

OFFICE OF FEDERAL/STATE RELATIONS
WASHINGTON, D.C. 20001



TOMMY G. THOMPSON
GOVERNOR

STATE OF WISCONSIN

Fax

To: Chris Jennings

From: Mary Kay Mantho

Fax:

Pages:

Date:

☐ Urgent

☐ For Review

☐ Please Comment

● Comments:

Chris -
Attached is info. on BadgerCare in Milwaukee that
you might find interesting.

Mary Kay

P.S. I'm sorry if I offended you this morning - I
really would like some info. on how the
revised Rx plan impacts states.



Tommy G. Thompson
Governor

Joe Loean
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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June 22, 2000

The Honorable Thomas Barrett
U.S. House of Representatives
1214 Longworth House Office Building
Washington, DC 20515-4905

Dear Representative Barrett:

Enclosed are data you have requested on the BadgerCare/Medicaid population in Milwaukee, broken out by race. We have based the comparison on all the "family Medicaid" (AFDC-related, Healthy Start and BadgerCare) participants in Milwaukee. This is because, in Milwaukee, many persons have such low incomes that they qualify for Medicaid, rather than BadgerCare. (The back-up sheet provides data by program: BadgerCare, Healthy Start, and AFDC-related "family Medicaid.")

I have also included a write-up of our outreach initiatives and Milwaukee coordination. As you can see, we have enrolled more than 50 percent of the Milwaukee BadgerCare target population in the first eleven months of the program. We fully expect to enroll the remaining target population in the next year.

Please feel free to call me if you have any questions. Thank you, again, for your help.

Sincerely,

A handwritten signature in cursive script, appearing to read "Peggy".

Peggy L. Bartels
Administrator

PLB:dd
DO06045

Enclosures

cc: Joe Loean, DHFS Secretary
Pris Boroniec, DHCF Deputy Administrator

Family Medicaid (including BadgerCare) Enrollment in Wisconsin by Race ¹
May 2000 Caseload Report

	Milwaukee ²	Wisconsin
White	11%	42%
African - American	52%	24%
American Indian/Eskimo/Aleutian Native	.60%	2%
Asian/Pacific Islander	3%	3%
Southeast Asian	.20%	1%
Hispanic	10%	7%
Other	30%	31%
Unknown ³	23%	21%

Wisconsin Population Below the Poverty Level
U.S Census - 1993

	Milwaukee	Wisconsin
Population below 100% of the Federal Poverty Level	19.4%	10.9%

Wisconsin Population by Race
U.S. Census - 1996 Data

	Milwaukee	Wisconsin
White	73.4%	92.2%
African - American	23.7%	5.5%
American Indian/Eskimo/Aleutian Native	.8%	.9%
Asian/Pacific Islander	2.1%	1.4%
Hispanic	5.9%	2.4%

Prepared by Susan Wood
Division of Health Care Financing
June 16, 2000

¹ This information is self-reported and is not a required entry in the CARES system. More than 20% of households do not provide this information.

² Since July 1999 when BadgerCare was implemented, 5960 Milwaukee children have been enrolled in BadgerCare or Medicaid. This is almost half of the target group of low income uninsured children. DHFS expects to reach the remaining children in the target group over the upcoming months.

RACE AS A % OF TOTAL BY PROGRAM (MILWAUKEE)

RACE	BADGER CARE		HEALTHY START		FAMILY MA	
	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD
A ASIAN OR PACIFIC ISLANDER	3.963273	4.85782	5.280528	6.118538	2.260812	3.233062
B BLACK NOT OF HISPANIC ORIGIN	44.76887	35.48735	32.0132	40.18547	56.53804	49.88428
H HISPANIC ORIGIN	11.83171	8.972364	10.12101	14.09741	9.924889	10.14274
I AMERICAN INDIAN/ ESKIMO	0.813573	0.414682	0.680066	0.537534	0.863002	0.458835
S SOUTHEAST ASIAN	0.32543	0.384045	0.440044	0.41133	0.184085	0.212354
T OTHER	0.4648	0.87257	0.440044	0.453388	0.21158	0.326699
U UNKNOWN	11.75035	31.08215	19.25183	28.18154	11.70433	27.13234
W WHITE	28.08089	14.21801	31.79318	12.05478	18.2835	8.629875

RACE AS A % OF REPRESENTATION IN FAMILY TYPE (MILWAUKEE)

% OF TOTALS			
RACE	ADULT	CHILD	TOTAL
A ASIAN OR PACIFIC ISLANDER	2.269812	3.233062	2.966822
B BLACK NOT OF HISPANIC ORIGIN	56.53804	49.88428	51.7089
H HISPANIC ORIGIN	9.924889	10.14274	10.08247
I AMERICAN INDIAN/ ESKIMO	0.852002	0.458835	0.587388
S SOUTHEAST ASIAN	0.194085	0.212354	0.207309
T OTHER	0.23358	0.326699	0.300256
U UNKNOWN	11.70433	27.13234	22.88808
W WHITE	18.2835	8.629875	11.28111

RACE AS A % OF TOTAL BY PROGRAM (NOT IN MILWAUKEE)

RACE	BADGER CARE		HEALTHY START		FAMILY MA	
	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD
A ASIAN OR PACIFIC ISLANDER	1.722389	1.741731	2.92631	5.65808	1.700363	4.513985
B BLACK NOT OF HISPANIC ORIGIN	2.924853	3.088012	2.474062	4.253482	5.778785	7.332526
H HISPANIC ORIGIN	2.681538	3.38868	3.29875	5.23998	3.202488	4.887776
I AMERICAN INDIAN/ ESKIMO	1.524305	1.351604	2.208034	2.111018	2.438877	2.521581
S SOUTHEAST ASIAN	0.529789	0.888029	1.010907	2.159908	0.53283	1.750891
T OTHER	0.192087	0.228221	0.159617	0.396381	0.189157	0.370338
U UNKNOWN	13.28951	28.41915	15.80888	21.15207	12.71988	23.0078
W WHITE	77.1757	63.51443	74.11546	59.02813	73.43828	66.6155

RACE AS A % OF REPRESENTATION IN FAMILY TYPE (NOT IN MILWAUKEE)

% OF TOTALS			
RACE	ADULT	CHILD	TOTAL
A ASIAN OR PACIFIC ISLANDER	1.700363	4.513985	3.614253
B BLACK NOT OF HISPANIC ORIGIN	5.778785	7.332526	8.835665
H HISPANIC ORIGIN	3.202488	4.887776	4.348847
I AMERICAN INDIAN/ ESKIMO	2.438877	2.521581	2.495038
S SOUTHEAST ASIAN	0.53283	1.750891	1.361143
T OTHER	0.189157	0.370338	0.312394
U UNKNOWN	12.71988	23.0078	19.71779
W WHITE	73.43828	55.5155	61.31487

RACE AS A % OF TOTAL BY PROGRAM (TOTAL STATE)

RACE	BADGER CARE		HEALTHY START		FAMILY MA	
	ADULT	CHILD	ADULT	CHILD	ADULT	CHILD
A ASIAN OR PACIFIC ISLANDER	2.194173	2.542116	3.384747	5.784021	1.90438	3.862345
B BLACK NOT OF HISPANIC ORIGIN	11.73181	12.73054	8.226221	14.02021	23.98267	24.88306
H HISPANIC ORIGIN	4.581375	4.837038	4.627249	7.848891	5.810615	7.027798
I AMERICAN INDIAN/ ESKIMO	1.374722	1.119742	1.806988	1.683087	1.870205	1.681472
S SOUTHEAST ASIAN	0.486779	0.524584	0.899743	1.694358	0.41128	1.124222
T OTHER	0.249605	0.317765	0.214228	0.411873	0.205051	0.352587
U UNKNOWN	12.94978	27.51021	14.85718	22.51446	12.35808	24.68735
W WHITE	66.42205	50.92303	65.87404	48.2331	53.67972	38.48119

RACE AS A % OF REPRESENTATION IN FAMILY TYPE (TOTAL STATE)

% OF TOTALS			
RACE	ADULT	CHILD	TOTAL
A ASIAN OR PACIFIC ISLANDER	1.90438	3.862345	3.380199
B BLACK NOT OF HISPANIC ORIGIN	23.98267	24.88306	24.44404
H HISPANIC ORIGIN	5.810615	7.027798	6.598735
I AMERICAN INDIAN/ ESKIMO	1.870205	1.681472	1.736612
S SOUTHEAST ASIAN	0.41128	1.124222	0.908374
T OTHER	0.205051	0.352587	0.307905
U UNKNOWN	12.35808	24.68735	20.95397
W WHITE	53.67972	38.48119	41.64818



DIVISION OF CHILDREN AND FAMILY SERVICES

Tommy G. Thompson
Governor

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Medicaid/BadgerCare Outreach Initiatives
Impact upon Milwaukee

1. Medicaid and BadgerCare Enrollment of Children in Milwaukee

- Medicaid provides health insurance for 166,000 residents of Milwaukee County.
- BadgerCare has been very successful in providing health insurance for Milwaukee's children. Since July 1999 when BadgerCare was implemented, 5960 children have been enrolled in Medicaid, including BadgerCare.
- In the first eleven months of full implementation of BadgerCare, Wisconsin has provided health insurance coverage for about 50% of the target group of uninsured children in Milwaukee, and we expect to reach the remaining children over the coming months.
- This is right on pace with our projections for Milwaukee's share of statewide BadgerCare enrollment and far ahead of the experience of other states – nationally 24% of uninsured children have been enrolled in the State – Children's Health Insurance Program since its implementation in 1998.
- Children represent two-thirds of the Family Medicaid caseload (the combination of AFDC-related categories, Healthy Start and BadgerCare) – the statewide total as of May 2000 is 191,923. In Milwaukee the total number of children is 75,851 – 39.5% of the statewide enrollment of children.
- Compliments to Milwaukee County Department of Human Services for handling a huge increase in workload associated with BadgerCare at the same time they have implemented many changes that improve customer service.

2. Outreach efforts in Milwaukee – our thanks to the Milwaukee BadgerCare Coordinating Committee

- A great example of public and private agencies collaborating on a shared goal - successful implementation of BadgerCare in Milwaukee.
- Formed in the spring of 1999 under the leadership of Mayor Norquist and County Executive Ament.
- The Committee, chaired by Dr. Seth Foldy, the City Health Commissioner, has focused on setting and monitoring their enrollment target, coordinating outreach efforts of many public and private agencies, and improving customer service.
- Special thanks for their contributions to this effort to:
 - Bill Bazan of the Hospital Association – Chair of the outreach committee.
 - Terry Perry, Director of the Milwaukee Office of Congressman Tom Barrett for her work on public policy and access issues.
 - Senator Peggy Rosensweig, an active member of the group, for her leadership.
 - Tom Brophy of the Medical College of Wisconsin - Co-chair of the public policy committee.
 - Debra Blanks, CEO of the Social Development Commission – Co-chair of the public policy committee.

- Dick Buschmann, Administrator of the Financial Assistance Division, Milwaukee County Human Services Department.
- Ramon Wagner and Ken Germanson of Community Advocates.
- Theresa Reagan of the Children's Health Alliance of Wisconsin.
- Shirin Cabraal of Legal Action of Wisconsin.
- Dr. Ernestine Willis of the Medical College of Wisconsin.

3. A summary of the outreach initiatives DHFS has funded and supported in Milwaukee for Medicaid and BadgerCare (1997-99)

- Lots of new training for community agencies, health care providers, advocates and public health staff.
- Funding for the City of Milwaukee and suburban public health agencies to conduct outreach.
- Grant to Latino Health Organization for translation services.
- Grant to Community Advocates for advocacy and problem-solving services for Medicaid applicants.
- Paid TV and radio advertising for both Medicaid for families and BadgerCare in the Milwaukee market.
- New funding to Milwaukee County to plan for BadgerCare start-up, to handle the increased volume of eligibility determinations, and to establish many new outstation sites to improve program access.
- Outstations – there are now more than 50 sites in Milwaukee County where customers can apply for Medicaid and BadgerCare, coordinated with the food stamp, child care and Energy Assistance programs. This includes many new sites at most of the Milwaukee hospitals.

4. Future plans - Medicaid Program Simplification

- Plans for the next year include introducing a new one-page application form, piloting a mail-in application for Medicaid and BadgerCare in 3 to 4 counties (including Milwaukee), coordination with food stamp and school lunch programs, and launching new outreach efforts to elderly and disabled.
- Continue to support things that work – outstations, marketing the value of health insurance and training of community groups on the basics of Medicaid and BadgerCare and how to apply, to assure that families eligible for health insurance through these programs can take advantage of them.
- Continue to fine-tune outreach efforts to target the families who may be eligible for Medicaid or BadgerCare.
- Evaluating policy changes to standardize income and asset limits across the Medicaid sub-programs.
- Goal is to make the current application and review process more responsive to customers, more equitable, and less costly to administer – we welcome advice about how best to do so.

**WISCONSIN TITLE XXI AMENDMENT
AND SECTION 1115 DEMONSTRATION FACT SHEET**

Names of Both Plans

(Title XIX and Title XXI): BadgerCare

Title XIX Plan Submitted: December 18, 1998

Title XXI Amendment Submitted: December 30, 1998

Date Plans Approved: January 22, 1999

Effective Date of Plans: July 1, 1999

Background

- The State of Wisconsin initially received approval to use funding from the Children's Health Insurance Program (CHIP) to expand Medicaid coverage under their State Plan for children ages 15 through 18 who are in families with incomes below 100 percent of the Federal Poverty Level (FPL). This approval was given on May 29, 1998 and the State implemented this expansion on April 1, 1999.
- Under both an amendment to their CHIP and the Department's Section 1115 demonstration authority for a Title XIX expansion, a second Medicaid expansion was implemented to include all remaining children not currently covered by Medicaid and their parents with family income up to 185 percent of the FPL. The parents are covered at the regular Federal Medical Assistance Percentage (FMAP) using the Department's Section 1115 demonstration authority for a Title XIX expansion. The children are covered under the Title XXI (CHIP) enhanced FMAP. However, the State can also receive the enhanced FMAP for both the parents and the children if cost-effectiveness for family coverage through employer-sponsored insurance (ESI) can be demonstrated under Title XXI criteria.
- Once a family is enrolled, eligibility is retained in the program until the family income reaches above 200 percent FPL. Children living with a caretaker relative are also covered if they are not otherwise covered by Medicaid under the State Plan, but the caretaker relative for these children is not covered under this expansion.
- There is a regular Medicaid buy-in program for families who do not meet Title XXI cost-effectiveness criteria for ESI. However, the enhanced match is only for the children while the parents are covered under the regular Title XIX FMAP rate. The Title XXI (CHIP) enhanced FMAP is only available for the entire family if cost-effectiveness is met

under Title XXI criteria.

Children Covered Under Program

- The Medicaid State Plan covers all children from 0 through age 5 years of age in families with incomes less than 185 percent FPL, and children who are 6 through 14 years in families with incomes less than 100 percent FPL. The State has enrolled under their Medicaid State Plan using CHIP funding approximately 3,500 children who are 15 through 18 years of age in families with incomes up to 100 percent. This is more than triple their original projections for this age group.
- By FFY 2002, the State projects that both the CHIP amendment and the Title XIX eligibility expansion will cover approximately 23,000 new children through the age of 18 who do not currently meet AFDC-related Medicaid standards and their parents, approximately 27,000 adults.

Administration

- The BadgerCare Demonstration, which is inclusive of CHIP and the Title XIX eligibility expansion for adults, is administered by the Wisconsin Department of Health and Family Services.
- Both the Medicaid expansion for adults and the CHIP expansion for the children were implemented concurrently. The eligibility determinations for both Medicaid and BadgerCare are done by the State.
- The State verifies access to employer-sponsored insurance (ESI) coverage. After verification has been made, the State makes a determination if it is cost-effective to purchase family coverage either through its own Health Insurance Premium Payment (HIPP) Program using title XIX dollars or through the title XXI cost-effectiveness test. The State receives the enhanced match for the entire family only if title XXI cost-effectiveness criteria is met. For children enrolled under ESI through the HIPP Program, there is an enhanced match only for the Medicaid service expenditure for the children. Expenditures for the parents will be at the State's regular Medicaid match.

Health Care Delivery System

- The State uses its current Medicaid managed care delivery system.

Benefit Package

- The Medicaid benefit package is offered. Families enrolled in ESI receive a Medicaid wrap-around for services not included in the employer's benefit insurance.

Cost Sharing

Premiums---

- Families with incomes above 150 percent FPL pay a premium between 3 and 3.5 percent of family income. Premiums are collected through several methods: 1) direct payment by check or money order; 2) wage withholding, or 3) electronic funds transfer. Failure to pay premiums results in the disenrollment of the family from BadgerCare. The family is not eligible to re-enroll for another six months except for reasons of good cause (i.e. an administrative error in the recording the non-payment of premiums or a change in the family composition.)

Copayments---

- There are no copayments or deductibles for BadgerCare.

Crowd-Out Activities

- The State will conduct various surveys to determine if there are any changes in the scope and the extent of employer-based coverage. Specifically, the State will study the effects of the employment rates, patterns of employment, health care costs inflation, employer net earnings, employer size and any other variables to assess the impact of BadgerCare on employer-based coverage.
- All major insurers in the State are required to submit on a semi-annual basis a report to Wisconsin Medicaid of all they currently insure. This data is matched with the Medicaid eligibility files to determine if insurance exists for recipients and their non-Medicaid eligible dependents. This process will assist the State in determining access to other public and private health insurance coverage.
- For children and families under title XXI, there will be no ESI buy-in when the employer pays less than 60 percent of the premium and/or any member of a family has been covered by employer-sponsored insurance in the past six months.
- Applicants currently covered by health insurance or have been covered in the last three calendar months prior to the month of application, and who have a health insurance policy that meets the definition of Health Insurance Portability and Accountability Act (HIPAA) are not eligible for BadgerCare.
- Applicants who have had *access* to insurance in the past 18 months are not also eligible for BadgerCare. Specifically, this policy will apply to BadgerCare applicants who are employed but do not have coverage and have been with the same employer for the past 18

months and could have had access to insurance through that same employer within the past 18 months with employer paying at least 80 percent or more of the family premium.

Outreach Activities

- The State expanded its application sites for Medicaid to include a unit of ten Milwaukee County eligibility workers at 22 new sites. These sites include DSH hospitals, FQHCs, school-based clinics and community-based organizations representing Milwaukee County's underserved and multi-cultural activities. Although present outreach efforts have been primarily focused in Milwaukee County, there are efforts underway to place eligibility workers at outstation sites in other counties of the State. Many outstation sites will be co-located with other programs such as WIC.
- The state uses public information campaigns currently in place to assure that accurate information is conveyed to recipients concerning the impact of welfare reform on Medicaid eligibility.

Financial Information

First Year Costs:

1998 CHIP Allotment---\$ 40,663,039

FMAP--- 71.2 percent

Second Year Costs:

1999 CHIP Allotment--\$ 40,441,141

FMAP---71.2 percent

September 15, 1999

BADGERCARE WAIVER AMENDMENT REQUEST

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BADGERCARE WAIVER AMENDMENT REQUEST

I. OVERVIEW

A. Introduction

The State of Wisconsin ~~has received requests for approval from the federal Health Care Financing Administration (HCFA) for a health care program for families with children called BadgerCare. Under the authority of a~~ **This document is an amended Section 1115(a) waiver, Wisconsin request to implement BadgerCare as a Medicaid expansion with an enrollment threshold, beginning April 1 for 15-18 year old children up to 100% of the Federal Poverty Level (FPL), and for families with children up to 185% of the FPL with eligibility continuing up to 200% FPL, July 1, 1999. We changed only those sections of our January 21, 1998, 1115(a) waiver request that are necessary to implement BadgerCare as a Medicaid expansion with an enrollment threshold. Wisconsin is filing this Section 1115 waiver amendment based on HCFA guidance.**

~~In addition to this waiver, Wisconsin will submit an amendment to our Title XXI state plan to incorporate modifications to cover children and families with employer sponsored coverage under BadgerCare.~~

With this submission, Wisconsin is further amending our Section 1115(a) waiver to request that BadgerCare adults receive the enhanced Title XXI federal match rate and funding for expenditures for services, effective July 1, 2000. All other aspects of BadgerCare, except as noted in this waiver amendment, remain the same. This waiver amendment demonstrates that Wisconsin has met its goals for BadgerCare.

We believe that your approval of this amendment is strongly justified by our experience with BadgerCare.

Successful Enrollment of Children. Wisconsin's approach of providing coverage to the entire family in our S-CHIP program has proven to be extremely successful in meeting the key objective of enrolling eligible children. According to the most recent data on S-CHIP programs as indicated in HCFA's *The State Children's Health Program. Annual Enrollment Report, October 1, 1998 - September 30, 1999*, 1,979,450 children are enrolled nationally in state S-CHIP programs. This represents 24.6% of the 8,060,000 low-income uninsured children under 200% of the FPL.

In the first eight months of our program, from July 1999 through February 2000, we have enrolled 19,294 children in BadgerCare. In addition, 8,253 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program. This represents a total of 27,547 children that have enrolled

in BadgerCare and Medicaid since the implementation of BadgerCare in July 1999. The most recent figures from the 1998 Wisconsin Family Health Survey show that there are 54,000 low-income uninsured children under 200% of the FPL. BadgerCare has reduced the number of uninsured children under 200 percent of the FPL from 54,000 to 26,453.

