (optional)

State: Wisconsin

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Woman who are pregnant or post-partum who would qualify under the state's Pregnant Women eligibility group, except for income.

Package Header

Package ID	WI2020MS0008O	**SPA ID**	WI-20-0016
Submission Type	Official	**Initial Submission Date**	9/28/2020
Approval Date	11/23/2020	**Effective Date**	7/1/2020
Superseded SPA ID	TN-13-033		
	User-Entered		

The state covers the Medically Needy Pregnant Women eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are pregnant or post-partum, as defined in 42 CFR 435.4.

2. Would qualify under the Pregnant Women eligibility group, except for income.

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

State: Wisconsin

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

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B. Financial Methodologies

1. The financial methodology used is:

- ○ a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- ◉ b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ◉ Yes
- ○ No

The less restrictive income methodologies are:

☐ The difference between one income standard and another is disregarded.

- ○ Between the following percentages of the FPL:
- ◉ Between the medically needy income limit and a percentage of the FPL:
- ○ Between the SSI Federal Benefit Rate and:
- ○ Between other income standards:

FPL 300.00%

☐ All income increases are disregarded between redeterminations.

Description: Income increases which occur after a spenddown amount is initially certified are disregarded for the remainder of the spenddown budget period.

3. Less restrictive methodologies are used in calculating countable resources.

- ◉ Yes
- ○ No

The less restrictive resource methodologies are:

☐ All resources are disregarded. No resource test is applied.

State: Wisconsin

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

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	User-Entered		

C. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

D. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

E. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Package Header

Package ID	WI2020MS0008O	**SPA ID**	WI-20-0016
Submission Type	Official	**Initial Submission Date**	9/28/2020
Approval Date	11/23/2020	**Effective Date**	7/1/2020
Superseded SPA ID	TN-13-033		
	User-Entered		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Children under age 18 who would qualify under the state's categorically needy eligibility groups, except for income.

Package Header

Package ID	WI2020MS0008O	**SPA ID**	WI-20-0016
Submission Type	Official	**Initial Submission Date**	9/28/2020
Approval Date	11/23/2020	**Effective Date**	7/1/2020
Superseded SPA ID	TN-13-033		
	User-Entered		

The state covers the Medically Needy Children under Age 18 eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 18.

2. Would qualify as categorically needy, except for income.

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Package Header

Package ID	WI2020MS0008O	**SPA ID**	WI-20-0016
Submission Type	Official	**Initial Submission Date**	9/28/2020
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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Children under age 18 who would qualify under the state's categorically needy eligibility groups, except for income.

Package Header

Package ID	WI2020MS0008O	**SPA ID**	WI-20-0016
Submission Type	Official	**Initial Submission Date**	9/28/2020
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Superseded SPA ID	TN-13-033		
	User-Entered		

The state covers the Medically Needy Children under Age 18 eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 18.

2. Would qualify as categorically needy, except for income.

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

State: Wisconsin

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Package Header

Package ID WI2020MS0008O
SPA ID WI-20-0016
Submission Type Official
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User-Entered

B. Financial Methodologies

1. The financial methodology used is:

- ○ a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- ◉ b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- ◉ Yes
- ○ No

The less restrictive income methodologies are:

☐ The difference between one income standard and another is disregarded.

- ○ Between the following percentages of the FPL:
- ◉ Between the medically needy income limit and a percentage of the FPL:
- ○ Between the SSI Federal Benefit Rate and:
- ○ Between other income standards:

FPL 150.00%

☐ All income increases are disregarded between redeterminations.

Description: Income increases which occur after a spenddown amount is initially certified are disregarded for the remainder of the spenddown budget period.

3. Less restrictive methodologies are used in calculating countable resources.

- ◉ Yes
- ○ No

The less restrictive resource methodologies are:

☐ All resources are disregarded. No resource test is applied.

State: Wisconsin

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

Package Header

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C. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

D. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

E. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

State: Wisconsin

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | WI2020MS0008O | WI-20-0016

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Individuals who are age 65 or older or who have blindness or a disability who do not qualify as categorically needy.

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
Approval Date	06/09/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0010		
	System-Derived		

The state covers the optional Medically Needy Populations Based on Age, Blindness or Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1.Meet at least one of the following:

a. Are age 65 or older;

b. Have blindness; or

c. Have a disability.

2. Are not otherwise eligible for categorically needy coverage under the state plan.

3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
Approval Date	06/09/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0010		
	System-Derived		

B. Individuals Covered

The state covers the following populations:

- ☐ 1. Individuals age 65 or older
- ☐ 2. Individuals with blindness
- ☐ 3. Individuals who have a disability

Medically Needy Populations Based on Age, Blindness or Disability

Package Header

Package ID WI2025MS0001O
SPA ID WI-25-0005
Submission Type Official
Initial Submission Date 3/31/2025
Approval Date 06/09/2025
Effective Date 1/1/2025
Superseded SPA ID WI-24-0010
System-Derived

C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

(•) Yes
( ) No

2. The financial methodology used is:

a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

(•) Yes ( ) No

The less restrictive income methodologies are:

☐ The difference between one income standard and another is disregarded.

( ) Between the following percentages of the FPL:

(•) Between the medically needy income limit and a percentage of the FPL:

FPL 100.00%

( ) Between the SSI Federal Benefit Rate and:

( ) Between other income standards:

☐ Census Bureau wages are disregarded.

Description of disregard: All wages paid by the Census Bureau for temporary employment related to the decennial Census are excluded.

☐ A specified type of income is disregarded:

Name of income type:	Description:
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are excluded.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as income.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the Internal Revenue Code is disregarded.
Court-ordered Support and Payments	Court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees are considered unavailable.
Amounts Deemed to Children	Deeming to other eligible children an ineligible parent's income in excess of that which makes one child ineligible. Deemed parental income is equally split among siblings and no further computations are done.
In-kind support and maintenance	In-kind support and maintenance is totally exempt unless regular, predictable and received in return for a service or product delivered.
Combat Zone Additional Pay	Any additional payment received under chapter 5 of title 37, United States Code, by a member of the United States Armed forces deployed to a designated combat zone shall be excluded from household income for the duration of the member’s deployment if the additional pay is the result of deployment to or while serving in a combat zone, and it was not received immediately prior to

Name of income type:	Description:
	serving in the combat zone.
Tribal Gaming Per Capita Payments	The first five hundred dollars of tribal per capita payments from tribally managed gaming revenues are excluded in determining eligibility. These payments are distributed from local tribal funds from gaming operations and have not been held in trust by the Secretary of Interior. These payments are not otherwise excluded under federal law (e.g., P.L. 98-64).

☐ All income increases are disregarded between redeterminations.

Description: Income increases which occur after a spenddown amount is initially certified are disregarded for the remainder of the spenddown budget period.

☐ Specific income changes are disregarded between redeterminations.

☐ Income increases due to the cost of living adjustment received from Social Security are disregarded.

Description: The annual COLA is disregarded until the month following the month in which the new federal poverty levels are published.

c. Less restrictive methodologies are used in calculating countable resources.

