DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 27 2012

Mr. Brett Davis
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street
P.O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

This letter responds to your request to amend Wisconsin's section 1115 Demonstrations, entitled "BadgerCare" (Project #11-W-00125/5) and "BadgerCare Plus for Childless Adults" (Project 11-W-00242/5), to limit Medicaid eligibility for certain non-pregnant, nondisabled adults with incomes above 133 percent of the Federal poverty level (FPL). The Centers for Medicare & Medicaid Services (CMS) is approving Wisconsin's request to apply more restrictive eligibility standards consistent with section 1902(gg)(3) of the Social Security Act, which specifies that the maintenance of effort provision shall not apply to non-pregnant, nondisabled adults with incomes above 133 percent of the FPL if a State has certified to CMS that it has a budget deficit. On January 20, 2012, CMS acknowledged Wisconsin's budget deficit certification for State fiscal years 2012 and 2013. This certification grants the State a time-limited non-application of the maintenance of effort provision, and expires on June 30, 2013. Accordingly, CMS is granting your request to amend Wisconsin's BadgerCare and BadgerCare Plus for Childless Adults section 1115 Demonstrations effective July 1, 2012, through June 30, 2013.

The amended Demonstrations will provide new authorities enabling the State to implement the following changes as applied to both parent/caretaker relatives covered through the BadgerCare Demonstration, including those eligible for Medicaid under Transitional Medical Assistance (TMA), and childless adults with income above 133 percent of the FPL covered through the BadgerCare Plus for Childless Adults Demonstration:

- A sliding scale monthly premium for the affected non-pregnant, nondisabled adult population ranging from 3 percent for adults with income at 134 percent of the FPL up to 9.5 percent for those with income exceeding 300 percent of the FPL; and
- A 12-month eligibility restriction on re-enrollment under the Medicaid State plan or Demonstration for adults who fail to make a premium payment.

Under the amended BadgerCare Demonstration, the State will have the authority to apply a 9.5 percent affordability test with respect to employer sponsored insurance that meets minimum benefit standards. This authority, however, will not apply to those parent and caretaker relatives that are eligible for TMA. Finally, the amended BadgerCare Demonstration expands the State's current authority to waive retroactive eligibility to parent and caretaker relatives with income between 134 and 150 percent of the FPL, as well as to those eligible for TMA.

Under the BadgerCare Plus for Childless Adults Demonstration, as amended, coverage will continue to be provided to some childless adults who would not otherwise receive coverage under the State plan. The Demonstrations will test the use of measures in Medicaid to prevent the substitution of public coverage for affordable private coverage. The State has maintained that the use of the 9.5 percent affordability test (specifically applied under the BadgerCare Demonstration) and the sliding scale premiums enforced through the use of a 12-month restriction on re-enrollment are both necessary to ensure maximum coverage for this population given the State's certified budget deficit. These policies will enable the State to test the effects on enrollment, utilization, and health outcomes of imposing an affordability test relative to the availability of employer sponsored insurance and a sliding scale premium for nondisabled, non-pregnant adults whose incomes will, in 2014, make them potentially eligible to purchase insurance with a premium tax credit on the Affordable Insurance Exchange.

The CMS approval of the BadgerCare and BadgerCare Plus for Childless Adults Demonstrations amendments is conditioned upon continued compliance with the enclosed set of both Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. The award is subject to our receiving your written acknowledgement of the award and acceptance of both sets of STCs within 30 days of the date of this letter.

Additionally, the State must, by May 31, 2012, complete the required steps to validate budget neutrality for the BadgerCare Plus for Childless Adults Demonstration as outlined in the Demonstration's STCs. If these conditions are not met, CMS will withhold Federal match for administrative costs attributable to the Demonstration.

A copy of the revised BadgerCare STCs and waiver authorities is enclosed, as well as the revised BadgerCare Plus for Childless Adults STCs and expenditure authorities.