Therefore, Wisconsin has enrolled 51% of the **eligible** low-income uninsured children population through the BadgerCare program **compared to the national S-CHIP enrollment rate of 24.6%.**

By June 2001, BadgerCare enrollment is projected to be 81,990, compared to 67,535 now budgeted. Higher BadgerCare enrollment will increase the number of covered children from the current 19,294 to 25,757 by June 2001. We also project Healthy Start children will double, increasing from 8,253 to 16,000. Therefore, by June 2001 we will have enrolled **more than 42,000 children in BadgerCare/Medicaid, or over 80% of the 54,000 uninsured children under 200% of the FPL in Wisconsin. Attachment 1 shows BadgerCare's most current actual enrollment as of February 2000.**

- ***Covering Parents Does Not Supplant Funds for Children.*** Covering parents in the initial years of BadgerCare will not supplant S-CHIP funds allocated for Wisconsin's children. The use of Wisconsin's FFY 1998 S-CHIP allocation for parents assures that funding allocated to Wisconsin will support the enrollment of additional children in BadgerCare through a model that truly enhances the enrollment of children in S-CHIP and Medicaid.

With the waiver, Wisconsin will spend all of its initial S-CHIP allocations by FFY 2001. On an ongoing basis beginning in federal fiscal year 2002, our annual S-CHIP allocation for children of \$29.6 million FED is actually less than our projected expenditures of \$34.8 million FED for children in BadgerCare.

By the end of FFY 2002, Wisconsin will need to appropriate an additional \$49.7 million in state funding to maintain BadgerCare enrollment even with the Title XXI waiver amendment.

- ***Insuring Children-Only Slows Enrollment.*** By simplifying eligibility for the entire family, families are encouraged to seek health care coverage, resulting in more children enrolled in Medicaid and BadgerCare.

Along with children in BadgerCare, Wisconsin has significantly increased Medicaid enrollment of low-income children in Healthy Start with the implementation of BadgerCare. This occurred because Wisconsin simplified and built on its Medicaid eligibility criteria for children in creating the BadgerCare program. Medicaid eligibility under Healthy Start

is provided for children up to age six (under 185% of the FPL) and for children up to age 19 (under 100% of the FPL) prior to BadgerCare. In implementing BadgerCare the income and asset requirements for young children were extended to the entire family (185% of the FPL and no asset test). As a result families are no longer confused about who qualifies and more children are enrolled – the parents and older children in BadgerCare and the younger children in Medicaid.

This simplification has had a positive and measurable impact on Medicaid enrollment in Wisconsin. From June 1998 to June 1999, the year before BadgerCare implementation, Healthy Start enrollment remained constant at approximately 66,900 children. During the period July 1999 to January 2000 (with Medicaid outreach, followed by BadgerCare implementation in July) the number of children enrolled in Healthy Start climbed from 66,283 to 75,076. The most dramatic increase occurred between July 1999 and February 2000, with Healthy Start enrollment rising by 1,000 per month.

If Wisconsin had implemented BadgerCare for children only, and children were enrolled at the national average of 24.6% of uninsured children for S-CHIP, we would have enrolled only 13,284 children from April 1999 through February 2000 vs. the 27,547 that did enroll in BadgerCare and Medicaid.

- *Effective Strategy of Outreach and Enrollment.* BadgerCare is more successful than S-CHIP programs nationwide at enrolling uninsured children because:
 - Family-based coverage brings in parents and parents bring in children. The 8,253 children enrolled in Healthy Start, in theory, could have enrolled prior to BadgerCare, since the eligibility criteria have not changed. Since BadgerCare, Medicaid Healthy Start enrollment has increased by an average of 1,000 per month.
 - Coverage and eligibility are seamless and integrated. Families apply for “BadgerCare,” not realizing some family members actually qualify for Medicaid through Healthy Start. Because the benefits and delivery system are identical, families are able to obtain health care without confusion or administrative barriers.
 - Simple and convenient applications for families. Wisconsin’s commitment to health care coverage has converted the old “one-stop shopping” model at the “welfare office” to a more diverse, multi-faceted model, where applications are processed on-site, in real time, at clinics, hospitals, schools, and other locations convenient to families. We have implemented several changes to make the application process user friendly and to minimize barriers to enrollment, including eliminating the asset test for BadgerCare, improving the integration of the

Medicaid/BadgerCare/Food Stamp/TANF application process, and extending Medicaid review dates from six to twelve months.

- **Aggressive Advertising.** BadgerCare has been heavily promoted throughout the state (through health care providers and community-based organizations) and in the media (television and radio ads by Governor Tommy Thompson and legislators). In Wisconsin, our families know about and support BadgerCare.
- ***Expanded State Commitment to BadgerCare.*** Wisconsin has shown a strong commitment to providing adequate funding for BadgerCare in the light of higher than expected enrollment in the program. The original State Fiscal Year 2000 budget projection assumed that BadgerCare enrollment would level off after March 2000 and reach a final enrollment of 67,535 in June 2001. We are now projecting BadgerCare enrollment will continue to grow at a higher rate after March 2000 and reach a final enrollment of 81,990 in June 2001.

Under terms of the original BadgerCare waiver, Wisconsin could cap enrollment at the funded level through enactment of an “enrollment trigger” that would stop new enrollment, so as to not exceed budgeted funding. Wisconsin currently has 57,482 people in BadgerCare, or 94% of the budgeted enrollment. We are projecting we will exceed the cap sometime in April or May 2000.

To cover the projected enrollment, Governor Thompson has proposed additional funding for BadgerCare. Currently, \$56.6 million in state (GPR) funding and \$101.8 million in federal (FED) funding is budgeted for BadgerCare in the 1999-01 biennium. Legislation has been introduced to further increase BadgerCare funding by \$20.7 million GPR and \$23.6 million FED.

Wisconsin is also committed to covering more than double its original projection of increased Medicaid eligibles (7,123) resulting from BadgerCare to over 16,000 projected by June 2001. This translates into an additional annual Medicaid cost of \$16 million, of which \$4.7 million is state funds.

- ***Effective, Budget-Neutral Use of Federal Funds.*** With the two-year delay in obtaining federal approval for our BadgerCare waiver, Wisconsin will lapse Title XXI funds without an approved waiver amendment to allow the state to use this funding to support parents enrolled in BadgerCare. Without the approved waiver amendment, Wisconsin will lose \$15.7 million in federal S-CHIP funding on September 30, 2000, \$12.2 million on September 30, 2001, and \$13.3 million on September 30, 2002. This is a total of \$41.2 million in

federal S-CHIP funding that is projected to lapse. Approximately \$40.4 million of these funds have already been appropriated and allocated to Wisconsin under current federal law.

With a waiver, Wisconsin will need \$11 million less over the biennium to support the expanded enrollment and increased rates. Even with a waiver, Wisconsin will spend \$74.6 GPR million for BadgerCare over the 1999-01 biennium, instead of the \$56.6 GPR million originally authorized.

On an ongoing basis beginning in federal fiscal year 2002, our annual S-CHIP allocation of \$29.6 million FED is actually less than our projected expenditures of \$34.8 million FED for children in BadgerCare. Covering parents in the initial years of BadgerCare will not supplant S-CHIP funds allocated for Wisconsin's children. With the proposed BadgerCare expansion, we project we will cover all eligible low-income children and their parents who do not have access to health insurance.

Granting this waiver is budget neutral to the federal government, since Wisconsin's S-CHIP funds are already allocated. If granted this waiver amendment, Wisconsin will spend only its existing, budgeted S-CHIP allocation.

A Title XXI waiver amendment would recognize the outstanding accomplishment of BadgerCare, consistent with the President's intent, namely the integration of Medicaid and S-CHIP to create a health insurance program that is simple and accessible for low-income families with children.

B. Description of BadgerCare

Summary

BadgerCare ensures access to health care for all children and parents in uninsured families with income below 185% of the federal poverty level (FPL). Once enrolled, families may remain in BadgerCare until family income exceeds 200% of the FPL. No asset test is required.

BadgerCare fills gaps between Medicaid and private insurance without supplanting or "crowding out" private insurance. BadgerCare ~~will~~ extends health care coverage to low-income families with children through a Medicaid expansion under Titles XIX and XXI, with a rollback for this expansion, as allowed under federal law, and a threshold mechanism to protect existing families enrolled in BadgerCare.

In addition, the state's current Medicaid entitlement ~~will be~~ is maintained.

Cost Sharing

Families with income at or above 150% of the FPL pay a monthly premium of 3% ~~to 3.5%~~ of family income. Premiums will not be required for self-identified American Indian/Alaska Native (AI/AN) children. Procedures are being developed in consultation with Wisconsin tribes and Great Lakes Intertribal Council (GLITC) to assure exemptions for self-identified AI/AN children. Procedures for implementing these provisions are currently being developed with the Wisconsin Tribal Health Directors.

Premium Collection

BadgerCare premiums ~~are will be~~ collected through wage withholding or an alternative, automated system. Families who fail to pay the required premium are subject to a restrictive reenrollment period of not more than six months, with exceptions provided for good cause.

Additional Children and Families Covered

BadgerCare is projected to cover an additional ~~48,800~~81,990 uninsured, low-income Wisconsin residents, including ~~22,700~~25,757 children and ~~26,100~~56,233 parents. (In addition, it is anticipated that an additional ~~7,300~~16,000 children will be identified as eligible for Medicaid.)

A family of three, which is the average BadgerCare family size, would:

- Have no premium with income under 150% of the FPL* (~~\$20,000~~ \$21,225 annually/\$10.20 per hour).
- Pay a premium of \$60 per month at 180% of the FPL (~~\$24,000~~ 25,470 annually/\$12.25 per hour)
- Be ineligible for BadgerCare with income in excess of 200% of the FPL (~~\$27,000~~ 28,300 annually/\$13.5013.61 per hour).

Crowd-Out of Private Insurance

As required under federal law, families with health insurance ~~are will~~ not ~~be~~ eligible for BadgerCare.

In addition, families with access to insurance where the employer pays at least 80% of the cost of family coverage ~~are will be~~ ineligible for BadgerCare. The State ~~will~~ purchases health insurance coverage through the enrollees' employer plan where it is cost-effective to do so; families who qualify for this option are eligible to receive wraparound services to BadgerCare coverage if such services are not covered by

* FPL as of May 1, 2000.

the employer plan. The State ~~will~~ approves buy-in for BadgerCare enrollees employee coverage when the employer pays between 60% and 80% of the premium; as required by HCFA, families covered by an employer-sponsored plan in the previous six months are not eligible for the buy-in.

Finally, BadgerCare ~~will~~ requires a maximum three-month, retrospective check for private insurance.

BadgerCare Enrollment Threshold

As allowed under federal law, if BadgerCare enrollment is projected to exceed budgeted enrollment levels, a new enrollment threshold will be established for new applicants. An expedited review and approval process will be specified for modifications to the income threshold in the federal waiver. In addition, the state will provide a minimum of 30 days public notice prior to any change in the income threshold.

Families already enrolled in BadgerCare who continue to meet eligibility criteria in effect on the date they were enrolled ~~will~~ ~~would~~ not be terminated from BadgerCare. All families in BadgerCare will be required to report significant changes that may affect eligibility within 10 days and to undergo a redetermination for BadgerCare every 12 months.

Health Care Benefits/Delivery System

BadgerCare benefits ~~are~~ ~~will be~~ identical to the comprehensive package of benefits and services covered by Wisconsin Medicaid. The existing Wisconsin Medicaid HMO managed care system, including provisions for quality assurance, for improved health outcomes and for grievances, ~~are in effect~~ ~~will be used~~ for BadgerCare.

Funding

Federal waivers ~~were~~ ~~are~~ required to implement BadgerCare. BadgerCare ~~expanded~~ ~~will expand~~ Medicaid coverage in families with income up to 185% of the FPL through an 1115(a) waiver using a combination of Title XIX (for parents) and Title XXI (for children) funding. **We are now requesting an amendment to our 1115 waiver to use Title XXI to cover children and their parents' health care costs, including care for families who qualify for employer-sponsored coverage, at the Title XXI match rate.** ~~As allowed under Title XXI, the State will fund children's health care costs and families who qualify for employer-sponsored coverage through Wisconsin's CHIP allocation at the enhanced financial match rate. Parents will be funded through Title XIX at the regular match rate. Expanded Medicaid coverage uses pPremium cost sharing as the state match for federal funds will be an offset to total costs.~~

~~The total amount of funding is \$69.0 million — \$47.6 million in federal, \$16.6 million in state, and \$4.8 million in premium revenue.~~

~~The State of Wisconsin is further amending its Section 1115(a) waiver to request that BadgerCare adults receive the enhanced Title XXI federal match rate for expenditures for services, effective July 2000. The enhanced Title XXI federal match rate would be applicable to adults receiving services in BadgerCare HMOs or fee for service, and to adults receiving services from employer-sponsored coverage.~~

Currently, \$56.6 million in state (GPR) funding and \$101.8 million in federal (FED) funding is budgeted for BadgerCare in the state's 1999-01 biennium. Legislation is pending in the State Legislature to increase funding for BadgerCare enrollment and HMO rates by \$20.7 million GPR.

HCFA approval of this waiver amendment will provide Wisconsin an additional amount of federal funding for state fiscal year 2001 (July 2000 through June 2001) the state's 1999-01 biennium of \$36.2 million. Therefore, the revised funding for the state's 1999-01 biennium would be \$138 million FED and \$63 million GPR our currently budgeted levels.

Goals

BadgerCare provides access to affordable health care for low-income families with children. In particular, BadgerCare:

- Provides a safeguard against unintentionally increasing the number of uninsured children and parents through welfare reform.
- Complements Wisconsin Works (W-2) by eliminating barriers to successful employment.
- Assures access to health care for all low-income families who do not have employer insurance.
- Integrates employer health insurance and Medicaid, while building on the health care system that is a reality to working families.
- Promotes personal responsibility through cost sharing.
- Improves health outcomes and reduces uncompensated health care costs by establishing a "medical home" for all low-income families with children.
- Streamlines eligibility procedures and HMO enrollment for health care.

II. REQUESTED TITLE XIX WAIVERS AND TITLE XXI STATE PLAN AMENDMENT

BadgerCare will require the following ~~waivers and plan~~ amendments to our 1115 waiver:

~~A. Children's Health Insurance Program (Title XXI) State Plan Application~~ A Title XXI State Plan application describing the expansion of Title XIX coverage for children under age 19 living with their parent(s) and whose family income does not exceed 185% FPL at the time of application. Once eligible, children can remain eligible as long as they continue to meet BadgerCare requirements described in the Title XXI State Plan and their family's income does not exceed 200% of the FPL. In addition, we intend to use Title XXI funds to cover the purchase of employer-sponsored insurance for families when cost effective.

~~B. Section 1115(a) Waiver~~ Under section 1115(a) of the Social Security Act, Wisconsin requests waivers of Medicaid law and regulations in the following areas:

~~1. Waiver of Federal Matching Funds for BadgerCare Premiums~~

~~Under Title XIX, Wisconsin requests waivers of all relevant Medicaid laws and regulations which would allow Wisconsin to receive federal matching funds, at the regular Medicaid rate, for premiums collected for parents in the BadgerCare program. Under Title XXI, the premiums collected for children in BadgerCare will reduce overall program costs; remaining costs are then eligible for Title XXI matching funds.~~

21. Coverage of Parents under the BadgerCare/Medicaid Waiver

Wisconsin **received** ~~requests~~ the necessary waivers of federal law and regulation to allow for the:

- Disregard of income equal to the difference between 185% (for applicant groups) or 200% (for recipient groups) of the federal poverty level for their family size and the applicable AFDC payment standard in determining the Medicaid eligibility of custodial parents of children under age 19 and the spouses of such custodial parents.
- Disregard of all countable, nonexempt assets of the custodial parents of children under age 19 and the spouses of such custodial parents. This asset disregard will not apply to other caretaker relatives of deprived children. [This will require waivers of two sections: 1) eliminate the asset test found in 1902(a)(10)(ii) for BadgerCare eligibles. The asset test will still apply to persons who are Medicaid eligible; and 2) waive the section that relates to similar scope, amount and duration of Medicaid coverage for adults who are not custodial parents or their spouse (NLRR relatives, Child Welfare Parents, etc.).
- The State of Wisconsin is further amending this Section 1115(a) waiver application on March 10, 2000 to request that BadgerCare adults receive the enhanced Title XXI federal match rate for expenditures for services, effective July 2000. The enhanced Title XXI federal match rate would be

applicable to adults receiving services in BadgerCare HMOs or fee-for-service, and to adults receiving services from employer-sponsored coverage.

- Termination or denial of Medicaid eligibility for custodial parents of children under age 19 and the spouses of such parents who are covered by a group health insurance plan (that meets the definition of a HIPAA standard plan) or who have dropped such coverage in three months prior to a Medicaid determination of eligibility. [This needs to be waived to make the parents' coverage requirements the same as those for the children, since the definition of 'targeted low-income children' already includes this restriction. There is no section to 'waive,' but this would require the DHHS Secretary to allow Wisconsin to impose a more restrictive test on the Medicaid demonstration coverage group of parents (and their spouses)].
- Termination or denial of Medicaid eligibility for custodial parents of children under age 19 and the spouses of such parents who have access to an employer's group family plan in which the employer pays 80% or more of the monthly health insurance premium. [There is no section to 'waive,' but this would require the Secretary of the federal Department of Health and Human Services to allow the state to impose a more restrictive test on the Medicaid expansion group of children and their parents than is imposed on existing groups].

In order to implement such policies, Wisconsin ~~received requests for~~ **approval** of section 1902 of the Social Security Act and Chapter 42, Section 435 of the Code of Federal Regulations. These waivers are necessary because the aforementioned federal law and regulations do not include provisions that would allow Wisconsin to add this new eligibility group. Wisconsin also **received approval for** ~~requests for~~ any other waivers of federal law or regulation, not mentioned above, that ~~are determined to be~~ were necessary to allow Wisconsin to implement BadgerCare.

32. Premium

In order to collect a premium from those custodial parents and their spouses who would be covered under Medicaid through the application of these waivers and whose total family income ~~is equal to or exceeds~~ 150% of the FPL, as well as calculate a premium for coverage of 3% ~~to 3.5%~~ of total family income, Wisconsin requests a waiver of Sections 1902(a)(14) and 1916 of the Social Security Act, as well as, Chapter 42, Section 447.51 of the Code of Federal Regulations. Failure to pay the premium will result in the closure of the BadgerCare eligibility for all family members who are not otherwise eligible for Medicaid **or are self-identified American Indian/Alaska Native (AI/AN) children.**

Any BadgerCare family that is required to pay a premium as part of continuing eligibility but fails to do so within prescribed time limits, **are will** ~~be~~ ineligible for BadgerCare for six calendar months. Good cause exceptions **are made** ~~will be made~~ that would alleviate the unfair imposition of this restrictive re-enrollment period on persons whose failure to pay the premium was the result of actions or persons outside of the household.

43. Backdating

Wisconsin **received approval for requests** ~~requests~~ elimination of 3-month Medicaid eligibility backdating option for BadgerCare applicants. Eligibility ~~will~~ begins on the first day of the month in which all BadgerCare eligibility requirements are met.

54. Enrollment Threshold

Wisconsin **received approval for requests** ~~requests~~ an expedited federal review and approval process in which Wisconsin ~~is will be~~ allowed to modify the BadgerCare income limits for new applicants when existing funds are not sufficient to enroll all new eligible persons. In this situation, Wisconsin ~~is will~~ also ~~be~~ allowed to continue coverage for families participating in the program who continue to meet the income eligibility criteria in effect on the date they enrolled in BadgerCare.

To comply with the State's non-entitlement requirement and federal law which allows states to roll back optional Medicaid coverage, Wisconsin **determines** ~~the would decide on an~~ enrollment "threshold." This is the number of families that the State anticipates that it can enroll within the State budget appropriation. ~~The following may ree actions would~~ happen if the number of families enrolled in BadgerCare reaches this threshold:

- a. **End New Enrollment.** HCFA would approve an amendment to the Medicaid 1115 waiver to change the enrollment threshold to accommodate new enrollment. This would mean that no new applications would be approved above the new threshold, although the applications would be kept on a waiting list in the event that additional State funds are appropriated. The amendment would be approved by HCFA through an expedited review process.
- b. **Continue Eligibility for Existing Enrollees.** To provide continuity of care to people already enrolled in BadgerCare, an amendment would be approved by HCFA through an expedited review process, to permit ongoing eligibility for families who continue to meet BadgerCare eligibility criteria in effect on the date they were enrolled. Although families would be required to report significant changes that may affect eligibility within 10 days and to undergo a redetermination for BadgerCare every 12 months, if a family continues to meet the eligibility criteria on the date they were enrolled they would not be terminated from BadgerCare.

65. Additional Funds for Coverage

If the State did approve additional funds, HCFA would approve an additional amendment to reopen new enrollment for families with children up to 185% of the FPL. Depending on the amount of additional funding authorized, the State would amend the eligibility criteria for BadgerCare to ensure enrollment of additional low-income families up to the new income threshold authorized for BadgerCare.

76. Maintaining Current Medicaid Program

Wisconsin ~~will~~ ~~could~~ maintain its Medicaid entitlement for children, parents and pregnant women eligible through our existing mandatory and optional AFDC and OBRA criteria. To ensure the enrollment of low-income families and children in the appropriate program, the application and eligibility determination process for Medicaid and BadgerCare ~~are~~ ~~will be~~ coordinated, with those eligible for the state's Medicaid entitlement enrolled in that program.

C. Accelerated Phase-In of OBRA '90 Children

As allowed under the Omnibus Budget Reconciliation Act of 1993 and under Title XXI, Wisconsin has an approved Title XXI State Plan Amendment that would expand Medicaid to include all children ages 6 through 18 whose family income does not exceed 100% of the FPL regardless of their birthdate. This change ~~will~~ allows Wisconsin to enroll those children who were born before September 30,

1983, with family income no greater than 100% of the FPL, and claim the enhanced Title XXI funding for these children.