◉ Yes ○ No

The less restrictive resource methodologies are:

☐ General resource disregard:

Name of disregard:	Description:
Irrevocable burial trust interest.	Interest from irrevocable burial trusts is counted as

Name of disregard:	Description:
	an asset unless it has been specifically declared irrevocable in writing.
Availability of assets.	Assets are not considered available unless they will be available in cash within 30 days (e.g., cash value of life insurance); value is suspended until asset becomes available.
Exclusion of real property	Nonexempt real property is considered unavailable when the property owner lists it for sale with a realtor at its fair market value or a joint owner who is outside the fiscal test group refuses to sell the property.
Disregard of the "first moment of the month" rule for counting of resources.	The state considers persons eligible if their resources are at or below the resource standard at any time in the month.
Reimbursement of incorrectly collected cost shares or personal liability amounts.	Reimbursement of cost share for home and community based waivers or personal liability amounts for institutional care incorrectly collected from a member are disregarded as a resource for nine (9) months beginning the month after the month in which the amount is reimbursed.
Independence Accounts	Accounts meeting the criteria described in the reviewable unit for the Work Incentives eligibility group.
Guaranteed Income Programs	Means-tested, “guaranteed income” payments from privately funded, non-profit organizations are disregarded as a resource.
Tribal General Welfare Assistance	Tribal General Welfare Assistance (GWA) that is exempt from taxation under Section 139E of the

Name of disregard:	Description:
	Internal Revenue Code is disregarded as an asset for 12 months following the month of receipt.
Medicare Advantage Supplemental Benefits	Medicare Advantage Supplemental Benefits are disregarded as a resource.
Disregard assistance received in conjunction with medical or social services	Assistance received in conjunction with governmental or nongovernmental medical or social services that is not counted as income under 20 CFR 416.1103(a) and (b) is also not counted as a resource.

☐ The state uses a less restrictive methodology with respect to resources set aside for burial.

☐ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Exemption of Certain Burial Trusts	For burial agreements funded by trusts, which Wisconsin state law permits only $3,000 of the funds within which to be irrevocable, $1,500 of funds in excess of the limit, which would otherwise be deemed revocable by operation of the irrevocable limit imposed by state law and thereby a countable resource under SSI policy, shall be disregarded.

☐ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Medically Needy Populations Based on Age, Blindness or Disability

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
Submission Type	Official	**Initial Submission Date**	3/31/2025
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Superseded SPA ID	WI-24-0010		
	System-Derived		

D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

Package ID	WI2025MS0001O	**SPA ID**	WI-25-0005
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	System-Derived		

E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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Superseded SPA ID	WI-24-0010		
	System-Derived		

F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0001O | WI-25-0005

Package Header

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	System-Derived		

G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

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Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Children under Age 19 with a Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

Children under age 19 with a disability who would be eligible if they were in a medical institution (known as Katie Beckett).

Package Header

Package ID	WI2019MS0006O	**SPA ID**	WI-19-0014
Submission Type	Official	**Initial Submission Date**	12/20/2019
Approval Date	N/A	**Effective Date**	10/1/2019
Superseded SPA ID	WI-09-022, WI-91-0030		
	User-Entered		

The state operates the Children under Age 19 with a Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 19 and qualify as an individual with a disability under section 1614(a) of the Act.

2. For whom the state has determined the following:

a. The individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities;

b. It is appropriate to provide such care for the child outside such an institution; and

c. The estimated cost for the individual's care is not greater than the cost which would otherwise be expended within an appropriate institution.

3. Would be eligible for one or more of the following Medicaid eligibility groups if in a medical institution:

- ☐ a. Individuals in Institutions Eligible under a Special Income Level
- ☐ b. Age and Disability-related Poverty Level
- ☐ c. Medically Needy Individuals
- ☐ d. Individuals Eligible for but Not Receiving Cash Assistance
- ☐ e. Other eligibility group(s):

Children under Age 19 with a Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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	User-Entered		

B. Financial Methodologies and Standards

1. The income and resource methodologies and standards for the group used to determine institutional eligibility are used for this group.

2. Less restrictive methodologies are used in calculating countable income.

○ Yes
● No

3. Less restrictive methodologies are used in calculating countable resources.

● Yes
○ No

The less restrictive resource methodologies are:

☐ The following less restrictive methodologies are used:

Name of methodology:	Description:
Parental and child asset disregard	Parental assets are disregarded when determining Medicaid eligibility for children with disabilities living at home, exactly as they are for children with disabilities residing in an institution. Child assets are also disregarded.

Children under Age 19 with a Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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C. Cost Effectiveness Determination

1. The cost-effectiveness determination is performed:

- (•) a. Annually
- ( ) b. Semi-annually
- ( ) c. Other frequency:

2. The calculation is made at the individual level, using the following methodology:

- ( ) a. Standard methodology is used.
- (•) b. An alternative methodology is used.

Description:

The State estimates the annual cost of a prospective Katie Beckett participant's care outside of an institution based upon average annual expenditures incurred by the State for children participating in the Katie Beckett program. This annual cost is compared with the estimated annual cost that would have been charged to the Medical Assistance program if the child were in an institution meeting the child's level of care needs. Annual institutional rates are extrapolated from the daily rates allowed through the Medical Assistance program.

Children under Age 19 with a Disability

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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D. Additional Information (optional)

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Eligibility | WI2018MS0003O | WI-18-0005

Package Header

Package ID	WI2018MS0003O	**SPA ID**	WI-18-0005
Submission Type	Official	**Initial Submission Date**	4/5/2018
Approval Date	6/13/2018	**Effective Date**	1/1/2018
Superseded SPA ID	N/A		

The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

☑ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

◉ SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

☑ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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Submission Type	Official	**Initial Submission Date**	12/20/2019
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Superseded SPA ID	See Supplemental Package User-Entered		

The state will apply the methodologies as described below, and consistent with 42 CFR 435.601, 435.602, and 435.831.

A. Basic Financial Methodology

1. The state applies the income and resource methodologies of the SSI program when determining eligibility for a population based on age (65 or older) or having blindness or a disability, with the exceptions described below in B. through G.

2. The state applies the financial methodologies of either the SSI program or the AFDC program in effect as of July 16, 1996 (whichever is most closely related) when determining eligibility for a population based on age (as a child), pregnancy, or status as a caretaker relative, with the exceptions described below in B. through G.

B. Use of Less Restrictive Methodologies

1. The state elects to apply income and/or resources methodologies that are less restrictive than those used under the cash assistance programs, in accordance with 42 CFR 435.601(d).

- (●) Yes
- ( ) No

2. The less restrictive income and resource methodologies are described on the RU for each applicable eligibility group.

State: Wisconsin

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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C. Financial Responsibility of Relatives

1. In determining financial eligibility for an individual, the state does not include income and resources from anyone other than the individual's spouse, and for individuals under age 21 or who have blindness or disability, the individual's parent.

a.The state includes the income and resources of a spouse or parent only when they are living with the individual in the same household, except as follows:

i. In the case of spouses who are age 65 or older or who have blindness or disability and who share the same room in a Medicaid institution, the state:

- ○ (1) Considers these couples either as living together or as living separately for the purpose of counting income and resources, whichever is more advantageous to the couple.
- ● (2) Considers these couples as living separately for the purpose of counting income and resources.

ii. Where applicable, the state determines income and resource eligibility consistent with the spousal impoverishment rules of section 1924 of the Act, as described in the Resource Assessment and Eligibility reviewable unit.

b. In the case of individuals under age 21 for whom AFDC is the most closely related cash assistance program, the income and resources of parents and spouses are included only if the individual would have been considered a dependent under the state's approved AFDC state plan in effect as of July 16, 1996.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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D. Family Size

1. The family size of an individual for whom the SSI income and resource methodologies are used (as described in section A) includes the persons identified below:

a. The individual applying, or

b. If the individual lives together with his or her spouse, the individual applying and the spouse, or

c. If the individual lives together with his or her parent(s) and the individual is under 21 or has blindness or a disability, the individual applying and the parent(s).

