



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

MEDICAID HEALTH HOMES IN WISCONSIN:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Wisconsin's Health Home Program at a Glance	
Health Home Eligibility Criteria	HIV/AIDS and 1 other chronic condition or at risk of another chronic condition
Qualifying Conditions	HIV/AIDS
Enrollment*	188
Designated Providers	AIDS Service Organizations (ASOs)
Administrative/ Service Framework	ASOs, which are specialized HIV/AIDS service providers identified under Wisconsin statute, are the sole health home provider. Health home eligibility is limited to the categorically and medically needy in 4 noncontiguous counties in the state
Required Care Team Members	<ul style="list-style-type: none"> • Primary care physician • Nurse • Case manager • Mental health or substance abuse professional • Dentist • Pharmacist • Other members as deemed necessary or desirable
Payment System	Per member per month (PMPM) care management fee, plus annual flat fee
Payment Level	PMPM: \$102.95; Fee: \$359.00
Health Information Technology (HIT) Requirements	ASO health homes must have an electronic health record (EHR) that is accessible to all care team members, and contains a given patient's treatment plan. Additionally, the state requires the EHRs have the capacity to interface with specialty and inpatient care providers through the state's health information exchange or another mechanism
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

Wisconsin's Section 2703 Health Home State Plan Amendment (SPA) was approved on January 29, 2013, with a retroactive effective date of October 1, 2012. It targets individuals with a single chronic condition--HIV--who have at least one other diagnosed chronic condition or are at risk of developing another. AIDS Service Organizations (ASOs), which are specialized HIV/AIDS service providers identified under Wisconsin statute, are the sole health home provider. In the approved SPA, health home eligibility is limited to the categorically and medically needy in four noncontiguous counties in the state, three of which are served by one ASO: the AIDS Resource Center of Wisconsin (ARCW). Though ARCW provides limited services in the fourth county, primary responsibility for coordinating care in that area lies with a second ASO, the AIDS Network, which is not qualified as a health home. As a result, eligibility for health home enrollment is in practice currently limited to those who are able to enroll with ARCW.

Implementation Context

As of May 2013, there were more than 1.1 million Medicaid beneficiaries in Wisconsin, roughly 730,000 of whom are enrolled in some form of risk-based managed care.¹ In addition to covering low-income residents who are elderly, blind, and disabled (as defined by Supplemental Security Income guidelines), Wisconsin offers coverage to all children, to childless and caretaker adults living at or below 200% of the federal poverty level (FPL), and pregnant women living at 300% of FPL. These various populations are subject to differing benefit and premium structures, depending on eligibility category and income levels.² Under the current governor's proposal for Medicaid reform, however, eligibility for Medicaid will be reduced to 100% of FPL, and current beneficiaries who have incomes above this level will be required to purchase coverage through the new state health insurance marketplace.³ This change has been delayed until April 2014.

HIV/AIDS in Wisconsin

Wisconsin statute requires that all providers in the state, as well as blood and plasma centers, correctional facility clinics, military entrance processing centers, and laboratories submit confidential, name-associated reports of confirmed cases of HIV/AIDS to the Wisconsin Department of Health Services (DHS). As of December 2011, an estimated 8,300 Wisconsin residents were living with HIV/AIDS. More than half of these cases resided in Milwaukee County, and another 12% lived in Dane County (two of the four counties targeted by the state in its health homes SPA).⁴

ASOs are major providers of HIV prevention and treatment services in the state. Under Wisconsin statute, they are defined as "nonprofit corporations or public agencies that provide, or arrange for the provision of, comprehensive services to prevent HIV

infection and comprehensive health and social services for persons who have HIV infection.”⁵ Wisconsin has two designated ASOs, the AIDS Network and ARCW. Each organization is responsible for a service area; the AIDS Network covers 13 counties in the southern part of the state and operates three sites, while ARCW covers the remaining 59 counties and operates nine sites.⁶ Both entities were established in the 1980s and offer a range of medical and social services to their clients, including case management, dental care, mental health screening and referral, and prevention services.

