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June 8, 2007 Joint Committee on Finance Paper #383

BadgerCare Plus and Related Initiatives (DHFS -- MA -- General)

Bill Section

[LFB 2007-09 Budget Summary: Page 251, #5]

CURRENT LAW

Medical Assistance. Medical assistance (MA) is an entitlement program, jointly funded by states and the federal government, which funds acute and long-term care services to certain groups of low-income individuals. MA is administered by states within federal guidelines relating to eligibility, types of services, provider reimbursement, and administrative operating procedures. Most program benefits are funded on a 42% GPR/58% FED matching basis.

The MA program has numerous financial eligibility requirements. Certain expenses, such as child care, are deducted from household income as part of eligibility determination. Additionally, other types of income, such as Wisconsin Works (W-2) payments, kinship care payments, and a portion of child support payments, may not be counted when determining a family's income. Some of the current eligibility requirements for "Family MA" (MA for low-income families with dependent children and pregnant women) are described in Attachment 1.

BadgerCare. BadgerCare funds health services for individuals in low-income families who are not eligible for MA. BadgerCare is closely tied to the MA program with respect to eligibility, service delivery, and administration. However, MA and BadgerCare are budgeted as separate programs and have a number of significant differences.

BadgerCare is partially funded with federal funds available from two federal programs -- the state children's health insurance program (SCHIP) and MA. Consequently, BadgerCare operates under federal requirements applicable to both programs. Further, Wisconsin received approval of a waiver of certain federal requirements under MA in order to implement

BadgerCare. This waiver approval was granted based on a plan submitted and approved by the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS). BadgerCare operates under the parameters established in that approved plan. The current waiver agreement was scheduled to terminate on March 31, 2007. However, CMS has extended the waiver under which BadgerCare operates, as a result of DHFS' current negotiations with CMS.

BadgerCare recipients are eligible to receive all of the services that are available to MA recipients. Approximately 65% of BadgerCare recipients are enrolled in health maintenance organizations (HMOs). Average capitation costs for BadgerCare clients are generally higher than capitation payments the MA program makes on behalf of low-income families enrolled in MA. As with MA capitation rates, the actual amount paid to an HMO for an enrollee is based on the enrollee's age, gender, and area of residence.

The current eligibility requirements for BadgerCare are described in Attachment 2.

GOVERNOR

A complete summary of the Governor's BadgerCare Plus proposal is provided in the Legislative Fiscal Bureau's March, 2007, summary of the Governor's budget recommendations, beginning on page 251. This summary highlights the major components of this proposal.

Funding. Provide $127,400 (-$2,121,300 GPR, -$2,512,100 FED, and $4,760,800 PR) in 2007-08 and $31,463,100 ($2,121,300 GPR, $7,480,200 FED, and $21,861,600 PR) in 2008-09 to reflect the net effect of: (a) implementing a new program, BadgerCare Plus, which would merge the current Family MA program and the BadgerCare programs, and provide health care coverage for certain populations not currently covered under MA or BadgerCare; and (b) funding several related initiatives.

The Governor's budget combines funding for MA benefits and BadgerCare benefits so that funding for services provided under each program would no longer be budgeted in separate appropriations.

Federal Waiver. The bill would require DHFS to request a waiver and submit amendments to the state MA plan, to the DHHS Secretary to implement BadgerCare Plus. If DHHS approved the state plan amendments and approved a waiver that is consistent with all of the provisions in the bill relating to BadgerCare Plus, DHFS would be required to implement BadgerCare Plus, beginning on January 1, 2008, the effective date of the state plan amendments, or the effective date of the waiver, whichever is latest.

If DHHS does not approve the state plan amendments or DHHS does not grant a waiver that is consistent with all of the provisions in the bill relating to BadgerCare Plus, BadgerCare Plus could not be implemented. If CMS approves the state plan amendments, but the approval is

not continued, or if a waiver that is consistent with all the provisions in the bill is granted but not continued in effect, BadgerCare Plus would be discontinued, and current law would resume.

Expansion Populations. BadgerCare Plus would expand MA/BadgerCare eligibility to three groups of recipients that are not currently eligible for coverage.

(a) All children (up to age 18), regardless of income and youths ages 18 through 20 who, at the time they reached age 18, were in out-of-home care;

(b) Pregnant women in families with income up to 300% of the federal poverty level (FPL); and

(c) Certain parents and caretaker relatives in families with income up to 200% of the FPL, including parents with children in foster care and certain self-employed parents, including farmers (depending on depreciation).

Table 1 shows the 2007 FPL guidelines, by family size.

TABLE 1

2007 Federal Poverty Guidelines

Number in Family	100%	150%	185%	200%	300%
1	$10,210	$15,315	$18,889	$20,420	$30,630
2	13,690	20,535	25,327	27,380	41,070
3	17,170	25,755	31,765	34,340	51,510
4	20,650	30,975	38,203	41,300	61,950
5	24,130	36,195	44,641	48,260	72,390
6	27,610	41,415	51,079	55,220	82,830
7	31,090	46,635	57,517	62,180	93,270
8	34,570	51,855	63,955	69,140	103,710
Each Additional Child	$3,400	$5,100	$6,290	$6,800	$10,200

Table 2 shows the administration's estimates of the average annual number of additional individuals who would be enrolled in BadgerCare Plus in calendar year 2009, by income group.

TABLE 2

Additional BadgerCare Plus Recipients as of Calendar Year 2009
(Annual Average)

Children

Under 150% of the FPL	150%-185% of the FPL	185%-200% of the FPL	200%-300% of the FPL	300% of the FPL or Greater	Total
800	1,400	1,700	6,400	2,400	12,700

Adults (Age 19 and Over)

Under 150% of the FPL	150%-185% of the FPL	185%-200% of the FPL	200%-300% of the FPL	300% of the FPL or Greater	Total
1,300	3,800	800	2,500	5,000	13,400

Total New Recipients -- 26,100

Current MA/BadgerCare Populations. Current Family MA and BadgerCare recipients would be considered part the BadgerCare Plus recipient population. There would no longer be a distinction between the MA and BadgerCare programs for these recipients. All eligible recipients would be subject to BadgerCare Plus eligibility criteria. Currently, MA and BadgerCare low-income family recipients who are served in managed care do not have to pay nominal copayments. Under BadgerCare Plus, recipients enrolled in managed care would be subject to pay the nominal copayments that fee-for-service recipients currently pay. The current BadgerCare requirement that individuals in families with income above 150% FPL provide employer verification of insurance coverage would continue to apply.

Administrative Simplification. Under the current Family MA/BadgerCare programs, there are over 20 different eligibility groups, to which different rules apply with respect to what type of income is counted in determining an individual's eligibility. Under BadgerCare Plus only student earnings and child support payments would be subtracted from a family's gross income in determining an individual's eligibility. These simplified eligibility rules would apply to all eligible recipients, not just the BadgerCare Plus expansion populations.