2. The family size of an individual for whom the AFDC income and resource methodologies are used (as described in section A.), includes the persons who would have been included in the family under the state's July 16, 1996 AFDC state plan, except where the state has elected to use the MAGI-like methodologies (as described in section E).

3. The state defines family size for one or more of the following FPL eligibility groups to include others beyond those identified in D.1. and D.2.

- (•) Yes
- ( ) No
- [ ] a. Qualified Medicare Beneficiaries (described in section 1902(a)(10)(E)(i) of the Act)
- [ ] b. Specified Low Income Medicare Beneficiaries (described in section 1902(a)(10)(E)(iii) of the Act)
- [ ] c. Qualifying Individuals (described in section 1902(a)(10)(E)(iv) of the Act)
- [ ] d. Qualified Disabled and Working Individuals (described in section 1902(a)(10)(E)(ii) of the Act)
- [ ] e. Age and Disability-Related Poverty Level (described in section 1902(a)(10)(A)(ii)(X) of the Act)
- [ ] f. Work Incentives (described in section 1902(a)(10)(A)(ii)(XIII) of the Act)
- [ ] g. Family Opportunity Act Children with a Disability (described in section 1902(a)(10)(A)(ii)(XIX) of the Act)
- [ ] h. Individuals Receiving State Plan Home and Community-Based Services (described in 42 CFR 435.219)

4. The state uses the same definition of family size for the selected FPL eligibility groups.

- ( ) Yes
- (•) No

Work Incentives

5. The following family size definition is used for this eligibility group:

(•) a. Family is defined as the individual, the individual's spouse and the individual's children under age 18 living together in the same household. If the individual is a child, the child's parents and siblings under age 18 are also included in the household if living together.

Optional description:

( ) b. The state uses another definition of family.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

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	User-Entered		

E. Use of MAGI-like Methodologies

1. The state uses MAGI-like methodologies for one or more populations for whom the most closely related cash assistance program would be the AFDC program in effect as of July 16, 1996.

(•) Yes

( ) No

2. The election to use MAGI-like methodologies is described on the RU for each applicable eligibility group.

3. The MAGI-like methodology is consistent with 42 CFR 435.603(b) through (f) with respect to definitions, household income, and definition of household, except:

a. The agency elects to use the MAGI definition of parent when considering the financial responsibility of relatives, which includes natural or biological parents, as well as adopted parents and stepparents.

(•) Yes

( ) No

b. Less restrictive methodologies can be used, as described in section B.

c. The financial responsibility requirements for relatives are applicable, as described in section C.

d. The countable income deductions for the medically needy are applicable, when the MAGI-like methodologies are applied to the medically needy, as described in section F.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

Package Header

Package ID	WI2019MS0006O	**SPA ID**	WI-19-0014
Submission Type	Official	**Initial Submission Date**	12/20/2019
Approval Date	N/A	**Effective Date**	10/1/2019
Superseded SPA ID	See Supplemental Package		
	User-Entered		

F. Countable Income Deductions for the Medically Needy

In determining countable income for individuals who are age 65 or older or who have blindness or a disability, the state deducts:

1. Amounts that would be deducted in determining eligibility under SSI.

2. The highest amounts that would be deducted in determining eligibility for optional state supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | WI2019MS0006O | WI-19-0014

Package Header

Package ID	WI2019MS0006O	**SPA ID**	WI-19-0014
Submission Type	Official	**Initial Submission Date**	12/20/2019
Approval Date	N/A	**Effective Date**	10/1/2019
Superseded SPA ID	See Supplemental Package User-Entered		

G. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0002O | WI-25-0006-A

Individuals who receive an optional state supplementary payment.

Package Header

Package ID	WI2025MS0002O	**SPA ID**	WI-25-0006-A
Submission Type	Official	**Initial Submission Date**	3/28/2025
Approval Date	04/25/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0003-A System-Derived		

The state covers the Optional State Supplement Beneficiaries eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Receive an optional state supplement that meets the conditions described in sections C and D.

2. Except for income, would be eligible for SSI.

3. Do not have gross income exceeding 300% of the SSI Federal Benefit Rate (FBR).

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0002O | WI-25-0006-A

Package Header

Package ID	WI2025MS0002O	**SPA ID**	WI-25-0006-A
Submission Type	Official	**Initial Submission Date**	3/28/2025
Approval Date	04/25/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0003-A		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0002O | WI-25-0006-A

Package Header

Package ID	WI2025MS0002O	**SPA ID**	WI-25-0006-A
Submission Type	Official	**Initial Submission Date**	3/28/2025
Approval Date	04/25/2025	**Effective Date**	1/1/2025
Superseded SPA ID	WI-24-0003-A		
	System-Derived		

C. Optional State Supplement Program

1. The optional state supplement program is administered:

- ○ a. Solely by the federal government. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments.
- ○ b. By a combination of federal and state administration. The state has an agreement with the Social Security Administration under section 1616 of the Act regarding the administration of optional state supplementary payments for some classifications of individuals, while state supplementary payments for other classifications of individuals are administered by the state.
- ◉ c. Solely by the state.

2. Payments under the optional state supplement program are:

a. Based on need and paid in cash on a regular basis;

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement; and

c. Available to all individuals in each population selected in section B.

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0002O | WI-25-0006-A

Package Header

Package ID	WI2025MS0002O	**SPA ID**	WI-25-0006-A
Submission Type	Official	**Initial Submission Date**	3/28/2025
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Superseded SPA ID	WI-24-0003-A		
	System-Derived		

D. Income Standard of Optional State Supplement Program

1. The income standard for the optional state supplement:

a. Varies by political subdivision.

- ○ Yes
- ◉ No

b. Varies by payment classification.

