State: Wisconsin

MMDL Forms

Medicaid Administration

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: Wisconsin

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Department of Health Services

Type of Agency:

- ( ) Title IV-A Agency
- (•) Health
- ( ) Human Resources
- ( ) Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Section 49.45 Wisconsin Statutes

The single state agency supervises the administration of the state plan by local political subdivisions.

(•) Yes ( ) No

The state statutory citation for the legal authority under which the agency supervises the administration of the plan on a statewide basis is:

Section 49.45 (2), Wisconsin Statutes

The state statutory citation under which the single state agency has legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is:

Section 49.45 (2), Wisconsin Statutes

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Medicaid Administration

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 11/19/13

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Department of Administration, Division of Hearings and Appeals

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Division of Hearings and Appeals (DHA), which resides in the Department of Administration (DOA), conducts fair hearings of determinations of eligibility by the Department of Health Services (DHS) and counties and tribes who are delegated responsibility for that function. DHA also conducts hearing for Medicaid services/ benefits.

Petitioners may file objections with DHS regarding a proposed decision by DHA, and may seek a rehearing with DHA and/or file an appeal to a circuit court of final decisions.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

DHA conducts this function based on an agreement between the DHS and DOA. DHS retains control of policy issues.

DHS assures that DHA complies with all federal and state Medicaid laws, regulations and policies.

DHS retains oversight of the State Plan and has a process in place to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DHA.

Medicaid Administration

DHS assures that every applicant and beneficiary is informed in writing of the fair hearing process, how to contact DHA, and how to obtain information about fair hearings from that agency.

Any DHA decision that finds a DHS policy in conflict with law or that is a significant case of first impression is rendered as a proposed decision and submitted to DHS to make the final decision. Also, DHS reviews all decisions that DHA renders as final to determine if DHA is correctly applying the law and DHS policy. If not, DHS will instruct DHA as to the proper interpretation for future cases.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☒ The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

☒ Medicaid agency

☐ Title IV-A agency

☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

☒ Medicaid agency

☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

◉ Yes ○ No

Medicaid Administration

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Department of Health Services administers a wide range of services to clients in the community and at state institutions, regulates certain care providers, and supervises and consults with local public and voluntary agencies. Its responsibilities span public health; mental health and substance abuse; long-term support and care; services to people who have a disability, medical assistance, and children's services; aging programs; physical and developmental disability services; sensory disability programs; operation of care and treatment facilities; quality assurance programs; nutrition supplementation programs; medical assistance; and health care for low-income families, elderly, and disabled persons.

The department is administered by a secretary who is appointed by the governor with the advice and consent of the senate. The office of the secretary is responsible for the planned and coordinated execution of the various health and social services provided by the Department. The Department is divided into six divisions and three offices. The secretary appoints the division administrators from outside the classified service. The Department maintains regional, district, and sub-offices and institutions across the state. The six program divisions and three offices are the following:

— Division of Public Health
— Division of Health Care Access and Accountability
— Division of Mental Health and Substance Abuse Services
— Division of Quality Assurance
— Division of Long Term Care
— Division of Enterprise Services

— Office of Legal Counsel
— Office of Policy Initiatives and Budget
— Office of the Inspector General

The Division of Health Care Access and Accountability provides access to health care for low-income persons, the elderly, and people with disabilities. It administers the Medical Assistance (Medicaid), BadgerCare Plus, SeniorCare, Chronic Disease Aids, General Relief, and FoodShare programs.

The Division of Hearings and Appeals (DHA), which resides in the Department of Administration (DOA), conducts fair hearings of determinations of eligibility by the Department of Health Services and counties and tribes who are delegated responsibility for that function.

The Department of Health Services administers the Medicaid and other programs. The State Medicaid Director is the Administrator of the Division of Health Care Access and Accountability.

The Division of Health Care Access and Accountability (DHCAA) is composed of the Office of the Administrator and five Bureaus:

Bureau of Benefits Management (BBM)
Bureau of Enrollment Policy and Systems (BEPS)
Bureau of Fiscal Management (BFM)
Bureau of Operational Coordination (BOC)
Disability Determination Bureau (DDB)

Office of the Administrator (AO)

The Administrator's Office is responsible for setting overall policy direction of the Medicaid programs and securing financial well-

Medicaid Administration

being of all Medicaid programs accountable to the Secretary. The AO is responsible for decision making on all policies and processes that have long term or serious impacts on the Medicaid programs, excluding long term care programs; supervision of Bureau Directors; policy and project management for high priority Medicaid projects; and oversight of the South East Wisconsin Liaison position with a focus on improving stakeholder relations in Milwaukee and Southeastern Wisconsin.

Bureau of Benefits Management (BBM)

The Bureau of Benefits Management supports and advises the Medicaid Director on health benefits administered under the Medicaid program, including:

— Management of the Pharmacy Benefit.

— Managed Care Contract Compliance, including administering the statewide BadgerCare Plus and Medicaid SSI HMO Contracts; member grievances and fair hearings process, and the provider appeals process.

— Managing contracts for the provision of benefits, including incontinence supplies, eyeglasses, hearing aids, and transportation management.

— Benefit Design and Policy Development, for all Medicaid and BadgerCare Plus partial and full-benefit programs numerous policy areas, including physician, dental, mental health, school-based services, therapies, family planning, transportation, home health and DME/DMS; and making claims adjudication decisions.

— Provider Communications and Training, including production and distribution of Provider Updates and other communications; supervision, training, and ongoing support of the Provider Services unit and Professional Services Representatives; and supervision of and collaboration with the specialized dental unit.

— Quality Management and Initiatives, including maintaining HMO Member Quality Standards, developing pay-for performance standards, overseeing the Quality Dashboard, and publishing the ForwardHealth Quality Report website.

Bureau of Enrollment Policy and Systems (BEPS)
The Bureau of Enrollment Policy and Systems assures that eligibility policy, authorized under state and federal law as well as the Medicaid State Plan, is implemented in systems and operations and communicated clearly to members. It The Bureau is composed of the following sections:

— Policy Section
— Communications Section
— Systems Section
— Medicaid Quality Assurance Section
— FoodShare Quality Assurance Section
— Income Maintenance Training Section
— Second Party Review Section

as well as the following entities:

— Eligibility Management Central Application Processing Operation (EM CAPO)
— CARES Call Center

Collectively these entities perform a variety of functions, a partial list of which follows:

—— Assure eligibility program compliance with federal statutes and regulations, and maintain and update the eligibility portions of the Medicaid State Plan and federal 1115 waivers.

— Author “operations memos” that establish statewide processes for executing eligibility policy.

— Conduct communications with members, both directly through eligibility and renewal notices as well as through information

Medicaid Administration

provided to the public through web sites and other avenues.

— Manage the CARES and ACCESS systems as well as the interface between CARES and interChange so claims processing reflects accurate eligibility status.

— Manage system implementation of HMO enrollment.

— Maintain “medical status codes” used to track members by eligibility category.

— Perform quality assurance measures to assure accuracy of Medicaid benefit determinations and case closures.

— Assure the accuracy of FoodShare benefit determinations and case closures, as well as timely application processing for FoodShare.

— Plan, develop, and implement training for Income Maintenance programs, with input from consortia partners, other supervisors, and workgroups and by reviewing performance improvement indicators.

— Determine eligibility for SeniorCare, the Wisconsin Funeral & Cemetery Aids Program, Wisconsin Well Woman Medicaid, and the BadgerCare Plus Basic Plan.

— Maintain the CARES Call Center to provide policy, process and system support to IM agencies for IM programs through e-mail and telephone.

— Input, review, and track findings for Income Maintenance Programs, including FoodShare, using the new Income Maintenance Quality Assurance (IMQA) Tool.

— Evaluate cases across all consortia and monitor performance in order to improve payment accuracy and reduce fraud, waste and abuse.

— Monitors fair hearing decisions made by DHA for compliance with Medicaid policy.

Bureau of Fiscal Management (BFM)

The Bureau of Fiscal Management supports and advises the Medicaid director on all health care fiscal and budget issues and is responsible for management of the Medicaid budget, including all of the following:

Fiscal Monitoring and Financial Management
Medicaid Budget Development and Monitoring
Rate Setting
Cost Containment and Revenue Maximization

Fiscal Monitoring and Financial Management

Bureau staff calculate, prepare and submit state requests for financial transactions; review and authorize Medicaid payments processed by the contracted fiscal agent; compile required financial reporting, federal waiver reporting, and cost reporting; and conduct bank account management.

Medicaid Budget Development and Monitoring

Bureau staff develop projections of monthly expenditures, the weekly checkwrite, caseload, and cash balances. They perform fiscal analysis of pending legislation; maintain the coordination of benefits agreement (COBA) for crossover claims system design and maintenance; and, in consultation with the Office of Policy Initiatives and Budget (OPIB), develop the DHCAA budget request.

Rate Setting

Medicaid Administration

Bureau staff conduct rate setting activities. These include the calculation of HMO, hospital and non-institutional rates, as well as transportation rates. Staff assemble and maintain member encounter data; make assessment rates determinations; and study options for payment reform. Staff negotiate with CMS to win approval of changes to the Medicaid state plan. Staff also conduct systems modifications related to physicians, HMOs and hospital payment methodologies. Finally, Bureau staff conduct rate negotiations with providers.

Cost Containment and Revenue Maximization

The Bureau is responsible for oversight of Department rate reform initiatives; provider assessments; coordinating with contactors; and conducting federal revenue maximization projects.

Bureau of Operational Coordination (BOC)

The Bureau of Operational Coordination oversees all major Medicaid Management and Information Systems (MMIS) system projects and Centers for Medicare and Medicaid Services (CMS) mandates while coordinating and managing all fiscal agent contracts for the Medicaid program.