Benefits under BadgerCare Plus. BadgerCare Plus would serve all current MA/BadgerCare family and children populations, as well as the expanded populations, under two distinct plans. The "standard plan," which is the current MA benefit plan, would be provided to all recipients in families with income under 200% of the FPL. A list of services covered under the standard plan is

provided in Attachment 3. The other plan, which DHFS refers to as the "benchmark plan," would be available for recipients in families with income above 200% of the FPL and certain self-employed families. The benchmark plan would offer services similar to the standard MA plan, but would include more extensive service limitations and copayment requirements. A list of the benefits and copayments that would be established under the benchmark plan is provided in Attachment 4.

Individuals eligible for coverage under the standard plan would include: (a) a pregnant woman whose family income does not exceed 200% of the FPL; (b) a child under one year of age whose mother, on the day on which the child was born, was eligible for and receiving benefits under MA or BadgerCare Plus under the regular MA plan; (c) a child whose family income does not exceed 200% of the FPL; (d) an individual whose family income does not exceed 200% of the FPL and who is the parent or caretaker relative of a child who is, generally, living in the home of the parent or caretaker relative; (e) certain migrant workers and their dependents already deemed eligible by another state and still within the eligible period; and (f) an individual between 18 and 20 years of age who was in foster care on his or her 18th birthday.

Individuals eligible for the benchmark plan would include: (a) a pregnant woman whose family income is between 200% and 300% of the FPL; (b) a child under one year of age whose mother, on the day on which the child was born, was eligible for and receiving BadgerCare Plus benefits under the benchmark plan; (c) any child whose family income is between 200% and 300% of the FPL; and (d) a self-employed individual whose family income is between 200% and 300% of the FPL, who is the parent or caretaker relative of a child who is, generally, living in the home of the parent or caretaker relative. Finally, any child whose family income exceeds 300% of the FPL could purchase coverage under the benchmark plan at the full per member per month cost of the coverage.

DHFS contracted with the actuarial firm PricewaterhouseCoopers to develop a model to estimate the cost of providing coverage to these new eligibility groups. According to the model, by calendar year 2009, approximately 12,700 additional children and 13,400 additional adults would receive coverage through BadgerCare Plus.

Premium Groups. Under BadgerCare Plus, certain covered populations would be required to pay monthly premiums. Families would be required to pay premiums for the following four groups: (a) children in families with income over 200% of the FPL; (b) parents and caretakers in families with income between 150% and 200% of the FPL; (c) pregnant women in families with income between 200% and 300% of the FPL; and (d) certain self-employed parents in families with income less than 200% of the FPL.

The administration's cost estimates assume that monthly premiums would be assessed to both current and new groups of individuals who would be covered under BadgerCare Plus. Table 3 lists the monthly premiums that would be paid for each covered individual. There are some limitations on total monthly payments for premiums per individual and family, and these limitations vary by income and plan.

TABLE 3

Monthly Premiums under BadgerCare Plus, by Eligibility Group

BadgerCare Plus Eligibility Category	Monthly Premium
All AFDC/Healthy Start children (Current eligibles)	None
Children in families with income under 200% of the FPL	$0
Children in families with income between 200% and 300% of the FPL	30
Children in families with income that exceeds 300% of the FPL	70
Adults in families with income between 150% and 185% of the FPL	55
Adults in families with income between 185% and 200% of the FPL	80
Adults in families with income between 200% and 300% of the FPL	125
Adults in families with income that exceeds 300% of the FPL	184
Pregnant Women in families with income greater than 200% of the FPL	125

Projected Savings. The administration assumes that, in the 2007-09 biennium, these changes would reduce total MA and BadgerCare benefits costs. There are three sources of this savings: (a) "migration savings," which would result if nearly all current MA and BadgerCare recipients enroll in HMOs, since the average capitation payments the MA program makes to HMOs is less than the average MA cost of providing services to recipients on fee-for-service basis; (b) copayment benefits savings, which would result by requiring most BadgerCare Plus standard plan recipients, including recipients enrolled in HMOs, to pay nominal copayments for certain services, and copayment savings that would result by requiring all benchmark plan recipients to pay copayments for services, and reducing provider payments, including capitation payments, to reflect these increased cost-sharing requirements; and (c) reducing funding budgeted for contracted state administrative costs.

Employer Verification of Insurance. DHFS would create a database of employers, which would include information about whether the employer offers health insurance coverage and the percentage of premiums that employees are required to pay. County eligibility staff would have access to the database, so they would be able to use this information at the time an individual applies for BadgerCare Plus to determine whether the individual has, or has had, access to employer-subsidized health care. Employers would be required to update the database annually. Employers who do not comply or provide alternate paper work regarding insurance coverage would be required to pay a penalty to reimburse the state for providing health care coverage for their employees.

Related Initiatives. Based on the administration's estimates of the net benefits savings that would result by enrolling additional current MA and BadgerCare recipients into HMOs, imposing new cost-sharing requirements on current enrollees, and reducing funding for contracted administrative costs, DHFS would fund several items to fully expend the

administration's estimate of the net projected savings of the proposal in the 2007-09 biennium. These items are described below.

1. *Dental Access.* DHFS would issue a request for information (RFI) to solicit interest among health care providers for designing and managing a dental service delivery system for BadgerCare Plus recipients. The goal of the RFI process is to bring forward new and innovative service delivery models. DHFS would encourage models that expand upon current local partnerships that are providing dental care to MA recipients.

If DHFS does not find that the responses to the RFI meet the stated goal, DHFS proposes to develop two pilot initiatives to determine a reasonable, long-term solution to increasing access to dental services. One pilot initiative would be a pay-for-performance effort targeting fee-for-service providers in a selected geographical region of the state. The second pilot initiative would explore the feasibility of a public health model for dental services, building on the work of the federally qualified health centers and existing community partnerships.

2. *Healthy Living Incentives.* Currently, 14 HMOs participate in the pay-for-performance (P4P) initiative. In P4P, HMOs and DHFS develop strategies to address public health issues, such as smoking, lead poisoning, and utilization of dental services and establish measurable target goals. DHFS provides incentive payments to HMOs, based on their progress in meeting these goals. DHFS proposes to add five system-level and individual incentives for: (a) increases in well-child visits and childhood immunization rates; (b) reductions in smoking among enrollees; (c) reductions in childhood obesity; (d) reductions in infant mortality, especially among populations of color; and (e) reductions in inappropriate use of emergency room care.

3. *HMO Expansion Incentive.* The HMO expansion incentive is intended to encourage health plans to enter geographical service areas that have one or fewer health plans available to serve recipients. The bill would provide approximately $660,000 ($270,500 GPR and $389,500 FED) in 2007-08 and $1,340,000 ($541,900 GPR and $798,100 FED) in 2008-09 for this purpose. DHFS has not yet determined how it would distribute the incentive funds.