- ○ Yes
- ◉ No

Income Standard

Individual	Couple
$1050.78	$1582.05

Optional State Supplement Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | WI2025MS0002O | WI-25-0006-A

Package Header

Package ID	WI2025MS0002O	**SPA ID**	WI-25-0006-A
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Superseded SPA ID	WI-24-0003-A		
	System-Derived		

E. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

This view was generated on 4/25/2025 3:43 PM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O

SPA ID WI-22-0013

Submission Type Official

Initial Submission Date 6/27/2022

Approval Date 9/15/2022

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The Department proposes changes to the Medical Assistance (MA) maximum fee rates for substance use disorder (SUD) Health Home rates. Two new billing tiers have been added to the per-member-per-month reimbursement rate that providers receive for administering the six core health home services. The billing requirements to qualify for tiers of reimbursement will no longer be determined by direct time (time spent with the member in-person or via telehealth) but rather by delivery of core service time, regardless of whether the member is present.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$289999
Second	2023	$695997

Federal Statute / Regulation Citation

Section 1945 of the Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
WI 22-0013 Submission Package.	7/13/2022 4:10 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O

SPA ID WI-22-0013

Submission Type Official

Initial Submission Date 6/27/2022

Approval Date 9/15/2022

Effective Date N/A

Superseded SPA ID N/A

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Federal Budget Impact and Statute/Regulation Citation

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First	2022	$289999
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Federal Statute / Regulation Citation

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Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
WI 22-0013 Submission Package.	7/13/2022 4:10 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program

SUD Health Home

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
Public Notice SUD Health Home SPA	9/8/2022 4:24 PM EDT	

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program

SUD Health Home

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Upload copies of public notices and other documents used

Name	Date Created	
Public Notice SUD Health Home SPA	9/8/2022 4:24 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O
SPA ID WI-22-0013
Submission Type Official
Initial Submission Date 6/27/2022
Approval Date 9/15/2022
Effective Date N/A
Superseded SPA ID N/A

Name of Health Homes Program:

SUD Health Home

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☐ All Indian Health Programs

☐ All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

Date of consultation:	Method of consultation:
5/11/2022	Tribal Directors Meeting

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
5.11.22 Meeting Agenda_ Tribal Consulations_ SPA Q2	7/13/2022 4:41 PM EDT	

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O

SPA ID WI-22-0013

Submission Type Official

Initial Submission Date 6/27/2022

Approval Date 9/15/2022

Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

SUD Health Home

Date of consultation
3/10/2022

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
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	User-Entered		

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- [ ] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Mandatory Medically Needy

- [ ] Medically Needy Pregnant Women
- [ ] Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

- [ ] Medically Needy Children Age 18 through 20
- [ ] Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- [ ] Medically Needy Aged, Blind or Disabled
- [ ] Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

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Superseded SPA ID WI-21-0012
User-Entered

Population Criteria

The state elects to offer Health Homes services to individuals with:

☐ Two or more chronic conditions

☐ One chronic condition and the risk of developing another

Specify the conditions included:

☐ Mental Health Condition

☐ Substance Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI over 25

☐ Other (specify):

Specify the criteria for at risk of developing another chronic condition:

Having or being at risk of developing another medical condition, including conditions frequently associated with or with increasing prevalence of Substance Use Disorder:
•Attention deficit hyperactivity disorder (ADHD)
•Anxiety Disorders
•Asthma
•Chronic Pain
•Chronic obstructive pulmonary disease (COPD)
•Diabetes
•Heart Disease
•Hepatitis A, B, and C
•HIV/AIDS
•Hypertension
•Liver/Kidney Disease
•Mood Disorder
•Other Substance Use Disorder
Having or being at risk of developing another medical condition, including conditions frequently associated with or with increasing prevalence of Substance Use Disorder:
•Attention deficit hyperactivity disorder (ADHD)
•Anxiety Disorders
•Asthma
•Chronic Pain
•Chronic obstructive pulmonary disease (COPD)
•Diabetes
•Heart Disease
•Hepatitis A, B, and C
•HIV/AIDS
•Hypertension
•Liver/Kidney Disease
•Mood Disorder
•Other Substance Use Disorder
•Pregnant or within 120 days postpartum
•Post-traumatic stress disorder (PTSD)
•Psychotic Disorder
•Traumatic Brain Injury and Cognitive Disorders

If a member with SUD presents with a risk or condition not listed above, the Hub and Spoke providers have the discretion to clinically assess the member's needs for health home services on a case by case basis.

Resources:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5373082/
https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf
https://www.drugabuse.gov/sites/default/files/soa.pdf

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

Package Header

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User-Entered

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- (•) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

Describe the process used:

H&S providers and their partners will follow a “no wrong door” approach in providing members access to the program. Members may be referred for services through self-referral, managed care entities, county programs, community partners, primary care providers, hospitals, or others. Hub staff will receive referrals to screen the member to determine eligibility for Medicaid and health home services. If the person is not enrolled in Medicaid, but eligible, H&S staff will assist that person with enrollment.

Medicaid-enrolled individuals with the required diagnosis and treatment needs will be informed of the program and how to participate. If an individual gives consent to participate, the H&S team will work with the member to conduct an initial, comprehensive assessment and will promote engagement with evidence-based approaches, such as Motivational Interviewing and harm reduction. H&S providers should ensure continuity of care by providing consistent contacts throughout the intake, screening, and enrollment, to the greatest extent possible.

Providers must maintain documentation of enrollment verification and consent to participate in the member’s record. The member can choose not to participate at any time by notifying their H&S provider.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- ☐ Fee for Service
  - ☐ Individual Rates Per Service
  - ☐ Per Member, Per Month Rates
  - ☐ Fee for Service Rates based on
    - ☐ Severity of each individual's chronic conditions
    - ☐ Capabilities of the team of health care professionals, designated provider, or health team
    - ☐ Other
  - ☐ Comprehensive Methodology Included in the Plan
  - ☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Hub providers may bill one of Five tiers of services per member per month (PMPM) depending on the intensity of services provided. Hub and spoke providers must meet minimum core service hours to be reimbursed for each of the Five intensity tiers.
Members receiving high intensity Level 5 services are reevaluated regularly to determine the appropriateness of this level of service.

- ☐ PCCM (description included in Service Delivery section)
- ☐ Risk Based Managed Care (description included in Service Delivery section)
- ☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O

Submission Type Official

Approval Date 9/15/2022

Superseded SPA ID WI-21-0012
User-Entered

SPA ID WI-22-0013

Initial Submission Date 6/27/2022

Effective Date 5/1/2022

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

5/1/2022

Website where rates are displayed

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

Health Homes Payment Methodologies

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The costs built into the rate for each intensity level are based on the number of expected hours spent administering the six core services per member per month, the distribution of professionals expected to administer those services, the cost of employing these professionals, and the associated administrative overhead costs. The estimated number of hours spent at each intensity level and the distribution of professionals accounting for these hours are based on data provided by the pilot sites, a review of comparable services at the state and national level, and the expertise of state program sta . The cost of employing the professionals is based on salaries provided by the pilot sites, the reimbursement of similar professional for other Wisconsin Medicaid services, and Wisconsin Department of Workforce Development (DWD) data.
2. Hubs and Spokes are teams of providers supported by a PMPM payment. Payment will be made monthly, covering the previous month's service by Hub site providers. Providers will be required to use the following Healthcare Common Procedure Coding System procedure codes when submitting professional claims for reimbursement:H001: Comprehensive Annual AssessmentH006: Monthly Engagement in Services.
3. Hub providers may bill for the comprehensive assessment once for each new member that enrolls in the health home and annually for members whose health and support needs dictate the need.
Providers must meet minimum core service hours requirements to bill each intensity level for a given member. The corresponding intensity levels and core health home service hours are as follows:
Level 1 - 1 hour of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 2 - 4.5 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 3 - 8 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 4 - 13 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 5 - 18 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
The core hours do not include the provision of any services that are reimbursed under other Medicaid bene ts and only the six Health Home Services are paid or reimbursed under the methodology described in this SPA. Hours spent conducting the initial assessment do not count toward the minimum service requirements.
Health home providers must submit a claim to receive payment.
4. Hub providers are required to submit quarterly reports that include core hours spent with each member, and record of a direct contact with each member. These reports will be reviewed against submitted claims to ensure that the proper intensity level was billed for each member. Hub providers are also required to ll out a complexity scale for each member during their comprehensive assessment.. Hub providers are expected to update this complexity scale for a member if their condition changes.
5. The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care. Rates will be updated accordingly.