~~Under Wisconsin law, the Department cannot implement this change until the BadgerCare waiver has been approved.~~

III. CONCEPTUAL FRAMEWORK FOR BADGERCARE

A. Family-Based Approach of BadgerCare and Its Effect on Participation of Children

Wisconsin will extend health care coverage to custodial parents (and their spouses) as well as their children through this **waiver amendment 1115(a) waiver** and the Title XXI state plan amendment **with Title XXI funds**.

This family-based approach strengthens the ability of Wisconsin to achieve the Title XXI goal of providing health care to uninsured children. There is empirical evidence that a family-based approach to providing health care is more effective in enrolling children than a children-only approach to providing health care.

Dr. Kenneth Thorpe of Tulane University has studied past Medicaid expansions in a large number of states. He has estimated that, on average, children-only expansions of Medicaid bring about 45% of potential eligibles into the program, whereas offering family-based expansions bring in 75% of potential eligibles.

~~An additional BadgerCare component that will support the Title XXI goal of increasing children's health coverage is the outreach plan of Wisconsin Medicaid and BadgerCare. The series of outreach activities for BadgerCare that build upon the ongoing Medicaid outreach activities will increase the participation rate for children that are eligible for either Medicaid or BadgerCare. Wisconsin's experience with BadgerCare re-enforces Dr. Thorpe's findings.~~

- ***Successful Enrollment of Children.*** Wisconsin's approach of providing family coverage in BadgerCare has been extremely successful in meeting the key S-CHIP objective of enrolling eligible children. According to the most recent data on S-CHIP programs as indicated in HCFA's *The State Children's Health Program, Annual Enrollment Report, October 1, 1998 - September 30, 1999*, 1,979,450 children are enrolled nationally in state S-CHIP programs. This represents 24.6 percent of the 8,060,000 low-income uninsured children under 200 percent of the FPL.

In the first eight months of our program, from July 1999 through February 2000, we have enrolled 19,294 children in BadgerCare. In addition, 8,253 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program. This represents a total of 27,547 children that have enrolled in BadgerCare/Medicaid since the implementation of the BadgerCare program in July 1999.

The most recent figures from the 1997-1998 Wisconsin Family Health Survey show that there are 54,000 low-income uninsured children under 200 percent of the FPL. BadgerCare has reduced the number of uninsured children under 200 percent of the FPL from 54,000 to 26,453. Wisconsin has enrolled 51 percent of the low-income uninsured children population through the BadgerCare program compared to the national S-CHIP enrollment rate of 24.6 percent.

By June 2001, BadgerCare enrollment is projected to be 81,990, compared to 67,535 now budgeted. Higher BadgerCare enrollment will increase the number of children from the current 19,294 to 25,757 by June 2001. We also project Healthy Start children will double, increasing from 8,253 to 16,000. Therefore, by June 2001 we will have enrolled over 42,000 children, or over 80% of the 54,000 uninsured children under 200 percent of the FPL in Wisconsin.

- *Covering Parents Does Not Supplant Funds for Children.* If granted this waiver amendment, Wisconsin will spend all of its S-CHIP allocation by FFY 2001 and be \$81.9 million over our allotment by the end of FFY 2002. Even with the Title XXI waiver amendment, Wisconsin needs an additional \$49.7 million GPR in FFY 2002 to maintain BadgerCare's projected enrollment. Without the Title XXI waiver amendment, Wisconsin will run out of money sooner, even with a substantial commitment of state funds, and will stop insuring newly uninsured children.
- *Insuring Children-Only Slows Enrollment.* By simplifying eligibility for the entire family, families are encouraged to seek health care coverage, resulting in more children enrolled in Medicaid and BadgerCare.

Along with children in BadgerCare, Wisconsin has significantly increased Medicaid enrollment of low-income children in Healthy Start with the implementation of BadgerCare. This occurred because Wisconsin simplified and built on its Medicaid eligibility criteria for children in creating the BadgerCare program. Medicaid eligibility under Healthy Start is provided for children up to age six (under 185% of the FPL) and for children up to age 19 (under 100% of the FPL) prior to BadgerCare. In implementing BadgerCare the income and asset requirements for young children were extended to the entire family (185% of the FPL and no asset test). As a result families are no longer confused about who qualifies and more children are enrolled – the parents and older children in BadgerCare and the younger children in Medicaid.

This simplification has had a positive and measurable impact on Medicaid enrollment in Wisconsin. From June 1998 to June 1999, the year before BadgerCare implementation, Healthy Start enrollment remained constant at approximately 66,900 children. During the period July 1999 to January

2000 (with Medicaid outreach, followed by BadgerCare implementation in July) the number of children enrolled in Healthy Start climbed from 66,283 to 75,076. The most dramatic increase occurred between July 1999 and February 2000, with Healthy Start enrollment rising by 1,000 per month.

If Wisconsin had implemented BadgerCare for children only, and children were enrolled at the national average of 24.6% of uninsured children for S-CHIP, we would have enrolled only 13,284 children from April 1999 through February 2000 vs. the 27,547 that did enroll in BadgerCare and Medicaid.

B. Historical Background and Issues in Health Care Coverage for Low-Income Families

For more than ten years Wisconsin has successfully implemented numerous welfare reform initiatives to strengthen families by promoting self-sufficiency and independence through employment. From 1987 to 1997, the number of AFDC recipients declined from 287,488 to 94,802, a drop of 67%. Wisconsin eliminated the AFDC program effective September 1, 1997, and replaced it with a new program called Wisconsin Works (W-2). The existing AFDC caseload was phased out from September 1997 through February 1998.

Over that same ten-year period, low-income children, families and pregnant women qualifying for Medicaid under AFDC and Healthy Start guidelines, fell from 331,353 to 243,494. The decrease in the number of Medicaid recipients of 26.5% is significantly less than the decline in AFDC due, in part, to Wisconsin's expansion of Medicaid eligibility criteria over that time. In addition, Wisconsin has implemented innovative and progressive Medicaid initiatives that:

- Assure broad-based eligibility for low-income families, pregnant women and children through categorically and medically needy criteria;
- Cover Medicaid services through one of the most comprehensive benefit packages in the nation;
- Promote quality assurance through contract standards that focus on health outcomes, consumer preference, and continuous improvement; and
- Deliver medical care through an extensive, cost-effective managed care system.

However, even with broad-based eligibility, Medicaid does not cover all members in intact families, or provide access to affordable health care on a long-term basis to all low-income, uninsured families who work.

Federal welfare reform severed the link between government-funded Temporary Assistance to Needy Families (TANF, formerly AFDC) work programs and

categorical eligibility for Medicaid. TANF recipients (W-2 in Wisconsin) are not automatically eligible for Medicaid. Instead, under the Personal Responsibility and Work Opportunity Reconciliation Act (PL 104-193), each state is required to maintain Medicaid eligibility based on its AFDC standards (income and asset levels) and methodologies in effect on July 16, 1996. Limited changes for determining Medicaid eligibility ~~may be made~~ **were permitted** to adjust AFDC standards for inflation and to use a less restrictive methodology.

On September 1, 1997, Wisconsin implemented Wisconsin Works (W-2), its TANF program, which replaces AFDC. As part of the State's comprehensive, supportive services for low-income families, Wisconsin's goal is to assure that families who move from welfare to work will not join the ranks of the uninsured. In the wake of welfare reform, many families do not have access to affordable, employer-sponsored health insurance. Other families no longer understand they may be eligible for Medicaid. **As a result, in part, of changes in the welfare system, family Medicaid caseload showed a decline from 1995 (486,000 individuals) to 395,000 by mid-1997. The caseload decline leveled off as of the end of 1997, due in part to the success of outreach efforts. Through June 1999 Wisconsin's caseload was stable with about 400,000 individuals total, including about 215,000 in the family Medicaid group – children, their caretakers, and pregnant women.**

Since July 1999 the family Medicaid caseload has increased substantially and is at 454,913 at the end of February 2000, with the increase coming from BadgerCare and Healthy Start children, now at 275,424 (comprised of 80,107 adults and 195,317 children). Some trends in the family Medicaid caseload from 1995 to the present are noted:

- **Family Medicaid Caseload Decline During 1996 and 1997.** The number of family Medicaid recipients decreased from 296,000 in December 1995 to 220,000 in December 1997. This period coincides with the phasing out of AFDC and the implementation of Wisconsin Works (W-2).
- **Family Medicaid Caseload Stabilized from 1998 to Mid 1999.** The family Medicaid caseload stabilized late in 1997 and in 1998. From January 1998 to June 1999, the number of recipients ranged between 215,000 and 221,000. There were 215,000 family Medicaid recipients in June 1999. The stabilization was the result of a concerted statewide outreach effort.
- **Combined Family Medicaid/BadgerCare Caseload Has Increased Since Mid 1999.** Since enrollment in Wisconsin BadgerCare began in July 1999, the BadgerCare program caseload has increased to 57,482 (February 2000). With the BadgerCare program and an increase of 8,253 in Healthy Start children, the combined family Medicaid/BadgerCare caseload has increased significantly since mid-1999. The combined family Medicaid/BadgerCare

caseload increased from 222,000 recipients in July 1999 to 275,424 in February 2000. Statewide outreach efforts, including training, TV ads, and agency collaboration contributed to this growth.

~~Since January 1995, the Medicaid caseload of low income adults and children on AFDC has fallen from 267,942 to 135,776, a decrease of 132,166 recipients, or 49%, from January 1995 November 1998.~~

~~To an extent, this decline has been offset by an increase in pregnant women and children eligible under Healthy Start, which has increased from 44,665 to 80,631 or 35,966 recipients in the same period of time.~~

~~In total, however, 96,200 fewer low income children and adults are now enrolled in Medicaid than were enrolled in January 1995.~~

~~In addition to the issues of low income working families eventually losing Medicaid, and the difficulty of finding affordable employer based health insurance for newly working families, there is the overall issue of rising levels of the uninsured among the general population who have never been on public assistance.~~

~~According to the 1996 Wisconsin Family Health Survey, produced by the Wisconsin Division of Health, 4% of Wisconsin households had no health insurance in the previous 12 months, and 6% of households had no health insurance for part of the previous 12 months. At any one time, 8% of Wisconsin households had no health insurance.~~

~~To address these issues, BadgerCare provides access to affordable health care for all uninsured children and adults in low income families, without supplanting or crowding out employer provided insurance. As a bold and innovative model in response to a unique and emerging social problem, BadgerCare is an opportunity to coordinate public funding of health care through Titles XIX and XXI to meet the needs of low income, uninsured families and children, while building a bridge between private health insurance and public health care programs.~~

C. Goals of BadgerCare

Some families who join the workforce have access to affordable, employer-provided health care. For many others, however, access and affordability is an issue. Through a comprehensive, integrated program, BadgerCare **has built** ~~builds~~ a bridge between Medicaid and employer-provided health care coverage, just as welfare reform is now transforming the ties between welfare and work.

To preserve access to health care for low-income families and children, **Wisconsin recognized that Medicaid needed to** ~~must~~ change to recognize that a majority of low-income families now work, that AFDC income standards required for Medicaid are significantly less than the minimum wage, and that health care is not always accessible or affordable through employment. Through strengthening the ability of

both parents to be employed and to care for their children, BadgerCare ~~has~~ supported the transition to independence.

In addition, given the different and more generous standards for W-2 and the complexity and intricacies of former AFDC rules, many low-income families are no longer eligible for Medicaid based on prior AFDC standards or no longer understand that they may be eligible under obsolete, confusing AFDC standards.

Just as welfare reform is now experimenting with creative links between cash assistance and employment, BadgerCare is an innovative and progressive model to effectively integrate Medicaid with employment-based health insurance.

In addition to helping transition low-income families from welfare to work, BadgerCare is also helping working poor families gain access to health insurance. Approximately 40% of BadgerCare enrollees are persons with no recent involvement with the welfare system. The major goal of BadgerCare is to improve the health of Wisconsin's low-income families with children by providing access to affordable health care for low-income families with children.

Additional goals of BadgerCare include the following:

- Provide a safeguard against unintentionally increasing the number of uninsured families and children through welfare reform;
- Complement W-2 by eliminating barriers to successful employment;
- Assure access to health care for all low-income families who do not have employer insurance;
- Integrate employer health care and Medicaid without supplanting private insurance, and build on the health care system that is a reality to other working families;
- Promote personal responsibility through cost-sharing;
- Improve health outcomes and reduce unnecessary and uncompensated health care costs by establishing a medical "home" for all low-income families and children, thereby strengthening health care prevention in the community; and
- Streamline eligibility procedures and Health Maintenance Organization (HMO) enrollment for health care.

In building on the success of the state's existing HMO program, BadgerCare ~~will~~ provides Wisconsin Medicaid's comprehensive benefits and services through a health care delivery system with strong quality assurance safeguards. Currently, 18 of 24 licensed HMOs in Wisconsin participate in the Wisconsin Medicaid HMO program. In 1999~~8~~, Medicaid-certified HMOs ~~will~~ participated in 70 of the State's 72 counties (fee-for-service [FFS] remains in the two remaining small, rural

counties). With clear and measurable performance standards, and ongoing, continuous quality improvement activities, the Wisconsin Medicaid HMO program has demonstrated improved health outcomes. The Wisconsin Medicaid HMO contract for low-income families with children is frequently identified as one of the best in the nation.

BadgerCare ~~will~~ prevents crowd-out of private insurance by buying in employee premium costs for employees who have access to employer-based group health coverage where it is cost effective to do so. In these situations, BadgerCare ~~will~~ provides wraparound services to these bought-in private health insurance plans up to the Medicaid benefit level, including any deductibles, coinsurance, and copayments that may be imposed on the employee by the private health insurance plan.

D. BadgerCare has met the goals listed above in our January 1998 waiver request.

The most important goals were to provide access to health insurance to Wisconsin's low-income families with children. Since July 1999, BadgerCare insured 57,482 people, including 38,188 parents and 19,424 children, in addition to an additional 8,253 children in Medicaid. Over 90% of those enrolled have incomes below 150% of the federal poverty level. Only 9% of all families enrolled pay premiums.

Additional goals listed that we also met:

- **Provide a safeguard against unintentionally increasing the number of uninsured families and children through welfare reform.**

BadgerCare and Medicaid enrollment increases have insured an additional 65,735 (out of 144,000 total) individuals in families with children with incomes below 200% of the federal poverty level.

- **Assure access to health insurance for families who do not have insurance.**

BadgerCare is reaching those families who are the most likely to be uninsured. Over 90% of families enrolled have incomes below 150% of the federal poverty level.

Based on the survey of employers that Wisconsin does to verify BadgerCare enrollees current insurance status, 64% of employers surveyed indicate that the employee has no access to family coverage.

- **Promote personal responsibility through cost sharing.** The 3% monthly premium has not deterred families from enrolling. We have received very few complaints about the amount of the premium and have few people refuse BadgerCare because of the premium.

- **Improve health outcomes and prevention.** Wisconsin Medicaid's long-standing HMO program is the delivery system for BadgerCare. Families enrolled in both Medicaid and BadgerCare are enrolled in the same HMO with the same coordinated health prevention and promotion requirements.
- **Coverage and eligibility are seamless and integrated.** Families apply for "BadgerCare," not realizing some family members actually qualify for Medicaid or Healthy Start. Because the benefits and delivery system are identical, families are able to obtain health care without confusion or administrative barriers.

Simple and convenient applications for families. Wisconsin's commitment to health care coverage has converted the old "one-stop shopping" model at the "welfare office" to a more diverse, multi-faceted model, where applications are processed on-site, in real time, at clinics, hospitals, schools, and other locations convenient to families.

Aggressive Advertising. BadgerCare has been heavily promoted throughout the state locally (through health care providers and community-based organizations) and in the media (print, radio and television ads by Governor Tommy Thompson and legislators). In Wisconsin, everyone knows about BadgerCare.

E. Conclusion

The State of Wisconsin has a strong and progressive tradition in structuring government programs to address the needs of its citizens. Wisconsin is a leader among states in initiating innovative programs that foster inherent social goals, while preserving and strengthening bonds between the private and public sectors. For Medicaid, BadgerCare is an opportunity to meet the needs of low-income, uninsured families and children, while building a bridge between the public and private sectors.

In designing BadgerCare, an explicit choice was made to provide access to affordable health care for all uninsured children and adults in low-income families, without supplanting or crowding out employer-provided insurance. Thus, BadgerCare does not extend a Medicaid entitlement, at no cost, solely to children in low and middle-income families, many of whom may already have private health insurance.

IV. COMPONENTS OF BADGERCARE

A. Eligibility

1. Wisconsin Medicaid Eligibility: Current System and Caseload Trends

a) Standards

Medicaid eligibility for families and pregnant women is based on two standards: 1) AFDC standards that existed on July 16, 1996, prior to the enactment of federal welfare reform; and 2) federal and state Medicaid expansions that have gradually increased the eligibility limits for children and pregnant women since 1987. Applications are processed by county agency workers located in the 72 Wisconsin counties, using a computer-assisted interactive interview. Currently, mail and phone-in applications are not used. Policy is implemented through a statewide automated system.

b) Automation

An important component of the eligibility determination system in Wisconsin is the extensive statewide, automated, integrated eligibility determination system called Client Assistance for Reemployment and Economic Support (CARES). An eligibility worker collects family and financial data through an interactive interview prompted by CARES, which then determines eligibility by applying federal and state law for four programs (Medicaid, food stamps, child care and cash assistance) and generates the appropriate notices and benefits. Because the policy logic is built into the system, CARES prompts the worker to gather the correct data, and applies that data in a standardized and consistent way for each case, thereby assuring the integrity of the eligibility determination process.

c) Impact of Federal Welfare Reform

Current federal law severs the link between the receipt of cash assistance and categorical eligibility for Medicaid. These multiple standards have created fragmented programs for low-income families, resulting in confusion for recipients, providers, county eligibility staff, advocates and the public. Maintenance of these separate systems not only increases state and federal administrative costs, but also reduces Medicaid participation rates.

In Wisconsin, income and asset tests for Wisconsin Works (W-2), the state's TANF program, are now more liberal than those used for Medicaid eligibility. Higher income and asset standards for W-2 are designed to simplify eligibility and to expand participation to those who need supportive services to move from welfare to work.

In this new environment, Wisconsin has made a significant investment in welfare reform. Budgeted expenditures for the comprehensive W-2 welfare reform program in Wisconsin total over \$100 million more than the estimated cost to continue the State's prior AFDC program.

However, despite aggressive outreach, coordination, education and outstationing efforts, Medicaid enrollment of eligible children and families will continue to be a challenge because:

- Medicaid is no longer automatically linked to receipt of cash assistance;
- AFDC-related Medicaid guidelines are complex and difficult to explain;
- Within families, some are covered, others not, depending on complicated categorically and medically needy eligibility provisions; and
- With welfare reform, AFDC standards are increasingly obsolete, and oftentimes more restrictive than TANF requirements.

d) Application Process and Sites

Families who want to receive Medicaid can apply at the county department of social or human services, at the tribal or W-2 agency or at outstation sites. Since federal policy requires that government workers conduct the eligibility determination, including the entry of data, verification of entries, running and confirming of eligibility, Wisconsin has co-located county workers at W-2 agencies that are run by non-public organizations. There are nine counties that have W-2 programs that are run by private organizations; two of those nine counties have W-2 programs run by private for-profit agencies and the remaining seven counties have private non-profit agencies running W-2 programs.

W-2 is a comprehensive work-based program operated by W-2 agencies housed in Job Centers in all Wisconsin counties. Locating all job-related services, such as food stamps, child care and Medicaid, as well as other community job-search services in the same agency, assures that all programs operate under the terms of performance-based contracts with the state.

Many counties have implemented eligibility outstationing since the BadgerCare waiver was submitted in December 1998. See section 18 for a detailed explanation of Wisconsin's current outstationing efforts.

~~e) Caseload Trends~~

~~There has been a steady decline in the total number of recipients covered by the Wisconsin Medicaid program in the period January 1995 to November 1998.~~

~~Total number of recipients in January 1995 was 486,858.~~

~~Total number of recipients in December 1997 was 395,946.~~

~~The total Medicaid caseload, including AFDC Medicaid related, SSI and elderly recipients, as of November 1998, represents about 8% of the Wisconsin population of 5 million.~~

~~The decrease has occurred in the AFDC-related Medicaid cases, which dropped from 267,942 individuals covered in January 1995 to 135,776 as of November 1998, a reduction of 132,166 individuals.~~

~~During the same time period the Healthy Start component of the caseload saw has seen steady growth.~~

~~There were 44,665 pregnant women and children covered as of January 1995.~~

~~The Healthy Start caseload, as of November 1998, was 80,631.~~

~~The SSI-related caseload has remained steady throughout this time period, with about 124,000 individuals covered each month.~~

~~The timing of the decline in the AFDC related caseload reflecteds the strong Wisconsin economy, low unemployment rates, and increased work opportunities for families on AFDC as Wisconsin tested a number of alternatives to the old welfare system. "Pay for Performance," a welfare reform waiver that linked employment program participation directly to the benefit amount, was implemented in March 1996, while the state's TANF program, W-2, was implemented in two pilot counties in the spring of 1997. W-2 was has now been implemented statewide, with conversion from AFDC to W-2 occurring over the period September 1997 through March 1998.~~

~~See Appendix A of the January 21, 1998 BadgerCare waiver submission for a more detailed description of the current Wisconsin Medicaid eligibility provisions.~~

2. Eligibility Changes Under BadgerCare

BadgerCare will maintains the Medicaid entitlement for all low-income families, pregnant women and children currently eligible for Medicaid, and expand eligibility for all Medicaid-covered services to include families with children up to 185% of the FPL (200% if the family became eligible at or below 185% of the FPL).