Your project officer is Ms. Jessica Schubel, and she is available to answer any questions concerning your section 1115 demonstration. Ms. Schubel's contact information is as follows:

Jessica L. Schubel, MPH
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882

E-mail: jessica.schubel@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Schubel and to Ms. Verlon Johnson, Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Ms. Johnson's contact information is as follows:

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

If you have additional questions, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

Marilyn Tavenner
Acting Administrator

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00125/5**

TITLE: **Wisconsin BadgerCare**

AWARDEE: **Wisconsin Department of Health Services**

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the affected population, as described for the Demonstration project from the approval date through June 30, 2013 in the event the State does not certify, prior to April 1, 2013, that the State projects a budget deficit for State fiscal year 2014.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Wisconsin to implement the Wisconsin BadgerCare Medicaid section 1115 Demonstration. The populations affected by these waivers include:

1. Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act, who are non-pregnant, non-disabled, and whose countable family income is above 133 percent of the of the FPL; and

2. Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1902(a)(10)(A)(ii)(I) of the Act, who are non-pregnant, non-disabled, and whose countable family income is above 133 percent of the FPL, up to and including 200 percent of the FPL.

1. Provision of Medical Assistance **Section 1902 (a)(8)**
Eligibility **Section 1902(a)(10)**

To enable the State to prevent substitution of public coverage for private coverage by not providing medical assistance for individuals in Population 2 who initially apply for Medicaid after July 1, 2012, whose eligibility is being redetermined in an annual review after July 1, 2012, or who are enrolled in Medicaid and obtain new employment after July 1, 2012, in the following two circumstances:

a) When the individual has, or had, access to employer-sponsored major medical health insurance (individual or family) in which the monthly premium that would be paid by the individual does not exceed 9.5 percent of household income (for self-only coverage) during the most recent open or special enrollment period within the previous 12 months, except when the individual, during that time period:

   i. Lost health insurance coverage due to loss of employment;

ii. Lost health insurance coverage due to discontinuation of health benefits to all employees by the client's employer; or

iii. Had one or more members of the individual's family, during the open or special enrollment period, covered through:

1. A private health insurance policy; or
2. Medicaid, or CHIP, unless the eligible individual had a family income at or above 133 percent of the FPL.

b) When the individual has, or had, coverage through insurance as described in subparagraph (a) in the 3 months prior to application except when the individual, during the 3 months prior to their application, lost health insurance coverage due to:

i. Loss of employment, other than a voluntary termination;

ii. Loss of employment due to the employee's incapacitation;

iii. Change in employment in which the new employer does not offer coverage;

iv. End of coverage due to death, divorce, age or reduced (involuntary) hours of employment; and

v. Discontinuation of health benefits to all employees by the client's employer.

To enable the State to enforce premium payment requirements under the Demonstration by not providing medical assistance for individuals in the affected populations (both populations 1 and 2) who have been disenrolled from coverage under the State plan, or from under a demonstration, within the prior 12-month period as a result of not paying the required monthly premium.

3. Premiums **Section 1902(a)(14) insofar as it incorporates section 1916**

To permit the State to impose monthly premiums based on household income on individuals in the affected populations.

4. Eligibility Standards and Methods **Section 1902(a)(17)**

To permit the State to apply eligibility standards and methods that vary from those otherwise applicable under the State plan by enabling the State to consider access to, or coverage under, major medical health insurance (individual or family) through an employer in which the monthly premium paid by the individual does not exceed 9.5 percent of household income

(for self-only coverage) for Population 2 who apply for, obtain new employment or whose eligibility is subject to annual redetermination, after July 1, 2012, and who are otherwise eligible for such benefits under the approved State plan.

5. Retroactive Eligibility **Section 1902(a)(34)**

To enable the State to not provide retroactive eligibility for the affected populations.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00125/5**

TITLE: **Wisconsin Medicaid Section 1115 Health Care Reform Demonstration (BadgerCare)**

AWARDEE: **Wisconsin Department of Health Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Wisconsin's BadgerCare section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Wisconsin Department of Health Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, extent of Federal involvement in the Demonstration, and the State's obligations to CMS during the life of the Demonstration. The STCs are effective starting July 1, 2012, unless otherwise specified. All previously approved STCs and Waivers are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2013; however, the State's authority to implement the 9.5 percent affordability test, the sliding scale premiums and the 12-month restrictive re-enrollment period as applied to the affected populations described in STC 16 will expire on June 30, 2013, in the event the State does not certify, prior to April 1, 2013, that the State projects a budget deficit for State fiscal year 2014.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Description and Objectives;
III. General Program Requirements;
IV. Eligibility;
V. Benefits;
VI. Cost Sharing;
VII. Delivery System;
VIII. General Reporting Requirements;
IX. General Financial Requirements under Title XIX;
X. Evaluation of the Demonstration; and
XI. Schedule of State Deliverables During the Demonstration.