The Bureau is composed of a bureau director and three sections:

Systems and Vendor Management and Administrative Support
Data and Security Management Section
Contracts and Fiscal Management Section

BOC Director

The Bureau Director serves as the Wisconsin Medicaid Director for MMIS; as the liaison with CMS on MMIS; as the MMIS/Fiscal Agent Contract Manager; as liaison with the Department's Bureau of Human Resources, and performs project management for large MMIS system changes.

Systems and Vendor Management and Administrative Support

Staff in this section provide contract management for the Department's contracts with the Department's fiscal agent and the Department's MMIS contractor. Staff also provide management of MMIS and decision support system; as well as the ForwardHealth Portal. For information technology (IT), staff provide project management, IT strategic planning, including modification management for interChange, CARES, and other functions. Staff in this section provide project support on CMS Mandates and manage Medicaid Health Information Technology (HIT) incentive payments and planning; the ICD-10 diagnosis code project; and the National Correct Coding Initiative (NCCI). The Bureau conducts user acceptance testing for interChange and CARES; and works to ensure HIPAA compliance and conduct HIPAA 5010 transactions. Bureau staff manage the SPEC Vision Volume Purchase contract. Staff in this section also coordinate Division-wide initiatives. Bureau staff in this Section manage the DHCAA Call Center and web mail and controlled correspondence management; as well as process orders for supplies and services and travel and training requests.

Data and Security Management Section

Staff in this section are responsible for management of all internal and external data and reporting for interChange, CARES, and FoodShare; production of standard Medicaid and FoodShare enrollment data reports; conducting eligibility verification and issuing ID Cards. The Security Officer, who is housed in this section, provides access to DHS Network and all systems to all staff entitled to that access. The Privacy Officer, located in this section, coordinates with the Department Privacy Office and the CAPS Team. Additional functions located in this section are COOP (Continuity of Operations Planning); and the Division's Records Custodian and Open Records management, network and computer support, and intranet maintenance.

Contracts and Fiscal Management Section

The Contracts and Fiscal Management Section is responsible for all contract administration, including County Income Maintenance (IM) contracts; liaison with Department procurement; FoodShare EBT (electronic benefits transfer) vendor management; member

Medicaid Administration

fraud activities; fiscal management for administrative costs and budgets; advanced planning documents (APD) for federal funding; preparation of cost allocation plans; and collections and recovery budget monitoring.

Disability Determination Bureau (DDB)

The Disability Determination Bureau provides medical decisions for the Social Security Administration's disability claims and processes disability claims for various State of Wisconsin programs, including Medicaid programs:

Social Security Disability Insurance (SSDI), Supplemental Security Insurance (SSI), Title 19 Medicaid Disability, Katie Beckett Childhood Disability (MA), and Medicaid Purchase Plan Disability.

Medicaid eligibility is based on the Social Security Administration's guidelines for determination of disability. All Title 19 Medicaid Disability claims use the same standards for case determinations as those used for SSI.

County consortia and tribal governments assist in the eligibility determination process for the Wisconsin Medicaid program. There are 72 counties in Wisconsin. All but two - Milwaukee & Menominee- conduct eligibility determinations. For Menominee County, eligibility determinations are performed by the Menominee Tribe. For Milwaukee County, the eligibility function is performed by the Department, through its organizational entity MilES (Milwaukee Enrollment Services). Functions of MilES include:
• Walk-in customer service and case-specific troubleshooting for customers
• Self-help area for customers to manage their caseload using ACCESS
• Homeless mail distribution, interoffice mail services and BadgerCare premium payment processing
• Program integrity reviews and process requests for fair hearings
• Program eligibility determinations for applications, renewals and changes for initial and continuing eligibility for Medicaid (MA) and CHIP program benefits
• Ongoing caseload management including processing verification, alerts, and data exchange data
• Program eligibility determinations & ongoing, specialized case management for customers requesting and receiving Long Term Care MA services
• Program eligibility determinations for applications and renewals and ongoing case management for Elderly, Blind & Disabled cases, including MA deductibles, presumptive disability requests and special status MA programs
• Mobile Unit serves local community sites on a rotational basis for program eligibility determinations and case troubleshooting
• Answer daily calls regarding general and case specific questions from customers & the public
• Process case changes and submitted verification documents
• Outreach to customers affected by programmatic eligibility changes
• Answer daily calls received regarding the Affordable Care Act and the Marketplace
• Processing of applications transferred from the federal Marketplace to MilES

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The executive branch includes the state's six constitutional officers - the governor, lieutenant governor, secretary of state, state treasurer, attorney general, and state superintendent of public instruction.

The term "department" is used to designate a principal administrative agency within the executive branch. There are currently 17 departments in the executive branch. In most cases a department is headed by a secretary with the advice and consent of the senate.

The Department of Children and Families provides or oversees county provision of various services to assist children and families, including services for children in need of protection or services for their families, adoption and foster care services, licensing of facilities that care for children, background investigations of child caregivers, and child abuse and neglect investigations. It administers the Wisconsin Works (W-2) program, including the child care subsidy program, child support enforcement and paternity establishment, and programs related to the Temporary Assistance to Needy Families (TANF) income support program. The department works to ensure families have access to high quality and affordable early care and education and also administers

Medicaid Administration

the licensing and regulation of day care centers.

The Department of Health Services administers a wide range of services to clients in the community and at state institutions, regulates certain care providers, and supervises and consults with local public and voluntary agencies. Its responsibilities span public health; mental health and substance abuse; long-term support and care; services to people who have a disability, medical assistance, and children's services; aging programs; physical and developmental disability services; sensory disability programs; operation of care and treatment facilities; quality assurance programs; nutrition supplementation programs; medical assistance; and health care for low-income families, elderly, and disabled persons.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ( ) Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- (•) The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Income recipients.
Social Security Administration Field Office staff are federal government employees. Their functions in regard to determining eligibility for SSI and Medicaid are all of the following:
• Complete Medicaid-only items in the SSI application and redetermination processes (i.e., assignment of rights, third party liability, transfer of resources and Medicaid qualifying trust items).
• Determine the Medicaid State and county of residence.
• Refer individuals to their local Medicaid and other agencies when appropriate.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ( ) An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ( ) An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

( ) Yes (•) No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

Medicaid Administration

- [ ] Counties
- [ ] Parishes
- [x] Other

Type of local subdivision: County Consortia and Tribes

Are all of the local subdivisions indicated above used to administer the state plan?

- [ ] Yes
- [x] No

Remove

Names of local subdivisions used to administer the state plan: See names listed below.

Description of the staff and functions of the local subdivisions (provide only once if they all have the same description. If they do not, provide as many descriptions as needed, and indicate for each description to which local subdivision it applies.):

Names of County Consortia: Bay Lake, Capital, East Central, Great Rivers, IM Central, Moraine Lakes, Northern, Southern, WKRP, and Western

Counties are independent units of government. There are 72 counties in Wisconsin. Of the 72 counties, 70 are organized into 10 Consortia that administer Medicaid for their geographic area. The Consortia administer the Medicaid program under statutory authority with specific requirements spelled out in contracts with the Department of Health Services. Medicaid in Milwaukee County is administered directly by the Department of Health Services. Medicaid in Menominee County is administered by the Menominee Tribe. Eligibility staff of the Consortia are employees of the counties. Functions performed by the consortia include:

- Conducting application processing
- Eligibility processing services
- Providing in-person services
- Coordination with state staff and consortia partners to ensure provision of the following administrative functions:
  - o Subrogation
  - o Benefit recovery
  - o Fair hearings
  - o Fraud prevention and identification
- Case-specific troubleshooting for customers
- Medicaid premium payment processing
- Program integrity reviews
- Program eligibility determinations for applications, renewals and changes for initial and continuing eligibility for Medicaid (MA) program benefits for all categories of Medicaid eligibility except for: women with breast and cervical cancer eligible under 1902(a)(10)(A)(ii)(XVIII), SeniorCare (an 1115 waiver drug benefit program) and children eligible under 1902(e)(3) whose eligibility is determined by staff in the Department of Health Services.
- Ongoing caseload management including processing verification, alerts, and data exchange data
- Program eligibility determinations & ongoing, specialized case management for customers requesting and receiving Long Term Care MA services
- Program eligibility determinations for applications and renewals and ongoing case management for Elderly, Blind & Disabled cases, including medically needy deductibles, presumptive disability requests and special status MA programs
- Answer daily calls regarding general and case specific questions from customers & the public
- Process case changes and submitted verification documents
- Outreach to customers affected by programmatic eligibility changes
- Answer daily calls received regarding the Affordable Care Act and the Marketplace
- Processing of applications transferred from the federal Marketplace

Remove

Medicaid Administration

Names of local subdivisions used to administer the state plan: See names listed below.