3. Eligibility Determination and Processing:

a) Simplified Process

Wisconsin's long-range goal with the development of BadgerCare is to improve access to health care by covering additional families with children, and simplifying the application process for both current Medicaid recipients, and the newly-eligible families who will be covered under BadgerCare.

BadgerCare ~~will be~~ is built upon the structure that supports the Medicaid program, with county workers processing applications, using the CARES system for the interactive interview and eligibility determination. This minimizes administrative costs, and integrates the program delivery to families, who may have some family members who qualify for Medicaid coverage and some who qualify under the BadgerCare expansion.

Wisconsin ~~has will~~ standardized eligibility policy between BadgerCare and Medicaid to the extent possible, and ~~has built~~ new intake options that offer alternatives to working parents. We plan to develop and offer the option of a simplified application that would be widely available and easily completed for families who prefer a mail-in application. **We will be piloting a one-page application form and streamlined process later this year.**

The new application process ~~was will be~~ marketed in multiple ways, including through employers, using the state's network of supportive services for families now entering the work force. This ~~will~~ assured coordination with other health care plans offered by employers, while promoting access to BadgerCare as a transitional, affordable option for low-income, working families without private insurance.

b) Coordination with Current Wisconsin Medicaid Eligibility System

(1) Systems support

The CARES system and the Wisconsin Medicaid Management Information System (MMIS) ~~will~~ provides automated support and ~~integrations~~ of the Medicaid and BadgerCare eligibility determination processes.

- CARES is Wisconsin's automated system that determines eligibility for W-2, Medicaid, child care assistance and food stamps. It ~~will be~~ is used to determine eligibility for BadgerCare.

- The CARES system is ~~will be~~ used to screen BadgerCare applicants for potential eligibility for Wisconsin Medicaid and to determine their eligibility for BadgerCare.
- Every effort is ~~will be~~ made to use automated letters, simple forms, phone call follow-up, and automated matching to gather complete data, to verify data for applications, and to inform applicants of outcomes and program coverage decisions.
- Eligibility information is ~~will be~~ transmitted to the MMIS through the CARES/MMIS Interface Subsystem.
- The MMIS uses the Medicaid eligibility data to issue ID cards, enroll families in HMOs, and process claims.

Before a family can qualify for BadgerCare, they must be tested for Medicaid eligibility. This is to ensure that the state preserves the entitlement to Medicaid for families who qualify, ~~and that the state uses the lower Federal Financial Participation (FFP) rate for Medicaid, before having families qualify under the higher enhanced FFP under Title XXI.~~

Each individual who requests BadgerCare is ~~will be~~ tested for Medicaid eligibility first. Those persons who qualify for Medicaid ~~are will be~~ automatically enrolled in that program and are ineligible for BadgerCare. A child who is eligible for Medicaid and for whom the parent has requested Medicaid will have his or her needs included in the BadgerCare group to set the family size, but the child's income and assets will not be counted. An adult eligible for Medicaid who is legally responsible for a potentially eligible member of the BadgerCare group will be included as a counted adult whose income and needs are included in the BadgerCare group.

A person is eligible for Medicaid if the worker confirms the person as Medicaid eligible. Persons who are eligible for Medicaid, except for excess income, ~~will~~ have a choice between setting-up a Medicaid spenddown or choosing BadgerCare eligibility. Both BadgerCare eligibility and the spenddown amount will be calculated. The eligibility worker ~~will~~ works with the applicant group to determine whether the Medicaid spenddown or BadgerCare is the best choice for their household. This choice is ~~will be~~ based upon what medical expenses have already been incurred or are expected to be incurred, the amount of the spenddown, and whether a BadgerCare premium is assessed.

4. Family Members

For BadgerCare, the group consists of all children under age 19 living with a parent in the household for whom the family is requesting coverage, the natural or adoptive custodial parents of these children, and the spouse of the custodial parent living with the family. Even if a custodial parent is covered by employer health insurance, their income and needs ~~are will be~~ counted in determining BadgerCare eligibility for other members of the family. When a child is excluded from BadgerCare coverage because s/he is eligible for Medicaid, the child's needs will be included in the eligibility determination and post-eligibility processes.

SSI members of a family ~~are will be~~ treated in BadgerCare the same as they are treated by AFDC-related Medicaid. The finances and needs of a SSI family member ~~are will not be~~ counted in determining BadgerCare eligibility.

5. Nonfinancial Requirements

The nonfinancial requirements for BadgerCare ~~are will be~~ the same as the requirements for AFDC-related Medicaid. This includes the requirements to:

- Provide social security numbers (or cooperate in applying for SSNs) for all family members who are requesting Medicaid and BadgerCare.
- Cooperate in providing and verifying information necessary for the Medicaid and BadgerCare eligibility determination and post-eligibility process.
- Cooperate with child support in identifying and establishing Medical Support Liability of non-custodial parents.

The date that the BadgerCare applicant group signs the application and includes the applicant's name and address is the filing date. The BadgerCare group will be eligible from the first of the month in which all BadgerCare criteria are met. There is no 3-month 'backdating' for BadgerCare.

6. Insurance Coverage

Persons who are covered by employer health insurance plans that meet the Health Insurance Portability and Accountability Act (HIPAA) standards ~~are will not be~~ eligible for BadgerCare. The eligibility worker ~~will~~ collects insurance information from the household and verify the coverage. The HIPAA standard will be included in a question to the applicant family asking whether this is a major medical health insurance plan. If so, the covered individual(s) will not be eligible for BadgerCare. EDS, Wisconsin Medicaid's fiscal agent, will also check for unreported coverage through the automated

insurance disclosure process. This system matches recipient IDs against the databases of health insurance companies. When previously unreported insurance coverage is discovered, EDS will inform the worker who will close BadgerCare coverage with timely notice. If the recipient knowingly withheld this information, Medicaid fraud prosecution will be considered.

Persons who have access to employer health insurance that meets HIPAA standards and for which the employer pays 80% or more of the cost are ineligible for BadgerCare. In addition, any person who has access to health care coverage for a Wisconsin State employee, will be ineligible for BadgerCare. Because the “access” issues are complicated, workers ~~will~~ certify BadgerCare and then EDS ~~will~~ checks with the employer to see if “access” exists, the amount of the family group health plan premium and the percent paid by the employer.

7. Income

The same income availability and exemption policies ~~are will be~~ used for BadgerCare that are used for AFDC-related Medicaid.

The same deductions will also be made to gross income in determining BadgerCare total family income as are for AFDC-related Medicaid, including:

- \$50 Child Support Disregard
- \$90 Work-related Expense Deduction
- \$175/\$200 Dependent Care Deduction

For farm and self-employment income, depreciation ~~is will be~~ added back into the family's net income to arrive at total family income.

8. Income Limit

For new applicants, total family income ~~is will be~~ tested against 185% of the federal poverty level (FPL). If total family income does not exceed 185% of the FPL, the family meets the income requirement.

For families that have been confirmed as eligible, and have chosen to participate in BadgerCare, the family can remain eligible as long as their total family income does not exceed 200% of the FPL. A family that has become ineligible for one calendar month is considered a new applicant.

9. Calculating the Premium

BadgerCare eligible families with total family income ~~equal to or~~ greater than 150% of the FPL ~~will~~ pay a premium. The premium ~~is will be~~ calculated

based upon their total family income and will be ~~between 3% to 3.5%~~ of total family income. Total family income has the same definition used for AFDC-related Medicaid, as described in the Income section of this chapter.

Family premium calculations will exclude self-identified American Indian/Alaska Native (AI/AN) children. Procedures for self-identification are being developed with the Wisconsin Tribal Health Directors.

~~This waiver continually refers to the premium share as being a range between 3% and 3.5% of family income. A range is used because the Wisconsin statutes that authorized BadgerCare allow the Department to charge more than 3%, up to 3.5%, if additional money is needed to fund BadgerCare, subject to approval by the Wisconsin legislature's Joint Committee on Finance.~~

10. Assets

Although BadgerCare has no asset test, asset information must be collected in order to complete the mandatory Medicaid eligibility test. The application ~~will~~ includes a question that asks the family whether their total assets (a short definition will be included) exceed \$1,000 (the asset limit for AFDC-related Medicaid). If the answer is affirmative, no asset information ~~is will be~~ collected or verified.

11. Fair Hearing

There ~~are will be~~ safeguards to assure that each applicant and participant is treated fairly and equally. The fair hearing/grievance procedure used in Medicaid ~~has been will be~~ extended to BadgerCare.

12. Notices/Letters

A notice ~~is will be~~ generated by the CARES system whenever eligibility is approved, denied, or redetermined. The notice ~~is will be~~ sent on a timely basis, meaning that any negative change cannot occur to the eligibility of the household without receiving a notice at least ten calendar days prior to the action taking place.

13. BadgerCare and Providers

As in the current Medicaid program, each individual ~~will~~ receives a card indicating coverage. ~~We expect to implement a~~ A magnetic stripe card ~~has been at about the same time BadgerCare is implemented. The magnetic stripe card will be~~ and is used for both BadgerCare and Medicaid.

All but two of the 18 current HMOs have met the January 1, 2000, through December 31, 2001, certification requirements. Medicaid providers will be certified as eligible to provide services and goods to

~~BadgerCare participants. All current HMOs will also be certified for BadgerCare if they continue to meet Wisconsin Medicaid's contractual requirements.~~

~~Providers have been will be informed of the expansion of Wisconsin's health care program with BadgerCare. The Department will alert them to the pending implementation of BadgerCare and how it will affect their business practices.~~

14. Cost-Sharing

Families with income ~~at or~~ above 150% of the FPL must pay a monthly premium of 3% ~~to 3.5%~~ of family income. Premium shares are to be collected through wage withholding or an alternative, automated system. Only one premium share will be assessed per family. The frequency of premium collection ~~is still being determined, but will likely~~ be monthly.

Premiums will not be required for American Indian/Alaska Native (AI/AN) children. Procedures for self-identification of AI/AN children are currently being developed with the Wisconsin Tribal Health Directors.

As in the current Medicaid HMO program, BadgerCare ~~does will~~ not have copayments or deductibles.

All populations currently eligible for Medicaid receive benefits without paying a premium share. These populations include:

- All AFDC-Medicaid and AFDC-related Medicaid-eligible individuals;
- Low-income pregnant women and children under age six with family income less than 185% of the FPL (under Healthy Start); and
- Children up to age 15, who are born after September 30, 1993, in families with income less than 100% of the FPL (under Healthy Start). (Under BadgerCare, the age of children in this group would increase from 15 to 19.)

Through the expansion, BadgerCare extends coverage with no premium share to all low-income families with children at or below 150% of the FPL. Cost for families newly-eligible through BadgerCare will be required for:

- Families with income between 150% and 185% of the FPL.
- Families with income between 185% and 200% of the FPL.

15. Payment and Non-Payment of Premiums

For applicant groups, eligibility for BadgerCare is determined for the application month and the next month. If a premium is required, the applicant must pay the premium for month two only. Month one coverage is 'free,' but requires payment of month two in order to qualify. The first month's premium is given to the eligibility worker. All other payments are sent directly to a centralized premium collection site.

For recipient groups with a premium (who choose to pay directly), the State sends a 'coupon' that lists the amount of the premium, when it is due, and a self-addressed envelope. Recipients ~~are will be~~ asked to send payment to a centralized premium collection site using the state-provided addressed and stamped envelope by the 10th of the month prior to the month for which the premium is owed. For example, the premium for July 1999 is due on June 10, 1999. If the payment is not received, a warning letter is sent out at Adverse Action (13 working days before the end of the calendar month) of that month, i.e., June. The warning letter merely alerts the group that no payment has been received and that payment needs to be sent soon. If no payment has been received by Adverse Action of the month for which the payment is required, (i.e., July) the state will terminate BadgerCare eligibility for all group members at the end of that calendar month. Non-expansion Medicaid eligible group members will not be affected. If payment for that month (i.e., July) is not received before the end of the following calendar month (i.e., August), a restrictive re-enrollment period will be applied.

However, if the payment for a month (i.e., July) is received any time that month or the month following (i.e., August) the restrictive re-enrollment period will not be applied.

16. Restrictive Re-enrollment Period

In order to prevent adverse selection into BadgerCare, Wisconsin has devised a restrictive re-enrollment period (RRP). For those families who have been determined and confirmed as BadgerCare-eligible and who are premium payers, when that family fails to pay their premium within the allotted time period, the family will not be allowed re-enrollment into BadgerCare for six calendar months. Good cause reasons, however, ~~have been will be~~ specified to allow the family to re-enroll. For example, if the family's premium failed to be received at the centralized premium collection center because of some administrative error (bank, employer, state's), BadgerCare eligibility would be restored. Similarly, if a significant change in household composition occurred, BadgerCare eligibility could be restored at that time.

17. Adding Choice to the System

For families who are not involved with W-2, adding new sites to apply for health care coverage will improve access to health care for persons who may otherwise not hear about the availability of BadgerCare.

To support these new intake options, a new short application form will be developed for families who only want to apply for health care coverage.

After pilot testing later this year, it will be widely available through employers, health care providers and community-based agencies, and well as through the Internet.

All completed applications ~~are will be~~ entered into the CARES system for processing and BadgerCare eligibility determination. CARES systems changes ~~are will be~~ necessary to support these new intake options, and will be developed as a second phase of BadgerCare implementation.

The proposed system reflects W-2 agencies that provide integrated and streamlined services to applicants, regardless of their status as public or private agencies. It also includes the new intake options for families to provide mail and phone access. ~~We believe that~~ These improvements in service delivery ~~will~~ ~~could~~ greatly improve access to the Medicaid program, ~~and as well as~~ provide a solid foundation for the outreach, eligibility and enrollment functions in BadgerCare.

~~18. Outreach Efforts~~

~~a) Outreach Plan~~

~~The outreach program for BadgerCare will complement and build upon current Medicaid outreach initiatives that are underway to respond to federal welfare reform. This plan has been developed over the past year with significant public input.~~

~~Our goals in developing the outreach plan are to:~~

~~Support and enhance the implementation of W-2.~~

~~Assure the participation of eligible families in Medicaid and BadgerCare.~~

~~Invest in proven activities that will support access to health care for families.~~

~~Improve the health status of the Wisconsin population.~~

b) ~~Public Information Campaign~~

- ~~— A comprehensive and coordinated effort is underway to assure that accurate information is available to recipients, agencies that work with them, as well as to county and W-2 agencies, about the impact of welfare reform on Medicaid eligibility. This public information campaign will provide the platform for BadgerCare. It will be coordinated with the extensive marketing effort underway with the implementation of W-2 to connect with the business community and employers around the state.~~
- ~~— A new recipient brochure describing the differences between W-2 and Medicaid has been distributed (over 300,000 printed), accompanied by an order form and poster. An updated Medicaid brochure is now in the final stages of review; the themes and information in this brochure will also be used for bus posters, radio ads, and a television media campaign. The campaign will be updated to incorporate BadgerCare, once approval is granted.~~
- ~~— A direct mailing to current and former Medicaid recipients occurred in the spring of 1998 to assure that all have accurate information about the changes undertaken in the welfare system and how to take advantage of health care coverage available through Medicaid.~~
- ~~— Fact sheets describing various Medicaid program components are being developed as the base for various informational materials and for training. This technique will also be used to support BadgerCare implementation. Fact sheets have been developed on a range of topics, such as Newborn Eligibility, SSI Medicaid, Immigrants, Presumptive Eligibility, and Backdating Eligibility. These will be published on the Wisconsin Medicaid site on the Internet, and used as the basis for provider bulletins and computer based mini training courses on various topics of interest to agencies, employers and health care providers that work with families who may be eligible for these programs.~~
- ~~— Materials for beneficiaries are tested with focus groups, and translated as appropriate, into Spanish and Hmong, and existing advocacy networks and mailing lists are continuously updated to assure timely and accurate information about the impact of welfare reform.~~

c) ~~Training~~

- ~~— New training materials and presentations on Medicaid eligibility are under development, and will be one vehicle for BadgerCare training.~~

~~Training for health care providers will be developed and offered by the state's fiscal agent and HMO enrollment contractor. Training packages that can be used by other groups to reach their members will be available, for example, for staff of medical clinics and school nurses. Training for advocacy groups and community based agencies will be developed and offered by Automated Health Systems, Inc., the Wisconsin Medicaid program's enrollment contractor, using regional managed care forums as well as other venues.~~

~~Training for workers in W-2 and county agencies will be coordinated with and offered through the Department of Workforce Development.~~

~~d) Case Specific Problem Resolution~~

~~Wisconsin has included a problem resolution component in our outreach plan to provide one on one assistance to current and former recipients having problems accessing and navigating the changes in W-2 and Medicaid. Service offered at a toll free number operated by the state is being expanded to include the capacity to research cases on both CARES and the MMIS, and to follow up with county agency staff to get case problems resolved.~~

~~In addition to improved services to recipients and advocates, a redesign of state level help desk functions for county and W-2 staff has been completed. A new Call Center is in operation at the Department of Workforce Development, with expert back up on Medicaid issues provided by staff of the Medicaid program. This service will be coordinated with the 800 number currently available to recipients and advocates.~~

~~e) Community-based initiatives to complement the statewide activities~~

~~Support for regional and local outreach initiatives that compliment the statewide outreach plan will also be provided, working with the county, tribal, and public health network throughout the state. The goal is to have a plan developed for each of the Department of Health and Family Services regions to reflect the interests and priorities of the communities within the region. Groups involved include local public health agencies, county and W-2 agencies, advocacy and community based agencies, and the regional staff of the Departments of Workforce Development and Health and Family Services.~~

~~The regional plan will include specific strategies to assure access to the Medicaid program for priority populations, including tribal agencies.~~

~~f) Outstationing of Eligibility Workers~~

~~With the separation of automatic Medicaid eligibility from cash assistance, and the implementation of W-2, the expansion of sites to apply for Medicaid will help to facilitate coverage of all eligible populations and also provide another avenue for BadgerCare applications.~~

~~A unit of ten Milwaukee County eligibility workers will be outstationed at new sites at health facilities and other community locations that serve families who may be eligible for Medicaid. The workers will have access to the CARES system to process applications and determine Medicaid eligibility.~~

~~The state is also working with groups in several other areas of the state who are exploring outstationing options, and outstanding initiatives are also underway in many other counties.~~

18. Outreach Efforts

a) Outreach Plan

The Department of Health and Family Services (DHFS) has made a sustained commitment to assure that the residents of Wisconsin are informed about the Wisconsin Medicaid/BadgerCare program. The resulting outreach campaign was designed to complement key strategies of the Department in promoting a healthy population which includes:

- Extending health care coverage to uninsured working families by program and policy changes such as BadgerCare, which expands Medicaid coverage for families with income at or below 185% of the federal poverty level;
- Establishing a health home and access to quality preventive services through statewide expansion of managed care;
- Supporting “Healthy Community” initiatives under the leadership of the state’s public health agencies; and
- Removing barriers to program utilization.

b) Public Information Campaign

Wisconsin’s marketing campaign was designed to provide Medicaid/BadgerCare program information in a variety of formats to a wide audience throughout the state. Over the past two years DHFS has implemented a plan to provide Medicaid information to the public

followed closely by a public information campaign about BadgerCare. The following kinds of informational efforts were used to inform people about Medicaid and BadgerCare: Brochures, Posters, Buttons and “Seat Belt Pals”, Radio ads, Print media ads, Bus Posters, TV spots, and the DHFS Internet website.

The following is a listing of the major efforts in this area, with product distribution, and findings where measurable:

- *Brochures and Other Promotional Products*
 1. W-2 and Medicaid brochure, to explain the difference between the programs and that Medicaid is an entitlement. Distribution statewide of more than 600,000 brochures in English, Spanish, and Hmong.
 2. A brochure entitled “*Need Help Paying for Your Children’s Health Care*” were distributed in spring of 1999. Distribution statewide of more than 600,000 brochures in English, Spanish, and Hmong.
 3. BadgerCare brochures have been distributed with the message that the program provides health insurance for working families. More than 850,000 copies (also in Spanish and Hmong) have already been distributed to a statewide mailing list that includes health care providers, public health departments, advocacy and other community organizations, economic support agencies, and school systems.
- *Direct Mail*

DHFS conducted a direct mail campaign in the spring of 1998 to 18,000 families whose AFDC case closed for reasons such as “family request” or “lack of review”. Informational telephone surveys of the larger social service agencies provided information that the mailing did not have a significant impact on Medicaid applications. In addition, caseload data does not show any increase in applications during the time period of the mailing.

- ***TV and Radio Ads***

1. **Birthday Party Ad.** A TV ad called *"The Birthday Party"* promoting the importance of health insurance for children has been in use in Wisconsin since early 1999, encouraging families to explore Medicaid coverage for their children. This ad has been updated to describe the coverage now available under BadgerCare.
2. **BadgerCare Ad.** An ad featuring Wisconsin Governor Tommy G. Thompson introducing BadgerCare was broadcast in the state's five major media markets during July 1999. The ad reached over 90% of the target audience, adults ages 25 – 45. During the first three months of BadgerCare implementation the Milwaukee BadgerCare hotline logged over 8,000 calls. When asked how they heard about BadgerCare, about 34% responded that they had seen the ad on TV, the single largest response group.
3. **Spanish TV and Radio Ads.** In response to demand for customer service in Spanish, DHFS ran TV and radio ads in the southeastern part of the state (Milwaukee, Waukesha, Racine, and Kenosha). Applications for Medicaid/BadgerCare increased at local community organization/outstation sites as a result of this effort.