4. *Innovative Partnerships.* DHFS would expand the Milwaukee Public Schools student health initiative by hiring an additional 24 nurses or other health care professionals to serve the 37 schools currently without health care services or with individual education plan services only. Two key components of the expansion are increased coordination among all school nursing staff and current health care providers to ensure that all eligible students are enrolled in BadgerCare Plus. Priority would be given to elementary schools with both high student poverty levels and poor attendance rates.

5. *Marketing and Outreach.* Marketing and outreach would include marketing BadgerCare Plus to target populations, including efforts to educate and inform those currently enrolled in MA and BadgerCare about program changes that would result from the implementation of BadgerCare Plus. The marketing and outreach campaign would include

brochures, posters, radio spots, and other creative strategies to reach the target population. DHFS would issue a request for proposal for a portion of the marketing and outreach activities.

6. *Mini-Grants for Outreach.* Mini-grants for outreach would be used to help support non-traditional entry points such as Boys and Girls Clubs, Head Start, YMCA/YWCAs, and faith- based organizations in identifying and enrolling low-income children in BadgerCare Plus. DHFS would issue a request for proposal for these activities.

7. *Benefit Counselors*. Funding is provided to help current MA and BadgerCare recipients transition to BadgerCare Plus. These counselors might also assist DHFS in disseminating health literacy information and help individuals learn how to better manage their health.

8. *Health Living Curriculum*. DHFS would work with community-based organizations, HMOs, hospitals, and other providers to develop easily accessible and understandable health information that could be used in a variety of settings with a diverse group of individuals. The information would include topics such as: (a) appropriate use of care in hospital emergency rooms and other health care settings; and (b) the importance of punctuality for health care appointments, well-child visits, smoking cessation, and exercise

9. *Evaluation*. An evaluation would be conducted, in partnership with an outside entity, to determine if BadgerCare Plus met its intended goals and if outcome measures were achieved.

Table 4 summarizes the funding components of the BadgerCare Plus proposal.

TABLE 4

BadgerCare Plus and Related Initiatives
Governor's Recommendations

	2007-08				2008-09			
	GPR	FED	PR	Total	GPR	FED	PR	Total
BadgerCare Plus								
Projected Savings								
MA and BadgerCare Benefits	-$6,877,600	-$10,479,900	$0	-$17,357,500	-$14,627,000	-$22,866,900	$0	-$37,493,900
State Administration	-588,100	-661,900	0	-1,250,000	-1,174,200	-1,325,800	0	-2,500,000
Total	-$7,465,700	-$11,141,800	$0	-$18,607,500	-$15,801,200	-$24,192,700	$0	-$39,939,000
Projected Costs								
MA and BadgerCare Benefits	$2,632,200	$4,832,800	$4,760,800	$12,225,800	$13,206,300	$24,699,200	$21,861,600	$59,767,100
State Administration	282,100	517,900	0	800,000	0	0	0	0
Total	$2,914,300	$5,350,700	$4,760,800	$13,025,800	$13,206,300	$24,699,200	$21,861,600	$59,767,100
Net Costs (Savings) of BC Plus	-$4,551,400	-$5,791,100	$4,760,800	-$5,581,700	-$2,594,900	$06,500	$21,861,600	$19,773,200
Related Initiatives								
Benefits								
Dental Access	$1,186,200	$1,707,900	$0	$2,894,100	$2,408,400	$3,547,000	$0	$5,955,400
Healthy Living P4P Initiatives	473,400	681,600	0	1,155,000	948,300	1,396,700	0	2,345,000
HMO Expansion Incentives	270,500	389,500	0	660,000	541,900	798,100	0	1,340,000
Innovative Partnerships (MPS)					747,900	1,101,600	0	1,849,500
Administration								
Marketing and Outreach	250,000	250,000	0	500,000	0	0	0	0
Mini-grants for Outreach	100,000	100,000	0	200,000	0	0	0	0
Benefit Counselors	100,000	100,000	0	200,000	0	0	0	0
Healthy Living Curriculum	50,000	50,000	0	100,000	0	0	0	0
Evaluation	0	0	0	0	69,700	130,300	0	200,000
Cost of Related Initiatives	$2,430,100	$3,279,000	$0	$5,709,100	$4,716,200	$6,973,700	$0	$11,689,900
Net Cost of Proposal	-$2,121,300	-$2,512,100	$4,760,800	$127,400	$2,121,300	$7,480,200	$21,861,600	$31,463,100

DISCUSSION POINTS

1. The BadgerCare Plus initiative is a comprehensive proposal that includes several goals, including: (a) expanding health care coverage to targeted groups of low-income individuals; (b) creating an option to enable certain individuals with higher incomes to obtain health care coverage by enrolling in a benchmark plan offered through the state, which would differ from current MA coverage; (c) reducing differences in the way income is treated for the purpose of determining eligibility for Family MA, and hence, simplifying the enrollment process and treating individuals who qualify for Family MA more similarly in determining their eligibility for benefits; (d) increasing copayments and establishing premium requirements for certain groups of recipients, for the purpose of partially funding the eligibility expansion and, to some extent, discouraging inappropriate use of certain services; and (e) making funding available for certain related initiatives.

2. Many of the program's details would need to be negotiated between DHFS and CMS. These negotiations have occurred for months, in recognition that the current waiver under which BadgerCare operates was scheduled to expire on March 31, 2007. However, under SB 40, DHFS would only be permitted to implement the proposal if CMS approvals were consistent with all of the statutory provisions included in the bill. Several program details are not specified in the bill, including the proposed premium structure for individuals and families that would be enrolled in BadgerCare Plus.

Eligibility Expansion

3. The bill would extend MA eligibility to: (a) all children, regardless of income, including youth ages 18 through 20 aging out of foster care; (b) pregnant women with income up to 300% of the FPL; and (c) certain parents and caretaker relatives with income up to 200% of the FPL.

Coverage of Children

4. Based on the results of the 2005 Wisconsin Family Health Survey, it is estimated that approximately 110,000 children were uninsured for part or all of 2005. Of these children, 29,000 children were living in households with income less than 100% of the FPL and an additional 30,000 children were living in households with income between 100% and 200% of the FPL. In 2005, 28% of Wisconsin residents with income below 100% of the FPL and 19% with income below 200% of the FPL were uninsured for part or all of 2005. In total, approximately 235,000 Wisconsin adults ages 18 to 65 were uninsured for all of 2005.

5. There are several arguments that could be made in favor of the Governor's proposal to provide all children, regardless of income, access to health care coverage. First, there are many studies that show a correlation between health insurance coverage and health status, and that the cost of health services provide a barrier for many people, including children, to receiving health

care.

For example, in an article that appeared in the March 14, 2007, *Journal of the American Medical Association,* Dr. Jack Hadley summarized his study that compared medical care use and short-term health changes among uninsured individuals and insured nonelderly individuals following unintentional injuries or the onset of chronic conditions (defined in the article as a "health shock"). The study showed statistically significant differences in the care insured and uninsured individuals received. Specifically, the study showed that uninsured individuals, compared with insured individuals: (a) were less likely to obtain any medical care and less likely to receive recommended follow-up care; and (b) had fewer outpatient visits, office-based visits, and prescription medicines.