The DHS manages Wisconsin’s HIV/AIDS program, which coordinates and oversees HIV/AIDS prevention, screening, and treatment efforts. The program collaborates with a range of public and private sector agencies and organizations, including local health departments, community-based organizations, academia, and advocacy groups to develop and implement the statewide response to the disease. This response encompasses several initiatives, including regular provider trainings, targeted outreach to groups most affected by the disease, and grant-funded projects such as Linkage to Care, which is a four-year Health Resources and Services Administration Special Project of National Significance grant that seeks to develop innovative ways to improve access to and retention in treatment. As a major insurer of the HIV-positive population in Wisconsin, the state Medicaid program works closely with the HIV/AIDS program on these efforts.

Funding for these activities come from federal, state, and private sector sources. In FY 2011, Wisconsin received more than \$20 million in federal grants to support HIV/AIDS prevention and treatment, \$13 million of which came from Ryan White Program funding alone.⁷ The state also provides a substantial amount of support, with the Medicaid program spending approximately \$30 million annually to cover services for HIV-positive beneficiaries. In addition, the state provides direct support to ASOs through the Michael Johnson Life Care Services and Early Intervention Program. This program, established by the legislature in 1993,⁸ provides more than \$3.5 million annually to support case management and care coordination services offered by ARCW and the AIDS Network. These funds support 40 case managers statewide.⁹

For the last several years, the state has been encouraging the implementation of a medical home model for its HIV/AIDS providers.⁴ State legislation¹⁰ passed in May 2010 allows entities which receive support from the Michael Johnson program and meet certain additional criteria to bill Medicaid for care coordination services. Qualifying criteria are identical to those listed in the Section 2703 Health Homes SPA. ARCW was instrumental in identifying Section 2703 health homes as an opportunity for enhanced funding for care coordination services and in developing the legislation that made the SPA possible. In 2011, the organization received medical home accreditation from the National Committee for Quality Assurance (NCQA), and is currently the sole HIV/AIDS medical home operating in the state.

Implications for the Wisconsin Section 2703 Medicaid Health Homes Evaluation

Wisconsin presents an unusual case for the long-term evaluation, both in terms of the target population and the designated provider. No other state in the health homes evaluation has targeted a single chronic condition or a single provider, which raises questions about comparability to other health home programs. In addition, ARCW has been offering some form of case management and care coordination services for almost 20 years, which will make it difficult to identify a "health home effect." It may be possible to identify a comparison group of HIV-positive beneficiaries served by ARCW or other nonhealth home providers operating outside of the targeted counties. To delineate any health homes effect, it will be critical to establish the baseline structures and processes at ARCW health home sites, and what changes--if any--were made as a result of becoming a health home. It also will be important to consider beneficiaries' time with ARCW before and after health home designation in assessing effects.

Population Criteria and Provider Infrastructure

Wisconsin offers health home services to beneficiaries with HIV who have at least one other chronic condition, or who are at-risk for developing another chronic condition. The at-risk criteria adopted by the state include individuals who, in addition to being diagnosed with HIV/AIDS, meet clinical benchmarks related to CD4 cell counts (a measure of immune system strength), low body weight as measured by conventional Body Mass Index (BMI) criteria, and certain cardiovascular and metabolic risk indicators (see Table 1). Chronic conditions are defined as any condition that has lasted six months, is likely to last at least another six months, or which is likely to recur. Under the approved SPA, health home services may be offered in four counties: Brown, Kenosha, Milwaukee, and Dane, which together contain the state's four largest cities.

The providers designated in the SPA are the two ASOs operating in the state, the AIDS Network and ARCW. These specialized providers offer comprehensive care services to people living with HIV. As previously noted, however, the AIDS Network has not qualified as a health home. Therefore, ARCW--which has primary care coordination responsibility in the remaining three counties and has qualified as a health home--is the *de facto* sole provider of health home services under the SPA as approved. ARCW offers only housing and limited preventive services in Dane County, so only beneficiaries in the remaining three counties currently have access to a health home.