Description of the staff and functions of the local subdivisions (provide only once if they all have the same description. If they do not, provide as many descriptions as needed, and indicate for each description to which local subdivision it applies.):

Names of Tribes administering the state plan: Red Cliff, Forest County Potawatomi, Lac Courte Oreilles, Lac du Flambeau, Menominee, Oneida, Bad River, Sokaogon Chippewa, and Stockbridge Munsee

There are 11 American Indian tribes within Wisconsin. Of those 11 tribes, 9 make eligibility determinations for Medicaid. The tribes administer the Medicaid program under statutory authority with specific requirements spelled out in contracts with the Department of Health Services. Eligibility staff are employees of the tribes. Functions performed by the tribes include:

- Conducting application processing
- Eligibility processing services
- Providing in-person services
- Coordination with state staff to ensure provision of the following administrative functions:
  - o Subrogation
  - o Benefit recovery
  - o Fair hearings
  - o Fraud prevention and identification
- Case-specific troubleshooting for customers
- Medicaid premium payment processing
- Program integrity reviews
- Program eligibility determinations for applications, renewals and changes for initial and continuing eligibility for Medicaid (MA) program benefits for all categories of Medicaid eligibility except for: women with breast and cervical cancer eligible under 1902(a)(10)(A)(ii)(XVIII), SeniorCare (an 1115 waiver drug benefit program) and children eligible under 1902(e)(3) whose eligibility is determined by staff in the Department of Health Services.
- Ongoing caseload management including processing verification, alerts, and data exchange data
- Program eligibility determinations & ongoing, specialized case management for customers requesting and receiving Long Term Care MA services
- Program eligibility determinations for applications and renewals and ongoing case management for Elderly, Blind & Disabled cases, including medically needy deductibles, presumptive disability requests and special status MA programs
- Answer daily calls regarding general and case specific questions from customers & the public
- Process case changes and submitted verification documents
- Outreach to customers affected by programmatic eligibility changes
- Answer daily calls received regarding the Affordable Care Act and the Marketplace
- Processing of applications transferred from the federal Marketplace

Add

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

Medicaid Administration

- [x] The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- [x] There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- [ ] There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

- [ ] When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- [x] The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☐ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☐ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

- (•) Age 19
- ( ) Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ◉ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

Enter the standard by region

Remove Region

Name of region: Area 1

Description: Counties and Tribal areas in Area 1: Brown, Kenosha, Outagamie, Sheboygan, Dane, La Crosse, Ozaukee, Washington, Dodge, Marathon, Racine, Waukesha, Dunn, Manitowoc, Rock, Winnebago, Eau Claire, Milwaukee, St.Croix, Fond du Lac, and Ho-Chunk (but only if residing on tax free lands in La Crosse or Marathon County)

	Household size	Standard ($)	
+	1	342	X
+	2	565	X
+	3	674	X
+	4	806	X
+	5	929	X

Medicaid Eligibility

+	6	1.018	X
+	7	1,113	X
+	8	1,194	X
+	9	1.268	X
+	10	1.320	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 52

Remove Region

Name of region

Area 2

Description

Counties and Tribal areas in Area 2:
Adams, Ashland, Bad River, Barron, Bayfield, Buffalo, Calumet, Chippewa, Clark, Columbia, Crawford, Door, Douglas, Florence, Forest, Green, Green Lake, Grant, Iowa, Iron, Jackson, Jefferson, Juneau, Kewaunee, Lafayette, Langlade, Lincoln, Marinette, Marquette, Menominee, Monroe, Oconto, Oneida, Pepin, Pierce, Polk, Portage, Price, Richland, Rusk, Sauk, Sawyer, Shawano, Taylor, Trempeleau, Vernon, Vilas, Walworth, Washburn, Waupaca, Waushara, Lac Courte Oreilles, Lac du Flambeau, Menominee Tribe , Mole Lake, Potawatomi, Red Cliff, St.Croix Tribe , Stockbridge-Munsee

	Household size	Standard ($)	
+	1	337	X
+	2	556	X
+	3	663	X
+	4	795	X
+	5	917	X
+	6	1.004	X
+	7	1.100	X
+	8	1,181	X

Medicaid Eligibility

+	9	1,253	X
+	10	1,306	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 53

Add Region

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

(•) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

Enter the standard by region

Remove Region

Name of region: Area 1

Description: Counties and Tribal areas in Area 1: Brown, Kenosha, Outagamie, Sheboygan, Dane, La Crosse, Ozaukee, Washington, Dodge, Marathon, Racine, Waukesha, Dunn, Manitowoc, Rock, Winnebago, Eau Claire, Milwaukee, St.Croix, Fond du Lac, and Ho-Chunk (but only if residing on tax free lands in La Crosse or Marathon County)

	Household size	Standard ($)	
+	1	249	X
+	2	440	X
+	3	518	X
+	4	618	X

Medicaid Eligibility

+	5	709	X
+	6	766	X
+	7	830	X
+	8	879	X
+	9	921	X
+	10	943	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 20

Remove Region

Name of region

Area 2

Description

Counties and Tribal areas in Area 2:
Adams, Ashland, Bad River, Barron, Bayfield, Buffalo, Calumet, Chippewa, Clark, Columbia, Crawford, Door, Douglas, Florence, Forest, Green, Green Lake, Grant, Iowa, Iron, Jackson, Jefferson, Juneau, Kewaunee, Lafayette, Langlade, Lincoln, Marinette, Marquette, Menominee, Monroe, Oconto, Oneida, Pepin, Pierce, Polk, Portage, Price, Richland, Rusk, Sauk, Sawyer, Shawano, Taylor, Trempeleau, Vernon, Vilas, Walworth, Washburn, Waupaca, Waushara, Lac Courte Oreilles, Lac du Flambeau, Menominee Tribe, Mole Lake, Potawatomi, Red Cliff, St.Croix Tribe , Stockbridge-Munsee and Ho-Chunk

	Household size	Standard ($)	
+	1	241	X
+	2	426	X
+	3	501	X
+	4	599	X
+	5	689	X
+	6	743	X
+	7	806	X

Medicaid Eligibility

+	8	854	X
+	9	894	X
+	10	914	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 20

Add Region

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

(•) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

Enter the standard by region

Medicaid Eligibility

Name of region

Description

	Household size	Standard ($)	
+	1		X

Additional incremental amount

Yes No

Increment amount $

Add Region

The dollar amounts increase automatically each year

Yes No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

Statewide standard

Standard varies by region

Standard varies by living arrangement

Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

Statewide standard

Standard varies by region

Standard varies by living arrangement

Standard varies in some other way

Medicaid Eligibility

The dollar amounts increase automatically each year

Yes No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☐ A qualified hospital is a hospital that:

- ☐ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.
- ☐ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

☐ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ☐ Pregnant Women
- ☐ Infants and Children under Age 19
- ☐ Parents and Other Caretaker Relatives
- ☐ Adult Group, if covered by the state
- ☐ Individuals above 133% FPL under Age 65, if covered by the state
- ☐ Individuals Eligible for Family Planning Services, if covered by the state
- ☐ Former Foster Care Children
- ☐ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

(•) Yes ( ) No

Select one or both:

[X] The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: The state will use the first year's experience to develop these standards, in consultation with the Wisconsin Hospital Association.

[X] The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: The state will monitor, by hospital, the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period. The state may offer additional training to hospitals with Medicaid enrollment levels that fall below 90 percent of the number of PE determinations made in a 12-month period. The state will review this target percentage, in consultation with the Wisconsin Hospital Association, after the first year of PE implementation. The state will adjust this target if indicated.

[ ] The presumptive period begins on the date the determination is made.

[ ] The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

[ ] Periods of presumptive eligibility are limited as follows:

( ) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

(•) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

( ) Yes (•) No

[ ] The presumptive eligibility determination is based on the following factors:

[ ] The individual’s categorical or non-financial eligibility for the group for which the individual’s presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

[ ] Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

[X] State residency

[X] Citizenship, status as a national, or satisfactory immigration status

Medicaid Eligibility

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

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

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☒ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

Grandmother or grandfather, aunt or uncle, first cousin, nephew or niece, or any preceding generation denoted by the prefix grand-, great-, or great-great, and including those through adoption.
Spouse of any of the above even after the marriage ends by death, divorce, or separation.

☐ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

Medicaid Eligibility

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

Medicaid Eligibility

(•) A percentage of the federal poverty level: 101 %

( ) The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) Other dollar amount

[■] Income standard chosen:

Indicate the state's income standard used for this eligibility group:

( ) The minimum income standard

( ) The maximum income standard

( ) The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

(•) Another income standard in-between the minimum and maximum standards allowed

( ) The state's AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) The state's TANF payment standard, not converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

(•) Other income standard in-between the minimum and the maximum standards allowed.

The amount of the income standard for this eligibility group is:

(•) A percentage of the federal poverty level: 95 %

( ) A dollar amount

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Medicaid Eligibility

○ Yes ◉ No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 15 - 0006

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

☐ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☐ Income standard used for this group

☐ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

☐ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

The amount of the maximum income standard is: 301 % FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

Medicaid Eligibility

(•) Yes ( ) No

[ ] The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

[•] The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

- [■] The woman must be pregnant
- [■] Household income must not exceed the applicable income standard at 42 CFR 435.116.
- [▨] State residency
- [▨] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- [▨] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- [ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- [ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- [ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- [ ] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- [ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- [ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- [ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act
- [ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- [ ] Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Medicaid Eligibility

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Ad hoc organizations	Entities not defined above and who are not Medicaid providers may also apply as a partner to make determinations for pregnant women under age 19. The Department will review these applications on a case-by-case basis.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19

S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with honsehold income at or below standards established by the state based on age gronp.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

Enter the amount of the maximum income standard: 301 % FPL

☑ Income standard chosen

The state's income standard used for infants under age one is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☑ Income standard for children age one through age five, inclusive

☑ Minimum income standard

Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 186 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☑ Income standard for children age six through age eighteen, inclusive

☑ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

☑ Income standard chosen

The state's income standard used for children age six through eighteen is:

Medicaid Eligibility

(●) The maximum income standard

( ) If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

(●) Yes ( ) No

Presumptive Eligibility for Children	S16
1902(a)(47) 1920A 42 CFR 435.1101 42 CFR 435.1102	
[■] The state provides Medicaid coverage to children when determined presumptively eligible by a qualified entity under the following provisions:	

Medicaid Eligibility

If the state has elected to cover Optional Targeted Low-Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the higher of the standard used for Optional Targeted Low-Income Children or the standard used for Infants and Children under 19 (42 CFR 435.118), for that child's age.

If the state has not elected to cover Optional Targeted Low Income Children (42 CFR 435.229), the income standard for presumptive eligibility is the standard used under the Infants and Children under Age 19 eligibility group (42 CFR 435.118), for that child's age.