- ***DHFS Internet Site***

Medicaid/BadgerCare brochures, fact sheets and other products have now been included on this site. Other recent additions are caseload information reported both by county, and statewide, to permit tracking of monthly participation; and demographic reports describing the Wisconsin population that is below 200% of poverty and uninsured, to help inform outreach efforts.

c) **Training**

Wisconsin has made a significant investment in training on Medicaid and BadgerCare eligibility for both eligibility workers and for staff of agencies that work with potential applicants, including W-2 agencies, advocates, public health and health care providers. A new series of courses for eligibility workers on Medicaid eligibility was launched in 1997 as welfare reform program changes fundamentally changed the way in which Medicaid eligibility was determined.

Training courses for local Medicaid eligibility staff were designed and closely coordinated by the Department of Health and Family Services and the Department of Workforce Development. The following courses were given throughout the state at regional training centers: AFDC Medicaid, Family Fiscal Unit, Healthy Start, Institutional Medicaid, Medicaid Basics, Medicaid Advanced, Medicaid Deductibles, Medicaid Extensions, SSI-Related Medicaid, and Medicaid Management Information Systems. A total of 347 training sessions were held with a total participation of 4,383 participants who rated the sessions with an overall evaluation of 4.3 out of 5 (5 being the best).

DHFS directed and supported six unique training efforts for BadgerCare implementation:

1. A two-day intensive course for eligibility workers who process BadgerCare applications.
2. A one-day basics course for staff who are responsible for W-2 program.
3. A shorter basics course for other Income Maintenance (IM) and W-2 agency staff, such as resource specialists and receptionists.
4. BadgerCare Basics for staff of community-based organizations, health care providers, public health departments, advocacy agencies and others, offered by Automated Health Systems, Inc., the state's enrollment contractor for managed care.
5. The Wisconsin Primary Health Care Association, in collaboration with staff of the Marshfield Clinic, provided a course to the staff of Federally Qualified Health Centers around the state who process Healthy Start applications, so they can also process BadgerCare applications.
6. The Great Lakes Intertribal Council offered training sessions for staff of the tribal health centers who perform outreach and benefit counseling services.

Eligibility staff attendance for BadgerCare training totaled 1,368 participants who rated the training very high (4.1 out of 5, with 5 being the best).

The HMO enrollment contractor, Automated Health Systems, Inc. trained 1,654 participants on Medicaid and BadgerCare basics. The sessions were conducted around the state and included a wide variety

of agencies: Public health agencies, WIC agencies, school staff, preschool staff, child care agencies, health care providers, HMOs, utility company staff, legal service agencies, insurance agencies, dental providers, Hmong agencies, Spanish agencies, food pantries, homeless shelters, employment and training agencies, elderly agencies, tribal health agencies, adoption agencies, federal agencies (including HCFA staff), and members of the faith community. To date the agency has trained 1,654 participants with very positive evaluations.

d) Problem Solving Services

The Medicaid/BadgerCare Recipient Services hotline (1-800-362-3002) operated by the state's fiscal agent now provides expanded services and new evening and weekend hours. In addition to general program information, callers get assistance in how and where to apply for Medicaid and BadgerCare and help in resolving case problems. Staff at the hotline provide trouble-shooting services and research case-specific problems, including computer systems issues. These services are now available weekdays until 9 p.m. and all day Saturday. The hotline averages about 1,000 calls each day.

In addition to the statewide services, specialized services for customers in Milwaukee County are being offered during the start-up of BadgerCare. Staff at the Milwaukee hotline (1-888-947-4600) have been trained to mail out application materials to families and to assist families in navigating the eligibility determination system in Milwaukee County, which represents about one-third of the statewide Medicaid caseload. This hotline averages 500 calls per week.

e) Community-based initiatives to complement the statewide activities

Funds have been provided to economic support agencies for outreach, including outstationing of eligibility workers; to tribal health care agencies; public health departments; and community agencies for targeted outreach activities for Medicaid and BadgerCare. The funding is intended to support the efforts of these agencies to inform the community, to coordinate local initiatives, to build an infrastructure for improved service delivery at the local level, and to find and enroll families in Medicaid/BadgerCare as well as other types of supportive services programs such as Food Stamps and Child Care. The target population for these efforts is low-income working families and immigrant families.

- ***County and Tribal Economic Support Services.*** Administrative funds were awarded in April 1999 to counties and tribal agencies. The purpose was to support the new costs associated with BadgerCare, including case processing, premium collection and planning and coordinating local outreach initiatives, such as outstations.
- ***Public Health Agency Demonstration Projects.*** Medicaid outreach funds were allocated by formula to 140 local public health agencies. The grants extended from July 1, 1998 to September 30, 1999. In addition, funding was also allocated to hire five regional outreach specialists. These regional staff were assigned to provide technical assistance to local efforts; work with schools to identify uninsured children; and monitor the local departments' contracts. The major work efforts of public health agencies were:
 1. ***BadgerCare "OBRA Teen" Campaign.*** The Division of Public Health served as the state's lead agency in news media promotion of the April 1, 1999, start for extending BadgerCare to low-income teens. The DPH crafted a news release used by 11 newspapers statewide, with readerships of about 92,000. As of November, the enrollment category had exceeded 4,000.
 2. ***Healthy Start Outreach.*** Outreach for Healthy Start, a marketing name for Medicaid coverage of certain pregnant women and children, reached all-time high enrollments for five consecutive months during the outreach funding period. Enrollment has risen by nearly 10 percent in 1999 and now exceeds 88,000. More than 412,000 Healthy Start brochures were distributed during the grant period.
 3. ***"Back to School" Initiative.*** Promoting BadgerCare and Medicaid among Wisconsin's nearly 1 million school children, DPH staff pursued promising strategies favored by outreach advocates nationwide.
 4. ***Medicaid Outreach Funds Targeted to Immunization Activities.*** Medicaid outreach funds were used by local health departments for education and outreach activities to educate and refer families involved in immunization for Medicaid eligibility.

f) **Outstationing of Eligibility Workers**

Outstationing demonstration projects were conceived with several goals - increase the number of Medicaid recipients, and improve customer service. Outstationing is generally considered a community-based initiative and its success is the result of reaching into community neighborhoods and immediately determining program eligibility. In conjunction with improved administrative and operational rules for the health care coverage programs, the CARES system is accessible through technology provided by laptop computers, portable printers and cellular telephones.

Eight Wisconsin counties were involved in some kind of outreach and outstationing project. These are: Milwaukee, Dane, Kenosha, Sheboygan, Monroe, Fond du Lac, Oneida, and LaCrosse. Three counties, Milwaukee, Dane and Kenosha manage comprehensive service models.

As of February 2000, Wisconsin had over 70 outstationing sites, and the number increases on a regular basis. Attachment 2 is a state map of outstationing sites and the most current listing of sites for Milwaukee County. Most have personal computer sites with dial-up, real-time capability to the CARES application processing system. In addition, all outstation sites have the capability to enter an application on CARES from an applicant's home.

Outstationing has proven to be very successful. For the period of June 1, 1999 through September 30, 1999, 3,288 Medicaid applications were taken at over 60 outstation sites. Although, the majority of applications were for Medicaid many were also for other services such as food stamps, Child Care, etc. Outstationing has also generated significant inquiry activity. Between June 1, 1999, and September 30, 1999, 11,106 inquiries were made and of those contacts 4,288 application appointments were scheduled. During this time period a majority of the applications taken were for some form of Medicaid. Of the total 3,288 program applications taken, 2,596 (79%) were for Medicaid programs. In addition, the following results were derived from county, provider, and customer surveys:

- **Receipt of Program Information.** Forty-six percent of the customers surveyed stated they became aware of the outstation program through a medical referral, and an additional 20% stated they became aware of the program through word-of-mouth.

- **Assistance Program Requests.** Forty-six percent of the customers received Medicaid services followed by 24% – food stamps, 6% – Child Care, and 14% - W-2 services.

Expansion of Healthy Start Outstationing. Starting in July DHFS expanded initial application receipt activities at the Healthy Start sites to include eligibility for Family Medicaid and BadgerCare. The sites include all Federally Qualified Health Centers and Disproportionate Share Hospitals throughout the state. This activity was done as a demonstration leading to further expansion to other sites next year.

g) Outreach Effectiveness -

The successful implementation of BadgerCare as both a S-CHIP initiative as well as a Medicaid enrollment initiative can be traced to the following outreach strategies. The specifics on each are listed above.

- 1. Statewide capacity building.** This effort (laying the foundation for BadgerCare) was started two years before program implementation. This was accomplished through a series of general training efforts for community organizations about Medicaid and technical training sessions for income maintenance agencies. In addition, outreach grants to public health agencies and advocate agencies increased collaboration at the local level, in particular in large urban areas such as Milwaukee, Kenosha, and Madison. These educational and collaborative efforts laid the groundwork for the outreach efforts needed for BadgerCare.
- 2. Outstationing of eligibility staff and FQHC outstationing expansion.** Both outstationing efforts increased program access points for customers and expanded the DHFS customer service model.
- 3. Program start-up funding.** Additional funding for local social service agencies before BadgerCare implementation allowed for effective local planning to deal with caseload increases.
- 4. Training.** Similar training efforts for BadgerCare as were completed for Medicaid provided useful information for social service agencies for eligibility decisions and provided community groups the information to deliver effective outreach.

5. **Name change important.** The program name was changed from Medicaid to BadgerCare. This change sent a message to new applicants that health insurance for low-income working families was no longer associated with welfare. One family, at the end of the application process, inquired about also applying for life insurance. This illustrates that many families do not view BadgerCare as welfare, but rather as health insurance.
6. **TV promotion at program start-up.** One of the most cost-effective strategies we found to reach a target audience about a product is through television advertising. A well-organized TV campaign with an upbeat ad featuring Governor Thompson, encouraging working families to apply for BadgerCare, delivered program information to about 90% of our target group.
7. **Outreach efforts for all family members.** The BadgerCare policy that provides coverage for parents as part of the program has created an additional incentive to bring new families into the application process. This is illustrated by the increase in the Healthy Start caseload (the application rate has doubled since July) with the implementation of BadgerCare. Households attracted by outreach efforts that appealed to all family members completed the process. Since most of these families are low income, the younger children are eligible for Healthy Start. BadgerCare brought these families in to the program.

h) Systems changes

The way in which the automated systems for eligibility determination interface with the customer are very important to the customer. These systems can be a barrier to understanding eligibility in relation to a case-specific situation, so efforts are underway to address some of these concerns as part of the state's outreach plan. Major changes have been made to the Wisconsin system to implement W-2 and to separate Medicaid eligibility determination logic from the old AFDC program logic in this system (called CARES).

Modifications were also made to the CARES screens that are used to identify the programs being requested, so that it is now assumed that an applicant wants to apply for Medicaid along with the application for other programs supported by CARES (i.e., W-2, Food Stamps, and Child Care).

Improvements to recipient notices generated by CARES have been included on the CARES work schedule as one component of the state's outreach strategy.

Options for expanding the hours of availability of the CARES system for county agency workers have been implemented to provide more flexibility to accommodate the needs of working families.

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B. Coordination With Private Health Insurance

1. Insurance Verification and the Eligibility/Enrollment Process

The eligibility determination and enrollment process ~~will~~ includes a number of checks to prevent the crowd-out of employer health care coverage described below:

a) Application Process with Focus on Employer Health Insurance Verification:

- Applicants ~~are will~~ initially ~~be~~ screened for BadgerCare eligibility.
- Family members are only eligible for BadgerCare if:
 - They are not enrolled in any health insurance plan as defined in HIPAA;

- They have not been enrolled in a health plan meeting HIPAA criteria during the past three months; and
 - They do not currently have *access* to an employer-subsidized plan in which the employer pays 80% or more of the premium cost for family coverage.
- Applicants who currently have coverage or access to employer health insurance ~~have been will be~~ informed that they may still apply for Medicaid.
 - At the time of application, family members who state they meet the insurance-related eligibility criteria listed above ~~can be~~ made eligible for BadgerCare benefits on a fee-for-service (FFS) basis, pending verification of their insurance status.
 - Families members or entire families who state they currently have *access* to employer family health care coverage subsidized at less than 80% of the premium cost, ~~are will be~~ eligible for BadgerCare benefits on a FFS basis, pending verification of access to employer family health care coverage.
 - If a family currently has *access* to employer health care coverage subsidized at more than 60% but less than 80% of the premium cost and have not been covered in last six months, they may be eligible for BadgerCare through the Health Insurance Premium Payment (HIPP) Program. This program ~~will~~ pays the employee's cost of private health insurance, including the employee's premium share, coinsurance and deductibles, if it is more cost effective than providing services directly.
 - If HIPP is determined to be cost-effective, then families ~~are will be~~ required to accept their employers' coverage as a condition of BadgerCare eligibility and ~~are will not be~~ allowed to reject their employers' coverage and enroll in BadgerCare directly instead. However, families who qualify for the HIPP Program ~~are will also be~~ eligible to receive wraparound services that are covered by Medicaid or BadgerCare, but are not payable by the private health insurance plan.
 - If it is not cost-effective to purchase the employer-subsidized insurance, family members ~~are will be~~ enrolled in BadgerCare.
 - For those families in which there are some members who qualify for Medicaid and others who qualify for BadgerCare, e.g., a pregnant woman or children who qualify for Healthy Start, and a father who has access to employer-subsidized health insurance coverage subsidized at less than 80% of the premium cost, the BadgerCare eligible members ~~will~~ receive BadgerCare FFS benefits pending

verification of access to employer health care coverage and qualification for the HIPPP Program.

- EDS ~~will~~ checks access to family group health insurance for all BadgerCare eligibles.

b) Verification of Employer Insurance:

- EDS ~~will~~ receives daily notifications of BadgerCare applicants from the CARES system. EDS ~~will~~ contacts the employers of all applicants to verify current coverage or coverage within the previous three months of verify family health insurance meeting HIPAA standards and for current access to family health insurance subsidized by the employer at 80% or more of the premium cost. Verification ~~is will be~~ done through mailing Employer Verification of Insurance Coverage (EVIC) forms to the employers.
- If the verification shows that BadgerCare family members are currently covered or were covered within the past three months by an insurance plan meeting HIPAA standards, or currently have access to such a plan subsidized at 80% or more of the premium cost, eligibility for BadgerCare ends.
- If the verification shows that BadgerCare family members currently have no coverage nor had coverage within the previous three months to family health insurance through the employer, and they currently do not have access subsidized at 80% or more of the premium cost, they ~~will~~ continue to receive BadgerCare benefits on a FFS basis while selecting an HMO. An HMO enrollment packet ~~is will be~~ sent to them by mail.
- If the verification shows that BadgerCare family members have access to employer family health insurance coverage subsidized at less than 80% of the premium cost, they continue to receive BadgerCare benefits on a FFS basis, pending qualification for the HIPPP Program.
- EDS ~~will~~ also collects information from employers to determine cost-effectiveness by mail, telephone, or FAX machine on an as-needed basis to supplement information received from the EVIC forms. The following information ~~is will be~~ collected and retained in the HIPPP Program database:
 - Length of employer health insurance coverage;
 - Employer payment frequency and method of payment;
 - Premium amounts;

- Employer contribution amounts and coverage; and
 - Who is covered under the insurance.
- For a discussion of the HIPP cost-effectiveness test, see Number 2 of this section ~~(page 32)~~.
 - EDS ~~will notify~~ the employee, employer, insurance company, if necessary, and the involved certifying agency of the cost-effectiveness decision and terms of the agreement.
 - EDS ~~will establish~~ a communication protocol with each employer regarding notification of the applicant's employment, coverage levels and premium amounts.
 - EDS ~~will monitor~~ employers' health insurance plans for open enrollment periods and will conduct an employer telephone inquiry to obtain the necessary cost-effectiveness information to facilitate insurance buy-in when available.
 - EDS ~~will gather~~ information regarding the applicant's access to and/or participation in the employer's health insurance plan beyond the previous three-month period for informational purposes only. EDS and state staff will monitor this information for crowd-out impact. (The impact of BadgerCare on employer-based coverage will be assessed as part of the overall evaluation of BadgerCare.)
 - EDS ~~will verify~~ health insurance coverage through the existing insurance disclosure process with insurance carriers and telephone inquiries. EDS currently electronically receives insurance information from over 95% of the market share of insurance carriers in the state.

2. The Health Insurance Premium Payment (HIPP) Program -- Cost-Effectiveness Test

At this point, we have received verification that the family has access to employer-subsidized family health care coverage, subsidized at less than 80% but more than 60% of the premium cost. The family has been made BadgerCare eligible on a FFS basis. The next step is to determine whether it is cost-effective to buy them into the available employer-sponsored insurance through the HIPP Program ~~or through the Title XXI cost-effectiveness test~~. If it is not cost-effective, the family ~~will~~ chooses between the BadgerCare HMO programs available to recipients living in their service area.

Employers ~~are will be~~ contacted to obtain specific information about their insurance plans so that:

- Cost effectiveness can be determined. EDS ~~will~~ determines the cost of the family premium, how much the employer pays, and what types of services the plan covers.
- Premium payments can be made. EDS ~~will~~ determines whether the employer, insurer or recipient will be reimbursed, as well as frequency and payment method.
- Full insurance information can be added to the recipient's eligibility record for coordination of benefits activities in claims processing. This information ~~would~~ includes group and subscriber numbers, begin and end dates of coverage and indicators of services covered by the plan.
- The following information is ~~will be~~ collected and retained in the HIPP Program database:
 - Length of employer health insurance coverage;
 - Employer payment frequency and method of payment;
 - Premium amounts;
 - Employer contribution amounts and coverage; and
 - Who is covered under the insurance.
- Families in Wisconsin ~~are will only be~~ eligible to participate in HIPP if:
 - they had no employer-sponsored group coverage within the previous six months (exceptions are allowed if prior coverage was involuntarily terminated by other than the current employer), and
 - the employer contributes at least 60%, but less than 80%, of the premium share for family coverage (families whose employer contributes more than 80% of the premium share are not eligible for BadgerCare).
- When the information needed for the cost-effectiveness determination is received, the cost effectiveness comparison is made between:
 - The cost of BadgerCare HMO enrollment for the family children (plus certain additional services covered on a FFS basis, such as family planning, dental, or chiropractic), up to the full Medicaid level of services; and
 - The cost of the BadgerCare portion of the employer-subsidized insurance premium (including the cost of co-insurance and deductible reimbursement to the providers), plus the cost of wrap-around services to provide the full Medicaid level of services. In addition, the state may include administrative costs for data collection, processing,

notifications, telephone charges and other maintenance costs of the HIPD process in its cost effectiveness calculation.

- If cost of ESI is less than enrollment of the family children only in BadgerCare, the state will claim costs for purchase of ESI under Title XXI for both adults and children.

~~➤ Another calculation will be made to compare costs of ESI vs. enrollment of the family in BadgerCare. If ESI is less expensive, the state will charge adults at regular FMAP.~~

- If BadgerCare subsidizes employee participation in employer health care plans that do not cover the same benefits as Wisconsin Medicaid, the State will provide wraparound coverage to bring the employer-subsidized benefit package up to the Medicaid benefit level. Medicaid coordination of benefits and claims processing system currently allows wraparound services to be paid on a FFS basis. This ensures Medicaid recipients with private health plans receive the full Medicaid benefits package, at Medicaid payment levels, through wraparound services. Medicaid billing instructions inform providers how to get paid for services not covered by private insurance.
- The estimated additional fee-for-service costs for a family in a BadgerCare HMO ~~is will be~~ based on FFS claims history for recipients in Medicaid AFDC-related/Healthy Start programs without other insurance on file. The estimated wrap-around costs for those with private health insurance coverage ~~is will be~~ based on claims history for AFDC-related/Healthy Start FFS recipients with similar private insurance coverage on file.
- The classification of employer-subsidized plans ~~is will be~~ made possible when the employer provides the requested insurance benefits information. ~~It is anticipated that the c~~Coverage areas ~~will~~ either match the coverage flags in use on the insurance segments on Medicaid eligibility files (e.g., drug, physician and dental), or broader categories (e.g., major medical, major medical plus drugs, managed care).
- If the cost comparison shows that it is not cost-effective to buy in to the employer's health insurance plan, the family selects an HMO. However, in the interest of maximizing the use of private insurance, it is possible that if the cost comparison shows it is only slightly more expensive to purchase private coverage, we may approve the buy-in.
- If the cost comparison shows that it is cost-effective to buy in to the employer's health care plan, procedures for paying for the premiums, coinsurance, deductibles, and wrap-around services ~~are will be~~ implemented. As soon as the recipient is enrolled in the employer-

subsidized plan, the insurance segment will be added to the eligibility file, and cost avoidance of claims ~~will~~ occurs. In addition, premium payments ~~are will be~~ made to the employer, insurer or recipient. At that point, the BadgerCare eligibility file will reflect the insurance, and providers will be able to bill BadgerCare for the applicable coinsurance and deductibles in addition to wrap-around services. Provider billing instructions **have been** ~~will be~~ issued to notify providers how to bill for wraparound services.

3. Mechanisms to prevent “crowd-out”:

a) Background

Title XXI includes a number of provisions reflecting Congressional concern about the potential for Title XXI to supplant private sector health insurance coverage. The Department shares these concerns and ~~will has~~ incorporated a number of measures into BadgerCare to prevent crowd-out.

b) Current BadgerCare Measures to Control Crowd-Out

The BadgerCare program ~~will~~ includes the following measures to control crowd-out:

- Applicants who have coverage under an employer’s group health insurance plan as defined in HIPAA would not be eligible for BadgerCare.
- Applicants who have access to family health insurance subsidized by an employer at 80% or more of the premium cost, will not be eligible for BadgerCare.
- Wisconsin ~~intends to~~ regards applicants who currently are covered or were covered during the three months prior to application under employer family health insurance as ineligible for BadgerCare. However, exceptions will be made where prior coverage ended due to reasons unrelated to the availability of BadgerCare. These reasons ~~will~~ include, but are not limited to:
 - Loss of employment due to factors other than voluntary termination;
 - Change to a new employer that does not offer coverage;
 - Change of address so that the individual is now outside the employer-sponsored insurance plan’s service territory;
 - Discontinuation of health benefits to all employees by the applicant’s employer; and

➤ Expiration of COBRA coverage period.