AIDS Resource Center of Wisconsin

ARCW was established in Milwaukee in 1985, and has since expanded to nine cities statewide. ARCW clinic sites in Brown, Kenosha, and Milwaukee counties offer medical, behavioral health, and social services, as well as preventive services such as sexually transmitted infection screening and needle exchange. Dental clinics are also available on-site in Brown and Milwaukee counties, and the Milwaukee site offers

clinical pharmacy services through its on-site pharmacy. Services not provided directly at a given clinic location are referred to other providers in the community. Given ARCW's high level of service co-location, patient referrals are low--1.2 referrals per patient per year on average¹¹--and are typically for specialty medical and behavioral health services such as OB/GYN or crisis stabilization services. The care team designated in the SPA must include a primary care physician, nurse, case manager, mental health or substance abuse professional, dentist, and pharmacist. Optional care team members may include outreach workers, peer specialists, dieticians, or other community care representatives. Each care team must have an identified care coordinator, as well as a leader who is responsible for ensuring communication and coordination both among team members and with the health home patient. The team leader and care coordinator can be the same individual.

Health home members who do not have a mental health diagnosis are routinely screened for depression and substance abuse, and the state will provide technical assistance to support additional efforts to integrate primary and behavioral health care, including training on Screening, Brief Intervention, and Referral to Treatment protocols, designed to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Enrollment

Eligible beneficiaries are auto-enrolled into the health home program, after which time ARCW is responsible for contacting the beneficiary to inform them of the benefits of enrollment and offer them the opportunity to disenroll. By agreeing to participate in the initial assessment and care planning process, the beneficiary consents to enrollment. Those who are enrolled in managed care may not be simultaneously enrolled in a health home because of concerns about duplication of services. As of June 2013, ARCW had 521 potentially eligible clients; of these, 142 were enrolled in the health home program, while 209 were in managed care. As of January 2014, there were 188 health home enrollees. Contacts with the remaining eligible clients are ongoing.¹¹

Service Definitions and Provider Standards

Full-service definitions are reproduced in Table 2. Aside from care coordination--which is the responsibility of the team lead--services are not explicitly assigned to a particular provider within the care team.

The SPA lists three broad standards for qualifying ASOs:

1. That it be located in a setting that integrates medical, behavioral, pharmacy, and dental care.

2. That it agree to meet the 11 health home functions outlined in State Medicaid Director's Letter #10-024, "Health Homes for Enrollees with Chronic Conditions."¹²
3. That it be accredited as a medical home by a nationally recognized certification program, or that it meet a range of standards which align closely with those established by NCQA for its medical home accreditation process.

Requirements also include having written standards for patient access and communication, using electronic charting tools to organize clinical information, and establishing systematic processes for tracking test results, referrals, and performance against quality measures.

Use of Health Information Technology

ASO health homes must have an electronic health record (EHR) that is accessible to all care team members, and contains a given patient's treatment plan. This treatment plan must be updated regularly by the team lead/care coordinator to reflect patient education interventions, transitional care needs, referrals and follow-up, and any support services provided. The state requires that providers adopt EHRs that have the capacity to interface with specialty and inpatient care providers, but it is unclear from the SPA whether there is a defined timeline for adoption or whether this interface will take place through the state's health information exchange (HIE) or another mechanism. The state HIE is still under development, but current plans call for a decentralized, or federated exchange model, whereby patient information can be retrieved and assembled from the EHR of participating providers.¹³

The provider standards outlined in the SPA also stipulate that ASOs use data to demonstrate that they meet requirements related to patient access and communication, identify diagnoses and conditions among their patient panel, and measure and report on provider performance.

Payment Structure

Wisconsin is using two payment methodologies: a per person per month (PMPM) case rate paid to the ASO for providing at least one health home service per month, and a flat fee that covers the initial assessment and development of a care plan for each new enrollee. This latter service can be billed once a year if the care needs of the health home member require another comprehensive assessment and care plan review. Current rates are \$102.95 for the PMPM, and \$359.37 for initial assessment and care plan development.¹⁴

Quality Improvement Goals and Measures

The SPA lists two goals: (1) reduce the risk of complicating opportunistic infections and improve health outcomes; and (2) ensure integration of oral and medical health care for HIV patients. Table 3 lists the corresponding measures used to measure progress against these goals.

Evaluation Measures and Methods

The evaluation measures and methodology described in the SPA are reproduced in Table 4. Most of the data used for evaluation purposes will come from claims and will be reported quarterly. Providers also will submit semi-annual reports on a variety of indicators not detailed in the SPA, and health home members will also be surveyed, both formally and informally. The frequency or methodology employed for these surveys is not reported in the SPA. Though the state will review and monitor the program, it does not plan to conduct a formal evaluation.