☑ Children under the following age may be determined presumptively eligible:

Under age 19

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

☑ Household income must not exceed the applicable income standard described above, for the child's age.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

Medicaid Eligibility

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☒ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☒ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- ☒ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☒ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☒ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☒ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☒ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☒ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☒ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☒ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Faith-based organizations	Faith-based organizations providing services to low-income children and families	X
+	Community-based organizations	Community-based organizations providing health or social services to lowincome children and families.	X

Medicaid Eligibility

	Name of entity	Description	
+	Ad hoc organizatons	Entities not defined above may also apply for certification to temporarily enroll children in BadgerCare Plus. The Department will review these applications on a case-by-case basis. The Department will make a decision based on several factors, including: geographic location, population typically served by the agency, and the agency's ability to meet the Department's requirements for making timely determinations.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Adult Group	**S32**
1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	
The state covers the Adult Group as described at 42 CFR 435.119. ○ Yes ◉ No	

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals above 133% FPL

S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

( ) Yes (•) No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Coverage of Parents and Other Caretaker Relatives **S51**

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21

S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(●) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☑ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

☑ Be under age 21, or a lower age, as defined within the reasonable classification.

☑ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

☑ Not be eligible and enrolled for mandatory coverage under the state plan.

☑ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(●) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☑ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

Medicaid Eligibility

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

○ Yes ◉ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children **S11**

☐ Individuals for whom public agencies are assuming full or partial financial responsibility.

☐ Individuals in adoptions subsidized in full or part by a public agency

☒ Individuals in nursing facilities, if nursing facility services are provided under this plan

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☒ Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☒ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

Medicaid Eligibility

☐ Other reasonable classifications

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once S11 form above is complete to view the income standards form.

Individuals in nursing facilities, if nursing facility services are provided under this plan

☒ Income standard used

☒ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☒ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Medicaid Eligibility

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.

Medicaid Eligibility

☑ Income standard used

☑ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

Medicaid Eligibility

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☑ Income standard used

☑ Minimum income standard

Medicaid Eligibility

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

Medicaid Eligibility

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

○ Yes ◉ No

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

Medicaid Eligibility

○ Yes ◉ No

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

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

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(•) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (•) No

[■] There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children

S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

(●) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the state plan as of March 23, 2010.

(●) Yes ( ) No

☐ Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

☐ Individuals are covered under this eligibility group, as follows:

( ) All children under age 18 or 19 are covered:

(●) The reasonable classification of children covered is:

( ) Under age 1

( ) Age 1 through age 5, inclusive

(●) Age 6 through age 18, inclusive

( ) Under age [ ]

( ) Age [ ] through age [ ]

☐ Income standard used for this classification

☐ Minimum income standard

Medicaid Eligibility

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 200% FPL.

○ A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

☑ The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

151 % FPL

☑ Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

◉ The maximum income standard.

○ The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

- ○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.
- ○ If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.
- ○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is: 151 % FPL

- ■ There is no resource test for this eligibility group.
- ■ Presumptive Eligibility
  - ■ Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals with Tuberculosis

S55

1902(a)(10)(A)(ii)(XII)
1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

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

[■] Are infected with tuberculosis.

[■] Are not otherwise eligible for mandatory coverage under the Medicaid state plan.

[■] Have household income under a standard established by the state.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] Income standard used for this group

[■] Maximum income standard

First indicate the maximum income standard that could be used for this group and then indicate the income standard the state uses for the group.

The state elects to convert the effective income level for coverage of this eligibility group in effect in the Medicaid state plan as of March 23, 2010 and December 31, 2013 to MAGI-equivalent standards.

( ) Yes (•) No

The state's maximum income standard for this eligibility group is:

(•) The break-even point for earned income under the SSI program.

( ) The effective income level for this eligibility group under the Medicaid state plan in effect as of March 23, 2010, not converted to a MAGI-equivalent standard.

( ) The effective income level for this eligibility group under the Medicaid state plan in effect as of December 31, 2013, not converted to a MAGI-equivalent standard.

[■] Income standard chosen

The state's income standard used for this eligibility group is:

(•) The maximum income standard.

( ) If not chosen as the maximum income standard, the break-even point for earned income under the SSI program.

( ) Another income standard less than the maximum standard allowed.

[■] Individuals qualifying under this group are eligible only for the following services, provided the service is related to the diagnosis, treatment or management of the individual's tuberculosis.

[■] Prescribed drugs, described in 42 CFR 440.120

Medicaid Eligibility

- ☒ Physician services, described in 42 CFR 440.50
- ☒ Outpatient hospital and rural health clinic described in 42 CFR 440.20 and Federally-qualified health center services
- ☒ Laboratory and x-ray services (including services to confirm the presence of the infection), described in 42 CFR 440.30
- ☒ Clinic services, described in 42 CFR 440.90
- ☒ Case management services defined in 42 CFR 440.169
- ☒ Services other than room and board designed to encourage completion of regimens of prescribed drugs by out-patients, including services to observe directly the intake of prescription drugs.

☒ Limitations related to tuberculosis-related services may be found in the Benefits section.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents

S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

(●) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

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

[■] Are under the following age

(●) Under age 21

( ) Under age 20

( ) Under age 19

[■] Were in foster care under the responsibility of a state on their 18th birthday.

[■] Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

[■] Have household income at or below a standard established by the state.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

[■] The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

(●) All children under the age selected

( ) A reasonable classification of children under the age selected:

[■] Income standard used for this eligibility group

[■] Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Medicaid Eligibility

- [x] Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

- [x] No income test was used (all income was disregarded) for this eligibility group under (check all that apply):
  - [x] The Medicaid state plan as of March 23, 2010.
  - [x] The Medicaid state plan as of December 31, 2013.
  - [ ] A Medicaid 1115 demonstration as of March 23, 2010.
  - [ ] A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

- [x] Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

This eligibility group does not use an income test (all income is disregarded).

- [x] There is no resource test for this eligibility group.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] The individual may be a male or a female.

[■] Income standard used for this group

[■] Maximum income standard

[✓] The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is the highest of the following:

(•) The state's current effective income level for the Pregnant Women eligibility group (42 CFR 435.116) under the Medicaid state plan.

( ) The state's current effective income level for pregnant women under a Medicaid 1115 demonstration.

( ) The state's current effective income level for Targeted Low-Income Pregnant Women under the CHIP state plan.

( ) The state's current effective income level for pregnant women under a CHIP 1115 demonstration.

The amount of the maximum income standard is: 301 % FPL

[■] Income standard chosen

The state's income standard used for this eligibility group is:

(•) The maximum income standard

( ) Another income standard less than the maximum standard allowed.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Medicaid Eligibility

- [x] In determining eligibility for this group, the state uses the following household size:
  - [ ] All of the members of the family are included in the household
  - [x] Only the applicant is included in the household
  - [ ] The state increases the household size by one
- [x] In determining eligibility for this group, the state uses the following income methodology:
  - ( ) The state considers the income of the applicant and all legally responsible household members (using MAGI-based methodology).
  - (•) The state considers only the income of the applicant.
- [x] Benefits for this eligibility group are limited to family planning and related services described in the Benefit section.
- [x] Presumptive Eligibility

  The state makes family planning services and supplies available to individuals covered under this group when determined presumptively eligible by a qualified entity.

  (•) Yes ( ) No

  The state also covers medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting during the presumptive eligibility period.

  (•) Yes ( ) No

  - [x] The presumptive period begins on the date the determination is made.
  - [x] The end date of the presumptive period is the earlier of:

    The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

    The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

  - [x] Periods of presumptive eligibility are limited as follows:
    - ( ) No more than one period within a calendar year.
    - ( ) No more than one period within two calendar years.
    - (•) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
    - ( ) Other reasonable limitation:

Medicaid Eligibility

The state requires that a written application be signed by the applicant or representative.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The individual must not be pregnant.

[■] Household income must not exceed the applicable income standard specified for this group.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses entities, as defined in section 1920C, to determine eligibility presumptively for this eligibility group. These entities must be eligible to receive payment for services under the state's approved Medicaid state plan and determined by the state to be capable of determining presumptive eligibility for this group.

The types of entities used to determine presumptive eligibility for this eligibility group are:

	Name of entity	Description	
+	Medicaid Providers	Furnishes health care items or services covered under the state's approved Medicaid state plan, is eligible to receive payments under the plan and is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.	X
+	Tribal Health Facilities	Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization and is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.	X
+	WIC Program	Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966 and is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.	X

[☑] The state assures that it has communicated the requirements for entities, at 1920C of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

Medicaid Eligibility

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131009

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
State Residency

S88

42 CFR 435.403

State Residency

- [x] The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- [ ] Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - [ ] Intends to reside in the state, including without a fixed address, or
  - [ ] Entered the state with a job commitment or seeking employment, whether or not currently employed.
- [ ] Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- [ ] Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - [ ] Residing in the state, with or without a fixed address, or
  - [ ] The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- [ ] Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - [ ] Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - [ ] Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - [ ] If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- [ ] Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- [ ] Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- [ ] Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- [ ] IV-E eligible children living in the state, or

Medicaid Eligibility

- Otherwise meet the requirements of 42 CFR 435.403.