- The Department intends to purchase family coverage made available by the employer of any member of an eligible family. This will occur when the Department determines that purchasing the employer coverage would be more cost-effective than providing the coverage directly under BadgerCare.
- The Department will not buy-in to employer insurance when the employer pays less than 60% of the premium.
- Participating families with incomes ~~at or~~ above 150% of the FPL can be assessed a premium cost share of 3% ~~to 3.5%~~ of their monthly family income. **Family premium calculations will exclude self-identified American Indian/Alaska Native (AI/AN) children.** **Procedures are currently being developed with the Wisconsin Tribal Health Directors.**
- The Department ~~will~~ limits eligibility to those families whose income does not exceed 185% of the FPL. Employer-subsidized health insurance is not common among families with income this low.
- A provision of 1995 Wisconsin Act 289 required Wisconsin employers offering employee health insurance to include all employees. This was designed to prevent employers from offering a health insurance plan to only higher-compensated employees.
- **Legislation passed in Wisconsin** ~~has legislation pending to~~ created a small employer insurance pool.

c) Additional Measures to Control Crowd-Out

While we believe the measures listed above will be sufficient to prevent crowd-out, implementation of BadgerCare ~~is~~ ~~will be~~ carefully monitored to assess any adverse impact BadgerCare may create for both employee use of employer-subsidized coverage, and employer reductions in offering coverage to workers. Monitoring ~~is~~ ~~can be~~ done using reports produced by the Department's Center for Health Statistics. If it appears additional measures are needed, the state is investigating the following mechanisms as additional tools to use in preventing insurance crowd-out:

- Establishing limited entry/enrollment periods for BadgerCare. This will encourage employees to purchase on-going medical care through employer-subsidized insurance, rather than depending on BadgerCare exclusively for episodes of ill-health.

- Enactment of insurance reforms to encourage coverage of all employees. Wisconsin intends to continue working with employers and the state Office of the Commissioner of Insurance to encourage broad-based health coverage of all employees.

C. Enrollment Process and Service Delivery System for BadgerCare

1. Current Medicaid HMO enrollment process.

All AFDC Medicaid, AFDC-related Medicaid and Healthy Start eligible recipients throughout the state are eligible to participate in Wisconsin Medicaid's HMO program.

Once eligibility is established, recipients receive an enrollment packet including the listing of available HMOs, how to choose an HMO and who to contact for assistance in determining if their current health care provider is participating in an HMO. Recipients may make a choice at any time within the process by sending in the enrollment form or contacting the enrollment contractor and enrolling over the telephone.

If a recipient has not chosen an HMO within two weeks of receiving an enrollment packet, a reminder card is sent encouraging them to send in their HMO choice form or contact the enrollment contractor for assistance. At the same time, the enrollment contractor is supplied the list of recipients who were sent reminder cards for the purpose of telephone and mail outreach.

If a recipient has not chosen an HMO after four weeks, the recipient is assigned to an HMO certified to provide services in the zip code the recipient resides. An enrollment form is sent with the notice of auto-assignment, giving the recipient a final opportunity to change HMOs if they are not satisfied with their assigned HMO. Recipients also receive a notice confirming enrollment in their assigned HMO for the following month. Recipients are covered FFS until they are enrolled into an HMO.

Recipients are auto-assigned to HMOs on a random and equal basis up to each HMO's enrollment limit. For example, if there are three available HMOs in a zip code, each will receive one-third of auto-assigned cases.

In addition, once the recipient is within their first three months of enrollment in an HMO, whether they have chosen or have been assigned, they still have the opportunity to change to a different HMO during that month.

2. BadgerCare Enrollment Process

As described in the eligibility section of this waiver **amendment**, Wisconsin ~~intends to~~ **has** streamlined the process to the extent possible to allow families to apply for Medicaid/BadgerCare at convenient locations and times.

Enrollment for BadgerCare ~~uses will utilize~~ the same enrollment process that is currently used for Medicaid. We believe it is necessary to have coordinated enrollment for both Medicaid and BadgerCare because we expect many families to have both Medicaid and BadgerCare eligibles. Like Medicaid, BadgerCare enrollees ~~are will only be~~ required to join an HMO if there are two or more HMOs in their county. In areas of the state that do not have HMO services available, BadgerCare ~~is will be~~ available on a FFS basis.

Recipients determined eligible for BadgerCare ~~are will be~~ provided a packet of informational materials regarding the plans available to them in their area and will be required to select an HMO. The enrollment date ~~is will be~~ the earliest possible month after a family has chosen an HMO. Recipients will be covered on a FFS basis until HMO enrollment is effective.

3. Enrollment Contractor

Wisconsin contracts with a statewide enrollment contractor to provide assistance, education and outreach to Medicaid recipients regarding the Medicaid managed care program. The enrollment contractor's role is to perform enrollment, education, outreach and advocacy for Medicaid managed care enrollees. The enrollment contractor is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. It is a resource for enrollees to receive help in making the appropriate choices and resolving problems. Recipients may call a 1-800-toll free phone number to obtain assistance in selecting an appropriate HMO or may have a face-to-face meeting at numerous outstationing sites across the state.

The state ~~has intends to~~ expanded the services of the enrollment contractor and **has** incorporated additional outreach and education functions to support enrollment for BadgerCare. These additional functions ~~will include~~ after-hours availability. ~~Currently the enrollment contractor is available by phone from 8:00 a.m. to 6:00 p.m. and in person at six regional sites from 8:00 a.m. to 4:30 p.m.~~ The current hours are 7:00 a.m. to 6:00 p.m., Monday through Friday for the call center. Six regional office sites, housed within county Job Centers and human services offices, are staffed to coincide with the Job Center's hours. The availability of enrollment staff at these county agencies ranges from 7:00 a.m. to 6:00 p.m., Monday through Friday. A total of seven full-time equivalents (FTEs) are regularly scheduled at the 70 outstation sites throughout the state. In addition, the

enrollment contractor staff co-locates with 30 county eligibility worker outstation sites throughout the state.

The enrollment contractor provided statewide training on BadgerCare eligibility basics for community-based agencies and advocates from July 14, 1999, through September 28, 1999. A total of 1,114 persons attended the training. A combined Medicaid and BadgerCare eligibility basics will be offered in the summer of 2000.

4. Disenrollments and Exemptions

Wisconsin Medicaid has short term and long term exemptions from HMO participation. In some situations a recipient may be exempt from joining an HMO. Exempted recipients receive FFS care for all Medicaid-covered services. Exemptions are granted to an individual who meets the specific criteria. The exemptions currently allowed for Medicaid will also be allowed for BadgerCare. See Appendix B of our January 21, 1998 BadgerCare waiver submission for a listing of HMO exemptions.

5. BadgerCare Delivery System

a) Wisconsin Medicaid Benefit Package

The Wisconsin Medicaid benefit package is among the most comprehensive and extensive in the nation. The BadgerCare benefit package ~~is will be~~ the same as the Wisconsin Medicaid benefit package. The service delivery system for BadgerCare ~~is will be~~ through HMOs built upon Wisconsin's current Medicaid managed care program. Wisconsin currently has a mandatory statewide Medicaid managed care program under the authority of a 1915(b) waiver.

As is currently the case under Wisconsin's Medicaid Managed Care program, HMOs under contract with the state ~~are will be~~ required to provide or prior authorize all primary care services and all necessary specialty services. The HMO is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted.

The following are Wisconsin Medicaid covered services for HMO enrollees that are provided and reimbursed on a FFS basis:

- Prenatal Care Coordination
- Targeted Case Management
- Common Carrier Transportation
- School-based services
- Tuberculosis-related Services

Dental and chiropractic services are optional services HMOs can elect to provide. If an HMO chooses not to provide dental and chiropractic services, BadgerCare and Medicaid recipients are eligible to receive them on a FFS basis.

b) Contract Requirements

Wisconsin's Medicaid HMO Program contracts only with HMOs that are licensed by the Wisconsin Office of the Commissioner of Insurance (OCI) under Wisconsin insurance law.

The state relies primarily on OCI regulations, reporting, audit, and enforcement procedures to assure the basic financial stability of contracting HMOs.

The current Medicaid HMO contract includes requirements for:

- Access to care (e.g., proximity of providers, availability of specialists, timeliness of care);
- Education and communication with recipients;
- Emergency care and 24-hour coverage;
- Grievance process;
- Provider appeals process;
- Marketing provisions;
- Cultural and ethnic responsiveness;
- Quality improvement; and
- Coordination and collaboration with community-based organizations.

The 2000-2001 HMO contract for Medicaid and BadgerCare has been reviewed by the HCFA Regional Office. Appendix C of the January 21, 1998 BadgerCare waiver submission contains the 1998-1999 Medicaid HMO contract. All safeguards and protections for recipients contained in this contract will also apply to all BadgerCare enrollees. Additional requirements and specifications, as necessary will be added through an amendment to the contract for BadgerCare.

c) Service Areas

The current, January 1, 1998, through December 31, 1999, Medicaid/ BadgerCare HMO contract is extended through March 31, 2000. The January 1, 2000, through December 31, 2001, Medicaid/BadgerCare HMO contract will be implemented on April 1, 2000, and will apply retroactively back to January 1, 2000. The AFDC, Healthy Start children and Healthy Start pregnant women capitation rates for Calendar Year 2000 will apply retroactively back

to January 1, 2000. The BadgerCare rates will apply back to July 1, 1999.

~~Currently, there are 18 of 24 licensed HMOs providing services to Medicaid in 70 of the State's 72 counties. Appendix D of the January 21, 1998 BadgerCare waiver submission contains a listing of the HMOs currently participating in Medicaid managed care, enrollment totals as of January 1998, and service area maps by each HMO.~~

For Medicaid, there must be two or more HMOs participating in a zip code in order for recipients who live in those zip codes to be required to join an HMO. If no HMO is available, BadgerCare recipients will receive benefits on a FFS basis. As noted earlier, qualified exemptions from HMO enrollment ~~are will be~~ available for BadgerCare recipients. Appendix D of the January 21, 1998 BadgerCare waiver submission contains a map and a chart of HMOs by county and Appendix B of the January waiver lists qualified exemptions.

d) Access

The HMO will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The HMO will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of the recipients enrolled in the plan.

Recipients will be restricted to receive services included under the waiver either from the HMO or from another qualified provider to whom the participant was referred by the HMO. The recipient's health care delivery will be managed by the HMO. HMO enrollment will enhance existing provider-patient relationships and establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery.

6. BadgerCare Quality Assurance System

a) Background

Wisconsin was one of the first states to contract with HMOs to provide health care services to Medicaid recipients. Rapidly rising costs, fragmented care delivery, and concerns about access to care and quality prompted a search for alternatives to the FFS Medicaid system. Since the inception of the Wisconsin Medicaid HMO program in 1984, many other states have followed Wisconsin's lead and have implemented Medicaid managed care programs.

b) General quality

BadgerCare ~~is will be~~ committed to assuring quality, access and choice to its participants and to being a proactive partner with the private sector in achieving the highest possible health outcomes for recipients. This ~~is will be~~ accomplished ~~using utilizing~~ a multi-pronged approach including a variety of monitoring and oversight activities and public forums. This multi-pronged approach is modeled on our current Medicaid HMO program which mandates extensive performance requirements, informal complaint and formal grievance processes, and a high degree of community-based involvement.

BadgerCare ~~will~~ includes several quality assurance mechanisms to evaluate and improve the quality of medical care provided to BadgerCare recipients. Every managed care organization under contract with the state ~~is will be~~ required to have an active quality assurance system, including designated quality assurance staff devoted to evaluation of the care provided to BadgerCare recipients.

The quality assurance activities carried out in BadgerCare ~~will~~ focus on specific medical service delivery concerns. These medical and service delivery concerns ~~will~~ include the following:

- Access to care;
- Timeliness of care;
- Appropriateness of care;
- Appropriateness of setting;
- Appropriateness of amount of care;
- Consistency with current standards of medical practice;
- Education and communication with recipients; and
- Ethnic and cultural responsiveness.

In addition, each BadgerCare managed care organization ~~is will be~~ required to demonstrate how the organization has attempted to improve care and service for BadgerCare recipients enrolled in their program. The state ~~will~~ monitors compliance with the contract standards for BadgerCare (as with Medicaid) in a number of ways:

- An independent contractor ~~will~~ reviews a sample of recipient medical records annually to determine the adequacy of care and services being provided. The documentation in the medical record ~~is will be~~ compared to specific criteria and standards developed by the Wisconsin Medicaid medical consultants with provider input.

Medical consultants who are specialists in the area under review will conduct a number of on-site administrative and clinical audits.

- Grievance audits and review of grievances received from recipients and providers will assure that the contracted managed care organizations are complying with the rules of BadgerCare.
- The Wisconsin Medicaid contract ~~will~~ continues to require each HMO to employ at least one full-time internal advocate for recipients to help ensure that the HMO remains responsive to recipients' concerns.
- HMOs ~~are will be~~ required to conduct and report the results of quality of care studies at least annually. These studies assess the quality of care in clinical priority areas.
- HMOs ~~are will be~~ required to submit data on performance indicators.
- Financial incentives to HMOs will be linked to health care outcomes.

c) Health Care Access and Outcomes

The Wisconsin Medicaid HMO program and its partners, the HMOs, recipients, recipient advocates, local providers, and community-based organizations, understand that holding managed care organizations accountable in improving the access to and quality of care is a continuous process.

Data on Medicaid HMOs is collected and published annually, and audit findings, indicate steady improvement in the provision of primary care by managed care organizations. After thorough analysis of the data, the state has demonstrated that managed care is superior to the traditional FFS system in the delivery of maternal and child health care.

In linking BadgerCare recipients to a “medical home” and in requiring strong quality assurance efforts, Wisconsin Medicaid plans to continue this progress and improvement in health care outcomes in the BadgerCare program.

D. Budget Neutrality

1. Introduction

The State of Wisconsin requests an amendment to its 1115 Demonstration, entitled BadgerCare, originally submitted on January 21, 1998, revised on December 18, 1998, and approved on January 23, 1999, to request that BadgerCare adults receive the enhanced Title XXI federal match rate for expenditures for services, effective July 2000.

On the advice of HCFA, it is our understanding that for the purpose of requesting the Title XXI federal match rate for uninsured parents of children covered either under Title XIX or Title XXI, it is not necessary to demonstrate budget neutrality.

Attachment 5, the required S-CHIP Budget Plan Template, was provided to us by HCFA and is submitted as part of this waiver amendment. The template identifies the estimated federal and state share of costs for the entire BadgerCare Program (benefits and administration), for the FFY 2000 through FFY 2002, assuming the Title XXI matching rate for parents. Expenditures for adults from July 1, 2000 through September 30, 2000, are included in FFY 2000 amounts.

The benefit costs reflect a statewide average 8% rate increase Per Member Per Month (PMPM) for the period retroactive to July 1, 1999 through December 31, 2000, and a 3.48% rate increase each year thereafter. The PMPM amounts also include approximately \$5.2 million each year in risk sharing liability. This amendment assumes that 80% of all BadgerCare eligibles will be enrolled in managed care effective July 1, 2000.

The template reflects Wisconsin's intention to claim the full 10% for administration allowable under S-CHIP in each FFY.

Attachment 6 contrasts the estimated federal costs for FFY 1999 through 2002 under Wisconsin's currently approved waiver to the costs under this waiver amendment. The attachment also shows the estimated Title XXI allotments and estimated federal funds lapsed or carried over, by year, if any. The current waiver amounts reflect full enrollment effective September 30, 2000. The amounts shown under the waiver amendment reflect additional enrollment of children and adults supported by additional state and federal funding as well as increased funding for HMO rates.

Attachment 7 contrasts the estimate of child and adult BadgerCare enrollees for FFY 1999 through 2002 under Wisconsin's currently approved waiver to the estimate of enrollee months under this proposed waiver amendment.

~~This section presents forecasted enrollment and costs for the BadgerCare waiver amended to fund all adults under Title XIX XXI. Adults with incomes at or above 150% of the federal poverty level are will be required to pay a monthly premium for coverage of their family. Subsequently, these cost-sharing revenues will be used as state matching funds to federal financial participation in the cost of adult coverage. These revenues will not constitute more than 50% of the State's required share of the total costs of adult coverage.~~

~~The new structure of BadgerCare will maintain family only coverage, with all adults and children will now become eligible under an expansion of Title XIX income limits. All children and adults will be funded under Title XXI. Adults must have children to be eligible for BadgerCare. In addition, the State will impose premium cost sharing from of 3% to 3.5% of grossnet monthly income for those families with income above 150% of the federal poverty level. These premium cost sharing funds will, in turn, be used as State match to fund adult health care coverage underwith a Title XIX federal match rate for the premiums.~~

~~A summary of all BadgerCare expenditures under the proposed expansion and waiver are detailed in the summary table at the beginning of the exhibits.~~

~~2. Caseload Assumptions With Waiver~~

~~a) Overview~~

~~The attached charts include amended average enrollment for adults and children covered under BadgerCare. Estimates for AFDC MA, Healthy Start were supplied to HCFA in the initial waiver application and therefore, are left out of this application. The changes made to the waiver application for low income family coverage do not affect the previously submitted estimates of AFDC MA, Healthy Start.~~

~~b) New BadgerCare Eligibles~~

~~Total amended annual member months in the BadgerCare program are attached as Chart 1. This estimate differs from the original waiver in that the starting date for BadgerCare has been delayed from July 1, 1998, to July 1, 1999.~~

~~The groups included in the estimate are the expanded OBRA children aged 15-18 whose family income is below 100% of the FPL, and the children of adults enrolled in BadgerCare whose family income is below 185% at enrollment or 200% after initial eligibility determination. Adults are separated into those below 150% of the FPL and those above 150% of the FPL. This separation is made to display enrollment for~~

~~those subject to a cost sharing requirement, and those not subject to cost sharing.~~

~~OBRA children between ages 15 and 18 decline over the five year period because OBRA law expands Healthy Start eligibility annually for those children born after September 30, 1983 that are under 19 years of age. At September 30, 2002, all children under age 19 and below 100% of the federal poverty level will be eligible for Medicaid, and thus, be covered under Title XIX, rather than Title XXI.~~

3. Base Estimate

~~Based on an analysis of the 1990 census data, it is anticipated that the number of children and adults between 75% and 149% of the FPL total 188,441. Data from the 1996 Wisconsin Family Health Survey and the 1990 census also indicate that the number of children and adults in this FPL cohort without health insurance is 47,688, or approximately 20% of the total population between 75% to 149% of FPL, of whom 17,704 are children. Wisconsin's estimates assume that 100% of these children and adults would present themselves to be eligible.~~

~~There are an additional 144,380 children and adults who are between 150% and 185% of the FPL. The Family Health Survey data indicate that approximately 22%, or 31,763 of the total between 150% and 185% of the FPL are without access to health insurance. This population estimate was reduced by a participation factor based on a study by Leighton Ku and Teresa A. Coughlin, published by the Urban Institute concerning the use of sliding fee scale premiums in subsidized insurance programs. The study found that only 35% of uninsured families would participate in a health insurance program that requires a premium cost share of 3% to 3.5% of gross family income. Therefore, it is assumed that 11,117 children and adults between 150% and 185% of the FPL would participate in BadgerCare with a premium cost share.~~

~~The remaining growth of the BadgerCare population, both children and adults, is based upon the estimated caseload leaving the State's Wisconsin Works program, which is the TANF funded work and training program for unemployed parents. The four year participation forecasted by the State is:~~

ESTIMATED BADGERCARE ENROLLMENT BY CALENDAR YEAR		
BadgerCare Enrollment		
	Calendar Year	Average Annual Enrollment
Children	1999	5,600
Adults	(6 months)	6,400

~~ESTIMATED BADGERCARE ENROLLMENT BY CALENDAR YEAR~~		
~~BadgerCare Enrollment~~		
	~~Calendar Year~~	~~Average Annual Enrollment~~
~~Children~~	~~2000~~	~~21,700~~
~~Adults~~		~~24,900~~
~~Children~~	~~2001~~	~~24,300~~
~~Adults~~		~~27,400~~
~~Children~~	~~2002~~	~~23,700~~
~~Adults~~		~~26,400~~

~~Costs to cover the BadgerCare population will primarily be incurred through monthly per member per month (PMPM) premiums paid to Wisconsin Health Maintenance Organizations (HMOs) for the provision of health care services. The State will incur some fee for service costs to cover ancillary services included in the Medicaid State Plan and not provided by some HMOs in Wisconsin. The need for these wrap-around services occur most frequently in rural Wisconsin areas, where demand for these services is insufficient to accurately capitate. These costs are included in the average, statewide PMPM used in this estimate.~~

~~HMO PMPM costs for the expanded population are assumed to be identical to the AFDC-related population. These costs are assumed to grow at 3% for calendar year 1999 and at 3.4% from 2000-2004. The biennial budget for state fiscal year 1999 authorized a 3.0% HMO rate increase.~~

~~Costs estimates include a premium cost sharing requirement for families at or above 150% of the FPL. The cost share will be a maximum of 3.5% of net monthly income, or about \$72 a month for a family of four at 150% of the FPL.~~

~~This premium revenue is then allocated between children and adults by total estimated costs for the respective groups. Premium cost sharing attributable to adults is used as state match for the adult costs funded under with a Title XIX federal match rate for the premiums. The state share of these total costs for adults is 41.24%. The premium revenue will never equal more than 100 percent of the state general purpose revenue provided for the required match, or 50 percent of the total state funding responsibility.~~

~~Premium cost sharing attributable to children is used to reduce the total costs of insuring the children. The result of this subtraction from total costs is then allocated to the state and federal shares at the appropriate Title XXI financial participation rates of 71.19% federal and 28.81% state.~~

~~In Attachment 1, Chart 2 includes both the average PMPM and total costs for all BadgerCare adults. Chart 3 of Attachment 1 lists the total federal costs for all BadgerCare and AFDC related groups with and without the waiver. BadgerCare groups assume a Title XXI federal match rate. Chart 4 of Attachment 1 shows all eligible months and costs for Title XXI funded children and adults. Chart 4 also includes the premium revenues allocated to children and PMPM costs. The federal share of these PMPM costs is also listed directly below the total PMPM. Chart 5 includes administrative cost for BadgerCare.~~

E. Evaluation Design and Data

This chapter of the waiver application presents the plan for evaluating Wisconsin's BadgerCare Program. It includes the identification of the study objectives and accompanying evaluation hypotheses as well as the data sources and analysis for addressing those hypotheses. The scope of what is outlined here is not intended to be exhaustive of the possible areas of investigation but rather provide a general overview of the relevant research issues and an assurance that the necessary database will exist for conducting the evaluation. A detailed evaluation design will be prepared by the evaluator when the 1115 waiver is approved.