II. PROGRAM DESCRIPTION AND OBJECTIVES

BadgerCare was created in April 1999 as a health insurance program for low-income working families with children. BadgerCare is intended to provide health care coverage to families whose incomes are too high for Medicaid and who do not have access to affordable health insurance. By extending health care coverage to uninsured low-income families, BadgerCare originally sought to provide a safeguard against increasing the number of uninsured families and

children as a result of Wisconsin's welfare reform program. BadgerCare was designed to bridge the gap between low-income Medicaid coverage and employer-provided health care coverage. BadgerCare will continue its primary objective by serving as the link between the current Medicaid system for low-income families with children and the BadgerCare Plus and Federal health care subsidy programs provided under the Patient Protection and Affordable Care Act of 2010. The Demonstration will also enable the State to maintain existing benefits for other State plan populations.

In the State's September 28, 2010, extension request, it indicated that its primary need for the Demonstration's extension was to continue current State Medicaid eligibility policies for the population of non-pregnant parents and caretaker relatives with family income at 150 percent up to and including 200 percent of the Federal poverty level (FPL). As part of Wisconsin's November 10, 2011, amendment request, it has expanded the hypotheses that it intends to test with the BadgerCare Demonstration. Specifically, the Demonstration will enable the State to test the effects of increasing premiums on enrollment, utilization, and health outcomes on the non-pregnant, non-disabled parent/caretaker relative population by permitting a restrictive re-enrollment policy, sliding scale premiums in excess of 5 percent of household income, and the application of the 9.5 percent affordability test in advance of 2014.

In order to evaluate these hypotheses, as part of the Demonstration, the State will review statistics on disenrollment for nonpayment of premiums, utilization and cost data, and quality measures related to the parents/caretaker relatives enrolled under the Demonstration as specified in paragraph 32.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.** If mandated changes in the Federal law require State legislation, the changes must take

effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under Federal law.

5. **State Plan Amendments.** The State will not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and Federal financial participation (FFP) will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a) An explanation of the public process used by the State, consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

    b) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    c) If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

    As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met.

b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

d) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and results of this testing.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its Web site the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment it has received, the State's response to the comment, and how the State incorporated the received comment into the revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the State must ensure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR 431.230. In addition, the State must conduct either an ex parte review or administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate, subject to adequate public notice, the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved Medicaid State plan, when any program

changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR 431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal and/or extension of this Demonstration (42 CFR 431.408(b)(3)).

The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY

16. **Affected Populations**.

a) The Medicaid State plan populations included in this Demonstration consist of:

i. Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act, who are non-pregnant, non-disabled, and whose countable family income is above 133 percent of the of the FPL; and

ii. Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1902(a)(10)(A)(ii)(I) of the Act, who are non-pregnant, non-disabled, and whose countable family income is above 133 percent of the FPL, up to and including 200 percent of the FPL.

b) Under this demonstration, the State may exclude from enrollment for medical assistance, for a period of 12 months, individuals in the affected population as described in subparagraph (a)(ii) above, who either apply for Medicaid after July 1, 2012, whose eligibility is being re-determined in an annual review after July 1, 2012, or who obtain new employment after July 1, 2012,and who:

i. Have, or had, access to employer-sponsored major medical health insurance (individual or family) in which the monthly premium that would be paid by the individual does not exceed 9.5 percent of household income (for self-only coverage) during the most recent open or special enrollment period

within the previous 12 months, except when the individual, during that time period:

1) Lost health insurance coverage due to loss of employment;

2) Lost health insurance coverage due to discontinuation of health benefits to all employees by the client's employer; or