Higher proportions of uninsured individuals reported a decrease in health status (reported as "much worse") approximately 3.5 months following a health shock, compared with insured individuals. In addition, uninsured individuals with unintentional injuries were more likely to report not having fully recovered, and no longer receiving treatment, than insured individuals.

6. Second, ensuring that children receive routine, preventive health care services can reduce or eliminate the need to provide more expensive care later in their lives, and may also reduce the amount of uncompensated care rendered by health care providers.

7. Third, by expanding eligibility for BadgerCare, most of the costs of services provided to children would be supported primarily with federal MA and SCHIP matching funds and premiums paid by plan participants.

8. Alternatively, several arguments could be offered in opposition to the proposed eligibility expansion. First, it could also be argued that there is currently sufficient access to MA and BadgerCare for children in low-income families in Wisconsin, since: (a) all children up to age 19 are eligible for MA if they live in families with countable income that does not exceed 100% of the FPL, and all children up to age six in families with income up to 185% of the FPL are currently eligible for MA coverage; and (b) BadgerCare currently offers coverage for all individuals (both adults and children) in families with countable income up to 185% of the FPL if the family does not have access to employer-subsidized health care (health care where the employer pays at least 80% of the monthly premium cost).

9. Information from the 2005 Wisconsin Family Health Survey indicates that, of the estimated 110,000 children who were uninsured for all or part of the past year, 29,000 (26%) were in families with income less than 100% of the FPL, and therefore could have been eligible for enrollment in MA. An additional 30,000 children lived in families with income between 100% and 200% of the FPL, which suggests that nearly all of them could either be eligible for MA, BadgerCare, or have access to employer-subsidized care. In total, approximately 59,000 children, or approximately 54% of the total estimated number of children who were uninsured for all or part of the past year, were either eligible for MA, BadgerCare or employer-subsidized health care.

The survey results suggest that many more children could be enrolled in MA and

BadgerCare, based on the current financial eligibility requirements for these programs. Consequently, increasing the income limit for program eligibility may not increase program enrollment for children in families with the lowest incomes.

10. Second, the results of the most recent U.S. Census Bureau's Current Population Survey indicate that the percentage of Wisconsin's children who lack insurance is well below the national average. Table 5 compares the survey results for Wisconsin with the U.S. national average.

TABLE 5

U.S. Census Bureau Estimates of Insurance Coverage of Children
Current Population Survey -- Collected in 2006

Coverage of Children	Insured	Uninsured	Total
Wisconsin			
Number of Children			
Families with Income Below 100% of the FPL	151,000	26,000	177,000
Families with Income Above 100% of the FPL	1,056,000	63,000	1,119,000
Percentage of Children			
Families with Income Below 100% of the FPL	85.3%	14.7%	100.0%
Families with Income Above 100% of the FPL	94.4%	5.6%	100.0%
United States			
Number of Children			
Families with Income Below 100% of the FPL	10,496,000	2,400,000	12,896,000
Families with Income Above 100% of the FPL	54,895,000	5,494,000	60,389,000
Percentage of Children			
Families with Income Below 100% of the FPL	81.4%	18.6%	100.0%
Families with Income Above 100% of the FPL	90.9%	9.1%	100.0%

The Census Bureau's 2006 survey suggests that in Wisconsin, 14.7% of children in families with income below 100% of the FPL lacked health insurance (even though all of them would be eligible for coverage under the state's MA program), compared with an estimated 18.6% nationally. In addition, while most uninsured children in the state live in families with income that exceeds 100% of the FPL (as one would expect, since the great majority of children live in families with income that exceeds 100% of the FPL), the estimated percentage of children in these families in Wisconsin who lack health insurance is 5.6%, compared with a national average of 9.1%, or approximately 38% lower than the national average.

11. Third, some would oppose the expansion of publicly-funded health programs due to concerns that these programs "crowd out" private health care coverage, resulting in increasing

public costs of these programs without corresponding increases in coverage. Under this argument, the state's efforts should be to reduce the cost of health care for both employers, employees and consumers, rather than to expand publicly-funded programs.

Youth Aging Out of Foster Care

12. Under federal law, all children whose out-of-home care costs are partially reimbursed under Title IV-E of the Social Security Act are categorically eligible for MA. Wisconsin's MA program also provides coverage for children whose out-of-home care costs are not paid under Title IV-E. A youth in out-of-home care in either group remains eligible for MA until he or she reaches the age of 18 or, if he or she is expected to finish high school or complete a general education diploma (GED) program, the age of 19.

13. A recent study of foster youth transitions to adulthood, conducted by the University of Wisconsin-Madison, examined the experiences of youths after they were discharged from out-of-home care in Wisconsin. The study concluded that these youths are more likely to experience physical and sexual victimization, unemployment and underemployment, homelessness, incarceration, and public assistance utilization than other youths their age.

The study also reported that 44% of participating youths had difficulty obtaining medical care most or all of the time after they left foster care. The most frequently cited reasons for difficulty in accessing medical care were that they had no insurance coverage (51%) or not enough money to pay for the medical care (38%). The study reported that youths who have left out-of-home care are unlikely to have the income or savings to access needed health care -- 46% reported having over $250 in savings upon leaving out-of-home care. Additionally, these young adults do not have access to the same social resources, such as family members, that could assist them in accessing health services as other young adults have.

14. The study showed that this population has higher than average health care needs, particularly mental health care needs, than youths their age who have not been placed in out-of-home care. The study reported that 47% of youths participating in the study received mental health services in the year before leaving foster care. In the year after leaving out-of-home care, 21% of these youths received mental health services. However, the study reported no change in these youths' need for mental health services from the previous year, when they were still in the child welfare system. The study concluded that, "although the receipt of mental health services decreased dramatically over time, there is no evidence that the young adults' need for services decreased."

15. After turning 19 years of age, some youths that had been in out-of-home care can remain eligible for MA, or become eligible for BadgerCare, if they meet other eligibility criteria for these programs. Under MA, children in out-of-home care receive comprehensive health care services, including mental health and substance abuse services. The administration estimates that over 600 youths who leave out-of-home care would be covered under BadgerCare Plus annually, once the program is fully implemented.

Caretaker Relatives

16. The bill would provide MA coverage to certain relative caretakers in families with income up to 200% of the FPL. This group includes individuals who care for children in out-of-home care for less than six months, and parents or caretakers (with similar income restrictions) with children in out-of-home care for more than six months who are working toward unifying the family by complying with permanency plan objectives.

17. Under current law, a biological parent's MA coverage is terminated once a child is removed from a home. DHFS indicates that approximately 1,500 caretakers lose their eligibility each year due to the removal of a child from a home.

18. In its December, 2006, report titled, "The Bureau of Milwaukee Child Welfare Qualitative Service Review," DHFS found that over 50% of parents with children in out-of-home placements had mental health or substance abuse treatment needs. Providing access to MA-funded treatment services for these parents may hasten the reunification of the child with the family. Because court-ordered out-of-home care costs are paid by the state and the counties, it is possible that providing these services would reduce out-of-home care costs.