Periodically language was added to give us flexibility to do exactly what we did when we made the last update to include more intensity levels for reimbursement. This means when potential inefficiencies are either brought to our attention by the pilot sites, or identified by DHS through program review.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

The State assures to CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or bene ts, other delivery systems including waivers, other Medicaid health homes, and other state plan services. Members cannot be eligible for SUD Health Home services if enrolled in the HIV/AIDS health home, Targeted Case Management, or Prenatal Care Coordination.

The State assures that no duplication of services and reimbursement. Case management, the only similar service, we require the pilot sites to coordinate with the other entities (HMO, MCO, Counties) which provide case management to ensure no duplication of services. If a member is enrolled in an MCO or HMO that also provides care coordination related services, each entity (the Health Home and the MCO/HMO) must designate a sole point of contact to coordinate care and determine roles for non-duplication of services. In addition, we also explicitly directed the Hub site that operates in the county in which the AIDS/HIV Health Home operates to not enroll a member who was also enrolled in the AIDS/HIV Health Home, or to perform enrollment options counseling in tandem with the AIDS/HIV Health Home staff to help the member determine which Health Home would best meet that member's needs. So, there can be only one HH serving a member at a time.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Hub and Spoke SPA Redline_Pages	9/8/2022 4:09 PM EDT	
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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	5/1/2022
Superseded SPA ID	WI-21-0012		
	User-Entered		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

The H&S providers will complete an initial assessment to develop a plan of care that includes primary care, addiction and behavioral health care, and essential social services to address the needs of the whole person through a team-based care model. The assessment will apply ASAM level of care criteria and when indicated, the provider may promptly engage the individual in treatment. Immediate evidence-based interventions, such as medication assisted treatment (MAT), may begin prior to completion of the full assessment.

The care plan will be developed with the member. The plan will be based on the assessment and tailored to meet the member's needs and goals. The care plan will include well-defined measurable goals, timeframes, the person's preferred natural support network, and the specific, evidence-based services the team will provide or arrange. Health Home staff should motivate and engage the person in planning their treatment.

The Hub will determine the complexity of the person's treatment needs, and delegate care coordination activities to the Hub or the Spoke. Health Homes will identify and connect providers and specialists involved in the person's care to promote integrated healthcare, and identify the roles and communication protocols for all involved providers. Trauma-sensitive and trauma-informed approaches must be used when needed to facilitate the person's engagement.

Periodic reassessment of the person's progress and outcomes will include health status, quality of life, participation in care plan services, satisfaction with services, and availability of community supports. Treatment plan updates may be necessary, including moving from one care setting to another, developing quality improvement activities, and linkages with long term care services and supports. Reassessment will occur annually or more frequently, based upon the intensity of treatment or changes in the person's goals and/or condition. Reassessments will include current information on the person's confidence and readiness for change, adherence to treatment, use of emergency services, and any identified barriers to recovery.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The needs identified during the assessment will be incorporated into the care plan and documented in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's comprehensive care plans with the purpose of accessing relevant care plan information for service delivery across providers and health systems.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Contributes to conducting initial assessments and reassessments, the formulation of the comprehensive care plan through engaging with members identifying team roles and responsibilities, and recommending evidence-based interventions.

☐ Nurse Practitioner

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

☐ Nurse Care Coordinators

Description

Contributes to the formulation of the comprehensive care plan through identifying appropriate linkages and referrals and coordinating across service and provider settings.

☐ Nurses

☐ Medical Specialists

☐ Physicians

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

☐ Physician's Assistants

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

- [ ] Pharmacists
- [ ] Social Workers

Description

Contributes to the formulation of the comprehensive care plan through identifying appropriate linkages and referrals and coordinating across service and provider settings.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinator	May serve as an initial point of contact for referrals to the program, conducts initial screening and triage, determines eligibility for services, gathers necessary information for the initial assessment, and coordinates follow-up appointments.
Peer Supports	Act as a resource broker for the patient, providing advocacy for patients, assisting with resources, assisting with transportation, support groups and developing a wellness plan.

Care Coordination

Definition

Care coordination involves implementing the individualized comprehensive care plan, in order to engage the member in their home and community, attain member goals, and improve chronic conditions. The care coordinator will facilitate linkages between the member's various care and treatment providers. Components of care coordination include knowledge of and respect for the member's needs and preferences, resource management, advocacy, and communication between providers and family members. Care coordination services will be proactive and based on the member's individualized needs and preferences.

Care coordination involves implementing the individualized comprehensive care plan, in order to engage the member in their home and community, attain member goals, and improve chronic conditions. The care coordinator will facilitate linkages between the member's various care and treatment providers. Components of care coordination include knowledge of and respect for the member's needs and preferences, resource management, advocacy, and communication between providers and family members. Care coordination services will be proactive and based on the member's individualized needs and preferences.

H&S providers serving children and youth will place particular emphasis on coordination with Primary Care Providers, schools, child protective services, juvenile justice, foster parents, or other youth support networks. In collaboration with the youth receiving services, family and natural supports will be included and encouraged to participate in treatment planning and service coordination.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Care coordination needs will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and care coordination needs.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

- [ ] Nurses
- [ ] Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Care Coordinators	Provide mobile outreach with a focus on coordinating community-based services with the member whom may also be responsible for other facilitation among team members or health care providers.

Health Promotion

Definition

The H&S team will work with each member to identify health promoting activities, screen for both medical and mental health conditions, and provide linkages for the person to access appropriate physical health care services, such as immunizations or dental care. Health Promotion begins with the initial assessment and continues during the development of a formal comprehensive care plan. The H&S team will talk with the member to assess their readiness for change and provide the member with the appropriate level of encouragement and support to engage in healthy behavior choices and/or lifestyle choices.

The H&S team will also screen for past experience with trauma, as well as for frequently co-occurring health conditions including HIV/AIDS, TB, and infectious hepatitis.

The H&S team will also provide health education to the member and their self-identified support systems regarding chronic conditions, prevention education, and promoting healthy lifestyle choices, such as:

- Smoking prevention and cessation
- Stress reduction
- Nutritional counseling
- Obesity reduction and prevention
- Engaging in regular physical activity
- Disease-specific or chronic care management
- Personal goal-setting for wellness and recovery

H&S providers working with children and youth will emphasize prevention health initiatives, including strategies to build resilience and provide trauma informed care, while actively involving parents/guardians, and other support networks. This will include identifying conditions contributing to risk due to family, physical, or social factors, and working with the youth to address these areas.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health promotion activities will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and health promotion needs.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the

member in identifying and accessing health promotion activities and resources.