TABLE 1. Target Population and Designated Providers--Wisconsin	
SPA Approval (Effective Date)	January 29, 2013 (October 1, 2012)
Designated Provider(s)	ASOs operating in Brown, Kenosha, Milwaukee, and Dane counties. ARCW is the sole provider in those counties.
Health Home Team Composition	<ul style="list-style-type: none"> • Primary care physician • Nurse • Case manager • Mental health or substance abuse professional • Dentist • Pharmacist • Other members as deemed necessary or desirable
Target Population	<p>Beneficiaries diagnosed with HIV who have a chronic condition or are at risk of developing another. "At-risk" individuals are defined as meeting 1 of the following criteria:</p> <ul style="list-style-type: none"> • CD4 cell count of less than 200 cells/μL or CD4 cells accounting for fewer than 14% of all lymphocytes • BMI lower than 18.5 • Fasting plasma blood sugar of 100-125 mg/dL or HbA1c 5.7-6.4% • Systolic pressure between 120-139 mm/Hg; diastolic pressure between 80-89 mm/Hg • Cholesterol greater than 200 mg/dL • HDL levels <40 mg/dL for men and <50mg/dL for women • LDL levels >130 mg/dL
Qualifying Chronic Conditions	In addition to HIV, any condition which is present for at least 6 months and expected either to reoccur or last at least another 6 months

TABLE 2. Health Home Service Definitions--Wisconsin	
Care Coordination	Ongoing management of the patient's medical, behavioral, pharmacological, dental, and community care needs by a designated team lead. The team lead will ensure that the patient has a current, written, person-centered, multidisciplinary care and treatment plan that addresses all aspects of the patient's care (including preventive care needs, all medical sub-specialties, institutional care, home and community care).
Comprehensive Care Management	The use of evidence-based guidelines to provide systematic, responsive and coordinated management of all aspects of primary and specialty care (physical and behavioral needs) for individuals with HIV, including the early identification of individuals who meet the criteria for health home enrollment.
Health Promotion	All activities aimed at prevention, assisting the patient in better understanding their disease, and learning how to direct the care and treatment they receive. This includes enhanced patient education and active promotion of self-management and self-care.
Comprehensive Transitional Care	Includes establishment of an automatic referral arrangement between institutional care providers and the health home provider to ensure that there is immediate communication and/or referrals of HIV patients who are admitted or are seen in the emergency department. Automatic referrals include the establishment of policies and procedures to ensure that there is systematic and timely sharing of information related to the patient's institutional or emergency department care. Transitional care will include timely face-to-face or telephone contacts with the patient (or the patient's authorized representative) following emergency department visit or institutional discharge, a review of the discharge summary with the patient, and support in receiving the recommended care, including scheduling follow-up appointments and filling prescriptions.
Individual and Family Support Services	Includes activities related to advocating on the member's behalf and mobilizing services and support for the member. It will include contacts with anyone identified as instrumental to the member's day-to-day support and care, including peer-to-peer information sharing and support. Information must be communicated in a manner that is simple, clear, straightforward and culturally appropriate.
Referral to Community and Social Supports	Includes activities related to providing assistance to members to ensure they have access to social support services identified in the care plan. To the extent feasible, the health home provider will establish meaningful working relationships with community-based organizations that provide services to individuals with HIV infection.

TABLE 3. Health Home Goals and Quality Measures--Wisconsin	
Reduce the Risk of Complicating Opportunistic Infections and Improve Health Outcomes	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> • Percentage of health home patients with a CD4 count \leq350 cells per microliter who initiate antiretroviral therapy • Percentage of health patients with an undetectable viral load within 6 months of anti-retroviral therapy initiation
Ensure Integration of Oral and Medical Health Care for HIV Patients	<u>Quality of care measures:</u> <ul style="list-style-type: none"> • Percentage of HIV+ oral health patients aged 1+ years who had a dental and medical health history (initial or updated) at least once in the measurement year