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

(•) Yes ( ) No

[x] The state has interstate agreements with the following selected states:

- [x] Alabama
- [x] Alaska
- [x] Arizona
- [x] Arkansas
- [x] California
- [x] Colorado
- [x] Connecticut
- [x] Delaware
- [x] District of Columbia
- [x] Florida
- [x] Georgia
- [x] Hawaii
- [x] Idaho
- [x] Illinois
- [x] Indiana
- [x] Iowa
- [x] Kansas
- [x] Kentucky
- [x] Louisiana
- [x] Maine
- [x] Maryland
- [x] Massachusetts
- [x] Michigan
- [x] Minnesota
- [x] Mississippi
- [x] Missouri
- [x] Montana
- [x] Nebraska
- [x] Nevada
- [x] New Hampshire
- [x] New Jersey
- [x] New Mexico
- [ ] New York
- [x] North Carolina
- [x] North Dakota
- [x] Ohio
- [x] Oklahoma
- [x] Oregon
- [x] Pennsylvania
- [x] Rhode Island
- [x] South Carolina
- [x] South Dakota
- [x] Tennessee
- [x] Texas
- [x] Utah
- [x] Vermont
- [x] Virginia
- [x] Washington
- [x] West Virginia
- [ ] Wisconsin
- [ ] Wyoming

[x] The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- [x] Are IV-E eligible
- [ ] Are in the state only for the purpose of attending school
- [ ] Are out of the state only for the purpose of attending school
- [ ] Retain addresses in both states
- [x] Other type of individual

Medicaid Eligibility

	Name of Type	Description	
+	Institutionalized	Individuals placed in a Wisconsin institution by an agreement State (or local government agency of that State) will be deemed to remain residents of the State that made the placement, unless a Wisconsin state or local government agency assumes responsibility for the individual's care. Individuals residing in a Wisconsin institution who would otherwise be considered residents of an agreement state under 435.403(h) or (i) will be deemed to be Wisconsin residents. Individuals placed in an institution in an agreement state by a Wisconsin state or local government agency will be deemed to remain residents of Wisconsin unless the other state or local government agency assumes responsibility for the individual's care. Individuals residing in an institution in an agreement state who would otherwise be considered residents of Wisconsin under 435.403(h) or (i) will be deemed to be residents of the agreement State. The list of States with which we have agreements and the dates of those agreements follows: Alabama 4/27/87 Arkansas 5/21/82 California 4/21/82 Georgia 4/19/82 Idaho 5/20/82 Kansas 7/12/82 Kentucky 5/14/82 Maryland 7/27/82 Minnesota 12/14/82 Mississippi 4/11/82 New Mexico 4/6/82 North Dakota 4/13/82 Ohio 4/23/82 Pennsylvania 5/20/82 South Carolina 4/27/82 South Dakota 4/6/82 Texas 4/28/82 Virginia 6/29/82 West Virginia 4/20/82	X
+	Other Adoption Assistance States	Wisconsin also has agreements with the States of New York and Wyoming to coordinate the provision of medical benefits and services to children receiving adoption assistance.	X

The state has a policy related to individuals in the state only to attend school.

Yes No

Medicaid Eligibility

☐ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

◉ Yes ○ No

Provide a description of the definition:

Once established, Wisconsin residence is retained until the individual indicates they no longer have the intent to return to Wisconsin, or declares to be a resident of another state. Being out-of-state, in and of itself, does not end Wisconsin residence. Residence is not lost when a Medicaid group or group member is temporarily out-of-state. Temporary absence ends when:
1. Another state determines the person is a resident there for Medicaid purposes.
2. The person states that they no longer intend to reside in Wisconsin
3. Other information is provided that indicates the person is no longer a resident.

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
Citizenship and Non-Citizen Eligibility

S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

☐ The state provides Medicaid eligibility to otherwise eligible individuals:

☐ Who are citizens or nationals of the United States; and

☐ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

☐ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

○ Yes ◉ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

◉ Yes ○ No

The date benefits are furnished is:

○ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

◉ Other date, as described:

Benefits are furnished to applicants as of the date the agency determines they are otherwise eligible and are only pending for verification of citizenship and identity. This date can be any time within the normal application processing time frame.

Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

(•) Yes ( ) No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

(•) Yes ( ) No

[x] Pregnant women

[x] Individuals under age 21:

( ) Individuals under age 21

( ) Individuals under age 20

(•) Individuals under age 19

[ ] An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

[ ] An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   [ ] Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   [ ] Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   [ ] Granted employment authorization under 8 CFR 274a.12(c);

   [ ] Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   [ ] Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   [ ] Granted Deferred Action status;

   [ ] Granted an administrative stay of removal under 8 CFR 241;

   [ ] Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   [ ] Has been granted employment authorization; or

   [ ] Is under the age of 14 and has had an application pending for at least 180 days;

Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

☐ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

☐ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

[redacted]

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

[redacted]

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

[redacted]

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

[redacted]

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Children in Out-of-Home Care

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Children with Non-IV-E Adoption Assistance	Voluntary	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. No

Select a method of geographic variation:

- (•) By county.
- ( ) By region.
- ( ) By city or town.
- ( ) Other geographic area.

Specify counties:

The geographic area includes the following six Southeast counties:
Kenosha
Milwaukee
Ozaukee
Racine
Washington
Waukesha

Any other information the state/territory wishes to provide about the population (optional)

Excludes children in a secure facility or a residential care center

Alternative Benefit Plan

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/ territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☐ Letter

☐ Email

☒ Other:

Describe:

The Department will inform individuals about voluntary enrollment at various points following the child's placement into out-of-home care. Parent(s) or legal guardians receive a notice after their child is placed in care, which identifies the benefits of the program and explains the voluntary nature of the Care4Kids program. The Department will make multiple attempts to communicate with the parent(s) or legal guardians to review the program and confirm the parent(s) or legal guardians choice of health care plan. During contact parent(s) or legal guardians are informed the program is voluntary, there is no cost sharing, the benefits provided by Care4Kids, and that they are able to disenroll at any time for any reason. Parents who determine they do not wish to enroll their child will receive a letter reminding them of their option to enroll and the benefits of enrolling in the Care4Kids Program. Parent(s) or legal guardians who do not have a phone number will receive a letter providing them with information regarding the voluntary nature of the Care4Kids program, the benefits their child will receive if they choose to enroll, and the process for disenrollment. The document will provide contact information should they have questions regarding the Care4Kids program. Parent(s) or legal guardians will also be notified that if they do not contact the department the courts may give consent for the child to be enrolled in the Care4Kids program.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

Alternative Benefit Plan

When did/will the state/territory inform the individuals?

Following the removal of a child from their home, the Department of Children and Families (DCF) will promptly provide the parent(s) or legal guardian with a Department approved handout describing the voluntary nature of the Care4Kids program. The handout will provide additional information including a short list of benefits available to the child if he/she enrolls in the Care4Kids program, notice of the parent(s) or legal guardian's right to disenroll the child from the program at any time, and that the Department will be attempting to make contact with the parent(s) or legal guardian in the very near future.

After the child's placement in out-of-home care, the Department will begin multiple attempts to make contact with the parent(s) or legal guardians if contact information was provided. When contact is made with the parent(s) or legal guardian, the Department will provide a verbal comparison of the benefits of the Care4Kids and the state Medicaid plan. The Department will also emphasize the voluntary nature of the program, that there is no cost sharing, and the parent(s) or legal guardian's right to disenroll from the program at any time. Parents who determine they would like to enroll their child in Care4Kids are informed they will receive a "member handbook" from the provider in the near future. The member handbook informs parents that they have the right to voluntarily disenroll their child from Care4Kids at any time and for any reason. Parents who determine they do not wish to enroll their child will receive a letter reminding them of their option to enroll and the benefits of enrolling in the Care4Kids Program.

When the Department is not able to make contact with the parent(s) or legal guardians, the Department will send a letter to the parents. The letter will provide information regarding the voluntary nature of the Care4Kids program, the benefit comparison between the state Medicaid plan and the Care4Kids plan, and the right to disenroll their child at any time. The Department will provide a description of the process to disenroll their child and contact information should they have questions or wish to disenroll their child. Additionally, when the parent(s) or legal guardians are not available, the Department will notify DCF and request involvement of the courts to allow enrollment of the child in the Care4Kids program.

In summary, the parents will receive information regarding enrollment, disenrollment, and benefits at the following points during their child's out-of-home care:

- When the child is initially removed from the home, the Child Welfare Worker will share the one page handout with the parents.
- When the Enrollment Specialist receives the parent(s) contact information, three attempts will be made to contact the parent(s) by phone to share benefit information including the difference between the Medicaid benefit and the Care4Kids benefit, the parent(s) ability to choose either program, the disenrollment process, and to obtain and document their enrollment decision.
- When the Enrollment Specialist is not able to contact the parent(s) via a working phone, they will send the parent(s) a letter providing information on the benefits, the disenrollment process and their option to enroll their child in the Care4Kids benefit. The letter allows the parent 10 days to contact the Enrollment Specialist and express their choice of benefit.
- When the parent determines, after conversation with the Enrollment Specialist, that they do not wish to have their child enrolled in Care4Kids, the Enrollment Specialist will send the parent a letter reminding them of the benefits of Care4Kid, providing information on their right to enroll their child, if eligible, at any time, and the contact information for the Enrollment Specialist.
- When the parent determines, after conversation with the Enrollment Specialist, that they want to have their child enrolled in the Care4Kids benefit, the parent will receive a Member Handbook that includes additional information related to benefits, their right to disenroll their child at any time, and contact information.
- When the parent is not available and the courts allow enrollment in the Care4Kids program, the parent will receive a Member Handbook that includes additional information related to benefits, their right to disenroll their child at any time, and contact information.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

If at any time after the child is enrolled and the parent/legal guardian is no longer interested in the child receiving the ABP benefit for any reason, they will contact the Enrollment Specialist. The parent/legal guardian will be able to obtain the contact information from the Member Handbook, the Child Welfare Worker and/or the child's Health Care Manager. A toll-free number will be provided to the parent or legal guardian with all informational mailings.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

Alternative Benefit Plan

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

- [ ] In the eligibility system.
- [ ] In the hard copy of the case record.
- [x] Other:

Describe:

Information will be documented in the state's MMIS.

What documentation will be maintained in the eligibility file? (Check all that apply.)