3) Had one or more members of the individual's family, during the open enrollment period, covered through:

a. A private health insurance policy; or

b. Medicaid, or CHIP, unless the eligible individual had a family income at or above 133 percent of the FPL.

ii. Have, or had, coverage through insurance as described in subparagraph (i) in the 3 months prior to application except when the individual, during the 3 months prior to his/her application, lost health insurance coverage due to:

1) Loss of employment, other than a voluntary termination;

2) Loss of employment due to the employee's incapacitation;

3) Change in employment in which the new employer does not offer coverage;

4) End of coverage due to death, divorce, age, or reduced (involuntary) hours of employment; and

5) Discontinuation of health benefits to all employees by the client's employer.

c) The State may exclude from enrollment for medical assistance, for a period of 12 months, individuals in the affected populations as described in subparagraph (a) above (both populations (i) and (ii)) who have been disenrolled from coverage under the State plan or from under a demonstration within the prior 12-month period as a result of not paying the required monthly premium.

V. BENEFITS

17. The affected populations will receive all available Medicaid State plan benefits to which they are allowed.

VI. COST SHARING

18. **Premiums.** The affected populations will be subject to monthly premiums based on the

sliding scale as outlined below. Pre-payment of the first month's premium payment is required at time of enrollment. Demonstration participants are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled. Demonstration participants who fail to make a premium payment will be prohibited from re-enrolling into the Medicaid program for a period of 12 months.

Monthly Premium Amount based on FPL

FPL %	Monthly Premium Amount as a Percentage of Income
134 - 139%	3.0%
140 - 149%	3.5%
150 - 159%	4.0%
160 - 169%	4.5%
170 - 179%	4.9%
180 - 189%	5.4%
190 - 199%	5.8%
200 - 209%	6.3%
210 - 219%	6.7%
220 - 229%	7.0%
230 - 239%	7.4%
240 - 249%	7.7%
250 - 259%	8.1%
260 - 269%	8.3%
270 - 279%	8.6%
280 - 289%	8.9%
290-299%	9.2%
300% and above	9.5%

** Calculated at 300 percent of the FPL –the monthly premium cannot exceed 9.5 percent of household income for individuals with income above 300 percent of the FPL.

a) The following individuals are exempt from the premium amounts outlined above:
   i. American Indians exempt under section 1916(j) of the Act;
   ii. Pregnant women;
   iii. Parents and caretakers who are blind or disabled individuals; and
   iv. BadgerCare Plus enrollees up to age 21 who, on his or her 18th birthday, were in foster care under the State's responsibility.

b) The State will monitor and include in the quarterly report information related to disenrollments from the BadgerCare demonstration including nonpayment of premiums.

19. **Copayments**. Individuals participating in the Demonstration will be subject to copayments as specified in the Medicaid State plan.

VII. DELIVERY SYSTEMS

20. Services will be furnished primarily through the Wisconsin Medicaid managed care delivery system.

VIII. GENERAL REPORTING REQUIREMENTS

21. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX outlined in Section IX.

22. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et seq., unless expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

23. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, managed care organization (MCO) operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, family planning issues, the benefit package, audits, lawsuits, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

24. **Quarterly Progress Reports.** The State must submit progress reports in the format outlined below no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to (Attachment A – Quarterly Report Guidelines):

    a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;

    b) Action plans for addressing any policy, administrative, or budget issues identified;

    c) Quarterly enrollment reports will be provided to CMS for the affected population, including member months;

    d) Evaluation activities and interim findings; and

    e) The State must report Demonstration program enrollment on a quarterly basis using the quarterly report format in Attachment A.

    Quarterly report for the quarter ending September 30 is due **November 30.**
    Quarterly report for the quarter ending December 31 is due **February 28.**

Quarterly report for the quarter ending March 31 is due **May 31.**
Quarterly report for the quarter ending June 30 is due **August 31.**

25. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy, and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

26. **Transition Plan**. On or before July 1, 2012, the State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals affected by the Demonstration, including how the State plans to coordinate any transition of these individuals to alternate coverage options available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in sub-paragraphs a) through c) below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a) **Seamless Transitions**. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to coordinate any transition of individuals affected by the Demonstration to an alternate coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible.

    b) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

    c) **Implementation.**

        i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning the affected population to either Medicaid, the Exchange, or other coverage options in 2014. Individuals receiving continued coverage under the State plan will not be required to submit a new application.

        ii. On or before December 31, 2013, the State must provide notice to the affected population of any transition requirements using procedures that minimize demands on the affected population.