☐ Nurses

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

Description

May provide assistance in conducting health screening to inform member needs and aids the member in identifying and accessing health promotion activities and resources.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Care Coordinators	Provide health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.
Cultural Advisors	Assist the member on learning about Native American culture and how embracing the traditional practices can assist someone through their substance use patterns.
Peer Supports	Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care streamlines member movement from one setting to another, between levels of care, and between physical health and behavioral health treatment service providers. Transitions may be from any long-term care facility, institution, or other out-of-home setting back to the community. The H&S team works closely with the member before and during a transition back to the community and shares information with discharging organizations to prevent gaps in care that could result in re-admission or overdose.

H&S providers will develop collaborative relationships with treatment providers, hospital staff, managed care organizations, long-term care agencies, community corrections agents, residential treatment programs, county and tribal agencies, primary care and specialty mental health/substance use disorder treatment providers that provide day treatment, residential treatment, and psycho-social rehabilitation services. Engagement with all stakeholders in a person's transition will emphasize a trauma-sensitive and trauma-informed approach. Additional activities include working with discharge planners to schedule follow-up appointments with primary or specialty care providers within a maximum of seven days of discharge (or fewer if needed for MAT continuity), and working with the people receiving services to help facilitate attendance at scheduled appointments.

Transitional care services will vary by the age of children and youth, and may include transitions to or from residential care facilities or foster care families. Among transitional-age youth, services will address the needs of participants and families as the individuals approach a shift into adult services and programs.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Transitional care needs will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and transitional care needs. In addition, H&S providers will be educated on and encouraged to use the states HIE to receive real time notifications when members seek emergency room services or will be discharged from hospitals to facilitate coordination of care.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Ensures the member is receiving the appropriate level of care to progress to recovery and stabilization in advance of the transition and may consult on clinical and high risk needs, providing coverage as needed.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Facilitates seamless transition of care and follow-up for members being discharged from various settings such as hospitals, residential treatment facilities, jails, and other agencies. This includes focusing on health promotion and self-management in advance of the transition and supporting members in their transition planning through coordinating the movement between levels of care and linking to resource.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description

Facilitates seamless transition of care and follow-up for members being discharged from various settings such as hospitals, residential treatment facilities, jails, and other agencies. Ensures the member is receiving the appropriate level of care to progress to recovery and stabilization in advance of the transition. Supports the members in their transition planning through coordinating the movement between levels of care and linking to resource, especially among clinical care providers.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinators	Develop relationships and coordinates with discharge planners throughout the region affiliated with hospitals, residential treatment facilities, jails, and other agencies in order to promote seamless discharge planning. Supports members in their transition planning through coordinating the movement between levels of care and linking to resources, especially among community support service providers.
Peer Supports	Act as a resource broker for the patient, providing advocacy for patients, assisting with resources, assisting with transportation, support groups and developing a wellness plan.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support may include any people the member identifies as instrumental in supporting their recovery. Services will include: working with families based upon agreements with the member in treatment; active community outreach to engage and support individuals by meeting members where they are in the community; assisting the member with their medication and treatment adherence; helping the family learn to support treatment monitoring in the home environment; addressing co-dependency challenges; and assisting the member to achieve personal goals and recovery outcomes.

The H&S team will regularly assess the member's readiness to address issues related to family relationships and dynamics. The H&S team will work with the person to improve family relations or to re-engage family members who may have distanced themselves as the person progresses in treatment. Family-based therapy or family team meetings will be available to support those relationships to support the person's long term health and recovery.

Specialized individual support services may include training the person's support network on Naloxone administration and other harm reduction strategies, as well as providing access to Naloxone. Supports will be dynamic and flexible to build rapport and meet the safety needs of the person by including family and person's preferred support network when possible.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Individual and family support activities will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to update member's care plans and individual and family support needs to share relevant information across providers and health systems.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Facilitates individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Provides specialized advocacy on behalf of the member or family with other SUD treatment service providers.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Facilitates individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Provides specialized advocacy on behalf of the member or family with other health care providers.

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Cultural Advisors	Provide healing ceremonies, cultural learning and cultural identity work to promote individual and family support.
Care Coordinators	Facilitate individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Provides specialized advocacy on behalf of the member or family with other community-based support service agencies.
Peer Supports	Facilitate individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Will encourage the member to participate in self-help groups and develop a network of healthy relationships with family members or others who are identified by the member, including support to repair family and friend relationships.

Referral to Community and Social Support Services

Definition

Beginning with the initial assessment, the H&S team will assess needs related to financial strain, housing, food assistance, employment, transportation, and other resources. They will refer the member to community-based organizations and other key community stakeholders with the resources and services to support the member's health and well-being.
Referrals will be driven by the assessment process and the person's expressed requests, and noted on the person's care plan. The H&S will designate staff to assist in coordinating and monitoring the following types of services:

- Benefit eligibility (disability, food share, etc.);
- Support to return to meaningful activity/work;
- Subsidized or supportive housing;
- Peer or family support;
- Legal services as appropriate;
- Others as appropriate

To create and recruit a robust network of resources, the H&S will identify and partner with social service providers and community based organizations and will develop cooperative agreements that allow monitoring of the member's participation in the community agency. The H&S will provide training and technical assistance as needed regarding effective interventions for the population. Examples of potential partners include:

- Faith-based organizations;
- Community mental health organizations;

- Social integration opportunities including Recovery Centers;
- Appropriate cultural support centers;
- Mutual help groups (12 Step groups, Smart Recovery, Recovery Support organizations, Peer Run Respite programs, and warm lines)
- Housing assistance providers

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Referral activities and social support needs based on the initial and ongoing assessments will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans regarding their social support needs.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery.

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery. Interacts with various internal and external partners to ensure the member needs are met to support ongoing recovery.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Care Coordinators	Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery. Interacts with various internal and external partners to ensure the member needs are met to support ongoing recovery.
Peer Supports	Refers, connects, and may accompany the member to applying for other benefits, accessing medical and behavioral services, and accessing educational, community, or social supports as necessary to support ongoing recovery.

Package Header

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	User-Entered		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Members may be referred for health home services through self-referral, managed care entities, county programs, community partners, primary care providers, hospitals, or others. Referred individuals will be screened to determine eligibility for Medicaid and the H&S Integrated Recovery Support Service Health Home. Some members may present to the H&S after an urgent/emergent need, such as discharging from a hospital due to detox, or because they require immediate induction for Medication Assisted Treatment (MAT). Other members may present to H&S providers from referrals that are not considered as urgent or that believe the member will receive more comprehensive care and progress in their recovery through health home services.

Members with immediate needs may receive SUD treatment prior to or in conjunction with being informed about available health home services. Once the member's immediate health care needs are met, and once consent to participate and releases of information are complete, Hub staff complete an initial assessment to inform the comprehensive care plan. During care plan development, staff schedule necessary appointments with the member to ensure access to medications, testing and treatment, peer supports, and other health care services identified. The completed care plan will then be a roadmap to guide providers and members to other treatments and health home services essential to promote member recovery and wellness.

H&S providers will reassess members regularly to update their care plan and to ensure members are receiving and being referred to necessary services and resources. If a member's needs have been addressed and stabilized by the Hub, they may begin to receive services and supports from the lower-intensity Spoke sites. Through ongoing consultation, the Hub and Spoke sites will determine if members continue to receive the appropriate level of care and adjust as needed.