- [x] Copy of correspondence sent to the individual.
- [ ] Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- [ ] Other:

- [x] The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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

Select one of the following:

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

Name of benefit package: Care4Kids

Selection of the Section 1937 Coverage Option

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

- ☑ Benchmark Benefit Package.
- ☐ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ☐ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ☐ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ☐ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ☑ Secretary-Approved Coverage.
  - ☑ The state/territory offers benefits based on the approved state plan.
  - ☐ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ☐ The state/territory offers the benefits provided in the approved state plan.
    - ☑ Benefits include all those provided in the approved state plan plus additional benefits.
    - ☐ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ☐ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ☐ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

The plan includes all benefits, including EPSDT, in the state's approved Medicaid state plan. Care4Kids will also cover additional services focused on specific needs of children in out-of-home care. A key component of the additional services is health care coordination. Children in out-of-home care often have difficulty accessing appropriate medical and behavioral health care in the traditional fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many children in out-of-home care have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. Care4Kids will provide care coordination and enhanced services for children in out-of-home care

Alternative Benefit Plan

in southeast Wisconsin, where over half of the children in out-of-home care are living.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: United Health Care Insurance Company - Choice Plus

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

The state's intent is to provide children in out-of-home care with all the services identified the state's approved state plan. The state's approved plan includes all services listed in the Base Benchmark Plan (see ABP 5). The state's intent is also to link children with identified health needs to services and resources in a coordinated manner to ensure the achievement of desired health outcomes and the effectiveness of health and related health care services.

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan. However, in recognition of the special needs of children in out-of-home care, the PIHP will have the flexibility to offer services in an amount, duration or scope that may be greater than those identified in the state plan. All children in Care4Kids will be provided with services in response to their individual health care needs, as determined by a comprehensive evaluation of their medical, mental, dental and developmental status.

The results of the initial assessments will dictate the amount, duration and scope of services provided to each child. Each child will have a comprehensive health care plan, developed with input from a multidisciplinary team of professionals, with the child's primary care provider and child welfare worker at the center of the team. Other members of the team will depend on the needs of the individual child. Given this framework of service identification, prioritization and delivery, traditional prior authorization requirements could add an unnecessary and redundant barrier to efficient service provision to a population that often require services posthaste. The PIHP will make the determination regarding the need for traditional prior authorization.

PRA Disclosure Statement

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Alternative Benefit Plan Cost-Sharing ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

There is no cost sharing for this ABP.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

UnitedHealthcare Insurance Company - Choice Plus

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

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

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services Collapse All

Benefit Provided:
Physician Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services as described in the State Plan and as allowed under Section 1905(a)(5). Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Benefit Provided:
Outpatient Hospital Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services as described in the state plan and allowed under 1905(a)(2)(A).

Benefit Provided:
Home Health Services-Nursing & Home Health Aide

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under Section 1905(a)(7) of the Social Security Act.

Remove

Benefit Provided:

Other Licensed Practitioners - Chiropractor

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under 1905(a)(6).

Benefit Provided:

Other Licensed Practitioners - Podiatrist

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under 1905(a)(6).

Benefit Provided:

Hospice Care Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services described in the state plan and allowed under 1905(a)(18). Children are allowed concurrent curative care as required under Section 2302 of the ACA.

Benefit Provided:

Clinic Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No authorization. As allowed under Section 1905(a)(9) of the Social Security Act. This includes services provided in Ambulatory Surgery Centers and dialysis facilities.

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided: Outpatient Hospital Services/Emergency Room

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Hospital - Ambulance Transportation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes ground and air ambulance services.

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospitalization

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as allowed under 1905(a)(1). Includes hospice care. Certain specific items and services are covered with prior authorization; for example, certain transplants.

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care Collapse All

Benefit Provided:
Physician Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services described in State Plan and allowed under 1905(a)(5)(A). Services include routine prenatal care, labor, delivery, routine post-partum care and any other service related to treating pregnancy or delivery complications.

Benefit Provided:
Nurse Midwife Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes services described in State Plan and allowed under 1905(a)(17).

Benefit Provided:
Laboratory and Radiology Services

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services as described in the State Plan and allowed under 1905(a)(3). Services include pregnancy test, ultra sound, and recommended newborn screening for congenital and metabolic disorders.

Remove

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under 1905(a)(1), including the delivery and care for the newborn.

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under 1905(a)(2)(A).

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided: Inpatient Hospital/Inpatient Psychiatric Hospital

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient hospitalizations are covered as allowed under Sections 1905(a)(1) and 1905(a)(16) of the Social Security Act. Coverage of inpatient psychiatric hospital services is for individuals under age 21 years old.

Benefit Provided: Psychotherapy Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as allowed under 1905(a)(5), 1905(a)(6) and 1905(a)(13) of the Social Security Act.

Benefit Provided: Alcohol and Other Drug Abuse (AODA)

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as allowed under 1905(a)(5), 1905(a)(6) and 1905(a)(13) of the Social Security Act.

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Wisconsin's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs and 1905(a)(12). Coverage of prescription drugs meets all reporting requirements and provisions of section 1927 of the social security act.

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices Collapse All

Benefit Provided:
Home Health Care-Supplies, Equipment, Appliances

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services as allowed in the state plan and 1905(a)(7). Services include, the rental, purchase, replacement and repair of equipment. Orthotics, prosthetics, cochlear implants and hearing instruments are covered in this category also. Disposable medical supplies include diabetic and incontinence supplies.

Benefit Provided:
Physical Therapy and Related Services - PT

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Services as described in the state plan and allowed under Section 1905(a)(11) of the Social Security Act.

Benefit Provided:
Physical Therapy and Related Services - OT

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under Section 1905(a)(11) of the Social Security Act.

Remove

Benefit Provided:

Physical Therapy and Related Services - ST

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Rehabilitative and habilitative services are provided within the scope of practice as defined under state law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as described in the state plan and allowed under Section 1905(a)(11) of the Social Security Act. Services include hearing services and other services provided by an audiologist.

Benefit Provided:

Home Health Care - Therapy Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Respiratory Care Services for Ventilator Dependent

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as covered in the state plan and allowed under Section 1905(a)(13) and 1902(e)(9)(A) through (C) of the Social Security Act.

Benefit Provided:

Prosthetic Devices

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services as covered in the state plan and allowed under Section 1905(a)(12) of the Social Security Act.

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

Benefit Provided:

Other Laboratory & X-ray Services - Diagnostic Lab

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are as covered under the state plan and allowed under Section 1905(a)(3) of the Social Security Act.

Add

Alternative Benefit Plan

Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Wisconsin covers preventive services as allowed under Section 1905(a)(13)(A) of the Social Security Act.

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

EPSDT services are covered for members under the age of 21 years. Coverage are as included in the state plan and as described under 1905(a)(4)(B) , including all items and services delineated in subsection (r).

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Diabetes Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician and OLP-Podiatry services, and under EHB 1. Ambulatory Patient Services.

Base Benchmark Plan: Eye examinations/foot care as indicated in the individual category.

Base Benchmark Benefit that was Substituted: Home Health Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as home health services and under EHB 1. Ambulatory Patient Services.

Base Benchmark Plan: Limited to 60 visits per year. One visit equals up to 4 hours of skilled care services. Limit does not include any service which is billed only for the administration of intravenous infusion.

Base Benchmark Benefit that was Substituted: Hospice Care
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as hospice care services and under EHB 1. Ambulatory Patient Services and EHB 3 - Inpatient Hospitalization.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Lab, X-Ray and Major Diagnostics - Outpatient
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as physician services and other lab and x-ray services, and under EHB 1. Ambulatory Patient Services and EHB 8. Laboratory Services.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Ostomy Supplies
Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as home health care-supplies, equipment,

Alternative Benefit Plan

and appliances and under EHB 7. Rehabilitative and habilitative services and devices.

Base Benchmark Plan: No limitation

Remove

Base Benchmark Benefit that was Substituted:

Pharmaceutical Products - Outpatient

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication:Duplication: covered under the Wisconsin Medicaid state plan as home health care-supplies, equipment, and appliances and under EHB 7. Rehabilitative and Habilitative Services and Devices.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:

Physician Fees for Surgical and Medical Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:

Physician Office Services - Sickness and Injury

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:

Preventive Care Services - Physician Office

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services and EHB 9. Preventive and Wellness Services and Chronic Disease Management.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:

Preventive Care Services - Lab, X-Ray, Other Tests

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services and EHB 9. Preventive and Wellness Services and Chronic Disease Management.

Base Benchmark Plan: No limitation

Remove

Base Benchmark Benefit that was Substituted: Reconstructive Procedures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, Inpatient and Outpatient Hospital and under EHB 1. Ambulatory Patient Services and EHB 3. Hospitalization.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Scopic Procedures-Outpatient Diagnostic/Therapeuti

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Respiratory Care Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as respiratory care services and under EHB 7. Rehabilitative and Habilitative Services.

Base Benchmark Plan: Limited to 60 visits per year.

Base Benchmark Benefit that was Substituted: Surgery - Outpatient

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as outpatient hospital services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: No limitation

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Therapeutic Treatments -Outpatient

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as outpatient hospital and clinic services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Urgent Care Center Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as outpatient hospital and clinic services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted: Kidney Disease Treatment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as physician, outpatient hospital and clinic services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: Depends on service

Base Benchmark Benefit that was Substituted: Temporomandibular Joint Disorders

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician services, and under EHB 1. Ambulatory Patient Services

Base Benchmark Plan: Benefits for diagnostic procedures and non-surgical treatment are limited to $1,250 per calendar year.

Base Benchmark Benefit that was Substituted: Emergency Health Services - Outpatient

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as hospital outpatient services and under EHB 2. Emergency Services.

Alternative Benefit Plan

Base Benchmark Plan: No limitation

Remove

Base Benchmark Benefit that was Substituted:
Outpatient Hospital - Emergency Transportation

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as outpatient hospital services - emergency transportation and under EHB 2. Emergency Services.

Base Benchmark Plan: Prior approval for non-emergency ground or air ambulance.

Base Benchmark Benefit that was Substituted:
Hospital - Inpatient Stay

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as hospital inpatient services and under EHB 3. Hospitalization.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:
Transplantation Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as hospital inpatient services and under EHB 3. Hospitalization.

Base Benchmark Plan: Notification to health plan required prior to transplant. Pre-transplantation evaluation at a transplant center required. Except for cornea transplants, transplants must be performed at a Designated Facility.