In addition, more comprehensive reporting will be performed on an annual basis as part of the State Plan requirements for Title XXI.

1. Background for Evaluation

~~The State of Wisconsin assumes that the Wisconsin Department of Health and Family Services (DHFS), Office of Strategic Finance (OSF) will perform the evaluation of BadgerCare. We are assuming this due to the fact that~~ BadgerCare is based on Title XXI, a new federal program, and the requirements of Title XXI include extensive annual monitoring and evaluation on the part of state agencies. ~~In fact,~~ There will be significant overlap between the annual reporting requirements described in the Title XXI State Plan and the overall evaluation of the BadgerCare program described below.

The goals of Title XXI are to improve the health of Wisconsin's low-income families with children by reducing the number and percentage of children that are uninsured, and to do this in a way that prevents crowd out of private health insurance. BadgerCare incorporates these goals, while expanding the focus from children to whole families. The evaluation of BadgerCare will measure the extent to which these goals are accomplished. We will also evaluate the impact that increased rates of health insurance have had on BadgerCare recipients' utilization of services and on health outcomes. Finally, as a Section 1115 waiver, we will measure the ongoing budget neutrality and cost-effectiveness of BadgerCare in the light of Medicaid and Title XXI requirements, respectively.

2. Evaluation Objectives

The primary objective of the evaluation is to determine the extent to which the BadgerCare Program results in increased access to medical services through the provision of affordable health care. The main questions to be addressed by the evaluation can be organized under four general categories:

- a) Access to health care coverage: The general question is whether BadgerCare results in an increased number of people with health care coverage. Specific questions include:
 - Has BadgerCare reduced the number of uninsured **children and adults** in Wisconsin?
 - Do persons who choose to participate in BadgerCare drop other insurance to participate in the BadgerCare Program?
 - Are certain population groups (e.g., income groups) more likely to enroll in BadgerCare?
 - Are some geographic areas of the state more successful than others in enrolling persons in BadgerCare?
 - What are the characteristics of BadgerCare enrollees and how do they differ from Medicaid recipients?
 - What factors are responsible for persons choosing to enroll in BadgerCare, e.g., a choice of providers, perceived quality of care improvements, low cost of benefit package, etc.
 - **How successful is BadgerCare in meeting the goals of S-CHIP in enrolling uninsured children?**
- b) Access to health care: The basic question to be addressed here is whether BadgerCare results in improved access to services due to increased health care coverage. Specific questions include:
 - Has there been an increased use of services as a result of participation in BadgerCare? This will probably be measured on a longitudinal basis, measuring changes over time for BadgerCare recipients, since it will be difficult to measure utilization of recipients prior to BadgerCare enrollment if they had no prior health insurance.
 - Is there a more appropriate use of services for persons participating in BadgerCare, e.g., are persons utilizing more preventive services such as well child exams, immunizations, prenatal care services,

etc.? And, conversely, are persons utilizing fewer acute care services such as emergency room care as a result of BadgerCare? This will probably be measured on a longitudinal basis, measuring changes over time for BadgerCare recipients, since it will be difficult to measure utilization of recipients prior to BadgerCare enrollment if they had no prior health insurance.

c) Health outcomes and quality of care: The general question related to outcomes and quality is whether participation in BadgerCare has led to measurable improvements in health status of enrollees. Specific questions include:

- Do selected utilization measures (sentinel events) suggest improvements in the health status and quality of care for BadgerCare enrollees?
- Are selected medical outcomes such as birth outcomes improved as a result of participation in BadgerCare?
- Do BadgerCare enrollees report that they are satisfied with the cost and quality of care they receive and their access to services?
- Do BadgerCare enrollees report improved levels of health status when comparing health status at enrollment to two years after enrollment?

d) Impact on Welfare Reform

One of the major goals of BadgerCare is to provide a health care bridge for former AFDC-related families who make too much money working to qualify for Medicaid but who don't yet have access to affordable private health insurance. BadgerCare is an incentive to help families stay employed. Specific questions related to BadgerCare's impact on welfare reform include:

- Has BadgerCare helped former AFDC-related eligibles move to employment?
- Has BadgerCare provided a temporary or permanent bridge to employer-sponsored health insurance?

e) Delivery system impacts: A major initiative such as BadgerCare often results in changes in the way services are organized and delivered. It is hoped that these changes result in a more responsive and efficient delivery system. Specific questions related to delivery system changes include:

- Has BadgerCare stimulated the development of additional managed care organizations particularly where few previously existed?
- Has BadgerCare had an effect on employer's insurance offerings to its employees?
- Has the availability of health care coverage under BadgerCare led to less reliance on welfare and a greater likelihood of seeking and retaining employment?
- What effect has BadgerCare had on Medicaid caseload and costs?
- Did BadgerCare reduce the amount of uncompensated care?

3. Research Hypotheses

The hypotheses to be tested are organized around the same four general areas as in the previous section. Again the hypotheses are not meant to be a comprehensive list but rather illustrative of the hypotheses that the evaluator will consider.

a) Access to health care coverage

- BadgerCare will increase the number of insured Wisconsin residents, primarily children.
- BadgerCare will increase the number of children insured by enrolling entire families.
- BadgerCare will improve the outreach and enrollment of Medicaid-eligible children and adults.
- Persons who enroll in BadgerCare will not drop other insurance coverage in order to participate in BadgerCare.
- Employers will not change the coverage they offer in response to the availability of BadgerCare.
- Enrollees in BadgerCare will be more similar demographically to the general population than to the Medicaid population.
- Enrollees in BadgerCare will report that they are satisfied with the price they have to pay for coverage.
- Enrollees in BadgerCare will report they are satisfied with the choice of coverage available to them.

b) Access to services

- A greater share of BadgerCare enrollees will have a primary care physician than the general public.
- Utilization of services patterns for BadgerCare enrollees will be more similar to the general public than to the Medicaid population.
- BadgerCare and Medicaid enrollees will report satisfaction with the simplified eligibility process.
- BadgerCare enrollees will report that they are satisfied with their access to services as measured by waiting times for appointments, etc.
- Enrollees in BadgerCare will be satisfied with their ability to get referrals to specialists.
- Pregnant women enrolled in BadgerCare will have greater access to prenatal care services than a comparison population.

c) Health outcomes and quality of care

- BadgerCare enrollees will self-report improved health status.
- BadgerCare enrollees will utilize more preventive and primary care services than a comparison population.
- BadgerCare enrollees will have greater continuity of care than a comparison population.
- BadgerCare enrollees will have fewer preventable hospitalizations than a comparison population.
- Enrollees in BadgerCare will report they are satisfied with the quality of care they receive.

d) Delivery System Impacts

- BadgerCare will not result in employers reducing their health insurance benefit packages.
- Persons enrolling in BadgerCare will not drop existing coverage to enroll in BadgerCare.
- Enrollment in BadgerCare will increase the likelihood of obtaining employment.
- Enrollment in BadgerCare will reduce the likelihood that an enrollee will utilize welfare services.

- BadgerCare will result in greater HMO capacity in Wisconsin.
 - BadgerCare will result in long term savings for the Medicaid program.
- e) Evaluation of Budget Neutrality for Medicaid and Cost-Effectiveness for Title XXI.
- The Medicaid expansion groups of eligibles in BadgerCare will be found to have a budget neutral impact on Medicaid expenditures.
 - The ESI Title XXI groups of families in BadgerCare will be found to be cost-effective in comparison to covering only adults and children under Title XXI BadgerCare HMOs and/or fee-for-service.

4. Data Sources/Analysis Plan

The analysis plan uses a variety of approaches and multiple data sources. Some aspects of the analysis are much more difficult to quantify than others. While there is considerable existing data available, some analyses will require primary data collection through direct contact via a survey or other means. Some parts of the evaluation will require the development of a control or comparison group to determine program impact. The primary sources of data envisioned for this evaluation are as follows:

***Surveys** - An enrollee satisfaction survey will be administered to obtain data to test a number of hypotheses. The survey will provide information on enrollees' satisfaction with their choice of plan, the care they receive, the premiums, the accessibility of care and the quality of care. The survey will also be a basis for self-reported health status and health risk behavior data as well as utilization data. A stratified random sample of enrollees will be selected to ensure geographic and demographic representation. Consideration will be given to whether it will be necessary to conduct this survey at least twice, once as a baseline and at least one follow-up.

***Interviews** - To obtain information on employers' response to BadgerCare it will be necessary to contact employers through either a survey or an interview method or both. The favored approach will be to survey a sample of employers and based on the survey results select a small number for in-depth interviews.

***HMO Histories** - Enrollee and service specific data will be generated for many BadgerCare enrollees. These data will form the basis for special studies and auditing individual recipients. Quality of care and access issues will be addressed using these data as a sampling frame. The data received through

the ongoing Medicaid managed care Quality Improvement program will serve as the source for such data.

***Special reports** - Special ad hoc reports will be designed based on claims or aggregate HMO reporting. These reports can be used to monitor BadgerCare performance on various utilization and health status measures. Sentinel indicators will be identified and included in these reports.

Some special reports may be developed to monitor service utilization and outcomes for BadgerCare enrollees who have been bought into health insurance plans offered through their employers. In these cases, detailed utilization data may not be available in a feasible and cost-effective manner, so proxy measures may have to be developed.

***Medical Records Audits** – The current auditing of the Medicaid managed care program, performed by DHFS staff and contractors, will be expanded to encompass the BadgerCare program.

Control Group

A number of hypotheses suggest an evaluation design that requires a control group or a pre-post design. A suitable control group for many of the hypotheses will be Medicaid recipients either selected randomly or matched on characteristics to better mirror the BadgerCare enrollees. On other occasions a pre-post analysis will dictate that baseline information be collected and then replicated at a later date.

Other control groups may be some subset of the general insured population that may have health insurance with a less generous benefit package than BadgerCare.

F. Public Process

1. Public Meetings and Hearings

The Department of Health and Family Services (DHFS) ~~has~~ scheduled and held numerous meetings with various interested entities to discuss the BadgerCare proposal and to elicit comments, concerns, and ideas in order to improve the proposal. The schedule for the meetings and the range of entities that we ~~have~~ met with are described below.

- **HMO Regional Forums** – DHFS staff hold regional forums for all parties involved in the statewide Medicaid managed care program for AFDC/Healthy Start recipients. There are five DHFS regions and a separate forum for Milwaukee. These regional forums are held quarterly and there are usually two regional forums held every month. Participants

in these forums include the HMOs, local public health agencies, various provider and recipient advocacy associations, the state-contracted HMO ombudsmen and the HMO outreach/enrollment provider, and others on an ad-hoc basis.

In the months of October, November, and December 1997, a portion of each forum ~~was has been~~ devoted to discussion of BadgerCare. The schedule for these three months' forums is listed below:

October 14, 1997 -	Southeastern Regional Forum
October 21, 1997 -	Northeastern Regional Forum
November 12, 1997 -	Southern Regional Forum
November 18, 1997 -	Western Regional Forum
December 9, 1997 -	Northern Regional Forum

- Ongoing Meetings with Interested Parties – DHFS staff have been involved in a continuous series of meetings and discussions concerning BadgerCare with a wide variety of interested parties. The schedule for the last three months of meetings that ~~were have been~~ held are listed below:

October 1, 1997 -	Community Physicians' Group
October 15, 1997 -	Council on American Indian Health
October 21, 1997 -	Wisconsin Association of Mfg. and Commerce and Independent Business Association
October 23, 1997 -	Maternal and Child Health Coalition
October 24, 1997 -	Health Care Conference on Universal Coverage
November 5, 1997 -	HealthWatch in Milwaukee (HealthWatch is a Consolidated group of regional recipient advocacy agencies)
November 5, 1997 -	Wisconsin Merchants Federation
November 10, 1997 -	Advisory Committee to Department of Workforce Development on Child Care
November 12, 1997 -	State Medical Society Maternal and Child Health (main physician association)
November 18, 1997 -	Council on American Indian Health
November 19, 1997 -	Social Development Commission
November 20, 1997 -	Wisconsin Association of Health Departments and Boards
November 21, 1997 -	Public Health Advisory Committee/Health Insurance Agents
November 21, 1997 -	Southeastern WI DHFS Regional Directors
December 3, 1997 -	Medical Assistance Advisory Committee
December 5, 1997 -	Black Health Coalition/Latino Health
December 5, 1997 -	Wisconsin Social Services Association

December 11, 1997 -	Milwaukee Recipient Advocates and Regional FQHCs
December 15, 1997 -	Statewide Maternal and Child Health Council
December 18, 1997 -	Milwaukee HMO Forum
December 18, 1997 -	Dept. of Workforce Development Income Maintenance Advisory Committee
January 8, 1998 -	Wisconsin Counties Human Services Association Executive Committee
January 8, 1998 -	Wisconsin Mental Health Council
February 29, 2000	Meeting with Tribal Health Directors on new federal cost-sharing requirements for S-CHIP

- **Meetings/Discussions Focused on Specific BadgerCare Policies**

DHFS staff has had ongoing focused meetings and discussion with relevant parties outside of the DHFS that have more specific policy interests.

Wage Withholding

We have had detailed discussions with the Wisconsin Association of Manufacturers and Commerce, the Wisconsin Merchants Federation, and the Independent Business Association of Wisconsin on the subject of implementing a system of wage withholding or other automated system, through the employer, in which employees pay their BadgerCare monthly premiums.

The main concern of these organizations that a wage withholding system for premium payment be kept simple and relatively stable (i.e., not subject to constant changes in the premium schedule and sliding scale). Otherwise, these groups thought wage withholding to be feasible. The goals of simplicity and stability will be incorporated into the BadgerCare implementation.

Crowd-out

We have detailed discussions with the Wisconsin Merchants Federation, the Wisconsin Independent Business Association of Wisconsin, the Wisconsin Insurance Underwriters Association, the Wisconsin Office of the Commissioner of Insurance, the Department of Economics at the University of Wisconsin, and Medicaid programs in California, New York, Massachusetts, and Minnesota to discuss the feasibility of various proposals to prevent “crowd-out” of private insurance with the implementation of BadgerCare.

The federations of merchants and independent businesses were strongly against the state imposing unfunded mandates, or expensive requirements

on businesses in order to prevent businesses from making business decisions on whether to offer insurance to their employees or on the employee share of employer offered insurance. The DHFS has clarified to these organizations that we are not intending any such proposals. Rather, as discussed with the Wisconsin Office of the Commissioner of Insurance, current Wisconsin insurance law is considered sufficient basis to prevent “gaming” of BadgerCare by employers – namely, the current statutory provision that prevents employers from offering health insurance to only some of their employees but not to others.

The State of Wisconsin is considering a program of creating a risk pool for small businesses that currently cannot afford to purchase insurance for their employees. This is a program separate from BadgerCare, but would contribute to the prevention of crowd-out if it increased the feasibility of employers providing health insurance to their employees. The Wisconsin Insurance Underwriters Association expressed some concern that the way this risk pool could be structured might have a negative impact on their business. The Wisconsin Office of the Commissioner of Insurance agreed to work with them to reduce this potential negative impact.

2. Communication and Feedback Process for Public Meetings, Hearings, and Other Interested Parties, Including Written Comments/Response

The DHFS has had and will have a comprehensive set of procedures to communicate with various parties on our proposal for BadgerCare and to receive and discuss feedback on BadgerCare received from these parties.

- **Communication and Distribution of BadgerCare Documents to Interested Parties**

We have developed a mailing list of 500 persons representing Wisconsin counties, tribes, legislators, provider associations, and advocacy groups for the distribution of written products relating to BadgerCare. The BadgerCare concept paper was distributed to a large number of interested parties via this mailing list. The BadgerCare waiver will also be distributed through this mailing list. Documents are also placed on the Internet for access to any interested party.

This distribution of written documents is an ongoing process that will continue throughout the development and implementation of BadgerCare.

Communication about DHFS proposals is an ongoing process that has been described above.

- **Feedback Process for Public Meetings, Hearings, and Other Interested Parties, Including Written Comments/Responses**

In our meetings with various interested parties, and in our distribution of various written BadgerCare documents, we have solicited written questions, ideas, and concerns about BadgerCare from any interested parties.

The DHFS has received many written questions and concerns about BadgerCare from various individuals and organizations. We have found these questions and concerns fruitful, in that they have helped DHFS staff focus on various implications, permutations, and impacts of BadgerCare that were not immediately apparent and to address these implications and impacts.

The DHFS has responded to various verbal and written comments by publishing a Question and Answer document on December 4, 1997. This document was distributed via the same mailing list as previously mentioned and posted on the Internet. ~~The BadgerCare question and answer document is attached to the waiver in Appendix E.~~

Through the course of BadgerCare development and implementation, we envision a continuing series of verbal and written feedback from interested parties, and a series of question and answer documents and/or individual policy statements or other means of response to various questions.

In addition to written questions from various parties, the DHFS has also received a variety of written expressions of support for various aspects of BadgerCare. ~~A selection of these written expressions of support is attached to the waiver in Appendix E.~~

3. BadgerCare Website

Detailed information about BadgerCare is available on the DHFS website at www.dhfs.state.wi.us/badgercare for applicants, employers and the general public. The website includes a program description, the eligibility requirements, application information and enrollment statistics. See Attachment 4 for an example of the website format and information available. This site is updated on a monthly basis.

34. Coordination of BadgerCare with Native Americans

The DHFS has had long experience in working closely with Native Americans in developing and implementing State health programs. Appendix G details minutes of four meetings the Department attended with Wisconsin tribes on managed care and BadgerCare during 1997.

For statewide Medicaid HMO implementation, Medicaid staff met with tribal health directors over an 18-month period to coordinate HMO expansion with the needs of the tribes and with Indian Health Service responsibilities. A special disenrollment procedure was developed for tribal members that involves close coordination with Indian Health Clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non-HMO affiliated Indian Health Clinics could still be reimbursed by Medicaid FFS funds for services provided to tribal members enrolled in HMOs, so that Indian Health Service funds would not be jeopardized by the expansion of the HMO program.

We continue to hold regular meetings with tribal leaders to discuss health care related issues. We intend to use these meeting to solicit input and provide information to the tribes on BadgerCare.

DHFS staff attend regular meetings with the Great Lakes Inter-Tribal Council, Inc. (GLITC Inc.) and individual Tribal Health Clinics to discuss various aspects of BadgerCare and how they may impact on the Indian Health Service. In addition, staff attend regular meetings of the Council on American Indian Health and the soon to be established Wisconsin American Indian Forum. The forum, as its predecessor the council, will meet monthly to explore a wider range of issues than just health issues; social service issues will also be explored.

The DHFS plans to maintain the current special procedures for Native Americans that we have in the Medicaid managed care program in the BadgerCare program. Additional special procedures might be required for Native Americans in BadgerCare. Our goal is to assure that BadgerCare is coordinated with Indian Health Service benefits and funding sources so that HIS benefits and funds are used most effectively for those Native Americans that do not have alternative sources of health care.

45. BadgerCare Public Notices

Wisconsin will make necessary assurances that its 1115 waiver will meet the state notice procedures:

Wisconsin's DHFS will send all stakeholders a copy of the waiver request and a public review process will be used during the waiver implementation period. Stakeholders will be invited to send the Department their comments on this proposed request. This waiver request will also be available on the Department's Web site.