Name	Date Created	
Provider A Workflow	4/26/2021 3:39 PM EDT	
Provider B Workflow	4/26/2021 3:39 PM EDT	
Provider C Workflow	4/26/2021 3:39 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WI2024MS0010O | WI-24-0024 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2024MS0010O	**SPA ID**	WI-24-0024
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Approval Date	01/08/2025	**Effective Date**	12/31/2024
Superseded SPA ID	WI-22-0013		
	System-Derived		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will use paid claims data to compare costs for providing health care services to members enrolled in the H&S program prior to the implementation of the health home and annually thereafter to identify the areas of cost reduction. The state will also assess the costs of providing services to members with SUD and a co-occurring condition who are not enrolled in the health home and compare these costs and outcomes to those of members in the health home. The calculation method will be the same for dual-eligibles. Medicare data is not available to the State and therefore is not considered in cost-savings estimates.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state will require H&S providers to electronically store care plans in an electronic medical record (EMR) format or via a care coordination software platform in order to securely share information across provider sites. In addition, the state will strongly encourage the use of health information technology (HIT) within the first year of implementation. This will include the use of electronic medical records (EMRs) and the state selected health information exchange (HIE) to interface between Hubs, Spokes, and other relevant providers identified in the care plan and that the member may interact with. Finally, the state will provide the necessary technical assistance to support the implementation and use of HIT among H&S providers.

Health Homes Monitoring, Quality Measurement and Evaluation

Package Header

Package ID	WI2024MS0010O	**SPA ID**	WI-24-0024
Submission Type	Official	**Initial Submission Date**	12/20/2024
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Superseded SPA ID	WI-22-0013		
	System-Derived		

Quality Measurement and Evaluation

- [ ] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [ ] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [ ] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

This view was generated on 1/8/2025 2:46 PM EST

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WI2024MS0011O | WI-24-0025 | HIV/AIDS Health Home

Package Header

Package ID	WI2024MS0011O	**SPA ID**	WI-24-0025
Submission Type	Official	**Initial Submission Date**	12/20/2024
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Superseded SPA ID	12-008		
	User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

HIV/AIDS Health Home

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

This is a digital submission of SPA WI-12-008, HIV/AIDS Care Coordination Benefit. This program was created by 2009 Wisconsin Act 221 and provides care coordination for HIV/AIDS patients.

General Assurances

- [ ] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [ ] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [ ] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [ ] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [ ] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [ ] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

Package Header

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SPA ID WI-24-0025
Submission Type Official
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Effective Date 10/1/2024
Superseded SPA ID 12-008

User-Entered

- ○ Health Homes services will be available statewide
- ◉ Health Homes services will be limited to the following geographic areas
- ○ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ◉ By county
- ○ By region
- ○ By city/municipality
- ○ Other geographic area

Specify which counties:

1. Brown
2. Dane
3. Kenosha
4. Milwaukee

Health Homes Population and Enrollment Criteria

Package Header

Package ID	WI2024MS0011O	**SPA ID**	WI-24-0025
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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WI2024MS0011O | WI-24-0025 | HIV/AIDS Health Home

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Population Criteria

The state elects to offer Health Homes services to individuals with:

☐ Two or more chronic conditions

☐ One chronic condition and the risk of developing another

Specify the conditions included:

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25
☐ Other (specify):

Name	Description
HIV	The population includes Medicaid and BadgerCare Plus members with a diagnosis of HIV and who have at least one other diagnosed chronic condition, or is at risk of developing another chronic condition.

Specify the criteria for at risk of developing another chronic condition:

The population includes Medicaid and BadgerCare Plus members with a diagnosis of HIV and who have at least one other diagnosed chronic condition, or is at risk of developing another chronic condition. Individuals at “at-risk” for developing another chronic condition
include:
- Individuals having a CD4 cell count of less than 200 cells/uL or CD4 cells accounting for fewer than 14 percent of all lymphocytes
- Individuals with a body mass index <18.5 kg/ m
2
- Individuals whose fasting plasma blood sugar is 100-125 mg/dL or A1C 5.7% - 6.4%
- Individuals with systolic pressure between 120 - 139 mm Hg; diastolic pressure between 80 – 89 mm Hg
- Individuals with hyperlipidemia:
Total cholesterol >200 mg/dL
HDL levels <40 mg/dL for men and <50mg/dL for women
LDL levels >130 mg/dL

For the purposes of this benefit, a chronic condition is defined as one that has lasted at least 6 months, can reasonably be expected to continue for six months, or is likely to recur.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WI2024MS0011O | WI-24-0025 | HIV/AIDS Health Home

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ○ Opt-In to Health Homes provider
- ◉ Referral and assignment to Health Homes provider with opt-out
- ○ Other (describe)

Describe the process used:

Members meeting the above criteria will be automatically enrolled in the health home. Health home providers will be responsible for educating members about the benefits of health home enrollment and inform them of the option to disenroll. Members agree to health home services by actively participating in the assessment and care plan process.

☐ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

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HIV AIDS Health Home Enrollment Info 12202024	12/20/2024 2:34 PM EST	

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☐ Other (Specify)

Provider Type	Description
AIDS Service Organizations	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute ch 252.12(12)(a)8, for the purpose of providing life care services to persons diagnosed as having AIDS/HIV . The AIDS Service Organization (ASO) as the designated provider will provide health home services using a multidisciplinary approach. ASOs provide services to a significant number of Medicaid members with HIV infection. The ASOs will be responsible for outreach and communication to patients and organizations that provide services to individuals with HIV infection. The outreach will include educating patients and the AIDS/HIV community stakeholders about health homes. The professionals listed below are identified as “best practice” for meeting the needs of all individuals with HIV infection. The other members of the multidisciplinary team will be optional as determined by each patient’s health care and psychosocial needs. The other, optional members of the team could include outreach

Provider Type	Description
	workers, peer specialists, dieticians community care representatives (for example, fitness coach). There will be no restriction on the make up of the other members of the team. The ultimate decision will be between the member and his or her primary health care provider.

Health Homes Providers

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- [ ] Teams of Health Care Professionals
- [ ] Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The core team of health care professionals will include experts in the care and treatment of individuals diagnosed with HIV infection. In addition to the patient's primary health care provider, the designated health home must ensure that the following professionals are part of the core team:
A registered nurse
A case manager
A mental health or substance abuse professional
A dentist
A pharmacist
The patient and core team members will be central to the initial comprehensive assessment of needs and to the development of a single care plan. The single care plan will address all aspects of the member's care and treatment, including their community care needs. Each team will have a lead to ensure that there is communication, coordination and consultation among the team. For example, the team lead will do the following:
- Ensure that the member's care and treatment needs are addressed using a multidisciplinary team approach. This includes identifying individuals the member deems central to addressing his or her health care and social services needs.
- Ensure that the member is at the center of the team and is identified as an active and informed participant in his or her own care.
- Ensure that the member and providers on the team know each other.
- Ensure that the role and responsibility of each person on the team is defined for the member.
- Ensure that each member has an identified care coordinator.
- Ensure that team members share information regarding patient care, treatment, medications prescribed, recommended self-care and upcoming visits.
Each patient will have an identified care coordinator who will be responsible for the overall coordination of the patient's care. The team lead and the care coordinator can be the same individual.
Linkages between primary and behavioral health services are basic to the provision of services to patients diagnosed with HIV infection. Health home patients who do not have a diagnosis of mental health or substance use disorder will be routinely screened for depression and substance use. The integration of behavioral and physical health will occur within the health home through the required composition of a core team that includes representatives of both disciplines. The state will provide technical assistance to the extent necessary. For example, the Department will provide SBIRT (screening, brief intervention, referral, and treatment) training to help ensure that substance abuse screening is provided as a matter of course for all health home members. The state will continue to collaborate with the ASOs and set up calls and site audits/visits to support and monitor health home services and to ensure that health home services are provided in accordance with the requirements outlined under "Provider Standards."