Base Benchmark Benefit that was Substituted:
Congenital Heart Disease Surgeries

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as hospital inpatient services and under EHB 3. Hospitalization.

Base Benchmark Plan: No limitation

Base Benchmark Benefit that was Substituted:
Pregnancy - Maternity Services

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan under several categories, including physician, nurse midwife, lab and x-ray and hospital inpatient/outpatient services and EHB 4. Maternity and Newborn Care.

Base Benchmark Plan: No limitation

Remove

Base Benchmark Benefit that was Substituted: Mental Health Services- In/Outpatient/Transitional

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as inpatient hospital and outpatient psychotherapy services and under EHB 5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment.

Base Benchmark Plan: No Limitation

Base Benchmark Benefit that was Substituted: Substance Use Disorder Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as inpatient hospital and outpatient alcohol and other drug abuse (AODA) treatment services and under EHB 5. Mental Health and Substance Use. Disorder Services, including Behavioral Health Treatment.

Base Benchmark Plan: No Limitation.

Base Benchmark Benefit that was Substituted: Prescription Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Prescribed Drugs and under EHB 6. Prescription Drugs.

Base Benchmark Plan: No Limitation. OTC drugs that do not require a prescription are not covered.

Base Benchmark Benefit that was Substituted: Hearing Aids

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as home health care-supplies, equipment, and appliances and under EHB 7. Rehabilitative and Habilitative Services and Devices.

Alternative Benefit Plan

Base Benchmark Plan: Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every three years. Children under age 18, benefits are limited to one hearing aid per ear, every three years (no dollar limit).

Remove

Base Benchmark Benefit that was Substituted: Home Health Care - Durable Medical Equipment

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as home health care-supplies, equipment, and appliances and under EHB 7. Rehabilitative and Habilitative Services and Devices.

Base Benchmark Plan: Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. Includes coverage of cochlear implants. Benefits for insulin pumps are limited to one pump per year.

Base Benchmark Benefit that was Substituted: Prosthetic Devices

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Prosthetic Devices and under EHB 7. Rehabilitative and Habilitative Services and Devices.

Base Benchmark Plan: Limited to $2,500 per year. Benefits are limited to a single purchase of each type of prosthetic device every three years. Items related to reconstructive surgery following cancer have no limit.

Base Benchmark Benefit that was Substituted: Rehabilitation Services - Therapy and Manipulative

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physical Therapy and Related Services and under EHB 7. Rehabilitative and Habilitative Services and Devices.

Base Benchmark Plan: Limited to 20 visits per year for each therapy (PT, OT, Speech, Pulmonary rehabilitation therapy); 36 visits for cardiac rehabilitation therapy; 30 visits of post-cochlear implant aural therapy. No limit on manipulative treatment services.

Base Benchmark Benefit that was Substituted: Autism Spectrum Disorder Services

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: This benefit was replaced with EPSDT, under the EHB10. Pediatric services, including oral and vision care.

Base Benchmark Plan: Limit will depend on the service provided. Additionally, benefits for intensive level

Alternative Benefit Plan

services are covered to $51,700 per child per year, with a minimum of 20 hours care per week for four years. Non-intensive Level Services are covered to $25,850 per child per year.

Remove

Base Benchmark Benefit that was Substituted:

Lab, X-Ray and Diagnostic - Outpatient

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Other Laboratory and X-Ray Services and under EHB 8. Laboratory Services.

Base Benchmark Plan: No Limitation

Base Benchmark Benefit that was Substituted:

Diabetes Self-Management and Training

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Physician Services and under EHB 1. Ambulatory Patient Services and EHB 9 . Preventive and Wellness Services and Chronic Disease Management.

Base Benchmark Plan: No Limitation

Base Benchmark Benefit that was Substituted:

Chiropractic

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as Other Licensed Practitioners - Chiropractor Services and under EHB 1. Ambulatory patient services.

Base Benchmark Plan: Covers manipulative treatment only with no visit limitation.

Base Benchmark Benefit that was Substituted:

Home Health Care - Therapies (OT/PT)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Wisconsin Medicaid state plan as home health services and under EHB 7. Ambulatory Patient Services.

Base Benchmark Plan: Limited to 60 visits per year.

Add

Alternative Benefit Plan

☐ Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:
Targeted Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as allowed under 1915(a)(19) of the SSA. Children in this ABP could receive services under the following target groups: Birth to Three, children at risk of physical, mental or emotional dysfunction, children with asthma, individuals with tuberculosis, high-risk pregnant and post-partum individuals, individuals with HIV infection, children who are severely emotionally disturbed, individuals with a physical or sensory disability, individuals who are developmentally disabled, individuals who are alcohol or drug dependent.

Other 1937 Benefit Provided:
Mental Health Crisis Intervention Services - Rehab

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:
Community Recovery Services - Rehab

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:

Comprehensive Community Services - Rehab

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:

Community Support Program Services - Rehab

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:

Directly Observed Therapy for Individuals with Tb

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other:
No authorization. Services as allowed under 1905(a)(13) and 1902(z)(2)(F) of the SSA.

Other 1937 Benefit Provided:
Federally-Qualified Health Centers

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Clinic and ambulatory services as allowed under 1905(a)(2)(C) and as further defined in section 1861(aa) of the Social Security Act.

Other 1937 Benefit Provided:
Rural Health Clinic Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Clinic and ambulatory services as allowed under 1905(a)(2)(B) and as further defined in section 1861(aa) of the Social Security Act.

Other 1937 Benefit Provided:
Dental Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Dental services covered in the state plan and allowed under 1905(a)(10) and 1905(a)5(B). Dental services include dentures.

Other 1937 Benefit Provided:
Family Planning Services and Supplies

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Contraceptive management services as described in the state plan and allowed under Section 1905(a)(4)(C). Coverage does not include, infertility treatments, surrogate parenting (including obstetric care and other related services), and the reversal of sterilizations.

Other 1937 Benefit Provided:
Pediatric/Family Nurse Practitioner Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services in the state plan and as allowed under section 1905(a)(21) of the Social Security Act.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as covered in the state plan and allowed under 1905(a)(24) of the Social Security Act.

Other 1937 Benefit Provided:
Private Duty Nursing

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as described in the state plan and allowed under Section 1905(a)(8) of the Social Security Act.

Other 1937 Benefit Provided:
Other Licensed Practitioners - Optometrist

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as described in the state plan and allowed under 1905(a)(6). Includes coverage

Alternative Benefit Plan

of eyeglasses.

Remove

Other 1937 Benefit Provided:
Medical Day Treatment - Mental Health-Rehab

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:
Medical Day Treatment - AODA-Rehab

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization. Services as allowed under 1905(a)(13) of the SSA.

Other 1937 Benefit Provided:
Intensive In-home Psychotherapy-Rehab

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other:

No authorization. Services as allowed under 1905(a)(13) of the SSA.

Remove

Other 1937 Benefit Provided:

Tobacco Cessation for Pregnant Women

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other 1937 Benefit Provided:

Intermediate Care Facilities for Intellectual/Dev

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

30 days

Scope Limit:

None

Other:

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

Add

Alternative Benefit Plan

Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130814

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Benefits Assurances ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

The Alternative Benefit Plan includes all of the services provided under Wisconsin Medicaid state plan including all benefits under EPSDT. Since the Alternative Benefit Plan focuses on children in foster care, Wisconsin will monitor providers to ensure that benefits under EPSDT are available to all children based on best practices and each child's needs. The contract with providers requires that they maintain an enhanced periodicity schedule for EPSDT services as recommended by the American Academy of Pediatrics and the Child Welfare League of America.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- [x] The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- [x] The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- [x] The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- [x] The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- [x] The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- [x] The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Service Delivery Systems ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [ ] Managed Care Organizations (MCO).
  - [x] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

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

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

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

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

a. There is no reduction in the benefit package offered to this population; they will continue to receive the full benefit package whether they choose the Alternative Benchmark Plan or Medicaid fee-for-service.
b. There is no cost sharing for either plan.

Alternative Benefit Plan

c. Participation will be voluntary upon entry into out-of-home care.
d. Parent(s) or guardian may change their choice between these two Medicaid options at any time for any reason.

The State has held separate meetings with Tribal representatives to discuss, in detail, all aspects of the Medicaid Program choices that parent(s) or guardian will have regarding their child's Medicaid program. The purpose of these meetings is to reinforce the message that participation is voluntary for all children in out-of-home care.

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

At the time of a child's entry into out-of-home care, the child's parent(s) or guardian will be offered a choice to enroll the child in the alternative benchmark program or fee-for-service Medicaid. The parent(s) or guardian will be informed using unbiased information, both verbally and in writing, indicating that their choice of Medicaid Program for their child is voluntary, and that they may change their mind at any time regarding their choice between Medicaid fee-for-service and the alternative benchmark plan. This information will be provided to the parent(s) or guardian by various members of the Care4Kids team beginning at the time the child is removed from the home and lasting through the enrollment in Care4Kids. For more details on the enrollment process, please refer to ABP2.

As a child is taken into custody by child welfare, many things that are expectations of our medical home are already the best practices of our child welfare system. Whether the family chooses Care4Kids or not, the activities from the provider perspective are the same regardless of participation in Care4Kids. We require the initial screening so we are aware of chronic or acute conditions or needs of the child. We have our enrollment system set up so that if the family says yes, the PIHP is paid the capitated payment. We also have made sure our capitated payment system can account on a per day basis, a child's enrollment status. If the parent does not enroll in the Care4Kids, the medical provider is going to submit their claims to our Fee For Service system because the current provider is a MA provider.

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a prepaid inpatient health plan (PIHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

○ PIHPs are paid on a risk basis.

○ PIHPs are paid on a non-risk basis.

PIHP Procurement or Selection Method

Indicate the method used to select PIHPs:

○ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PIHPs:

Certification based on specified criteria.