TABLE 4. Evaluation Methodology--Wisconsin	
Hospital Admission Rates	The state will use claims data for fee-for-service claims paid on behalf of members enrolled in the health home. The state will compare admission rates for the health home participants to the rates of members with HIV who are not participating. Additionally, the state will use pre-implementation (baseline) data to compare to post-implementation rates.
Chronic Disease Management	The state will use claims data (e.g., office visits, lab testing, pharmacy, emergency department visits) to monitor chronic disease management. In addition, providers will be required to submit semi-annual reports responding to a series of identified indicators (for example, the number of face-to-face visits between the member and the care coordinator and the number of patients who received self-management counseling and support).
Coordination of Care for Individuals with Chronic Conditions	The state will use claims data to determine the amount of care coordination provided. The state will monitor data reports and survey results from health home providers to further determine the level and frequency of coordination activities.
Assessment of Program Implementation	The state Medicaid and Public Health (HIV) Divisions will collaborate on the assessment of program implementation. Assessment activities are to be determined but could include joint health home visits and reviews of reports and data.
Processes and Lessons Learned	The state Medicaid and Public Health (HIV) Divisions will collaborate on the review of the processes established by the health homes. The state will work in partnership with health home providers to identify aspects of the health home implementation that work and those that need modification. A significant portion of this activity will rely on the outcome of member surveys (both formal and informal).
Assessment of Quality Improvements and Clinical Outcomes	The state Medicaid and Public Health (HIV) Divisions will use the clinical outcome measures described above to assess quality improvements and gains/setbacks in clinical outcomes within the health homes.
Estimates of Cost Savings	On an annual basis, the state will analyze the cost of providing care to beneficiaries within and outside of the health home. Analyses of the level of utilization for routine care versus emergency care (inpatient hospital, emergency department and ambulance transportation) are contemplated, but details were not specified in the SPA.

Endnotes

1. Wisconsin ForwardHealth Portal website. "Monthly Enrollment by MCO." Available from: <https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage>. Accessed June 7, 2013.
2. Wisconsin Department of Health Services website. "BadgerCare Plus: Common Questions." Available from: <http://www.dhs.wisconsin.gov/badgercareplus/faq.htm>. Accessed June 10, 2013.
3. Wisconsin Department of Health Services website. "Joint Committee on Finance Testimony of Secretary-Elect Kitty Rhoades Department of Health Services March 20, 2013." Available from: <http://www.dhs.wisconsin.gov/aboutdhs/initiatives/budget/KR32013.pdf>. Accessed June 8, 2013.
4. Wisconsin HIV/AIDS Community Planning Network. "Wisconsin HIV/AIDS Strategy: 2012-2015." September 2012. Available from: <http://wihiv.wisc.edu/communityplanning/libraryDownload.asp?docid=753>.
5. "Wisconsin Statute 252.12(1)(b)." Available from: <http://docs.legis.wisconsin.gov/statutes/statutes/252/12/1/b>.
6. A map of their respective sites are available from: <http://www.aidsnetwork.org/assets/Uploads/map.pdf> and <http://www.arcw.org/locations/>.
7. Kaiser Family Foundation website. "State Health Facts: Total Federal HIV/AIDS Grant Funding, FY2011." Available from: <http://kff.org/hivaids/state-indicator/total-federal-grant-funding/>. Accessed June 10, 2013.
8. "Wisconsin Statute 252.12(2)(a)8." Available from: <http://docs.legis.wisconsin.gov/statutes/statutes/252/12/2/a/1>.
9. Wisconsin Department of Health Services website. "Life Care Services and Early Intervention." Available from: http://www.dhs.wisconsin.gov/aids-hiv/resources/overviews/AIDS_life_care.htm.
10. "2009 Wisconsin Act 221." May 2010. Available from: <http://docs.legis.wisconsin.gov/2009/related/acts/221.pdf>.
11. Personal communication with ARCW staff members. June 4, 2013.
12. Centers for Medicare and Medicaid Services. "Health Homes for Enrollees with Chronic Conditions." State Medicaid Director Letter #10-024, November 16, 2010. Available from: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.
13. Wisconsin Statewide Health Information Network website. "FAQ on WISHIN and HIE." Available from:

<http://www.wishin.org/ResourceCenter/FAQLibrary/FAQonWISHINHIE.aspx>. Accessed June 10, 2013.

14. Personal communication with Wisconsin DHS staff. June 3, 2013.

This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report “***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***”. The full report is available at: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm>.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)

Executive Summary: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm>
HTML: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm>
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