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The state will provide technical assistance to the extent necessary. For example, the Department will provide SBIRT (screening, brief intervention, referral, and treatment) training to help ensure that substance abuse screening is provided as a matter of course for all health home members. The state will continue to collaborate with the ASOs and set up calls and site audits/visits to support and monitor health home services and to ensure that health home services are provided in accordance with the requirements outlined under "Provider Standards."

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Providers are expected to provide comprehensive case management, care coordination, health promotion services, comprehensive transitional care, individual and family support services, and referral to community and social support services. See attached for original state plan submission.

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Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

        Describe below

        Reimbursement will be the same regardless of the frequency or intensity of care management activities.
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Reimbursement will be the same regardless of the frequency or intensity of care management activities.

- [ ] PCCM (description included in Service Delivery section)
- [x] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Reimbursement will be limited to a monthly case rate. The reimbursement will be the same regardless of the frequency or intensity of care management activities provided within the month, except that health home providers will be required to provide at least one care management activity during the billable month. Health home providers must submit a claim to receive payment.

Allowable care management activities include:

- Comprehensive care management
- Care coordination and monitoring
- Assessment and care plan updates
- Health promotion
- Comprehensive transitional care (including appropriate follow-up from inpatient to other settings)
- Individual and family support services (including authorized representatives)
- Referral to community and social support services
- Activities related to updating the care plan and documenting contacts

Allowable activities will include face-to-face, telephone and other modes of communication among the care team, the member and collaterals. Direct health care or social services are not covered.

This fee is reimbursable only for eligible members who have gone through the assessment and care plan development process and who have an assigned care coordinator. Reimbursement will be limited to the lesser of the amount billed or the established maximum fee.

The state considered the following factors in developing the monthly rate: the development of a core health home team, associated Medicaid reimbursement rates (based on max fee schedule), claims data to determine appropriate levels of service across provider types, and the acuity and chronicity of members being served. Reimbursement will be the same for private and public providers.

Maximum allowable fees and reimbursement rates under the methods and standards set forth in this Attachment are published in the schedules posted online on the Wisconsin Medicaid website at:

Health Homes Payment Methodologies

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved The State assures CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, including management care, other delivery systems including waivers, any future health homes, and other state plan services.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management involves the use of evidence-based guidelines to provide systematic, responsive and coordinated management of all aspects of primary and specialty care (physical and behavioral needs) for individuals with AIDS/HIV.
Comprehensive care management includes early identification of individuals who meet the criteria for health home

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All contacts with health home members will be documented in the electronic health record. The patient's electronic health record will be accessible to all members of the patient's core team.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Designated AIDS Service Organization Providers	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute

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Care Coordination

Definition

Care coordination is the ongoing management of the patient's medical, behavioral, pharmacological, dental care, and community care needs by a designated team lead.
The team lead will ensure that the patient has a current, written, individualized, multidisciplinary care and treatment plan that addresses all aspects of the patient's care (including preventive care needs, all medical subspecialties, institutional care, home and community care).

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The patient's treatment plan will be electronic and must be accessible to all members of the patient's core team.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Designated AIDS Service Organization Provider	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute

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Health Promotion

Definition

Health promotion services include all activities aimed at prevention, assisting the patient in better understanding their disease and, learning how to direct the care and treatment they receive.
Enhanced patient education and active promotion of self-management and self care are part of health promotion.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The designated team lead will be responsible for ensuring that the patient's electronic treatment plan is updated to include all patient education, including medication management and self care regimen.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
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- [ ] Dieticians
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- [ ] Other (specify)

Provider Type	Description
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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care involves the establishment of an automatic referral arrangement between institutional care providers and the health home provider to ensure that there is immediate communication and/or referrals of patients with AIDS/HIV who are admitted to the institution or are seen in the emergency room. Automatic referrals include the establishment of policies and procedures to assure that there is systematic and timely sharing of information related to the patient's institutional or emergency room care.
Transitional care will include timely face-to-face or telephone contacts with the patient (or the patient's authorized representative) after an emergency room visit or a hospital or nursing home discharge. Transitional care includes reviewing the discharge summary with the patient and assisting them in receiving the recommended care, including scheduling follow-up appointment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The care coordinator will be responsible for ensuring that the patient's electronic treatment plan is updated to reflect all transitional care needs.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Designated AIDS Service Organizations Providers	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute

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Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services include activities related to advocating on the member's behalf and mobilizing services and support for the member. It will include contacts with anyone identified as instrumental to the member's day-to-day support and care. Peer-to-peer information sharing and support are included in these support services.
Individual and family support services include imparting information in a manner that is simple, clear, straightforward and culturally appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The care coordinator will update the patient's electronic health record to reflect all activities related to individual and family support services.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Designated AIDS Service Organization Providers	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute

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Referral to Community and Social Support Services

Definition

Referral to community and social support services includes activities related to providing assistance to members to ensure they have access to social support services identified in the care plan.
To the extent feasible, the health home provider will establish meaningful working relationships with community-based organizations that provide services to individuals with HIV infection.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The care coordinator will document all referrals and the outcome of those referrals in the patient's electronic health record.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Designated AIDS Service Organizations Providers	Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute

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Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Each patient will have an identified care coordinator who will be responsible for the overall coordination of the patient's care. The team lead and the care coordinator can be the same individual.
Linkages between primary and behavioral health services are basic to the provision of services to patients diagnosed with HIV infection. Health home patients who do not have a diagnosis of mental health or substance use disorder will be routinely screened for depression and substance use. The integration of behavioral and physical health will occur within the health home through the required composition of a core team that includes representatives of both disciplines.

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Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will use paid claims data to compare costs for providing health care services to members enrolled in the H&S program prior to the implementation of the health home and annually thereafter to identify the areas of cost reduction. The state will also assess the costs of providing services to members with SUD and a co-occurring condition who are not enrolled in the health home and compare these costs and outcomes to those of members in the health home. The calculation method will be the same for dual-eligibles. Medicare data is not available to the State and therefore is not considered in cost-savings estimates.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state will require H&S providers to electronically store care plans in an electronic medical record (EMR) format or via a care coordination software platform in order to securely share information across provider sites. In addition, the state will strongly encourage the use of health information technology (HIT) within the first year of implementation. This will include the use of electronic medical records (EMRs) and the state selected health information exchange (HIE) to interface between Hubs, Spokes, and other relevant providers identified in the care plan and that the member may interact with. Finally, the state will provide the necessary technical assistance to support the implementation and use of HIT among H&S providers.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- ☐ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- ☐ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- ☐ The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), 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.

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