Other PIHP-Based Service Delivery System Characteristics

Alternative Benefit Plan

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PIHP. Yes

List the benefits or services that will be provided apart from the PIHP, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Chiropractic services	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Community Recovery Services (CRS)	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Community Support Programs (CSP)	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Comprehensive Community Services (CCS)	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Crisis Intervention Services	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Directly observed therapy (DOT) for individuals with tuberculosis	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Pharmacy Services	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Medication Therapy Management	The service delivery system will be a fee-for-service based on the established fee-for-service schedule.	X
+	Non-emergency transportation services	This benefit will be provided through a transportation manager.	X
+	Provider-administered drugs and their administration.	The benefit will be provided based on the establish fee-for-service schedule.	X
+	School-based services	The benefit will be provided based on the establish fee-for-service schedule.	X
+	Targeted case management	The benefit will be provided based on the establish fee-for-service schedule.	X

PIHP service delivery is provided on less than a statewide basis. Yes

The limited geographic area where this service delivery system is available is as follows:

- (•) PIHP service delivery is available only in designated counties.
- ( ) PIHP service delivery is available only in designated regions.
- ( ) PIHP service delivery is available only in designated cities and municipalities.
- ( ) PIHP service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

The counties in the service delivery area includes:
Kenosha
Milwaukee

Alternative Benefit Plan

Ozaukee
Racine
Washington
Waukesha

PIHP Participation Exclusions

Individuals are excluded from PIHP participation in the Alternative Benefit Plan: No

General PIHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- Mandatory participation.
- Voluntary participation. Indicate the method for effectuating enrollment:
  - Affirmative selection of PIHP.
  - State enrolls individual in PIHP and permits disenrollment.
  - Other:

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- Traditional state-managed fee-for-service
- Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Non-emergency services will be provided under an administrative service arrangement with a transportation broker. The PIHP will be responsible for including all services, including those paid on a fee-for-service basis in the child's care plan. The PIHP will also be responsible for ensuring that the child has access to these services, and will follow up on all referrals.

Alternative Benefit Plan

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130718

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

General Assurances ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- F

Payment Methodology ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

☐ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

☐ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☑ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☑ The state includes an indicator in the Eligibility Verification System
- ☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☑ Other process

Description:

Providers receive this information in the Wisconsin online provider handbook. The online handbook includes information regarding copayment amounts, exemptions, limitations, collecting/refunding copayments, and a statement that providers may not deny services to members who fail to make a copayment.

☐ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. No

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

Medicaid Premiums and Cost Sharing

The state has established differential cost sharing for preferred and non-preferred drugs. No

☐ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Ambulatory Surgery Centers (ASC)	3.00	$	Procedure	Copay limited to procedure codes with a maximum reimbursement greater than $50.	Remove
Add	Chiropractic reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Chiropractic reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Chiropractic reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Chiropractic reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Dental reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Dental reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Dental reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Dental reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Disposable Medical Supplies reimbursed at $10 or less	0.50	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $10.01 to $25	1.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at $25.01 to $50	2.00	$	Item		Remove
Add	Disposable Medical Supplies reimbursed at more than $50	3.00	$	Item		Remove

Medicaid Premiums and Cost Sharing

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Diabetic Supplies	0.50	$	Prescription		Remove
Add	Drugs — Generic	1.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Brand	3.00	$	Item	Copayments for drugs are limited to $12 per member, per provider, per month. Over-the-counter (OTC) drugs are excluded from this $12 maximum.	Remove
Add	Drugs — Over-the-Counter	0.50	$	Prescription		Remove
Add	Durable Medical Equipment reimbursed at $10 or less	0.50	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $10.01 to $25	1.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at $25.01 to $50	2.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Durable Medical Equipment reimbursed at more than $50	3.00	$	Item	No copayment on rental items and repairs.	Remove
Add	Hearing Services reimbursed at $10 or less	0.50	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hearing Services reimbursed at more than $50	3.00	$	Procedure	No copayment on hearing aid batteries.	Remove
Add	Hospital — Inpatient	3.00	$	Day	$75 cap per inpatient stay.	Remove
Add	Hospital — Outpatient	3.00	$	Visit		Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Mental Health and Substance Abuse Treatment — Outpatient reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 15 hours or $825 of services, whichever comes first, per calendar year.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10 or less	0.50	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physical and Occupational Therapy, and Speech and Language Pathology reimbursed at more than $50	3.00	$	Procedure	Copayment obligation is limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year. Copayment limits calculated separately for each discipline.	Remove
Add	Physician Services reimbursed at $10 or less	0.50	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Physician Services reimbursed at $10.01 to $25	1.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at $25.01 to $50	2.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Services reimbursed at more than $50	3.00	$	Procedure	No copayment for the following: • US Preventive Services Task Force (USPSTF) recommendations with an A or B rating; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); • Anesthesia; • Clozapine management. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Laboratory Services	1.00	$	Other	Unit is per lab test. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Physician Radiology and Portable Xray Services	3.00	$	Procedure	Copayments are applicable on professional claims only. All radiation oncology services and add-on codes are exempt from the copayment requirement. Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $10 or less	0.50	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $10.01 to $25	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at $25.01 to $50	2.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Podiatry reimbursed at more than $50	3.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove
Add	Routine Foot Care	1.00	$	Procedure	Copayment limited to $30.00 per provider, per calendar year.	Remove

Medicaid Premiums and Cost Sharing

Add	Vision Care reimbursed at $10 or less	0.50	$	Procedure		Remove
Add	Vision Care reimbursed at $10.01 to $25	1.00	$	Procedure		Remove
Add	Vision Care reimbursed at $25.01 to $50	2.00	$	Procedure		Remove
Add	Vision Care reimbursed at more than $50	3.00	$	Procedure		Remove
Add	Vision Care — Eyeglasses, New	3.00	$	Pair	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Frame, Lens, or Temple Replacement	2.00	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Vision Care — Eyeglasses, Repair	0.50	$	Item	No copayment for contracted frames ordered from the SPEC (State Purchase Eyeglass Contract) provider.	Remove
Add	Transportation — Non-emergency Ambulance Trips	2.00	$	Trip		Remove
Add	Transportation — Specialized Medical Vehicle (SMV)	1.00	$	Trip		Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add							Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Medicaid Premiums and Cost Sharing

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 14 - 0012

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 20 - 0018

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Wisconsin

OMB Control Number: 0938-1148

Transmittal Number: WI - 20 - 0018

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☐ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☐ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☐ 133% FPL; and
- ☐ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☐ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☐ SSI Beneficiaries (42 CFR 435.120).
- ☐ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☐ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☐ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☐ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☐ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☐ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☐ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☐ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☐ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ○ Under age 21
- ◉ Other reasonable category

Description:

Individuals under age 21 who are in: Nursing Facilities, Intermediate Care Facilities, Skilled Nursing Facilities and Institutions for Mental Diseases.

Individuals under age 19.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☐ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☐ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☑ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation

- [ ] The state runs periodic claims reviews
- [x] The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- [x] The Eligibility and Enrollment and MMIS systems flag exempt recipients
- [ ] Other procedure

Additional description of procedures used is provided below (optional):

The Wisconsin Medicaid and BadgerCare Plus application for health care coverage includes questions to determine if the applicant is a member, child, or grandchild of a member of an American Indian or Alaskan Native tribe; if s/he is eligible to receive services from a Tribal clinic, Indian Health Services (IHS) or urban Indian health program; or, if s/he has ever received services from one of the above. Based on the responses to the questions, an indicator is triggered to "Yes" on the member's eligibility file in MMIS. The "Yes" indicator exempts the member from the copay requirement. Providers using the Eligibility Verification System (EVS) to check eligibility receive a response indicating that the member is exempt from the co-payment requirement.

- [ ] To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):
  - [x] The MMIS system flags recipients who are exempt
  - [ ] The Eligibility and Enrollment System flags recipients who are exempt
  - [ ] The Medicaid card indicates if beneficiary is exempt
  - [x] The Eligibility Verification System notifies providers when a beneficiary is exempt
  - [ ] Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

- [x] The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

- [x] The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- [x] Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.
  - [ ] The percentage of family income used for the aggregate limit is:

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (●) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. [Yes]

[■] Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- [ ] As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.
- [☒] Managed care organization(s) track each family's incurred cost sharing, as follows:

  All managed care organizations have elected to not impose cost sharing on their recipient members.

- [☒] Other process:

  A monthly family cap is determined each month by the eligibility system. The family cap is split between all individuals subject to copayments with each individual having their own monthly cap. As claims are submitted for dates of services within the individual's current monthly cap period, the state applies the incurred cost sharing for that service to the individual's limit. Once the individual reaches the limit, based on incurred cost sharing and any applicable premiums, the state notifies the individual and providers that the individual has reached his or her limit for the current month, and is no longer subject to cost sharing.

[■] Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The eligibility system (CARES) determines the monthly family income and derives from that the monthly 5% cap amount. CARES also determines if a member of the family has to pay any premiums. Any such premium amount is subtracted from the 5% cap and the remaining amount is sent to the MMIS system as the monthly cap amount for copayments. CARES then issues a notice to the member informing them of the cap amount. The MMIS provides the cap amounts to providers and tracks all copayments required for services received in the month. When those

copayments reach the cap, MMIS informs providers that the member is no longer subject to copayments for the rest of the month. In addition, a file is sent to CARES, which then issues a letter to the member informing them that they have reached the limit for the month.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The state will use the same appeals process available for eligibility determinations

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Claims will be adjusted when it's discovered that a member has paid over their aggregate limit. Providers are expected to reimburse members for their excess payments.

Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Reassessment of the family aggregate limit would be done systematically in conjunction with any change in circumstance and/or other eligibility reviews that would happen for a family.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). Yes

Description of additional aggregate limits:

Wisconsin has aggregate limits on the following benefits:

- Drugs
- Inpatient services
- Outpatient services
- Physician services
- Podiatry services
- Therapy services

Refer to G2a and G2c for details.

PRA Disclosure Statement