Attachment 1

Budget Neutrality Summary and Overview

~~The attached charts summarizing the budget projections for BadgerCare and AFDC related populations include:~~

~~**Chart 1** includes historical and projected member months for AFDC related populations. This chart also includes the proposed Title XIX adult expansion group that will be funded under Title XIX XXI Medicaid both with and without the waiver. The starting date for this expansion group was moved back one year from the original waiver submission, to July 1, 1999. The AFDC related population includes both those member months under managed care and those under fee for service.~~

~~**Chart 2** includes total expenditures for historical AFDC related populations, as well as projections through calendar year 2003. This chart also shows projected expenditures for the Title XIX expansion group to be funded under Title XIX XXI Medicaid. These expenditures are shown both with and without waiver.~~

~~**Chart 2A** shows per member per month rates for the eligibility groups listed in Chart 2.~~

~~**Chart 3** shows only the total federal financial participation for the groups included in Chart 2. BadgerCare groups assume a Title XXI federal match rate.~~

~~**Chart 4** shows member months, expenditures and per member, per month rates for the expansion groups to be funded through Title XXI. These groups include only adults and children. Premium revenue includes that portion of the BadgerCare premium cost sharing that is allocated to children.~~

~~**Chart 5** shows administrative costs under BadgerCare with a waiver and without a waiver. The state is showing that this expansion could have taken place without a waiver. Thus, there are no additional costs related to the waiver. Any added costs associated with systems changes, premium collection system enhancements, and eligibility determination (includes HIPAA) will be allocated between Title XXI and Title XIX. Any costs allocated to Title XXI in excess of the 10% limit of benefits paid will be charged to Medicaid at the regular FMAP.~~

Trend Factor for AFDC Medicaid

~~Medicaid trend factors were projected using the Milliman & Robertson, Inc (M&R). Health Cost Index Database™. This tool, developed by M&R, estimates future trends based on non-Medicare utilization, charge, and intensity/mix historical data. In order to estimate trends for a Medicaid population, M&R's blended commercial and Medicaid charge trends were replaced with the State of Wisconsin's budgeted provider reimbursement increases. This process resulted in a projected increase of 3.4% from 1998 to 1999.~~

~~For calendar year 1999, the increase in reimbursement rates is 3% based on the rate to be paid for AFDC related groups under the Medicaid managed care program. The Fee for Service-Equivalent increase for groups not enrolled in managed care is estimated to be 3.4%. For the years 2000-2004, all health care costs are estimated to increase 3.4% per year.~~

Attachment 1

February BadgerCare Enrollment

Attachment 2

Map and Listing of Medicaid BadgerCare Outstations

Attachment 3

Forward Card

Attachment 4

Web Site Table of Contents

Attachment 5

S-CHIP Template

S-CHIP Budget Plan Template	FFY 2000 Federal Fiscal Year First Year Costs	FFY 2001 Federal Fiscal Year Second Year Costs	FFY 2002 Federal Fiscal Year Third Year Costs
Benefit Costs			
Insurance payments			
Managed care	\$ 35,938,478	\$ 110,131,800	118760510
per member/per month rate @ # of eligibles	\$ 139.51	\$ 137.32	\$ 138.45
Fee for Service	\$ 13,408,151	\$ 31,407,101	\$ 33,574,740
Total Benefit Costs	\$ 49,346,629	\$ 141,538,901	\$ 152,335,250
(Offsetting beneficiary cost sharing payments)	\$ 564,304	\$ 1,435,700	\$ 1,507,500
Net Benefit Costs	\$ 48,782,324	\$ 140,103,201	\$ 150,827,750
Administration Costs			
Personnel			
General administration	\$ 5,420,258	\$ 15,567,022	\$ 16,758,639
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	\$ 5,420,258	\$ 15,567,022	\$ 16,758,639
10% Administrative Cost Ceiling	\$ 5,420,258	\$ 15,567,022	\$ 16,758,639
Federal Share (multiplied by enh-FMAP rate)	\$ 38,586,819	\$ 110,837,199	\$ 119,321,509
State Share	\$ 15,615,764	\$ 44,833,024	\$ 48,264,880
TOTAL PROGRAM COSTS	\$ 54,202,583	\$ 155,670,223	\$ 167,586,389

Note: Federal Fiscal Year (FFY) 1999 is October 1, 1998 through September 30, 1999.

Attachment 6

Estimated Federal Costs FFY 1999-2002

S-CHIP Costs under Current Approved Waiver

	<u>FFY 1999</u>	<u>FFY 2000</u>	<u>FFY 2001</u>	<u>FFY 2002</u>
Total S-CHIP Benefit Costs net of cost-sharing	\$3,028,382	\$28,542,661	\$35,684,449	\$34,342,371
Federal Share of Costs	\$2,155,905	\$20,319,520	\$25,407,328	\$24,451,768
Federal Funding available for Administrative Costs	\$ 239,545	\$ 2,257,724	\$ 2,823,036	\$ 2,716,863
 Total S-CHIP Allotment	 \$40,441,140	 \$40,441,124	 \$40,441,124	 \$29,647,230
Carryover S-CHIP funds from prior year**	\$40,633,000	\$78,678,690	\$80,882,264	\$80,882,249
Unused S-CHIP Funding at Federal fiscal year end	\$78,678,690	\$96,542,569	\$93,093,025	\$83,360,847
 Allowable carryover	 \$81,074,140	 \$80,882,264	 \$80,882,249	 \$70,088,354
 Unspent S-CHIP funding	 \$ _____	 \$(15,660,305)	 \$(12,210,776)	 \$(13,272,493)

Assuming Adults eligible for S-CHIP funding as of July 1, 2000

	<u>FFY 1999</u>	<u>FFY 2000</u>	<u>FFY 2001</u>	<u>FFY 2002</u>
Total Cost for S-CHIP Eligibles (including OBRA teens)	\$3,028,382	\$48,782,324	\$140,103,201	\$153,819,732
Federal Share of BadgerCare Children/Adults	\$2,155,905	\$34,728,137	\$99,753,479	\$109,519,649
Federal Funding available for Administrative Costs	\$ 239,545	\$ 3,858,682	\$11,083,720	\$ 12,168,850
 Total S-CHIP Allotment	 \$40,441,140	 \$40,441,124	 \$40,441,124	 \$29,647,230
Carryover S-CHIP funds from prior year**	\$40,633,000	\$78,678,690	\$80,532,996	\$10,136,921
Unused S-CHIP Funding at Federal fiscal year end	\$78,678,690	\$80,532,996	\$10,136,921	\$(81,904,348)
 Allowable carryover	 \$81,074,140	 \$80,882,264	 \$80,882,249	 \$70,088,354
 Federal Funding reverting back to HCFA	 \$ -	 \$ -	 \$ -	 \$ -

Attachment 7

Estimated BadgerCare Enrollment

Enrollment under Current Approved Waiver

	<u>FFY 1999</u>	<u>FFY 2000</u>	<u>FFY 2001</u>	<u>FFY 2002</u>	<u>FFY 2003</u>
Enrollment Months - Children ages 16-18 under 100% FPL	18,629	51,345	43,200	24,000	-
Average number of individuals served per month	3,105	4,279	3,600	2,000	-
Enrollment Months - Children below 150%	11,682	153,288	197,749	197,749	197,749
Average number of individuals served per month	3,894	12,774	16,479	16,479	16,479
Enrollment Months - Children above 150%	2,764	36,268	46,788	46,788	46,788
Average number of individuals served per month	921	3,022	3,899	3,899	3,899
Enrollment Months - Adults below 150%	103,863	444,353	586,884	586,884	586,884
Average number of individuals served per month	17,311	37,029	48,907	48,907	48,907
Enrollment Months - Adults above 150%	11,228	48,036	63,444	63,444	63,444
Average number of individuals served per month	1,871	4,003	5,287	5,287	5,287

Assuming Adults Eligible for S-CHIP Funding as of July 1, 2000

	<u>FFY 1999</u>	<u>FFY 2000</u>	<u>FFY 2001</u>	<u>FFY 2002</u>	<u>FFY 2003</u>
Enrollment Months - Children ages 16-18 under 100% FPL	18,629	51,345	43,200	24,000	0
Average number of individuals served per month	3,105	4,279	3,600	2,000	0
Enrollment Months - Children below 150%	11,682	153,288	210,955	232,051	255,256
Average number of individuals served per month	3,894	12,774	17,580	19,338	21,271
Enrollment Months - Children above 150%	2,764	36,268	49,913	52,408	55,029
Average number of individuals served per month	921	3,022	4,159	4,367	4,586
Enrollment Months - Adults below 150%	103,863	444,353	607,516	668,268	735,095
Average number of individuals served per month	17,311	37,029	50,626	55,689	61,258
Enrollment Months - Adults above 150%	11,228	66,529	90,958	95,506	100,281
Average number of individuals served per month	1,871	5,544	7,580	7,959	8,357

March 10, 2000

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
200 Independence Avenue, Room 314 G
Washington, DC 20201

Dear Ms. DeParle:

The State of Wisconsin requests an amendment to its Medicaid Section 1115 Demonstration, entitled BadgerCare, originally submitted on January 21, 1998, revised on December 18, 1998, and approved as project No. 11-W-00125/5.

Scope and Authority

This amendment would allow the State of Wisconsin to claim Title XXI funding under the State Children's Health Insurance Program (S-CHIP) for services provided to the BadgerCare Demonstration Population 2. Demonstration Population 2 includes custodial parents of children who are eligible under the State Plan or under Demonstration Population 1, and the spouses of these custodial parents, with income up to 200% of the Federal Poverty Level (FPL). We request that this change be effective beginning July 1, 2000. The July 1 date is critical to ensure Wisconsin does not lapse its federal fiscal year (FFY) 1998 S-CHIP allocation. The inability to fully expend the 1998 S-CHIP allocation is primarily due to the two-year time period needed to assure federal review and approval of our BadgerCare waiver.

This amendment is requested under the authority of Section 2107(e)(2)(A) of the Title XXI provisions of the Balanced Budget Act of 1997. Moreover, this amendment is consistent with the President's budget initiative, called "FamilyCare," that would provide additional funding for states to expand Title XXI to cover the parents of children enrolled in Titles XIX and XXI.

BadgerCare Implementation and Reporting

Wisconsin implemented BadgerCare Phase I in April 1999 for the OBRA expansion children, and Phase II in July 1999 for the remaining low-income families with children. Since its implementation, we have reported monthly, as required, to the federal Health Care Financing Administration (HCFA) on the status of the BadgerCare Demonstration. Wisconsin's HMO program, the delivery system for both family Medicaid and BadgerCare, was extensively reviewed on-site by HCFA regional office staff on August 9 and 10, 1999, and was found to meet federal requirements. Our CHIP Evaluation for BadgerCare will be completed and submitted to HCFA by the March 31, 2000 due date. With the completion of these activities, Wisconsin has met the requirements specified by HCFA that are necessary to secure a Section

1115 waiver of Title XXI provisions. As of April 2000 Wisconsin will have one year of experience with our CHIP program, and our first CHIP evaluation of BadgerCare will be complete.

Justification

We believe that federal approval of our amendment is strongly justified by our experience with BadgerCare.

In just eight months since the full implementation of BadgerCare in July 1999, Wisconsin has enrolled over 51% of our uninsured children in families with income under 200% of the FPL. With our family-based coverage for low-income families with children, we have experienced tremendous success in enrolling uninsured children in Medicaid/BadgerCare. Through integrating Medicaid and S-CHIP under BadgerCare, we have simplified eligibility and enrollment for families with children, coordinated cost-sharing and crowd out policies across programs, and supported Medicaid by eliminating the stigma of a "welfare" program. Based on our experience, we are confident that we have created a seamless system for low-income families with children to access Medicaid and S-CHIP. As a result, we believe we have enrolled proportionately more of our uninsured children in BadgerCare and Medicaid than any other state. In addition, this success has been achieved in a very short period of time.

Wisconsin has appropriated significant state funding for BadgerCare and we continue to demonstrate a strong financial commitment through the Governor's recent recommendation to further increase state funding for BadgerCare and Medicaid enrollment. Wisconsin has consistently maintained program funding to assure that all eligible uninsured children in Wisconsin have access to BadgerCare.

With the Title XXI waiver we will be able to expend our 1998 S-CHIP allocation to continue BadgerCare's success without supplanting funding for uninsured children or lapsing funds in future years. While we recognize that the Title XXI allocation is targeted to children, the philosophy, simplicity and effectiveness of our family-based coverage model has significantly enhanced Wisconsin's coverage of children in S-CHIP and Medicaid. Consequently, Wisconsin should be granted federal approval to use its existing Title XXI allocation to support this innovative and successful program for children.

The following points provide more detailed information on our waiver amendment.

- *Successful Enrollment of Children.* Wisconsin's approach of providing family coverage in BadgerCare has been extremely successful in meeting the key S-CHIP objective of enrolling eligible children. According to the most recent data on S-CHIP programs as indicated in HCFA's *The State Children's Health Program, Annual Enrollment Report, October 1, 1998 - September 30, 1999*, 1,979,450 children are enrolled nationally in state

S-CHIP programs. This represents 24.6% of the 8,060,000 low-income uninsured children under 200% of the FPL.

In the first eight months of our program, from July 1999 through February 2000, we have enrolled 19,294 children in BadgerCare. In addition, 8,253 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program. This represents a total of 27,547 children that have enrolled in BadgerCare/Medicaid since the implementation of the BadgerCare program in July 1999.

The most recent figures from the 1997-1998 Wisconsin Family Health Survey show that there are 54,000 low-income uninsured children under 200% of the FPL. BadgerCare has reduced the number of uninsured children under 200% of the FPL from 54,000 to 26,453. Wisconsin has enrolled 51% of our low-income uninsured child population in health care through the BadgerCare program compared to the national S-CHIP enrollment rate of 24.6%.

By June 2001, BadgerCare enrollment is projected to be 81,990, compared to 67,535 now budgeted. Higher BadgerCare enrollment will increase the number of children from nearly 19,300 currently to 25,800 by June 2001. We also project Healthy Start children will double, increasing from almost 8,300 now to almost 16,000 by June 2001. Therefore, by June 2001 we will have enrolled more than 42,000 children in BadgerCare/Medicaid, or over 80% of the 54,000 uninsured children under 200% of the FPL in Wisconsin.

- *Covering Parents Does Not Supplant Funds for Children.* Covering parents in the initial years of BadgerCare will not supplant S-CHIP funds allocated for Wisconsin's children. The use of Wisconsin's FFY 1998 S-CHIP allocation for parents assures that funding allocated to Wisconsin will support the enrollment of additional children in BadgerCare through a model that truly enhances the enrollment of children in S-CHIP and Medicaid.

With the waiver, Wisconsin will spend all of its initial S-CHIP allocations by FFY 2001. On an ongoing basis beginning in federal fiscal year 2002, our annual S-CHIP allocation for children of \$29.6 million FED is actually less than our projected expenditures of \$34.8 million FED for children in BadgerCare.

By the end of FFY 2002, Wisconsin will need to appropriate an additional \$49.7 million in state funding to maintain BadgerCare enrollment even with the Title XXI waiver amendment.

- *Insuring Children-Only Slows Enrollment.* By simplifying eligibility for the entire family, families are encouraged to seek health care coverage, resulting in more children enrolled in Medicaid and BadgerCare.

Along with children in BadgerCare, Wisconsin has significantly increased Medicaid enrollment of low-income children in Healthy Start with the implementation of

BadgerCare. This occurred because Wisconsin simplified and built on its Medicaid eligibility criteria for children in creating the BadgerCare program. Medicaid eligibility under Healthy Start is provided for children up to age six (under 185% of the FPL) and for children up to age 19 (under 100% of the FPL) prior to BadgerCare. In implementing BadgerCare the income and asset requirements for young children were extended to the entire family (185% of the FPL and no asset test). As a result families are no longer confused about who qualifies and more children are enrolled – the parents and older children in BadgerCare and the younger children in Medicaid.

This simplification has had a positive and measurable impact on Medicaid enrollment in Wisconsin. From June 1998 to June 1999, the year before BadgerCare implementation, Healthy Start enrollment remained constant at approximately 66,900 children. During the period July 1999 to January 2000 (with Medicaid outreach, followed by BadgerCare implementation in July) the number of children enrolled in Healthy Start climbed from 66,283 to 75,076. The most dramatic increase occurred between July 1999 and February 2000, with Healthy Start enrollment rising by 1,000 per month.

If Wisconsin had implemented BadgerCare for children only, and children were enrolled at the national average of 24.6% of uninsured children for S-CHIP, we would have enrolled only 13,284 children from April 1999 through February 2000 vs. the 27,547 that did enroll in BadgerCare and Medicaid.

- *Effective Strategy of Outreach and Enrollment.* BadgerCare is more successful than S-CHIP programs nationwide at enrolling uninsured children because:
 - Family-based coverage brings in parents and parents bring in children. The 8,253 children enrolled in Healthy Start, in theory, could have enrolled prior to BadgerCare, since the eligibility criteria have not changed. Since BadgerCare, Medicaid Healthy Start enrollment has increased by an average of 1,000 per month.
 - Coverage and eligibility are seamless and integrated. Families apply for “BadgerCare,” not realizing some family members actually qualify for Medicaid through Healthy Start. Because the benefits and delivery system are identical, families are able to obtain health care without confusion or administrative barriers.
 - Simple and convenient applications for families. Wisconsin’s commitment to health care coverage has converted the old “one-stop shopping” model at the “welfare office” to a more diverse, multi-faceted model, where applications are processed on-site, in real time, at clinics, hospitals, schools, and other locations convenient to families. We have implemented several changes to make the application process user friendly and to minimize barriers to enrollment, including eliminating the asset test for BadgerCare, improving the integration of the Medicaid/BadgerCare/Food Stamp/TANF application process, and extending Medicaid review dates from six to twelve months.

- Aggressive Advertising. BadgerCare has been heavily promoted throughout the state (through health care providers and community-based organizations) and in the media (television and radio ads by Governor Tommy Thompson and legislators). In Wisconsin, our families know about and support BadgerCare.
- *Expanded State Commitment to BadgerCare.* Wisconsin has shown a strong commitment to providing adequate funding for BadgerCare in the light of higher than expected enrollment in the program. The original State Fiscal Year 2000 budget projection assumed that BadgerCare enrollment would level off after March 2000 and reach a final enrollment of 67,535 in June 2001. We are now projecting BadgerCare enrollment will continue to grow at a higher rate after March 2000 and reach a final enrollment of 81,990 in June 2001.
- Under terms of the original BadgerCare waiver, Wisconsin could cap enrollment at the funded level through enactment of an “enrollment trigger” that would stop new enrollment, so as to not exceed budgeted funding. Wisconsin currently has 57,482 people in BadgerCare, or 94% of the budgeted enrollment. We are projecting we will exceed the cap sometime in April or May 2000.
- To cover the projected enrollment, Governor Thompson has proposed additional funding for BadgerCare. Currently, \$56.6 million in state (GPR) funding and \$101.8 million in federal (FED) funding is budgeted for BadgerCare in the 1999-01 biennium. Legislation has been introduced to further increase BadgerCare funding by \$20.7 million GPR and \$23.6 million FED.
- Wisconsin is also committed to covering more than double its original projection of increased Medicaid eligibles (7,123) resulting from BadgerCare to over 16,000 projected by June 2001. This translates into an additional annual Medicaid cost of \$16 million, of which \$4.7 million is state funds.
- *Effective, Budget-Neutral Use of Federal Funds.* With the two-year delay in obtaining federal approval for our BadgerCare waiver, Wisconsin will lapse Title XXI funds without an approved waiver amendment to allow the state to use this funding to support parents enrolled in BadgerCare. Without the approved waiver amendment, Wisconsin will lose \$15.7 million in federal S-CHIP funding on September 30, 2000, \$12.2 million on September 30, 2001, and \$13.3 million on September 30, 2002. This is a total of \$41.2 million in federal S-CHIP funding that is projected to lapse. (Please note that the Title XXI federal funds identified as at risk of lapsing have been adjusted slightly to reflect the enrollment in BadgerCare of the Phase I OBRA expansion children.) Approximately \$40.4 million of these funds have already been appropriated and allocated to Wisconsin under current federal law.

With a waiver, Wisconsin will need \$11 million less over the biennium to support the expanded enrollment and increased rates. Even with a waiver, Wisconsin will spend \$74.6 GPR million for BadgerCare over the 1999-01 biennium, instead of the \$56.6 GPR million originally authorized.

On an ongoing basis beginning in federal fiscal year 2002, our annual S-CHIP allocation of \$29.6 million FED is actually less than our projected expenditures of \$34.8 million FED for children in BadgerCare. Covering parents in the initial years of BadgerCare will not supplant S-CHIP funds allocated for Wisconsin's children. With the proposed BadgerCare expansion, we project we will cover all eligible low-income children and their parents who do not have access to health insurance.

Granting this waiver is budget neutral to the federal government, since Wisconsin's S-CHIP funds are already allocated. If granted this waiver amendment, Wisconsin will spend only its existing, budgeted S-CHIP allocation.

A Title XXI waiver amendment would recognize the outstanding accomplishment of BadgerCare, consistent with the President's intent, namely the integration of Medicaid and S-CHIP to create a health insurance program that is simple and accessible for low-income families with children.

Waiver Amendment

Enclosed is an application to amend Wisconsin's Section 1115 Demonstration Waiver to use Title XXI funds for parents as well as children. The application is essentially the same document that was submitted on December 18, 1998. However, we made the following changes based on changes in federal and state law or policy that occurred since December 1998:

- Revised language made to the appropriate sections in order to request a Title XXI enhanced federal match rate for services to Demonstration Population 2.
- Changed original references to a BadgerCare premium amount of 3% - 3.5% to 3%. The current BadgerCare premium amount is 3% of net monthly family income.
- Modified the original language referencing cost-sharing to indicate that cost-sharing will not be applied to American Indian/Alaskan Native children. This change is being made to comply with the February 28, 2000, State Medicaid Director letter from HCFA and the proposed CHIP regulations.
- Revised budget information including the required S-CHIP templates.
- Incorporated updated projected enrollment of children and adults.
- Included updated information about Wisconsin's successful outreach initiatives.

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
March 10, 2000
Page 7

Revised language is indicated by underlines and strikethroughs.

Also enclosed are amended pages of the Title XXI State Plan (submitted on December 30, 1988), in Section 6.3.2 - Purchase of Family Coverage. The revision allows for Title XXI funding for adults in cases where the children are Title XXI and where the cost of the Employer Sponsored Insurance (the premium subsidy, coinsurance, and wraparound services costs) for the whole family is less than the cost of the whole family under BadgerCare.

Thank you for your prompt review of the enclosed documents for BadgerCare. I look forward to hearing from you soon.

Sincerely,

Peggy L. Bartels
Administrator

PLB:dd
MC03005.GS

Attachments

cc: Joe Leean, DHFS Secretary
Tim Westmoreland
Cindy Mann
Nicole Tapay
Maria Boulmetis
Pam Carlson