19. Federal law requires state MA programs to cover all persons who would be eligible for MA under the former aid to families with dependent children (AFDC) eligibility rules. These rules require the MA program to treat parents and caregiver relatives the same for MA eligibility purposes. However, as part of the first BadgerCare waiver, CMS required the state to request a waiver of this federal requirement.

20. The administration argues that low-income relative caretakers should be provided the same benefit (MA coverage) that biological parents receive, and that providing health care coverage to these caregivers may improve the health and well-being of the children in their care. DHFS estimates that there are approximately 3,500 caretaker relatives who may qualify for MA coverage under this provision.

CMS Approval

21. DHFS would need to obtain approval from CMS to implement BadgerCare Plus. Some aspects of the program would require a state plan amendment, while others would require a waiver of federal law. DHFS plans to request a waiver from CMS to enable the state to: (a) provide MA standard plan benefits to parents and caretakers with incomes between 100% and 200% of the FPL; (b) assess premiums that do not exceed 5% of income for parents and caretaker relatives with incomes greater than 150% FPL; (c) eliminate current "family fiscal unit" rules, which eligibility staff currently use to determine eligibility for non-BadgerCare health care programs; and (d) eliminate extended MA coverage for individuals who have been eligible, for three of the last six months, for AFDC-related MA and lose that eligibility because of earnings, child support payments received, or loss of an earnings disregard.

22. The administration's cost estimate assumes that the state would obtain more funding

under the state children's health insurance program than it currently receives. Wisconsin currently expends more SCHIP funds for its BadgerCare program than CMS initially allocates to the state by using SCHIP funding CMS reallocates from other states that do not fully use their initial allocations. (Unlike MA, federal funding provided under SCHIP is limited to the amounts appropriated by Congress, although, similar to MA, program benefits costs are paid on state/FED matching basis.) If CMS does not approve the use of additional SCHIP funds for any groups in BadgerCare Plus, DHFS estimates that the state costs of the program would increase by approximately $3.1 million GPR, compared to the administration's current estimates.

23. According to DHFS, most of the issues with CMS have been resolved, but the following issues remain outstanding (a) whether the state could offer presumptive eligibility for all children in families with income less than 150% of the FPL; (b) whether the state could require pregnant women to pay premiums as a condition of eligibility; and (c) issues regarding the state's SCHIP allotment due the addition of certain parents and caretaker relatives. DHFS staff believes that these issues can be resolved so that the new eligibility standards could be implemented by January, 2008.

Projected Savings

24. The administration assumes that the cost of expanding coverage will be more than offset by savings that the program would realize by increasing the proportion of MA recipients who receive services through HMOs, increasing copayments for services, and reducing contracted administrative costs.

Managed Care Migration Savings

25. Approximately 40% of all of the administration's projected benefits savings are assumed to result from enrolling current MA and BadgerCare recipients in managed care, rather than continuing to provide MA services on a fee-for-service basis. The savings estimate assumes that 80% of the current fee-for-service enrollees in the low-income family groups would enroll in HMOs. Approximately 40% of the enrollees would enroll in managed care in 2007-08 and an additional 40% would enroll in managed care in 2008-09. The administration assumes that a savings of 5.8% per member per month would be realized by serving enrollees in managed care, rather than on a fee-for-service basis.

26. DHFS will only realize these savings if HMOs are willing to serve this number of additional current and future MA/BadgerCare/BadgerCare Plus recipients, based on the projected capitation rates budgeted in the bill. Projected capitation rates vary significantly based on age, pregnancy status, gender, and recipient cost sharing. Further, HMOs will need to begin serving recipients in areas of the state they do not currently serve.

27. Federal law prohibits states from requiring an MA recipient to enroll in an HMO if the recipient cannot choose between two or more HMOs. However, DHFS has obtained federal approval of a state plan amendment that permits DHFS to require any recipient to enroll in an HMO, even if the recipient does not have a choice of HMOs.

28. This rural expansion initiative is scheduled to be implemented in September, 2007, in Grant, Vernon, Sauk, Juneau, Richland, Buffalo, Monroe, and Crawford counties, and will affect approximately 5,800 Family MA- and BadgerCare-eligible individuals.

29. The HMO contracts for calendar year 2007 included two incentives for HMOs to increase enrollment of Family MA recipients. The first incentive provides a 7% increase in capitation payment rates for any new BadgerCare recipient that is added as a result of the HMO: (a) increasing an enrollment limit ("cap") in an area where coverage is limited due to an enrollment cap; or (b) serving a recipient in a new geographical area.

30. The bill would provide $660,000 ($270,500 GPR and $389,500 FED) in 2007-08 and $1,340,000 ($541,900 GPR and $798,100 FED) in 2008-09 to provide incentives to HMOs to expand their enrollment caps. It is difficult to know whether this amount of funding will provide incentive to HMOs to expand. The Executive Director of the Wisconsin Association of Health Plans indicates that the adequacy of the capitation rates HMOs will receive in 2008 and future years will determine whether HMOs will expand to serve new areas of the state and serve additional Family MA recipients to enable the state to realize the savings the administration assumes.

31. It is projected that 1,442,600 member months of fee-for-service care will be provided to low-income families in MA and BadgerCare in 2007. By calendar year 2009 it is projected that 288,500 member months of fee-for-service care will be provided to the same categories of individuals. As a result, DHFS estimates that 80% of current low-income family fee-for-service recipients will be served by HMOs by calendar year 2009.

32. Table 6 shows the number of MA and BadgerCare recipients that are enrolled in HMOs as of March, 2007, and the maximum number of MA and BadgerCare enrollees each HMO has indicated it will serve.

TABLE 6

March, 2007, HMO Enrollment Totals and CY 2007 Maximum Enrollment Levels by HMO

Health Maintenance Organization	March, 2007 Enrollment Total	CY 2007 Maximum Enrollment
Abri Health Plan	8,181	70,000
Children's Community Health Plan	7,031	60,000
Compcare	26,736	40,000
Dean Health Plan/Dane	6,286	11,000
Dean Southeast	1,022	100,000
Dean Health Plan/All Other	3,859	5,000
GHC - Eau Claire	17,206	22,000
GHC - South Central WI	3,842	4,000
Health Tradition	5,811	7,500
Managed Health Services	91,153	175,000
MercyCare Health Plan	9,679	20,000
Network Health Plan	45,577	85,000
Security Health Plan	23,800	25,000
UHC/THP (Obsolete/phasing out)	0	40,000
UnitedHealthcare	115,064	160,000
Unity Health Plans	3,544	3,500
Total	368,791	828,000

Savings Resulting from Assessing Copayments to HMO Enrollees

33. The administration estimates that approximately 60% of the projected MA and BadgerCare benefits savings would be realized by increasing cost-sharing requirements for current and new recipients. BadgerCare Plus recipients in the standard plan, with some exceptions, would be required to pay a nominal copayment for certain services. Under current MA and BadgerCare policy, fee-for-service recipients are required to pay nominal copayments ranging from $.50 to $3.00, but recipients that are served in HMOs do not pay copayments.