27. **Final Evaluation Report.** The State shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

28. **Reporting Expenditures.** The State must report quarterly expenditures associated with the affected populations under this Demonstration on the CMS-64 report.

29. **Standard Medicaid Funding Process.** The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

    c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration, and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

30. **Extent of Federal Financial Participation for the Demonstration.** CMS will provide FFP at the applicable Federal matching rate for the following:

    a) Administrative costs;

    b) Net expenditures of the Medicaid program and prior period adjustments which are paid in accordance with the approved State Plan (including disproportionate share hospital payments); and

    c) Net medical assistance expenditures made under section 1115 waiver authority, including those made in conjunction with the BadgerCare Demonstration.

31. **State Certification of Funding Conditions**. The State certifies that the following conditions for non-Federal share of Medicaid expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

X. EVALUATION OF THE DEMONSTRATION

32. **State Must Evaluate Components of the Demonstration.** As outlined below, the evaluation describes whether the State met the Demonstration goal and objectives with recommendations for future efforts. The State must submit to CMS for approval a revised evaluation design no later than July 1, 2012. At a minimum, the revised draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. Specifically, the evaluation must test the following specific hypotheses related to the affordability test, premiums, and 12-month restrictive re-enrollment period imposed on the affected population:

1. Is there any impact on utilization and/or costs associated with individuals who were disenrolled, but re-enrolled after the 12-month restrictive re-enrollment period?
2. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?
3. What impact does the 12-month waiting period for failure to make a premium payment have on the payment of premiums and on enrollment? Does this impact vary by income level (if so, include a break out by income level)?
4. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?
5. How is enrollment or access to care affected by the application of new, or increased, premium amounts?
6. Are there discernable characteristics with respect to individuals and/or the policies that are available to them, who have been determined to have affordable coverage, e.g., part-time/full-time, large/small employer, etc.?

Methods by which the State can evaluate these hypotheses include enrollment data, premium statistics, utilization and cost data associated with this population compared to the parent/caretaker population outside of the Demonstration, as well as the Demonstration's population prior to July 1, 2012. In addition, the State must also evaluate the number of individuals who have met the affordability test, and if possible, include the margin by which they have met the test. For example, indicate whether the individual's monthly contribution was between 0 – 2 percent, 3 – 5 percent, 6 – 9.5 percent.

The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from the other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

33. **Renewal and Final Evaluation Plans and Evaluation Reports.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 32, within 60 days of receipt of CMS comments. The State must implement the approved evaluation design and report on its progress on each of the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration and/or with each Demonstration renewal request. CMS will provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

34. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate with CMS or the

independent evaluator selected by CMS. The State will submit the required data to CMS and/or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

Date	**Deliverable**
July 1, 2012	Revised Evaluation Design, paragraph 32
July 1, 2012	Transition Plan, paragraph 26
Quarterly	**Deliverables**
	Requirements for Quarterly Report, paragraph 24
	Enrollment Reports, paragraph 24(c)
Annual	**Deliverables**
	Submit Draft Annual Reports, paragraph 25

Attachment A - Quarterly Report Guidelines

As written in STC paragraph 24, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. An electronic copy of the report narrative is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – Wisconsin Department of Health Services, Wisconsin BadgerCare

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 12 (7/01/10 - 6/30/11)
Federal Fiscal Quarter: 4/2009 (7/09 - 9/09)

INTRODUCTION:

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

ENROLLMENT INFORMATION:

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0."

Note: Enrollment counts should be person counts, not participant months.

Population Groups (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in Current Quarter**	**No. Involuntary Disenrolled in Current Quarter**
Population 1 – Parent/Caretakers			

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:

Reasons for Involuntary Disenrollments:

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial Developments/Issues:

Identify all significant developments/issues/problems with financial accounting and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS: