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November 10, 2011

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Health Services: Request for Authorization to Implement Changes to the Medical Assistance Program -- Agenda Item IV

REQUEST

The Department of Health Services (DHS) requests that the Joint Committee on Finance approve the following items: (a) its proposed request to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to waive maintenance of effort requirements that apply to the state's medical assistance (MA) program under the federal Patient Protection and Affordable Care Act (PPACA), and other federal requirements relating to the state's MA program; and (b) other changes to the MA program that conflict with current state law.

BACKGROUND

Wisconsin's MA Program. DHS administers the state's MA and MA-related programs, which provide healthcare services to various groups of individuals pursuant to different and sometimes overlapping state and federal laws and regulations. As of September, 2011, these programs served approximately 1,177,300 individuals. Table 1 shows current MA enrollment by major eligibility category.

TABLE 1

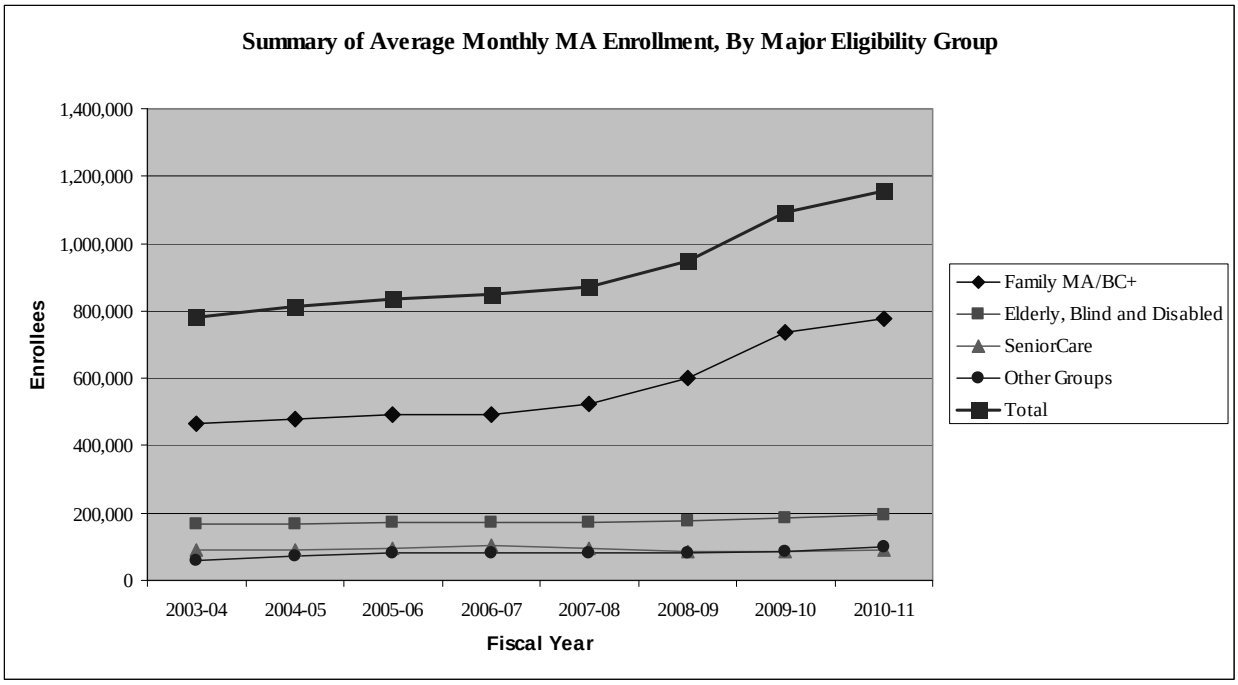
Medical Assistance Enrollment by Major Eligibility Category
September, 2011

BadgerCare Plus	748,900
BadgerCare Plus Core Plan	32,200
Total BadgerCare Plus Enrollment	781,100
Elderly, Blind, and Disabled (EBD) MA	198,800
SeniorCare	87,800
Family Planning Services Only Program	64,700
Other Individuals (inc. BC+ Basic Plan)	44,900
Total MA and MA-Related Enrollment	1,177,300

MA enrollment has increased significantly in recent years. Part of that increase can be attributed to program changes such as the implementation of BadgerCare Plus in February, 2008, and the statewide expansion of the BadgerCare Plus Core Plan (coverage for nonelderly adults without dependent children) in July, 2009. State and national economic conditions have also contributed to the enrollment increases, especially in the BadgerCare Plus program, as rising unemployment, lower incomes, and declining access to employer-sponsored health insurance caused more people to apply for and to receive medical assistance. In January, 2008, total enrollment in the low-income family components of the MA program that were forerunners to BadgerCare Plus was approximately 500,600 individuals. By September, 2011, enrollment in BadgerCare Plus (including the BadgerCare Plus Core Plan) had grown to 781,100, an increase of more than 280,000 individuals. Chart 1 shows total average monthly enrollment in the state's MA and MA-related programs, including SeniorCare, during the 2003-04 through 2010-11 period.

CHART 1

Total Average Monthly Enrollment
2003-04 through 2010-11



Total MA benefit expenditures also increased during this period. This is shown in Attachment 1, which summarizes total benefit expenditures, by fund source, for the MA and MA-related programs, including SeniorCare, for the period 2003-04 through 2010-11. The attachment also shows funding budgeted for those expenditures in 2011-12 and 2012-13. The expenditure figures shown in the attachment are "net" benefit expenditures in that they reflect several revenue sources such as drug manufacturer rebates used to offset program costs.

Total net MA benefit expenditures increased by a greater percentage (67%) than program enrollment (48%) during the 2003-04 to 2010-11 period. One reason for this relatively greater increase was the hospital assessment created in 2009 Act 2, which authorized DHS to collect an assessment from most hospitals in the state. A portion of those assessment revenues, along with federal MA matching funds, is then returned to hospitals in the form of higher MA reimbursement rates. In 2008-09, 2009-10, and 2010-11, this increased total MA benefit expenditures by approximately $582.0 million, $614.0 million, and $672.0 million, respectively. A second reason expenditures outpaced enrollment was the enactment of 2011 Act 27, which provided DHS with $431.3 million ($147.0 million GPR and $284.3 million FED) to make two additional monthly capitation payments to MA managed care organizations in 2010-11 in order to capture the higher federal matching rate that existed prior to July 1, 2011. The shifting of these monthly capitation payments from 2011-12 to 2010-11 partly explains why MA benefit expenditures in 2010-11 were higher than the preceding year, and why they are higher than budgeted expenditures in 2011-12.

Attachment 1 also shows that the federal share of total MA benefit expenditures increased significantly in the three most recent fiscal years. This resulted from provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), which increased states' federal medical assistance percentages (FMAPs) during the period October 1, 2008, through December 31, 2010 (a period later extended through June 30, 2011). In 2010-11, this federal legislation increased Wisconsin's FMAP from approximately 60% to 68.75%, in turn generating approximately $600 million in additional federal matching funds for the state. Effective July 1, 2011, the state's FMAP reverted to a more typical rate of approximately 60%.

Act 32 Provisions. Expiration of the ARRA-enhanced FMAP combined with greater-than-projected growth during the 2009-11 biennium gave rise to a substantial GPR funding gap in the MA program entering the 2011-13 biennium. 2011 Act 32 (the 2011-13 biennial budget act) filled a portion of that gap by providing approximately $1.24 billion in additional GPR to fund MA benefit costs (note that a portion of that additional funding was shifted to 2010-11 to make the additional capitation payments described above).

The additional funding provided in Act 32 factored in projected savings from several initiatives adopted during the budget process, most notably an enrollment cap in the Family Care program. Act 32 also assumed DHS would achieve an additional $466.6 million ($190.5 million GPR, $293.9 million FED, and -$17.8 million PR) in savings in the MA program during the 2011-13 biennium. Act 32 did not specify how DHS was to achieve those additional savings. Instead, the Legislature directed DHS to study the MA program and to propose policies that could make any of several changes, ranging from increased recipient cost-sharing, to modified benefit packages, to lowered income levels for purposes of determining program eligibility.

On September 30, 2011, DHS submitted the first of what will be quarterly reports to the Committee's Co-Chairs on the fiscal status of the MA program. That report, mandated by Act 32, provided updated projections as to the overall condition of the MA program and described changes the Department had implemented or planned to implement in the program.

In addition to the changes specified in Act 32, and the program changes DHS can make within its existing administrative authority (such as modifying provider reimbursement rates), Act 32 authorized DHS to pursue certain changes to the MA program that could potentially conflict with current state law. The Department's authority in this regard, however, is limited to a series of MA-related statutes specifically identified in Act 32, and is subject to this Committee's approval through a 14-day passive review process, and subject to any necessary federal approvals from CMS.

Regarding the latter, the federal Patient Protection and Affordable Care Act (PPACA) imposed a maintenance of effort (MOE) requirement that prohibits a state, at the risk of losing federal MA matching funds, from having in effect "eligibility standards, methodologies, or procedures" with respect to its MA program or any MA waiver program that are more restrictive than those that were in effect on March 23, 2010. For adults, this MOE requirement is in effect until the Secretary of the U.S. Department of Health and Human Services (DHHS) certifies that a health benefits exchange is fully operational in the state (which is assumed to be January 1, 2014).

For children under age 19, the MOE requirement runs through September 30, 2019.

Anticipating that DHS would propose changes to the MA program that imposed more restrictive eligibility criteria on MA recipients, Act 32 required DHS to request a waiver from the DHHS Secretary to permit the department to have in effect eligibility standards, methodologies, and procedures under the state MA plan or waivers of federal law related to MA that are more restrictive than those in place on March 23, 2010. That same provision in Act 32 further states that if the Department's MOE waiver request does not receive federal approval before December 31, 2011, DHS shall reduce income levels on July 1, 2012 for the purposes of determining eligibility to 133 percent of the federal poverty level (FPL) for adults who are not pregnant and not disabled, to the extent permitted under PPACA. Under current law, these individuals are eligible for BadgerCare Plus if their income does not exceed 200% of the FPL. Attachment 2 lists income by family size, for various percentages of the FPL.

This language in Act 32 refers to a provision in PPACA that creates a limited exception to the MOE requirement for non-pregnant, non-disabled adults who are eligible for MA at the state's option and whose family income exceeds 133% of the FPL. This MOE exception is available to states from January 1, 2011, through December 31, 2013, if the state certifies to the DHHS Secretary that "with respect to the State fiscal year in which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit." This provision further states that "Upon submission of such a certification to the Secretary, [the MOE requirement] shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence." DHS has estimated that approximately 53,000 non-pregnant, non-disabled adults in households with incomes greater than 133% of the FPL would lose their BadgerCare Plus eligibility if this MOE exception is exercised.

On October 31, 2011, DHS submitted to the Committee the MOE waiver request required under Act 32. That request has ten components, all of which DHS submitted for the Committee's approval under the Act 32 provisions. The Department's submission also seeks the Committee's approval to make several other changes to the MA program that, while not requiring a waiver of the PPACA MOE requirements, would otherwise conflict with current state law and therefore require Committee approval under Act 32. By letter dated November 1, 2011, the Committee Co-Chairs notified DHS that an objection had been made to the submission, and that the Committee would schedule a meeting at which time it would act upon the request.

The Department's MOE Waiver Request

The Department has submitted for the Committee's approval what it refers to as its "Medicaid 2014 Waiver." The associated materials indicate that DHS intends to submit this request for CMS approval under section 1115 of the federal Social Security Act. That section authorizes CMS to waive various requirements of federal MA law if, in the judgment of the DHHS Secretary, the state's request is for an "experimental, pilot, or demonstration" project that "is likely to further the objectives of the [Medicaid program]." While not expressly presented as such, the Department's proposal seeks a waiver of the PPACA MOE requirements, as well as several other federal law

provisions.

A stated objective of the waiver request is to "test" the potential impact of changes scheduled to go into effect in 2014 under PPACA, including "crowd-out policies, cost-sharing requirements, income determination methods, adverse selection provisions, the relevance of Transitional Medicaid and the impact of real-time eligibility on verification requirements and retroactive and presumptive determinations." For instance, the Department states that beginning in 2014, PPACA will disqualify lower-income families from government-subsidized health coverage if they have access to an employer-sponsored plan that does not require premiums in excess of 9.5% of household income. To "test" the potential impact of that policy, the waiver would allow DHS to terminate the eligibility of certain BadgerCare Plus recipients (children with family income above 133% of the FPL and adults with income greater than 100% of the FPL) if they have access to employer-sponsored plans that requires them to pay premiums less than 9.5% of their family income. In this particular example, the connection between the Department's proposal and PPACA is somewhat attenuated given that in 2014, PPACA will require state MA programs to cover all individuals (including adults) with income up to 133% of the FPL, not just those with income up to 100% of the FPL. (Note that beginning in 2014, revised income determination methods under PPACA will disregard 5% of household income). In addition, the PPACA MOE requirement for children runs through September 30, 2019, meaning that absent the changes sought in the Department's waiver request, PPACA requires Wisconsin to continue to offer medical assistance to children in families with income greater than 133% of the FPL through that date.

The Department's submission also contains the following note: "Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement." That note reflects the Department's view that PPACA gives the state unilateral authority to exercise the MOE exception for these individuals, provided the state certifies to the DHHS Secretary that it has, or will have, a state budget deficit for the period in question. The relevant provision in PPACA states that "Upon submission of such a certification, [the MOE requirement] shall not apply . . . ." To date, CMS has provided limited guidance as to how it will apply this exception. In any event, a more accurate statement of the PPACA MOE requirements is not that those requirements do not apply to non-pregnant, non-disabled adults whose income exceeds 133% of the FPL, but rather that the requirements do apply, subject to the exception for states that certify to having a budget deficit.

Note that unless otherwise indicated, the proposals in the Department's MOE waiver request only apply to BadgerCare Plus recipients. They do not directly apply to elderly, blind, and disabled MA recipients (EBD MA), nor do they apply to participants in the other MA-related programs. However, families that have members enrolled in both BadgerCare Plus and EBD MA could be affected by some of the proposed changes to BadgerCare Plus described below.

The ten components of the Department's MOE waiver request are described below. In each case, the discussion includes a summary of current law, a description of the substantive elements of the proposal, and an analysis of the proposal's estimated effects on BadgerCare Plus enrollees and program expenditures. It should be noted that the effect of each proposal will be dependent upon a

variety of factors such as economic conditions, behavioral changes, and other healthcare options.

MAINTENANCE OF EFFORT

1. Increase Family Premiums to 5% of Household Income for Families with Income Greater than 150% of the FPL

Current Law: The following individuals (subject to the exceptions noted below) must pay premiums to obtain coverage under BadgerCare Plus: (a) children in families with income greater than 200% of the FPL; and (b) parents and caretaker relatives with family income between 150% and 200% of the FPL (non-pregnant adults with income greater than 200% of the FPL are not eligible for BadgerCare Plus).

Individual premiums for children are set on an income-based sliding scale and cannot exceed the full per member per month cost of coverage for a child with a family income of 300% of the FPL. Individual premiums for adults are also set on an income-based sliding scale and cannot exceed 5% of family income. In addition, the premiums paid by individual members of a family cannot, in the aggregate, exceed 5% of family income. Consistent with federal law, BadgerCare Plus recipients with family income less than 150% of the FPL are not required to pay premiums to participate in the program.

The following individuals are statutorily exempt from paying BadgerCare Plus premiums: (a) children who are Native Americans or Alaskan Natives with family income not greater than 300% of the FPL; (b) children under one year of age whose mothers were eligible for and receiving medical assistance on the date the child was born ("continuously eligible newborns"); (c) children in families with income not greater than 200% of the FPL; (d) pregnant women with family income not greater than 200% of the FPL (in practice, virtually all pregnant women are individually exempt from paying BadgerCare Plus premiums, and that exemption would continue under the proposal); (e) children in families with income greater than 150% of the FPL who qualify for BadgerCare Plus by meeting a deductible; (f) young adults under age 21 exiting foster care; and (g) individuals who qualify for BadgerCare Plus when their income increases above 100% of the FPL ("transitional MA").

Participants in the BadgerCare Plus Core Plan do not currently have monthly premium obligations. Instead, those individuals pay a $60 annual enrollment fee to participate in that program.

Proposal: The Department's proposal would replace the existing individual-based BadgerCare Plus premiums with a family-based premium that applies to families with income greater than 150% of the FPL, regardless of the number of family members enrolled in BadgerCare Plus, and regardless of their status (child versus adult). The new family-based premium would be set at 5% of household income. Reductions from the new premium amounts would be available if the family is also paying premiums for major medical health insurance for other members of the family. Those potential reductions, which cannot exceed the amount of the other premiums being paid by the family, are as follows: (a) 50% for families between 150% and 200% of the FPL; (b)

33% for families between 200% and 250% of the FPL; and (c) 20% for families between 250% and 300% of the FPL.

The proposal maintains the current exemptions for pregnant women, continuously eligible newborns, children who are Native Americans and Alaskan Natives, young adults exiting foster care, and children who qualify for BadgerCare Plus by meeting a deductible. The exemption for transitional MA enrollees would be eliminated as part of the Department's proposal to end transitional MA. The exemption for children in families with income less than 200% of the FPL would be modified to limit that exemption to children in families with income less than 150% of the FPL.

Table 2 compares current BadgerCare Plus premiums to those proposed by the Department for a family of three with two children and one adult. Similar comparisons could be presented for families of different sizes and compositions. The "current" premium amounts in the table assume all three family members are enrolled in BadgerCare Plus. The proposed premium amounts in the table do not reflect reductions that might apply in the event the family is also paying premiums for major medical health insurance for one of its other members.

TABLE 2

BadgerCare Plus Premiums for Three-Person Family:
Two Children, One Adult

Percent of FPL	Current Annual Premiums	Proposed Annual Premiums	Increase
<150%	$0	$0	$0
>150% to 160%	120	1,390	1,270
>160% to 170%	324	1,482	1,158
>170% to 180%	816	1,575	759
>180% to 190%	1,464	1,668	204
>190% to 200%	1,760	1,760	0
200% FPL	1,853	1,853	0
>200% to 210%	240	1,853	1,613
>210% to 220%	240	1,946	1,706
>220% to 230%	240	2,038	1,798
>230% to 240%	360	2,131	1,771
>240% to 250%	552	2,224	1,672
>250% to 260%	816	2,316	1,500
>260% to 270%	1,056	2,409	1,353
>270% to 280%	1,320	2,502	1,182
>280% to 290%	1,632	2,594	962
>290% to 300%	1,968	2,687	719
300% or Greater	2,341	2,780	439

While Table 2 compares current BadgerCare Plus premiums to the premiums under the proposal, the Department might contend that a more appropriate comparison for purposes of its demonstration project would compare its proposed premiums to the premiums families might pay in 2014 under PPACA. One such comparison is shown in Table 3, which compares the Department's proposed premiums to the maximum premiums the same family would pay for health insurance purchased through an exchange beginning in 2014, assuming they qualify for the premium tax credits established under PPACA, and based on current federal poverty guidelines. In general, individuals can qualify for PPACA premium tax credits in 2014 if they have incomes between 133% and 400% of the FPL and they do not have access to "affordable" employer-sponsored insurance. An affordable employer-sponsored plan for these purposes must meet the following two criteria: (a) employee premiums cannot exceed 9.5% of family income; and (b) the plan must pay for at least 60% of covered expenses). In 2014, PPACA requires state MA programs to cover all individuals with family income not greater than 133% of the FPL, and therefore those individuals will not be eligible for premium tax credits for coverage purchased through an exchange.

TABLE 3

Proposed Premiums for a Family of Three Compared to Maximum Premiums for Subsidized Coverage Purchased Through an Exchange in 2014

Percent of FPL	Proposed Annual Premiums	Maximum Annual Premium For Subsidized Coverage Through Exchange	Difference
150%	$1,390	$1,112	$278
160	1,482	1,322	160
170	1,575	1,575	0
180	1,668	1,794	-126
190	1,760	2,056	-296
200	1,853	2,335	-482

Note that unlike Table 2, the income range in Table 3 only extends to 200% of the FPL. That is because non-pregnant adults with incomes above that level are not eligible for BadgerCare Plus. They are eligible, however, for subsidized coverage purchased through an exchange beginning in 2014, provided they meet the necessary requirements.

A second possible basis for comparing the premiums that would be imposed under the Department's waiver proposal and the premiums families might pay under PPACA is to consider the federal legislation's rules regarding the "affordability" of employer-sponsored insurance. Under PPACA, beginning in 2014, families with income greater than 133% of the FPL who have access to employer-sponsored insurance will not be eligible for premium tax credits for coverage purchased through an exchange if the premium they pay for that employer-sponsored insurance is less than

9.5% of their family income (provided also that the employer-sponsored plan pays at least 60% of the covered expenses). Table 4 compares the amount of premium that would be paid by a family of three under the Department's proposal to the 9.5% affordability standard for employer-sponsored insurance beginning in 2014 under PPACA. For the same reasons as discussed with respect to Table 3, the income range shown in Table 4 does not extend beyond 200% of the FPL.

TABLE 4

Proposed Premiums for a Family of Three Compared to 9.5% Affordability Standard for ESI Under PPACA

Percent of FPL	Proposed Annual Premiums	9.5% of Family Income	Difference
133%	$0	$2,341	$2,341
150	1,390	2,641	1,251
160	1,482	2,817	1,335
170	1,575	2,993	1,418
180	1,668	3,169	1,501
190	1,760	3,345	1,585
200	1,853	3,521	1,668

Estimated Effect: DHS estimates that its premium proposal would affect 91,538 current BadgerCare Plus recipients. Those recipients include 57,664 children, 29,372 BadgerCare Plus adults, and 4,502 Core Plan participants. Not included in those totals, but also impacted by the proposal, are individuals with family income less than 200% of the FPL who are currently eligible for BadgerCare Plus under the transitional MA rules. The impact of the Department's premium proposal on those individuals is discussed separately in the "Eliminate Transitional MA" item.

The Department estimates that its proposal would generate annualized savings of $82.4 million ($32.9 million GPR and $49.5 million FED). Those estimated savings stem from two sources: (a) the projected impact the new premiums would have on BadgerCare Plus enrollment; and (b) the increased premium revenue generated by recipients who remain in the program.

Projected Enrollment Impact. DHS estimates that 19,223 individuals would disenroll from BadgerCare Plus in response to the higher premiums imposed under its proposal. That estimate includes 12,109 children, 6,169 BadgerCare Plus adults, and 945 Core Plan participants. The annualized savings attributed to that projected enrollment impact is $40.3 million ($16.1 million GPR and $24.2 million FED). That savings estimate was developed by multiplying average annual per person costs by the projected number of disenrollees.

The Department's estimate assumes that 21% of the 91,538 BadgerCare Plus recipients subject to the new premiums would disenroll from the program. DHS developed that estimate in

part by reviewing published articles that studied the enrollment impact of increased cost-sharing in state MA programs. The Department appears to have particularly relied on a 2005 study by James Marton entitled "The Impact of Introduction of Premiums into a SCHIP Program" which was summarized in a 2006 report by Mathematica. As summarized by Mathematica, the Marton study found that when the state of Kentucky introduced a premium in 2003 on children in its SCHIP program with family incomes between 150% and 200%, the probability that those children would disenroll increased from 5% to 21% in the first six months, and that the introduction of premiums reduced the length of enrollment.

This office reviewed a number of academic articles and case studies pertaining to the enrollment impact of increasing premiums in public insurance programs. The findings from all of them suggest that the Department's proposal to increase premiums on most portions of the BadgerCare Plus population with incomes above 150% of the FPL will decrease program enrollment. The studies vary, however, with regard to the income groups at issue, the size of the premium increases, program re-enrollment policies, and whether the premiums introduced were new or an increase. Therefore, it is difficult to generalize their conclusions. Among the studies reviewed by this office were the following:

- A May, 2011, paper published by the Georgetown University Health Policy Institute estimated that increasing premiums to 3% and 4% of income for families in BadgerCare Plus with incomes between 100% and 200% FPL would decrease enrollment by 49,400 and 87,300 individuals, respectively. The Georgetown paper based its estimate on an article by Leighton Ku and Teresa A. Coughlin entitled "Sliding-Scale Premium Health Insurance Program: Four States' Experiences" published in the Winter 1999/2000 volume of the journal Inquiry. In this article, the authors found that program participation as a percent of a state's uninsured population declined from approximately 43% when premiums comprised 2% of family income to approximately 20% when premiums were 5% of family income. The Georgetown paper overstates the disenrollment impact that might result from the Department's proposal if for no other reason than that the latter would only apply to BadgerCare Plus recipients with family income of 150% of the FPL or above. Given the distribution of BadgerCare Plus enrollment by income level, recipients with incomes between 150% and 200% of the FPL comprise less than half of all recipients with incomes between 100% and 200% of the FPL.

- A 2006 study by researchers from the Urban Institute, Kansas Health Institute and University of Kentucky, found that when Kansas, Kentucky, and New Hampshire increased premiums by between $5 and $30 per family per month or per child per month for each of their eligibility groups between 150% and 300% of the FPL in SCHIP, the states' enrollment growth rates in the six months after the premium increases were between 18 and 21 percentage points lower than they were in the six months prior to the increase. Kentucky saw overall caseload decrease by 16 percent and caseload did not return to its prior level in the six months after the premium increases.

- A May, 2005, article from the Kaiser Commission on Medicaid and the Uninsured found that when Vermont increased the premium obligations of families with incomes between

185%-300% FPL to a range from $25 to $70 per month, approximately 6% of individuals were disenrolled for nonpayment of premiums in the first month. Vermont did not have re-enrollment restrictions at that time, so most of these individuals re-enrolled the next month. Only 2% were still disenrolled in the second month. That same Kaiser article reports that in January 2002, when Rhode Island imposed new premiums of $43 to $58 per month on families with incomes above 150% of the FPL, 18% of families with a premium were disenrolled due to nonpayment within the first three months.

• In 2004, the Office for Oregon Health Policy and Research examined the impact of a number of changes to the Oregon Health Plan (OHP) for individuals from 0% to 100% FPL, including reduced benefits, copayments for most services, increased premiums, and a six month re-enrollment restriction. As a result of these changes, enrollment in OHP decreased by nearly 50%, with the most substantial decrease among individuals with no reported income. Although many of the changes that were implemented in the OHP are similar in nature to those proposed by DHS, a significant difference is that the Department's premium proposal would only apply to individuals with family income of 150% of the FPL or higher, whereas the Oregon changes only applied to individuals with income below 100% of the FPL (with the most substantial enrollment impacts to participants with no reported income).

Of the studies reviewed by the office, the experience in Rhode Island is arguably the most comparable to the premium changes proposed by DHS. Rhode Island introduced a monthly premium of $58 on families with income above 150% of the FPL, and experienced an 18% disenrollment effect. The Department's proposal, as it would impact a family of 3 as shown in Table 2, would impose relatively higher premium increases for families with incomes up to 180% of the FPL than occurred in Rhode Island, and relatively lower increases for families between 180% and 200% of the FPL. For families with income above 200% of the FPL, the Department's premiums are generally higher. Therefore, while direct comparisons are difficult to make, the studies reviewed by this office suggest that the Department's 21% disenrollment assumption, while perhaps somewhat conservative, appears reasonable.

Increased Premiums. The second source of savings attributed to the proposal would result from the additional premiums paid by recipients expected to remain in the program. Using the assumptions described above, DHS estimates that 72,315 current BadgerCare Plus and BadgerCare Plus Core Plan participants will remain in the program and pay the higher premiums. For the 68,759 impacted BadgerCare recipients, the additional premiums would average $563 per person per year. For the 3,556 impacted Core Plan recipients, the additional premiums would be $944 per person per year. In total, the annualized additional premium revenue to the program is estimated to be $42.1 million ($16.8 million GPR and $25.3 million FED). The projected biennial savings are somewhat greater because DHS assumes the new premiums will go into effect April 1, 2012.

2. Terminate Eligibility for Individuals with Access to Private Insurance Where the Family Pays a Premium Less than 9.5% of Household Income

Current Law: Current state law disqualifies certain individuals from participating in

BadgerCare Plus if within the past 12 months they had access to other forms of health insurance coverage, or if they currently have access to or coverage under such insurance. The disqualification rules can also apply if the individual dropped their other health insurance coverage prior to applying for BadgerCare Plus. The current disqualification rules (also referred to as "crowd-out" rules) only apply to individuals with family income greater than 150% of the FPL, and only apply if the other insurance coverage is employer-sponsored insurance (ESI) for which the employer pays at least 80% of the premium, or coverage under the State of Wisconsin employee health plan. Pregnant women, children under age 19 who meet deductibles, young adults under age 21 leaving foster care, and continuously eligible newborns are generally not subject to these crowd-out provisions.

There are several good cause exemptions for individuals who had past access to other insurance coverage during the 12 months prior to applying for BadgerCare Plus. Those exceptions are as follows: (a) the employer discontinued health insurance coverage for all employees; (b) the individual's employment ended; and (c) the individual had a family member who was covered by other private health insurance or Medicaid. There are also several good cause exemptions for dropping coverage, including the following: (a) employment ended for a reason other than voluntary termination; (b) the individual changed to a new employer that does not offer coverage; (c) the employer discontinued coverage for all employees; (d) the individual's coverage terminated due to the death or change in marital status of the policyholder; and (e) certain special circumstances for pregnant women. No good cause exemptions exist for not enrolling in a health plan to which the individual currently has access.

Determination of current or past access to health insurance is conducted using the Employer Verification of Health Insurance (EVHI) database during eligibility determination. EVHI uses reports submitted by employers on whether they offer insurance, and how much of the premium the employee pays.

Proposal: The Department's waiver request would generally disqualify from BadgerCare Plus anyone who had past access or currently has access to employer-sponsored major medical insurance for which the employee's monthly premium contribution is less than 9.5% of family income. This would apply to children with family income over 133% of the FPL and to parents and caretaker relatives with family income over 100% of the FPL. The proposal would also disqualify individuals if they are currently covered by such employer-sponsored insurance or if they are currently covered by other privately-purchased coverage for which their premiums are less than 9.5% of family income. The Department indicates that these provisions would replace the existing crowd-out rules that currently only apply to individuals with family income greater than 150% of the FPL, and that only apply to ESI for which the employer pays at least 80% of the premiums or to coverage under the State of Wisconsin employee health plan.

Current or Past Access to Coverage to ESI. Under the proposal, an individual would be deemed to have access to coverage if any of the following applies: (a) he or she currently has access to employer-sponsored coverage where the premiums paid by the employee do not exceed 9.5% of household income, or had access to such coverage at any time in the prior 12 months; or (b) he or she will have access to such coverage from a household member's current employer in the three

months following the month of application for BadgerCare Plus, redetermination of eligibility, or beginning of employment. The following exemptions would be allowed: (a) the employer discontinued health insurance coverage for all employees; (b) the individual's employment ended; and (c) the individual had a family member who was covered by other private health insurance or Medicaid.

Current Coverage. The proposal would also disqualify individuals who are currently covered under major medical insurance, provided either through an employer or purchased privately, if the monthly premium paid by the family does not exceed 9.5% of family income, or individuals who were covered under such a policy any time in the three months prior to applying for BadgerCare Plus. Exemptions from these new crowd-out rules would be allowed in the following cases: (a) the individual lost coverage for employment-related reasons, including involuntary termination of employment, or voluntary termination due to a health condition of the individual or immediate family member; (b) the individual lost coverage due to the death or change in marital status of the policyholder; (c) the federal continuation of coverage period expired for that individual; (d) the coverage is owned by someone not residing with the family, and continuation of the coverage is beyond the individual's control; and (e) the insurance only covers services in a service area beyond a reasonable driving distance.

Estimated Effect: The main changes associated with this item that are likely to impact BadgerCare Plus enrollment are changing the affordability standard from a maximum employee contribution of 20% of the total premium, to premium costs not greater than 9.5% of family income, and lowering the income threshold for applying the crowd-out provisions from 150% of the FPL to 100% of the FPL for parents and caretakers, and to 133% of the FPL for children.

The Department estimated the enrollment and cost savings impact of these provisions by looking at actual data related to "other insurance" access and coverage among current BadgerCare Plus recipients. By their estimates, 27,862 individuals would no longer be eligible for BadgerCare Plus after application of the new crowd-out rules. That figure includes 11,274 children and 16,588 adults. The estimated savings to the program on an annualized basis are $24.6 million ($9.8 million GPR and $14.8 million FED). The projected biennial savings are somewhat greater because the Department assumed an April 1, 2012 implementation date.

As noted, the waiver language submitted to the Committee indicates that the proposed crowd-out rules would apply to children with family income greater than 133% of the FPL and to adults with family income greater than 100% of the FPL. In that respect, the proposal would not appear to be a true "test" of the 2014 PPACA requirements, given that PPACA will require states to offer medical assistance to all individuals (including adults) with incomes up to 133% of the FPL beginning in 2014.

Table 5 shows 9.5% of total income for various family sizes and income levels. At each level, the annual premium obligation for available employer-sponsored coverage would have to exceed the indicated amount in order for any members of that family to qualify for BadgerCare Plus.

TABLE 5

Minimum Annual Private Insurance Premium to Exempt Family from Proposed Crowd-Out Provisions (9.5% of Income)

	% of FPL*					
Family Size	150%	175%	200%	225%	250%	275%
1	$1,552	$1,810	$2,069	$2,328	$2,586	$2,845
2	2,096	2,446	2,795	3,144	3,494	3,843
3	2,641	3,081	3,521	3,961	4,401	4,841
4	3,185	3,716	4,247	4,777	5,308	5,839
5	3,729	4,351	4,972	5,594	6,215	6,837
6	4,274	4,986	5,698	6,410	7,123	7,835

*Parents and Caretakers not eligible for BadgerCare Plus at incomes over 200% of the FPL

3. Terminate Eligibility for Young Adults with Access to Health Insurance through a Parent's Coverage

Current Law: Current state law disqualifies certain individuals from participating in BadgerCare Plus if within the past 12 months they had access to other forms of health insurance coverage, or if they currently have access to or coverage under such insurance. Generally speaking, the current provisions only apply to individuals with family income greater than 150% of the FPL and only apply to ESI for which the employer pays at least 80% of the premium. A more comprehensive description of the current "crowd-out" rules and the exceptions thereto is provided in the preceding section.

State and federal law require private insurance plans that provide dependent coverage to provide such coverage to adult children of policyholders until the adult child reaches the age of 26. (State law requiring coverage up to the age of 27 is in effect until January 1, 2012, when it will change to age 26 pursuant to provisions in Act 32.) In general, this dependent coverage must be provided to all dependents under age 26, including to adult children who are married, or have access to employer-sponsored insurance. This coverage requirement does not apply to an adult child's children, although state law requires coverage of any children of a dependent who is under 18 years of age.

Proposal: The Department's proposal would change the crowd-out rules for individuals between the ages of 19 and 26 ("young adults") such that those individuals would no longer be eligible for BadgerCare Plus if they currently have, or during the preceding 12 months had access to coverage through their parent's employer-sponsored major medical health insurance. The new rules would not apply in cases where the young adult's parent lost their employment, or where the parent's employer discontinued health benefits to all employees. Furthermore, DHS indicates that this proposal would apply to young adults whose parents have ESI coverage, rather than young

adults whose parents simply have access to such coverage.

The new rules would apply to pregnant women, parents and caretaker relatives with family income greater than 100% of the FPL. Children of these young adults would not lose their eligibility for BadgerCare Plus in the event their parents are disqualified. Core Plan participants would not be impacted because they are already subject to the new rules.

Estimated Effect: An estimated 46,000 young adults between the ages of 19 and 26 currently participate in BadgerCare Plus. Of that population, approximately 14,000 have income greater than 100% of the FPL, thereby making them subject to this proposal. DHS estimates that 2,851 of those young adults would lose their BadgerCare Plus eligibility if the proposal is approved by the Committee and by CMS (because crowd-out rules are a form of "eligibility standards, methodologies, or procedures" they implicate PPACA's MOE requirement). The estimated annualized savings that would result from this enrollment effect are $8.9 million ($3.6 million GPR and $5.3 million FED).

The Department's estimate assumes that approximately 20% of young adults with income greater than 100% of the FPL would lose their BadgerCare Plus eligibility if this proposal is implemented. The agency developed that estimate by counting the number of young adults in BadgerCare Plus who are identified in the Department's information systems as currently having other third-party insurance coverage. Other sources reviewed by this office suggest that the parents of young adults in BadgerCare Plus may have higher rates of employer-sponsored insurance coverage than DHS assumed when it developed its savings estimate for this item. If that is the case, the 20% disenrollment assumption used by DHS in this instance may be conservative. That said, the Department also indicated that it is difficult to identify the other insurance coverage of non-participants, and that difficulty may have a limiting effect on the proposal's reach. For these reasons, the impact of this particular proposal, if implemented, may vary from the Department's initial estimates.

As with MOE Item #2, it could also be argued that the Department's proposal to apply these new crowd-out rules to young adults with incomes greater than 100% of the FPL does not provide an accurate "test" of PPACA, since states will be required to provide medical assistance to young adults with incomes up to 133% of the FPL beginning in 2014.

4. Increase Eligibility Restrictions Related to Non-Payment of Premiums

Current Law: If a BadgerCare Plus recipient who is required to pay a premium either does not pay a premium when due or requests that his or her coverage be terminated, their coverage terminates and they are not eligible for BadgerCare Plus for six consecutive calendar months following the date on which their coverage terminated, except for any month during that six-month period when their family income does not exceed 150% of the FPL.

By rule, this six-month disqualification period (also referred to as a restrictive re-enrollment period or "RRP") does not apply if the individual failed to pay the premium for either of two "good

cause" reasons. First, the eligibility restriction does not apply if the individual's failure to pay was due to a circumstance beyond the individual's control, provided that all past due premiums have been paid in full. Circumstances beyond the individual's control include a problem with an electronic funds transfer from a bank account to the BadgerCare Plus program, a problem with an employee's wage withholding, an administrative error in processing the premium, or any other circumstance affecting payment of the premium which DHS determines is beyond the individual's control, but not including insufficient funds.

Second, the eligibility restriction does not apply if the individual's failure to pay was due to a significant change in household composition. Significant changes in household composition include instances where the following people no longer reside in the home and have not resided in the home for at least 30 consecutive days: (a) a parent or parent's spouse; (b) a person not in the BadgerCare Plus eligibility group but who is legally responsible for a person in the eligibility group; and (c) a caretaker relative of a minor in the eligibility group.

Under current practice, the Department sends a premium invoice to BadgerCare Plus recipients on the tenth of each month, one month before the premium is due. If the recipient has not paid the premium by the due date, DHS sends the individual a termination notice indicating that any recipient who owes a premium will lose their program eligibility if payment is not received by the end of the month. If payment is made by the end of the month in which it was due, the recipient retains their BadgerCare Plus eligibility for that month. If the recipient does not pay the premium in the month it was due, but does pay it by the end of the following month, their eligibility is restored for the month that payment was due. If the premium is not paid by the end of the following month, any recipient for whom the premium is owed will no longer be eligible for the program as of the next day and cannot re-enroll for six months.

Proposal: The Department's proposal would extend the RRP for non-payment of a BadgerCare Plus premium from six months to twelve months.

In addition, the proposal would impact the number of individuals within the family who would be subject to the new twelve-month RRP, as follows. Under current law, the six-month RRP only applies to the BadgerCare Plus recipient for whom a premium is owed but not paid. Thus, under the current rules, if a parent with family income between 150% and 200% of the FPL fails to pay their own individual premium, that parent's children remain eligible for the program because children with income under 200% of the FPL do not currently owe premiums. Under the Department's proposal, a family's failure to pay the new family-based premium would subject all members of that family (including the children) to the new twelve-month RRP.

In the case of a family that includes a pregnant woman or other individuals exempt from paying premiums (for instance, continuously eligible newborns and individuals enrolled in EBD MA), the Department indicates that non-payment of a family premium would not subject those exempt individuals to the twelve-month RRP. Instead, the RRP would only apply to non-exempt members of the family.

The proposal would not change the existing "good cause" reasons for missing a payment.

Estimated Effect: DHS estimates that the proposal would generate annualized savings of $1.6 million ($0.7 million GPR and $0.9 million FED). The projected biennial savings are greater, based on the Department's assumed implementation date of April 1, 2012.

DHS developed this savings estimate by taking the number of BadgerCare Plus recipients who are subject to the current six-month RRP each year, and then adjusted that total to remove individuals who did not attempt to re-enroll in the program during the six-month period following the current six-month RRP. That methodology resulted in the estimate that 1,830 individuals would be subject to the new twelve-month RRP, including 654 children, 954 BadgerCare Plus adults, and 222 Core Plan participants.

The Department's estimate appears to be conservative. First, for the reasons described above, children in families with income less than 200% of the FPL are not currently subject to BadgerCare Plus premiums and therefore are not subject to the current six-month RRP. Under the family-based premium proposed by DHS, those children now would be subject to a family premium and would be subject to the new twelve-month RRP in the event the family does not pay that premium. Second, other aspects of the Department's proposal would increase both the amount of premiums and the amount of copayments required of families with income between 150% and 200% of the FPL. While DHS has separately estimated that a number of BadgerCare Plus recipients will disenroll from the program in response to those higher premiums, it seems reasonable to assume that non-payment rates would also increase beyond the current experience for those BadgerCare Plus recipients whom DHS has projected will remain in the program.

Finally, the proposal arguably limits some families' flexibility with respect to which family members will participate in BadgerCare Plus. For example, currently a two-person family (mother and five-year old child) at 175% of the FPL does not owe a premium for the child, but must pay a premium for the mother to participate in BadgerCare Plus. If economic circumstances dictate, that mother could discontinue her own participation in BadgerCare Plus (and be subject to a six-month RRP) without impacting the child's eligibility. Under the proposal, if economic circumstances prevented the mother from being able to afford the new family-based premium, both the mother and the child would be subject to the new twelve-month RRP. While this proposed change may make the BadgerCare Plus program more similar to private coverage, it would represent a potentially significant change from current law.

5. Expedite Disenrollment of Individuals Determined to be Ineligible for the Program

Current Law: Under current administrative rules, when a BadgerCare Plus recipient's eligibility ends, their program benefits continue until the end of that calendar month, except in the case of the recipient's death. Federal regulations prohibit states from terminating a Medicaid recipient's eligibility until at least ten days after the recipient has been notified of the finding of ineligibility and has had an opportunity to contest the finding.

Proposal: Under the proposal, DHS would discontinue a BadgerCare Plus recipient's coverage ten days after a notice of ineligibility has been mailed to the recipient, rather than maintaining coverage through the end of the month, as is currently required.

Estimated Effect: DHS estimates that shortening the eligibility grace period as indicated would reduce BadgerCare Plus benefit costs by approximately $11.9 million ($4.8 million GPR and $7.1 million FED) annually. That estimate reflects the actual number of individuals that currently lose eligibility, multiplied by the average per member per month costs those individuals incurred in the time between when they were notified that they lost eligibility and when their benefits ended at the end of the month.

This proposal would not eliminate eligibility for any BadgerCare Plus recipient. Instead, the proposal would only shorten the period between when an individual is found ineligible for MA and when they lose access to benefits.

6. Eliminate Retroactive Eligibility

Current Law: The term "retroactive eligibility" refers to MA coverage for services provided for any of the three months prior to the month of application if the applicant met the eligibility criteria in that month. Under current law, the following BadgerCare Plus recipients qualify for retroactive eligibility: (a) any pregnant woman; and (b) any child, parent, or caretaker relative whose family income is less than 150% of the FPL. This state law provision mirrors the comparable federal requirement that applies to all MA recipients. The state's current BadgerCare Plus waiver exempts enrollees in families with income greater than 150% of the FPL from this federal retroactive coverage requirement.

Proposal: DHS proposes to eliminate retroactive eligibility for all BadgerCare Plus recipients. The Department's waiver materials indicate that this proposal is related to the Department's objective of having real-time eligibility systems in place within the first year of the demonstration project. "Real-time eligibility" refers to an automated eligibility system that allows a county or state eligibility worker to immediately determine an applicant's program eligibility.

Estimated Effect: DHS estimated the cost savings of this proposal by reviewing MA payments made for services provided to BadgerCare Plus enrollees, prior to their applying for BadgerCare Plus, who would no longer have MA coverage for these services. In extracting data from a recent year, DHS found that 29,840 BadgerCare Plus enrollees had applied for, and qualified for retroactive eligibility. However, the number of individuals who would potentially be adversely affected by this policy would be significantly less (approximately 7,600), since most of the individuals who requested and qualified for retroactive eligibility did not receive services paid by the MA program during the three-month period prior to application. The Department estimates that the annual savings of this proposal would be approximately $6.7 million ($2.7 million GPR and $4.0 million FED). As this proposal is anticipated to be implemented in July, 2012, DHS assumed that it would realize one year of savings in the 2011-13 biennium.

It is possible that eliminating retroactive eligibility may encourage some individuals to apply for and enroll in the MA program earlier than they do currently, before they require or receive services, since they would no longer be able to avoid potential out-of-pocket costs they incur prior to their application for MA coverage. To the extent this occurs, the actual cost savings of this proposal would be less than DHS estimates.

However, if the elimination of retroactive coverage does not encourage individuals to enroll in the program before they require or receive services, the individual would be responsible for any costs of services he or she receives prior to application and enrollment in MA. Since most health care providers require patients to demonstrate that they have the means to pay for non-emergency services (either by showing evidence of coverage under MA or other third-party payer), some services that would otherwise be provided to recipients may be delayed until the individual applies for, and is enrolled in, MA. However, if a health care provider renders services to an individual with no MA or other third-party coverage, the provider would bill the individual for the services provided, based on the provider's usual and customary charges.

7. Eliminate Presumptive Eligibility for Children

Current Law: Pregnant women and children can qualify for "presumptive eligibility" under BadgerCare Plus if a qualified health care provider or a qualified entity determines, based on preliminary information available to the provider or entity, that these individuals' family income does not exceed certain thresholds. For pregnant women the threshold is 300% of the FPL, and for children the threshold is 150% of the FPL. In these cases, the pregnant woman or child is presumed to be eligible for BadgerCare Plus, even though their eligibility has not yet been determined by a county or state eligibility worker. The woman or child then has until the last day of the month following the month in which the provider or entity made the preliminary eligibility determination to apply for BadgerCare Plus. If they apply within that time, their presumptive eligibility continues until a county or state eligibility worker determines whether they are eligible for the program. If they do not apply within that time, their presumptive eligibility ends on the last day of the month following the month in which the provider or entity made the preliminary eligibility determination. During her period of presumptive eligibility a pregnant woman is eligible for ambulatory prenatal care services only. During a child's period of presumptive eligibility they are eligible for full benefits under the BadgerCare Plus Standard Plan.

Federal law gives states the option but does not require them to provide presumptive eligibility for children under the age of 19 and pregnant women.

Proposal: DHS proposes to eliminate presumptive eligibility for infants and children, while maintaining presumptive eligibility for pregnant women. Although not stated explicitly in the waiver request, DHS indicates that it would implement this policy only after it has implemented a real-time, online application process, under which an individual's eligibility could be determined by a county or state eligibility worker immediately upon the submission of a completed application.

Estimated Effect: In 2010-11, an average of 190 children had presumptive eligibility status

in each month. Based on a review of costs incurred by these children during the presumptive eligibility period, DHS estimated that the annual savings associated with this change would be approximately $0.6 million ($0.2 million GPR and $0.4 million FED).

The same arguments regarding retroactive eligibility apply to this item, in that the elimination of presumptive eligibility may encourage MA eligible families to enroll in the program earlier, prior to when they need for MA-covered services. If so, the savings associated with this proposal may be somewhat less than the DHS estimate.

8. Count Income of all Adults, Except Grandparents, Living in a Household for at least 60 days

Current Law: Sections 49.471(e) and (f) of the statutes define "family" and "family income" for purposes of determining eligibility for BadgerCare Plus. A "family" is defined to include all children for whom assistance is requested, their minor siblings, including half-brothers, half-sisters, stepbrothers and stepsisters, and any parents of these minors and their spouses. "Family income" is defined as the total gross earned and unearned income received by all members of a family.

The Department's current BadgerCare Plus eligibility handbook defines a "BadgerCare Plus Test Group" as the primary person (the person or persons whose eligibility for benefits is at issue) plus any individuals living in the primary person's or persons' household whose income and or needs are considered when determining financial eligibility. Inclusion in the test group is determined by qualifying relationships and legal responsibility, which are defined in the handbook. The handbook defines a "parent" as any natural or legally adoptive mother or father, of any age.

Based on the statutory definition of "family income" and the guidance provided by the current handbook, the income of individuals who reside in the household who are not family members, and for whom no legal responsibilities have been established, is not considered in determining an individual's eligibility for BadgerCare Plus.

Under federal law, state MA agencies may not consider income and resources of any relative, other than the spouse of an individual or a parent for a child who is under age 21 or blind or disabled, as available to an individual. Consequently, DHS is seeking a waiver of this federal requirement, in addition to the MOE provisions enacted as part of PPACA.

Proposal: DHS is requesting an amendment to the current BadgerCare Plus waiver agreement to redefine "income" to include the total income of all adults, excluding grandparents, living in the household for at least 60 days. The administration's intent is to also apply this policy to individuals who apply for coverage under the Core Plan. It is not clear how the Department's proposal can be characterized as a "test" of PPACA, since PPACA does not contain provisions that would similarly re-define the number of individual whose income is included when determining MA eligibility.

If approved, the income of adults who reside in a household who are not family members and

who may have no legal responsibilities relating to family members would be considered in determining a family's income for the purpose of determining financial eligibility and cost-sharing requirements for BadgerCare Plus coverage. Examples of individuals whose income would be counted, provided they lived in the house for at least 60 days, include:

- A boyfriend or girlfriend who is not an adoptive parent and who does not have any formal legal support obligations to the mother or child;

- A sibling or other relative who does not have any formal legal support obligations to the mother or child; and

- Non-relative adults, such as friends, who do not have any formal legal support obligations to the mother or child;

Although these individuals' income would be counted as part of the BadgerCare Plus Test Group, they would not necessarily be eligible for BadgerCare Plus benefits.

Estimated Effect: Little is known about the number of households with BadgerCare Plus members that include non-legally responsible adults. Counting the income of these individuals would potentially make some individuals who are currently eligible for BadgerCare Plus ineligible. In addition, counting this additional income would result in some MA recipients paying greater premiums, as a result of the family having greater countable income, compared to current law.

The savings estimate DHS attached to this proposal includes anticipated savings from two sources. First, the Department estimates that 2,589 individuals would no longer be eligible for BadgerCare Plus as a result of this policy change, including 229 children, 102 pregnant women and newborns, and 2,258 adults. The estimated annualized savings associated with this disenrollment impact are $7.6 million ($3.0 million GPR and $4.6 million FED). Second, DHS estimates that 9,034 individuals would pay higher premiums as a result of the proposal. The annualized amount of those additional premiums would total $8.1 million ($3.2 million GPR and $4.9 million FED). This estimate is based on the agency's assumption that the new policy would take effect July 1, 2012, resulting in one year of savings in the 2011-13 biennium.

The Department developed its savings estimate on available data regarding the composition of households who are enrolled in the FoodShare program. The state's FoodShare program collects information on all adults living in a household, since this information is used in determining FoodShare program eligibility and benefit levels. By assuming that the households with BadgerCare Plus recipients have the same ratio of "excluded adults" to "included adults" as households with FoodShare recipients, DHS estimated the effect of including the income of these other adults on households with BadgerCare Plus recipients, including how many of these families would no longer qualify for BadgerCare Plus benefits, and how many individuals would be subject to higher cost-sharing requirements. The method DHS used to develop this estimate appears reasonable.

It is possible that this policy may affect decisions regarding where people live, since the presence of a non-legally responsible adult in the household could adversely affect the family's BadgerCare Plus eligibility and benefits. The administration argues that as a member of the household, non-legally responsible adults should be expected to share in some of the costs of maintaining the family, including health care costs. The administration also argues that counting these individuals' income could eliminate certain "inequities." For example, under current law, if a man lives with a woman and the woman's child, and the man is not married to the woman and is not the father of the child, his income is not counted for the purpose of determining whether the woman and child are eligible for BadgerCare Plus. However, if the man is married to the women, his income would be counted, which may result in the woman and child no longer meeting the income eligibility standard for BadgerCare Plus.

9. Require Verification of State Residency Prior To Enrollment

Current Law: In order to be eligible for benefits under Wisconsin's MA program, an individual must be a state resident. Section 49.001 (6) of the statutes defines "residence" as "the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation" and indicates that "physical presence is prima facie evidence of intent to remain." The term "residence" is not referenced elsewhere in the MA statutes.

Current administrative rules address issues relating to the verification of information MA applicants are required to provide. DHS is required to deny eligibility for MA when an applicant or recipient is able to produce required verifications, but refuses or fails to do so. However, if an MA applicant is unable to produce verifications or requires assistance to do so, DHS may not deny assistance, but must instead proceed immediately to verify the data elements. The rules require DHS to verify several specific items, including residency, "when applicable."

The BadgerCare Plus eligibility handbook indicates that in order for an individual to be eligible for BadgerCare Plus, the individual must meet the following two standards: (a) be physically present in Wisconsin; and (b) express intent to reside in Wisconsin, unless he or she is incapable of indicating intent. Once established, Wisconsin residency is retained until one of the following occurs: (a) the person notifies the state that they no longer intend to reside in Wisconsin; (b) another state determines the person is a resident in that state for MA; or (c) other information is provided that indicates the person is no longer a resident.

Homeless persons living in Wisconsin meet the requirement of being physically present in Wisconsin. DHS is responsible for using its own address or some other fixed address for purposes of mailing the BadgerCare Plus card to eligible applicants who have no fixed dwelling place or mailing address.

Federal regulations define who state residents are for the purpose of MA eligibility, but do not specify the type of documentation a state may require of an MA applicant or recipient.

DHS indicates that its current practice is to require MA recipients to verify residence only in cases where the individual's residency is questionable. For example, an eligibility worker may

request documentation of residency if the worker finds that the applicant identifies an out-of-state employer.

Under the FoodShare program, all applicants, other than individuals who are homeless and migrant workers, are tested for residency. The current DHS FoodShare eligibility handbook lists the following sources that may be used to document an individual's residency:

- Current rent receipt that shows the individual's address;
- Current mortgage receipt;
- Current lease agreement;
- Landlord inquiry;
- Current utility bill with address and responsible person's name;
- Check stub with current address;
- Driver's license;
- Home visit;
- Subsidized housing authority approval;
- Post office statement or collateral contact;
- Library card;
- Voter registration
- Piece of mail received at claimed residence;
- Real estate tax statement or receipt;
- Weatherization program approval or denial;
- Renter or homeowner's insurance document;
- School registration record;
- Letter from employer offering a job;
- Telephone book;
- Motor vehicle registration;
- List of residents from a treatment center, group home, etc.; and
- Written statement from a non-relative.

Proposal: Under the Department's waiver request, each BadgerCare Plus applicant would be required to provide verification of their state residency, both at the time of initial application and at each required eligibility renewal. DHS indicates that applicants could use the same documentation to verify residency for MA as are currently used to verify residency for FoodShare benefits.

Estimated Effect: It is not known how many non-residents might currently be enrolled in BadgerCare Plus. Consequently, any savings estimates attached to this proposal are uncertain.

In order to produce its estimate of the effect of this change, DHS used information on how many individuals were initially denied MA eligibility due to their inability to verify that they were residents in the state, and doubled that estimate. Based on this methodology, DHS assumed that 5,487 individuals (2,940 children, 384 pregnant women and newborns, and 2,163 other adults) would no longer be eligible for BadgerCare Plus, resulting in annual savings of approximately

$14.9 million ($6.0 million GPR and $8.9 million FED).

This proposal could be viewed as a means of reducing fraud in the program, and, as such, would improve program integrity. For the reasons noted above, however, the savings estimate associated with this proposal is uncertain.

10. Eliminate Transitional MA

Current Law: Under current state law, BadgerCare Plus recipients whose income increases above 100% of the FPL, either due to an increase in earned income, an increase in child support income, or both, are eligible for transitional MA. Individuals who qualify for transitional MA remain eligible for the BadgerCare Plus Standard Plan and remain free of premium requirements (just as they were when their family income was less than 100% of the FPL) while they are in transitional MA. This is the case even if the income received from the sources cited above increase the individual's family income to levels where they would otherwise be required to pay premiums, switch to the Benchmark Plan, or become ineligible for BadgerCare Plus.

For example, if an adult in BadgerCare Plus with family income less than 100% of the FPL obtains new employment that causes their income to exceed 200% of the FPL, they would remain eligible for the program, even though adults with income greater than 200% of the FPL are not typically eligible to participate. Moreover, the adult in this example would not have premium obligations, even though adults with incomes between 150% and 200% of the FPL typically do pay premiums. A child of the adult in this example would also be eligible for transitional MA, meaning they could continue to participate in the Standard Plan (rather than the Benchmark Plan) and they would continue to be free of any premium obligations, even though children with family income greater than 200% of the FPL typically must pay premiums.

The transitional MA period is twelve months in cases where the increased income results from additional earned income, and four months when the increase results from additional child support. If an individual's family income drops back below 100% of the FPL while they are on transitional MA, they are once again eligible for standard BadgerCare Plus.

Transitional MA was incorporated into federal law as part of the Family Support Act of 1998, and the requirement that states provide transitional MA has been extended on several occasions, including an extension enacted under the Personal Responsibility and Work Opportunity Reconciliation of 1996. According to various sources, the original purpose of the transitional MA requirement is to remove disincentives that might exist for low-income individuals to leave traditional welfare and obtain employment.

Proposal: The Department's proposal would eliminate transitional MA in Wisconsin. According to the waiver materials, the transitional MA requirement has never been adjusted to reflect the fact that since it was originally mandated, the income eligibility threshold for adults under BadgerCare Plus has increased to 200% of the FPL. In the Department's view, that increase reduces the need for transitional MA, since adults with income less than 100% of the FPL can now

double that income and remain eligible for medical assistance in Wisconsin. DHS also maintains that elimination of transitional MA is an appropriate subject for its demonstration project since the future status of the federal requirement is uncertain.

Estimated Effect: The Department estimates that the elimination of transitional MA would generate annualized savings of approximately $27.3 million ($10.9 million GPR and $16.4 million FED). Assuming an implementation date of April 1, 2012, the projected savings to the MA program over the 2011-13 biennium are somewhat greater. As with several of its other MOE proposals, the Department's savings estimate for this item has several facets.

First, DHS estimated how many individuals would lose their eligibility for BadgerCare Plus due to the elimination of transitional MA. Based on actual enrollment data, DHS determined that 540 children with incomes greater than 300% of the FPL and 2,875 adults with incomes greater than 200% of the FPL would experience that impact. The estimated annual savings associated with the disenrollment of these individuals is $10.5 million ($4.2 million GPR and $6.3 million FED).

Second, DHS estimated the impacts to the remaining 15,813 individuals in transitional MA with family incomes greater than 150 % of the FPL who would now be subject to the Department's new 5% premium schedule. Of those 15,813 individuals, DHS assumed that 3,321 would disenroll from BadgerCare Plus, including 2,028 children and 1,293 adults. The annual savings resulting from these individuals' anticipated disenrollment is $7.0 million ($2.8 million GPR and $4.2 million FED). DHS developed that savings estimate by applying the same 21% disenrollment rate assumption as it applied to the other segments of the BadgerCare Plus population that would be subject to the proposed premium increases. That assumption may be conservative for these former transitional MA enrollees, given that under the program's current rules, these individuals do not pay premiums to participate in the program.

Third, DHS estimated that the 12,492 former transitional MA enrollees who remain in BadgerCare Plus and pay additional premiums would generate savings for the program in the form of additional premium revenue. Those 12,492 individuals include 7,628 children and 4,864 adults. DHS estimates that those 12,492 individuals would pay $9.8 million in additional premiums, annually. This would reduce annual funding needed for the program by $3.9 million GPR and $5.9 million FED.

Finally, the Department's cost projections for this item include the projected cost of providing the aforementioned premium reductions that would be available to families who are also paying major medical health insurance premiums for other persons in the family. DHS estimated those costs during the 2011-13 biennium to total $5.0 million ($2.0 million GPR and $3.0 million FED).

Table 6 summarizes the Department's estimates of the enrollment impacts, additional premiums, and other cost savings for each of the MOE waiver proposals. Note that the table indicates a total projected "Enrollment Impact" of 64,748 individuals. That projected enrollment impact is the aggregate of the following effects: (a) 22,544 individuals projected to leave the program as a result of higher premiums; (b) 30,713 individuals projected to become ineligible due

to revised other insurance "crowd-out" rules; (c) 2,589 individuals projected to become ineligible due to revised methods of counting family income; (d) 5,487 individuals projected to become ineligible due to a failure to verify state residency; (e) 3,415 individuals projected to lose their eligibility (for several reasons) due to the elimination of transitional MA.

MA INCOME ELIGIBILITY STANDARDS IN OTHER STATES

Attachment 3 compares the current MA income eligibility standards for several groups of children and adults for each state and the District of Columbia. The information was based on a recent national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families. However, since states' MA programs can vary significantly with respect to benefit plans and cost sharing requirements, it is difficult to draw conclusions, based on the limited information available from the survey summary.

TABLE 6

DHS Estimates Effects of MOE Waiver Items

	5% Premium For Families w/income >150% FPL	End Eligibility for individuals w/access to ESI w/premium <9.5% of Family Income	End Eligibility for Young Adults w/access to Parent Coverage	Increase Elig. Restrictions for Non-payment of Premium	Expedite Disenrollment of Ineligible Individuals	Eliminate Retroactive Eligibility	Eliminate Presumptive Eligibility for Children	Count Income of All Adults (ex. Grandparents) in Household	Require Verification of Residency	Eliminate Transitional Medicaid	Totals
Est. Enrollment Impact											
Pregnant Women/Newborns	0	0	0	0	0	0	0	102	384	0	486
Children	12,109	11,274	0	0	0	0	0	229	2,940	2,568	29,120
Adults	6,169	16,588	2,851	0	0	0	0	2,258	1,716	4,168	33,750
Core Plan	945	0	0	0	0	0	0	0	447	0	1,392
Total	19,223	27,862	2,851	0	0	0	0	2,589	5,487	6,736	64,748
Projected Annual Savings from Enrollment Impacts											
GPR	$16,100,000	$9,800,000	$3,600,000	$0	$0	$0	$0	$3,000,000	$6,000,000	$7,000,000	$45,500,000
FED	24,200,000	14,800,000	5,300,000	0	0	0	0	4,600,000	8,900,000	10,500,000	68,300,000
Total	$40,300,000	$24,600,000	$8,900,000	$0	$0	$0	$0	$7,600,000	$14,900,000	$17,500,000	$113,800,000
Projected Annual Savings From Additional Premiums											
GPR	$16,800,000	$0	$0	$0	$0	$0	$0	$3,200,000	$0	$3,900,000	$23,900,000
FED	25,300,000	0	0	0	0	0	0	4,900,000	0	5,900,000	36,100,000
Total	$42,100,000	$0	$0	$0	$0	$0	$0	$8,100,000	$0	$9,800,000	$60,000,000
Other Projected Annual Savings											
GPR	$0	$0	$0	$700,000	$4,800,000	$2,700,000	$200,000	$0	$0	$0	$8,400,000
FED	0	0	0	1,100,000	7,100,000	4,000,000	400,000	0	0	0	12,600,000
Total	$0	$0	$0	$1,800,000	$11,900,000	$6,700,000	$600,000	$0	$0	$0	$21,000,000
Total Projected Annual Savings from MOE Waiver Items											
GPR	$32,900,000	$9,800,000	$3,600,000	$700,000	$4,800,000	$2,700,000	$200,000	$6,200,000	$6,000,000	$10,900,000	$77,800,000
FED	49,500,000	14,800,000	5,300,000	1,100,000	7,100,000	4,000,000	400,000	9,500,000	8,900,000	16,400,000	117,000,000
Total	$82,400,000	$24,600,000	$8,900,000	$1,800,000	$11,900,000	$6,700,000	$600,000	$15,700,000	$14,900,000	$27,300,000	$194,800,000
Total Projected Biennial Savings from MOE Waiver Items											
Biennium GPR	$41,125,000	$12,290,000	$3,600,000	$700,000	$4,800,000	$2,700,000	$200,000	$6,200,000	$6,000,000	$12,600,000	$90,215,000
Biennium FED	61,875,000	18,470,000	5,300,000	1,100,000	7,100,000	4,000,000	400,000	9,500,000	8,900,000	18,900,000	135,545,000
Total Biennium	$103,000,000	$30,760,000	$8,900,000	$1,800,000	$11,900,000	$6,700,000	$600,000	$15,700,000	$14,900,000	$31,500,000	$225,760,000

Less Estimated Biennial Cost of Premium Reductions for Families Paying other Major Medical Insurance Premiums -$5,000,000

ITEMS RELATING TO BENCHMARK PLANS

1. The Alternative Benchmark Plan

Current Law: Virtually all BadgerCare Plus recipients with family income not greater than 200% of the federal poverty level (FPL) are eligible for coverage under the BadgerCare Plus Standard Plan. These recipients constitute more than 90% of total BadgerCare Plus enrollment. Also referred to as traditional MA, the Standard Plan covers a wide range of healthcare services, many of which are mandatory under federal law, while others are provided at the state's option. Service-related cost-sharing (copayments) for Standard Plan enrollees is nominal. Moreover, providers cannot deny services or equipment to Standard Plan members if they fail to pay a required copayment.

A much smaller group of BadgerCare Plus enrollees (approximately 18,000 of the total BadgerCare Plus enrollment of 781,000), most of whom are children in families with income greater than 200% of the FPL, are currently enrolled in the BadgerCare Plus Benchmark Plan. The Benchmark Plan derives its name from provisions in federal law which allow states to offer certain MA recipients benefits that are tied to any of several benchmark coverage plans, including the following: (a) the standard Blue Cross/Blue Shield preferred provider option service plan offered to federal employees; (b) the health benefits coverage plan that is offered and generally available to state employees in the state; (c) the health insurance coverage offered by an HMO that has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state; and (d) coverage approved by the Secretary of the federal Department of Health and Human Services that in the Secretary's determination provides adequate coverage for the targeted population. These same provisions allow states to offer certain MA recipients "benchmark equivalent" coverage as defined under federal law.

Generally speaking, the Benchmark Plan covers a somewhat more limited range of services, and requires greater recipient cost-sharing, than the Standard Plan. In addition, the statutes allows providers to deny services or equipment to recipients if they do not pay a required copayment.

Proposal: The Department's proposal would require almost all BadgerCare Plus recipients with family income between 100% and 200% of the FPL to switch from the Standard Plan to a newly-developed Alternative Benchmark Plan. DHS estimates that approximately 263,000 BadgerCare Plus enrollees would be impacted by this switch, including 157,600 children and 105,400 adults. Pregnant women, along with several other small eligibility groups, would not be subject to the proposed change.

As part of this proposal, DHS has developed an Alternative Benchmark Plan. The Alternative Benchmark Plan is similar to the existing Benchmark Plan, as shown in Attachment 4, which compares the coverage and copayment features of the Standard Plan, the current Benchmark Plan, and the proposed Alternative Benchmark Plan. As that Attachment indicates, all three coverage plans provide coverage for the federally-mandated early and periodic screening, diagnosis, and treatment (EPSDT) benefit, under which children under age 21 receive periodic screening and

diagnosis, and receive medically necessary services indicated through those screenings.

Regarding recipient cost-sharing, the Department's proposal contains the following additional elements. First, for those BadgerCare Plus enrollees with income between 100% and 150% of the FPL who are being switched from the Standard Plan to the new Alternative Benchmark Plan, aggregate service-related cost-sharing would be capped at 5% of household income. Thus, for a family of three with income equal to 125% of the FPL ($22,938), their total service-related cost-sharing under the proposed Alternative Benchmark Plan would be capped at 5% of household income ($1,147), regardless of how many individuals in the family are enrolled in BadgerCare Plus. Because these individuals will be exempt from premiums, the 5% cap on copayments would represent their total maximum cost-sharing under the proposal.

Second, for BadgerCare Plus enrollees with income between 150% and 200% of the FPL, the Department's proposal would, as explained earlier, impose a family premium equal to 5% of household income. Copayments for these individuals, however, would not be capped. In addition, enrollees in the Alternative Benchmark Plan could be denied services or equipment if they fail to pay a requirement copayment.

Estimated Effect: DHS estimates that this policy change will generate annual savings of approximately $45.3 million ($17.4 million GPR and $27.9 million FED). Assuming an implementation date of January 1, 2012, the estimated savings over the 2011-13 biennium are $68.2 million ($26.2 million GPR and $42.0 million FED). That estimate is based on the Department's assumption that per child costs under the Alternative Benchmark Plan will be approximately 3% lower than per child costs under the Standard Plan, and that per adult costs under the Alternative Benchmark Plan will be approximately 11.7% lower than per adult costs under the Standard Plan. Those estimates are based on the relative costs of the Standard Plan and the existing Benchmark Plan. Arguably, they might be somewhat conservative if the new copayment requirements impact the utilization of healthcare services by individuals with incomes between 100% and 200% of the FPL to a greater degree than is the case for current Benchmark Plan enrollees, all of whom have family income in excess of 200% of the FPL.

The Department has provided to this office a summary of the estimated cost-sharing impacts its proposal will have on families with income equal to 150% of the FPL. That summary is shown as Attachment 5. The attachment compares what families at that income level, on average, would pay monthly under the Department's premium and Alternative Benchmark Plan proposals compared to what they currently pay under the BadgerCare Plus Standard Plan. The attachment also compares these cost-sharing estimates to the estimated cost sharing for similar families under the state employee health plan.

For example, as shown in Attachment 5, the Department estimates that the average total BadgerCare Plus cost sharing (premiums and copayments) for a family of three comprised of one adult and two children with income at 150% of the FPL will increase from $30.35 to $227.74 per month, an increase of $197.39 per month. Annualized those projected cost-sharing increases total $2,368.68.

The precise impact of the higher copayment requirements is difficult to gauge, in part because most BadgerCare Plus recipients receive covered services through an HMO. The Department has indicated that the responsibility of BadgerCare Plus HMO enrollees to pay the program's designated copayments is left to each HMO and its contractual relationships with its network of service providers. The Wisconsin Association of Health Plans, in turn, has indicated that HMO policies regarding the collection of BadgerCare Plus copayments vary. For the current Benchmark Plan, however, DHS has indicated that its understanding of prevailing HMO policies is to collect copayments from BadgerCare Plus recipients. It therefore appears reasonable to anticipate that HMOs would require participants in the Alternative Benchmark Plan to pay required copayments as a condition of receiving covered services.

2. Birth-to-3 Program Benchmark Plan

Current Law: Under the Birth-to-3 program, state, federal and local funds support a statewide, comprehensive program of services for infants and toddlers with disabilities, and their families. A child is eligible if he or she is under three years of age and has a significant developmental delay or has a physical or mental condition likely to result in a developmental delay. The most frequently used services by Birth-to-3 program participants include mandatory service coordination, communication services, special instruction, occupational therapy, physical therapy, and family education. In November, 2011, approximately 5,974 children were in the Birth-to-3 program.

DHS is required to audit and pay allowable charges to certified MA providers on behalf of recipients receiving services under the Birth-to-3 program that are provided by a special educator. These services can include those related to early intervention, assistive technology and devices, audiology, communication, family education and counseling, health care, medical, nursing, nutrition, occupational therapy, physical therapy, psychological, social work, special instruction, transportation, and vision. Currently, counties provide the non-federal funding for services provided in the Birth-to-3 program.

Proposal: Under the proposal, DHS would submit to CMS an amendment to the state plan that would establish a MA benchmark plan for MA eligible children in the Birth-to-3 program. If approved, the state plan amendment would allow more of the services currently offered in the Birth-to-3 program to be eligible for matching federal funds under MA. Counties would continue to provide the non-federal funding for these services.

Services offered under the Birth-to-3 benchmark plan include screening, developmental services, consultation services, special instruction, speech, occupational, and physical therapy, and targeted case management. Individuals eligible for MA would continue to receive benefits under the BadgerCare Plus standard plan. DHS indicates that approximately 3,300 children would participate in the Birth-to-3 benchmark plan. It should be noted that none of the other proposals discussed in this paper apply to disabled individuals, including Birth-to-3 participants. Participation in the Birth-to-3 benchmark plan would be voluntary and parents would be able to remove their child from the program at any time.

Estimated Effect: The proposal is budget neutral. DHS argues that due to the program's current reliance on state and county funding, best practices in the Birth-to-3 program are either not being implemented or are being fully supported through state and county funding sources. The proposed benchmark plan would allow the Department to bill these services as MA eligible and collect federal matching funds. DHS believes that these changes would increase use of identified best practices and reduce the county costs of the program.

The Department also indicated in its waiver request that it is possible that access to Birth-to-3 services may increase, as more providers might be willing to participate in the program if the increased federal matching funds generated through the benchmark plan are used to increase provider rates.

3. Conversion of Community Recovery Services (CRS) program from a 1915(i) Home and Community Based State Plan Benefit to a 1937 Benchmark Alternative Benefits Plan

Current Law: The Department is required to provide community recovery services, subject to certain limitations. In part, these limitations require that the county in which the individual resides elects to provide the community recovery services through the MA program, and specify that DHS may only provide these services if the recipient, the services, and the providers meet conditions set forth in the approved 1915(i) plan amendment.

The CRS program provides psycho-social rehabilitative services to MA-eligible individuals with severe and persistent mental illness. These services include community living supportive services, peer specialist supports, and supported employment. Participation is voluntary. Currently, 154 individuals receive services through the CRS program.

Proposal: Under the proposal, DHS will submit a state plan amendment to CMS requesting that the CRS program be converted from a 1915(i) State Plan benefit to a 1937 Benchmark Alternative Benefit. Currently, the CRS program is available in a limited number of counties. PPACA requires that benefits provided as part of a 1915(i) Home and Community Based Services plan be provided statewide. The Department indicates that statewide implementation is not financially feasible. If approved by CMS, converting the CRS program to a 1937 Benchmark Alternative Benefit would allow the Department to continue to provide the CRS program in those counties where it currently exists. The CRS benchmark plan would remain voluntary.

Estimated Effect: The proposal would alter the form of the agreement DHS has with CMS that allows the state to receive federal matching funds for services provided under the CRS program. DHS indicates that the proposal would be cost neutral and that no change would be made to the benefits provided to CRS program participants.

PATIENT-CENTERED MEDICAL HOMES FOR CERTAIN MA POPULATIONS

Current Law: Wisconsin statutes specify the services and benefits that are available to MA

recipients enrolled in the standard plan. This section authorizes DHS to provide care coordination services to certain individuals with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

2009 Wisconsin Act 221 directed DHS to develop a proposal to increase MA reimbursement to agencies that receive grants under the Division of Public Health's to provide services to individuals with HIV/AIDS to which either of the following applies: (a) the provider is recognized by the national Committee on Quality Assurance as a patient-centered medical home (PCMH); or (b) the DHS Secretary determines that the provider performs well with respect to all of several standards established in the act. The DHS proposal must provide for payment of a monthly per-patient care coordination fee to these providers, and set the increases in MA reimbursement rates and the monthly patient care coordination fee so that together they provide sufficient incentive for providers to satisfy the conditions listed under (a) or (b) above. Act 221 requires that the state's share of the cost of increasing reimbursement rates and the monthly per-patient care coordination fees be paid from the current Division of Public Health appropriation to support HIV/AIDS services, rather than the state-funded MA benefits appropriations. Finally, the act required DHS to begin implementing the proposal beginning January 1, 2011. Providing care coordination services to targeted groups, together with paying health care providers for these and other enhanced services, are two primary features of PCMHs. DHS is proceeding to implement this provision.

The statutes do not authorize the MA program to offer care coordination services to other groups of MA recipients.

Proposal: DHS proposes to establish PCMHs for certain groups of MA recipients: (a) children in foster care; (b) pregnant women; (c) individuals leaving the criminal justice system; and (d) individuals with two or more chronic conditions.

These populations would be enrolled in an alternative benefit plan that would include all MA services for which they are currently eligible, plus additional services, including health care coordination, that are consistent with a medical home model. Enrollees would not be subject to any cost-sharing for the additional services provided to them. These programs would operate on an "all in/opt out" model, under which all eligible individuals would be enrolled, but individuals could voluntarily choose to disenroll after six months.

1. Children in Foster Care (Alternative Benefit Plan B). DHS would establish a medical home for approximately 2,500 children in foster care who live in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha Counties. These children would be eligible to receive care coordination and services through a medical home model for 12 months after a child reunifies with his or her birth family, or moves to an adoptive family or relative guardian, provided they are still eligible for MA after the child's permanency plan is achieved. DHS and the Department of Children and Families (DCF) would set performance-based standards related to health care and child outcomes that are based on national standards within the child welfare and MA programs. To address behavioral and mental health needs of these children, the medical home would coordinate behavioral health treatment, including evidence-based practices unique to the needs of each child,

oversight of psychotropic medications, flexible delivery settings, mobile crisis response and stabilization services, and peer-to-peer interventions.

In order to be certified as a health system to provide a medical home for children in this target population, the health system would need to meet the following requirements:

- Have a provider network that includes the following: (a) a sufficient number of pediatric specialists, or family practitioners with experience working with children with special health care needs to serve the target population: (b) behavioral health specialists with experience working with children with special health care needs, including training or knowledge of trauma-informed care; (c) a memorandum of understanding or contract with dental providers if not included in the network; and (d) access to a mental health mobile crisis intervention team 24 hours a day, seven days a week.

- Have a health management system that includes: (a) a process to facilitate effective care coordination across multiple disciplines within the health care system and with external providers; (b) a process for managing referrals or prior authorization to providers outside of the health care system as needed for continuity of care; (c) a written agreement for coordination of care and services between with the counties and the DCF Bureau of Milwaukee Child Welfare (BMCW) that defines the roles and responsibilities of the provider and the home county (or BMCW); (d) a written agreement for coordination of care and services between the provider and the county for the provision of mental health services, including crisis intervention services; (e) an individualized, comprehensive, and periodically updated written plan of care for each child; (f) a process to identify and prioritize children with special health and behavioral health care needs; and (g) a medical records system that contains information about the child's care, treatment, or services and promotes continuity of care among internal and external providers.

- Have the capacity to provide the following services within the health care system: (a) an initial health screen upon entry into foster care; (b) a comprehensive health assessment within 30 days of entry into foster care; and (c) an enhanced periodicity schedule for HealthCheck screens.

- Have the capacity to provide the following services within the health care system or through a contract or agreement with providers or agencies outside of the network without prior approval: (a) a behavioral health evaluation by a mental health professional; (b) the person conducting the evaluation must have experience working with children with special needs or children in foster care; (c) a dental examination for all children within three months of entry into foster care or documentation that the exam was completed within six months of entry into foster care.

- Have a lead physician responsible for the health management system, who is a pediatrician or a family practice physician with experience working with children with special health care needs of with children in foster care.

- A demonstrated experience with managing the complex medical, developmental and

psychosocial needs of children in foster care, as well as knowledge of the child welfare system.

In addition, the health care system must accept payment based on an all-inclusive rate for services available under the standard plan (with specified exceptions), and have the capacity to report clinical and administrative quality measures, such as appropriate dental screening and treatment, enhanced HealthCheck screenings, screenings for behavioral health issues, reduction in inappropriate use of emergency room and inpatient hospital services, appropriate asthma treatment, age-appropriate immunizations, and effective medication management.

DHS would pay certified Medicaid health systems an all-inclusive rate that would be calculated using current expenditures for this population of children. DHS would implement the state plan amendment on January 1, 2012.

2. Pregnant Women (Alternative Benefit Plan F). DHS would establish a medical home, to coordinate care and improve health outcomes for pregnant women not enrolled in managed care organizations and who receive MA services on a fee-for-service basis.

In its submission, DHS noted that Wisconsin has one of the worst infant mortality rates among African Americans in the country, and ranks low with respect to key indicators, such as time of entry into prenatal care, and rates for prematurity and low-birth weights. Approximately 85% of African American births in Wisconsin are to MA-eligible women living in the southeastern part of the state.

Under the proposal, benefits would be provided under a medical home framework that includes the following: (a) assignment of an obstetric care provider who is experienced in providing care to high-risk pregnant populations; (b) coordination of health care through a multi-disciplinary team, including the obstetric provider, which would identify the health and psychosocial needs of each pregnant woman; (c) the identification of a lead team, which may be the obstetric care provider or a care coordinator; (d) the prompt development of a patient-centered, multidisciplinary care plan; (e) timely follow-up for referrals; (f) establishment of regular communication between the obstetric care provider and other health care providers; (g) services provided through open and flexible scheduling; and (h) establishment of an electronic care plan and regular communication between, at a minimum, the obstetric care provider and the care coordinator.

Providers would be required to offer the following services: (a) systematic assessment, counseling and referral for tobacco, alcohol and other substance abuse; (b) routine screening for domestic violence and depression; (c) evidence-informed care and treatment, including treatment for periodontal disease; (d) an enhanced schedule for prenatal visits; (e) mobile response and stabilization services; (f) oversight of psychotropic medication, including pharmacy consultant services; and (g) increased schedule of laboratory tests related to the identification and treatment of infections known to prompt preterm labor, including testing for urinary tract infections, sexually-transmitted diseases, asymptomatic bacteriuria and Chlamydia. .

3. Individuals Leaving the Criminal Justice System (Alternative Benefit Plan E). DHS would establish a medical home to coordinate care for individuals with severe mental illness leaving the criminal justice system and the state's mental health institutes (MHIs). This program would target the following three groups of MA-eligible individuals: (a) persons placed in the community under supervision after leaving prisons and the MHIs; (b) individual who have multiple chronic health conditions who are exiting the prison system; and (c) individuals participating in either the conditional release program or the Opening Avenues to Re-entry Success (OARS) program who are placed within communities in the southeast region of the state.

In addition to providing the full MA benefits under the standard plan to this population, DHS would offer care coordination, medical assessments, and medication therapy management services.

Corrections staff and MHIs staff would provide outreach and information sharing to the target populations, such as: (a) informing eligible individuals in writing about their enrollment in the program, including their option to leave the program after six months; (b) informing eligible individuals about how to discontinue their participation; (c) letting individuals and families know that there is no cost or reduction in benefits; (d) educating eligible individuals and families about the benefits of participating in the program, including improved communication and coordination between all health care providers; and (e) documenting requests for disenrollment.

4. Individuals with Two or More Chronic Conditions (Alternative Plan D). DHS would establish a medical home to coordinate care for BadgerCare Plus and SSI-eligible MA recipients who: (a) have two or more chronic conditions, such as asthma, diabetes or heart conditions, but excluding mental health comorbidities; and (b) have two or more emergency room visits or one hospitalization in the past two years. DHS has not yet determined where the pilot area would be.

The National Committee for Quality Assurance (NCQA) is a private, not-for profit organization dedicated to improving health care quality. The NCQA defines a PCMH as:

"a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for patient care, providing for the patient's health care needs, and arranging for appropriate care with other qualified clinicians."

PCMHs that meet NCQA's standards receive national recognition. Under this program, PCMHs may obtain NCQA recognition by meeting specific elements included in the following six broad categories: (a) enhanced access and continuity of services; (b) the collection and use data for population management; (c) use evidence-based guidelines for preventive, acute, and chronic care management, including medication management; (d) the provision of self-care support and community resources by assisting patients and their families in self-care management with information, tools and resources; (e) tracking and coordinating tests, referrals and transition of care; and (f) the use performance and patient experience data for continuous quality improvement. A plan may obtain NCQA recognition by meeting performance standards on a point-based system.

Currently, there are approximately 1,500 PCMHs nationwide that have obtained NCQA recognition.

In August, 2011, Health Affairs published an article by Marcy Takach, the program Director for the National Academy for State Health Policy, entitled Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results. Although states have only recently begun implementing PCMHs for their MA populations, the author concluded that the limited data from these states demonstrate positive trends, and have encouraged state policy makers to expand or continue their efforts. These conclusions were based on standardized surveys of states and web-based research that was verified through correspondence with state policy-makers.

States that implement MA PCMH programs must establish qualification standards, which are frequently based on the NCQA guidelines. However, some states modify the NCQA standards, adopt standards from other accreditation organizations, or create their own standards. Once states define their qualification standards, providers that meet the state's PCMH standards may qualify for new incentive payments to support the enhanced services. These incentive payments may take several forms, including: (a) monthly care management fees, typically ranging from $3 to $4 per member per month, plus fee-for-service payments; (b) enhanced fee-for-service payments for certain office or outpatient visits during which the patient receives evaluation and management services; (c) lump-sum payments to fund up-front costs, such as additional staff or infrastructure costs; (d) payments to networks and teams, in addition to monthly care management fees; and (e) performance-based incentive payments.

While noting that independent evaluations of the cost-effectiveness of the PCMH model are not yet available for many states that have recently enacted PCMH programs, Ms. Takach reviewed limited data available from three states -- Oklahoma, Colorado, and Vermont -- and found evidence of reduced per patient costs, and increases in patient access to care as a result of establishing PCMHs.

Estimated Effect: Current research suggests that the establishment of medical homes for targeted populations may have the potential to reduce health care costs. However, the Department's medical home initiatives are in the early stages of development. While DHS staff have had discussions with several health systems that have expressed interest in these proposals, DHS has not developed information regarding the potential increases in the costs of additional services that would be provided to enrollees and enhanced payments to providers, nor savings associated with reduced utilization of services by enrollees that DHS assumes would occur.

The Department's documents relating to the establishing PCMHs for these four population groups suggests a potential net savings of approximately $9.3 million ($3.7 million GPR and $5.6 million FED) in the 2011-13 biennium. In addition, the Department is development proposals to establish PCMHs for additional target groups.

FISCAL SUMMARY

In its September 30, 2011, report to the Committee, DHS indicated that the required savings target for the MA program for the remainder of the 2011-13 biennium is $554.4 million (all funds). That target reflects the Department's updated biennial projections for the MA program through September 30, 2011. The Department's estimated biennial savings associated with the items in this submission total $298.3 million. The Department expects to realize the remainder of the $554.4 million through other initiatives.

ALTERNATIVES

The alternatives presented for the Committee are divided into the following three groups: (a) items relating to the MOE waiver request; (b) items that would establish new benchmark plans for BadgerCare Plus populations; and (c) items that would establish medical homes for several target populations.

The Committee could approve the Department's request, as submitted, exercising its authority, provided under Act 32, to direct DHS to seek a waiver of several requirements of federal law (including a waiver of the PPACA MOE requirement) and to direct DHS to implement policies that would supersede current state statutes relating to eligibility, cost-sharing, and services provided under the program subject to that federal approval (Alternatives A1, B1, and C1).

Alternatively, the Committee could modify the Department's request by deleting any of the components of the request (Alternatives A2, B2, and C2). Under these options, DHS would be unable to implement any of the proposals deleted by the Committee, since these proposals would conflict with current state law, and could not be forwarded to CMS for approval as part of a waiver request or state plan amendment. If the Committee chooses to delete any items from the DHS proposal, DHS would not be able to realize any potential savings that may result from their implementation. Consequently, DHS would need to develop alternative proposals to reduce program costs in order to avoid a potential funding shortfall in the program in the 2011-13 biennium. Any such proposals that would conflict with current MA statutes would be brought before the Committee at a later date. However, some proposals, including proposals to increase funding available for the program, may require legislation.

Finally, the Committee could reject the entire proposal. Under this option, DHS would be prohibited from submitting the MOE waiver request to CMS, and DHS could not make any changes to the program that would conflict with current state law. Similar to the second option, this option would most likely require the administration and, perhaps, the Legislature, to address a potential shortfall in funding for MA benefits in the 2011-13 biennium.

With respect to the MOE waiver request, Act 32 states that if the waiver request does not receive federal approval before December 31, 2011, the Department shall reduce the income eligibility level for non-pregnant, non-disabled adults to 133% of the FPL. These individuals are currently eligible for the program if their income does not exceed 200% of the FPL. DHS estimates

that approximately 53,000 such individuals could lose their BadgerCare Plus eligibility under this provision. The estimated annual savings to the program associated with their disenrollment is approximately $150 million ($60.0 million GPR and $90.0 million FED).

A. Items Requested as Part of the Maintenance of Effort Waiver

1. Approve all of the items included in the MOE waiver request.

2. Delete one or more of the following items included in the MOE waiver request.

a. Increase premiums to 5% of family income for families with income greater than 150% of the FPL.

b. Terminate eligibility for individuals and families with access to employer-based health insurance where the employee contribution to the premium is less than 9.5% of household income.

c. Discontinue eligibility for young adults covered under parents' policies.

d. Increase eligibility restrictions related to non-payment of premiums.

e. Disenroll individuals, and therefore coverage for services, closer to the date an individual is determined to be ineligible.

f. Repeal retroactive eligibility for all BadgerCare Plus recipients.

g. Repeal presumptive eligibility for children.

h. Count income of all adults, except grandparents, who are living in a household for at least 60 days.

i. Require verification of state residency prior to enrollment.

j. Eliminate Transitional MA.

B. Items Relating to Benchmark Plans

1. Approve all of the items that relate to benchmark plans.

2. Delete one or more of the following items relating to benchmark plans.

a. Transfer all BadgerCare Plus recipients in families with income greater than 100% of the FPL to a BadgerCare Plus benchmark benefit plan.

b. Establish a benchmark benefit plan for children enrolled in the Birth to 3 program.

c. Convert the state's 1915(i) waiver, which provides community recovery services, to a 1937 benchmark alternative plan.

C. Medical Homes for Selected Populations

1. Approve all of the items relating to establishing medical homes for selected populations.

2. Delete one or more of the following items relating to the establishment of medical homes.

a. Medical homes for children in foster care.
b. Medical homes for pregnant women.
c. Medical homes for individuals leaving the criminal justice system.
d. Medical homes for individuals with two or more chronic conditions.

Prepared by: Charles Morgan, Eric Peck, Grant Cummings, and Sam Austin
Attachments

ATTACHMENT 1

All Funds Benefit Expenditures for the MA and MA-Related Programs, including SeniorCare, 2003-04 through 2010-11 (Actual) and 2011-13 (Budgeted)

	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	Budgeted 2011-12	Budgeted 2012-13
MA (ex. SeniorCare)										
GPR	$764,700,000	$1,661,200,000	$1,361,500,000	$1,766,400,000	$1,756,400,000	$1,102,500,000	$1,286,000,000	$1,446,400,000	$1,891,800,000	$2,015,300,000
FED	2,725,200,000	2,698,000,000	2,706,500,000	2,774,300,000	2,905,800,000	3,878,800,000	4,675,100,000	4,960,900,000	4,007,100,000	4,266,900,000
SEG	735,000,000	10,300,000	359,900,000	127,300,000	212,100,000	875,500,000	635,100,000	666,500,000	650,700,000	666,800,000
PR	7,000,000	9,100,000	8,700,000	10,700,000	46,400,000	64,500,000	66,900,000	64,700,000	68,400,000	61,200,000
Total MA (ex. SeniorCare)	$4,231,800,000	$4,378,600,000	$4,436,500,000	$4,678,600,000	$4,920,700,000	$5,921,300,000	$6,663,100,000	$7,138,400,000	$6,618,000,000	$7,010,300,000
SeniorCare										
GPR	$38,200,000	$45,400,000	$44,400,000	$45,700,000	$38,800,000	$34,000,000	$18,300,000	$20,400,000	$29,200,000	$30,900,000
FED	41,500,000	45,100,000	45,700,000	41,900,000	33,500,000	50,700,000	16,700,000	23,100,000	30,100,000	31,700,000
PR	31,200,000	39,400,000	50,600,000	53,200,000	54,800,000	40,000,000	80,500,000	64,300,000	55,100,000	58,100,000
Total SeniorCare	$110,900,000	$129,800,000	$140,700,000	$140,700,000	$127,100,000	$124,700,000	$115,500,000	$107,900,000	$114,400,000	$120,600,000
MA and SeniorCare										
GPR	$802,900,000	$1,706,600,000	$1,405,800,000	$1,812,100,000	$1,795,200,000	$1,136,500,000	$1,304,200,000	$1,466,800,000	$1,921,000,000	$2,046,200,000
FED	2,766,700,000	2,743,000,000	2,752,200,000	2,816,200,000	2,939,300,000	3,929,500,000	4,691,900,000	4,984,000,000	4,037,200,000	4,298,600,000
SEG	766,100,000	49,600,000	410,600,000	180,500,000	266,800,000	915,600,000	715,600,000	730,800,000	705,800,000	724,900,000
PR	7,000,000	9,100,000	8,700,000	10,700,000	46,400,000	64,500,000	66,900,000	64,700,000	68,400,000	61,200,000
Total MA and SeniorCare	$4,342,700,000	$4,508,400,000	$4,577,200,000	$4,819,400,000	$5,047,800,000	$6,046,000,000	$6,778,600,000	$7,246,300,000	$6,732,400,000	$7,130,900,000

ATTACHMENT 2

2011 Federal Poverty Levels

Family Members	100%	133%	150%	200%	300%
			Annual Income		
1	$10,890	$14,484	$16,335	$21,780	$32,670
2	14,710	19,564	22,065	29,420	44,130
3	18,530	24,645	27,795	37,060	55,590
4	22,350	29,726	33,525	44,700	67,050
5	26,170	34,806	39,255	52,340	78,510
6	29,990	39,887	44,985	59,980	89,970
7	33,810	44,967	50,715	67,620	101,430
8	37,630	50,048	56,445	75,260	112,890
			Monthly Income		
1	$908	$1,207	$1,361	$1,815	$2,723
2	1,226	1,630	1,839	2,452	3,678
3	1,544	2,054	2,316	3,088	4,633
4	1,863	2,477	2,794	3,725	5,588
5	2,181	2,901	3,271	4,362	6,543
6	2,499	3,324	3,749	4,998	7,498
7	2,818	3,747	4,226	5,635	8,453
8	3,136	4,171	4,704	6,272	9,408

ATTACHMENT 3

Comparison of State Medicaid Income Eligibility Standards for Low-Income Families
January, 2011

	Children, Age 0-19	Parents		Childless Adults		Pregnant Women
	Medicaid/ CHIP	Medicaid (or Look-Alike)	More limited Than Medicaid	Medicaid (or Look-Alike)	More Limited Than Medicaid	Medicaid/ CHIP
Alabama	300%	24%	-	-	-	133%
Alaska	175	81	-	-	-	175
Arizona	200	106	-	110%	-	150
Arkansas	200	17	-	-	-	200
California	250	106	200%	-	200%	200
Colorado	250	106	-	-	-	250
Connecticut	300	191	306	73	310	250
Delaware	200	120	-	110	-	200
District of Columbia	300	207	-	211	211	300
Florida	200	59	-	-	-	185
Georgia	235	50	-	-	-	200
Hawaii	300	100	200	100*	200	185
Idaho	185	39	-	-	-	133
Illinois	200 (300)	191	-	-	-	200
Indiana	250	36	200	-	200	200
Iowa	300	83	250	-	250	300
Kansas	241	32	-	-	-	150
Kentucky	200	62	-	-	-	185
Louisiana	250	25	-	-	-	200
Maine	200	200	300	-	300	200
Maryland	300	116	-	-	128	250
Massachusetts	300	133	300	-	300	200
Michigan	200	64	-	-	45*	185
Minnesota	275**	215	275	-	250	275
Mississippi	200	44	-	-	-	185
Missouri	300	25	-	-	-	185
Montana	250	56	-	-	-	150
Nebraska	200	58	-	-	-	185
Nevada	200	88	-	-	-	185
New Hampshire	300	49	-	-	-	185
New Jersey	250	133	200*	-	-	200
New Mexico	235	67	408*	-	414*	235
New York	400	150	-	100	-	200
North Carolina	200	49	-	-	-	185
North Dakota	160	59	-	-	-	133

	Children, Age 0-19	Parents		Childless Adults		Pregnant Women
	Medicaid/ CHIP	Medicaid (or Look-Alike)	More limited Than Medicaid	Medicaid (or Look-Alike)	More Limited Than Medicaid	Medicaid/ CHIP
Ohio	200%	90%	-	-	-	200%
Oklahoma	185	53	-	-	-	185
Oregon	300	40	201%	-	201%	185
Pennsylvania	300	46	208*	-	213*	185
Rhode Island	250	181	-	-	-	250 (350)
South Carolina	200	93	-	-	-	185
South Dakota	200	52	-	-	-	133
Tennessee	250	127	-	-	-	185
Texas	200	26	-	-	-	185
Utah	200	44	150*	-	150*	133
Vermont	300	191	300	160	300	200
Virginia	200	31	-	-	-	200
Washington	300	74	200*	-	200*	185
West Virginia	250	33	-	-	-	150
Wisconsin	300	200	-	-	200*	300
Wyoming	200	52	-	-	-	133

* Indicates that program enrollment is currently closed.
**Infants under 1 year of age are eligible up to 280% of FPL in Minnesota

Source: National survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families.

ATTACHMENT 4

BadgerCare Plus Standard Plan, Wisconsin Medicaid and Proposed BadgerCare Plus Benchmark Plan Covered Services Comparison Chart

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.
Chiropractic	Full coverage. $0.50 to $3.00 copayment per service.	Full coverage. $15.00 copayment per visit.	Full coverage. $15.00 copayment per visit.
Dental	Full coverage. $0.50 to $3.00 copayment per service.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and surgical procedures for pregnant women and children. Coverage limited to $750.00 per enrollment year. A $200.00 deductible applies to all services except preventive and diagnostic. Cost-sharing equal to 50 percent of allowable fee on all services. Pregnant women are exempt from deductible and cost-sharing requirements for dental services.	Full coverage for members 20 years of age and younger. For members 21 years of age and older, dental coverage is limited to: • Diagnostic • Preventive • Simple Restorative • Surgical Procedures • Dentures Cost Sharing: • 50% cost-sharing for dentures for adults • $15 copayment per visit for all members
Disposable Medical Supplies (DMS)	Full coverage. $0.50 to $3.00 copayment per service and $0.50 per prescription for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). $0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). $0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to 5 prescriptions per month for opioid drugs. Copayments are as follows: • $0.50 for OTC drugs. • $1.00 for generic drugs. • $3.00 for brand name drugs. Copayments are limited to $12.00 per member, per provider, per month. Over-the-counter drugs are excluded from this $12.00 maximum.	Generic-only formulary drug benefit and some OTC drugs. Members are limited to 5 prescriptions per month for opioid drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. $5.00 copayment with no upper limits.	Coverage of generic drugs, certain preferred brand name drugs on Wisconsin Medicaid's Preferred Drug List and some OTC drugs. Members are limited to 5 prescriptions per month for opioid drugs. Prior authorization will be available for select drug classes and brand medically necessary drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. Copayments are as follows: • $4.00 for generic drugs. • $8.00 for brand name drugs.
Durable Medical Equipment (DME)	Full coverage. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment.	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.	Full coverage. No copayment.	Full coverage. No copayment.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21.	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. $1.00 copayment per screening for members 18, 19, and 20 years of age.	Full coverage of HealthCheck screenings and other services for individuals under the age of 21.
Hearing Services	Full coverage. $0.50 to $3.00 copayment per procedure. No copayment for hearing aid batteries.	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of PDN, home health, and personal care services. No copayment.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.
Hospice	Full coverage. No copayment.	Full coverage, up to 360 days per lifetime. No copayment.	Full coverage, up to 360 days per lifetime. No copayment.
Inpatient Hospital	Full coverage. $3.00 copayment per day with a $75.00 cap per stay.	Full coverage. Copayments are as follows: • $100.00 per stay for medical stays. • $50.00 copayment per stay for mental health and/or substance abuse treatment.	Full coverage. Copayments are as follows: • $100.00 per stay for medical stays. • $50.00 copayment per stay for mental health and/or substance abuse treatment.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3.00 copayment per service, limited to the first 15 hours or $825.00 of services, whichever comes first, provided per calendar year. Copayment not required when services are provided in a hospital setting.	Coverage of this service is based on the Wisconsin State Employee Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), adult mental health day treatment for adults, substance abuse day treatment for adults and children, child/adolescent mental health day treatment, and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program, comprehensive community services, outpatient mental health services in the home and community for adults, community recovery services, and substance abuse residential treatment. $10.00 to $15.00 copayment per visit for all outpatient hospital services: • $10.00 per day for all day treatment services. • $15.00 per visit for narcotic treatment services (no copayment for lab tests). • $15.00 per visit for outpatient mental health diagnostic interview exam, psychotherapy — individual or group (no copayment for • electroconvulsive therapy and pharmacological management). • $15.00 per visit for outpatient substance abuse services.	Full Coverage (not including room and board.) up to 200% FPL. No copayment.
Nursing Home Services	Full coverage. No copayment.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Outpatient Hospital — Emergency Room	Full coverage. No copayment.	Full coverage. $60.00 copayment per visit (waived if the member is admitted to a hospital).	Full coverage. $100.00 copayment per visit (waived if the member is admitted to a hospital).
Outpatient Hospital	Full coverage. $3.00 copayment per visit.	Full coverage. $15.00 copayment per visit.	Full coverage. $15.00 copayment per visit.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP)	Full coverage. $0.50 to $3.00 copayment per service. Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits over 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits over 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.
Physician	Full coverage, including laboratory and radiology. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia, preventive services or clozapine management.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the Current BadgerCare Plus Benchmark Plan	Coverage Under the Proposed BadgerCare Plus Benchmark Plan
Podiatry	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year.	Full coverage. $15.00 copayment per visit.	Full coverage. $15.00 copayment per visit.
Prenatal/Maternity Care	Full coverage, including Prenatal Care Coordination (PNCC), and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	Full coverage including coverage of eyeglasses. $0.50 to $3.00 copayment per service.	One eye exam with refraction per enrollment year. $15.00 copayment per visit.	One eye exam with refraction and a single pair of eye glasses per enrollment year. $15.00 copayment per visit.
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $2.00 copayment for non-emergency ambulance trips. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.

Note: The covered services information in this chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services and PA information.

ATTACHMENT 5

Estimated Average Monthly Cost Sharing Under the Alternative Benchmark Plan (Premiums and Copayments) for Families With Income of 150% of FPL

	Income	Premium	Copayments	Total	% of Income
Group Size 3 1 Adult 1 Child 150% FPL = $1,839/month					
Standard plan	$1,839	$10.00	$ 20.35	$30.35	1.65%
Benchmark Plan	1,839	91.94	91.75	183.68	9.99
State Employee	1,839	201.00	67.36	268.36	14.59
Group Size 3 1 Adult 2 Children 150% FPL = $2,316/month					
Standard plan	2,316	10.00	20.35	30.35	1.31
Benchmark Plan	2,316	115.81	111.92	227.74	9.83
State Employee	2,316	201.00	101.04	302.04	13.04
Group Size 3 2 Adult 1 Child 150% FPL = $2,316/month					
Standard plan	2,316	10.00	32.45	42.45	1.83
Benchmark Plan	2,316	115.81	163.32	279.13	12.05
State Employee	2,316	201.00	101.04	302.04	13.04
Group Size 4 1 Adult 3 Children 150% FPL = $2,794/month					
Standard plan	2,794	10.00	36.84	46.84	1.68
Benchmark Plan	2,794	139.69	132.10	271.79	9.73
State Employee	2,794	201.00	134.72	335.72	12.02
Group Size 4 2 Adult 2 Children 150% FPL = $2,794/month					
Standard plan	2,794	10.00	40.70	50.70	1.81
Benchmark Plan	2,794	139.69	183.49	323.18	11.57
State Employee	2,794	201.00	134.72	335.72	12.02