34. Under BadgerCare Plus, recipients enrolled in HMOs would be required to make these nominal copayments. In addition, recipients enrolled in the benchmark plan would be required to pay both premiums and copayments for services. Attachment 4 lists the premium schedule and the copayment requirements under the benchmark plan. Finally, the administration assumes a small amount of savings due to a reduction in services that may be provided under the new copayment schedule.

35. DHFS would realize the savings from the new copayment requirements by slightly reducing capitation payments to HMOs to reflect that HMOs would be partially reimbursed for the services they provide to enrollees through copayments. Similarly, fee-for-service provider payment rates would reflect the availability of copayments paid by recipients. As under current

law, total reimbursement for providers that do not collect required copayments would be reduced by the amount of the copayment. Although the federal Deficit Reduction Act of 2005 permits providers to refuse service to MA recipients who do not pay copayments, the decision to refuse service is left to the provider.

Administrative Savings

36. The bill would reduce funding for contracted administrative services to reflect projected reductions in computer mainframe time within the computer system that county income maintenance (IM) staff would need to process program applications. Because DHFS pays for computer time by the unit, it is projected that significant processing time savings will result in program savings of approximately $1,600,000 (-$751,500 GPR and -$848,500 FED) per year. Although the amount of time county eligibility staff spend processing applications is expected to decrease, these savings could be offset by increases in caseload due to newly-eligible recipients. The bill would not modify funding DHFS allocates to counties to support county IM costs.

37. DHFS also plans to implement changes to the way the agency notifies program recipients. Currently, an MA recipient may receive multiple notices per week notifying them of slight changes in their eligibility status. For example, they might be notified that they have moved from one of the 22 possible eligibility groups to another due to a slight change in income. The notices often do not require any response from recipients, but are for notification purposes only. Due to computer systems changes recipients will no longer receive more than one notice per week. This change is projected to reduce postage costs by approximately $900,000 (-$422,700 GPR and -$477,300 FED) per year. This change also modifies the form to be more clear and concise.

38. DHFS is currently negotiating these proposed administrative changes with CMS. DHFS indicates that CMS is likely to approve changes that would permit DHFS to realize these savings.

"Crowd-Out"

39. As previously indicated, some argue that expanding publicly-funded health programs would, to some extent, replace privately-funded health care with publicly-funded care, a phenomenon that is commonly referred to as "crowd out." It is difficult to quantify the extent to which this has occurred with the MA expansions that occurred in the 1990s and, more recently, following the implementation of SCHIP, although there is a significant body of research in the area.

40. The BadgerCare Plus proposal includes the following provisions that are intended to address concerns over crowd-out. First, individuals would not be eligible for BadgerCare Plus if they have had insurance coverage in the past three months or had access to a group health insurance plan for which an employer subsidizes at least 80% of the monthly premium cost in the past six months. Second, some recipients would be required to pay premiums and copayments, which may make the plan somewhat less attractive than a plan offered through an employer. Third, the program would provide premium assistance to help low-income families pay the employee contribution of their employer-sponsored insurance. Currently, Wisconsin's health insurance premium payment (HIPP) program helps low-income families pay the employee

contribution of their employer-sponsored insurance.

41. The HIPP program is currently part of BadgerCare and pays the family's share of the monthly premium, co-insurance, and deductibles associated with the family health plan, along with any BadgerCare covered services not included it the family health plan through fee-for-service. BadgerCare Plus would increase enrollment in HIPP by providing premium assistance for: (a) children and parents in families with incomes below 150% of the FPL, even when the employer pays 80% or more of the premium when it is cost effective to do so; (b) pregnant women in families with incomes up to 300% of the FPL when the employer pays 80% or more of the premium (wrap-around benefits); and (c) children in families with incomes between 200% and 300% of the FPL when it is cost effective to do so.

42. HIPP would also be expanded in the following ways: (a) farm and other self-employed families would be covered; (b) self-funded insurance plans would be allowed to participate; (c) minimum employer contribution requirements would be eliminated and employer-sponsored insurance would be based solely on cost effectiveness; and (d) access to HIPP coverage would be permitted even if single or "plus one" coverage is the only coverage offered by an employer. In general, DHFS would determine whether the cost to the program of covering an eligible family or individual under private insurance is no more than the cost of covering them under MA.

Options for the Committee

43. The Committee could choose to adopt the Governor's proposal in its entirety, adopt parts of the Governor's proposal, and delete others, or delete the item from the budget.

For example, the Committee could reduce funding in the bill to reflect savings DHFS expects to realize by expanding managed care, since the administration expects this expansion to occur regardless of whether the Committee approves the rest of the proposal. Similarly, the Committee could reduce funding for program administration or to apply copayments to recipients currently served in managed care, both of which could be implemented independent of the rest of the proposal.

44. In addition, the Committee could choose to cover any of the proposed expansion populations, or any combination of the proposed expansion groups. The BadgerCare Plus proposal expands coverage to the following major groups: (a) all children; (b) youth ages 18-20 leaving out-of-home care; (c) pregnant women with income up to 300% FPL; (d) certain parent and caretaker relatives with income up to 200% FPL; and (e) certain self-employed adult parents of MA eligible children with income up to 200% FPL.

45. Finally, The Committee could adopt any combination of the proposed related initiatives, which are shown in Table 7. Some of these initiatives are more directly related to the BadgerCare Plus eligibility expansion than others. For example, the initiatives related to HMOs could have an effect on the success of the HMO expansion.

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Attachments

ALTERNATIVES -- BadgerCare Plus

	2007-08			2008-09		
	GPR	FED	Total	GPR	FED	Total
1. Managed Care and Admin. Savings						
Managed care savings	-$2,367,000	-$1,915,800	-$4,282,800	-$6,638,600	-$9,243,200	-$15,881,800
State administrative cost savings	-306,000	-144,000	-450,000	-1,174,200	-1,325,800	-2,500,000
TOTAL	-$2,673,000	-$2,059,800	-$4,732,800	-$7,812,800	-$10,569,000	-$18,381,800
2. Require Copayments under Managed Care for Current Recipients	-$4,510,600	-$8,564,100	-$13,074,700	-$7,988,400	-$13,623,700	-$21,612,100
3. Cover New Populations						
A. Cover all groups in the Governor's Bill	$2,632,200	$4,832,800	$7,465,000	$13,206,300	$24,699,200	$37,905,500
B. Approve or delete any of the following:						
1. Cover parents and caretaker relatives	$1,551,000	$2,192,600	$3,743,600	$7,218,100	$10,597,300	$17,815,400
2. Cover self-employed parents	293,500	482,800	776,300	1,468,400	2,591,600	4,060,000
3. Cover children	458,700	1,232,300	1,691,000	2,016,900	5,260,000	7,276,900
4. Cover pregnant women	329,000	925,100	1,254,100	1,945,400	5,087,000	7,032,400
5. Cover youths leaving out-of-home care	0	0	0	557,500	1,163,300	1,720,800
4. Related Initiatives						
A. Approve all related initiatives in SB 40	$2,430,100	$3,279,000	$5,709,100	$4,716,200	$6,973,700	$11,689,900
B. Approve or delete any of the following:						
1. Dental access	$1,186,200	$1,707,900	$2,894,100	$2,408,400	$3,547,000	$5,955,400
2. Healthy living P4P initiatives	473,400	681,600	1,155,000	948,300	1,396,700	2,345,000
3. HMO expansion incentives	270,500	389,500	660,000	541,900	798,100	1,340,000
4. Innovative partnerships (MPS)	0	0	0	747,900	1,101,600	1,849,500
5. Marketing and outreach	250,000	250,000	500,000	0	0	0
6. Mini-grants for outreach	100,000	100,000	200,000	0	0	0
7. Benefit counselors	100,000	100,000	200,000	0	0	0
8. Healthy living curriculum	50,000	50,000	100,000		0	0
9. Evaluation	0	0	0	69,700	130,300	200,000

ATTACHMENT 1

MA Eligibility for Families with Dependent Children and Pregnant Women

AFDC and AFDC-Related Groups. Families with dependent children are eligible for MA if they meet certain requirements related to the state's former aid to families with dependent children (AFDC) program, based on the requirements of that program that were in effect on July 16, 1996. Families eligible for AFDC and AFDC-related MA meet the same demographic standards for eligibility, but must meet different financial eligibility standards.

Generally, to be eligible for MA under the AFDC criteria, a family would have gross income below a certain level and net income at or below an amount equivalent to the AFDC payment levels in effect on July 16, 1996.

Under the AFDC-related criteria, there is no limit for gross income, but families must have net income at or below the AFDC assistance standard. The assistance standard is higher than the AFDC payment levels. The payment levels and assistance standards for rural counties are somewhat less.

Because the AFDC and AFDC-related income criteria are based on the payment levels and assistance standards in place at a point in time, these criteria represent a smaller percentage of the FPL every year, since the federal poverty level increases annually, based on inflation.

Another difference between the AFDC and AFDC-related criteria reflects the deductions available under each set of criteria. To determine net income under MA, families are allowed a number of deductions from gross income, including a deduction of $90 per month from earned income for work expenses and a deduction for dependent care costs (up to $175 per month or $200 per month, depending on the age of the dependent). Additionally, under the AFDC criteria, a family's net income reflects a deduction of $30 per month of earned income and one-third of any additional earned income, in addition to the $90 deduction for work expenses. This deduction is not available however, for determining eligibility under the AFDC-related criteria.

In addition, Wisconsin's MA program provides coverage to certain individuals that meet criteria related to the income requirements under the state's AFDC plan. These individuals include:

- Certain individuals in families that do not meet the AFDC assistance standard, but would have met the standard, except for certain circumstances;

- Children residing in licensed foster homes or group foster homes;

- Children for whom adoption assistance agreements are in effect and children adopted under state-established agreements;

- Children residing with relatives for whom kinship care payments are made;

- Children whose parents are eligible for SSI caretaker supplement payments;

- Relative caretakers, if the children are not temporarily absent and the children are considered deprived;

- Certain pregnant women; and

- Certain children residing in medical institutions, nursing facilities, psychiatric facilities or intermediate care facilities for the mentally retarded (ICFs-MR).

Healthy Start. Beginning in the 1980s, several changes to federal law expanded MA coverage to more groups of low-income pregnant women and children. In Wisconsin, these expansions became known as "Healthy Start." Under the Healthy Start criteria, MA covers pregnant women and children who are less than six years of age in families with countable income that does not exceed 185% of the FPL. Children ages six through 19 years old are eligible if the family's income is no more than 100% of the FPL. Generally, the parents of these children are not eligible for MA.

Spend-Down for Children and Pregnant Women. Individuals eligible for MA under the spend-down provision meet the demographic criteria of other MA-covered groups, but their income exceeds the limits that would otherwise apply. The following groups of low-income women and children are eligible for MA coverage under the spend-down provision:

- Any child under 18 years of age;

- An individual under the age of 21 who resides in an intermediate care facility, a skilled nursing facility or inpatient psychiatric hospital; and

- A pregnant woman (eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls).

Under the spend-down provision, a person can become eligible for MA after incurring medical expenses during a six-month period in an amount that equals the amount his or her income is above the medically needy income limits established by the state. In this way, the spend-down provision offers protection against catastrophic medical costs.

Presumptive Eligibility for Pregnant Women. A period of "presumptive eligibility" is available for pregnant women to ensure they have access to prenatal care. This period begins on the day on which a qualified provider determines, on the basis of preliminary information, that the household income of the woman meets MA eligibility criteria. This period ends when the woman is determined to be ineligible for MA, if she applies for MA or, if the woman fails to

apply for MA, the last day of the month following the month in which the determination of presumptive eligibility is made, whichever is earlier.

Transitional Eligibility. Federal law requires states to extend MA eligibility for certain individuals and families for specified periods. Families that would have lost eligibility for AFDC because of a change in income they earn from employment can remain eligible for up to twelve months based on certain conditions. Families who would have lost AFDC eligibility because their child or family support payments increase can remain eligible for four months under certain conditions. A pregnant woman remains MA eligible through the month in which the 60th day after her pregnancy falls, regardless of a change in household income. Additionally, an infant can remain eligible for MA for up to one year if the infant's mother was eligible for MA on the date the infant was born.

ATTACHMENT 2

Current BadgerCare Eligibility Requirements

Eligibility for BadgerCare is based on both financial and nonfinancial criteria.

Individuals in families with dependent children who are not eligible for MA may qualify for coverage under BadgerCare if the family's countable income is below 185% of the FPL. Once enrolled, a family's countable income may increase to 200% of the FPL before family members are no longer eligible for the program. Similar to most MA recipients (except those who qualify for MA based on age or disability) BadgerCare recipients do not need to meet an asset test to be enrolled in the program.

As with MA, certain kinds of expenses are deducted from household income and certain types of income are not included when determining countable income. For example, the following expenses and income are subtracted from a family's gross income, before taxes, to determine countable family income: (a) $90 per month for work-related expenses for each person in the family that works; (b) child care costs, up to $200 per month per child under age two and up to $175 per month per child age two and above; (c) for self-employed individuals and farmers, all deductions from gross income allowed under federal tax law except depreciation.

Families with incomes above 150% of the FPL must pay a monthly premium to be covered under BadgerCare. This premium is equivalent to approximately 5% of the family's income. Families in BadgerCare pay these premiums through direct payment by check or money order, electronic funds transfer, or wage withholding. These premium payments, together with revenue DHFS received from drug companies as manufacturer rebates, are program revenues that partially support program benefits.

The income eligibility criteria for BadgerCare are similar to the criteria for MA Healthy Start. Healthy Start covers pregnant women and children under age six in families with income not exceeding 185% of the FPL. However, Healthy Start does not cover men and non-pregnant women with income that exceeds the AFDC-related MA eligibility criteria, nor does it cover children six and older in families with income above 100% of the FPL. Those individuals not covered through the Healthy Start program may be eligible for BadgerCare.

A family that meets the financial and non-financial criteria for MA is eligible for MA, regardless of whether the family has access to health insurance. Because MA is a payer of last resort, if a person has access to other health insurance, MA only pays for services that are not covered from other sources. In contrast, a family that otherwise meets the financial and non-financial eligibility criteria for BadgerCare cannot qualify for BadgerCare if the family has insurance or access to a group health insurance plan for which an employer subsidizes at least 80% of the monthly premium cost. In addition, individuals who had health care coverage any time during the three months before they apply for BadgerCare are ineligible. DHFS may waive

these provisions for good cause. Good cause includes but is not limited to: non-voluntarily loss of employment, changing jobs to an employer that doesn't offer insurance, and employer discontinuation of insurance.

When a person applies for BadgerCare, all of his or her family members are first reviewed to determine whether they may be eligible for MA. If one or more of the family members are found to be eligible for MA, those individuals are enrolled in MA. The remaining family members are reviewed for BadgerCare eligibility.

Based on provisions included in 2003 Wisconsin Act 33, effective May 10, 2004, as a condition of eligibility, each member of a family who is employed is required to verify from his or her employer: (a) his or her earnings; (b) whether his or her employer provides health care coverage for which the family is eligible; and (c) the amount that the employer pays, if any, toward the cost of that coverage, excluding any deductibles or copayments required under the coverage. Before May 10, 2004, DHFS received some insurance information in a post-eligibility process conducted by the fiscal agent. Earnings were not verified unless the information provided by the applicant or recipient was considered questionable.

ATTACHMENT 3

MA Standard Plan Covered Services

- Physicians' services
- Early and periodic screening, diagnosis and treatment of individuals under 21 years of age (HealthCheck)
- Rural health clinic services
- The following federally mandated medical services if prescribed by a physician:
    - Inpatient hospital services, other than services in an institution for mental disease (IMD)
    - Outpatient hospital services
    - Skilled nursing home services other than in an IMD
    - Home health services, or nursing services if a home health agency is unavailable
    - Laboratory and x-ray services
    - Family planning services and supplies
    - Nurse-midwifery services
- Premiums, deductibles and coinsurance and other cost-sharing obligations for services otherwise paid under MA that are required for enrollment in a group health plan
- Payment of any of the deductible and co-insurance portions of the services listed above which are paid under Medicare and the monthly Part B premiums payable under the federal Social Security Act
- Dental services, dentures
- Optometrists' or opticians' services
- Transportation:
    - By emergency medical vehicle to obtain emergency medical care
    - By specialized medical vehicle to obtain medical care
    - By common carrier or private motor vehicle if authorized in advance by a county
- Chiropractors' services
- Eyeglasses
- The following medical services that are not federally mandated, if prescribed by a physician:
    - Intermediate care facility (ICF) services, other than IMD services
    - Physical and occupational therapy
    - Speech, hearing and language disorder services
    - Medical supplies and equipment
    - Inpatient hospital, skilled nursing facility and ICF services for patients in IMDs:
      --who are under 21 years of age
      --who are under 22 years of age and received services immediately prior to reaching age 21
      --who are 65 years of age or older
    - Medical day treatment, mental health and substance abuse services, including services provided by a psychiatrist and services provided by a psychiatrist in an individual's home or in the community if the individuals is at least 21 years of age
    - Nursing services, including services performed by a nurse practitioner
    - Legend (prescription) drugs and over-the-counter drugs listed in the Wisconsin's MA drug index
    - Personal care services
    - Substance abuse day treatment services
    - Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
    - Community-based psychosocial services
    - Respiratory care services to individuals who are ventilator-dependent for life support

Home and community-based services authorized under a waiver

- Case management services for enrollees with certain conditions
- Hospice care
- Podiatry services
- Care coordination for women with high-risk pregnancies
- Prenatal, postpartum and young child care coordination services for certain residents of Milwaukee County
- Care coordination and follow-up of individuals having lead poisoning or lead exposure, including lead inspections
- School medical services
- Mental health crisis intervention services
- Case management services for enrollees with high-cost chronic health conditions or high-cost catastrophic health conditions

ATTACHMENT 4

Benchmark Plan Benefits and Copayments

Recipients who are not eligible for standard plan MA benefits would have coverage of the following benefits and pay the following copayments:

- prescription drugs bearing only a generic name, as defined in Chapter 450 of the statutes, with a copayment of no more than $5 per prescription, and subject to the Badger Rx Gold program discounts;
- physician services, including one annual routine physical examination, with a copayment of no more than $15 per visit;
- inpatient hospital services as medically necessary, subject to coinsurance payment per inpatient stay of no more than 10% of the allowable MA rates and a copayment of no more than $50 per admission for psychiatric services;
- outpatient hospital services, subject to coinsurance payment of no more than 10% of the allowable MA rates for the services provided, except that use of emergency room services for treatment of a condition that is not an emergency medical condition, as defined in Chapter 632 of the state statutes, would require a copayment of no more than $75;
- laboratory and x-ray services, including mammography;
- home health services, limited to 60 visits per year;
- skilled nursing home services, limited to 30 days per year, and subject to coinsurance payment of no more than 10% of the allowable MA rates for the services provided;
- inpatient rehabilitation services, limited to 60 days per year, and subject to coinsurance payment of no more than 10% of the allowable MA rates for the services provided;
- physical, occupational, speech, and pulmonary therapy, limited to 20 visits per year for each type of therapy, and subject to coinsurance payment of no more than 10% of the MA rates for the services provided;
- cardiac rehabilitation, limited to 36 visits per year and subject to coinsurance payment of no more than 10% of MA rates for the services provided;
- inpatient, outpatient, and transitional treatment for nervous or mental disorders and alcoholism and other drug abuse problems, with a copayment of no more than $15 per visit and coverage limits that are the same as those under the state employee health plan;
- durable medical equipment, limited to $2,500 per year, and subject to coinsurance payment of no more than 10% of the MA rates for the articles provided;
- transportation to obtain emergency medical care only, as medically necessary, and subject to coinsurance payment of no more than 10% of the MA rates for the services provided;
- one refractive eye examination every two years, with a copayment of no more than $15 per visit.;
- 50% of allowable charges for preventive and basic dental services, including services for accidental injury and for the diagnosis and treatment of temporomandibular disorders. However, the coverage under this service would be limited to $750 per year, would apply only to pregnant women and children under 19 years of age, and would require an annual deductible of $200 and a copayment of no more than $15 per visit;
- early childhood developmental services, for children under six years of age;
- smoking cessation treatment, for pregnant women only; and
- prenatal care coordination, for pregnant women at high risk only.